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, numeric, or alphanumeric symbol used to identify a specific health care service, place of service, or diagnosis as follows:

A. "Billing code" means a procedure code as defined in item F plus any applicable modifiers as defined in subpart 10a. A billing code is used to identify a specific health care service, article, or supply for billing purposes.

B. "CPT code" means a numeric code included in the Current Procedural Terminology Coding System manual, incorporated by reference in part 5221.0405, item D. A CPT code is used to identify a specific medical service, article, or supply.

C. "HCPCS code" means a numeric or alphanumeric code included in the United States Health Care Financing Administration's Common Procedure Coding System. An HCPCS code is used to identify a specific medical service, article, or supply. HCPCS level I codes are the numeric CPT codes listed in the CPT manual, incorporated by reference in part 5221.0405, item D. HCPCS level II codes are alphanumeric codes created for national use. HCPCS level III codes are alphanumeric codes created for statewide use. HCPCS level II and level III codes are listed in the HCPCS manual, incorporated by reference in part 5221.0405, item E.

D. "ICD–9–CM code" means a numeric code included in the International Classification of Diseases, Clinical Modification manual, incorporated by reference in part 5221.0405, item A. An ICD–9–CM code is used to identify a particular medical or chiropractic diagnosis.

E. "Place of service code" means the code used to identify the type of facility and classification of service as inpatient or outpatient service on the HCFA 1500 claim form or the Uniform Billing Claim Form (UB–92 HCFA 1450), incorporated by reference in part 5221.0405, items B and C.

F. "Procedure code" means a numeric or alphanumeric code used to identify a particular health care service. Procedure codes used in this chapter include CPT codes, HCPCS codes, chiropractic procedure codes, and prescription numbers.

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. 6a. **Conversion factor.** "Conversion factor" means the dollar value of the maximum fee payable for one relative value unit of a compensable health care service delivered under Minnesota Statutes, chapter 176.

Subp. 6b. **Division.** "Division" means the Workers' Compensation Division of the Department of Labor and Industry.

Subp. 7. [Repealed, 18 SR 1472]

Subp. 8. [Repealed, 18 SR 1472]

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 5221.4000 to 5221.4070.

Subp. 10a. **Modifier.** "Modifier" means a two–digit number or two–letter symbol that is added to a procedure code to indicate that the service rendered differs in some material respect from the service as described in this chapter or in the CPT or HCPCS manual in effect on the date the service was rendered. Only those modifiers listed and described in the CPT manual in effect on the date the service was rendered may be used. Applicable modifiers must be used with a procedure code, even if the modifier has no effect on the payment level.

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

Subp. 11a. **Physician.** "Physician" means a person who is authorized by law to practice the medical profession within the United States, is in good standing in the profession, and

includes only those persons holding the degree D.O. (Doctor of Osteopathy) or M.D. (Doctor of Medicine), as defined in Minnesota Statutes, sections 176.011, subdivision 17, and 176.135, subdivision 2a.

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

Subp. 13. [Repealed, 18 SR 1472]

Subp. 14. [Repealed, 18 SR 1472]

Subp. 14a. **Relative value unit.** "Relative value unit" means the numeric value assigned to a health care service or procedure to represent or quantify its worth, as compared to a standard service.

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 15 SR 124; 18 SR 1472*

5221.0200 AUTHORITY.

This chapter is adopted under the authority of Minnesota Statutes, sections 175.171; 176.101, subdivision 3e; 176.135, subdivisions 2 and 7; 176.136; 176.231; and 176.83.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

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 the payer's maximum liability for medical services, articles, and supplies. This chapter also governs health care provider communication with parties; required reporting of medical, disability, and billing information under Minnesota Statutes, chapter 176; change of health care provider; and criteria for determining, serving, and filing maximum medical improvement.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

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; providers of medical services or supplies for compensable injuries under Minnesota Statutes, section 176.135, subdivision 1; and employees as defined in Minnesota Statutes, section 176.011, subdivision 9. This chapter shall be applied in all relevant determinations made by compensation judges at the department and the Office of Administrative Hearings, and by the commissioner.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 2545*

5221.0405 INCORPORATIONS BY REFERENCE.

The following documents are incorporated by reference to the extent cited in this chapter.

A. The International Classification of Diseases, Clinical Modification, 9th revision, 1991 (ICD–9–CM). It is subject to frequent change. It is published by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

B. The Federal Health Care Financing Administration claim form (HCFA–1500)(U2)(12–90). It is not subject to frequent change. It is developed by the United

States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

C. The Uniform Billing Claim form (UB–92, HCFA–1450) developed by the National Uniform Billing Committee. The federal Health Care Financing Administration determines the standards for printing this form. It is not subject to frequent change. It may be purchased from local commercial business office supply stores after April 1993. The form will be required by the federal Medicare program as of October 1993. It is available through the Minitex interlibrary loan system.

D. The Physician's Current Procedural Terminology, (CPT manual) 4th edition, 1993, and any subsequent revisions. It is subject to frequent change. It is published by and may be purchased from the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610. It is available through the Minitex interlibrary loan system.

E. The alphanumeric HCFA Common Procedural Coding System (HCPCS manual), January 1993 edition, and any subsequent revisions. It is subject to frequent change. It is published by the HCPCS subcommittee of Minnesota under the authority of the federal Health Care Financing Administration and may be obtained from the Minnesota Department of Human Services, Claims Processing Section, 444 Lafayette Road, Saint Paul, Minnesota 55155–3849. It is available through the Minitex interlibrary loan system.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530*

5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.

Subpart 1. **Scope.** This part prescribes information the health care provider is required to submit to the employer, insurer, or commissioner. This part does not preclude any party or the commissioner from requesting supplementary reports from the health care provider under Minnesota Statutes, section 176.231, subdivision 4.

Subp. 2. **Health care provider report.** Within ten days of receipt of a request for information on the prescribed health care provider report form from an employer, insurer, or the commissioner, a health care provider must respond on the report form or in a narrative report that contains the same information requested on the form.

The health care provider's report form prescribed by the commissioner must include the information required by items A to M. However, parties may also continue to use the maximum medical improvement and the physician's report forms prescribed by part 5220.2590 until January 1, 1994:

A. information identifying the employee and employer, and insurer, if known;

B. date of first examination for this injury or disease by the health care provider;

C. diagnosis and appropriate ICD–9–CM diagnostic codes for the injury or disease;

D. history of the injury or disease as given by the employee;

E. the relationship of the injury or disease to employment activities;

F. information regarding any preexisting or other conditions affecting the employee's disability;

G. information about future treatment including, but not limited to, hospital admission, surgery, or referral to another doctor;

H. information regarding any surgery that has been performed;

I. information regarding the employee's ability to work, any work restrictions, and dates of disability;

J. information regarding the employee's permanent partial disability rating, in accordance with subpart 4;

K. information regarding whether the employee is unable to return to former employment for medical reasons attributed to the injury;

L. information regarding maximum medical improvement in accordance with subpart 3; and

M. signature of health care provider, license or registration number, and identification information.

Subp. 3. **Maximum medical improvement.** For injuries occurring on or after January 1, 1984, or upon request for earlier injuries, the health care provider must report to the self–insured employer or insurer, maximum medical improvement, when ascertainable, on the health care provider report form or in a narrative report. "Maximum medical improvement" is a medical and legal concept defined by Minnesota Statutes, section 176.011, subdivision 25, as the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability.

A. For purposes of subitems (1) and (2), "the employee's condition" includes the signs, symptoms, physical and clinical findings, and functional status that characterize the complaint, illness, or injury. "Functional status" means the ability of an individual to engage in activities of daily life and vocational activities. Except as otherwise provided in item B:

(1) In determining maximum medical improvement, the following factors shall be considered by the health care provider as an indication that maximum medical improvement has been reached:

(a) there has been no significant lasting improvement in the employee's condition, and significant recovery or lasting improvement is unlikely, even if there is ongoing treatment;

(b) all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the employee's condition have been exhausted, or declined by the employee;

(c) any further treatment is primarily for the purpose of maintaining the employee's current condition or is considered palliative in nature; and

(d) any further treatment is primarily for the purpose of temporarily or intermittently relieving symptoms.

(2) The following factors should be considered by the health care provider as an indication that maximum medical improvement has not been reached:

(a) the employee's condition is significantly improving or likely to significantly improve, with or without additional treatment;

(b) there are diagnostic evaluations that could be performed that have a reasonable probability of changing or adding to the treatment plan leading to significant improvement; or

(c) there are treatment options that have not been applied that may reasonably be expected to significantly improve the employee's condition.

B. This item applies to musculoskeletal injuries that fall within any category under parts 5223.0070, 5223.0080, 5223.0110 to 5223.0150, and 5223.0170 for dates of injury before July 1, 1993, and that fall within any category under parts 5223.0370 to 5223.0390 and 5223.0440 to 5223.0550 for dates of injury on or after July 1, 1993. When more than one year has elapsed since the date of a musculoskeletal injury that falls within any of the above categories, the only factors in determining maximum medical improvement shall be whether a decrease is anticipated in the employee's estimated permanent partial disability rating or a significant improvement is anticipated in the employee's work ability as documented on the report of work ability described in subpart 6. If medical reports show no decrease in the employee's estimated permanent partial disability or no significant improvement in the employee's work ability in any three–month period later than one year after the injury, the employee is presumed to have reached maximum medical improvement. This presumption can only be rebutted by a showing that a decrease in the employee's permanent partial disability rating or significant improvement in the work ability has occurred or is likely to occur beyond this three–month period. The medical reports relied upon as establishing maximum medical improvement under this item must be served on the employee in accordance with item C.

This item applies only to injuries of the musculoskeletal system, except where the injury is a spinal cord injury resulting in permanent paralysis, a head injury with loss of consciousness, or where surgery has been performed within the previous six months. In these cases, the factors listed in item A shall be used to determine maximum medical improvement.

C. If the employer or insurer does not serve a notice of intention to discontinue benefits or a petition to discontinue benefits under Minnesota Statutes, section 176.238, at the same time a narrative maximum medical improvement report is served, then the report must be served with a cover letter containing the information in subitems (1) to (6). Serving the cover letter with the maximum medical improvement report does not replace the notice of intention to discontinue benefits or petition to discontinue benefits required by Minnesota Statutes, section 176.238. The cover letter must include:

(1) information identifying the employee by name, social security number, and date of injury;

(2) information identifying the employer and insurer;

(3) the date the report was mailed to the employee;

(4) a statement that the attached report indicates that in the opinion of the health care provider, the employee reached maximum medical improvement by the specified date or an explanation that the attached reports indicate the employee has reached maximum medical improvement under the circumstances specified in item B;

(5) the statement: "Maximum medical improvement is defined by Minnesota Statutes, section 176.011, subdivision 25, as the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability"; and

(6) the statement: "There may be an impact on your temporary total disability benefits. If we propose to stop your benefits, a notice of discontinuance of benefits will be sent to you first. If you have any questions concerning your benefits or maximum medical improvement, you may call the claims person at ..... or the workers' compensation division at ..... (specify telephone numbers)."

Subp. 4. **Permanent partial disability.** The health care provider must render an opinion of permanent partial disability when ascertainable, but no later than the date of maximum medical improvement. The rating must be reported on the health care provider report form or in a narrative report. In making a rating of permanent partial disability, the health care provider must specify any applicable category of the permanent partial disability schedule in effect for the employee's date of injury. If a zero rating is appropriate, this rating must also be reported.

The health care provider may refer the employee to another health care provider for an opinion of the employee's permanent partial disability rating if the primary health care provider feels unable to make the determination in complicated cases involving impairments to more than one body part or multiple citations under the permanent partial disability schedule. In such cases, the treating provider must be available for consultation with the evaluating provider, and must make all relevant medical records available, without charge to the payer. The evaluating provider is entitled to reimbursement from the payer for a consultation as limited by the medical fee schedule.

Subp. 5. **Required reporting to division.** For those injuries that are required to be reported to the division under Minnesota Statutes, section 176.231, subdivision 1, the self–insured employer or insurer or third–party administrator shall file with the division the health care provider report form prescribed in subpart 2 or a narrative report that indicates that the employee has reached maximum medical improvement, or that indicates a preliminary or final permanent partial disability rating. The commissioner shall, by written request under Minnesota Statutes, section 176.231, subdivisions 3 and 7, require the filing of the health care provider report at additional times as necessary to monitor compliance with Minnesota Statutes, chapter 176, in accordance with Minnesota Statutes, sections 176.231, subdivision 6, and 176.251. All reports filed under this subpart must include the appropriate ICD–9–CM diagnostic codes for the injury or disease.

Subp. 6. **Report of work ability.** Each primary health care provider as defined in part 5221.0430, subpart 1, must complete and submit to the employee a report of work ability. A health care provider providing service under the direction or prescription of another provider is not required to complete a report of work ability.

A. For all work injuries, the primary health care provider must complete a report of work ability within ten days of a request by an insurer or at the intervals stated in subitems (1) to (3), unless there are no restrictions or the restrictions are permanent and have been so indicated in a report of work ability:

(1) every visit if visits are less frequent than once every two weeks;

(2) every two weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; or

(3) upon expiration of the ending or review date of the restriction specified in a previous report of work ability. Open–ended durations of disability or restriction may not be given.

B. The report of work ability must be either on the form prescribed by the commissioner or in a report that contains the same information as the report of work ability. The report of work ability prescribed by the commissioner shall include:

(1) information identifying the employee and employer, and insurer, if known;

(2) the date of the most recent examination;

(3) information stating whether the employee is able to work without restrictions, able to work with restrictions, or unable to work;

(4) work restrictions stated in functional terms, if the employee is able to work with restrictions;

(5) the date any restriction of work activity is to begin and the anticipated ending or review date;

(6) the date of the next scheduled visit;

(7) the signature of the health care provider, license or registration number, and identification information; and

(8) a notice to the employee that a copy of the report must be promptly provided to the employer or workers' compensation insurer and assigned qualified rehabilitation consultant.

C. The report of work ability must be based on the health care provider's most recent evaluation of the employee's signs, symptoms, physical and clinical findings, and functional status.

D. The report of work ability must be provided to the employee and a copy of the report must be placed in the employee's medical record. Promptly upon receipt, the employee shall submit the report of work ability to the employer or the insurer and the assigned qualified rehabilitation consultant. The commissioner shall, by written request under Minnesota Statutes, sections 176.102, subdivision 7, and 176.231, subdivisions 3 and 7, require the filing of a report of work ability when necessary to monitor compliance with Minnesota Statutes, chapter 176, in accordance with Minnesota Statutes, sections 176.231, subdivision 6, and 176.251.

Subp. 7. **Charge for required reporting.** No charge may be assessed for completion of a health care provider report or report of work ability required by subparts 2 and 6, or for a narrative or other report prepared in lieu of a health care provider report or report of work ability. A provider may charge a reasonable amount for requested supplementary reports using CPT codes 99080 (special reports); or X9198 (special chiropractic reports).

Subp. 8. **Proper filing of documents with division.** A health care provider report or narrative report required by the division under this part may be filed by facsimile or electronic transmission, if available at the division. Filing is completed at the time that the facsimile or electronic transmission is received by the commissioner. A report received after 4:30 p.m. shall be deemed received on the next open state business day. The filed facsimile or transmitted information has the same force and effect as the original. Where the quality of the document is at issue, the commissioner shall require the original document to be filed.

A narrative report filed with the division must, at the top of the first page, identify the employee by name, social security number, and date of injury. The name of the self–insured employer, insurer, and administrator if appropriate, must also be identified. The filer must identify the reason the report is submitted, and must highlight the corresponding pertinent sections of the report.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.0420 HEALTH CARE PROVIDER PARTICIPATION WITH RETURN TO WORK PLANNING.

Subpart 1. **Cooperation with return to work planning.** In addition to completing the required report of work ability under part 5221.0410, subpart 6, a health care provider must participate cooperatively in the planning of an injured employee's return to work by communicating with the employee, employer, insurer, rehabilitation providers, and the commissioner in accordance with this part. A health care provider must release the employee to return to work, with restrictions if necessary, at the earliest appropriate time.

If no qualified rehabilitation consultant has requested an opinion under subpart 2, item B, subitem (1), the health care provider must respond within ten calendar days of receipt of a request by the employee, employer, or insurer regarding whether the physical requirements of a proposed job are within the employee's medical restrictions or whether the health care provider requires further information. The health care provider may respond in writing, in person, or by telephone. The health care provider may require that the proposed job be described in writing. The provider may also agree to review a videotape of the job.

Subp. 2. **Communication with assigned qualified rehabilitation consultant.** When an employee is receiving vocational rehabilitation services under Minnesota Statutes, section 176.102, the health care provider must communicate with the assigned qualified rehabilitation consultant as follows:

A. A valid patient authorization is required for communication with the assigned qualified rehabilitation consultant. Under part 5220.1802, it is the assigned qualified rehabilitation consultant's responsibility to obtain the patient authorization and send it to the health care provider. Within ten calendar days of receipt of a request for information, the health care provider must respond to the assigned qualified rehabilitation consultant in person, by telephone, or in writing when any of the circumstances specified in item B occur. When an opinion about a proposed job is requested, the health care provider may require that the proposed job be described in writing. The provider may also agree to review a videotape of the job.

B. The health care provider must respond to a request for communication from the assigned qualified rehabilitation consultant upon initial assignment of a qualified rehabilitation consultant. Thereafter, the health care provider must respond to a request no more than once in any 30–calendar day period, except that the provider must also respond to a request when any of the following occur:

(1) when an opinion is requested regarding whether the physical requirements of a proposed job are within the employee's restrictions;

(2) when there has been an unanticipated or substantial change in the employee's condition;

(3) when a job search is initiated; or

(4) when there has been a change in the employee's work status.

Subp. 3. **Reimbursement for services.** A health care provider may not require prepayment for communication required by this part. The provider must bill the employer and insurer for the services rendered. Return to work services must be described, coded, and billed as special services, distinct from, and in addition to, all medical and chiropractic office and hospital visits and consultations. The following procedure codes must be used for these services:

A. 99080, special reports;

B. 99199, unlisted special service;

C. X9198, special chiropractic reports; or

D. X9199, unlisted special chiropractic service.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.0430 CHANGE OF HEALTH CARE PROVIDER.

Subpart 1. **Primary health care provider.** The individual health care provider directing and coordinating medical care to the employee following the injury is the primary health care provider. If the employee receives medical care after the injury from a provider on two occasions, the provider is considered the primary health care provider if that individual directs and coordinates the course of medical care provided to the employee. The employee may have only one primary health care provider at a time. The selection of a provider by an employee covered by a certified managed care plan is governed by chapter 5218.

Subp. 2. **Change of health care provider.** Following selection of a primary provider, the employee may change primary providers once within the first 60 days after initiation of medical treatment for the injury without the need for approval from the insurer, the department, or a workers' compensation judge. Transfer of medical care coordination due to conditions beyond the employee's control such as retirement, death, cessation from practice of the primary provider, or a referral from the primary provider to another provider does not exhaust the employee's right to a change of provider without approval under this subpart. After the first 60 days following initiation of medical treatment for the injury, any further changes of primary provider must be approved by the insurer, the department, or a workers' compensation judge. If the employee is covered by a certified managed care plan, a change of providers is governed by chapter 5218, Minnesota Statutes, section 176.1351, subdivision 2, clause (11), and procedures under the plan.

Subp. 3. **Unauthorized change; prohibited payments.** If the employee or health care provider fails to obtain approval of a change of provider before commencing treatment where required by this part, the insurer is not liable for the treatment rendered prior to approval unless the insurer has agreed to pay for the treatment. Treatment rendered before a change of provider is approved under this subpart is not inappropriate if the treatment was provided in an emergency situation and prior approval could not reasonably have been obtained.

Subp. 4. **Change of primary provider not approved.** After the first 60 days following initiation of medical treatment for the injury, or after the employee has exercised the employee's right to change doctors once, the department, a certified managed care organization, or a compensation judge shall not approve a party's request to change primary providers, where:

A. a significant reason underlying the request is an attempt to block reasonable treatment or to avoid acting on the provider's opinion concerning the employee's ability to return to work;

B. the change is to develop litigation strategy rather than to pursue appropriate diagnosis and treatment;

C. the provider lacks the expertise to treat the employee for the injury;

D. the travel distance to obtain treatment is an unnecessary expense and the same care is available at a more reasonable location;

E. at the time of the employee's request, no further treatment is needed; or

F. for another reason, the request is not in the best interest of the employee and the employer.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.0500 EXCESSIVE CHARGES; LIMITATION OF PAYER LIABILITY.

Subpart 1. **Excessive health care provider charges.** A billing charge for services, articles, or supplies provided to an employee with a compensable injury is excessive if any of the conditions in items A to I apply to the charge. A payer is not liable for a charge which meets any of these conditions.

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

B. the charge exceeds the provider's current usual and customary charge, as specified in subpart 2, item B, for the same or similar service, article, or supply in cases unrelated to workers' compensation injuries; or

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

D. the service does not comply with the treatment standards and requirements adopted under Minnesota Statutes, section 176.83, subdivision 5, concerning the reasonableness and necessity, quality, coordination, level, duration, frequency, and cost of services; or

E. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, sections 176.83, 176.103, and 256B.0644; or

F. the service, article, or supply is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury or is provided at a level, duration, or frequency that is excessive, based on accepted medical standards for quality health care and accepted rehabilitation standards under Minnesota Statutes, section 176.136, subdivision 2, clause (2); or

G. the service, article, or supply was delivered in violation of the federal Medicare anti–kickback statutes and regulations as specified in part 5221.0700, subpart 1a; or

H. where approval for a change of doctor is required by part 5221.0430 for the provider submitting the charge, and approval has not been obtained from the payer, commissioner, or compensation judge; or

I. the service is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition, under Minnesota Statutes, section 176.136, subdivision 2, clause (3).

Subp. 2. **Limitation of payer liability.** A payer is not liable for health care charges which are excessive under subpart 1. If the charges are not excessive under subpart 1, a payer's liability for payment of charges is limited as provided in items A to F.

A. The payer's liability shall be limited to the maximum amount allowed for any service specified in the medical fee schedule of this chapter in effect on the date of the service, or the provider's usual and customary fee, whichever is lower.

B. Except as provided in items C to F, if the service is not included in parts 5221.4000 to 5221.4070, the payer's liability payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person, whichever is lower.

(1) A usual and customary charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraphs (a) and (b), means the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system.

(2) A prevailing charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1) in the previous calendar year for each service, article, or supply if the database for the service meets all of the following criteria:

(a) the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;

(b) there are at least 20 billings for the service, article, or supply; and

(c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

C. Under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (a), payment for services, articles, and supplies provided to an employee while an inpatient or outpatient at a hospital with 100 or fewer licensed beds or a patient at a nursing home participating in the medical assistance program shall be 100 percent of the usual and customary charge as defined in item B, unless the charge is determined by the commissioner or compensation judge to be unreasonable or excessive.

D. Under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital with more than 100 licensed beds shall be limited to 85 percent of the hospital's usual and customary charge as defined in item B, or 85 percent of the prevailing charge as defined in item B, whichever is lower. Outpatient charges for hospitals with more than 100 beds are limited by the maximum fees for any service set forth in parts 5221.4000 to 5221.4070. For hospitals with more than 100 beds, liability for outpatient charges that are not included in parts 5221.4000 to 5221.4070 is limited to 85 percent of the hospitals usual and customary, or prevailing charge, as described in item B. A hospital charge is considered an inpatient charge if the employee spent either the night before or the night after the service in the hospital, and there is an overnight room charge.

E. Charges for cost of copies of medical records and postage are governed by parts 5219.0100 to 5219.0300 and are not subject to the 85 percent reimbursement limit specified in item B. Travel expenses incurred by an employee for compensable medical services shall be paid at the rate equal to the rate paid by the employer for ordinary business travel expenses, or the rate paid by the state of Minnesota for employment–related travel, whichever is lower. Reimbursement for employee travel expenses is not subject to the 85 percent reimbursement limit specified in item B.

F. Charges for supplementary reports that are not required reports under part 5221.0410, subpart 7, and charges for return to work services under part 5221.0420, subpart 3, are not subject to the 85 percent reimbursement limit specified in item B.

Subp. 3. **Collection of excessive charges.** A provider may not collect or attempt to collect payment from an injured employee, or any other source, charges for a compensable injury which the payer has determined are excessive under subpart 1 or which exceed the maximum amount payable specified in subpart 2, unless payment is ordered by the commissioner, compensation judge, or workers' compensation court of appeals. Unless the provider or the employee has filed a claim for a determination of the amount payable with the commissioner, the health care provider must remove the charges from the billing statement.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

5221.0550 [Repealed, 18 SR 1472]

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 compensable by evaluating the charge and service according to the conditions of excessiveness and payer liability specified in part 5221.0500, subparts 1 and 2, and Minnesota Statutes, section 176.136, subdivision 2. If the payer determines that the provider has assigned an incorrect code for a service, the payer may determine the correct code for the service and evaluate liability for payment on the basis of the correct code.

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

(2) deny all or a portion of a charge on the basis that the injury is noncompensable; the charge is excessive or noncompensable under Minnesota Statutes, section 176.136, subdivision 2; or part 5221.0500, subparts 1 and 2; or the charges are not submitted on the appropriate billing form prescribed in part 5221.0700; or

(3) request specific additional information to determine whether the charge or 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.

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 or noncompensable charge under part 5221.0500, subparts 1 and 2, or Minnesota Statutes, section 176.136, subdivision 2;

C. denial of a charge for failure to submit it on the billing form prescribed in part 5221.0700, subpart 2; and

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

If payment is denied under item B, C, or D, the payer shall reconsider the charges in accordance with this rule as soon as reasonably possible, and no later than 30 calendar days after receipt of additional relevant information or documents. Notice of denial of part or all of a charge shall be given by the payer consistent with the guidelines in this subpart.

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

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

5221.0650 DATA COLLECTION, RETENTION, AND REPORTING REQUIREMENTS.

Subpart 1. **Scope.** This part applies to workers' compensation insurers, self–insurers, group self–insurers, adjusters, and third–party administrators who act on behalf of an insurer, self–insurer, the assigned risk plan, and the Minnesota Insurance Guaranty Association.

Subp. 2. **Purpose.** The purpose of this part is to establish procedures and requirements for reporting medical and related data regarding treatment of work–related injuries. The data shall be provided in order for the department to monitor and evaluate medical services and supplies under Minnesota Statutes, chapter 176.

Subp. 3. **Retention period.** Data described in subpart 4 shall be collected and stored by the parties listed in subpart 1, beginning July 1, 1994, for all medical services and supplies provided to an employee under Minnesota Statutes, chapter 176, for ten years from the date of injury, or four years from the date the claim is closed, whichever is later.

Subp. 4. **Required data.** The data in items A and B shall be collected and stored by the parties listed in subpart 1.

A. Required data for professional services and supplies includes all elements required on the uniform billing form under part 5221.0700, subpart 2a, and:

(1) an indication of open or closed claim status;

(2) an indication of whether the employee was incapacitated from performing labor or service for more than three calendar days under Minnesota Statutes, section 176.231, subdivision 1;

(3) the amount of payments made for individual medical services, articles, and supplies; and

(4) the name of the managed care plan if services were provided under contract with or referral by a certified workers' compensation managed care plan.

B. Required data for inpatient and outpatient hospital services and supplies includes all elements required on the uniform billing form under part 5221.0700, subpart 2b, and:

(1) an indication of open or closed claim status;

(2) an indication of whether the employee was incapacitated from performing labor or service for more than three calendar days under Minnesota Statutes, section 176.231, subdivision 1; and

(3) the name of the managed care plan if services were provided under a contract with or referral by a certified managed care plan for workers' compensation.

Subp. 5. **Reporting requirements.** The data in subpart 4 shall be periodically sampled according to the sampling specifications prescribed by the research design for a study initiated by the commissioner under Minnesota Statutes, sections 175.17, 175.171, 176.103, and 176.1351. The samples shall be reported within 90 days of the request of the commissioner. The requested data shall be provided without charge to the department by a mutually agreeable standard of information exchange such as hard copy, computerized form, or electronic data interchange.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

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. 1a. **Conflicts of interest.** All health care providers subject to this chapter are bound by the federal Medicare antikickback statute in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a–7b(b), and regulations adopted under it, pursuant to Minnesota Statutes, section 62J.23. Any medical services or supplies provided in violation of these provisions are not compensable under Minnesota Statutes, chapter 176.

Subp. 2. **Submission of information.** Providers except for hospitals must supply with the bill a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge. Hospitals must submit an appropriate record upon request by the payer. All charges billed after January 1, 1994, for workers' compensation health care services, articles, and supplies, except for United States government facilities rendering health care services for veterans must be submitted to the payer on the forms prescribed in subparts 2a, 2b, and 2c, and in accordance with items A to D.

A. Charges for services, articles, and supplies must be submitted to the payer directly by the health care provider actually furnishing the service, article, or supply. This includes but is not limited to the following:

(1) diagnostic imaging, laboratory, or pathology testing not actually performed by the health care provider, or employee of the health care provider, who ordered the test;

(2) equipment, supplies, and medication not ordinarily kept in stock by the hospital or other health care provider facility, purchased from a supplier for a specific employee;

(3) services performed by a health care provider at a hospital if the provider has an independent practice and is not a salaried employee of the hospital; and

(4) outpatient medications dispensed by a licensed pharmacy pursuant to an order written by a health care provider, as described in this subpart, including both prescription and nonprescription medications.

B. Charges must be submitted to the payer in the manner required by subparts 2a, 2b, and 2c within 60 days from the date the health care provider knew the condition being treated was claimed by the employee as compensable under workers' compensation.

C. When a provider orders a medication for an employee, the provider must also supply the employee with a document accurately describing the medication as ordered and including the words "workers' compensation," or the letters "W.C." on its face. This requirement applies to both prescription and nonprescription medications and may be fulfilled by a handwritten note on the provider's personalized stationary or prescription pad.

D. This part does not limit the collection of other information the provider may be required to report under any other state or federal jurisdiction.

Subp. 2a. **Federal health care financing administration claim form HCFA 1500 form.** Except as provided in subparts 2b and 2c, charges for all services, articles, and supplies that are provided for a claimed workers' compensation injury must be submitted to the payer on the HCFA 1500 form. Charges for dental services may be submitted on any standard dental claim form. The following information must be submitted in the appropriate field of the claim form shown in item B as follows:

(1) The name and address of the party making payment of the medical bill is the name and address of the self–insured employer or workers' compensation insurer at the time of injury, or workers' compensation third party administrator. This information must appear at the top of the form above the field labeled "HEALTH INSURANCE COVERAGES," position 1.

(2) The workers' compensation file number (the employee's social security number), if provided by employee, must appear in the field labeled "INSURED'S I.D. NUMBER," position 1a.

(3) The employee's name and address must appear in the fields labeled "PATIENT'S NAME" and "PATIENT'S ADDRESS," positions 2 and 5 respectively.

(4) The claim number, if known, of the workers' compensation payer listed in field 4 must appear in the field labeled "INSURED'S POLICY GROUP OR FECA NUMBER," position 11.

(5) If services were provided under a contract with or referral by a managed care plan certified for workers' compensation by the commissioner of labor and industry under Minnesota Statutes, section 176.1351, the name of the managed care organization must appear in the field labeled "INSURANCE PLAN NAME OR PROGRAM NAME," position 11c.

(6) The date of the injury must appear in the field labeled "DATE OF CURRENT ILLNESS OR INJURY," position 14.

(7) The name of the referring or ordering health care provider must appear in the field labeled "NAME OF REFERRING PHYSICIAN OR OTHER SOURCE," position 17 if the patient:

(a) was referred to the performing health care provider for consultation or treatment;

(b) was referred to an entity, such as a clinical laboratory, for a service; or

(c) obtained an order for an item or service from an entity, such as a durable medical equipment supplier.

(8) The Unique Physician Identifier Number (UPIN) of the referring or ordering health care provider listed in field 17 must appear in the field labeled "ID NUMBER OF REFERRING PHYSICIAN," position 17a. If the provider does not have a UPIN, the degree and license or registration number may be used instead of the UPIN.

(9) The appropriate ICD–9–CM code describing the principal diagnosis being treated must appear in the field labeled "DIAGNOSIS OR NATURE OF ILLNESS OR INJURY," position 21. Enter up to four codes in priority order for primary and secondary conditions.

(10) The date(s) of each service must appear separately in the field labeled "DATE(S) OF SERVICE," position 24A.

(11) The approved procedure codes and modifiers appropriate for the service, in accordance with subpart 3, must appear in the field labeled "PROCEDURES, SERVICES OR SUPPLIES," position 24D.

(12) The ICD–9–CM diagnosis code which relates to the date the service or procedure was performed must appear in the field labeled "DIAGNOSIS CODE," position 24E.

(13) The charge for each service must appear in the field labeled "$ CHARGES," position 24F.

(14) The code for Place of Service must appear in the field labeled "PLACE OF SERVICE," position 24B. The following Health Care Financing Administration (HCFA) codes must be used:

(a) 11 = office;

(b) 21 = hospital inpatient;

(c) 22 = hospital outpatient;

(d) 23 = emergency room – hospital; and

(e) 24 = ambulatory surgical center.

For all other places of service, the specific identifying code established by the HCFA must be used.

(15) The number of units of each service provided must appear in the field labeled "DAYS OR UNITS," position 24G.

(16) The health care provider who actually provided the service must be identified as appropriate in the field labeled "RESERVED FOR LOCAL USE," position 24K. The provider must be identified by a UPIN. If the provider does not have a UPIN, the degree and license or registration number may be used in lieu of the UPIN. If the provider does not have a UPIN or license or registration number, the name and degree of the person providing the service must be typed or printed.

(17) The signature of the health care provider, or the provider's representative, and the date signed must appear in the field labeled "SIGNATURE OF PHYSICIAN OR SUPPLIER," position 31.

(18) The name and address of the facility where the services were rendered must appear in the field labeled "NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED," position 32.

(19) The health care provider or supplier billing name, address, and telephone number must appear in the field labeled "PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #," position 33.

Subp. 2b. **Uniform billing claim form UB–92 (HCFA 1450).** Hospitals licensed under Minnesota Statutes, section 144.50, must submit itemized charges on the uniform billing claim form, UB–92, (HCFA 1450).

The following information must be submitted by hospitals in the appropriate fields of the UB–92 as follows:

(1) The name of the hospital submitting the bill and the complete mailing address to which the hospital wishes payment sent must appear in the form locator field 1.

(2) The patient's unique control number assigned by the provider to facilitate retrieval of financial records must appear in form locator field 3.

(3) The three–digit code approved by the National Uniform Billing Committee for indicating the type of bill must appear in form locator field 4 in the following sequence:

(a) type of facility – 1st digit

hospital	1
skilled nursing	2
home health	3
intermediate care	6
clinic	7
special facility	8

(b) bill classification (except clinics and special facilities) – 2nd digit

IP	1 or 2
OP	3

(c) bill classification (clinics only) – 2nd digit

rural health	1
hospital–based or independent renal dialysis center	2
free standing	3
outpatient rehab facility	4
comprehensive outpatient rehab facility	5

(d) bill classification (special facilities only) – 2nd digit

hospice (nonhospital–based)	1
hospice (hospital–based)	2
ambulatory surgery center	3

(e) frequency – 3rd digit in form locator is not information required by workers' compensation.

(4) The beginning and ending service dates of the period included on this bill must appear in form locator field 6.

(5) The patient's last name, first name, and middle initial must appear in this order in form locator field 12.

(6) The patient's address must appear in form locator field 13.

(7) The date the patient was admitted to the hospital for inpatient care must appear in form locator field 17.

(8) A code indicating the priority of this admission must appear in form locator field 19. Codes must be one of the following:

1	Emergency
2	Urgent
3	Elective

(9) If the services billed were provided for an employment–related accident the code 04 and the date of injury must appear in form locator field 32a.

(10) All outpatient services must be itemized on the UB–92 form as follows:

(a) The approved billing codes and modifiers appropriate for the service, in accordance with subpart 3, must appear in the form locator field 44.

(b) The date each service was provided must appear in the form locator field 45.

(c) The number of units of each service provided must appear in the form locator field 46.

(d) The total charge for each service (charge per service x number of services) must appear in form locator field 47.

(e) The sum of all charges in column 47 on this bill must appear as the last line in form locator field 47. Revenue code 001 should appear to the left of this total in form locator field 42.

(11) Inpatient services must be submitted to the payer on the UB–92 form but may be summarized as follows:

(a) The revenue code which identifies a specific accommodation or ancillary service may appear in form locator field 42.

(b) A description of the related revenue categories must appear in the form locator field 43. Abbreviations may be used.

(c) The total charges for the category of service summarized must appear in form locator field 47.

(d) The sum of all charges in column 47 on this bill must appear as the last line in form locator field 47. Revenue code 001 should appear to the left of this total in form locator field 42.

When the UB–92 form provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached to the UB–92 form. The itemized list must include:

i. Where a code is assigned to a service, the approved procedure codes and modifiers appropriate for the service, in accordance with subpart 3. Charges for supplies need not be coded, but a description and charge for specific articles and supplies must be itemized.

ii. The charge for each service.

iii. The number of units of each service provided.

iv. The date each service was provided.

(12) The name of the payer from which the provider might expect payment for the bill must appear in the form locator field 50. This is the self–insured employer, the workers' compensation insurer at the time of injury, or the third party administrator.

(13) The workers' compensation file number (the employee's social security number) if provided by the employee, must appear in form locator field 60.

(14) If services were provided under a contract with or referral by a managed care plan certified for workers' compensation by the commissioner of labor and industry under Minnesota Statutes, section 176.1351, the name of the managed care plan must appear in form locator field 61.

(15) The ICD–9–CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning admission of the patient for care) must appear in form locator field 67. Enter codes for diagnosis other than the principal diagnosis in form locator fields 68–75.

(16) The CPT–4 code that indicates the principal procedure performed during the period covered by this bill and the date on which the principal procedure was performed must appear in form locator field 80. Enter codes for procedures other than the principal procedure in form locator field 81.

(17) The attending health care provider who has primary responsibility for the patient's medical care and treatment must be identified in form locator field 82. Enter the UPIN and the name of the provider. If the provider does not have a UPIN, the degree and license or registration number may be used in lieu of the UPIN.

(18) The health care provider, other than the attending provider, who performed the principal procedure, if any, must appear in form locator field 83. Enter the UPIN and name of the provider. If the provider does not have a UPIN, the degree and license, or registration number may be used in lieu of the UPIN.

(19) An authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of this bill, must appear in form locator field 85. A facsimile signature is acceptable. The date the form is signed must be completed.

Subp. 2c. **Submission of pharmacy charges.** Itemized charges for all hospital outpatient and independent pharmacy medications provided for a claimed workers' compensation injury must be submitted to the payer on a claim form which includes the following information:

A. the workers' compensation file number (the employee's social security number), if provided by the employee;

B. the employee's name and address;

C. the insurer's name and address;

D. the date of the injury;

E. the name of the health care provider who ordered the medication;

F. if the medication was provided under a contract with, or by referral from a managed care plan certified for workers' compensation by the commissioner of labor and industry under Minnesota Statutes, section 176.1351, the name of the managed care plan;

G. the name and quantity of each medication provided;

H. the prescription number for the medication;

I. the date the medication was provided;

J. the total charge for each medication provided; and

K. the name, address, and telephone number of the pharmacy that provided the medication.

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, and according to the instructions and guidelines in this chapter and in the CPT or HCPCS manual in effect on the date the service was rendered.

A. Billing codes must include the correct procedure code found in the CPT or HCPCS manual in effect on the date the service was rendered or the correct chiropractic procedure code found in the medical fee schedule in effect on the date the service was rendered or the correct prescription number. The billing code must also include any appropriate modifier.

B. The codes for services in parts 5221.4030 to 5221.4070 may be submitted with two–digit or two–letter suffixes called "modifiers." Modifiers indicate that the service rendered differs in some material respect from the service as described in this chapter or in the CPT or HCPCS manual. Modifiers used must be those listed and described in the CPT manual in effect on the date the service was rendered.

C. Provider group designation.

(1) General. The provision of services by all health care providers is limited and governed by each provider's scope of practice as stated in the applicable statute. A provider shall not perform a service which is outside that provider's scope of practice, nor shall a provider use a procedure code for a service which is outside that provider's scope of practice. Services delivered at the direction and under the supervision of a licensed health care provider listed in this item are considered incident to the services of the licensed provider and are coded as though provided directly by the licensed provider. Services delivered by support staff such as aides, assistants, or other unlicensed providers are incident to the services of a licensed provider only if the licensed provider directly responsible for the unlicensed provider is on the premises at the time the service is rendered. Hospital charges are governed by part 5221.0500, subpart 2, items C and D. Outpatient charges by hospitals with more than 100 licensed beds are subject to the maximum fees in parts 5221.4000 to 5221.4070.

(2) Medical and surgical services. Procedure codes for medical and surgical services and supplies are listed in part 5221.4030. These include services delivered by the following types of providers or services provided incident to the services of the following types of providers: medical physicians, surgeons, osteopathic physicians, podiatrists, dentists, oral and maxillofacial surgeons, optometrists, opticians, speech pathologists, licensed psychologists, social workers, nurse practitioners, clinical nurse specialists, and physician's assistants.

(3) Pathology and laboratory services. Procedure codes for services and supplies provided by a pathologist or by a technician under the supervision of a physician are listed in part 5221.4040.

(4) Physical medicine and rehabilitation services. Procedure codes for services and supplies provided by a physician, an osteopathic physician, a physical therapist, or an occupational therapist or provided incident to the services of a physician, an osteopathic physician, a physical therapist, or an occupational therapist are listed in part 5221.4050.

(5) Chiropractic services. Procedure codes for services and supplies provided by a chiropractor or provided incident to a chiropractor's services are listed in part 5221.4060.

(6) Pharmacy services. Procedure codes for medications provided pursuant to the order of a health care provider, are described in part 5221.4070.

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. [Repealed, 18 SR 1472]

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

5221.0800 [Repealed, 18 SR 1472]

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 175.131; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 relat-

ing 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 re-evaluation 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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

5221.1210 [Repealed, 16 SR 622; 18 SR 1472]

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993)

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 system, 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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 procedure 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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 10 SR 765; 13 SR 2609; 14 SR 722; 15 SR 738; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 therapeutic 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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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).

5221.3150 FEES FOR MEDICAL SERVICES 600

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *13 SR 2609; 14 R 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 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; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *9 SR 601; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

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 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *14 SR 722; 15 SR 738; 16 SR 622; 18 SR 1472*

NOTE: This part is repealed only for services after the effective date of parts 5221.4000 to 5221.4300 (December 20, 1993).

5221.4000 APPLICATION SCHEDULE; INSTRUCTIONS.

Subpart 1. **Contents.** This part provides general guidelines for application of the relative value medical fee schedule. The medical fee schedule contains codes and descriptions of services, relative value units and additional descriptive information for each service, and the conversion factor.

Subp. 2. **Revisions.** The current medical fee schedule is effective until annual revisions are adopted, except that the commissioner may revise the medical fee schedule at any time to improve the schedule's accuracy, fairness, or equity, or to simplify the administration of the schedule.

Subp. 3. **Applicability.** The medical fee schedule applies to a charge for a particular health care service if:

A. the medical service is compensable under Minnesota Statutes, section 176.135;

B. the service conforms to a billing code listed in this chapter and meets the code descriptions which appear in this chapter or in the CPT or HCPCS manual in effect on the date the service was rendered; and

C. the service is listed under the appropriate provider group designation for the health care provider that rendered the service.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4010 EMPLOYER'S LIABILITY FOR SERVICES UNDER MEDICAL FEE SCHEDULE.

Unless the maximum fee is adjusted under part 5221.4034, 5221.4041, 5221.4051, or 5221.4061, the employer's liability for services included in parts 5221.4030 to 5221.4060 is limited to 100 percent of the fee schedule amount calculated according to the formula in part 5221.4020 or the provider's usual and customary fee for the service, whichever is lower. The employer's liability for pharmacy services is as provided in part 5221.4070.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4020 FORMULA FOR DETERMINING FEE SCHEDULE PAYMENT LIMITS; CONVERSION FACTOR.

Subpart 1. **Formula.** Except as provided in parts 5221.4034, 5221.4041, 5221.4051, 5221.4061, and 5221.4070, the maximum fee in dollars for a health care service subject to the medical fee schedule is calculated according to the following formula:

maximum fee = relative value unit (RVU) x conversion factor (CF).

Relative value units for all included services are listed in parts 5221.4030, 5221.4040, 5221.4050, and 5221.4060.

Subp. 2. **Conversion factor.** The conversion factor shall be updated annually, pursuant to Minnesota Statutes, section 176.136, subdivision 1a. The conversion factor for services included in parts 5221.4030 to 5221.4060 provided after October 1, 1993, is $52.05. This initial conversion factor is annually adjusted as follows:

A. for dates of service from October 1, 1994 to September 30, 1995: $52.91;

B. for dates of service from October 1, 1995 to September 30, 1996: $54.31; and

C. for dates of service from October 1, 1996 to September 30, 1997: $56.35.

As a sample calculation, the maximum fee for a new patient office examination by a physician, procedure code 99201, is 0.80 (relative value unit). This is multiplied by 52.05 (conversion factor for 1993). The total payment, excluding any applicable adjustment, would be equal to $41.64 for the service.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 21 SR 420*

5221.4030 MEDICAL/SURGICAL PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.**

A. Column 1 in subpart 2a is labeled "CPT/HCPCS procedure code." This is the specific code intended to identify the health care service described in column 4.

B. Column 2 in subpart 2a is labeled "Tech/Prof. MOD." Column 2 contains a modifier if there is a technical component (TC) and a professional component (26) for the service.

C. Column 3 in subpart 2a is labeled "status." These indicators, explained in subitems (1) to (5), provide additional information necessary to determine the maximum fee for the service.

(1) "A" indicates an active code. These services are separately paid under the medical fee schedule. There are RVUs for codes with this status. For example, procedure code number 99291, for critical care, first hour, is an active code with a total RVU of 5.27. The maximum fee for this service is calculated according to the formula in part 5221.4020.

(2) "B" indicates a bundled code. Payment for these services is always subsumed or bundled into payment for another service. There are no RVUs for these codes and no separate payment is made. For example, procedure code number 99371, for a telephone call from a hospital nurse regarding care of a patient, is a bundled code, with a total RVU of 0.00. This service is not separately payable because it is included in the payment for a hospital visit, procedure code number 99261.

(3) "P" indicates a bundled or excluded code. There are no RVUs for these services. Payment for these services is determined according to the following guidelines:

(a) If the item or service is provided incident to the services of a licensed provider, on the same day as the licensed provider service, payment for it is bundled into the

payment for the licensed provider service to which it is incident. For example, an elastic bandage, procedure code number A4202, is a "P" code. If a provider furnished an employee an elastic bandage while treating the employee for a tibia fracture, the cost of the bandage is included in the cost of the treatment, procedure code number 27750. No separate payment for the bandage is allowed.

(b) If the item or service is not provided incident to the services of a licensed provider, it is excluded from the fee schedule and liability for the service is limited by Minnesota Statutes, section 176.136, subdivision 1b.

(4) "T" indicates injections. RVUs are listed for these services, but separate payment is made only when there are no other services billed on the same date by the same provider. If any other services are billed on the same date by the same provider, these injection services are bundled into the service for which payment is made.

(5) "Z" indicates electrocardiograms. RVUs are listed for these services, but no separate payment shall be made for these services if they are provided during, as a result of, or in conjunction with any visit or consultation, including visits in critical care and all other sites.

D. Column 4 in subpart 2a is labeled "CPT/HCPCS description." This is a short narrative description of the procedure code. A complete description of the service appears in the CPT or HCPCS Manual in effect on the date the service was rendered.

E. Column 5 in subpart 2a is labeled "total RVU." These are the total relative value units for the service.

F. Column 6 in subpart 2a is labeled "global period." Symbols in column 6 indicate the application of the global surgery package in part 5221.4034, subpart 1.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. **List of medical/surgical procedure codes.**

A. Procedure code numbers 10040 to 19396 relate to skin procedures.

CPT/ HCPCS Procedure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
10040		A	Acne surgery	1.68	010
10060		A	Drainage of skin abscess	1.58	010
10061		A	Drainage of skin abscess	3.16	010
10080		A	Drainage of pilonidal cyst	2.15	010
10081		A	Drainage of pilonidal cyst	3.61	010
10120		A	Remove foreign body	1.68	010
10121		A	Remove foreign body	3.71	010
10140		A	Drainage of hematoma/fluid	1.99	010
10160		A	Puncture drainage of lesion	1.56	010
10180		A	Complex drainage, wound	3.36	010
11000		A	Surgical cleansing of skin	1.33	000
11001		A	Additional cleansing of skin	0.72	ZZZ
11040		A	Surgical cleansing, abrasion	0.92	000
11041		A	Surgical cleansing of skin	1.41	000
11042		A	Cleansing of skin/tissue	1.82	000
11043		A	Cleansing of tissue/muscle	3.84	010
11044		A	Cleansing of tissue/muscle/bone	5.38	010
11050		A	Trim skin lesion	0.81	000
11051		A	Trim 2 to 4 skin lesions	1.19	000
11052		A	Trim over 4 skin lesions	1.29	000
11100		A	Biopsy of skin lesion	1.34	000
11101		A	Biopsy, each added lesion	0.71	ZZZ

11200	A	Removal of skin tags	1.14	010
11201	A	Removal of added skin tags	0.44	ZZZ
11300	A	Shave skin lesion	1.07	000
11301	A	Shave skin lesion	1.55	000
11302	A	Shave skin lesion	1.99	000
11303	A	Shave skin lesion	2.69	000
11305	A	Shave skin lesion	1.22	000
11306	A	Shave skin lesion	1.74	000
11307	A	Shave skin lesion	2.13	000
11308	A	Shave skin lesion	2.90	000
11310	A	Shave skin lesion	1.45	000
11311	A	Shave skin lesion	1.94	000
11312	A	Shave skin lesion	2.38	000
11313	A	Shave skin lesion	3.19	000
11400	A	Removal of skin lesion	1.42	010
11401	A	Removal of skin lesion	1.97	010
11402	A	Removal of skin lesion	2.50	010
11403	A	Removal of skin lesion	3.11	010
11404	A	Removal of skin lesion	3.63	010
11406	A	Removal of skin lesion	4.79	010
11420	A	Removal of skin lesion	1.56	010
11421	A	Removal of skin lesion	2.23	010
11422	A	Removal of skin lesion	2.71	010
11423	A	Removal of skin lesion	3.51	010
11424	A	Removal of skin lesion	4.05	010
11426	A	Removal of skin lesion	5.74	010
11440	A	Removal of skin lesion	1.82	010
11441	A	Removal of skin lesion	2.45	010
11442	A	Removal of skin lesion	3.00	010
11443	A	Removal of skin lesion	3.97	010
11444	A	Removal of skin lesion	4.92	010
11446	A	Removal of skin lesion	6.33	010
11450	A	Removal, sweat gland lesion	5.51	090
11451	A	Removal, sweat gland lesion	6.97	090
11462	A	Removal, sweat gland lesion	4.98	090
11463	A	Removal, sweat gland lesion	6.01	090
11470	A	Removal, sweat gland lesion	6.14	090
11471	A	Removal, sweat gland lesion	7.01	090
11600	A	Removal of skin lesion	2.54	010
11601	A	Removal of skin lesion	3.33	010
11602	A	Removal of skin lesion	3.94	010
11603	A	Removal of skin lesion	4.66	010
11604	A	Removal of skin lesion	5.25	010
11606	A	Removal of skin lesion	6.77	010
11620	A	Removal of skin lesion	2.69	010
11621	A	Removal of skin lesion	3.75	010
11622	A	Removal of skin lesion	4.58	010
11623	A	Removal of skin lesion	5.59	010
11624	A	Removal of skin lesion	6.76	010
11626	A	Removal of skin lesion	7.90	010
11640	A	Removal of skin lesion	3.20	010
11641	A	Removal of skin lesion	4.57	010
11642	A	Removal of skin lesion	5.57	010
11643	A	Removal of skin lesion	6.60	010
11644	A	Removal of skin lesion	8.18	010

11646	A	Removal of skin lesion	10.51	010
11700	A	Scraping of 1–5 nails	0.66	000
11701	A	Scraping of additional nails	0.47	ZZZ
11710	A	Scraping of 1–5 nails	0.66	000
11711	A	Scraping of additional nails	0.40	ZZZ
11730	A	Removal of nail plate	1.60	000
11731	A	Removal of second nail plate	1.09	ZZZ
11732	A	Remove additional nail plate	0.64	ZZZ
11740	A	Drain blood from under nail	0.78	000
11750	A	Removal of nail bed	3.85	010
11752	A	Remove nail bed/finger tip	5.39	010
11755	A	Biopsy, nail unit	2.37	000
11760	A	Reconstruction of nail bed	2.51	010
11762	A	Reconstruction of nail bed	5.53	010
11765	A	Excision of nail fold, toe	1.18	010
11770	A	Removal of pilonidal lesion	5.48	010
11771	A	Removal of pilonidal lesion	10.22	090
11772	A	Removal of pilonidal lesion	11.80	090
11900	A	Injection into skin lesions	0.78	000
11901	A	Added skin lesion injections	1.23	000
11920	A	Correct skin color defects	2.93	000
11921	A	Correct skin color defects	3.50	000
11922	A	Correct skin color defects	0.89	ZZZ
11950	A	Therapy for contour defects	2.08	000
11951	A	Therapy for contour defects	2.44	000
11952	A	Therapy for contour defects	2.94	000
11954	A	Therapy for contour defects	3.10	000
11960	A	Insert tissue expander(s)	14.64	090
11970	A	Replace tissue expander	16.11	090
11971	A	Remove tissue expander(s)	5.12	090
11975	A	Insert contraceptive cap	2.69	XXX
11976	A	Removal of contraceptive cap	3.25	XXX
11977	A	Remove/reinsert contracept. cap	4.58	XXX
12001	A	Repair superficial wound(s)	2.25	010
12002	A	Repair superficial wound(s)	2.64	010
12004	A	Repair superficial wound(s)	3.38	010
12005	A	Repair superficial wound(s)	4.36	010
12006	A	Repair superficial wound(s)	5.51	010
12007	A	Repair superficial wound(s)	5.98	010
12011	A	Repair superficial wound(s)	2.48	010
12013	A	Repair superficial wound(s)	3.01	010
12014	A	Repair superficial wound(s)	3.65	010
12015	A	Repair superficial wound(s)	4.84	010
12016	A	Repair superficial wound(s)	6.24	010
12017	A	Repair superficial wound(s)	8.18	010
12018	A	Repair superficial wound(s)	10.87	010
12020	A	Closure of split wound	3.87	010
12021	A	Closure of split wound	2.48	010
12031	A	Layer closure of wound(s)	2.86	010
12032	A	Layer closure of wound(s)	3.53	010
12034	A	Layer closure of wound(s)	4.43	010
12035	A	Layer closure of wound(s)	5.43	010
12036	A	Layer closure of wound(s)	6.54	010
12037	A	Layer closure of wound(s)	7.99	010
12041	A	Layer closure of wound(s)	3.21	010

12042	A	Layer closure of wound(s)	3.93	010
12044	A	Layer closure of wound(s)	4.81	010
12045	A	Layer closure of wound(s)	5.85	010
12046	A	Layer closure of wound(s)	7.23	010
12047	A	Layer closure of wound(s)	8.94	010
12051	A	Layer closure of wound(s)	3.49	010
12052	A	Layer closure of wound(s)	4.27	010
12053	A	Layer closure of wound(s)	4.92	010
12054	A	Layer closure of wound(s)	6.14	010
12055	A	Layer closure of wound(s)	7.82	010
12056	A	Layer closure of wound(s)	10.21	010
12057	A	Layer closure of wound(s)	11.72	010
13100	A	Repair of wound or lesion	4.29	010
13101	A	Repair of wound or lesion	6.07	010
13120	A	Repair of wound or lesion	4.70	010
13121	A	Repair of wound or lesion	7.12	010
13131	A	Repair of wound or lesion	5.85	010
13132	A	Repair of wound or lesion	9.00	010
13150	A	Repair of wound or lesion	5.66	010
13151	A	Repair of wound or lesion	7.06	010
13152	A	Repair of wound or lesion	11.79	010
13160	A	Late closure of wound	13.23	090
13300	A	Repair of wound or lesion	11.31	010
14000	A	Skin tissue rearrangement	9.05	090
14001	A	Skin tissue rearrangement	12.98	090
14020	A	Skin tissue rearrangement	11.24	090
14021	A	Skin tissue rearrangement	16.13	090
14040	A	Skin tissue rearrangement	14.28	090
14041	A	Skin tissue rearrangement	19.20	090
14060	A	Skin tissue rearrangement	16.38	090
14061	A	Skin tissue rearrangement	22.61	090
14300	A	Skin tissue rearrangement	23.13	090
14350	A	Skin tissue rearrangement	15.75	090
15000	A	Skin graft procedure	4.82	ZZZ
15050	A	Skin pinch graft procedure	5.88	090
15100	A	Skin split graft procedure	13.14	090
15101	A	Skin split graft procedure	3.51	ZZZ
15120	A	Skin split graft procedure	15.75	090
15121	A	Skin split graft procedure	5.89	ZZZ
15200	A	Skin full graft procedure	12.01	090
15201	A	Skin full graft procedure	3.68	ZZZ
15220	A	Skin full graft procedure	12.77	090
15221	A	Skin full graft procedure	3.48	ZZZ
15240	A	Skin full graft procedure	15.01	090
15241	A	Skin full graft procedure	4.85	ZZZ
15260	A	Skin full graft procedure	17.58	090
15261	A	Skin full graft procedure	5.92	ZZZ
15350	A	Skin homograft procedure	6.30	090
15400	A	Skin heterograft procedure	6.09	090
15570	A	Form skin pedicle flap	12.29	090
15572	A	Form skin pedicle flap	11.88	090
15574	A	Form skin pedicle flap	11.80	090
15576	A	Form skin pedicle flap	7.75	090
15580	A	Attach skin pedicle graft	9.41	090
15600	A	Skin graft procedure	5.55	090

15610	A	Skin graft procedure	5.89	090
15620	A	Skin graft procedure	7.16	090
15625	A	Skin graft procedure	5.32	090
15630	A	Skin graft procedure	7.82	090
15650	A	Transfer skin pedicle flap	8.78	090
15732	A	Muscle–skin graft, head/neck	29.96	090
15734	A	Muscle–skin graft, trunk	37.41	090
15736	A	Muscle–skin graft, arm	33.25	090
15738	A	Muscle–skin graft, leg	25.66	090
15740	A	Island pedicle flap graft	20.77	090
15750	A	Neurovascular pedicle graft	23.75	090
15755	A	Microvascular flap graft	61.54	090
15760	A	Composite skin graft	16.21	090
15770	A	Derma–fat–fascia graft	14.83	090
15775	A	Hair transplant punch grafts	7.18	000
15776	A	Hair transplant punch grafts	10.05	000
15780	A	Abrasion treatment of skin	8.35	090
15781	A	Abrasion treatment of skin	8.65	090
15782	A	Abrasion treatment of skin	5.46	090
15783	A	Abrasion treatment of skin	6.12	090
15786	A	Abrasion treatment of lesion	2.64	010
15787	A	Abrasion, added skin lesions	0.58	ZZZ
15788	A	Chemical peel, face, epiderm	3.50	090
15789	A	Chemical peel, face, dermal	6.24	090
15792	A	Chemical peel, nonfacial	2.26	090
15793	A	Chemical peel, nonfacial	4.05	090
15810	A	Salabrasion	8.43	090
15811	A	Salabrasion	9.32	090
15819	A	Plastic surgery, neck	17.35	090
15820	A	Revision of lower eyelid	11.27	090
15821	A	Revision of lower eyelid	12.58	090
15822	A	Revision of upper eyelid	10.28	090
15823	A	Revision of upper eyelid	14.64	090
15831	A	Excise excessive skin tissue	22.71	090
15832	A	Excise excessive skin tissue	20.04	090
15833	A	Excise excessive skin tissue	16.92	090
15834	A	Excise excessive skin tissue	18.07	090
15835	A	Excise excessive skin tissue	18.71	090
15836	A	Excise excessive skin tissue	15.30	090
15837	A	Excise excessive skin tissue	14.54	090
15838	A	Excise excessive skin tissue	13.06	090
15839	A	Excise excessive skin tissue	11.67	090
15840	A	Graft for face nerve palsy	29.08	090
15841	A	Graft for face nerve palsy	40.02	090
15842	A	Graft for face nerve palsy	66.36	090
15845	A	Skin and muscle repair, face	28.36	090
15850	B	Removal of sutures	1.16	XXX
15851	A	Removal of sutures	1.18	000
15852	A	Dressing change, not for burn	1.34	000
15860	A	Test for blood flow in graft	3.45	000
15920	A	Removal of tail bone ulcer	10.72	090
15922	A	Removal of tail bone ulcer	15.88	090
15931	A	Remove sacrum pressure sore	11.41	090
15933	A	Remove sacrum pressure sore	17.43	090
15934	A	Remove sacrum pressure sore	19.78	090

15935	A	Remove sacrum pressure sore	25.66	090
15936	A	Remove sacrum pressure sore	22.81	090
15937	A	Remove sacrum pressure sore	28.04	090
15940	A	Removal of pressure sore	12.20	090
15941	A	Removal of pressure sore	18.04	090
15944	A	Removal of pressure sore	20.53	090
15945	A	Removal of pressure sore	23.70	090
15946	A	Removal of pressure sore	38.37	090
15950	A	Remove thigh pressure sore	10.16	090
15951	A	Remove thigh pressure sore	18.18	090
15952	A	Remove thigh pressure sore	18.14	090
15953	A	Remove thigh pressure sore	21.60	090
15956	A	Remove thigh pressure sore	33.11	090
15958	A	Remove thigh pressure sore	33.90	090
16000	A	Initial treatment of burn(s)	1.26	000
16010	A	Treatment of burn(s)	1.21	000
16015	A	Treatment of burn(s)	4.62	000
16020	A	Treatment of burn(s)	1.16	000
16025	A	Treatment of burn(s)	2.33	000
16030	A	Treatment of burn(s)	2.65	000
16035	A	Incision of burn scab	6.62	090
16040	A	Burn wound excision	3.44	000
16041	A	Burn wound excision	6.17	000
16042	A	Burn wound excision	5.68	000
17000	A	Destroy benign/premal lesion	1.07	010
17001	A	Destruction of add'l. lesions	0.39	ZZZ
17002	A	Destruction of add'l. lesions	0.30	ZZZ
17010	A	Destruction of skin lesion(s)	1.51	010
17100	A	Destruction of skin lesion	0.92	010
17101	A	Destruction of 2nd lesion	0.30	ZZZ
17102	A	Destruction of add'l. lesions	0.20	ZZZ
17104	A	Destruction of skin lesions	2.10	010
17105	A	Destruction of skin lesions	1.09	010
17106	A	Destruction of skin lesions	6.57	090
17107	A	Destruction of skin lesions	12.99	090
17108	A	Destruction of skin lesions	22.76	090
17110	A	Destruction of skin lesions	0.96	010
17200	A	Electrocautery of skin tags	1.02	010
17201	A	Electrocautery added lesions	0.54	ZZZ
17250	A	Chemical cautery, tissue	0.86	000
17260	A	Destruction of skin lesions	2.04	010
17261	A	Destruction of skin lesions	2.57	010
17262	A	Destruction of skin lesions	3.43	010
17263	A	Destruction of skin lesions	4.09	010
17264	A	Destruction of skin lesions	4.61	010
17266	A	Destruction of skin lesions	5.68	010
17270	A	Destruction of skin lesions	2.67	010
17271	A	Destruction of skin lesions	3.27	010
17272	A	Destruction of skin lesions	4.01	010
17273	A	Destruction of skin lesions	4.70	010
17274	A	Destruction of skin lesions	5.91	010
17276	A	Destruction of skin lesions	6.85	010
17280	A	Destruction of skin lesions	2.84	010
17281	A	Destruction of skin lesions	3.85	010
17282	A	Destruction of skin lesions	4.67	010

17283	A	Destruction of skin lesions	5.74	010
17284	A	Destruction of skin lesions	6.84	010
17286	A	Destruction of skin lesions	9.05	010
17304	A	Chemosurgery of skin lesion	11.78	000
17305	A	2nd stage chemosurgery	5.19	000
17306	A	3rd stage chemosurgery	4.31	000
17307	A	Follow–up skin lesion therapy	4.38	000
17310	A	Extensive skin chemosurgery	1.09	000
17340	A	Cryotherapy of skin	1.02	010
17360	A	Skin peel therapy	1.68	010
19000	A	Drainage of breast lesion	1.26	000
19001	A	Drain added breast lesion	0.69	ZZZ
19020	A	Incision of breast lesion	4.95	090
19030	A	Injection for breast X–ray	2.04	000
19100	A	Biopsy of breast	1.99	000
19101	A	Biopsy of breast	5.74	010
19110	A	Nipple exploration	6.92	090
19112	A	Excise breast duct fistula	6.07	090
19120	A	Removal of breast lesion	8.11	090
19125	A	Excision, breast lesion	9.13	000
19126	A	Excision, add'l. breast lesion	4.57	ZZZ
19140	A	Removal of breast tissue	9.74	090
19160	A	Removal of breast tissue	11.32	090
19162	A	Remove breast tissue, nodes	23.39	090
19180	A	Removal of breast	14.48	090
19182	A	Removal of breast	14.12	090
19200	A	Removal of breast	25.76	090
19220	A	Removal of breast	26.42	090
19240	A	Removal of breast	25.37	090
19260	A	Removal of chest wall lesion	19.63	090
19271	A	Revision of chest wall	32.69	090
19272	A	Extensive chest wall surgery	33.64	090
19290	A	Place needle wire, breast	1.75	000
19291	A	Place needle wire, breast	0.91	ZZZ
19316	A	Suspension of breast	24.34	090
19318	A	Reduction of large breast	27.21	090
19324	A	Enlarge breast	9.25	090
19325	A	Enlarge breast with implant	14.60	090
19328	A	Removal of breast implant	9.52	090
19330	A	Removal of implant material	11.52	090
19340	A	Immediate breast prosthesis	16.19	ZZZ
19342	A	Delayed breast prosthesis	22.65	090
19350	A	Breast reconstruction	16.12	090
19355	A	Correct inverted nipple(s)	12.81	090
19357	A	Breast reconstruction	30.30	090
19361	A	Breast reconstruction	40.25	090
19364	A	Breast reconstruction	46.49	090
19366	A	Breast reconstruction	38.15	090
19367	A	Breast reconstruction	47.19	090
19368	A	Breast reconstruction	53.64	090
19369	A	Breast reconstruction	51.16	090
19370	A	Surgery of breast capsule	14.47	090
19371	A	Removal of breast capsule	17.67	090
19380	A	Revise breast reconstruction	17.68	090
19396	A	Design custom breast implant	3.93	000

B. Procedure code numbers 20000 to 29898 relate to musculoskeletal procedures.

CPT/ HCPCS Proce- dure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
20000		A	Incision of abscess	2.75	010
20005		A	Incision of deep abscess	5.02	010
20200		A	Muscle biopsy	2.69	000
20205		A	Deep muscle biopsy	4.43	000
20206		A	Needle biopsy, muscle	2.03	000
20220		A	Bone biopsy, trocar/needle	2.62	000
20225		A	Bone biopsy, trocar/needle	4.41	000
20240		A	Bone biopsy, excisional	5.05	010
20245		A	Bone biopsy, excisional	7.50	010
20250		A	Open bone biopsy	10.13	010
20251		A	Open bone biopsy	11.53	010
20500		A	Injection of sinus tract	1.57	010
20501		A	Inject sinus tract for x–ray	1.07	000
20520		A	Removal of foreign body	2.56	010
20525		A	Removal of foreign body	5.65	010
20550		A	Inject tendon/ligament/cyst	1.26	000
20600		A	Drain/inject joint/bursa	1.16	000
20605		A	Drain/inject joint/bursa	1.16	000
20610		A	Drain/inject joint/bursa	1.27	000
20615		A	Treatment of bone cyst	2.76	010
20650		A	Insert and remove bone pin	3.23	010
20660		A	Apply, remove fixation device	4.19	000
20661		A	Application of head brace	8.47	090
20662		A	Application of pelvis brace	12.65	090
20663		A	Application of thigh brace	9.96	090
20665		A	Removal of fixation device	1.80	010
20670		A	Removal of support implant	2.50	010
20680		A	Removal of support implant	6.87	090
20690		A	Apply bone fixation device	7.51	ZZZ
20692		A	Apply bone fixation device	12.44	ZZZ
20693		A	Adjust bone fixation device	8.17	090
20694		A	Remove bone fixation device	6.65	090
20802		A	Replantation, arm, complete	80.87	090
20805		A	Replant forearm, complete	98.97	090
20808		A	Replantation, hand, complete	123.05	090
20816		A	Replantation digit, complete	60.66	090
20822		A	Replantation digit, complete	50.15	090
20824		A	Replantation thumb, complete	60.66	090
20827		A	Replantation thumb, complete	51.56	090
20838		A	Replantation, foot, complete	80.87	090
20900		A	Removal of bone for graft	8.10	090
20902		A	Removal of bone for graft	12.16	090
20910		A	Remove cartilage for graft	5.89	090
20912		A	Remove cartilage for graft	11.03	090

20920	A	Removal of fascia for graft	9.08	090
20922	A	Removal of fascia for graft	10.85	090
20924	A	Removal of tendon for graft	11.98	090
20926	A	Removal of tissue for graft	7.86	090
20950	A	Record fluid pressure, muscle	2.45	000
20955	A	Microvascular fibula graft	76.82	090
20969	A	Bone–skin graft	86.03	090
20970	A	Bone–skin graft, pelvis	84.27	090
20972	A	Bone–skin graft, metatarsal	84.92	090
20973	A	Bone–skin graft, great toe	90.58	090
20974	A	Electrical bone stimulation	4.33	ZZZ
20975	A	Electrical bone stimulation	6.25	ZZZ
21010	A	Incision of jaw joint	19.76	090
21015	A	Resection of facial tumor	11.92	090
21025	A	Excision of bone, lower jaw	9.37	090
21026	A	Excision of facial bone(s)	7.82	090
21029	A	Contour of face bone lesion	16.81	090
21030	A	Removal of face bone lesion	10.56	090
21031	A	Remove exostosis, mandible	5.84	090
21032	A	Remove exostosis, maxilla	8.33	090
21034	A	Removal of face bone lesion	22.62	090
21040	A	Removal of jaw bone lesion	4.88	090
21041	A	Removal of jaw bone lesion	11.03	090
21044	A	Removal of jaw bone lesion	21.24	090
21045	A	Extensive jaw surgery	29.79	090
21050	A	Removal of jaw joint	22.92	090
21060	A	Remove jaw joint cartilage	21.66	090
21070	A	Remove coronoid process	14.92	090
21100	A	Maxillofacial fixation	5.17	090
21110	A	Interdental fixation	10.78	090
21116	A	Injection, jaw joint X–ray	1.57	000
21120	A	Reconstruction of chin	8.57	090
21121	A	Reconstruction of chin	13.48	090
21122	A	Reconstruction of chin	14.84	090
21123	A	Reconstruction of chin	19.41	090
21125	A	Augmentation lower jaw bone	11.24	090
21127	A	Augmentation lower jaw bone	18.85	090
21137	A	Reduction of forehead	16.97	090
21138	A	Reduction of forehead	21.16	090
21139	A	Reduction of forehead	25.39	090
21144	A	Reconstruct midface, leFort	30.59	090
21145	A	Reconstruct midface, leFort	34.19	090
21146	A	Reconstruct midface, leFort	35.38	090
21147	A	Reconstruct midface, leFort	36.70	090
21150	A	Reconstruct midface, leFort	44.07	090
21151	A	Reconstruct midface, leFort	49.36	090
21154	A	Reconstruct midface, leFort	52.86	090
21155	A	Reconstruct midface, leFort	59.93	090
21159	A	Reconstruct midface, leFort	74.02	090
21160	A	Reconstruct midface, leFort	81.07	090
21172	A	Reconstruct orbit/forehead	48.45	090
21175	A	Reconstruct orbit/forehead	58.16	090
21179	A	Reconstruct entire forehead	38.76	090
21180	A	Reconstruct entire forehead	44.07	090
21181	A	Contour cranial bone lesion	16.97	090

21182	A	Reconstruct cranial bone	56.40	090
21183	A	Reconstruct cranial bone	61.70	090
21184	A	Reconstruct cranial bone	66.98	090
21188	A	Reconstruction of midface	38.76	090
21193	A	Reconstruct lower jaw bone	29.34	090
21194	A	Reconstruct lower jaw bone	34.00	090
21195	A	Reconstruct lower jaw bone	29.41	090
21196	A	Reconstruct lower jaw bone	32.42	090
21198	A	Reconstruct lower jaw bone	29.11	090
21206	A	Reconstruct upper jaw bone	24.16	090
21208	A	Augmentation of facial bones	21.36	090
21209	A	Reduction of facial bones	11.32	090
21210	A	Face bone graft	22.46	090
21215	A	Lower jaw bone graft	23.70	090
21230	A	Rib cartilage graft	21.42	090
21235	A	Ear cartilage graft	14.92	090
21240	A	Reconstruction of jaw joint	32.54	090
21242	A	Reconstruction of jaw joint	32.29	090
21243	A	Reconstruction of jaw joint	34.31	090
21244	A	Reconstruction of lower jaw	27.22	090
21245	A	Reconstruction of jaw	23.25	090
21246	A	Reconstruction of jaw	21.06	090
21247	A	Reconstruct lower jaw bone	49.30	090
21248	A	Reconstruction of jaw	28.27	090
21249	A	Reconstruction of jaw	47.90	090
21255	A	Reconstruct lower jaw bone	36.42	090
21256	A	Reconstruction of orbit	35.26	090
21260	A	Revise eye sockets	35.98	090
21261	A	Revise eye sockets	48.10	090
21263	A	Revise eye sockets	61.91	090
21267	A	Revise eye sockets	33.49	090
21268	A	Revise eye sockets	40.14	090
21270	A	Augmentation cheek bone	22.51	090
21275	A	Revision orbitofacial bones	20.17	090
21280	A	Revision of eyelid	13.12	090
21282	A	Revision of eyelid	9.49	090
21295	A	Revision of jaw muscle/bone	2.47	090
21296	A	Revision of jaw muscle/bone	7.68	090
21300	A	Treatment of skull fracture	1.83	000
21310	A	Treatment of nose fracture	1.39	000
21315	A	Treatment of nose fracture	3.33	010
21320	A	Treatment of nose fracture	4.34	010
21325	A	Repair of nose fracture	7.89	090
21330	A	Repair of nose fracture	11.95	090
21335	A	Repair of nose fracture	19.43	090
21336	A	Repair nasal septal fracture	9.73	090
21337	A	Repair nasal septal fracture	5.55	090
21338	A	Repair nasoethmoid fracture	11.42	090
21339	A	Repair nasoethmoid fracture	15.01	090
21340	A	Repair of nose fracture	19.55	090
21343	A	Repair of sinus fracture	21.87	090
21344	A	Repair of sinus fracture	28.23	090
21345	A	Repair of nose/jaw fracture	15.95	090
21346	A	Repair of nose/jaw fracture	19.88	090
21347	A	Repair of nose/jaw fracture	22.98	090

21348	A	Repair of nose/jaw fracture	28.28	090
21355	A	Repair cheek bone fracture	5.18	010
21356	A	Repair cheek bone fracture	9.96	010
21360	A	Repair cheek bone fracture	13.80	090
21365	A	Repair cheek bone fracture	27.23	090
21366	A	Repair cheek bone fracture	30.12	090
21385	A	Repair eye socket fracture	18.76	090
21386	A	Repair eye socket fracture	18.33	090
21387	A	Repair eye socket fracture	17.06	090
21390	A	Repair eye socket fracture	22.08	090
21395	A	Repair eye socket fracture	22.26	090
21400	A	Treat eye socket fracture	3.07	090
21401	A	Repair eye socket fracture	5.81	090
21406	A	Repair eye socket fracture	12.18	090
21407	A	Repair eye socket fracture	15.56	090
21408	A	Repair eye socket fracture	20.61	090
21421	A	Treat mouth roof fracture	11.25	090
21422	A	Repair mouth roof fracture	18.22	090
21423	A	Repair mouth roof fracture	20.17	090
21431	A	Treat craniofacial fracture	13.00	090
21432	A	Repair craniofacial fracture	15.28	090
21433	A	Repair craniofacial fracture	42.81	090
21435	A	Repair craniofacial fracture	30.45	090
21436	A	Repair craniofacial fracture	42.09	090
21440	A	Repair dental ridge fracture	5.73	090
21445	A	Repair dental ridge fracture	11.42	090
21450	A	Treat lower jaw fracture	5.75	090
21451	A	Treat lower jaw fracture	11.00	090
21452	A	Treat lower jaw fracture	3.34	090
21453	A	Treat lower jaw fracture	12.08	090
21454	A	Treat lower jaw fracture	17.15	090
21461	A	Repair lower jaw fracture	18.39	090
21462	A	Repair lower jaw fracture	21.57	090
21465	A	Repair lower jaw fracture	20.12	090
21470	A	Repair lower jaw fracture	32.21	090
21480	A	Reset dislocated jaw	1.49	000
21485	A	Reset dislocated jaw	6.03	090
21490	A	Repair dislocated jaw	17.66	090
21493	A	Treat hyoid bone fracture	2.77	090
21494	A	Repair hyoid bone fracture	13.69	090
21495	A	Repair hyoid bone fracture	10.41	090
21497	A	Interdental wiring	7.77	090
21501	A	Drain neck/chest lesion	5.50	090
21502	A	Drain chest lesion	11.11	090
21510	A	Drainage of bone lesion	9.13	090
21550	A	Biopsy of neck/chest	2.93	010
21555	A	Remove lesion neck/chest	5.85	090
21556	A	Remove lesion neck/chest	9.46	090
21557	A	Remove tumor, neck or chest	17.88	090
21600	A	Partial removal of rib	11.30	090
21610	A	Partial removal of rib	14.16	090
21615	A	Removal of rib	20.32	090
21616	A	Removal of rib and nerves	19.29	090
21620	A	Partial removal of sternum	13.61	090
21627	A	Sternal debridement	11.62	090

21630	A	Extensive sternum surgery	30.09	090
21632	A	Extensive sternum surgery	29.51	090
21700	A	Revision of neck muscle	10.28	090
21705	A	Revision of neck muscle/rib	14.47	090
21720	A	Revision of neck muscle	9.58	090
21725	A	Revision of neck muscle	11.82	090
21740	A	Reconstruction of sternum	25.41	090
21750	A	Repair of sternum separation	18.27	090
21800	A	Treatment of rib fracture	1.72	090
21805	A	Treatment of rib fracture	4.07	090
21810	A	Treatment of rib fracture(s)	14.30	090
21820	A	Treat sternum fracture	2.65	090
21825	A	Repair sternum fracture	14.37	090
21920	A	Biopsy soft tissue of back	2.87	010
21925	A	Biopsy soft tissue of back	6.38	090
21930	A	Remove lesion, back or flank	9.58	090
21935	A	Remove tumor of back	24.54	090
22100	A	Remove part of neck vertebra	15.03	090
22101	A	Remove part, thorax vertebra	15.47	090
22102	A	Remove part, lumbar vertebra	13.53	090
22105	A	Remove part of neck vertebra	24.79	090
22106	A	Remove part, thorax vertebra	21.73	090
22107	A	Remove part, lumbar vertebra	17.01	090
22110	A	Remove part of neck vertebra	22.27	090
22112	A	Remove part, thorax vertebra	22.44	090
22114	A	Remove part, lumbar vertebra	19.54	090
22140	A	Reconstruct neck spine	40.72	090
22141	A	Reconstruct thorax spine	44.31	090
22142	A	Reconstruct lumbar spine	48.85	090
22145	A	Reconstruct vertebra(e)	14.19	ZZZ
22148	A	Harvesting bone graft	7.41	ZZZ
22150	A	Reconstruct neck spine	41.31	090
22151	A	Reconstruct thorax spine	41.73	090
22152	A	Reconstruct lumbar spine	42.42	090
22210	A	Revision of neck spine	37.81	090
22212	A	Revision of thorax spine	37.07	090
22214	A	Revision of lumbar spine	34.84	090
22220	A	Revision of neck spine	38.32	090
22222	A	Revision of thorax spine	34.64	090
22224	A	Revision of lumbar spine	36.42	090
22230	A	Additional revision of spine	11.64	ZZZ
22305	A	Treat spine process fracture	4.45	090
22310	A	Treat spine fracture	5.46	090
22315	A	Treat spine fracture	14.38	090
22325	A	Repair of spine fracture	26.33	090
22326	A	Repair neck spine fracture	35.97	090
22327	A	Repair thorax spine fracture	34.85	090
22505	A	Manipulation of spine	3.18	010
22548	A	Neck spine fusion	49.05	090
22554	A	Neck spine fusion	40.01	090
22556	A	Thorax spine fusion	46.94	090
22558	A	Lumbar spine fusion	44.27	090
22585	A	Additional spinal fusion	11.47	ZZZ
22590	A	Spine and skull spinal fusion	42.50	090
22595	A	Neck spinal fusion	43.95	090

22600	A	Neck spine fusion	39.34	090
22610	A	Thorax spine fusion	34.54	090
22612	A	Lumbar spine fusion	43.27	090
22625	A	Lumbar spine fusion	43.89	090
22630	A	Lumbar spine fusion	41.22	090
22650	A	Additional spinal fusion	12.63	ZZZ
22800	A	Fusion of spine	40.63	090
22802	A	Fusion of spine	62.31	090
22810	A	Fusion of spine	49.30	090
22812	A	Fusion of spine	55.59	090
22820	A	Harvesting of bone	6.87	ZZZ
22830	A	Exploration of spinal fusion	24.54	090
22840	A	Insert spine fixation device	32.30	000
22842	A	Insert spine fixation device	36.42	000
22845	A	Insert spine fixation device	30.39	000
22849	A	Reinsert spinal fixation	25.77	090
22850	A	Remove spine fixation device	19.02	090
22852	A	Remove spine fixation device	19.10	090
22855	A	Remove spine fixation device	17.30	090
22900	A	Remove abdominal wall lesion	9.97	090
23000	A	Removal of calcium deposits	7.63	090
23020	A	Release shoulder joint	16.15	090
23030	A	Drain shoulder lesion	5.53	010
23031	A	Drain shoulder bursa	3.23	010
23035	A	Drain shoulder bone lesion	14.63	090
23040	A	Exploratory shoulder surgery	18.50	090
23044	A	Exploratory shoulder surgery	14.00	090
23065	A	Biopsy shoulder tissues	2.96	010
23066	A	Biopsy shoulder tissues	5.25	090
23075	A	Removal of shoulder lesion	4.19	010
23076	A	Removal of shoulder lesion	11.06	090
23077	A	Remove tumor of shoulder	22.88	090
23100	A	Biopsy of shoulder joint	13.55	090
23101	A	Shoulder joint surgery	12.60	090
23105	A	Remove shoulder joint lining	18.65	090
23106	A	Incision of collarbone joint	10.78	090
23107	A	Explore, treat shoulder joint	18.64	090
23120	A	Partial removal, collarbone	11.70	090
23125	A	Removal of collarbone	18.12	090
23130	A	Partial removal, shoulder bone	14.81	090
23140	A	Removal of bone lesion	11.03	090
23145	A	Removal of bone lesion	17.44	090
23146	A	Removal of bone lesion	13.18	090
23150	A	Removal of humerus lesion	15.02	090
23155	A	Removal of humerus lesion	19.17	090
23156	A	Removal of humerus lesion	16.37	090
23170	A	Remove collarbone lesion	11.54	090
23172	A	Remove shoulder blade lesion	11.82	090
23174	A	Remove humerus lesion	17.94	090
23180	A	Remove collarbone lesion	12.52	090
23182	A	Remove shoulder blade lesion	14.67	090
23184	A	Remove humerus lesion	18.30	090
23190	A	Partial removal of scapula	13.42	090
23195	A	Removal of head of humerus	18.75	090
23200	A	Removal of collarbone	20.94	090

23210	A	Removal of shoulder blade	21.22	090
23220	A	Partial removal of humerus	26.55	090
23221	A	Partial removal of humerus	35.26	090
23222	A	Partial removal of humerus	32.99	090
23330	A	Remove shoulder foreign body	2.39	010
23331	A	Remove shoulder foreign body	9.39	090
23332	A	Remove shoulder foreign body	21.22	090
23350	A	Injection for shoulder X-ray	1.55	000
23395	A	Muscle transfer, shoulder/arm	24.62	090
23397	A	Muscle transfers	30.57	090
23400	A	Fixation of shoulder blade	23.80	090
23405	A	Incision of tendon and muscle	16.01	090
23406	A	Incise tendon(s) and muscle(s)	20.66	090
23410	A	Repair of tendon(s)	23.86	090
23412	A	Repair of tendon(s)	27.31	090
23415	A	Release of shoulder ligament	15.19	090
23420	A	Repair of shoulder	28.62	090
23430	A	Repair biceps tendon	17.60	090
23440	A	Removal/transplant tendon	17.94	090
23450	A	Repair shoulder capsule	26.78	090
23455	A	Repair shoulder capsule	30.82	090
23460	A	Repair shoulder capsule	30.03	090
23462	A	Repair shoulder capsule	31.19	090
23465	A	Repair shoulder capsule	30.61	090
23466	A	Repair shoulder capsule	31.71	090
23470	A	Reconstruct shoulder joint	34.40	090
23472	A	Reconstruct shoulder joint	42.32	090
23480	A	Revision of collarbone	17.76	090
23485	A	Revision of collarbone	25.12	090
23490	A	Reinforce clavicle	21.68	090
23491	A	Reinforce shoulder bones	27.56	090
23500	A	Treat clavicle fracture	3.72	090
23505	A	Treat clavicle fracture	6.33	090
23515	A	Repair clavicle fracture	14.59	090
23520	A	Treat clavicle dislocation	3.52	090
23525	A	Treat clavicle dislocation	5.54	090
23530	A	Repair clavicle dislocation	14.11	090
23532	A	Repair clavicle dislocation	15.51	090
23540	A	Treat clavicle dislocation	3.76	090
23545	A	Treat clavicle dislocation	5.22	090
23550	A	Repair clavicle dislocation	16.00	090
23552	A	Repair clavicle dislocation	15.80	090
23570	A	Treat shoulder blade fracture	3.94	090
23575	A	Treat shoulder blade fracture	6.88	090
23585	A	Repair scapula fracture	16.86	090
23600	A	Treat humerus fracture	5.89	090
23605	A	Treat humerus fracture	9.76	090
23615	A	Repair humerus fracture	20.12	090
23616	A	Repair humerus fracture	44.23	090
23620	A	Treat humerus fracture	5.39	090
23625	A	Treat humerus fracture	7.80	090
23630	A	Repair humerus fracture	16.51	090
23650	A	Treat shoulder dislocation	5.47	090
23655	A	Treat shoulder dislocation	7.45	090
23660	A	Repair shoulder dislocation	16.95	090

23665	A	Treat dislocation/fracture	7.81	090
23670	A	Repair dislocation/fracture	18.05	090
23675	A	Treat dislocation/fracture	9.89	090
23680	A	Repair dislocation/fracture	22.77	090
23700	A	Fixation of shoulder	4.76	010
23800	A	Fusion of shoulder joint	31.17	090
23802	A	Fusion of shoulder joint	30.04	090
23900	A	Amputation of arm and girdle	32.42	090
23920	A	Amputation at shoulder joint	28.95	090
23921	A	Amputation follow-up surgery	9.74	090
23930	A	Drainage of arm lesion	4.53	010
23931	A	Drainage of arm bursa	2.45	010
23935	A	Drain arm/elbow bone lesion	10.71	090
24000	A	Exploratory elbow surgery	13.27	090
24006	A	Release elbow joint	16.53	090
24065	A	Biopsy arm/elbow soft tissue	2.88	010
24066	A	Biopsy arm/elbow soft tissue	7.91	090
24075	A	Remove arm/elbow lesion	5.98	090
24076	A	Remove arm/elbow lesion	10.10	090
24077	A	Remove tumor of arm/elbow	22.09	090
24100	A	Biopsy elbow joint lining	9.30	090
24101	A	Explore/treat elbow joint	14.14	090
24102	A	Remove elbow joint lining	18.31	090
24105	A	Removal of elbow bursa	7.56	090
24110	A	Remove humerus lesion	15.47	090
24115	A	Remove/graft bone lesion	17.34	090
24116	A	Remove/graft bone lesion	21.70	090
24120	A	Remove elbow lesion	12.95	090
24125	A	Remove/graft bone lesion	13.52	090
24126	A	Remove/graft bone lesion	15.86	090
24130	A	Removal of head of radius	13.30	090
24134	A	Removal of arm bone lesion	18.37	090
24136	A	Remove radius bone lesion	16.58	090
24138	A	Remove elbow bone lesion	14.37	090
24140	A	Partial removal of arm bone	18.17	090
24145	A	Partial removal of radius	14.10	090
24147	A	Partial removal of elbow	14.24	090
24150	A	Extensive humerus surgery	27.79	090
24151	A	Extensive humerus surgery	29.69	090
24152	A	Extensive radius surgery	17.00	090
24153	A	Extensive radius surgery	22.39	090
24155	A	Removal of elbow joint	22.85	090
24160	A	Remove elbow joint implant	12.75	090
24164	A	Remove radius head implant	11.84	090
24200	A	Removal of arm foreign body	2.31	010
24201	A	Removal of arm foreign body	7.65	090
24220	A	Injection for elbow X-ray	1.85	000
24301	A	Muscle/tendon transfer	18.40	090
24305	A	Arm tendon lengthening	10.41	090
24310	A	Revision of arm tendon	8.96	090
24320	A	Repair of arm tendon	19.94	090
24330	A	Revision of arm muscles	18.75	090
24331	A	Revision of arm muscles	20.63	090
24340	A	Repair of biceps tendon	15.24	090
24342	A	Repair of ruptured tendon	21.53	090

24350	A	Repair of tennis elbow	9.68	090
24351	A	Repair of tennis elbow	10.73	090
24352	A	Repair of tennis elbow	12.37	090
24354	A	Repair of tennis elbow	12.35	090
24356	A	Revision of tennis elbow	14.35	090
24360	A	Reconstruct elbow joint	28.23	090
24361	A	Reconstruct elbow joint	27.78	090
24362	A	Reconstruct elbow joint	27.89	090
24363	A	Replace elbow joint	42.68	090
24365	A	Reconstruct head of radius	16.14	090
24366	A	Reconstruct head of radius	20.75	090
24400	A	Revision of humerus	19.78	090
24410	A	Revision of humerus	29.49	090
24420	A	Revision of humerus	26.37	090
24430	A	Repair of humerus	28.26	090
24435	A	Repair humerus with graft	29.46	090
24470	A	Revision of elbow joint	17.00	090
24495	A	Decompression of forearm	14.00	090
24498	A	Reinforce humerus	22.61	090
24500	A	Treat humerus fracture	5.76	090
24505	A	Treat humerus fracture	9.74	090
24515	A	Repair humerus fracture	21.47	090
24516	A	Repair humerus fracture	21.47	090
24530	A	Treat humerus fracture	6.27	090
24535	A	Treat humerus fracture	11.82	090
24538	A	Treat humerus fracture	17.56	090
24545	A	Repair humerus fracture	20.54	090
24546	A	Repair humerus fracture	25.57	090
24560	A	Treat humerus fracture	4.95	090
24565	A	Treat humerus fracture	8.99	090
24566	A	Treat humerus fracture	13.79	090
24575	A	Repair humerus fracture	18.43	090
24576	A	Treat humerus fracture	5.01	090
24577	A	Treat humerus fracture	9.81	090
24579	A	Repair humerus fracture	20.01	090
24582	A	Treat humerus fracture	15.07	090
24586	A	Repair elbow fracture	30.45	090
24587	A	Repair elbow fracture	29.23	090
24600	A	Treat elbow dislocation	6.19	090
24605	A	Treat elbow dislocation	7.60	090
24615	A	Repair elbow dislocation	18.90	090
24620	A	Treat elbow fracture	10.74	090
24635	A	Repair elbow fracture	24.52	090
24640	A	Treat elbow dislocation	2.20	010
24650	A	Treat radius fracture	4.45	090
24655	A	Treat radius fracture	7.44	090
24665	A	Repair radius fracture	15.48	090
24666	A	Repair radius fracture	20.05	090
24670	A	Treatment of ulna fracture	4.49	090
24675	A	Treatment of ulna fracture	8.34	090
24685	A	Repair ulna fracture	17.51	090
24800	A	Fusion of elbow joint	22.22	090
24802	A	Fusion/graft of elbow joint	26.13	090
24900	A	Amputation of upper arm	17.26	090
24920	A	Amputation of upper arm	16.18	090

24925	A	Amputation follow–up surgery	13.29	090
24930	A	Amputation follow–up surgery	18.23	090
24931	A	Amputate upper arm and implant	23.95	090
24935	A	Revision of amputation	29.37	090
25000	A	Incision of tendon sheath	7.49	090
25020	A	Decompression of forearm	10.36	090
25023	A	Decompression of forearm	17.82	090
25028	A	Drainage of forearm lesion	7.17	090
25031	A	Drainage of forearm bursa	4.63	090
25035	A	Treat forearm bone lesion	13.72	090
25040	A	Explore/treat wrist joint	12.82	090
25065	A	Biopsy forearm soft tissues	3.20	010
25066	A	Biopsy forearm soft tissues	5.55	090
25075	A	Removal of forearm lesion	6.02	090
25076	A	Removal of forearm lesion	8.94	090
25077	A	Remove tumor, forearm/wrist	18.73	090
25085	A	Incision of wrist capsule	10.16	090
25100	A	Biopsy of wrist joint	8.80	090
25101	A	Explore/treat wrist joint	10.61	090
25105	A	Remove wrist joint lining	13.35	090
25107	A	Remove wrist joint cartilage	11.69	090
25110	A	Remove wrist tendon lesion	6.86	090
25111	A	Remove wrist tendon lesion	6.78	090
25112	A	Reremove wrist tendon lesion	8.49	090
25115	A	Remove wrist/forearm lesion	14.11	090
25116	A	Remove wrist/forearm lesion	15.41	090
25118	A	Excise wrist tendon sheath	9.97	090
25119	A	Partial removal of ulna	13.63	090
25120	A	Removal of forearm lesion	12.89	090
25125	A	Remove/graft forearm lesion	14.50	090
25126	A	Remove/graft forearm lesion	14.58	090
25130	A	Removal of wrist lesion	9.68	090
25135	A	Remove and graft wrist lesion	12.62	090
25136	A	Remove and graft wrist lesion	10.92	090
25145	A	Remove forearm bone lesion	12.33	090
25150	A	Partial removal of ulna	13.88	090
25151	A	Partial removal of radius	13.21	090
25170	A	Extensive forearm surgery	21.11	090
25210	A	Removal of wrist bone	10.90	090
25215	A	Removal of wrist bones	16.90	090
25230	A	Partial removal of radius	10.91	090
25240	A	Partial removal of ulna	10.71	090
25246	A	Injection for wrist X–ray	1.98	000
25248	A	Remove forearm foreign body	7.37	090
25250	A	Removal of wrist prosthesis	12.47	090
25251	A	Removal of wrist prosthesis	18.14	090
25260	A	Repair forearm tendon/muscle	12.41	090
25263	A	Repair forearm tendon/muscle	13.75	090
25265	A	Repair forearm tendon/muscle	18.31	090
25270	A	Repair forearm tendon/muscle	9.40	090
25272	A	Repair forearm tendon/muscle	10.52	090
25274	A	Repair forearm tendon/muscle	15.73	090
25280	A	Revise wrist/forearm tendon	11.45	090
25290	A	Incise wrist/forearm tendon	7.75	090
25295	A	Release wrist/forearm tendon	9.63	090

25300	A	Fusion of tendons at wrist	16.51	090
25301	A	Fusion of tendons at wrist	15.56	090
25310	A	Transplant forearm tendon	15.50	090
25312	A	Transplant forearm tendon	17.48	090
25315	A	Revise palsy hand tendon(s)	18.30	090
25316	A	Revise palsy hand tendon(s)	23.11	090
25320	A	Repair/revise wrist joint	19.34	090
25330	A	Revise wrist joint	20.96	090
25331	A	Revise wrist joint	28.64	090
25332	A	Revise wrist joint	21.75	090
25335	A	Realignment of hand	24.40	090
25337	A	Reconstruct ulna/radioulnar	18.55	090
25350	A	Revision of radius	16.57	090
25355	A	Revision of radius	19.54	090
25360	A	Revision of ulna	14.87	090
25365	A	Revise radius and ulna	22.85	090
25370	A	Revise radius or ulna	25.22	090
25375	A	Revise radius and ulna	26.02	090
25390	A	Shorten radius/ulna	19.55	090
25391	A	Lengthen radius/ulna	25.14	090
25392	A	Shorten radius and ulna	26.68	090
25393	A	Lengthen radius and ulna	30.46	090
25400	A	Repair radius or ulna	22.09	090
25405	A	Repair/graft radius or ulna	27.07	090
25415	A	Repair radius and ulna	25.18	090
25420	A	Repair/graft radius and ulna	31.35	090
25425	A	Repair/graft radius or ulna	25.54	090
25426	A	Repair/graft radius and ulna	27.91	090
25440	A	Repair/graft wrist bone	19.88	090
25441	A	Reconstruct wrist joint	24.72	090
25442	A	Reconstruct wrist joint	18.13	090
25443	A	Reconstruct wrist joint	20.14	090
25444	A	Reconstruct wrist joint	21.74	090
25445	A	Reconstruct wrist joint	20.62	090
25446	A	Wrist replacement	37.40	090
25447	A	Repair wrist joint(s)	20.41	090
25449	A	Remove wrist joint implant	22.31	090
25450	A	Revision of wrist joint	15.67	090
25455	A	Revision of wrist joint	18.68	090
25490	A	Reinforce radius	18.64	090
25491	A	Reinforce ulna	19.51	090
25492	A	Reinforce radius and ulna	24.02	090
25500	A	Treat fracture of radius	4.79	090
25505	A	Treat fracture of radius	8.83	090
25515	A	Repair fracture of radius	16.97	090
25520	A	Repair fracture of radius	12.30	090
25525	A	Repair fracture of radius	23.90	090
25526	A	Repair fracture of radius	25.41	090
25530	A	Treat fracture of ulna	4.58	090
25535	A	Treat fracture of ulna	8.80	090
25545	A	Repair fracture of ulna	16.63	090
25560	A	Treat fracture radius and ulna	4.71	090
25565	A	Treat fracture radius and ulna	10.35	090
25574	A	Treat fracture radius and ulna	15.43	090
25575	A	Repair fracture radius/ulna	21.16	090

25600	A	Treat fracture radius/ulna	5.56	090
25605	A	Treat fracture radius/ulna	9.67	090
25611	A	Repair fracture radius/ulna	13.69	090
25620	A	Repair fracture radius/ulna	15.94	090
25622	A	Treat wrist bone fracture	4.90	090
25624	A	Treat wrist bone fracture	8.28	090
25628	A	Repair wrist bone fracture	15.62	090
25630	A	Treat wrist bone fracture	5.09	090
25635	A	Treat wrist bone fracture	7.81	090
25645	A	Repair wrist bone fracture	14.07	090
25650	A	Repair wrist bone fracture	5.73	090
25660	A	Treat wrist dislocation	6.51	090
25670	A	Repair wrist dislocation	15.25	090
25675	A	Treat wrist dislocation	6.92	090
25676	A	Repair wrist dislocation	15.51	090
25680	A	Treat wrist fracture	8.29	090
25685	A	Repair wrist fracture	18.86	090
25690	A	Treat wrist dislocation	10.47	090
25695	A	Repair wrist dislocation	15.66	090
25800	A	Fusion of wrist joint	21.19	090
25805	A	Fusion/graft of wrist joint	24.62	090
25810	A	Fusion/graft of wrist joint	23.50	090
25820	A	Fusion of hand bones	16.90	090
25825	A	Fusion hand bones with graft	20.78	090
25830	A	Fusion radioulnar jnt/ulna	18.55	090
25900	A	Amputation of forearm	16.01	090
25905	A	Amputation of forearm	16.18	090
25907	A	Amputation follow-up surgery	13.60	090
25909	A	Amputation follow-up surgery	14.56	090
25915	A	Amputation of forearm	33.95	090
25920	A	Amputate hand at wrist	15.80	090
25922	A	Amputate hand at wrist	13.12	090
25924	A	Amputation follow-up surgery	16.08	090
25927	A	Amputation of hand	15.30	090
25929	A	Amputation follow-up surgery	12.46	090
25931	A	Amputation follow-up surgery	12.44	090
26010	A	Drainage of finger abscess	2.00	010
26011	A	Drainage of finger abscess	3.82	010
26020	A	Drain hand tendon sheath	8.10	090
26025	A	Drainage of palm bursa	9.27	090
26030	A	Drainage of palm bursa(s)	11.66	090
26034	A	Treat hand bone lesion	10.24	090
26035	A	Decompress fingers/hand	14.07	090
26037	A	Decompress fingers/hand	13.66	090
26040	A	Release palm contracture	6.24	090
26045	A	Release palm contracture	10.57	090
26055	A	Incise finger tendon sheath	6.16	090
26060	A	Incision of finger tendon	3.95	090
26070	A	Explore/treat hand joint	6.34	090
26075	A	Explore/treat finger joint	7.58	090
26080	A	Explore/treat finger joint	7.22	090
26100	A	Biopsy hand joint lining	6.79	090
26105	A	Biopsy finger joint lining	8.13	090
26110	A	Biopsy finger joint lining	6.62	090
26115	A	Removal of hand lesion	5.90	090

26116	A	Removal of hand lesion	9.27	090
26117	A	Remove tumor, hand/finger	13.86	090
26121	A	Release palm contracture	17.67	090
26123	A	Release palm contracture	18.63	090
26125	A	Release palm contracture	7.50	ZZZ
26130	A	Remove wrist joint lining	10.64	090
26135	A	Revise finger joint, each	12.02	090
26140	A	Revise finger joint, each	10.73	090
26145	A	Tendon excision, palm/finger	11.21	090
26160	A	Remove tendon sheath lesion	5.56	090
26170	A	Removal of palm tendon, each	7.72	090
26180	A	Removal of finger tendon	9.43	090
26200	A	Remove hand bone lesion	10.15	090
26205	A	Remove/graft bone lesion	14.24	090
26210	A	Removal of finger lesion	9.25	090
26215	A	Remove/graft finger lesion	12.91	090
26230	A	Partial removal of hand bone	10.63	090
26235	A	Partial removal, finger bone	10.41	090
26236	A	Partial removal, finger bone	9.20	090
26250	A	Extensive hand surgery	13.90	090
26255	A	Extensive hand surgery	21.51	090
26260	A	Extensive finger surgery	13.04	090
26261	A	Extensive finger surgery	17.01	090
26262	A	Partial removal of finger	10.60	090
26320	A	Removal of implant from hand	7.61	090
26350	A	Repair finger/hand tendon	12.08	090
26352	A	Repair/graft hand tendon	14.50	090
26356	A	Repair finger/hand tendon	14.98	090
26357	A	Repair finger/hand tendon	15.45	090
26358	A	Repair/graft hand tendon	16.84	090
26370	A	Repair finger/hand tendon	14.08	090
26372	A	Repair/graft hand tendon	15.35	090
26373	A	Repair finger/hand tendon	15.17	090
26390	A	Revise hand/finger tendon	17.39	090
26392	A	Repair/graft hand tendon	19.10	090
26410	A	Repair hand tendon	7.96	090
26412	A	Repair/graft hand tendon	12.48	090
26415	A	Excision, hand/finger tendon	15.31	090
26416	A	Graft hand or finger tendon	18.52	090
26418	A	Repair finger tendon	7.94	090
26420	A	Repair/graft finger tendon	12.61	090
26426	A	Repair finger/hand tendon	12.79	090
26428	A	Repair/graft finger tendon	13.00	090
26432	A	Repair finger tendon	7.32	090
26433	A	Repair finger tendon	8.74	090
26434	A	Repair/graft finger tendon	11.24	090
26437	A	Realignment of tendons	9.98	090
26440	A	Release palm/finger tendon	8.68	090
26442	A	Release palm and finger tendon	9.83	090
26445	A	Release hand/finger tendon	7.73	090
26449	A	Release forearm/hand tendon	12.53	090
26450	A	Incision of palm tendon	6.03	090
26455	A	Incision of finger tendon	5.60	090
26460	A	Incise hand/finger tendon	5.23	090
26471	A	Fusion of finger tendons	10.09	090

26474	A	Fusion of finger tendons	10.19	090
26476	A	Tendon lengthening	8.04	090
26477	A	Tendon shortening	9.40	090
26478	A	Lengthening of hand tendon	10.35	090
26479	A	Shortening of hand tendon	11.35	090
26480	A	Transplant hand tendon	13.67	090
26483	A	Transplant/graft hand tendon	17.18	090
26485	A	Transplant palm tendon	14.41	090
26489	A	Transplant/graft palm tendon	12.72	090
26490	A	Revise thumb tendon	16.53	090
26492	A	Tendon transfer with graft	18.60	090
26494	A	Hand tendon/muscle transfer	16.05	090
26496	A	Revise thumb tendon	18.80	090
26497	A	Finger tendon transfer	17.98	090
26498	A	Finger tendon transfer	26.53	090
26499	A	Revision of finger	17.04	090
26500	A	Hand tendon reconstruction	9.52	090
26502	A	Hand tendon reconstruction	12.58	090
26504	A	Hand tendon reconstruction	14.42	090
26508	A	Release thumb contracture	10.19	090
26510	A	Thumb tendon transfer	9.58	090
26516	A	Fusion of knuckle joint	11.31	090
26517	A	Fusion of knuckle joints	16.14	090
26518	A	Fusion of knuckle joints	15.77	090
26520	A	Release knuckle contracture	9.90	090
26525	A	Release finger contracture	9.05	090
26530	A	Revise knuckle joint	12.04	090
26531	A	Revise knuckle with implant	14.87	090
26535	A	Revise finger joint	10.11	090
26536	A	Revise/implant finger joint	13.95	090
26540	A	Repair hand joint	13.32	090
26541	A	Repair hand joint with graft	17.99	090
26542	A	Repair hand joint with graft	12.62	090
26545	A	Reconstruct finger joint	12.33	090
26548	A	Reconstruct finger joint	13.99	090
26550	A	Construct thumb replacement	42.46	090
26555	A	Positional change of finger	33.03	090
26560	A	Repair of web finger	10.26	090
26561	A	Repair of web finger	20.31	090
26562	A	Repair of web finger	20.57	090
26565	A	Correct metacarpal flaw	12.76	090
26567	A	Correct finger deformity	11.21	090
26568	A	Lengthen metacarpal/finger	17.69	090
26580	A	Repair hand deformity	32.33	090
26585	A	Repair finger deformity	27.76	090
26590	A	Repair finger deformity	35.65	090
26591	A	Repair muscles of hand	5.42	090
26593	A	Release muscles of hand	9.42	090
26596	A	Excision constricting tissue	17.66	090
26597	A	Release of scar contracture	18.20	090
26600	A	Treat metacarpal fracture	3.48	090
26605	A	Treat metacarpal fracture	5.17	090
26607	A	Treat metacarpal fracture	9.01	090
26608	A	Treat metacarpal fracture	9.01	090
26615	A	Repair metacarpal fracture	10.52	090

26641	A	Treat thumb dislocation	4.94	090
26645	A	Treat thumb fracture	6.63	090
26650	A	Repair thumb fracture	9.88	090
26665	A	Repair thumb fracture	14.17	090
26670	A	Treat hand dislocation	4.57	090
26675	A	Treat hand dislocation	9.12	090
26676	A	Pin hand dislocation	10.53	090
26685	A	Repair hand dislocation	12.83	090
26686	A	Repair hand dislocation	14.40	090
26700	A	Treat knuckle dislocation	4.49	090
26705	A	Treat knuckle dislocation	5.94	090
26706	A	Pin knuckle dislocation	10.03	090
26715	A	Repair knuckle dislocation	10.00	090
26720	A	Treat finger fracture, each	2.75	090
26725	A	Treat finger fracture, each	4.86	090
26727	A	Treat finger fracture, each	7.60	090
26735	A	Repair finger fracture, each	9.81	090
26740	A	Treat finger fracture, each	3.06	090
26742	A	Treat finger fracture, each	5.87	090
26746	A	Repair finger fracture, each	10.77	090
26750	A	Treat finger fracture, each	2.49	090
26755	A	Treat finger fracture, each	4.14	090
26756	A	Pin finger fracture, each	6.29	090
26765	A	Repair finger fracture, each	6.97	090
26770	A	Treat finger dislocation	3.70	090
26775	A	Treat finger dislocation	4.75	090
26776	A	Pin finger dislocation	6.90	090
26785	A	Repair finger dislocation	7.33	090
26820	A	Thumb fusion with graft	15.10	090
26841	A	Fusion of thumb	13.54	090
26842	A	Thumb fusion with graft	17.12	090
26843	A	Fusion of hand joint	14.23	090
26844	A	Fusion/graft of hand joint	16.28	090
26850	A	Fusion of knuckle	11.65	090
26852	A	Fusion of knuckle with graft	14.29	090
26860	A	Fusion of finger joint	9.18	090
26861	A	Fusion of finger joint, added	4.22	ZZZ
26862	A	Fusion/graft of finger joint	12.72	090
26863	A	Fuse/graft added joint	7.60	ZZZ
26910	A	Amputate metacarpal bone	12.90	090
26951	A	Amputation of finger/thumb	7.57	090
26952	A	Amputation of finger/thumb	10.43	090
26990	A	Drainage of pelvis lesion	10.17	090
26991	A	Drainage of pelvis bursa	8.05	090
26992	A	Drainage of bone lesion	21.00	090
27000	A	Incision of hip tendon	7.27	090
27001	A	Incision of hip tendon	10.29	090
27003	A	Incision of hip tendon	13.92	090
27005	A	Incision of hip tendon	12.71	090
27006	A	Incision of hip tendons	14.61	090
27025	A	Incision of hip/thigh fascia	16.89	090
27030	A	Drainage of hip joint	24.59	090
27033	A	Exploration of hip joint	24.97	090
27035	A	Denervation of hip joint	28.91	090
27040	A	Biopsy of soft tissues	4.06	010

27041	A	Biopsy of soft tissues	12.32	090
27047	A	Remove hip/pelvis lesion	9.26	090
27048	A	Remove hip/pelvis lesion	10.52	090
27049	A	Remove tumor, hip/pelvis	23.78	090
27050	A	Biopsy of sacroiliac joint	9.04	090
27052	A	Biopsy of hip joint	14.17	090
27054	A	Removal of hip joint lining	19.68	090
27060	A	Removal of ischial bursa	9.06	090
27062	A	Remove femur lesion/bursa	9.38	090
27065	A	Removal of hip bone lesion	11.09	090
27066	A	Removal of hip bone lesion	17.83	090
27067	A	Remove/graft hip bone lesion	25.40	090
27070	A	Partial removal of hip bone	17.70	090
27071	A	Partial removal of hip bone	19.59	090
27075	A	Extensive hip surgery	30.76	090
27076	A	Extensive hip surgery	35.81	090
27077	A	Extensive hip surgery	42.17	090
27078	A	Extensive hip surgery	22.06	090
27079	A	Extensive hip surgery	21.75	090
27080	A	Removal of tail bone	10.93	090
27086	A	Remove hip foreign body	2.44	010
27087	A	Remove hip foreign body	12.00	090
27090	A	Removal of hip prosthesis	21.95	090
27091	A	Removal of hip prosthesis	42.12	090
27093	A	Injection for hip X–ray	2.18	000
27095	A	Injection for hip X–ray	2.51	000
27097	A	Revision of hip tendon	16.52	090
27098	A	Transfer tendon to pelvis	16.52	090
27100	A	Transfer of abdominal muscle	19.10	090
27105	A	Transfer of spinal muscle	18.00	090
27110	A	Transfer of iliopsoas muscle	24.20	090
27111	A	Transfer of iliopsoas muscle	24.00	090
27120	A	Reconstruction of hip socket	36.23	090
27122	A	Reconstruction of hip socket	32.61	090
27125	A	Partial hip replacement	31.87	090
27130	A	Total hip replacement	45.28	090
27132	A	Total hip replacement	51.86	090
27134	A	Revise hip joint replacement	59.45	090
27137	A	Revise hip joint replacement	45.83	090
27138	A	Revise hip joint replacement	45.85	090
27140	A	Transplant of femur ridge	23.46	090
27146	A	Incision of hip bone	25.35	090
27147	A	Revision of hip bone	36.15	090
27151	A	Incision of hip bones	37.98	090
27156	A	Revision of hip bones	40.28	090
27158	A	Revision of pelvis	34.10	090
27161	A	Incision of neck of femur	30.85	090
27165	A	Incision/fixation of femur	34.47	090
27170	A	Repair/graft femur head/neck	32.83	090
27175	A	Treat slipped epiphysis	8.55	090
27176	A	Treat slipped epiphysis	22.27	090
27177	A	Repair slipped epiphysis	27.35	090
27178	A	Repair slipped epiphysis	22.10	090
27179	A	Revise head/neck of femur	23.90	090
27181	A	Repair slipped epiphysis	28.20	090

27185	A	Revision of femur epiphysis	11.64	090
27187	A	Reinforce hip bones	30.25	090
27193	A	Treat pelvic ring fracture	7.29	090
27194	A	Treat pelvic ring fracture	12.93	090
27200	A	Treat tail bone fracture	3.34	090
27202	A	Repair tail bone fracture	13.18	090
27215	A	Pelvic fracture(s) treatment	22.78	090
27216	A	Treat pelvic ring fracture	18.93	090
27217	A	Treat pelvic ring fracture	29.08	090
27218	A	Treat pelvic ring fracture	34.75	090
27220	A	Treat hip socket fracture	9.89	090
27222	A	Treat hip socket fracture	17.94	090
27226	A	Treat hip wall fracture	31.16	090
27227	A	Treat hip fracture(s)	36.92	090
27228	A	Treat hip fracture(s)	39.69	090
27230	A	Treat fracture of thigh	8.48	090
27232	A	Treat fracture of thigh	19.15	090
27235	A	Repair of thigh fracture	26.64	090
27236	A	Repair of thigh fracture	32.60	090
27238	A	Treatment of thigh fracture	10.37	090
27240	A	Treatment of thigh fracture	21.45	090
27244	A	Repair of thigh fracture	32.15	090
27245	A	Repair of thigh fracture	36.55	090
27246	A	Treatment of thigh fracture	8.58	090
27248	A	Repair of thigh fracture	23.41	090
27250	A	Treat hip dislocation	9.77	090
27252	A	Treat hip dislocation	14.23	090
27253	A	Repair of hip dislocation	26.33	090
27254	A	Repair of hip dislocation	32.10	090
27256	A	Treatment of hip dislocation	5.79	010
27257	A	Treatment of hip dislocation	9.86	010
27258	A	Repair of hip dislocation	29.44	090
27259	A	Repair of hip dislocation	36.87	090
27265	A	Treatment of hip dislocation	9.36	090
27266	A	Treatment of hip dislocation	12.61	090
27275	A	Manipulation of hip joint	4.05	010
27280	A	Fusion of sacroiliac joint	22.92	090
27282	A	Fusion of pubic bones	20.59	090
27284	A	Fusion of hip joint	31.52	090
27286	A	Fusion of hip joint	32.14	090
27290	A	Amputation of leg at hip	49.84	090
27295	A	Amputation of leg at hip	35.60	090
27301	A	Drain thigh/knee lesion	8.67	090
27303	A	Drainage of bone lesion	14.12	090
27305	A	Incise thigh tendon and fascia	9.63	090
27306	A	Incision of thigh tendon	6.46	090
27307	A	Incision of thigh tendons	8.60	090
27310	A	Exploration of knee joint	18.72	090
27315	A	Partial removal, thigh nerve	12.46	090
27320	A	Partial removal, thigh nerve	11.50	090
27323	A	Biopsy thigh soft tissues	3.66	010
27324	A	Biopsy thigh soft tissues	7.43	090
27327	A	Removal of thigh lesion	6.85	090
27328	A	Removal of thigh lesion	9.82	090
27329	A	Remove tumor, thigh/knee	24.69	090

27330	A	Biopsy knee joint lining	11.70	090
27331	A	Explore/treat knee joint	13.84	090
27332	A	Removal of knee cartilage	18.90	090
27333	A	Removal of knee cartilage	19.55	090
27334	A	Remove knee joint lining	19.15	090
27335	A	Remove knee joint lining	22.14	090
27340	A	Removal of kneecap bursa	8.13	090
27345	A	Removal of knee cyst	11.81	090
27350	A	Removal of kneecap	17.79	090
27355	A	Remove femur lesion	15.35	090
27356	A	Remove femur lesion/graft	17.58	090
27357	A	Remove femur lesion/graft	19.26	090
27358	A	Remove femur lesion/fixation	9.71	ZZZ
27360	A	Partial removal leg bone(s)	18.60	090
27365	A	Extensive leg surgery	29.20	090
27370	A	Injection for knee X-ray	1.59	000
27372	A	Removal of foreign body	8.55	090
27380	A	Repair of kneecap tendon	15.31	090
27381	A	Repair/graft kneecap tendon	21.97	090
27385	A	Repair of thigh muscle	16.82	090
27386	A	Repair/graft of thigh muscle	23.32	090
27390	A	Incision of thigh tendon	9.66	090
27391	A	Incision of thigh tendons	12.62	090
27392	A	Incision of thigh tendons	16.94	090
27393	A	Lengthening of thigh tendon	12.16	090
27394	A	Lengthening of thigh tendons	14.26	090
27395	A	Lengthening of thigh tendons	22.39	090
27396	A	Transplant of thigh tendon	15.03	090
27397	A	Transplants of thigh tendons	19.05	090
27400	A	Revise thigh muscles/tendons	17.08	090
27403	A	Repair of knee cartilage	17.42	090
27405	A	Repair of knee ligament	19.10	090
27407	A	Repair of knee ligament	19.13	090
27409	A	Repair of knee ligaments	28.32	090
27418	A	Repair degenerated kneecap	23.10	090
27420	A	Revision of unstable kneecap	21.13	090
27422	A	Revision of unstable kneecap	21.59	090
27424	A	Revision/removal of kneecap	21.89	090
27425	A	Lateral retinacular release	12.12	090
27427	A	Reconstruction, knee	21.40	090
27428	A	Reconstruction, knee	25.95	090
27429	A	Reconstruction, knee	24.19	090
27430	A	Revision of thigh muscles	19.14	090
27435	A	Incision of knee joint	16.43	090
27437	A	Revise kneecap	18.53	090
27438	A	Revise kneecap with implant	24.65	090
27440	A	Revision of knee joint	22.54	090
27441	A	Revision of knee joint	19.83	090
27442	A	Revision of knee joint	27.93	090
27443	A	Revision of knee joint	27.44	090
27445	A	Revision of knee joint	41.19	090
27446	A	Revision of knee joint	37.10	090
27447	A	Total knee replacement	47.92	090
27448	A	Incision of thigh	24.32	090
27450	A	Incision of thigh	29.27	090

27454	A	Realignment of thigh bone	29.60	090
27455	A	Realignment of knee	25.15	090
27457	A	Realignment of knee	27.13	090
27465	A	Shortening of thigh bone	26.24	090
27466	A	Lengthening of thigh bone	29.84	090
27468	A	Shorten/lengthen thighs	36.09	090
27470	A	Repair of thigh	32.97	090
27472	A	Repair/graft of thigh	38.07	090
27475	A	Surgery to stop leg growth	16.59	090
27477	A	Surgery to stop leg growth	23.71	090
27479	A	Surgery to stop leg growth	24.91	090
27485	A	Surgery to stop leg growth	16.98	090
27486	A	Revise knee joint replace	40.88	090
27487	A	Revise knee joint replace	54.72	090
27488	A	Removal of knee prosthesis	32.12	090
27495	A	Reinforce thigh	33.50	090
27496	A	Decompression of thigh/knee	9.71	090
27497	A	Decompression of thigh/knee	11.89	090
27498	A	Decompression of thigh/knee	13.55	090
27499	A	Decompression of thigh/knee	15.61	090
27500	A	Treatment of thigh fracture	11.17	090
27501	A	Treatment of thigh fracture	11.17	090
27502	A	Treatment of thigh fracture	17.89	090
27503	A	Treatment of thigh fracture	17.89	090
27506	A	Repair of thigh fracture	33.43	090
27507	A	Treatment of thigh fracture	30.33	090
27508	A	Treatment of thigh fracture	9.81	090
27509	A	Treatment of thigh fracture	11.38	090
27510	A	Treatment of thigh fracture	15.65	090
27511	A	Treatment of thigh fracture	29.96	090
27513	A	Treatment of thigh fracture	34.28	090
27514	A	Repair of thigh fracture	33.20	090
27516	A	Repair of thigh growth plate	10.14	090
27517	A	Repair of thigh growth plate	16.76	090
27519	A	Repair of thigh growth plate	27.69	090
27520	A	Treat kneecap fracture	5.97	090
27524	A	Repair of kneecap fracture	20.67	090
27530	A	Treatment of knee fracture	6.92	090
27532	A	Treatment of knee fracture	13.02	090
27535	A	Treatment of knee fracture	23.13	090
27536	A	Repair of knee fracture	27.30	090
27538	A	Treat knee fracture(s)	8.31	090
27540	A	Repair of knee fracture	24.34	090
27550	A	Treat knee dislocation	8.32	090
27552	A	Treat knee dislocation	11.14	090
27556	A	Repair of knee dislocation	27.08	090
27557	A	Repair of knee dislocation	31.82	090
27558	A	Repair of knee dislocation	32.77	090
27560	A	Treat kneecap dislocation	5.17	090
27562	A	Treat kneecap dislocation	11.09	090
27566	A	Repair kneecap dislocation	23.03	090
27570	A	Fixation of knee joint	3.57	010
27580	A	Fusion of knee	29.43	090
27590	A	Amputate leg at thigh	20.43	090
27591	A	Amputate leg at thigh	24.10	090

27592	A	Amputate leg at thigh	17.82	090
27594	A	Amputation follow–up surgery	10.37	090
27596	A	Amputation follow–up surgery	17.86	090
27598	A	Amputate lower leg at knee	20.64	090
27600	A	Decompression of lower leg	8.80	090
27601	A	Decompression of lower leg	8.77	090
27602	A	Decompression of lower leg	11.15	090
27603	A	Drain lower leg lesion	7.04	090
27604	A	Drain lower leg bursa	5.34	090
27605	A	Incision of Achilles tendon	4.08	010
27606	A	Incision of Achilles tendon	6.20	010
27607	A	Treat lower leg bone lesion	13.63	090
27610	A	Explore/treat ankle joint	15.35	090
27612	A	Exploration of ankle joint	14.94	090
27613	A	Biopsy lower leg soft tissue	2.85	010
27614	A	Biopsy lower leg soft tissue	7.79	090
27615	A	Remove tumor, lower leg	20.87	090
27618	A	Remove lower leg lesion	7.24	090
27619	A	Remove lower leg lesion	12.52	090
27620	A	Explore, treat ankle joint	12.27	090
27625	A	Remove ankle joint lining	17.31	090
27626	A	Remove ankle joint lining	20.01	090
27630	A	Removal of tendon lesion	8.02	090
27635	A	Remove lower leg bone lesion	16.06	090
27637	A	Remove/graft leg bone lesion	18.43	090
27638	A	Remove/graft leg bone lesion	19.93	090
27640	A	Partial removal of tibia	20.93	090
27641	A	Partial removal of fibula	16.18	090
27645	A	Extensive lower leg surgery	25.94	090
27646	A	Extensive lower leg surgery	23.43	090
27647	A	Extensive ankle/heel surgery	21.92	090
27648	A	Injection for ankle X–ray	1.51	000
27650	A	Repair Achilles tendon	18.86	090
27652	A	Repair/graft Achilles tendon	20.92	090
27654	A	Repair of Achilles tendon	21.20	090
27656	A	Repair leg fascia defect	7.81	090
27658	A	Repair of leg tendon, each	8.98	090
27659	A	Repair of leg tendon, each	12.64	090
27664	A	Repair of leg tendon, each	8.04	090
27665	A	Repair of leg tendon, each	10.50	090
27675	A	Repair lower leg tendons	13.72	090
27676	A	Repair lower leg tendons	16.08	090
27680	A	Release of lower leg tendon	9.84	090
27681	A	Release of lower leg tendons	12.82	090
27685	A	Revision of lower leg tendon	10.14	090
27686	A	Revise lower leg tendons	14.00	090
27687	A	Revision of calf tendon	11.72	090
27690	A	Revise lower leg tendon	15.32	090
27691	A	Revise lower leg tendon	17.85	090
27692	A	Revise additional leg tendon	4.06	ZZZ
27695	A	Repair of ankle ligament	14.64	090
27696	A	Repair of ankle ligaments	15.46	090
27698	A	Repair of ankle ligament	21.29	090
27700	A	Revision of ankle joint	20.61	090
27702	A	Reconstruct ankle joint	33.59	090

27703	A	Reconstruction, ankle joint	29.62	090
27704	A	Removal of ankle implant	13.62	090
27705	A	Incision of tibia	21.38	090
27707	A	Incision of fibula	8.91	090
27709	A	Incision of tibia and fibula	22.09	090
27712	A	Realignment of lower leg	23.73	090
27715	A	Revision of lower leg	26.65	090
27720	A	Repair of tibia	26.21	090
27722	A	Repair/graft of tibia	22.36	090
27724	A	Repair/graft of tibia	29.29	090
27725	A	Repair of lower leg	22.34	090
27727	A	Repair of lower leg	23.38	090
27730	A	Repair of tibia epiphysis	11.00	090
27732	A	Repair of fibula epiphysis	10.36	090
27734	A	Repair lower leg epiphyses	16.14	090
27740	A	Repair of leg epiphyses	17.90	090
27742	A	Repair of leg epiphyses	19.89	090
27745	A	Reinforce tibia	19.16	090
27750	A	Treatment of tibia fracture	6.63	090
27752	A	Treatment of tibia fracture	10.72	090
27756	A	Repair of tibia fracture	15.06	090
27758	A	Repair of tibia fracture	25.24	090
27759	A	Repair of tibia fracture	27.62	090
27760	A	Treatment of ankle fracture	5.60	090
27762	A	Treatment of ankle fracture	8.45	090
27766	A	Repair of ankle fracture	16.21	090
27780	A	Treatment of fibula fracture	4.59	090
27781	A	Treatment of fibula fracture	7.77	090
27784	A	Repair of fibula fracture	12.54	090
27786	A	Treatment of ankle fracture	5.40	090
27788	A	Treatment of ankle fracture	7.81	090
27792	A	Repair of ankle fracture	15.09	090
27808	A	Treatment of ankle fracture	5.64	090
27810	A	Treatment of ankle fracture	10.33	090
27814	A	Repair of ankle fracture	20.79	090
27816	A	Treatment of ankle fracture	6.49	090
27818	A	Treatment of ankle fracture	12.20	090
27822	A	Repair of ankle fracture	20.21	090
27823	A	Repair of ankle fracture	24.86	090
27824	A	Treat lower leg fracture	6.49	090
27825	A	Treat lower leg fracture	12.20	090
27826	A	Treat lower leg fracture	18.11	090
27827	A	Treat lower leg fracture	22.69	090
27828	A	Treat lower leg fracture	26.30	090
27829	A	Treat lower leg joint	12.42	090
27830	A	Treat lower leg dislocation	7.01	090
27831	A	Treat lower leg dislocation	8.59	090
27832	A	Repair lower leg dislocation	12.17	090
27840	A	Treat ankle dislocation	6.26	090
27842	A	Treat ankle dislocation	8.15	090
27846	A	Repair ankle dislocation	18.42	090
27848	A	Repair ankle dislocation	19.58	090
27860	A	Fixation of ankle joint	3.82	010
27870	A	Fusion of ankle joint	25.04	090
27871	A	Fusion of tibiofibular joint	17.04	090

27880	A	Amputation of lower leg	20.01	090
27881	A	Amputation of lower leg	22.80	090
27882	A	Amputation of lower leg	16.01	090
27884	A	Amputation follow–up surgery	11.15	090
27886	A	Amputation follow–up surgery	16.32	090
27888	A	Amputation of foot at ankle	19.15	090
27889	A	Amputation of foot at ankle	18.17	090
27892	A	Decompression of leg	9.81	090
27893	A	Decompression of leg	9.78	090
27894	A	Decompression of leg	12.17	090
28001	A	Drainage of bursa of foot	3.24	010
28002	A	Treatment of foot infection	6.21	010
28003	A	Treatment of foot infection	11.35	090
28005	A	Treat foot bone lesion	12.10	090
28008	A	Incision of foot fascia	7.03	090
28010	A	Incision of toe tendon	6.75	090
28011	A	Incision of toe tendons	5.87	090
28020	A	Exploration of a foot joint	9.46	090
28022	A	Exploration of a foot joint	7.32	090
28024	A	Exploration of a toe joint	6.64	090
28030	A	Removal of foot nerve	9.94	090
28035	A	Decompression of tibia nerve	11.51	090
28043	A	Excision of foot lesion	5.26	090
28045	A	Excision of foot lesion	8.70	090
28046	A	Resection of tumor, foot	15.23	090
28050	A	Biopsy of foot joint lining	8.13	090
28052	A	Biopsy of foot joint lining	7.75	090
28054	A	Biopsy of toe joint lining	5.61	090
28060	A	Partial removal foot fascia	9.57	090
28062	A	Removal of foot fascia	13.76	090
28070	A	Removal of foot joint lining	9.46	090
28072	A	Removal of foot joint lining	7.77	090
28080	A	Removal of foot lesion	7.48	090
28086	A	Excise foot tendon sheath	7.91	090
28088	A	Excise foot tendon sheath	7.45	090
28090	A	Removal of foot lesion	7.43	090
28092	A	Removal of toe lesions	5.66	090
28100	A	Removal of ankle/heel lesion	10.26	090
28102	A	Remove/graft foot lesion	14.62	090
28103	A	Remove/graft foot lesion	12.09	090
28104	A	Removal of foot lesion	9.46	090
28106	A	Remove/graft foot lesion	13.59	090
28107	A	Remove/graft foot lesion	10.27	090
28108	A	Removal of toe lesions	8.40	090
28110	A	Part removal of metatarsal	7.51	090
28111	A	Part removal of metatarsal	10.04	090
28112	A	Part removal of metatarsal	8.43	090
28113	A	Part removal of metatarsal	8.78	090
28114	A	Removal of metatarsal heads	17.13	090
28116	A	Revision of foot	11.95	090
28118	A	Removal of heel bone	11.62	090
28119	A	Removal of heel spur	10.84	090
28120	A	Part removal of ankle/heel	10.22	090
28122	A	Partial removal of foot bone	11.40	090
28124	A	Partial removal of toe	8.69	090

28126	A	Partial removal of toe	7.55	090
28130	A	Removal of ankle bone	14.84	090
28140	A	Removal of metatarsal	11.73	090
28150	A	Removal of toe	7.33	090
28153	A	Partial removal of toe	7.57	090
28160	A	Partial removal of toe	7.90	090
28171	A	Extensive foot surgery	17.44	090
28173	A	Extensive foot surgery	14.34	090
28175	A	Extensive foot surgery	11.28	090
28190	A	Removal of foot foreign body	2.46	010
28192	A	Removal of foot foreign body	6.58	090
28193	A	Removal of foot foreign body	8.00	090
28200	A	Repair of foot tendon	9.76	090
28202	A	Repair/graft of foot tendon	12.63	090
28208	A	Repair of foot tendon	7.07	090
28210	A	Repair/graft of foot tendon	11.87	090
28220	A	Release of foot tendon	8.37	090
28222	A	Release of foot tendons	12.08	090
28225	A	Release of foot tendon	5.93	090
28226	A	Release of foot tendons	7.87	090
28230	A	Incision of foot tendon(s)	6.55	090
28232	A	Incision of toe tendon	4.94	090
28234	A	Incision of foot tendon	4.80	090
28236	A	Transfer of foot tendon	16.15	090
28238	A	Revision of foot tendon	14.96	090
28240	A	Release of big toe	6.38	090
28250	A	Revision of foot fascia	10.39	090
28260	A	Release of midfoot joint	12.20	090
28261	A	Revision of foot tendon	15.14	090
28262	A	Revision of foot and ankle	24.89	090
28264	A	Release of midfoot joint	20.00	090
28270	A	Release of foot contracture	7.33	090
28272	A	Release of toe joint, each	5.81	090
28280	A	Fusion of toes	7.33	090
28285	A	Repair of hammertoe	8.97	090
28286	A	Repair of hammertoe	8.19	090
28288	A	Partial removal of foot bone	7.71	090
28290	A	Correction of bunion	11.07	090
28292	A	Correction of bunion	13.67	090
28293	A	Correction of bunion	18.30	090
28294	A	Correction of bunion	17.73	090
28296	A	Correction of bunion	18.02	090
28297	A	Correction of bunion	18.27	090
28298	A	Correction of bunion	16.80	090
28299	A	Correction of bunion	19.16	090
28300	A	Incision of heel bone	16.08	090
28302	A	Incision of ankle bone	18.64	090
28304	A	Incision of midfoot bones	15.49	090
28305	A	Incise/graft midfoot bones	20.38	090
28306	A	Incision of metatarsal	10.53	090
28307	A	Incision of metatarsal	12.33	090
28308	A	Incision of metatarsal	11.04	090
28309	A	Incision of metatarsals	16.28	090
28310	A	Revision of big toe	9.45	090
28312	A	Revision of toe	9.08	090

28313	A	Repair deformity of toe	7.50	090
28315	A	Removal of sesamoid bone	9.05	090
28320	A	Repair of foot bones	18.01	090
28322	A	Repair of metatarsals	12.99	090
28340	A	Resect enlarged toe tissue	13.44	090
28341	A	Resect enlarged toe	16.05	090
28344	A	Repair extra toe(s)	7.94	090
28345	A	Repair webbed toe(s)	11.27	090
28360	A	Reconstruct cleft foot	25.53	090
28400	A	Treatment of heel fracture	4.81	090
28405	A	Treatment of heel fracture	8.51	090
28406	A	Treatment of heel fracture	12.44	090
28415	A	Repair of heel fracture	23.12	090
28420	A	Repair/graft heel fracture	27.64	090
28430	A	Treatment of ankle fracture	4.61	090
28435	A	Treatment of ankle fracture	6.89	090
28436	A	Treatment of ankle fracture	8.98	090
28445	A	Repair of ankle fracture	18.39	090
28450	A	Treat midfoot fracture, each	3.78	090
28455	A	Treat midfoot fracture, each	5.67	090
28456	A	Repair midfoot fracture	4.88	090
28465	A	Repair midfoot fracture, each	12.56	090
28470	A	Treat metatarsal fracture	3.69	090
28475	A	Treat metatarsal fracture	5.25	090
28476	A	Repair metatarsal fracture	6.77	090
28485	A	Repair metatarsal fracture	10.32	090
28490	A	Treat big toe fracture	1.96	090
28495	A	Treat big toe fracture	2.67	090
28496	A	Repair big toe fracture	4.43	090
28505	A	Repair big toe fracture	6.79	090
28510	A	Treatment of toe fracture	1.95	090
28515	A	Treatment of toe fracture	2.54	090
28525	A	Repair of toe fracture	5.31	090
28530	A	Treat sesamoid bone fracture	2.06	090
28531	A	Treat sesamoid bone fracture	4.11	090
28540	A	Treat foot dislocation	2.53	090
28545	A	Treat foot dislocation	3.58	090
28546	A	Treat foot dislocation	5.89	090
28555	A	Repair foot dislocation	11.83	090
28570	A	Treat foot dislocation	3.24	090
28575	A	Treat foot dislocation	5.92	090
28576	A	Treat foot dislocation	6.77	090
28585	A	Repair foot dislocation	12.73	090
28600	A	Treat foot dislocation	2.49	090
28605	A	Treat foot dislocation	4.87	090
28606	A	Treat foot dislocation	8.29	090
28615	A	Repair foot dislocation	10.53	090
28630	A	Treat toe dislocation	2.74	010
28635	A	Treat toe dislocation	3.41	010
28636	A	Treat toe dislocation	5.47	010
28645	A	Repair toe dislocation	7.41	090
28660	A	Treat toe dislocation	1.84	010
28665	A	Treat toe dislocation	2.91	010
28666	A	Treat toe dislocation	5.23	010
28675	A	Repair of toe dislocation	5.91	090

28705	A	Fusion of foot bones	30.69	090
28715	A	Fusion of foot bones	25.59	090
28725	A	Fusion of foot bones	21.13	090
28730	A	Fusion of foot bones	19.67	090
28735	A	Fusion of foot bones	20.60	090
28737	A	Revision of foot bones	18.38	090
28740	A	Fusion of foot bones	11.75	090
28750	A	Fusion of big toe joint	10.56	090
28755	A	Fusion of big toe joint	8.42	090
28760	A	Fusion of big toe joint	11.22	090
28800	A	Amputation of midfoot	14.72	090
28805	A	Amputation thru metatarsal	14.59	090
28810	A	Amputation toe and metatarsal	9.89	090
28820	A	Amputation of toe	6.42	090
28825	A	Partial amputation of toe	5.77	090
29000	A	Application of body cast	4.21	000
29010	A	Application of body cast	4.58	000
29015	A	Application of body cast	4.93	000
29020	A	Application of body cast	4.06	000
29025	A	Application of body cast	3.24	000
29035	A	Application of body cast	3.90	000
29040	A	Application of body cast	4.41	000
29044	A	Application of body cast	4.41	000
29046	A	Application of body cast	4.85	000
29049	A	Application of shoulder cast	1.35	000
29055	A	Application of shoulder cast	3.08	000
29058	A	Application of shoulder cast	2.01	000
29065	A	Application of long arm cast	1.75	000
29075	A	Application of forearm cast	1.44	000
29085	A	Apply hand/wrist cast	1.42	000
29105	A	Apply long arm splint	1.42	000
29125	A	Apply forearm splint	0.99	000
29126	A	Apply forearm splint	1.21	000
29130	A	Application of finger splint	0.68	000
29131	A	Application of finger splint	0.98	000
29200	A	Strapping of chest	0.94	000
29220	A	Strapping of low back	1.05	000
29240	A	Strapping of shoulder	1.00	000
29260	A	Strapping of elbow or wrist	0.80	000
29280	A	Strapping of hand or finger	0.73	000
29305	A	Application of hip cast	4.09	000
29325	A	Application of hip casts	4.42	000
29345	A	Application of long leg cast	2.51	000
29355	A	Application of long leg cast	2.73	000
29358	A	Apply long leg cast brace	3.46	000
29365	A	Application of long leg cast	2.12	000
29405	A	Apply short leg cast	1.72	000
29425	A	Apply short leg cast	2.06	000
29435	A	Apply short leg cast	2.46	000
29440	A	Addition of walker to cast	0.82	000
29445	A	Apply rigid leg cast	3.64	000
29450	A	Application of leg cast	1.43	000
29505	A	Application long leg splint	1.30	000
29515	A	Application lower leg splint	1.23	000
29520	A	Strapping of hip	0.92	000

29530	A	Strapping of knee	0.95	000
29540	A	Strapping of ankle	0.83	000
29550	A	Strapping of toes	0.77	000
29580	A	Application of paste boot	1.37	000
29590	A	Application of foot splint	1.06	000
29700	A	Removal/revision of cast	1.23	000
29705	A	Removal/revision of cast	1.50	000
29710	A	Removal/revision of cast	1.83	000
29715	A	Removal/revision of cast	1.87	000
29720	A	Repair of body cast	0.94	000
29730	A	Windowing of cast	1.04	000
29740	A	Wedging of cast	1.54	000
29750	A	Wedging of clubfoot cast	1.80	000
29800	A	Jaw arthroscopy/surgery	9.54	090
29804	A	Jaw arthroscopy/surgery	20.52	090
29815	A	Shoulder arthroscopy	11.02	090
29819	A	Shoulder arthroscopy/surgery	17.72	090
29820	A	Shoulder arthroscopy/surgery	16.55	090
29821	A	Shoulder arthroscopy/surgery	19.05	090
29822	A	Shoulder arthroscopy/surgery	17.30	090
29823	A	Shoulder arthroscopy/surgery	20.34	090
29825	A	Shoulder arthroscopy/surgery	18.55	090
29826	A	Shoulder arthroscopy/surgery	21.51	090
29830	A	Elbow arthroscopy	11.43	090
29834	A	Elbow arthroscopy/surgery	12.53	090
29835	A	Elbow arthroscopy/surgery	12.94	090
29836	A	Elbow arthroscopy/surgery	15.07	090
29837	A	Elbow arthroscopy/surgery	13.74	090
29838	A	Elbow arthroscopy/surgery	15.13	090
29840	A	Wrist arthroscopy	9.00	090
29843	A	Wrist arthroscopy/surgery	11.99	090
29844	A	Wrist arthroscopy/surgery	12.37	090
29845	A	Wrist arthroscopy/surgery	15.01	090
29846	A	Wrist arthroscopy/surgery	17.37	090
29847	A	Wrist arthroscopy/surgery	14.26	090
29848	A	Wrist arthroscopy/surgery	8.25	090
29850	A	Knee arthroscopy/surgery	19.15	090
29851	A	Knee arthroscopy/surgery	24.34	090
29855	A	Tibial arthroscopy/surgery	22.25	090
29856	A	Tibial arthroscopy/surgery	26.06	090
29870	A	Knee arthroscopy, diagnostic	9.33	090
29871	A	Knee arthroscopy/drainage	13.60	090
29874	A	Knee arthroscopy/surgery	16.36	090
29875	A	Knee arthroscopy/surgery	15.21	090
29876	A	Knee arthroscopy/surgery	18.44	090
29877	A	Knee arthroscopy/surgery	17.25	090
29879	A	Knee arthroscopy/surgery	19.48	090
29880	A	Knee arthroscopy/surgery	20.35	090
29881	A	Knee arthroscopy/surgery	18.07	090
29882	A	Knee arthroscopy/surgery	19.89	090
29883	A	Knee arthroscopy/surgery	23.74	090
29884	A	Knee arthroscopy/surgery	16.69	090
29885	A	Knee arthroscopy/surgery	17.64	090
29886	A	Knee arthroscopy/surgery	14.58	090
29887	A	Knee arthroscopy/surgery	20.08	090

29888	A	Knee arthroscopy/surgery	32.14	090
29889	A	Knee arthroscopy/surgery	22.00	090
29894	A	Ankle arthroscopy/surgery	16.69	090
29895	A	Ankle arthroscopy/surgery	16.21	090
29897	A	Ankle arthroscopy/surgery	16.87	090
29898	A	Ankle arthroscopy/surgery	19.43	090

C. Procedure code numbers 30000 to 49905 relate to respiratory, cardiovascular, lymphatic, and diaphragm procedures.

CPT/ HCPCS Proce– dure Code	Tech Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
30000		A	Drainage of nose lesion	1.99	010
30020		A	Drainage of nose lesion	2.01	010
30100		A	Intranasal biopsy	1.67	000
30110		A	Removal of nose polyp(s)	2.95	010
30115		A	Removal of nose polyp(s)	7.23	090
30117		A	Removal of intranasal lesion	6.07	090
30118		A	Removal of intranasal lesion	17.74	090
30120		A	Revision of nose	12.29	090
30124		A	Removal of nose lesion	4.44	090
30125		A	Removal of nose lesion	12.75	090
30130		A	Removal of turbinate bones	4.94	090
30140		A	Removal of turbinate bones	6.50	090
30150		A	Partial removal of nose	17.00	090
30160		A	Removal of nose	21.32	090
30200		A	Injection treatment of nose	1.17	000
30210		A	Nasal sinus therapy	1.31	010
30220		A	Insert nasal septal button	3.08	010
30300		A	Remove nasal foreign body	1.48	010
30310		A	Remove nasal foreign body	3.63	010
30320		A	Remove nasal foreign body	8.90	090
30400		A	Reconstruction of nose	19.97	090
30410		A	Reconstruction of nose	28.05	090
30420		A	Reconstruction of nose	34.39	090
30430		A	Revision of nose	13.17	090
30435		A	Revision of nose	21.99	090
30450		A	Revision of nose	29.77	090
30460		A	Revision of nose	18.56	090
30462		A	Revision of nose	37.14	090
30520		A	Repair of nasal septum	13.21	090
30540		A	Repair nasal defect	14.46	090
30545		A	Repair nasal defect	22.18	090
30560		A	Release of nasal adhesions	1.80	010
30580		A	Repair upper jaw fistula	13.02	090
30600		A	Repair mouth/nose fistula	9.83	090
30620		A	Intranasal reconstruction	13.77	090
30630		A	Repair nasal septum defect	13.45	090
30801		A	Cauterization inner nose	1.52	010

30802	A	Cauterization inner nose	2.98	010
30901	A	Control of nosebleed	1.80	000
30903	A	Control of nosebleed	2.43	000
30905	A	Control of nosebleed	3.85	000
30906	A	Repeat control of nosebleed	3.59	000
30915	A	Ligation nasal sinus artery	11.95	090
30920	A	Ligation upper jaw artery	18.03	090
30930	A	Therapy fracture of nose	1.97	010
31000	A	Irrigation maxillary sinus	1.56	010
31002	A	Irrigation sphenoid sinus	2.35	010
31020	A	Exploration maxillary sinus	5.62	090
31030	A	Exploration maxillary sinus	13.22	090
31032	A	Explore sinus, remove polyps	14.71	090
31040	A	Exploration behind upper jaw	17.27	090
31050	A	Exploration sphenoid sinus	11.36	090
31051	A	Sphenoid sinus surgery	15.41	090
31070	A	Exploration of frontal sinus	8.99	090
31075	A	Exploration of frontal sinus	19.65	090
31080	A	Removal of frontal sinus	20.56	090
31081	A	Removal of frontal sinus	22.97	090
31084	A	Removal of frontal sinus	28.33	090
31085	A	Removal of frontal sinus	29.96	090
31086	A	Removal of frontal sinus	23.46	090
31087	A	Removal of frontal sinus	23.27	090
31090	A	Exploration of sinuses	23.82	090
31200	A	Removal of ethmoid sinus	9.55	090
31201	A	Removal of ethmoid sinus	15.32	090
31205	A	Removal of ethmoid sinus	18.11	090
31225	A	Removal of upper jaw	35.90	090
31230	A	Removal of upper jaw	44.13	090
31231	A	Nasal endoscopy, dx	2.18	000
31233	A	Nasal/sinus endoscopy, dx	3.74	000
31235	A	Nasal/sinus endoscopy, dx	3.76	000
31237	A	Nasal/sinus endoscopy, surg.	4.49	000
31238	A	Nasal/sinus endoscopy, surg.	7.66	000
31239	A	Nasal/sinus endoscopy, surg.	19.99	010
31240	A	Nasal/sinus endoscopy, surg.	6.14	000
31254	A	Revision of ethmoid sinus	10.97	000
31255	A	Removal of ethmoid sinus	16.49	000
31256	A	Exploration maxillary sinus	7.27	000
31267	A	Endoscopy, maxillary sinus	11.16	000
31276	A	Sinus surgical endoscopy	14.53	000
31287	A	Nasal/sinus endoscopy, surg.	9.28	000
31288	A	Nasal/sinus endoscopy, surg.	10.87	000
31290	A	Nasal/sinus endoscopy, surg.	30.28	010
31291	A	Nasal/sinus endoscopy, surg.	31.81	010
31292	A	Nasal/sinus endoscopy, surg.	24.58	010
31293	A	Nasal/sinus endoscopy, surg.	26.90	010
31294	A	Nasal/sinus endoscopy, surg.	30.73	010
31300	A	Removal of larynx lesion	25.55	090
31320	A	Diagnostic incision larynx	8.68	090
31360	A	Removal of larynx	35.70	090
31365	A	Removal of larynx	50.61	090
31367	A	Partial removal of larynx	37.21	090
31368	A	Partial removal of larynx	52.11	090

31370	A	Partial removal of larynx	36.68	090
31375	A	Partial removal of larynx	34.18	090
31380	A	Partial removal of larynx	36.77	090
31382	A	Partial removal of larynx	35.52	090
31390	A	Removal of larynx and pharynx	51.42	090
31395	A	Reconstruct larynx and pharynx	62.13	090
31400	A	Revision of larynx	17.37	090
31420	A	Removal of epiglottis	17.58	090
31500	A	Insert emergency airway	3.55	000
31502	A	Change of windpipe airway	1.27	000
31505	A	Diagnostic laryngoscopy	1.07	000
31510	A	Laryngoscopy with biopsy	2.52	000
31511	A	Remove foreign body, larynx	3.18	000
31512	A	Removal of larynx lesion	3.97	000
31513	A	Injection into vocal cord	5.09	000
31515	A	Laryngoscopy for aspiration	3.01	000
31520	A	Diagnostic laryngoscopy	4.30	000
31525	A	Diagnostic laryngoscopy	4.95	000
31526	A	Diagnostic laryngoscopy	6.06	000
31527	A	Laryngoscopy for treatment	6.42	000
31528	A	Laryngoscopy and dilatation	5.19	000
31529	A	Laryngoscopy and dilatation	5.27	000
31530	A	Operative laryngoscopy	7.22	000
31531	A	Operative laryngoscopy	8.83	000
31535	A	Operative laryngoscopy	7.41	000
31536	A	Operative laryngoscopy	7.86	000
31540	A	Operative laryngoscopy	9.74	000
31541	A	Operative laryngoscopy	9.22	000
31560	A	Operative laryngoscopy	10.72	000
31561	A	Operative laryngoscopy	12.98	000
31570	A	Laryngoscopy with injection	9.14	000
31571	A	Laryngoscopy with injection	8.86	000
31575	A	Diagnostic laryngoscopy	2.75	000
31576	A	Laryngoscopy with biopsy	4.67	000
31577	A	Remove foreign body, larynx	5.83	000
31578	A	Removal of larynx lesion	6.83	000
31579	A	Diagnostic laryngoscopy	4.73	000
31580	A	Revision of larynx	25.96	090
31582	A	Revision of larynx	38.64	090
31584	A	Repair of larynx fracture	31.95	090
31585	A	Repair of larynx fracture	8.38	090
31586	A	Repair of larynx fracture	14.17	090
31587	A	Revision of larynx	15.61	090
31588	A	Revision of larynx	23.14	090
31590	A	Reinnervate larynx	12.45	090
31595	A	Larynx nerve surgery	14.82	090
31600	A	Incision of windpipe	8.03	000
31601	A	Incision of windpipe	9.84	000
31603	A	Incision of windpipe	8.76	000
31605	A	Incision of windpipe	8.04	000
31610	A	Incision of windpipe	15.06	090
31611	A	Surgery/speech prosthesis	12.84	090
31612	A	Puncture/clear windpipe	2.14	000
31613	A	Repair windpipe opening	6.61	090
31614	A	Repair windpipe opening	13.23	090

31615	A	Visualization of windpipe	4.16	000
31622	A	Diagnostic bronchoscopy	6.54	000
31625	A	Bronchoscopy with biopsy	7.37	000
31628	A	Bronchoscopy with biopsy	8.86	000
31629	A	Bronchoscopy with biopsy	7.84	000
31630	A	Bronchoscopy with repair	7.82	000
31631	A	Bronchoscopy with dilation	8.57	000
31635	A	Remove foreign body, airway	8.49	000
31640	A	Bronchoscopy and remove lesion	10.33	000
31641	A	Bronchoscopy, treat blockage	11.98	000
31645	A	Bronchoscopy, clear airways	6.92	000
31646	A	Bronchoscopy, reclear airways	5.91	000
31656	A	Bronchoscopy, inject for x–ray	5.10	000
31700	A	Insertion of airway catheter	2.81	000
31708	A	Instill airway contrast dye	2.23	000
31710	A	Insertion of airway catheter	2.27	000
31715	A	Injection for bronchus x–ray	1.61	000
31717	A	Bronchial brush biopsy	2.89	000
31720	A	Clearance of airways	1.85	000
31725	A	Clearance of airways	3.45	000
31730	A	Intro windpipe wire/tube	5.44	000
31750	A	Repair of windpipe	18.53	090
31755	A	Repair of windpipe	28.76	090
31760	A	Repair of windpipe	33.41	090
31766	A	Reconstruction of windpipe	47.73	090
31770	A	Repair/graft of bronchus	37.42	090
31775	A	Reconstruct bronchus	39.59	090
31780	A	Reconstruct windpipe	34.59	090
31781	A	Reconstruct windpipe	40.16	090
31785	A	Remove windpipe lesion	25.75	090
31786	A	Remove windpipe lesion	37.19	090
31800	A	Repair of windpipe injury	12.12	090
31805	A	Repair of windpipe injury	23.22	090
31820	A	Closure of windpipe lesion	7.94	090
31825	A	Repair of windpipe defect	11.63	090
31830	A	Revise windpipe scar	8.15	090
32000	A	Drainage of chest	2.48	000
32002	A	Treatment of collapsed lung	3.66	000
32005	A	Treat lung lining chemically	3.37	000
32020	A	Insertion of chest tube	6.87	000
32035	A	Exploration of chest	14.05	090
32036	A	Exploration of chest	15.47	090
32095	A	Biopsy through chest wall	16.22	090
32100	A	Exploration/biopsy of chest	22.55	090
32110	A	Explore/repair chest	24.45	090
32120	A	Re–exploration of chest	20.08	090
32124	A	Explore chest, free adhesions	23.19	090
32140	A	Removal of lung lesion(s)	25.95	090
32141	A	Remove/treat lung lesions	27.05	090
32150	A	Removal of lung lesion(s)	23.97	090
32151	A	Remove lung foreign body	22.37	090
32160	A	Open chest heart massage	17.13	090
32200	A	Drainage of lung lesion	20.54	090
32215	A	Treat chest lining	18.45	090
32220	A	Release of lung	35.23	090

32225	A	Partial release of lung	25.30	090
32310	A	Removal of chest lining	24.93	090
32320	A	Free/remove chest lining	39.27	090
32400	A	Needle biopsy chest lining	3.30	000
32402	A	Open biopsy chest lining	14.91	090
32405	A	Biopsy, lung or mediastinum	4.14	000
32420	A	Puncture/clear lung	3.75	000
32440	A	Removal of lung	39.82	090
32442	A	Sleeve pneumonectomy	44.74	090
32445	A	Removal of lung	46.15	090
32480	A	Partial removal of lung	35.90	090
32482	A	Bilobectomy	37.61	090
32484	A	Segmentectomy	38.60	090
32485	A	Partial removal of lung	45.31	090
32486	A	Sleeve lobectomy	41.25	090
32488	A	Completion pneumonectomy	44.24	090
32500	A	Partial removal of lung	28.09	090
32520	A	Remove lung and revise chest	42.42	090
32522	A	Remove lung and revise chest	46.33	090
32525	A	Remove lung and revise chest	50.58	090
32540	A	Removal of lung lesion	26.19	090
32601	A	Thoracoscopy, diagnostic	9.27	000
32602	A	Thoracoscopy, diagnostic	10.21	000
32603	A	Thoracoscopy, diagnostic	11.63	000
32604	A	Thoracoscopy, diagnostic	13.05	000
32605	A	Thoracoscopy, diagnostic	10.75	000
32606	A	Thoracoscopy, diagnostic	12.66	000
32650	A	Thoracoscopy, surgical	18.45	090
32651	A	Thoracoscopy, surgical	25.30	090
32652	A	Thoracoscopy, surgical	35.23	090
32653	A	Thoracoscopy, surgical	23.97	090
32654	A	Thoracoscopy, surgical	24.45	090
32655	A	Thoracoscopy, surgical	27.33	090
32656	A	Thoracoscopy, surgical	26.84	090
32657	A	Thoracoscopy, surgical	28.09	090
32658	A	Thoracoscopy, surgical	25.82	090
32659	A	Thoracoscopy, surgical	26.40	090
32660	A	Thoracoscopy, surgical	38.63	090
32661	A	Thoracoscopy, surgical	22.82	090
32662	A	Thoracoscopy, surgical	31.94	090
32663	A	Thoracoscopy, surgical	36.50	090
32664	A	Thoracoscopy, surgical	25.43	090
32665	A	Thoracoscopy, surgical	30.62	090
32800	A	Repair lung hernia	21.34	090
32810	A	Close chest after drainage	18.82	090
32815	A	Close bronchial fistula	38.14	090
32820	A	Reconstruct injured chest	40.68	090
32851	A	Lung transplant, single	63.71	090
32852	A	Lung transplant with bypass	69.09	090
32853	A	Lung transplant, double	79.65	090
32854	A	Lung transplant with bypass	85.04	090
32900	A	Removal of rib(s)	27.63	090
32905	A	Revise and repair chest wall	33.48	090
32906	A	Revise and repair chest wall	42.37	090
32940	A	Revision of lung	30.55	090

32960	A	Therapeutic pneumothorax	2.85	000
33010	A	Drainage of heart sac	3.85	000
33011	A	Repeat drainage of heart sac	3.42	000
33015	A	Incision of heart sac	10.26	090
33020	A	Incision of heart sac	25.82	090
33025	A	Incision of heart sac	26.40	090
33030	A	Partial removal of heart sac	39.94	090
33031	A	Partial removal of heart sac	34.40	090
33050	A	Removal of heart sac lesion	22.82	090
33120	A	Removal of heart lesion	54.47	090
33130	A	Removal of heart lesion	34.35	090
33200	A	Insertion of heart pacemaker	24.43	090
33201	A	Insertion of heart pacemaker	21.06	090
33206	A	Insertion of heart pacemaker	14.55	090
33207	A	Insertion of heart pacemaker	17.04	090
33208	A	Insertion of heart pacemaker	17.66	090
33210	A	Insertion of heart electrode	6.73	000
33211	A	Insertion of heart electrode	6.83	000
33212	A	Insertion of pulse generator	11.10	090
33213	A	Insertion of pulse generator	12.04	090
33214	A	Upgrade of pacemaker system	13.47	090
33216	A	Revision implanted electrode	10.38	090
33217	A	Insert/revise electrode	10.74	090
33218	A	Repair pacemaker electrodes	9.96	090
33220	A	Repair pacemaker electrode	10.04	090
33222	A	Pacemaker aicd pocket	10.88	090
33223	A	Pacemaker aicd pocket	12.44	090
33233	A	Removal of pacemaker system	5.60	090
33234	A	Removal of pacemaker system	13.63	090
33235	A	Removal pacemaker electrode	15.45	090
33236	A	Remove electrode/thoracotomy	16.09	090
33237	A	Remove electrode/thoracotomy	22.92	090
33238	A	Remove electrode/thoracotomy	25.66	090
33240	A	Insert/replace pulse generator	13.10	090
33241	A	Remove pulse generator only	5.39	090
33242	A	Repair pulse generator/leads	14.27	090
33243	A	Remove generator/thoracotomy	31.45	090
33244	A	Remove generator	18.26	090
33245	A	Implant heart defibrillator	29.98	090
33246	A	Implant heart defibrillator	41.89	090
33247	A	Insert/replace leads	24.07	090
33249	A	Insert/replace leads/generator	31.51	090
33250	A	Ablate heart dysrhythm focus	31.54	090
33251	A	Ablate heart dysrhythm focus	40.92	090
33260	A	Ablate heart dysrhythm focus	29.35	090
33261	A	Ablate heart dysrhythm focus	38.20	090
33300	A	Repair of heart wound	32.09	090
33305	A	Repair of heart wound	38.43	090
33310	A	Exploratory heart surgery	29.56	090
33315	A	Exploratory heart surgery	36.17	090
33320	A	Repair major blood vessel(s)	31.01	090
33321	A	Repair major vessel	42.57	090
33322	A	Repair major blood vessel(s)	42.23	090
33330	A	Insert major vessel graft	32.96	090
33332	A	Insert major vessel graft	38.99	090

33335	A	Insert major vessel graft	44.17	090
33400	A	Repair of aortic valve	50.85	090
33401	A	Valvuloplasty, open	50.14	090
33403	A	Valvuloplasty, w/cp bypass	51.12	090
33404	A	Prepare heart–aorta conduit	61.13	090
33405	A	Replacement of aortic valve	62.06	090
33406	A	Replacement, aortic valve	74.27	090
33411	A	Replacement of aortic valve	73.41	090
33412	A	Replacement of aortic valve	75.31	090
33413	A	Replacement, aortic valve	79.47	090
33414	A	Repair, aortic valve	72.31	090
33415	A	Revision, subvalvular tissue	58.60	090
33416	A	Revise ventricle muscle	59.27	090
33417	A	Repair of aortic valve	65.64	090
33420	A	Revision of mitral valve	41.86	090
33422	A	Revision of mitral valve	57.92	090
33425	A	Repair of mitral valve	59.98	090
33426	A	Repair of mitral valve	61.42	090
33427	A	Repair of mitral valve	70.48	090
33430	A	Replacement of mitral valve	67.82	090
33460	A	Revision of tricuspid valve	50.43	090
33463	A	Valvuloplasty, tricuspid	60.30	090
33464	A	Valvuloplasty, tricuspid	62.01	090
33465	A	Replace tricuspid valve	62.72	090
33468	A	Revision of tricuspid valve	66.59	090
33470	A	Revision of pulmonary valve	40.68	090
33471	A	Valvotomy, pulmonary valve	48.81	090
33472	A	Revision of pulmonary valve	52.93	090
33474	A	Revision of pulmonary valve	52.93	090
33475	A	Replacement, pulmonary valve	65.73	090
33476	A	Revision of heart chamber	55.46	090
33478	A	Revision of heart chamber	59.79	090
33500	A	Repair heart vessel fistula	56.48	090
33501	A	Repair heart vessel fistula	31.76	090
33502	A	Coronary artery correction	35.44	090
33503	A	Coronary artery graft	52.70	090
33504	A	Coronary artery graft	55.73	090
33505	A	Repair artery w/tunnel	63.11	090
33506	A	Repair artery, translocation	63.11	090
33510	A	CABG, vein, single	55.86	090
33511	A	CABG, vein, two	61.32	090
33512	A	CABG, vein, three	66.78	090
33513	A	CABG, vein, four	72.24	090
33514	A	CABG, vein, five	77.68	090
33516	A	CABG, vein, six+	83.12	090
33517	A	CABG, artery–vein, single	5.45	090
33518	A	CABG, artery–vein, two	10.91	090
33519	A	CABG, artery–vein, three	16.35	090
33521	A	CABG, artery–vein, four	21.82	090
33522	A	CABG, artery–vein, five	27.27	090
33523	A	CABG, artery–vein, six+	32.74	090
33530	A	Coronary artery, bypass/reop.	16.05	ZZZ
33533	A	CABG, arterial, single	57.56	090
33534	A	CABG, arterial, two	64.73	090
33535	A	CABG, arterial, three	71.90	090

33536	A	CABG, arterial, four+	79.06	090
33542	A	Removal of heart lesion	60.53	090
33545	A	Repair of heart damage	72.57	090
33572	A	Open coronary endarterectomy	8.06	ZZZ
33600	A	Closure of valve	66.71	090
33602	A	Closure of valve	60.93	090
33606	A	Anastomosis/artery–aorta	72.31	090
33608	A	Repair anomaly w/conduit	73.06	090
33610	A	Repair by enlargement	72.31	090
33611	A	Repair double ventricle	74.27	090
33612	A	Repair double ventricle	75.11	090
33615	A	Repair (simple fontan)	73.54	090
33617	A	Repair by modified fontan	75.26	090
33619	A	Repair single ventricle	84.38	090
33641	A	Repair heart septum defect	48.30	090
33645	A	Revision of heart veins	53.22	090
33647	A	Repair heart septum defects	66.02	090
33660	A	Repair of heart defects	58.82	090
33665	A	Repair of heart defects	61.76	090
33670	A	Repair of heart chambers	74.27	090
33681	A	Repair heart septum defect	64.93	090
33684	A	Repair heart septum defect	66.89	090
33688	A	Repair heart septum defect	67.87	090
33690	A	Reinforce pulmonary artery	42.94	090
33692	A	Repair of heart defects	72.31	090
33694	A	Repair of heart defects	73.30	090
33696	A	Repair of heart defects	73.16	090
33697	A	Repair of heart defects	75.26	090
33698	A	Repair of heart defects	76.24	090
33702	A	Repair of heart defects	58.96	090
33710	A	Repair of heart defects	66.93	090
33720	A	Repair of heart defect	58.96	090
33722	A	Repair of heart defect	60.93	090
33730	A	Repair heart–vein defect(s)	72.92	090
33732	A	Repair heart–vein defect	61.51	090
33735	A	Revision of heart chamber	48.52	090
33736	A	Revision of heart chamber	51.01	090
33737	A	Revision of heart chamber	49.05	090
33750	A	Major vessel shunt	44.79	090
33755	A	Major vessel shunt	45.14	090
33762	A	Major vessel shunt	45.14	090
33764	A	Major vessel shunt and graft	45.14	090
33766	A	Major vessel shunt	46.12	090
33767	A	Atrial septectomy/septostomy	52.00	090
33770	A	Repair great vessels defect	75.01	090
33771	A	Repair great vessels defect	76.24	090
33774	A	Repair great vessels defect	63.71	090
33775	A	Repair great vessels defect	64.94	090
33776	A	Repair great vessels defect	70.81	090
33777	A	Repair great vessels defect	66.17	090
33778	A	Repair great vessels defect	80.28	090
33779	A	Repair great vessels defect	80.52	090
33780	A	Repair great vessels defect	81.25	090
33781	A	Repair great vessels defect	80.76	090
33786	A	Repair arterial trunk	76.24	090

33788	A	Revision of pulmonary artery	57.96	090
33800	A	Aortic suspension	30.80	090
33802	A	Repair vessel defect	41.23	090
33803	A	Repair vessel defect	43.18	090
33813	A	Repair septal defect	44.16	090
33814	A	Repair septal defect	57.98	090
33820	A	Revise major vessel	40.24	090
33822	A	Revise major vessel	41.23	090
33824	A	Revise major vessel	43.18	090
33840	A	Remove aorta constriction	54.00	090
33845	A	Remove aorta constriction	55.48	090
33851	A	Remove aorta constriction	54.49	090
33852	A	Repair septal defect	56.94	090
33853	A	Repair septal defect	73.30	090
33860	A	Ascending aorta graft	69.55	090
33861	A	Ascending aorta graft	71.52	090
33863	A	Ascending aorta graft	73.48	090
33870	A	Transverse aortic arch graft	86.74	090
33875	A	Thoracic aorta graft	61.46	090
33877	A	Thoracoabdominal graft	89.35	090
33910	A	Remove lung artery emboli	38.19	090
33915	A	Remove lung artery emboli	32.21	090
33916	A	Surgery of great vessel	43.82	090
33917	A	Repair pulmonary artery	61.80	090
33918	A	Repair pulmonary atresia	57.96	090
33919	A	Repair pulmonary atresia	74.15	090
33920	A	Repair pulmonary atresia	73.79	090
33922	A	Transect pulmonary artery	50.14	090
33935	A	Transplantation, heart/lung	128.08	090
33945	A	Transplantation of heart	110.68	090
33960	A	External circulation assist	26.96	XXX
33961	A	External circulation assist	18.48	XXX
33970	A	Aortic circulation assist	16.15	000
33971	A	Aortic circulation assist	9.73	090
33973	A	Insert balloon device	17.87	000
33974	A	Remove intra-aortic balloon	18.81	090
33975	A	Implant ventricular device	35.39	090
33976	A	Implant ventricular device	48.22	090
33977	A	Remove ventricular device	30.96	090
33978	A	Remove ventricular device	35.39	090
34001	A	Removal of artery clot	22.39	090
34051	A	Removal of artery clot	23.39	090
34101	A	Removal of artery clot	18.10	090
34111	A	Removal of arm artery clot	15.72	090
34151	A	Removal of artery clot	28.63	090
34201	A	Removal of artery clot	18.00	090
34203	A	Removal of leg artery clot	20.73	090
34401	A	Removal of vein clot	20.54	090
34421	A	Removal of vein clot	17.25	090
34451	A	Removal of vein clot	25.11	090
34471	A	Removal of vein clot	12.97	090
34490	A	Removal of vein clot	14.70	090
34501	A	Repair valve, femoral vein	17.54	090
34502	A	Reconstruct, vena cava	46.50	090
34510	A	Transposition of vein valve	21.22	090

34520	A	Cross–over vein graft	22.26	090
34530	A	Leg vein fusion	29.48	090
35001	A	Repair defect of artery	35.95	090
35002	A	Repair artery rupture, neck	33.53	090
35005	A	Repair defect of artery	28.25	090
35011	A	Repair defect of artery	25.42	090
35013	A	Repair artery rupture, arm	32.48	090
35021	A	Repair defect of artery	37.53	090
35022	A	Repair artery rupture, chest	37.62	090
35045	A	Repair defect of arm artery	23.81	090
35081	A	Repair defect of artery	46.09	090
35082	A	Repair artery rupture, aorta	54.50	090
35091	A	Repair defect of artery	53.31	090
35092	A	Repair artery rupture, aorta	65.49	090
35102	A	Repair defect of artery	48.17	090
35103	A	Repair artery rupture, groin	60.61	090
35111	A	Repair defect of artery	34.93	090
35112	A	Repair artery rupture, spleen	29.20	090
35121	A	Repair defect of artery	46.00	090
35122	A	Repair artery rupture, belly	52.47	090
35131	A	Repair defect of artery	34.77	090
35132	A	Repair artery rupture, groin	41.22	090
35141	A	Repair defect of artery	29.69	090
35142	A	Repair artery rupture, thigh	32.65	090
35151	A	Repair defect of artery	32.87	090
35152	A	Repair artery rupture, knee	25.93	090
35161	A	Repair defect of artery	35.22	090
35162	A	Repair artery rupture	39.26	090
35180	A	Repair blood vessel lesion	20.44	090
35182	A	Repair blood vessel lesion	27.72	090
35184	A	Repair blood vessel lesion	21.70	090
35188	A	Repair blood vessel lesion	22.18	090
35189	A	Repair blood vessel lesion	29.80	090
35190	A	Repair blood vessel lesion	23.42	090
35201	A	Repair blood vessel lesion	20.12	090
35206	A	Repair blood vessel lesion	19.84	090
35207	A	Repair blood vessel lesion	20.99	090
35211	A	Repair blood vessel lesion	35.10	090
35216	A	Repair blood vessel lesion	29.07	090
35221	A	Repair blood vessel lesion	27.53	090
35226	A	Repair blood vessel lesion	19.60	090
35231	A	Repair blood vessel lesion	26.28	090
35236	A	Repair blood vessel lesion	22.94	090
35241	A	Repair blood vessel lesion	36.22	090
35246	A	Repair blood vessel lesion	36.28	090
35251	A	Repair blood vessel lesion	26.86	090
35256	A	Repair blood vessel lesion	23.95	090
35261	A	Repair blood vessel lesion	25.13	090
35266	A	Repair blood vessel lesion	22.08	090
35271	A	Repair blood vessel lesion	34.25	090
35276	A	Repair blood vessel lesion	29.36	090
35281	A	Repair blood vessel lesion	34.39	090
35286	A	Repair blood vessel lesion	23.88	090
35301	A	Rechanneling of artery	32.09	090
35311	A	Rechanneling of artery	47.44	090

35321	A	Rechanneling of artery	25.65	090
35331	A	Rechanneling of artery	37.12	090
35341	A	Rechanneling of artery	43.19	090
35351	A	Rechanneling of artery	35.89	090
35355	A	Rechanneling of artery	32.31	090
35361	A	Rechanneling of artery	43.85	090
35363	A	Rechanneling of artery	48.55	090
35371	A	Rechanneling of artery	24.48	090
35372	A	Rechanneling of artery	24.85	090
35381	A	Rechanneling of artery	29.79	090
35390	A	Reoperation, carotid	5.11	ZZZ
35450	A	Repair arterial blockage	23.67	000
35452	A	Repair arterial blockage	11.62	000
35454	A	Repair arterial blockage	14.67	000
35456	A	Repair arterial blockage	17.74	000
35458	A	Repair arterial blockage	20.69	000
35459	A	Repair arterial blockage	19.99	000
35460	A	Repair venous blockage	9.67	000
35470	A	Repair arterial blockage	19.99	000
35471	A	Repair arterial blockage	23.67	000
35472	A	Repair arterial blockage	11.05	000
35473	A	Repair arterial blockage	14.67	000
35474	A	Repair arterial blockage	17.76	000
35475	A	Repair arterial blockage	20.69	000
35476	A	Repair venous blockage	9.67	000
35480	A	Atherectomy, open	25.22	000
35481	A	Atherectomy, open	12.32	000
35482	A	Atherectomy, open	16.05	000
35483	A	Atherectomy, open	19.43	000
35484	A	Atherectomy, open	21.65	000
35485	A	Atherectomy, open	14.68	000
35490	A	Atherectomy, percutaneous	25.22	000
35491	A	Atherectomy, percutaneous	12.32	000
35492	A	Atherectomy, percutaneous	16.05	000
35493	A	Atherectomy, percutaneous	19.43	000
35494	A	Atherectomy, percutaneous	21.65	000
35495	A	Atherectomy, percutaneous	14.68	000
35501	A	Artery bypass graft	39.63	090
35506	A	Artery bypass graft	39.55	090
35507	A	Artery bypass graft	38.31	090
35508	A	Artery bypass graft	37.35	090
35509	A	Artery bypass graft	37.94	090
35511	A	Artery bypass graft	26.95	090
35515	A	Artery bypass graft	29.67	090
35516	A	Artery bypass graft	34.36	090
35518	A	Artery bypass graft	33.51	090
35521	A	Artery bypass graft	34.30	090
35526	A	Artery bypass graft	33.05	090
35531	A	Artery bypass graft	46.76	090
35533	A	Artery bypass graft	42.85	090
35536	A	Artery bypass graft	45.50	090
35541	A	Artery bypass graft	45.90	090
35546	A	Artery bypass graft	48.12	090
35548	A	Artery bypass graft	41.84	090
35549	A	Artery bypass graft	45.85	090

35551	A	Artery bypass graft	46.76	090
35556	A	Artery bypass graft	36.38	090
35558	A	Artery bypass graft	31.14	090
35560	A	Artery bypass graft	44.69	090
35563	A	Artery bypass graft	23.20	090
35565	A	Artery bypass graft	33.60	090
35566	A	Artery bypass graft	43.26	090
35571	A	Artery bypass graft	38.32	090
35582	A	Vein bypass graft	52.37	090
35583	A	Vein bypass graft	38.86	090
35585	A	Vein bypass graft	44.75	090
35587	A	Vein bypass graft	41.01	090
35601	A	Artery bypass graft	36.96	090
35606	A	Artery bypass graft	37.05	090
35612	A	Artery bypass graft	33.10	090
35616	A	Artery bypass graft	33.22	090
35621	A	Artery bypass graft	32.46	090
35623	A	Bypass graft, not vein	24.66	090
35626	A	Artery bypass graft	45.22	090
35631	A	Artery bypass graft	43.19	090
35636	A	Artery bypass graft	36.13	090
35641	A	Artery bypass graft	45.68	090
35642	A	Artery bypass graft	28.39	090
35645	A	Artery bypass graft	28.58	090
35646	A	Artery bypass graft	50.61	090
35650	A	Artery bypass graft	31.89	090
35651	A	Artery bypass graft	50.55	090
35654	A	Artery bypass graft	42.34	090
35656	A	Artery bypass graft	33.73	090
35661	A	Artery bypass graft	28.90	090
35663	A	Artery bypass graft	31.52	090
35665	A	Artery bypass graft	33.96	090
35666	A	Artery bypass graft	38.40	090
35671	A	Artery bypass graft	31.27	090
35681	A	Artery bypass graft	23.00	ZZZ
35691	A	Arterial transposition	38.57	090
35693	A	Arterial transposition	24.58	090
35694	A	Arterial transposition	28.50	090
35695	A	Arterial transposition	28.50	090
35700	A	Reoperation, bypass graft	4.93	ZZZ
35701	A	Exploration, carotid artery	11.11	090
35721	A	Exploration, femoral artery	10.76	090
35741	A	Exploration popliteal artery	10.95	090
35761	A	Exploration of artery/vein	11.02	090
35800	A	Explore neck vessels	11.90	090
35820	A	Explore chest vessels	20.42	090
35840	A	Explore abdominal vessels	16.73	090
35860	A	Explore limb vessels	11.03	090
35870	A	Repair vessel graft defect	32.54	090
35875	A	Removal of clot in graft	18.27	090
35876	A	Removal of clot in graft	22.13	090
35901	A	Excision, graft, neck	15.30	090
35903	A	Excision, graft, extremity	16.69	090
35905	A	Excision, graft, thorax	24.99	090
35907	A	Excision, graft, abdomen	25.79	090

36000	A	Place needle in vein	0.52	XXX
36005	A	Injection, venography	1.44	000
36010	A	Place catheter in vein	4.72	XXX
36011	A	Place catheter in vein	5.16	XXX
36012	A	Place catheter in vein	6.37	XXX
36013	A	Place catheter in artery	4.81	XXX
36014	A	Place catheter in artery	5.45	XXX
36015	A	Place catheter in artery	6.37	XXX
36100	A	Establish access to artery	5.79	XXX
36120	A	Establish access to artery	4.49	XXX
36140	A	Establish access to artery	3.56	XXX
36145	A	Artery to vein shunt	4.95	XXX
36160	A	Establish access to aorta	5.04	XXX
36200	A	Place catheter in aorta	5.90	XXX
36215	A	Place catheter in artery	7.37	XXX
36216	A	Place catheter in artery	8.71	XXX
36217	A	Place catheter in artery	10.39	XXX
36218	A	Place catheter in artery	1.66	XXX
36245	A	Place catheter in artery	8.36	XXX
36246	A	Place catheter in artery	8.71	XXX
36247	A	Place catheter in artery	10.39	XXX
36248	A	Place catheter in artery	1.66	XXX
36260	A	Insertion of infusion pump	16.87	090
36261	A	Revision of infusion pump	7.53	090
36262	A	Removal of infusion pump	5.88	090
36400	A	Drawing blood	0.28	XXX
36405	A	Drawing blood	0.64	XXX
36406	A	Drawing blood	0.34	XXX
36410	A	Drawing blood	0.41	XXX
36420	A	Establish access to vein	1.55	XXX
36425	A	Establish access to vein	0.85	XXX
36430	A	Blood transfusion service	0.99	XXX
36440	A	Blood transfusion service	2.00	XXX
36450	A	Exchange transfusion service	4.20	XXX
36455	A	Exchange transfusion service	4.81	XXX
36460	A	Transfusion service, fetal	11.97	XXX
36470	A	Injection therapy of vein	1.32	010
36471	A	Injection therapy of veins	1.91	010
36481	A	Insertion of catheter, vein	12.63	000
36488	A	Insertion of catheter, vein	2.40	000
36489	A	Insertion of catheter, vein	2.44	000
36490	A	Insertion of catheter, vein	3.16	000
36491	A	Insertion of catheter, vein	3.33	000
36493	A	Repositioning of cvc	1.94	000
36500	A	Insertion of catheter, vein	3.62	000
36510	A	Insertion of catheter, vein	1.44	000
36520	A	Plasma and/or cell exchange	3.71	000
36522	A	Photopheresis	5.17	ZZZ
36530	A	Insertion of infusion pump	10.26	010
36531	A	Revision of infusion pump	9.28	010
36532	A	Removal of infusion pump	5.23	010
36533	A	Insertion of access port	8.61	010
36534	A	Revision of access port	7.34	010
36535	A	Removal of access port	4.26	010
36600	A	Withdrawal of arterial blood	0.61	XXX

36620	A	Insertion catheter, artery	1.90	000
36625	A	Insertion catheter, artery	3.08	000
36640	A	Insertion catheter, artery	4.65	000
36660	A	Insertion catheter, artery	1.91	000
36680	A	Insert needle, bone cavity	2.49	000
36800	A	Insertion of cannula	4.81	000
36810	A	Insertion of cannula	9.24	000
36815	A	Insertion of cannula	6.39	000
36821	A	Artery–vein fusion	16.51	090
36822	A	Insertion of cannula(s)	11.06	090
36825	A	Artery–vein graft	21.87	090
36830	A	Artery–vein graft	19.17	090
36832	A	Revise artery–vein fistula	15.77	090
36834	A	Repair A–V aneurysm	18.13	090
36835	A	Artery to vein shunt	10.46	090
36860	A	Cannula declotting	4.83	000
36861	A	Cannula declotting	6.85	000
37140	A	Revision of circulation	40.47	090
37145	A	Revision of circulation	41.21	090
37160	A	Revision of circulation	40.19	090
37180	A	Revision of circulation	39.04	090
37181	A	Splice spleen/kidney veins	43.75	090
37200	A	Transcatheter biopsy	6.23	000
37201	A	Transcatheter therapy infuse	13.10	000
37202	A	Transcatheter therapy infuse	10.26	000
37203	A	Transcatheter retrieval	9.10	000
37204	A	Transcatheter occlusion	32.79	000
37205	A	Transcatheter stent	13.66	000
37206	A	Transcatheter stent	6.82	ZZZ
37207	A	Transcatheter stent	13.66	000
37208	A	Transcatheter stent	6.82	ZZZ
37209	A	Exchange arterial catheter	2.44	000
37565	A	Ligation of neck vein	8.13	090
37600	A	Ligation of neck artery	9.45	090
37605	A	Ligation of neck artery	10.80	090
37606	A	Ligation of neck artery	10.94	090
37607	A	Ligation of fistula	9.35	090
37609	A	Temporal artery procedure	4.71	010
37615	A	Ligation of neck artery	10.69	090
37616	A	Ligation of chest artery	19.45	090
37617	A	Ligation of abdomen artery	23.14	090
37618	A	Ligation of extremity artery	9.51	090
37620	A	Revision of major vein	18.91	090
37650	A	Revision of major vein	8.70	090
37660	A	Revision of major vein	16.05	090
37700	A	Revise leg vein	7.60	090
37720	A	Removal of leg vein	10.95	090
37730	A	Removal of leg veins	14.42	090
37735	A	Removal of leg veins/lesion	19.25	090
37760	A	Revision of leg veins	18.30	090
37780	A	Revision of leg vein	5.63	090
37785	A	Revise secondary varicosity	4.66	090
37788	A	Revascularization, penis	37.26	090
37790	A	Penile venous occlusion	14.01	090
38100	A	Removal of spleen, total	21.65	090

38101	A	Removal of spleen, partial	20.52	090
38102	A	Removal of spleen, total	7.67	ZZZ
38115	A	Repair of ruptured spleen	21.14	090
38200	A	Injection for spleen X–ray	4.43	000
38230	A	Bone marrow collection	6.04	010
38240	A	Bone marrow transplantation	4.38	XXX
38241	A	Bone marrow transplantation	4.34	XXX
38300	A	Drainage lymph node lesion	2.12	010
38305	A	Drainage lymph node lesion	6.42	090
38308	A	Incision of lymph channels	8.18	090
38380	A	Thoracic duct procedure	11.42	090
38381	A	Thoracic duct procedure	20.58	090
38382	A	Thoracic duct procedure	14.79	090
38500	A	Biopsy/removal, lymph node(s)	4.61	010
38505	A	Needle biopsy, lymph node(s)	2.36	000
38510	A	Biopsy/removal, lymph node(s)	6.71	090
38520	A	Biopsy/removal, lymph node(s)	8.19	090
38525	A	Biopsy/removal, lymph node(s)	7.29	090
38530	A	Biopsy/removal, lymph node(s)	9.39	090
38542	A	Explore deep node(s), neck	10.01	090
38550	A	Removal neck/armpit lesion	10.04	090
38555	A	Removal neck/armpit lesion	21.17	090
38562	A	Removal, pelvic lymph nodes	17.25	090
38564	A	Removal, abdomen lymph nodes	18.31	090
38700	A	Removal of lymph nodes, neck	17.92	090
38720	A	Removal of lymph nodes, neck	29.13	090
38724	A	Removal of lymph nodes, neck	28.70	090
38740	A	Remove armpit lymph nodes	11.61	090
38745	A	Remove armpits lymph nodes	17.42	090
38746	A	Remove thoracic lymph nodes	7.01	ZZZ
38747	A	Remove abdominal lymph nodes	7.82	ZZZ
38760	A	Remove groin lymph nodes	15.64	090
38765	A	Remove groin lymph nodes	29.10	090
38770	A	Remove pelvis lymph nodes	28.41	090
38780	A	Remove abdomen lymph nodes	33.09	090
38790	A	Injection for lymphatic X–ray	3.21	000
38794	A	Access thoracic lymph duct	7.11	090
39000	A	Exploration of chest	11.71	090
39010	A	Exploration of chest	23.46	090
39200	A	Removal chest lesion	25.25	090
39220	A	Removal chest lesion	32.78	090
39400	A	Visualization of chest	10.79	010
39501	A	Repair diaphragm laceration	24.02	090
39502	A	Repair paraesophageal hernia	28.60	090
39503	A	Repair of diaphragm hernia	60.03	090
39520	A	Repair of diaphragm hernia	29.19	090
39530	A	Repair of diaphragm hernia	29.89	090
39531	A	Repair of diaphragm hernia	26.32	090
39540	A	Repair of diaphragm hernia	25.59	090
39541	A	Repair of diaphragm hernia	26.68	090
39545	A	Revision of diaphragm	20.78	090
40490	A	Biopsy of lip	2.00	000
40500	A	Partial excision of lip	10.13	090
40510	A	Partial excision of lip	10.87	090
40520	A	Partial excision of lip	9.43	090

40525	A	Reconstruct lip with flap	17.37	090
40527	A	Reconstruct lip with flap	20.80	090
40530	A	Partial removal of lip	10.66	090
40650	A	Repair lip	8.32	090
40652	A	Repair lip	9.76	090
40654	A	Repair lip	12.26	090
40700	A	Repair cleft lip/nasal	21.25	090
40701	A	Repair cleft lip/nasal	35.20	090
40702	A	Repair cleft lip/nasal	22.32	090
40720	A	Repair cleft lip/nasal	23.58	090
40761	A	Repair cleft lip/nasal	25.86	090
40800	A	Drainage of mouth lesion	1.90	010
40801	A	Drainage of mouth lesion	4.26	010
40804	A	Removal foreign body, mouth	1.80	010
40805	A	Removal foreign body, mouth	5.30	010
40806	A	Incision of lip fold	0.68	000
40808	A	Biopsy of mouth lesion	1.71	010
40810	A	Excision of mouth lesion	2.50	010
40812	A	Excise/repair mouth lesion	3.83	010
40814	A	Excise/repair mouth lesion	6.67	090
40816	A	Excision of mouth lesion	6.91	090
40818	A	Excise oral mucosa for graft	4.61	090
40819	A	Excise lip or cheek fold	3.57	090
40820	A	Treatment of mouth lesion	1.80	010
40830	A	Repair mouth laceration	2.42	010
40831	A	Repair mouth laceration	4.46	010
40840	A	Reconstruction of mouth	14.99	090
40842	A	Reconstruction of mouth	14.99	090
40843	A	Reconstruction of mouth	21.00	090
40844	A	Reconstruction of mouth	27.75	090
40845	A	Reconstruction of mouth	42.82	090
41000	A	Drainage of mouth lesion	2.05	010
41005	A	Drainage of mouth lesion	1.87	010
41006	A	Drainage of mouth lesion	4.11	090
41007	A	Drainage of mouth lesion	5.95	090
41008	A	Drainage of mouth lesion	4.29	090
41009	A	Drainage of mouth lesion	6.84	090
41010	A	Incision of tongue fold	1.59	010
41015	A	Drainage of mouth lesion	4.66	090
41016	A	Drainage of mouth lesion	7.61	090
41017	A	Drainage of mouth lesion	5.20	090
41018	A	Drainage of mouth lesion	8.88	090
41100	A	Biopsy of tongue	2.43	010
41105	A	Biopsy of tongue	2.47	010
41108	A	Biopsy of floor of mouth	1.90	010
41110	A	Excision of tongue lesion	2.84	010
41112	A	Excision of tongue lesion	5.14	090
41113	A	Excision of tongue lesion	6.69	090
41114	A	Excision of tongue lesion	14.67	090
41115	A	Excision of tongue fold	3.56	010
41116	A	Excision of mouth lesion	4.99	090
41120	A	Partial removal of tongue	16.60	090
41130	A	Partial removal of tongue	19.96	090
41135	A	Tongue and neck surgery	34.06	090
41140	A	Removal of tongue	43.73	090

41145	A	Tongue removal; neck surgery	52.03	090
41150	A	Tongue, mouth, jaw surgery	39.68	090
41153	A	Tongue, mouth, neck surgery	47.81	090
41155	A	Tongue, jaw, and neck surgery	55.38	090
41250	A	Repair tongue laceration	2.99	010
41251	A	Repair tongue laceration	4.40	010
41252	A	Repair tongue laceration	5.41	010
41500	A	Fixation of tongue	6.91	090
41510	A	Tongue to lip surgery	6.12	090
41520	A	Reconstruction, tongue fold	5.65	090
41800	A	Drainage of gum lesion	1.85	010
41805	A	Removal foreign body, gum	2.07	010
41806	A	Removal foreign body, jawbone	4.36	010
41822	A	Excision of gum lesion	5.41	010
41823	A	Excision of gum lesion	7.51	090
41825	A	Excision of gum lesion	2.82	010
41826	A	Excision of gum lesion	4.42	010
41827	A	Excision of gum lesion	7.24	090
41828	A	Excision of gum lesion	3.01	010
41830	A	Removal of gum tissue	2.67	010
41872	A	Repair gum	5.83	090
41874	A	Repair tooth socket	7.02	090
42000	A	Drainage mouth roof lesion	1.83	010
42100	A	Biopsy roof of mouth	2.09	010
42104	A	Excision lesion, mouth roof	3.30	010
42106	A	Excision lesion, mouth roof	4.96	010
42107	A	Excision lesion, mouth roof	9.37	090
42120	A	Remove palate/lesion	12.89	090
42140	A	Excision of uvula	2.97	090
42145	A	Repair, palate, pharynx/uvula	18.17	090
42160	A	Treatment mouth roof lesion	3.36	010
42180	A	Repair palate	4.83	010
42182	A	Repair palate	7.45	010
42200	A	Reconstruct cleft palate	17.14	090
42205	A	Reconstruct cleft palate	20.13	090
42210	A	Reconstruct cleft palate	22.96	090
42215	A	Reconstruct cleft palate	16.56	090
42220	A	Reconstruct cleft palate	12.52	090
42225	A	Reconstruct cleft palate	16.61	090
42226	A	Lengthening of palate	17.77	090
42227	A	Lengthening of palate	16.45	090
42235	A	Repair palate	13.30	090
42260	A	Repair nose to lip fistula	8.39	090
42280	A	Preparation, palate mold	3.56	010
42281	A	Insertion, palate prosthesis	3.32	010
42300	A	Drainage of salivary gland	2.91	010
42305	A	Drainage of salivary gland	7.94	090
42310	A	Drainage of salivary gland	2.61	010
42320	A	Drainage of salivary gland	4.25	010
42325	A	Create salivary cyst drain	4.87	090
42326	A	Create salivary cyst drain	8.14	090
42330	A	Removal of salivary stone	3.33	010
42335	A	Removal of salivary stone	5.83	090
42340	A	Removal of salivary stone	8.96	090
42400	A	Biopsy of salivary gland	1.63	000

42405	A	Biopsy of salivary gland	4.89	010
42408	A	Excision of salivary cyst	7.86	090
42409	A	Drainage of salivary cyst	5.68	090
42410	A	Excise parotid gland/lesion	15.36	090
42415	A	Excise parotid gland/lesion	29.75	090
42420	A	Excise parotid gland/lesion	34.50	090
42425	A	Excise parotid gland/lesion	24.26	090
42426	A	Excise parotid gland/lesion	45.77	090
42440	A	Excision submaxillary gland	15.13	090
42450	A	Excision sublingual gland	7.99	090
42500	A	Repair salivary duct	8.93	090
42505	A	Repair salivary duct	13.72	090
42507	A	Parotid duct diversion	11.00	090
42508	A	Parotid duct diversion	16.77	090
42509	A	Parotid duct diversion	19.13	090
42510	A	Parotid duct diversion	15.81	090
42550	A	Injection for salivary X–ray	1.71	000
42600	A	Closure of salivary fistula	8.72	090
42650	A	Dilation of salivary duct	1.18	000
42660	A	Dilation of salivary duct	1.67	000
42665	A	Ligation of salivary duct	4.61	090
42700	A	Drainage of tonsil abscess	2.48	010
42720	A	Drainage of throat abscess	4.62	010
42725	A	Drainage of throat abscess	12.35	090
42800	A	Biopsy of throat	2.13	010
42802	A	Biopsy of throat	2.58	010
42804	A	Biopsy of upper nose/throat	2.35	010
42806	A	Biopsy of upper nose/throat	3.02	010
42808	A	Excise pharynx lesion	4.92	010
42809	A	Remove pharynx foreign body	2.63	010
42810	A	Excision of neck cyst	6.61	090
42815	A	Excision of neck cyst	15.83	090
42820	A	Remove tonsils and adenoids	6.91	090
42821	A	Remove tonsils and adenoids	8.28	090
42825	A	Removal of tonsils	6.03	090
42826	A	Removal of tonsils	7.28	090
42830	A	Removal of adenoids	4.51	090
42831	A	Removal of adenoids	5.10	090
42835	A	Removal of adenoids	4.12	090
42836	A	Removal of adenoids	6.06	090
42842	A	Extensive surgery of throat	15.21	090
42844	A	Extensive surgery of throat	24.28	090
42845	A	Extensive surgery of throat	41.72	090
42860	A	Excision of tonsil tags	4.14	090
42870	A	Excision of lingual tonsil	7.63	090
42880	A	Excise nose/throat lesion	10.92	090
42890	A	Partial removal of pharynx	21.23	090
42892	A	Revision of pharyngeal walls	25.56	090
42894	A	Revision of pharyngeal walls	37.75	090
42900	A	Repair throat wound	9.50	010
42950	A	Reconstruction of throat	18.14	090
42953	A	Repair throat, esophagus	15.09	090
42955	A	Surgical opening of throat	10.07	090
42960	A	Control throat bleeding	3.43	010
42961	A	Control throat bleeding	7.05	090

42962	A	Control throat bleeding	12.99	090
42970	A	Control nose/throat bleeding	5.88	090
42971	A	Control nose/throat bleeding	8.66	090
42972	A	Control nose/throat bleeding	11.53	090
43020	A	Incision of esophagus	14.68	090
43030	A	Throat muscle surgery	16.96	090
43045	A	Incision of esophagus	32.71	090
43100	A	Excision of esophagus lesion	15.22	090
43101	A	Excision of esophagus lesion	25.74	090
43107	A	Removal of esophagus	52.36	090
43108	A	Removal of esophagus	60.77	090
43112	A	Removal of esophagus	53.87	090
43113	A	Removal of esophagus	61.77	090
43116	A	Partial removal of esophagus	57.79	090
43117	A	Partial removal of esophagus	56.58	090
43118	A	Partial removal of esophagus	59.78	090
43121	A	Partial removal of esophagus	51.58	090
43122	A	Partial removal of esophagus	51.58	090
43123	A	Partial removal of esophagus	59.78	090
43124	A	Removal of esophagus	49.88	090
43130	A	Removal of esophagus pouch	22.11	090
43135	A	Removal of esophagus pouch	28.13	090
43200	A	Esophagus endoscopy	3.86	000
43202	A	Esophagus endoscopy, biopsy	4.63	000
43204	A	Esophagus endoscopy and inject	8.76	000
43205	A	Esophagus endoscopy/ligation	6.57	000
43215	A	Esophagus endoscopy	6.32	000
43216	A	Esophagus endoscopy/lesion	6.23	000
43217	A	Esophagus endoscopy	6.73	000
43219	A	Esophagus endoscopy	6.55	000
43220	A	Esophagus endoscopy, dilation	4.92	000
43226	A	Esophagus endoscopy, dilation	5.54	000
43227	A	Esophagus endoscopy, repair	8.36	000
43228	A	Esophagus endoscopy, ablation	8.74	000
43234	A	Upper GI endoscopy, exam	4.74	000
43235	A	Upper GI endoscopy, diagnosis	5.60	000
43239	A	Upper GI endoscopy, biopsy	6.30	000
43241	A	Upper GI endoscopy with tube	6.39	000
43243	A	Upper GI endoscopy and inject.	10.37	000
43244	A	Upper GI endoscopy/ligation	8.29	000
43245	A	Operative upper GI endoscopy	7.93	000
43246	A	Place gastrostomy tube	10.13	000
43247	A	Operative upper GI endoscopy	7.91	000
43248	A	Upper GI endoscopy/guidewire	7.35	000
43249	A	Esophagus endoscopy, dilation	6.77	000
43250	A	Upper GI endoscopy/tumor	8.01	000
43251	A	Operative upper GI endoscopy	8.51	000
43255	A	Operative upper GI endoscopy	10.19	000
43258	A	Operative upper GI endoscopy	10.13	000
43259	A	Endoscopic ultrasound exam	9.09	000
43260	A	Endoscopy, bile duct/pancreas	12.11	000
43261	A	Endoscopy, bile duct/pancreas	12.42	000
43262	A	Endoscopy, bile duct/pancreas	16.63	000
43263	A	Endoscopy, bile duct/pancreas	12.19	000
43264	A	Endoscopy, bile duct/pancreas	18.09	000

43265	A	Endoscopy, bile duct/pancreas	15.95	000
43267	A	Endoscopy, bile duct/pancreas	15.01	000
43268	A	Endoscopy, bile duct/pancreas	16.34	000
43269	A	Endoscopy, bile duct/pancreas	13.61	000
43271	A	Endoscopy, bile duct/pancreas	15.23	000
43272	A	Endoscopy, bile duct/pancreas	13.19	000
43300	A	Repair of esophagus	20.85	090
43305	A	Repair esophagus and fistula	30.85	090
43310	A	Repair of esophagus	43.14	090
43312	A	Repair esophagus and fistula	42.39	090
43320	A	Fuse esophagus and stomach	27.39	090
43324	A	Revise esophagus and stomach	28.60	090
43325	A	Revise esophagus and stomach	27.62	090
43326	A	Revise esophagus and stomach	22.99	090
43330	A	Repair of esophagus	27.08	090
43331	A	Repair of esophagus	30.62	090
43340	A	Fuse esophagus and intestine	28.12	090
43341	A	Fuse esophagus and intestine	26.09	090
43350	A	Surgical opening, esophagus	19.80	090
43351	A	Surgical opening, esophagus	23.11	090
43352	A	Surgical opening, esophagus	20.64	090
43360	A	Gastrointestinal repair	49.94	090
43361	A	Gastrointestinal repair	57.79	090
43400	A	Ligate esophagus veins	27.32	090
43401	A	Esophagus surgery for veins	27.04	090
43405	A	Ligate/staple esophagus	30.73	090
43410	A	Repair esophagus wound	19.41	090
43415	A	Repair esophagus wound	30.12	090
43420	A	Repair esophagus opening	16.53	090
43425	A	Repair esophagus opening	26.55	090
43450	A	Dilate esophagus	2.09	000
43453	A	Dilate esophagus	3.07	000
43456	A	Dilate esophagus	6.12	000
43458	A	Dilation of esophagus	5.24	000
43460	A	Pressure treatment esophagus	5.56	000
43500	A	Surgical opening of stomach	14.45	090
43501	A	Surgical repair of stomach	23.56	090
43502	A	Surgical repair of stomach	25.54	090
43510	A	Surgical opening of stomach	18.07	090
43520	A	Incision of pyloric muscle	12.01	090
43600	A	Biopsy of stomach	2.44	000
43605	A	Biopsy of stomach	14.93	090
43610	A	Excision of stomach lesion	19.32	090
43611	A	Excision of stomach lesion	21.65	090
43620	A	Removal of stomach	38.35	090
43621	A	Removal of stomach	38.80	090
43622	A	Removal of stomach	40.15	090
43631	A	Removal of stomach, partial	32.15	090
43632	A	Removal stomach, partial	32.15	090
43633	A	Removal stomach, partial	32.59	090
43634	A	Removal stomach, partial	43.48	090
43635	A	Partial removal of stomach	3.30	ZZZ
43638	A	Partial removal of stomach	34.58	090
43639	A	Removal stomach, partial	35.08	090
43640	A	Vagotomy and pylorus repair	24.95	090

43641	A	Vagotomy and pylorus repair	24.95	090
43750	A	Place gastrostomy tube	10.38	010
43760	A	Change gastrostomy tube	1.84	000
43761	A	Reposition gastrostomy tube	3.23	000
43800	A	Reconstruction of pylorus	17.16	090
43810	A	Fusion of stomach and bowel	18.65	090
43820	A	Fusion of stomach and bowel	19.78	090
43825	A	Fusion of stomach and bowel	25.75	090
43830	A	Place gastrostomy tube	11.73	090
43831	A	Place gastrostomy tube	12.16	090
43832	A	Place gastrostomy tube	19.44	090
43840	A	Repair of stomach lesion	19.30	090
43842	A	Gastroplasty for obesity	29.25	090
43843	A	Gastroplasty for obesity	29.25	090
43846	A	Gastric bypass for obesity	34.65	090
43847	A	Gastric bypass for obesity	30.20	090
43848	A	Revision gastroplasty	38.94	090
43850	A	Revise stomach–bowel fusion	31.15	090
43855	A	Revise stomach–bowel fusion	31.01	090
43860	A	Revise stomach–bowel fusion	31.15	090
43865	A	Revise stomach–bowel fusion	34.37	090
43870	A	Repair stomach opening	13.01	090
43880	A	Repair stomach–bowel fistula	27.50	090
44005	A	Freeing of bowel adhesion	21.87	090
44010	A	Incision of small bowel	17.01	090
44015	A	Insert needle catheter, bowel	6.09	ZZZ
44020	A	Exploration of small bowel	19.51	090
44021	A	Decompress small bowel	18.74	090
44025	A	Incision of large bowel	19.79	090
44050	A	Reduce bowel obstruction	18.82	090
44055	A	Correct malrotation of bowel	20.56	090
44100	A	Biopsy of bowel	3.46	000
44110	A	Excision of bowel lesion(s)	17.63	090
44111	A	Excision of bowel lesion(s)	22.02	090
44120	A	Removal of small intestine	23.85	090
44121	A	Removal of small intestine	7.11	ZZZ
44125	A	Removal of small intestine	25.29	090
44130	A	Bowel to bowel fusion	20.89	090
44139	A	Mobilization of colon	3.57	ZZZ
44140	A	Partial removal of colon	29.81	090
44141	A	Partial removal of colon	30.79	090
44143	A	Partial removal of colon	28.85	090
44144	A	Partial removal of colon	28.60	090
44145	A	Partial removal of colon	36.25	090
44146	A	Partial removal of colon	39.12	090
44147	A	Partial removal of colon	33.57	090
44150	A	Removal of colon	35.81	090
44151	A	Removal of colon/ileostomy	29.54	090
44152	A	Removal of colon/ileostomy	40.49	090
44153	A	Removal of colon/ileostomy	46.22	090
44155	A	Removal of colon	40.87	090
44156	A	Removal of colon/ileostomy	33.45	090
44160	A	Removal of colon	28.16	090
44300	A	Open bowel to skin	14.59	090
44310	A	Ileostomy/jejunostomy	18.96	090

44312	A	Revision of ileostomy	8.69	090
44314	A	Revision of ileostomy	17.18	090
44316	A	Devise bowel pouch	24.06	090
44320	A	Colostomy	19.81	090
44322	A	Colostomy with biopsies	20.52	090
44340	A	Revision of colostomy	6.83	090
44345	A	Revision of colostomy	15.54	090
44346	A	Revision of colostomy	18.63	090
44360	A	Small bowel endoscopy	6.81	000
44361	A	Small bowel endoscopy, biopsy	7.53	000
44363	A	Small bowel endoscopy	7.13	000
44364	A	Small bowel endoscopy	9.36	000
44365	A	Small bowel endoscopy	8.87	000
44366	A	Small bowel endoscopy	11.04	000
44369	A	Small bowel endoscopy	11.84	000
44372	A	Small bowel endoscopy	11.16	000
44373	A	Small bowel endoscopy	9.22	000
44376	A	Small bowel endoscopy	9.86	000
44377	A	Small bowel endoscopy	10.37	000
44378	A	Small bowel endoscopy	13.14	000
44380	A	Small bowel endoscopy	3.60	000
44382	A	Small bowel endoscopy	4.51	000
44385	A	Endoscopy of bowel pouch	4.45	000
44386	A	Endoscopy, bowel pouch, biopsy	3.74	000
44388	A	Colon endoscopy	6.71	000
44389	A	Colonoscopy with biopsy	7.37	000
44390	A	Colonoscopy for foreign body	6.61	000
44391	A	Colonoscopy for bleeding	9.85	000
44392	A	Colonoscopy and polypectomy	9.36	000
44393	A	Colonoscopy, lesion removal	10.63	000
44394	A	Colonoscopy with snare	9.98	000
44500	A	Intro, gastrointestinal tube	0.86	000
44602	A	Suture, small intestine	18.36	090
44603	A	Suture, small intestine	23.23	090
44604	A	Suture, large intestine	21.84	090
44605	A	Repair of bowel lesion	24.52	090
44615	A	Intestinal stricturoplasty	20.62	090
44620	A	Repair bowel opening	16.40	090
44625	A	Repair bowel opening	22.92	090
44640	A	Repair bowel–skin fistula	20.72	090
44650	A	Repair bowel fistula	21.99	090
44660	A	Repair bowel–bladder fistula	22.19	090
44661	A	Repair bowel–bladder fistula	30.87	090
44680	A	Surgical revision, intestine	23.43	090
44800	A	Excision of bowel pouch	16.03	090
44820	A	Excision of mesentery lesion	15.85	090
44850	A	Repair of mesentery	14.97	090
44900	A	Drainage of appendix abscess	12.69	090
44950	A	Appendectomy	11.56	090
44955	A	Appendectomy	4.15	ZZZ
44960	A	Appendectomy	16.44	090
45000	A	Drainage of pelvic abscess	6.02	090
45005	A	Drainage of rectal abscess	3.37	010
45020	A	Drainage of rectal abscess	7.32	090
45100	A	Biopsy of rectum	5.47	090

45108	A	Removal of anorectal lesion	7.26	090
45110	A	Removal of rectum	40.09	090
45111	A	Partial removal of rectum	28.26	090
45112	A	Removal of rectum	42.14	090
45113	A	Partial proctectomy	42.81	090
45114	A	Partial removal of rectum	38.57	090
45116	A	Partial removal of rectum	31.32	090
45120	A	Removal of rectum	41.34	090
45121	A	Removal of rectum and colon	37.01	090
45123	A	Partial proctectomy	26.55	090
45130	A	Excision of rectal prolapse	23.04	090
45135	A	Excision of rectal prolapse	33.42	090
45150	A	Excision of rectal stricture	9.02	090
45160	A	Excision of rectal lesion	20.76	090
45170	A	Excision of rectal lesion	14.62	090
45190	A	Destruction rectal tumor	13.65	090
45300	A	Proctosigmoidoscopy	1.29	000
45303	A	Proctosigmoidoscopy	1.22	000
45305	A	Proctosigmoidoscopy; biopsy	1.93	000
45307	A	Proctosigmoidoscopy	3.08	000
45308	A	Proctosigmoidoscopy	2.76	000
45309	A	Proctosigmoidoscopy	3.26	000
45315	A	Proctosigmoidoscopy	3.84	000
45317	A	Proctosigmoidoscopy	4.11	000
45320	A	Proctosigmoidoscopy	4.96	000
45321	A	Proctosigmoidoscopy	3.75	000
45330	A	Sigmoidoscopy, diagnostic	2.25	000
45331	A	Sigmoidoscopy and biopsy	2.94	000
45332	A	Sigmoidoscopy	3.80	000
45333	A	Sigmoidoscopy and polypectomy	4.34	000
45334	A	Sigmoidoscopy for bleeding	5.81	000
45337	A	Sigmoidoscopy, decompression	5.60	000
45338	A	Sigmoidoscopy	4.95	000
45339	A	Sigmoidoscopy	6.54	000
45355	A	Surgical colonoscopy	4.75	000
45378	A	Diagnostic colonoscopy	8.03	000
45379	A	Colonoscopy	10.27	000
45380	A	Colonoscopy and biopsy	8.99	000
45382	A	Colonoscopy, control bleeding	11.78	000
45383	A	Colonoscopy, lesion removal	12.03	000
45384	A	Colonoscopy	11.63	000
45385	A	Colonoscopy, lesion removal	12.24	000
45500	A	Repair of rectum	13.27	090
45505	A	Repair of rectum	12.56	090
45520	A	Treatment of rectal prolapse	1.22	000
45540	A	Correct rectal prolapse	23.15	090
45541	A	Correct rectal prolapse	21.18	090
45550	A	Repair rectum; remove sigmoid	26.31	090
45560	A	Repair of rectocele	12.87	090
45562	A	Exploration/repair of rectum	20.18	090
45563	A	Exploration/repair of rectum	31.83	090
45800	A	Repair rectum bladder fistula	23.41	090
45805	A	Repair fistula; colostomy	28.84	090
45820	A	Repair recto urethral fistula	23.00	090
45825	A	Repair fistula; colostomy	26.31	090

45900	A	Reduction of rectal prolapse	2.33	010
45905	A	Dilation of anal sphincter	2.29	010
45910	A	Dilation of rectal narrowing	2.81	010
45915	A	Remove rectal obstruction	2.93	010
46030	A	Removal of rectal marker	1.65	010
46040	A	Incision of rectal abscess	6.81	090
46045	A	Incision of rectal abscess	6.00	090
46050	A	Incision of anal abscess	1.81	010
46060	A	Incision of rectal abscess	11.05	090
46070	A	Incision of anal septum	4.21	090
46080	A	Incision of anal sphincter	4.74	010
46083	A	Incise external hemorrhoid	2.03	010
46200	A	Removal of anal fissure	6.70	090
46210	A	Removal of anal crypt	3.38	090
46211	A	Removal of anal crypts	6.21	090
46220	A	Removal of anal tab	2.22	010
46221	A	Ligation of hemorrhoid(s)	2.13	010
46230	A	Removal of anal tabs	3.43	010
46250	A	Hemorrhoidectomy	7.44	090
46255	A	Hemorrhoidectomy	10.17	090
46257	A	Remove hemorrhoids and fissure	11.75	090
46258	A	Remove hemorrhoids and fistula	12.86	090
46260	A	Hemorrhoidectomy	13.52	090
46261	A	Remove hemorrhoids and fissure	13.96	090
46262	A	Remove hemorrhoids and fistula	14.32	090
46270	A	Removal of anal fistula	5.61	090
46275	A	Removal of anal fistula	10.52	090
46280	A	Removal of anal fistula	12.45	090
46285	A	Removal of anal fistula	6.42	090
46288	A	Repair anal fistula	10.92	090
46320	A	Removal of hemorrhoid clot	2.35	010
46500	A	Injection into hemorrhoids	1.89	010
46600	A	Diagnostic anoscopy	0.80	000
46604	A	Anoscopy and dilation	1.73	000
46606	A	Anoscopy and biopsy	1.21	000
46608	A	Anoscopy; remove foreign body	2.65	000
46610	A	Anoscopy; remove lesion	2.26	000
46611	A	Anoscopy	2.75	000
46612	A	Anoscopy; remove lesions	3.85	000
46614	A	Anoscopy; control bleeding	3.71	000
46615	A	Anoscopy	4.38	000
46700	A	Repair of anal stricture	13.28	090
46705	A	Repair of anal stricture	10.46	090
46715	A	Repair of anovaginal fistula	10.76	090
46716	A	Repair of anovaginal fistula	18.51	090
46730	A	Construction of absent anus	32.85	090
46735	A	Construction of absent anus	39.86	090
46740	A	Construction of absent anus	35.31	090
46742	A	Repair, imperforated anus	48.60	090
46744	A	Repair, cloacal anomaly	54.56	090
46746	A	Repair, cloacal anomaly	59.70	090
46748	A	Repair, cloacal anomaly	66.51	090
46750	A	Repair of anal sphincter	14.09	090
46751	A	Repair of anal sphincter	12.45	090
46753	A	Reconstruction of anus	11.55	090

46754	A	Removal of suture from anus	3.17	010
46760	A	Repair of anal sphincter	18.28	090
46761	A	Repair of anal sphincter	17.81	090
46762	A	Implant artificial sphincter	15.73	090
46900	A	Destruction, anal lesion(s)	2.24	010
46910	A	Destruction, anal lesion(s)	2.50	010
46916	A	Cryosurgery, anal lesion(s)	2.52	010
46917	A	Laser surgery, anal lesion(s)	3.93	010
46922	A	Excision of anal lesion(s)	3.23	010
46924	A	Destruction, anal lesion(s)	5.54	010
46934	A	Destruction of hemorrhoids	5.14	090
46935	A	Destruction of hemorrhoids	4.15	010
46936	A	Destruction of hemorrhoids	6.60	090
46937	A	Cryotherapy of rectal lesion	5.28	010
46938	A	Cryotherapy of rectal lesion	7.24	090
46940	A	Treatment of anal fissure	2.86	010
46942	A	Treatment of anal fissure	2.52	010
46945	A	Ligation of hemorrhoids	3.77	090
46946	A	Ligation of hemorrhoids	5.10	090
47000	A	Needle biopsy of liver	3.37	000
47001	A	Needle biopsy, liver	3.37	ZZZ
47010	A	Drainage of liver lesion	16.17	090
47015	A	Inject/aspirate liver cyst	16.20	090
47100	A	Wedge biopsy of liver	10.46	090
47120	A	Partial removal of liver	33.52	090
47122	A	Extensive removal of liver	52.35	090
47125	A	Partial removal of liver	48.33	090
47130	A	Partial removal of liver	53.14	090
47134	A	Partial removal, donor liver	62.63	XXX
47135	A	Transplantation of liver	137.09	090
47136	A	Transplantation of liver	102.44	090
47300	A	Surgery for liver lesion	17.38	090
47350	A	Repair liver wound	19.66	090
47355	A	Repair liver wound	20.19	090
47360	A	Repair liver wound	27.59	090
47400	A	Incision of liver duct	28.27	090
47420	A	Incision of bile duct	26.02	090
47425	A	Incision of bile duct	27.99	090
47460	A	Incise bile duct sphincter	30.93	090
47480	A	Incision of gallbladder	16.61	090
47490	A	Incision of gallbladder	9.82	090
47500	A	Injection for liver X–rays	3.54	000
47505	A	Injection for liver X–rays	1.97	000
47510	A	Insert catheter, bile duct	10.41	090
47511	A	Insert bile duct drain	12.94	090
47525	A	Change bile duct catheter	7.10	010
47530	A	Revise, reinsert bile tube	7.04	090
47550	A	Bile duct endoscopy	4.80	000
47552	A	Biliary endoscopy, thru skin	7.54	000
47553	A	Biliary endoscopy, thru skin	10.52	000
47554	A	Biliary endoscopy, thru skin	13.41	000
47555	A	Biliary endoscopy, thru skin	10.38	000
47556	A	Biliary endoscopy, thru skin	11.38	000
47600	A	Removal of gallbladder	19.18	090
47605	A	Removal of gallbladder	20.74	090

47610	A	Removal of gallbladder	24.46	090
47612	A	Removal of gallbladder	30.82	090
47620	A	Removal of gallbladder	28.46	090
47630	A	Remove bile duct stone	12.29	090
47700	A	Exploration of bile ducts	22.36	090
47701	A	Bile duct revision	36.03	090
47711	A	Excision of bile duct tumor	31.72	090
47712	A	Excision of bile duct tumor	37.33	090
47715	A	Excision of bile duct cyst	23.78	090
47716	A	Fusion of bile duct cyst	20.05	090
47720	A	Fuse gallbladder and bowel	22.24	090
47721	A	Fuse upper GI structures	27.34	090
47740	A	Fuse gallbladder and bowel	25.45	090
47741	A	Fuse gallbladder and bowel	32.41	090
47760	A	Fuse bile ducts and bowel	33.11	090
47765	A	Fuse liver ducts and bowel	35.45	090
47780	A	Fuse bile ducts and bowel	35.15	090
47785	A	Fuse bile ducts and bowel	39.18	090
47800	A	Reconstruction of bile ducts	32.39	090
47801	A	Placement, bile duct support	17.25	090
47802	A	Fuse liver duct and intestine	27.33	090
47900	A	Suture bile duct injury	30.30	090
48000	A	Drainage of abdomen	21.02	090
48001	A	Placement of drain, pancreas	24.86	090
48005	A	Resect/debride pancreas	28.11	090
48020	A	Removal of pancreatic stone	20.75	090
48100	A	Biopsy of pancreas	14.90	090
48102	A	Needle biopsy, pancreas	6.98	010
48120	A	Removal of pancreas lesion	23.77	090
48140	A	Partial removal of pancreas	33.29	090
48145	A	Partial removal of pancreas	36.71	090
48146	A	Pancreatectomy	39.28	090
48148	A	Removal of pancreatic duct	23.68	090
48150	A	Partial removal of pancreas	65.74	090
48152	A	Pancreatectomy	61.97	090
48153	A	Pancreatectomy	65.74	090
48154	A	Pancreatectomy	61.97	090
48155	A	Removal of pancreas	42.39	090
48180	A	Fuse pancreas and bowel	35.10	090
48400	A	Injection, intraoperative	3.13	ZZZ
48500	A	Surgery of pancreas cyst	21.58	090
48510	A	Drain pancreatic pseudocyst	19.63	090
48520	A	Fuse pancreas cyst and bowel	25.74	090
48540	A	Fuse pancreas cyst and bowel	30.04	090
48545	A	Pancreatorrhaphy	23.44	090
48547	A	Duodenal exclusion	33.88	090
48554	A	Transplant allograft pancreas	54.66	XXX
48556	A	Removal, allograft pancreas	22.21	090
49000	A	Exploration of abdomen	16.63	090
49002	A	Reopening of abdomen	16.19	090
49010	A	Exploration behind abdomen	18.94	090
49020	A	Drain abdominal abscess	14.44	090
49040	A	Drain abdominal abscess	16.05	090
49060	A	Drain abdominal abscess	16.71	090
49080	A	Puncture, peritoneal cavity	2.26	000

49081	A	Removal of abdominal fluid	2.05	000
49085	A	Remove abdomen foreign body	11.79	090
49180	A	Biopsy, abdominal mass	3.41	000
49200	A	Removal of abdominal lesion	18.59	090
49201	A	Removal of abdominal lesion	27.21	090
49215	A	Excise sacral spine tumor	30.55	090
49220	A	Multiple surgery, abdomen	27.48	090
49250	A	Excision of umbilicus	12.53	090
49255	A	Removal of omentum	9.89	090
49400	A	Air injection into abdomen	3.10	000
49420	A	Insert abdominal drain	3.91	000
49421	A	Insert abdominal drain	9.52	090
49422	A	Remove perm cannula/catheter	10.48	010
49425	A	Insert abdomen–venous drain	19.78	090
49426	A	Revise abdomen–venous shunt	14.61	090
49427	A	Injection, abdominal shunt	1.39	000
49428	A	Ligation of shunt	3.17	010
49429	A	Removal of shunt	10.15	010
49495	A	Repair inguinal hernia, init.	11.34	090
49496	A	Repair inguinal hernia, init.	14.08	090
49500	A	Repair inguinal hernia	9.95	090
49501	A	Repair inguinal hernia, init.	12.96	090
49505	A	Repair inguinal hernia	11.25	090
49507	A	Repair, inguinal hernia	13.10	090
49520	A	Rerepair inguinal hernia	13.77	090
49521	A	Repair inguinal hernia, rec.	15.14	090
49525	A	Repair inguinal hernia	13.22	090
49540	A	Repair lumbar hernia	13.80	090
49550	A	Repair femoral hernia	12.18	090
49553	A	Repair femoral hernia, init.	12.61	090
49555	A	Repair femoral hernia	14.12	090
49557	A	Repair femoral hernia, recur.	15.57	090
49560	A	Repair abdominal hernia	15.87	090
49561	A	Repair incisional hernia	17.77	090
49565	A	Rerepair abdominal hernia	16.72	090
49566	A	Repair incisional hernia	18.63	090
49568	A	Hernia repair with mesh	7.82	ZZZ
49570	A	Repair epigastric hernia	9.39	090
49572	A	Repair, epigastric hernia	11.66	090
49580	A	Repair umbilical hernia	7.96	090
49582	A	Repair umbilical hernia	10.31	090
49585	A	Repair umbilical hernia	9.91	090
49587	A	Repair umbilical hernia	10.89	090
49590	A	Repair abdominal hernia	12.92	090
49600	A	Repair umbilical lesion	15.20	090
49605	A	Repair umbilical lesion	31.62	090
49606	A	Repair umbilical lesion	26.81	090
49610	A	Repair umbilical lesion	16.10	090
49611	A	Repair umbilical lesion	17.49	090
49900	A	Repair of abdominal wall	8.65	090
49905	A	Omental flap	10.47	ZZZ

D. Procedure code numbers 50010 to 59870 relate to genitourinary and maternity procedures.

CPT/ HCPCS Procedure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
50010		A	Exploration of kidney	20.23	090
50020		A	Drainage of kidney abscess	19.71	090
50040		A	Drainage of kidney	21.32	090
50045		A	Exploration of kidney	24.76	090
50060		A	Removal of kidney stone	30.90	090
50065		A	Incision of kidney	34.27	090
50070		A	Incision of kidney	32.76	090
50075		A	Removal of kidney stone	41.78	090
50080		A	Removal of kidney stone	26.77	090
50081		A	Removal of kidney stone	36.30	090
50100		A	Revise kidney blood vessels	26.22	090
50120		A	Exploration of kidney	26.60	090
50125		A	Explore and drain kidney	27.13	090
50130		A	Removal of kidney stone	29.58	090
50135		A	Exploration of kidney	36.03	090
50200		A	Biopsy of kidney	5.35	000
50205		A	Biopsy of kidney	18.74	090
50220		A	Removal of kidney	30.06	090
50225		A	Removal of kidney	36.35	090
50230		A	Removal of kidney	39.92	090
50234		A	Removal of kidney and ureter	38.63	090
50236		A	Removal of kidney and ureter	41.99	090
50240		A	Partial removal of kidney	37.16	090
50280		A	Removal of kidney lesion	26.12	090
50290		A	Removal of kidney lesion	23.25	090
50320		A	Removal of donor kidney	39.10	090
50340		A	Removal of kidney	24.53	090
50360		A	Transplantation of kidney	53.99	090
50365		A	Transplantation of kidney	65.40	090
50370		A	Remove transplanted kidney	23.31	090
50380		A	Reimplantation of kidney	27.64	090
50390		A	Drainage of kidney lesion	5.01	000
50392		A	Insert kidney drain	8.06	000
50393		A	Insert ureteral tube	10.04	000
50394		A	Injection for kidney X–ray	1.34	000
50395		A	Create passage to kidney	8.63	000
50396		A	Measure kidney pressure	2.62	000
50398		A	Change kidney tube	2.02	000
50400		A	Revision of kidney/ureter	32.45	090
50405		A	Revision of kidney/ureter	40.67	090
50500		A	Repair of kidney wound	31.67	090
50520		A	Close kidney–skin fistula	27.15	090
50525		A	Repair renal–abdomen fistula	34.39	090
50526		A	Repair renal–abdomen fistula	31.07	090
50540		A	Revision of horseshoe kidney	33.42	090
50551		A	Kidney endoscopy	7.91	000
50553		A	Kidney endoscopy	7.76	000

50555	A	Kidney endoscopy and biopsy	11.47	000
50557	A	Kidney endoscopy and treatment	11.60	000
50559	A	Renal endoscopy; radio tracer	8.22	000
50561	A	Kidney endoscopy and treatment	12.97	000
50570	A	Kidney endoscopy	11.10	000
50572	A	Kidney endoscopy	18.01	000
50574	A	Kidney endoscopy and biopsy	18.44	000
50575	A	Kidney endoscopy	24.43	000
50576	A	Kidney endoscopy and treatment	20.07	000
50578	A	Renal endoscopy; radio tracer	15.92	000
50580	A	Kidney endoscopy and treatment	15.66	000
50590	A	Fragmenting of kidney stone	20.22	090
50600	A	Exploration of ureter	25.02	090
50605	A	Insert ureteral support	20.86	090
50610	A	Removal of ureter stone	27.25	090
50620	A	Removal of ureter stone	26.27	090
50630	A	Removal of ureter stone	27.31	090
50650	A	Removal of ureter	29.09	090
50660	A	Removal of ureter	31.80	090
50684	A	Injection for ureter X–ray	1.28	000
50686	A	Measure ureter pressure	1.91	000
50688	A	Change of ureter tube	1.55	010
50690	A	Injection for ureter X–ray	1.50	000
50700	A	Revision of ureter	27.35	090
50715	A	Release of ureter	29.70	090
50722	A	Release of ureter	26.62	090
50725	A	Release/revise ureter	30.19	090
50727	A	Revise ureter	13.21	090
50728	A	Revise ureter	19.44	090
50740	A	Fusion of ureter and kidney	31.24	090
50750	A	Fusion of ureter and kidney	32.83	090
50760	A	Fusion of ureters	31.39	090
50770	A	Splicing of ureters	34.18	090
50780	A	Reimplant ureter in bladder	31.68	090
50782	A	Reimplant ureter in bladder	32.80	090
50783	A	Reimplant ureter in bladder	33.74	090
50785	A	Reimplant ureter in bladder	35.56	090
50800	A	Implant ureter in bowel	28.55	090
50810	A	Fusion of ureter and bowel	31.72	090
50815	A	Urine shunt to bowel	39.44	090
50820	A	Construct bowel bladder	40.52	090
50825	A	Construct bowel bladder	58.47	090
50830	A	Revise urine flow	51.46	090
50840	A	Replace ureter by bowel	32.18	090
50845	A	Appendico–vesicostomy	34.11	090
50860	A	Transplant ureter to skin	25.54	090
50900	A	Repair of ureter	23.19	090
50920	A	Closure ureter/skin fistula	23.28	090
50930	A	Closure ureter/bowel fistula	30.76	090
50940	A	Release of ureter	23.87	090
50951	A	Endoscopy of ureter	7.62	000
50953	A	Endoscopy of ureter	8.00	000
50955	A	Ureter endoscopy and biopsy	9.45	000
50957	A	Ureter endoscopy and treatment	9.44	000
50959	A	Ureter endoscopy and tracer	7.93	000

50961		A	Ureter endoscopy and treatment	8.82	000
50970		A	Ureter endoscopy	12.59	000
50972		A	Ureter endoscopy and catheter	8.54	000
50974		A	Ureter endoscopy and biopsy	16.52	000
50976		A	Ureter endoscopy and treatment	15.78	000
50978		A	Ureter endoscopy and tracer	9.42	000
50980		A	Ureter endoscopy and treatment	10.15	000
51000		A	Drainage of bladder	1.29	000
51005		A	Drainage of bladder	1.50	000
51010		A	Drainage of bladder	3.58	010
51020		A	Incise and treat bladder	13.26	090
51030		A	Incise and treat bladder	10.80	090
51040		A	Incise and drain bladder	10.19	090
51045		A	Incise bladder, drain ureter	11.26	090
51050		A	Removal of bladder stone	13.51	090
51060		A	Removal of ureter stone	18.99	090
51065		A	Removal of ureter stone	15.50	090
51080		A	Drainage of bladder abscess	10.89	090
51500		A	Removal of bladder cyst	17.12	090
51520		A	Removal of bladder lesion	17.67	090
51525		A	Removal of bladder lesion	24.01	090
51530		A	Removal of bladder lesion	21.12	090
51535		A	Repair of ureter lesion	19.86	090
51550		A	Partial removal of bladder	25.69	090
51555		A	Partial removal of bladder	32.59	090
51565		A	Revise bladder and ureter(s)	36.75	090
51570		A	Removal of bladder	38.70	090
51575		A	Removal of bladder and nodes	51.98	090
51580		A	Remove bladder; revise tract	49.25	090
51585		A	Removal of bladder and nodes	58.61	090
51590		A	Remove bladder; revise tract	56.10	090
51595		A	Remove bladder; revise tract	69.77	090
51596		A	Remove bladder, create pouch	72.94	090
51597		A	Removal of pelvic structures	68.35	090
51600		A	Injection for bladder X–ray	1.18	000
51605		A	Preparation for bladder X–ray	1.45	000
51610		A	Injection for bladder X–ray	1.88	000
51700		A	Irrigation of bladder	1.11	000
51705		A	Change of bladder tube	1.39	010
51710		A	Change of bladder tube	2.07	010
51715		A	Endoscopic injection/implant	6.54	000
51720		A	Treatment of bladder lesion	2.44	000
51725		A	Simple cystometrogram	2.58	000
51725	26	A	Simple cystometrogram	2.18	000
51725	TC	A	Simple cystometrogram	0.40	000
51726		A	Complex cystometrogram	3.07	000
51726	26	A	Complex cystometrogram	2.57	000
51726	TC	A	Complex cystometrogram	0.50	000
51736		A	Urine flow measurement	1.27	000
51736	26	A	Urine flow measurement	1.12	000
51736	TC	A	Urine flow measurement	0.15	000
51741		A	Electro–uroflowmetry, first	2.17	000
51741	26	A	Electro–uroflowmetry, first	1.95	000
51741	TC	A	Electro–uroflowmetry, first	0.22	000
51772		A	Urethra pressure profile	2.61	000

51772	26	A	Urethra pressure profile	2.17	000
51772	TC	A	Urethra pressure profile	0.45	000
51784		A	Anal/urinary muscle study	2.63	000
51784	26	A	Anal/urinary muscle study	2.22	000
51784	TC	A	Anal/urinary muscle study	0.41	000
51785		A	Anal/urinary muscle study	2.63	000
51785	26	A	Anal/urinary muscle study	2.22	000
51785	TC	A	Anal/urinary muscle study	0.41	000
51792		A	Urinary reflex study	3.13	000
51792	26	A	Urinary reflex study	1.72	000
51792	TC	A	Urinary reflex study	1.41	000
51795		A	Urine voiding pressure study	3.06	000
51795	26	A	Urine voiding pressure study	2.14	000
51795	TC	A	Urine voiding pressure study	0.92	000
51797		A	Intra–abdominal pressure test	2.62	000
51797	26	A	Intra–abdominal pressure test	2.14	000
51797	TC	A	Intra–abdominal pressure test	0.47	000
51800		A	Revision of bladder/urethra	29.15	090
51820		A	Revision of urinary tract	24.88	090
51840		A	Attach bladder/urethra	19.71	090
51841		A	Attach bladder/urethra	23.94	090
51845		A	Repair bladder neck	20.33	090
51860		A	Repair of bladder wound	19.30	090
51865		A	Repair of bladder wound	25.65	090
51880		A	Repair of bladder opening	12.45	090
51900		A	Repair bladder/vagina lesion	24.09	090
51920		A	Close bladder–uterus fistula	18.47	090
51925		A	Hysterectomy/bladder repair	25.61	090
51940		A	Correction of bladder defect	45.18	090
51960		A	Revision of bladder and bowel	43.74	090
51980		A	Construct bladder opening	18.29	090
52000		A	Cystoscopy	3.42	000
52005		A	Cystoscopy and ureter catheter	4.68	000
52007		A	Cystoscopy and biopsy	5.99	000
52010		A	Cystoscopy and duct catheter	5.03	000
52204		A	Cystoscopy	4.87	000
52214		A	Cystoscopy and treatment	6.66	000
52224		A	Cystoscopy and treatment	6.19	000
52234		A	Cystoscopy and treatment	9.57	000
52235		A	Cystoscopy and treatment	12.85	000
52240		A	Cystoscopy and treatment	20.90	000
52250		A	Cystoscopy and radio tracer	7.52	000
52260		A	Cystoscopy and treatment	6.15	000
52265		A	Cystoscopy and treatment	4.37	000
52270		A	Cystoscopy and revise urethra	7.49	000
52275		A	Cystoscopy and revise urethra	8.30	000
52276		A	Cystoscopy and treatment	8.74	000
52277		A	Cystoscopy and treatment	11.24	000
52281		A	Cystoscopy and treatment	5.23	000
52283		A	Cystoscopy and treatment	5.34	000
52285		A	Cystoscopy and treatment	6.71	000
52290		A	Cystoscopy and treatment	7.07	000
52300		A	Cystoscopy and treatment	9.02	000
52305		A	Cystoscopy and treatment	9.00	000
52310		A	Cystoscopy and treatment	5.95	000

52315	A	Cystoscopy and treatment	9.49	000
52317	A	Remove bladder stone	13.21	000
52318	A	Remove bladder stone	17.47	000
52320	A	Cystoscopy and treatment	9.80	000
52325	A	Cystoscopy, stone removal	13.51	000
52327	A	Cystoscopy, inject material	9.07	000
52330	A	Cystoscopy and treatment	8.70	000
52332	A	Cystoscopy and treatment	6.20	000
52334	A	Create passage to kidney	8.34	000
52335	A	Endoscopy of urinary tract	10.79	000
52336	A	Cystoscopy, stone removal	16.21	000
52337	A	Cystoscopy, stone removal	18.74	000
52338	A	Cystoscopy and treatment	13.56	000
52339	A	Cystoscopy and treatment	15.05	000
52340	A	Cystoscopy and treatment	13.18	090
52450	A	Incision of prostate	12.30	090
52500	A	Revision of bladder neck	15.63	090
52510	A	Dilation prostatic urethra	14.05	090
52601	A	Prostatectomy (TURP)	23.97	090
52606	A	Control postop bleeding	11.02	090
52612	A	Prostatectomy, first stage	16.60	090
52614	A	Prostatectomy, second stage	13.47	090
52620	A	Remove residual prostate	11.63	090
52630	A	Remove prostate regrowth	16.17	090
52640	A	Relieve bladder contracture	12.78	090
52647	A	Laser surgery of prostate	19.86	090
52648	A	Laser surgery of prostate	21.10	090
52700	A	Drainage of prostate abscess	9.80	090
53000	A	Incision of urethra	3.86	010
53010	A	Incision of urethra	6.73	090
53020	A	Incision of urethra	2.64	000
53025	A	Incision of urethra	1.97	000
53040	A	Drainage of urethra abscess	7.98	090
53060	A	Drainage of urethra abscess	3.14	010
53080	A	Drainage of urinary leakage	10.10	090
53085	A	Drainage of urinary leakage	16.80	090
53200	A	Biopsy of urethra	3.76	000
53210	A	Removal of urethra	18.72	090
53215	A	Removal of urethra	25.10	090
53220	A	Treatment of urethra lesion	11.61	090
53230	A	Removal of urethra lesion	17.38	090
53235	A	Removal of urethra lesion	14.89	090
53240	A	Surgery for urethra pouch	10.60	090
53250	A	Removal of urethra gland	9.95	090
53260	A	Treatment of urethra lesion	4.15	010
53265	A	Treatment of urethra lesion	5.07	010
53270	A	Removal of urethra gland	3.89	010
53275	A	Repair of urethra defect	6.88	010
53400	A	Revise urethra, 1st stage	19.68	090
53405	A	Revise urethra, 2nd stage	24.75	090
53410	A	Reconstruction of urethra	24.62	090
53415	A	Reconstruction of urethra	30.99	090
53420	A	Reconstruct urethra, stage 1	24.71	090
53425	A	Reconstruct urethra, stage 2	24.91	090
53430	A	Reconstruction of urethra	23.14	090

53440		A	Correct bladder function	25.35	090
53442		A	Remove perineal prosthesis	13.88	090
53443		A	Reconstruction of urethra	29.62	090
53445		A	Correct urine flow control	31.07	090
53447		A	Remove artificial sphincter	22.00	090
53449		A	Correct artificial sphincter	17.99	090
53450		A	Revision of urethra	8.61	090
53460		A	Revision of urethra	9.29	090
53502		A	Repair of urethra injury	12.49	090
53505		A	Repair of urethra injury	12.66	090
53510		A	Repair of urethra injury	16.90	090
53515		A	Repair of urethra injury	22.21	090
53520		A	Repair of urethra defect	14.40	090
53600		A	Dilate urethra stricture	1.56	000
53601		A	Dilate urethra stricture	1.29	000
53605		A	Dilate urethra stricture	1.77	000
53620		A	Dilate urethra stricture	2.12	000
53621		A	Dilate urethra stricture	1.76	000
53640		A	Relieve bladder retention	2.20	000
53660		A	Dilation of urethra	1.01	000
53661		A	Dilation of urethra	0.99	000
53665		A	Dilation of urethra	1.14	000
53670		A	Insert urinary catheter	0.73	000
53675		A	Insert urinary catheter	1.97	000
54000		A	Slitting of prepuce	2.16	010
54001		A	Slitting of prepuce	3.03	010
54015		A	Drain penis lesion	6.06	010
54050		A	Destruction, penis lesion(s)	1.59	010
54055		A	Destruction, penis lesion(s)	1.83	010
54056		A	Cryosurgery, penis lesion(s)	1.74	010
54057		A	Laser surg. penis lesion(s)	2.91	010
54060		A	Excision of penis lesion(s)	3.12	010
54065		A	Destruction, penis lesion(s)	4.97	010
54100		A	Biopsy of penis	2.59	000
54105		A	Biopsy of penis	4.53	010
54110		A	Treatment of penis lesion	16.02	090
54111		A	Treat penis lesion, graft	22.74	090
54112		A	Treat penis lesion, graft	26.60	090
54115		A	Treatment of penis lesion	10.10	090
54120		A	Partial removal of penis	16.04	090
54125		A	Removal of penis	24.97	090
54130		A	Remove penis and nodes	34.26	090
54135		A	Remove penis and nodes	43.69	090
54150		A	Circumcision	2.35	010
54152		A	Circumcision	4.19	010
54160		A	Circumcision	4.21	010
54161		A	Circumcision	5.52	010
54200		A	Treatment of penis lesion	1.35	010
54205		A	Treatment of penis lesion	12.58	090
54220		A	Treatment of penis lesion	4.09	000
54230		A	Prepare penis study	2.75	000
54231		A	Dynamic cavernosometry	3.55	000
54235		A	Penile injection	1.64	000
54240		A	Penis study	2.37	000
54240	26	A	Penis study	1.86	000

54240	TC	A	Penis study	0.51	000
54250		A	Penis study	3.07	000
54250	26	A	Penis study	2.75	000
54250	TC	A	Penis study	0.31	000
54300		A	Revision of penis	17.42	090
54304		A	Revision of penis	21.28	090
54308		A	Reconstruction of urethra	17.86	090
54312		A	Reconstruction of urethra	23.01	090
54316		A	Reconstruction of urethra	27.91	090
54318		A	Reconstruction of urethra	18.65	090
54322		A	Reconstruction of urethra	20.35	090
54324		A	Reconstruction of urethra	27.02	090
54326		A	Reconstruction of urethra	25.87	090
54328		A	Revise penis, urethra	26.21	090
54332		A	Revise penis, urethra	29.27	090
54336		A	Revise penis, urethra	38.39	090
54340		A	Secondary urethral surgery	14.93	090
54344		A	Secondary urethral surgery	32.30	090
54348		A	Secondary urethral surgery	28.60	090
54352		A	Reconstruct urethra, penis	40.81	090
54360		A	Penis plastic surgery	18.81	090
54380		A	Repair penis	22.38	090
54385		A	Repair penis	25.67	090
54390		A	Repair penis and bladder	35.43	090
54400		A	Insert semi–rigid prosthesis	20.24	090
54401		A	Insert self–contd. prosthesis	24.36	090
54402		A	Remove penis prosthesis	14.98	090
54405		A	Insert multi–comp. prosthesis	30.86	090
54407		A	Remove multi–comp. prosthesis	24.40	090
54409		A	Revise penis prosthesis	20.96	090
54420		A	Revision of penis	18.97	090
54430		A	Revision of penis	16.91	090
54435		A	Revision of penis	9.98	090
54450		A	Preputial stretching	1.84	000
54500		A	Biopsy of testis	1.78	000
54505		A	Biopsy of testis	5.40	010
54510		A	Removal of testis lesion	8.49	090
54520		A	Removal of testis	10.50	090
54530		A	Removal of testis	15.77	090
54535		A	Extensive testis surgery	20.54	090
54550		A	Exploration for testis	12.95	090
54560		A	Exploration for testis	18.14	090
54600		A	Reduce testis torsion	11.47	090
54620		A	Suspension of testis	8.19	010
54640		A	Suspension of testis	14.85	090
54650		A	Orchiopexy (Fowler–Stephens)	19.26	090
54660		A	Revision of testis	8.38	090
54670		A	Repair testis injury	10.59	090
54680		A	Relocation of testis(es)	20.15	090
54700		A	Drainage of scrotum	4.35	010
54800		A	Biopsy of epididymis	4.40	000
54820		A	Exploration of epididymis	7.50	090
54830		A	Remove epididymis lesion	8.80	090
54840		A	Remove epididymis lesion	10.10	090
54860		A	Removal of epididymis	11.44	090

54861	A	Removal of epididymis	16.22	090
54900	A	Fusion of spermatic ducts	22.02	090
54901	A	Fusion of spermatic ducts	30.23	090
55000	A	Drainage of hydrocele	1.86	000
55040	A	Removal of hydrocele	10.33	090
55041	A	Removal of hydroceles	15.28	090
55060	A	Repair of hydrocele	9.62	090
55100	A	Drainage of scrotum abscess	2.70	010
55110	A	Explore scrotum	8.96	090
55120	A	Removal of scrotum lesion	6.70	090
55150	A	Removal of scrotum	12.37	090
55175	A	Revision of scrotum	9.68	090
55180	A	Revision of scrotum	17.36	090
55200	A	Incision of sperm duct	6.22	090
55250	A	Removal of sperm duct(s)	5.99	090
55300	A	Preparation, sperm duct X–ray	6.36	000
55400	A	Repair of sperm duct	15.13	090
55450	A	Ligation of sperm duct	6.70	010
55500	A	Removal of hydrocele	9.87	090
55520	A	Removal of sperm cord lesion	9.15	090
55530	A	Revise spermatic cord veins	10.97	090
55535	A	Revise spermatic cord veins	10.89	090
55540	A	Revise hernia and sperm veins	12.35	090
55600	A	Incise sperm duct pouch	10.69	090
55605	A	Incise sperm duct pouch	13.52	090
55650	A	Remove sperm duct pouch	18.90	090
55680	A	Remove sperm pouch lesion	9.44	090
55700	A	Biopsy of prostate	3.15	000
55705	A	Biopsy of prostate	7.96	010
55720	A	Drainage of prostate abscess	11.26	090
55725	A	Drainage of prostate abscess	13.61	090
55801	A	Removal of prostate	29.80	090
55810	A	Extensive prostate surgery	40.02	090
55812	A	Extensive prostate surgery	44.40	090
55815	A	Extensive prostate surgery	54.92	090
55821	A	Removal of prostate	27.28	090
55831	A	Removal of prostate	29.60	090
55840	A	Extensive prostate surgery	38.66	090
55842	A	Extensive prostate surgery	42.84	090
55845	A	Extensive prostate surgery	53.09	090
55860	A	Surgical exposure, prostate	20.85	090
55862	A	Extensive prostate surgery	29.43	090
55865	A	Extensive prostate surgery	47.38	090
55870	A	Electroejaculation	4.51	000
56300	A	Pelvis laparoscopy, dx	8.78	010
56301	A	Laparoscopy; tubal cautery	9.41	010
56302	A	Laparoscopy; tubal block	10.17	010
56303	A	Laparoscopy; excise lesions	11.92	010
56304	A	Laparoscopy; lysis	10.69	010
56305	A	Pelvic laparoscopy; biopsy	9.23	010
56306	A	Laparoscopy; aspiration	9.39	010
56307	A	Laparoscopy; remove adnexa	13.72	010
56308	A	Laparoscopy; hysterectomy	24.54	010
56309	A	Laparoscopy; remove myoma	10.99	010
56311	A	Laparoscopic lymph node biop.	16.22	010

56312	A	Laparoscopic lymphadenectomy	21.07	010
56313	A	Laparoscopic lymphadenectomy	25.44	010
56315	A	Laparoscopic appendectomy	11.56	090
56316	A	Laparoscopic hernia repair	11.25	090
56317	A	Laparoscopic hernia repair	13.77	090
56320	A	Laparoscopy, spermatic veins	10.89	090
56322	A	Laparoscopy, vagus nerves	15.51	090
56323	A	Laparoscopy, vagus nerves	18.63	090
56324	A	Laparoscopy, cholecystoenter	22.24	090
56340	A	Laparoscopic cholecystectomy	19.73	090
56341	A	Laparoscopic cholecystectomy	21.09	090
56342	A	Laparoscopic cholecystectomy	24.46	090
56350	A	Hysteroscopy; diagnostic	4.65	000
56351	A	Hysteroscopy; biopsy	5.11	000
56352	A	Hysteroscopy; lysis	7.42	000
56353	A	Hysteroscopy; resect septum	7.79	000
56354	A	Hysteroscopy; remove myoma	9.58	000
56355	A	Hysteroscopy; remove impact	5.35	000
56356	A	Hysteroscopy; ablation	9.39	000
56360	A	Peritoneoscopy	8.07	000
56361	A	Peritoneoscopy with biopsy	9.50	000
56362	A	Peritoneoscopy with cholangio	7.75	000
56363	A	Peritoneoscopy with biopsy	9.36	000
56405	A	I and D of vulva/perineum	2.24	010
56420	A	Drainage of gland abscess	2.22	010
56440	A	Surgery for vulva lesion	5.73	010
56441	A	Lysis of labial lesion(s)	3.75	010
56501	A	Destruction, vulva lesion(s)	2.09	010
56515	A	Destruction, vulva lesion(s)	4.71	010
56605	A	Biopsy of vulva/perineum	1.63	000
56606	A	Biopsy of vulva/perineum	0.83	000
56620	A	Partial removal of vulva	13.99	090
56625	A	Complete removal of vulva	18.21	090
56630	A	Extensive vulva surgery	25.92	090
56631	A	Extensive vulva surgery	36.01	090
56632	A	Extensive vulva surgery	42.68	090
56633	A	Extensive vulva surgery	30.07	090
56634	A	Extensive vulva surgery	40.15	090
56637	A	Extensive vulva surgery	44.47	090
56640	A	Extensive vulva surgery	42.68	090
56700	A	Partial removal of hymen	4.45	010
56720	A	Incision of hymen	1.23	000
56740	A	Remove vagina gland lesion	6.80	010
56800	A	Repair of vagina	6.99	010
56805	A	Repair clitoris	28.00	090
56810	A	Repair of perineum	6.90	010
57000	A	Exploration of vagina	5.16	010
57010	A	Drainage of pelvic abscess	8.38	090
57020	A	Drainage of pelvic fluid	2.24	000
57061	A	Destruction vagina lesion(s)	2.12	010
57065	A	Destruction vagina lesion(s)	6.29	010
57100	A	Biopsy of vagina	1.67	000
57105	A	Biopsy of vagina	3.41	010
57108	A	Partial removal of vagina	11.63	090
57110	A	Removal of vagina	22.45	090

57120	A	Closure of vagina	14.63	090
57130	A	Remove vagina lesion	5.35	010
57135	A	Remove vagina lesion	4.80	010
57150	A	Treat vagina infection	1.16	000
57160	A	Insertion of pessary	1.17	000
57170	A	Fitting of diaphragm/cap	1.27	000
57180	A	Treat vaginal bleeding	2.15	010
57200	A	Repair of vagina	6.76	090
57210	A	Repair vagina/perineum	8.40	090
57220	A	Revision of urethra	8.78	090
57230	A	Repair of urethral lesion	9.29	090
57240	A	Repair bladder and vagina	13.26	090
57250	A	Repair rectum and vagina	12.40	090
57260	A	Repair of vagina	17.37	090
57265	A	Extensive repair of vagina	18.05	090
57268	A	Repair of bowel bulge	14.06	090
57270	A	Repair of bowel pouch	15.06	090
57280	A	Suspension of vagina	18.00	090
57282	A	Repair of vaginal prolapse	17.92	090
57288	A	Repair bladder defect	23.82	090
57289	A	Repair bladder and vagina	15.22	090
57291	A	Construction of vagina	13.54	090
57292	A	Construct vagina with graft	19.75	090
57300	A	Repair rectum–vagina fistula	15.71	090
57305	A	Repair rectum–vagina fistula	17.18	090
57307	A	Fistula repair and colostomy	16.95	090
57310	A	Repair urethrovaginal lesion	10.68	090
57311	A	Repair urethrovaginal lesion	13.01	090
57320	A	Repair bladder–vagina lesion	17.46	090
57330	A	Repair bladder–vagina lesion	20.39	090
57335	A	Repair vagina	16.47	090
57400	A	Dilation of vagina	1.20	000
57410	A	Pelvic examination	0.98	000
57415	A	Removal vaginal foreign body	1.30	010
57452	A	Examination of vagina	1.73	000
57454	A	Vagina examination and biopsy	2.64	000
57460	A	Cervix excision	5.13	000
57500	A	Biopsy of cervix	1.61	000
57505	A	Endocervical curettage	1.80	010
57510	A	Cauterization of cervix	2.43	010
57511	A	Cryocautery of cervix	2.81	010
57513	A	Laser surgery of cervix	4.73	010
57520	A	Conization of cervix	7.85	090
57522	A	Conization of cervix	7.15	090
57530	A	Removal of cervix	8.50	090
57540	A	Removal of residual cervix	13.66	090
57545	A	Remove cervix, repair pelvis	11.85	090
57550	A	Removal of residual cervix	12.13	090
57555	A	Remove cervix, repair vagina	19.54	090
57556	A	Remove cervix, repair bowel	18.14	090
57700	A	Revision of cervix	5.89	090
57720	A	Revision of cervix	6.93	090
57800	A	Dilation of cervical canal	1.31	000
57820	A	D&C of residual cervix	3.98	010
58100	A	Biopsy of uterus lining	1.45	000

58120	A	Dilation and curettage (D&C)	5.48	010
58140	A	Removal of uterus lesion	16.96	090
58145	A	Removal of uterus lesion	16.51	090
58150	A	Total hysterectomy	23.84	090
58152	A	Total hysterectomy	27.66	090
58180	A	Partial hysterectomy	20.09	090
58200	A	Extensive hysterectomy	35.05	090
58210	A	Extensive hysterectomy	44.11	090
58240	A	Removal of pelvis contents	61.23	090
58260	A	Vaginal hysterectomy	22.04	090
58262	A	Vaginal hysterectomy	23.72	090
58263	A	Vaginal hysterectomy	25.95	090
58267	A	Hysterectomy and vagina repair	26.96	090
58270	A	Hysterectomy and vagina repair	24.27	090
58275	A	Hysterectomy, revise vagina	26.42	090
58280	A	Hysterectomy, revise vagina	26.26	090
58285	A	Extensive hysterectomy	30.72	090
58300	A	Insert intrauterine device	1.86	XXX
58301	A	Remove intrauterine device	1.23	000
58321	A	Artificial insemination	1.72	000
58322	A	Artificial insemination	1.90	000
58323	A	Sperm washing	0.41	000
58340	A	Inject for uterus/tube X–ray	1.50	000
58345	A	Reopen fallopian tube	8.33	010
58350	A	Reopen fallopian tube	1.75	010
58400	A	Suspension of uterus	12.00	090
58410	A	Suspension of uterus	12.80	090
58520	A	Repair of ruptured uterus	11.20	090
58540	A	Revision of uterus	15.59	090
58600	A	Division of fallopian tube	9.94	090
58605	A	Division of fallopian tube	8.11	090
58611	A	Ligate oviduct(s)	1.16	ZZZ
58615	A	Occlude fallopian tube(s)	6.96	010
58700	A	Removal of fallopian tube	13.03	090
58720	A	Removal of ovary/tube(s)	14.68	090
58740	A	Revise fallopian tube(s)	13.37	090
58750	A	Repair oviduct(s)	16.03	090
58752	A	Revise ovarian tube(s)	15.21	090
58760	A	Remove tubal obstruction	13.01	090
58770	A	Create new tubal opening	12.92	090
58800	A	Drainage of ovarian cyst(s)	6.77	090
58805	A	Drainage of ovarian cyst(s)	12.63	090
58820	A	Drainage of ovarian abscess	7.01	090
58822	A	Drainage of ovarian abscess	10.24	090
58825	A	Transposition, ovary(s)	10.23	090
58900	A	Biopsy of ovary(s)	11.32	090
58920	A	Partial removal of ovary(s)	13.90	090
58925	A	Removal of ovarian cyst(s)	13.79	090
58940	A	Removal of ovary(s)	13.83	090
58943	A	Removal of ovary(s)	31.22	090
58950	A	Resect ovarian malignancy	26.79	090
58951	A	Resect ovarian malignancy	41.06	090
58952	A	Resect ovarian malignancy	41.84	090
58960	A	Exploration of abdomen	24.90	090
58970	A	Retrieval of oocyte	6.41	000

58976		A	Transfer of embryo	6.95	000
59000		A	Amniocentesis	2.38	000
59012		A	Fetal cord puncture, prenatal	6.24	000
59015		A	Chorion biopsy	3.45	000
59020		A	Fetal contract stress test	2.18	000
59020	26	A	Fetal contract stress test	1.62	000
59020	TC	A	Fetal contract stress test	0.56	000
59025		A	Fetal nonstress test	1.21	000
59025	26	A	Fetal nonstress test	0.97	000
59025	TC	A	Fetal nonstress test	0.24	000
59030		A	Fetal scalp blood sample	3.69	000
59050		A	Fetal monitor with report	1.79	XXX
59051		A	Fetal monitor/interpret onl.	1.64	XXX
59100		A	Remove uterus lesion	10.69	090
59120		A	Treat ectopic pregnancy	15.86	090
59121		A	Treat ectopic pregnancy	13.02	090
59130		A	Treat ectopic pregnancy	14.23	090
59135		A	Treat ectopic pregnancy	23.49	090
59136		A	Treat ectopic pregnancy	15.80	090
59140		A	Treat ectopic pregnancy	9.87	090
59150		A	Treat ectopic pregnancy	11.52	090
59151		A	Treat ectopic pregnancy	16.14	090
59160		A	D&C after delivery	5.89	010
59200		A	Insert cervical dilator	1.40	000
59300		A	Episiotomy or vaginal repair	3.46	000
59320		A	Revision of cervix	4.51	000
59325		A	Revision of cervix	7.12	000
59350		A	Repair of uterus	9.00	000
59400		A	Obstetrical care	38.12	MMM
59409		A	Obstetrical care	24.12	MMM
59410		A	Obstetrical care	26.23	MMM
59412		A	Antepartum manipulation	3.11	MMM
59414		A	Deliver placenta	2.93	MMM
59425		A	Antepartum care only	7.33	MMM
59426		A	Antepartum care only	12.55	MMM
59430		A	Care after delivery	2.44	MMM
59510		A	Cesarean delivery	42.99	MMM
59514		A	Cesarean delivery only	27.95	MMM
59515		A	Cesarean delivery	30.05	MMM
59525		A	Remove uterus after cesarean	12.91	MMM
59812		A	Treatment of miscarriage	7.17	090
59820		A	Care of miscarriage	7.94	090
59821		A	Treatment of miscarriage	7.36	090
59830		A	Treat uterus infection	10.78	090
59840		A	Abortion	6.54	010
59841		A	Abortion	7.44	010
59850		A	Abortion	9.98	090
59851		A	Abortion	10.43	090
59852		A	Abortion	13.99	090
59855		A	Abortion	8.62	090
59856		A	Abortion	13.01	090
59857		A	Abortion	15.82	090
59870		A	Evacuate mole of uterus	7.40	090

E. Procedure code numbers 60000 to 69970 relate to neurological procedures.

CPT/ HCPCS Procedure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
60000		A	Drain thyroid/tongue cyst	2.37	010
60001		A	Aspirate/inject thyroid cyst	2.08	000
60100		A	Biopsy of thyroid	2.08	000
60200		A	Remove thyroid lesion	15.47	090
60210		A	Partial excision thyroid	20.18	090
60212		A	Partial thyroid excision	25.59	090
60220		A	Partial removal of thyroid	19.36	090
60225		A	Partial removal of thyroid	23.28	090
60240		A	Removal of thyroid	27.42	090
60252		A	Removal of thyroid	30.57	090
60254		A	Extensive thyroid surgery	37.66	090
60260		A	Repeat thyroid surgery	17.87	090
60270		A	Removal of thyroid	31.92	090
60271		A	Removal of thyroid	27.64	090
60280		A	Remove thyroid duct lesion	13.28	090
60281		A	Remove thyroid duct lesion	13.62	090
60500		A	Explore parathyroid glands	28.16	090
60502		A	Re-explore parathyroids	32.08	090
60505		A	Explore parathyroid glands	34.63	090
60512		A	Autotransplant, parathyroid	7.11	ZZZ
60520		A	Removal of thymus gland	30.82	090
60521		A	Removal thymus gland	32.81	090
60522		A	Removal of thymus gland	36.79	090
60540		A	Explore adrenal gland	29.00	090
60545		A	Explore adrenal gland	34.16	090
60600		A	Remove carotid body lesion	28.70	090
60605		A	Remove carotid body lesion	30.27	090
61000		A	Remove cranial cavity fluid	2.75	000
61001		A	Remove cranial cavity fluid	2.47	000
61020		A	Remove brain cavity fluid	2.89	000
61026		A	Injection into brain canal	3.83	000
61050		A	Remove brain canal fluid	2.82	000
61055		A	Injection into brain canal	4.08	000
61070		A	Brain canal shunt procedure	1.39	000
61105		A	Drill skull for examination	15.82	090
61106		A	Drill skull for exam/surgery	14.19	ZZZ
61107		A	Drill skull for implantation	10.79	000
61108		A	Drill skull for drainage	24.15	090
61120		A	Pierce skull for examination	15.91	090
61130		A	Pierce skull, exam/surgery	11.90	ZZZ
61140		A	Pierce skull for biopsy	30.48	090
61150		A	Pierce skull for drainage	32.58	090
61151		A	Pierce skull for drainage	13.79	090
61154		A	Pierce skull, remove clot	33.09	090
61156		A	Pierce skull for drainage	33.22	090
61210		A	Pierce skull; implant device	12.18	000
61215		A	Insert brain fluid device	20.02	090
61250		A	Pierce skull and explore	19.92	090

61253	A	Pierce skull and explore	23.63	090
61304	A	Open skull for exploration	49.45	090
61305	A	Open skull for exploration	56.81	090
61312	A	Open skull for drainage	47.29	090
61313	A	Open skull for drainage	47.15	090
61314	A	Open skull for drainage	51.15	090
61315	A	Open skull for drainage	52.97	090
61320	A	Open skull for drainage	44.64	090
61321	A	Open skull for drainage	48.61	090
61330	A	Decompress eye socket	29.25	090
61332	A	Explore/biopsy eye socket	48.36	090
61333	A	Explore orbit; remove lesion	49.12	090
61334	A	Explore orbit; remove object	32.73	090
61340	A	Relieve cranial pressure	27.83	090
61343	A	Incise skull, pressure relief	61.01	090
61345	A	Relieve cranial pressure	46.60	090
61440	A	Incise skull for surgery	47.26	090
61450	A	Incise skull for surgery	46.74	090
61458	A	Incise skull for brain wound	56.11	090
61460	A	Incise skull for surgery	54.10	090
61470	A	Incise skull for surgery	36.18	090
61480	A	Incise skull for surgery	32.81	090
61490	A	Incise skull for surgery	28.65	090
61500	A	Removal of skull lesion	39.09	090
61501	A	Remove infected skull bone	32.95	090
61510	A	Removal of brain lesion	53.30	090
61512	A	Remove brain lining lesion	56.37	090
61514	A	Removal of brain abscess	51.80	090
61516	A	Removal of brain lesion	51.97	090
61518	A	Removal of brain lesion	65.52	090
61519	A	Remove brain lining lesion	68.48	090
61520	A	Removal of brain lesion	75.67	090
61521	A	Removal of brain lesion	75.92	090
61522	A	Removal of brain abscess	49.80	090
61524	A	Removal of brain lesion	56.51	090
61526	A	Removal of brain lesion	66.40	090
61530	A	Removal of brain lesion	79.10	090
61531	A	Implant brain electrodes	36.45	090
61533	A	Implant brain electrodes	42.45	090
61534	A	Removal of brain lesion	26.83	090
61535	A	Remove brain electrodes	18.63	090
61536	A	Removal of brain lesion	53.78	090
61538	A	Removal of brain tissue	60.03	090
61539	A	Removal of brain tissue	55.44	090
61541	A	Incision of brain tissue	49.03	090
61542	A	Removal of brain tissue	49.66	090
61543	A	Removal of brain tissue	39.29	090
61544	A	Remove and treat brain lesion	52.85	090
61545	A	Excision of brain tumor	63.05	090
61546	A	Removal of pituitary gland	59.16	090
61548	A	Removal of pituitary gland	47.24	090
61550	A	Release of skull seams	26.62	090
61552	A	Release of skull seams	34.48	090
61556	A	Incise skull/sutures	38.72	090
61557	A	Incise skull/sutures	38.94	090

61558	A	Excision of skull/sutures	44.25	090
61559	A	Excision of skull/sutures	57.38	090
61563	A	Excision of skull tumor	46.91	090
61564	A	Excision of skull tumor	59.18	090
61570	A	Remove brain foreign body	41.22	090
61571	A	Incise skull for brain wound	44.78	090
61575	A	Skull base/brain stem surgery	68.21	090
61576	A	Skull base/brain stem surgery	64.27	090
61580	A	Craniofacial approach, skull	52.39	090
61581	A	Craniofacial approach, skull	59.46	090
61582	A	Craniofacial approach, skull	53.97	090
61583	A	Craniofacial approach, skull	61.59	090
61584	A	Orbitocranial approach/skull	59.63	090
61585	A	Orbitocranial approach/skull	66.72	090
61590	A	Infratemporal approach/skull	72.56	090
61591	A	Infratemporal approach/skull	76.10	090
61592	A	Orbitocranial approach/skull	69.03	090
61595	A	Transtemporal approach/skull	50.98	090
61596	A	Transcochlear approach/skull	61.95	090
61597	A	Transcondylar approach/skull	65.49	090
61598	A	Transpetrosal approach/skull	57.70	090
61600	A	Resect/excise cranial lesion	44.24	090
61601	A	Resect/excise cranial lesion	47.44	090
61605	A	Resect/excise cranial lesion	50.09	090
61606	A	Resect/excise cranial lesion	67.08	090
61607	A	Resect/excise cranial lesion	62.66	090
61608	A	Resect/excise cranial lesion	72.91	090
61609	A	Transect, artery, sinus	17.93	ZZZ
61610	A	Transect, artery, sinus	53.79	ZZZ
61611	A	Transect, artery, sinus	13.45	ZZZ
61612	A	Transect, artery, sinus	50.55	ZZZ
61613	A	Remove aneurysm, sinus	71.50	090
61615	A	Resect/excise lesion, skull	55.04	090
61616	A	Resect/excise lesion, skull	74.87	090
61618	A	Repair dura	28.31	090
61619	A	Repair dura	35.39	090
61624	A	Occlusion/embolization cath.	36.42	000
61626	A	Occlusion/embolization cath.	30.03	000
61680	A	Intracranial vessel surgery	70.96	090
61682	A	Intracranial vessel surgery	81.30	090
61684	A	Intracranial vessel surgery	70.93	090
61686	A	Intracranial vessel surgery	85.76	090
61690	A	Intracranial vessel surgery	63.64	090
61692	A	Intracranial vessel surgery	68.61	090
61700	A	Inner skull vessel surgery	69.87	090
61702	A	Inner skull vessel surgery	79.42	090
61703	A	Clamp neck artery	29.82	090
61705	A	Revise circulation to head	67.99	090
61708	A	Revise circulation to head	60.00	090
61710	A	Revise circulation to head	45.75	090
61711	A	Fusion of skull arteries	71.34	090
61712	A	Skull or spine microsurgery	8.51	ZZZ
61720	A	Incise skull/brain surgery	38.61	090
61735	A	Incise skull/brain surgery	30.88	090
61750	A	Incise skull; brain biopsy	29.68	090

61751	A	Brain biopsy with cat scan	38.08	090
61760	A	Implant brain electrodes	40.80	090
61770	A	Incise skull for treatment	36.51	090
61790	A	Treat trigeminal nerve	25.89	090
61791	A	Treat trigeminal tract	21.47	090
61793	A	Focus radiation beam	39.01	090
61795	A	Brain surgery using computer	11.43	000
61850	A	Implant neuroelectrodes	28.98	090
61855	A	Implant neuroelectrodes	24.17	090
61860	A	Implant neuroelectrodes	20.30	090
61865	A	Implant neuroelectrodes	39.35	090
61870	A	Implant neuroelectrodes	10.46	090
61875	A	Implant neuroelectrodes	16.68	090
61880	A	Revise/remove neuroelectrode	10.88	090
61885	A	Implant neuroreceiver	4.48	090
61888	A	Revise/remove neuroreceiver	5.62	010
62000	A	Repair of skull fracture	17.57	090
62005	A	Repair of skull fracture	27.10	090
62010	A	Treatment of head injury	39.62	090
62100	A	Repair brain fluid leakage	44.57	090
62115	A	Reduction of skull defect	37.02	090
62116	A	Reduction of skull defect	40.53	090
62117	A	Reduction of skull defect	45.83	090
62120	A	Repair skull cavity lesion	40.34	090
62121	A	Incise skull repair	39.80	090
62140	A	Repair of skull defect	27.46	090
62141	A	Repair of skull defect	33.55	090
62142	A	Remove skull plate/flap	24.17	090
62143	A	Replace skull plate/flap	22.27	090
62145	A	Repair of skull and brain	32.20	090
62146	A	Repair of skull with graft	27.40	090
62147	A	Repair of skull with graft	32.87	090
62180	A	Establish brain cavity shunt	28.52	090
62190	A	Establish brain cavity shunt	25.34	090
62192	A	Establish brain cavity shunt	27.40	090
62194	A	Replace/irrigate catheter	4.86	010
62200	A	Establish brain cavity shunt	31.99	090
62201	A	Establish brain cavity shunt	21.92	090
62220	A	Establish brain cavity shunt	29.34	090
62223	A	Establish brain cavity shunt	30.98	090
62225	A	Replace/irrigate catheter	9.83	090
62230	A	Replace/revise brain shunt	20.62	090
62256	A	Remove brain cavity shunt	12.97	090
62258	A	Replace brain cavity shunt	29.87	090
62268	A	Drain spinal cord cyst	7.05	000
62269	A	Needle biopsy spinal cord	5.99	000
62270	A	Spinal fluid tap, diagnostic	1.87	000
62272	A	Drain spinal fluid	2.43	000
62273	A	Treat lumbar spine lesion	3.43	000
62274	A	Inject spinal anesthetic	2.63	000
62275	A	Inject spinal anesthetic	2.51	000
62276	A	Inject spinal anesthetic	3.41	000
62277	A	Inject spinal anesthetic	3.14	000
62278	A	Inject spinal anesthetic	2.65	000
62279	A	Inject spinal anesthetic	2.55	000

62280	A	Treat spinal cord lesion	3.38	010
62281	A	Treat spinal cord lesion	3.66	010
62282	A	Treat spinal canal lesion	4.23	010
62284	A	Injection for myelogram	3.72	000
62287	A	Percutaneous diskectomy	15.53	090
62288	A	Injection into spinal canal	3.01	000
62289	A	Injection into spinal canal	2.89	000
62290	A	Inject for spine disk X–ray	5.58	000
62291	A	Inject for spine disk X–ray	4.93	000
62292	A	Injection into disk lesion	18.17	090
62294	A	Injection into spinal artery	14.27	090
62298	A	Injection into spinal canal	3.32	000
63001	A	Removal of spinal lamina	35.05	090
63003	A	Removal of spinal lamina	34.44	090
63005	A	Removal of spinal lamina	32.65	090
63011	A	Removal of spinal lamina	22.21	090
63012	A	Removal of spinal lamina	34.11	090
63015	A	Removal of spinal lamina	40.29	090
63016	A	Removal of spinal lamina	42.13	090
63017	A	Removal of spinal lamina	38.50	090
63020	A	Neck spine disk surgery	30.59	090
63030	A	Low back disk surgery	29.25	090
63035	A	Added spinal disk surgery	7.64	ZZZ
63040	A	Neck spine disk surgery	42.57	090
63042	A	Low back disk surgery	41.96	090
63045	A	Removal of spinal lamina	37.69	090
63046	A	Removal of spinal lamina	37.12	090
63047	A	Removal of spinal lamina	34.77	090
63048	A	Removal of spinal lamina	8.42	ZZZ
63055	A	Decompress spinal cord	46.84	090
63056	A	Decompress spinal cord	43.13	090
63057	A	Decompress spinal cord	7.60	ZZZ
63064	A	Decompress spinal cord	49.45	090
63066	A	Decompress spinal cord	6.01	ZZZ
63075	A	Neck spine disk surgery	39.24	090
63076	A	Neck spine disk surgery	9.81	ZZZ
63077	A	Spine disk surgery, thorax	40.53	090
63078	A	Spine disk surgery, thorax	6.16	ZZZ
63081	A	Removal of vertebral body	50.95	090
63082	A	Removal of vertebral body	10.89	ZZZ
63085	A	Removal of vertebral body	55.19	090
63086	A	Removal of vertebral body	8.42	ZZZ
63087	A	Removal of vertebral body	58.64	090
63088	A	Removal of vertebral body	10.70	ZZZ
63090	A	Removal of vertebral body	58.27	090
63091	A	Removal of vertebral body	6.03	ZZZ
63170	A	Incise spinal cord tract(s)	38.98	090
63172	A	Drainage of spinal cyst	39.44	090
63173	A	Drainage of spinal cyst	36.87	090
63180	A	Revise spinal cord ligaments	29.59	090
63182	A	Revise spinal cord ligaments	36.60	090
63185	A	Incise spinal column/nerves	31.13	090
63190	A	Incise spinal column/nerves	39.36	090
63191	A	Incise spinal column/nerves	30.77	090
63194	A	Incise spinal column and cord	31.94	090

63195	A	Incise spinal column and cord	32.24	090
63196	A	Incise spinal column and cord	37.17	090
63197	A	Incise spinal column and cord	35.31	090
63198	A	Incise spinal column and cord	40.70	090
63199	A	Incise spinal column and cord	46.73	090
63200	A	Release of spinal cord	31.22	090
63250	A	Revise spinal cord vessels	69.80	090
63251	A	Revise spinal cord vessels	64.24	090
63252	A	Revise spinal cord vessels	70.44	090
63265	A	Excise intraspinal lesion	44.33	090
63266	A	Excise intraspinal lesion	47.99	090
63267	A	Excise intraspinal lesion	40.56	090
63268	A	Excise intraspinal lesion	31.32	090
63270	A	Excise intraspinal lesion	45.04	090
63271	A	Excise intraspinal lesion	54.37	090
63272	A	Excise intraspinal lesion	49.36	090
63273	A	Excise intraspinal lesion	42.08	090
63275	A	Biopsy/excise spinal tumor	52.84	090
63276	A	Biopsy/excise spinal tumor	49.78	090
63277	A	Biopsy/excise spinal tumor	45.74	090
63278	A	Biopsy/excise spinal tumor	45.11	090
63280	A	Biopsy/excise spinal tumor	57.72	090
63281	A	Biopsy/excise spinal tumor	57.00	090
63282	A	Biopsy/excise spinal tumor	51.70	090
63283	A	Biopsy/excise spinal tumor	44.39	090
63285	A	Biopsy/excise spinal tumor	61.43	090
63286	A	Biopsy/excise spinal tumor	65.60	090
63287	A	Biopsy/excise spinal tumor	62.85	090
63290	A	Biopsy/excise spinal tumor	64.96	090
63300	A	Removal of vertebral body	41.17	090
63301	A	Removal of vertebral body	45.69	090
63302	A	Removal of vertebral body	48.68	090
63303	A	Removal of vertebral body	49.02	090
63304	A	Removal of vertebral body	50.79	090
63305	A	Removal of vertebral body	54.13	090
63306	A	Removal of vertebral body	54.24	090
63307	A	Removal of vertebral body	55.49	090
63308	A	Removal of vertebral body	9.74	ZZZ
63600	A	Remove spinal cord lesion	25.40	090
63610	A	Stimulation of spinal cord	16.76	000
63615	A	Remove lesion of spinal cord	28.16	090
63650	A	Implant neuroelectrodes	15.34	090
63655	A	Implant neuroelectrodes	26.05	090
63660	A	Revise/remove neuroelectrode	13.57	090
63685	A	Implant neuroreceiver	14.56	090
63688	A	Revise/remove neuroreceiver	11.62	090
63690	A	Analysis of neuroreceiver	1.17	XXX
63691	A	Analysis of neuroreceiver	1.13	XXX
63700	A	Repair of spinal herniation	28.31	090
63702	A	Repair of spinal herniation	31.86	090
63704	A	Repair of spinal herniation	35.39	090
63706	A	Repair of spinal herniation	40.70	090
63707	A	Repair spinal fluid leakage	24.63	090
63709	A	Repair spinal fluid leakage	32.18	090
63710	A	Graft repair of spine defect	23.69	090

63740	A	Install spinal shunt	25.58	090
63741	A	Install spinal shunt	18.50	090
63744	A	Revision of spinal shunt	15.98	090
63746	A	Removal of spinal shunt	11.76	090
63750	A	Insert spinal canal catheter	20.32	090
63780	A	Insert spinal canal catheter	8.51	090
64400	A	Injection for nerve block	1.62	000
64402	A	Injection for nerve block	1.92	000
64405	A	Injection for nerve block	2.00	000
64408	A	Injection for nerve block	2.51	000
64410	A	Injection for nerve block	2.23	000
64412	A	Injection for nerve block	1.85	000
64413	A	Injection for nerve block	2.19	000
64415	A	Injection for nerve block	1.79	000
64417	A	Injection for nerve block	2.17	000
64418	A	Injection for nerve block	2.23	000
64420	A	Injection for nerve block	1.86	000
64421	A	Injection for nerve block	2.62	000
64425	A	Injection for nerve block	2.38	000
64430	A	Injection for nerve block	2.23	000
64435	A	Injection for nerve block	1.98	000
64440	A	Injection for nerve block	2.18	000
64441	A	Injection for nerve block	2.87	000
64442	A	Injection for nerve block	2.69	000
64443	A	Injection for nerve block	2.05	ZZZ
64445	A	Injection for nerve block	2.01	000
64450	A	Injection for nerve block	1.83	000
64505	A	Injection for nerve block	2.01	000
64508	A	Injection for nerve block	2.20	000
64510	A	Injection for nerve block	2.04	000
64520	A	Injection for nerve block	2.18	000
64530	A	Injection for nerve block	2.92	000
64550	A	Apply neurostimulator	0.64	000
64553	A	Implant neuroelectrodes	3.34	010
64555	A	Implant neuroelectrodes	2.71	010
64560	A	Implant neuroelectrodes	3.90	010
64565	A	Implant neuroelectrodes	2.52	010
64573	A	Implant neuroelectrodes	7.88	090
64575	A	Implant neuroelectrodes	7.57	090
64577	A	Implant neuroelectrodes	7.57	090
64580	A	Implant neuroelectrodes	7.04	090
64585	A	Revise/remove neuroelectrode	3.03	010
64590	A	Implant neuroreceiver	4.40	010
64595	A	Revise/remove neuroreceiver	2.93	010
64600	A	Injection treatment of nerve	5.19	010
64605	A	Injection treatment of nerve	7.34	010
64610	A	Injection treatment of nerve	15.17	010
64612	A	Destroy nerve, face muscle	3.45	010
64613	A	Destroy nerve, spine muscle	3.45	010
64620	A	Injection treatment of nerve	3.91	010
64622	A	Injection treatment of nerve	4.98	010
64623	A	Injection treatment of nerve	1.94	ZZZ
64630	A	Injection treatment of nerve	4.93	010
64640	A	Injection treatment of nerve	3.46	010
64680	A	Injection treatment of nerve	4.38	010

64702	A	Revise finger/toe nerve	8.65	090
64704	A	Revise hand/foot nerve	10.23	090
64708	A	Revise arm/leg nerve	13.75	090
64712	A	Revision of sciatic nerve	17.35	090
64713	A	Revision of arm nerve(s)	20.76	090
64714	A	Revise low back nerve(s)	16.88	090
64716	A	Revision of cranial nerve	11.01	090
64718	A	Revise ulnar nerve at elbow	12.85	090
64719	A	Revise ulnar nerve at wrist	10.17	090
64721	A	Carpal tunnel surgery	9.37	090
64722	A	Relieve pressure on nerve(s)	10.82	090
64726	A	Release foot/toe nerve	4.74	090
64727	A	Internal nerve revision	6.66	ZZZ
64732	A	Incision of brow nerve	8.88	090
64734	A	Incision of cheek nerve	9.61	090
64736	A	Incision of chin nerve	9.07	090
64738	A	Incision of jaw nerve	10.82	090
64740	A	Incision of tongue nerve	10.80	090
64742	A	Incision of facial nerve	11.13	090
64744	A	Incise nerve, back of head	11.61	090
64746	A	Incise diaphragm nerve	9.86	090
64752	A	Incision of vagus nerve	11.10	090
64755	A	Incision of stomach nerves	24.95	090
64760	A	Incision of vagus nerve	14.10	090
64761	A	Incision of pelvis nerve	11.03	090
64763	A	Incise hip/thigh nerve	12.08	090
64766	A	Incise hip/thigh nerve	15.69	090
64771	A	Sever cranial nerve	13.80	090
64772	A	Incision of spinal nerve	14.33	090
64774	A	Remove skin nerve lesion	7.87	090
64776	A	Remove digit nerve lesion	7.88	090
64778	A	Added digit nerve surgery	6.09	ZZZ
64782	A	Remove limb nerve lesion	10.75	090
64783	A	Added limb nerve surgery	7.25	ZZZ
64784	A	Remove nerve lesion	15.68	090
64786	A	Remove sciatic nerve lesion	29.02	090
64787	A	Implant nerve end	8.13	ZZZ
64788	A	Remove skin nerve lesion	8.21	090
64790	A	Removal of nerve lesion	18.79	090
64792	A	Removal of nerve lesion	24.40	090
64795	A	Biopsy of nerve	5.62	000
64802	A	Remove sympathetic nerves	14.29	090
64804	A	Remove sympathetic nerves	27.87	090
64809	A	Remove sympathetic nerves	24.56	090
64818	A	Remove sympathetic nerves	19.02	090
64820	A	Remove sympathetic nerves	16.51	090
64830	A	Microrepair of nerve	5.34	ZZZ
64831	A	Repair of digit nerve	12.57	090
64832	A	Repair additional nerve	7.22	ZZZ
64834	A	Repair of hand or foot nerve	13.63	090
64835	A	Repair of hand or foot nerve	17.06	090
64836	A	Repair of hand or foot nerve	17.91	090
64837	A	Repair additional nerve	11.22	ZZZ
64840	A	Repair of leg nerve	22.98	090
64856	A	Repair/transpose nerve	21.90	090

64857	A	Repair arm/leg nerve	23.87	090
64858	A	Repair sciatic nerve	27.69	090
64859	A	Additional nerve surgery	8.10	ZZZ
64861	A	Repair of arm nerves	32.10	090
64862	A	Repair of low back nerves	40.43	090
64864	A	Repair of facial nerve	20.41	090
64865	A	Repair of facial nerve	27.87	090
64866	A	Fusion of facial/other nerve	27.22	090
64868	A	Fusion of facial/other nerve	25.38	090
64870	A	Fusion of facial/other nerve	30.03	090
64872	A	Subsequent repair of nerve	3.61	ZZZ
64874	A	Repair and revise nerve	5.41	ZZZ
64876	A	Repair nerve; shorten bone	6.13	ZZZ
64885	A	Nerve graft, head or neck	30.24	090
64886	A	Nerve graft, head or neck	36.06	090
64890	A	Nerve graft, hand or foot	27.86	090
64891	A	Nerve graft, hand or foot	26.66	090
64892	A	Nerve graft, arm or leg	25.87	090
64893	A	Nerve graft, arm or leg	29.86	090
64895	A	Nerve graft, hand or foot	33.09	090
64896	A	Nerve graft, hand or foot	37.92	090
64897	A	Nerve graft, arm or leg	31.51	090
64898	A	Nerve graft, arm or leg	34.17	090
64901	A	Additional nerve graft	20.81	ZZZ
64902	A	Additional nerve graft	24.23	ZZZ
64905	A	Nerve pedicle transfer	22.96	090
64907	A	Nerve pedicle transfer	32.46	090
65091	A	Revise eye	14.08	090
65093	A	Revise eye with implant	14.96	090
65101	A	Removal of eye	15.04	090
65103	A	Remove eye/insert implant	16.28	090
65105	A	Remove eye/attach implant	18.03	090
65110	A	Removal of eye	29.67	090
65112	A	Remove eye, revise socket	28.16	090
65114	A	Remove eye, revise socket	30.59	090
65125	A	Revise ocular implant	5.49	090
65130	A	Insert ocular implant	15.58	090
65135	A	Insert ocular implant	12.51	090
65140	A	Attach ocular implant	13.81	090
65150	A	Revise ocular implant	14.64	090
65155	A	Reinsert ocular implant	19.74	090
65175	A	Removal of ocular implant	13.56	090
65205	A	Remove foreign body from eye	1.16	000
65210	A	Remove foreign body from eye	1.31	000
65220	A	Remove foreign body from eye	1.25	000
65222	A	Remove foreign body from eye	1.51	000
65235	A	Remove foreign body from eye	12.85	090
65260	A	Remove foreign body from eye	19.15	090
65265	A	Remove foreign body from eye	22.27	090
65270	A	Repair of eye wound	3.05	010
65272	A	Repair of eye wound	5.26	090
65273	A	Repair of eye wound	7.20	090
65275	A	Repair of eye wound	5.74	090
65280	A	Repair of eye wound	16.37	090
65285	A	Repair of eye wound	24.55	090

65286	A	Repair of eye wound	10.04	090
65290	A	Repair of eye socket wound	11.40	090
65400	A	Removal of eye lesion	12.20	090
65410	A	Biopsy of cornea	3.11	000
65420	A	Removal of eye lesion	8.34	090
65426	A	Removal of eye lesion	11.67	090
65430	A	Corneal smear	1.42	000
65435	A	Curette/treat cornea	1.71	000
65436	A	Curette/treat cornea	5.56	090
65450	A	Treatment of corneal lesion	6.41	090
65600	A	Revision of cornea	5.83	090
65710	A	Corneal transplant	25.39	090
65730	A	Corneal transplant	30.65	090
65750	A	Corneal transplant	32.14	090
65755	A	Corneal transplant	32.69	090
65770	A	Revise cornea with implant	30.64	090
65772	A	Correction of astigmatism	9.32	090
65775	A	Correction of astigmatism	13.26	090
65800	A	Drainage of eye	3.67	000
65805	A	Drainage of eye	3.76	000
65810	A	Drainage of eye	10.13	090
65815	A	Drainage of eye	9.33	090
65820	A	Relieve inner eye pressure	17.32	090
65850	A	Incision of eye	23.45	090
65855	A	Laser surgery of eye	12.25	090
65860	A	Incise inner eye adhesions	8.65	090
65865	A	Incise inner eye adhesions	12.51	090
65870	A	Incise inner eye adhesions	11.90	090
65875	A	Incise inner eye adhesions	12.55	090
65880	A	Incise inner eye adhesions	13.68	090
65900	A	Remove eye lesion	18.85	090
65920	A	Remove implant from eye	16.42	090
65930	A	Remove blood clot from eye	14.86	090
66020	A	Injection treatment of eye	3.62	010
66030	A	Injection treatment of eye	1.75	010
66130	A	Remove eye lesion	12.94	090
66150	A	Glaucoma surgery	17.55	090
66155	A	Glaucoma surgery	17.22	090
66160	A	Glaucoma surgery	20.43	090
66165	A	Glaucoma surgery	16.89	090
66170	A	Glaucoma surgery	23.69	090
66172	A	Incision of eye	26.06	090
66180	A	Implant eye shunt	29.22	090
66185	A	Revise eye shunt	17.76	090
66220	A	Repair eye lesion	13.41	090
66225	A	Repair/graft eye lesion	24.54	090
66250	A	Follow–up surgery of eye	12.96	090
66500	A	Incision of iris	8.26	090
66505	A	Incision of iris	7.27	090
66600	A	Remove iris and lesion	17.78	090
66605	A	Removal of iris	24.47	090
66625	A	Removal of iris	12.25	090
66630	A	Removal of iris	13.42	090
66635	A	Removal of iris	13.82	090
66680	A	Repair iris and ciliary body	11.69	090

66682	A	Repair iris and ciliary body	13.32	090
66700	A	Destruction, ciliary body	10.52	090
66710	A	Destruction, ciliary body	10.80	090
66720	A	Destruction, ciliary body	10.54	090
66740	A	Destruction, ciliary body	10.72	090
66761	A	Revision of iris	10.43	090
66762	A	Revision of iris	12.10	090
66770	A	Removal of inner eye lesion	11.86	090
66820	A	Incision, secondary cataract	8.68	090
66821	A	After cataract laser surgery	7.77	090
66825	A	Reposition intraocular lens	15.20	090
66830	A	Removal of lens lesion	15.62	090
66840	A	Removal of lens material	17.32	090
66850	A	Removal of lens material	20.03	090
66852	A	Removal of lens material	23.13	090
66920	A	Extraction of lens	19.50	090
66930	A	Extraction of lens	20.43	090
66940	A	Extraction of lens	19.56	090
66983	A	Remove cataract, insert lens	22.15	090
66984	A	Remove cataract, insert lens	24.21	090
66985	A	Insert lens prosthesis	18.24	090
66986	A	Exchange lens prosthesis	24.21	090
67005	A	Partial removal of eye fluid	21.06	090
67010	A	Partial removal of eye fluid	20.41	090
67015	A	Release of eye fluid	13.27	090
67025	A	Replace eye fluid	13.32	090
67028	A	Injection eye drug	5.81	000
67030	A	Incise inner eye strands	11.71	090
67031	A	Laser surgery, eye strands	12.64	090
67036	A	Removal of inner eye fluid	31.96	090
67038	A	Strip retinal membrane	48.19	090
67039	A	Laser treatment of retina	37.16	090
67040	A	Laser treatment of retina	41.86	090
67101	A	Repair, detached retina	17.12	090
67105	A	Repair, detached retina	18.62	090
67107	A	Repair detached retina	32.34	090
67108	A	Repair detached retina	47.34	090
67109	A	Repair detached retina	28.38	090
67110	A	Repair detached retina	21.62	090
67112	A	Re–repair detached retina	32.97	090
67115	A	Release, encircling material	11.19	090
67120	A	Remove eye implant material	12.91	090
67121	A	Remove eye implant material	19.77	090
67141	A	Treatment of retina	12.19	090
67145	A	Treatment of retina	12.50	090
67208	A	Treatment of retinal lesion	14.89	090
67210	A	Treatment of retinal lesion	18.68	090
67218	A	Treatment of retinal lesion	26.30	090
67227	A	Treatment of retinal lesion	14.60	090
67228	A	Treatment of retinal lesion	21.97	090
67250	A	Reinforce eye wall	15.52	090
67255	A	Reinforce/graft eye wall	21.36	090
67311	A	Revise eye muscle	14.54	090
67312	A	Revise two eye muscles	17.40	090
67314	A	Revise eye muscle	16.53	090

67316	A	Revise two eye muscles	18.64	090
67318	A	Revise eye muscle(s)	13.79	090
67320	A	Revise eye muscle(s)	19.12	090
67331	A	Eye surgery follow–up	17.81	090
67332	A	Rerevise eye muscles	19.79	090
67334	A	Revise eye muscle with suture	13.99	090
67335	A	Eye suture during surgery	7.96	ZZZ
67340	A	Revise eye muscle	17.49	090
67343	A	Release eye tissue	12.95	090
67345	A	Destroy nerve of eye muscle	5.27	010
67350	A	Biopsy eye muscle	5.31	000
67400	A	Explore/biopsy eye socket	20.35	090
67405	A	Explore/drain eye socket	17.20	090
67412	A	Explore/treat eye socket	21.09	090
67413	A	Explore/treat eye socket	18.10	090
67414	A	Explore/decompress eye socket	18.63	090
67415	A	Aspiration orbital contents	3.83	000
67420	A	Explore/treat eye socket	30.60	090
67430	A	Explore/treat eye socket	23.64	090
67440	A	Explore/drain eye socket	28.72	090
67445	A	Explore/decompress eye socket	24.71	090
67450	A	Explore/biopsy eye socket	28.42	090
67500	A	Inject/treat eye socket	1.55	000
67505	A	Inject/treat eye socket	1.88	000
67515	A	Inject/treat eye socket	1.18	000
67550	A	Insert eye socket implant	19.63	090
67560	A	Revise eye socket implant	18.60	090
67570	A	Decompress optic nerve	20.25	090
67700	A	Drainage of eyelid abscess	1.81	010
67710	A	Incision of eyelid	2.00	010
67715	A	Incision of eyelid fold	2.70	010
67800	A	Remove eyelid lesion	2.31	010
67801	A	Remove eyelid lesions	3.27	010
67805	A	Remove eyelid lesions	3.59	010
67808	A	Remove eyelid lesion(s)	5.74	090
67810	A	Biopsy of eyelid	2.31	000
67820	A	Revise eyelashes	1.28	000
67825	A	Revise eyelashes	2.25	010
67830	A	Revise eyelashes	4.08	010
67835	A	Revise eyelashes	12.55	090
67840	A	Remove eyelid lesion	3.24	010
67850	A	Treat eyelid lesion	2.48	010
67875	A	Closure of eyelid by suture	3.13	000
67880	A	Revision of eyelid	7.58	090
67882	A	Revision of eyelid	11.02	090
67900	A	Repair brow defect	8.40	090
67901	A	Repair eyelid defect	15.83	090
67902	A	Repair eyelid defect	16.03	090
67903	A	Repair eyelid defect	15.80	090
67904	A	Repair eyelid defect	15.26	090
67906	A	Repair eyelid defect	12.26	090
67908	A	Repair eyelid defect	12.70	090
67909	A	Revise eyelid defect	12.12	090
67911	A	Revise eyelid defect	13.54	090
67914	A	Repair eyelid defect	8.94	090

67915	A	Repair eyelid defect	4.39	090
67916	A	Repair eyelid defect	11.78	090
67917	A	Repair eyelid defect	13.51	090
67921	A	Repair eyelid defect	7.21	090
67922	A	Repair eyelid defect	4.21	090
67923	A	Repair eyelid defect	12.72	090
67924	A	Repair eyelid defect	13.03	090
67930	A	Repair eyelid wound	4.88	010
67935	A	Repair eyelid wound	9.97	090
67938	A	Remove eyelid foreign body	1.82	010
67950	A	Revision of eyelid	13.04	090
67961	A	Revision of eyelid	12.78	090
67966	A	Revision of eyelid	15.06	090
67971	A	Reconstruction of eyelid	20.50	090
67973	A	Reconstruction of eyelid	26.52	090
67974	A	Reconstruction of eyelid	26.99	090
67975	A	Reconstruction of eyelid	13.17	090
68020	A	Incise/drain eyelid lining	1.85	010
68040	A	Treatment of eyelid lesions	1.31	000
68100	A	Biopsy of eyelid lining	2.37	000
68110	A	Remove eyelid lining lesion	2.99	010
68115	A	Remove eyelid lining lesion	4.29	010
68130	A	Remove eyelid lining lesion	8.93	090
68135	A	Remove eyelid lining lesion	2.55	010
68200	A	Treat eyelid by injection	1.02	000
68320	A	Revise/graft eyelid lining	11.51	090
68325	A	Revise/graft eyelid lining	16.14	090
68326	A	Revise/graft eyelid lining	15.55	090
68328	A	Revise/graft eyelid lining	18.12	090
68330'	A	Revise eyelid lining	10.47	090
68335	A	Revise/graft eyelid lining	16.23	090
68340	A	Separate eyelid adhesions	7.13	090
68360	A	Revise eyelid lining	9.53	090
68362	A	Revise eyelid lining	15.10	090
68400	A	Incise/drain tear gland	2.67	010
68420	A	Incise/drain tear sac	3.30	010
68440	A	Incise tear duct opening	1.67	010
68500	A	Removal of tear gland	18.48	090
68505	A	Partial removal tear gland	19.28	090
68510	A	Biopsy of tear gland	8.43	000
68520	A	Removal of tear sac	16.40	090
68525	A	Biopsy of tear sac	8.21	000
68530	A	Clearance of tear duct	6.53	010
68540	A	Remove tear gland lesion	18.62	090
68550	A	Remove tear gland lesion	24.33	090
68700	A	Repair tear ducts	8.97	090
68705	A	Revise tear duct opening	3.05	010
68720	A	Create tear sac drain	18.20	090
68745	A	Create tear duct drain	15.00	090
68750	A	Create tear duct drain	20.06	090
68760	A	Close tear duct opening	2.62	010
68761	A	Close tear duct opening	2.24	010
68770	A	Close tear system fistula	10.96	090
68800	A	Dilate tear duct opening(s)	1.54	010
68820	A	Explore tear duct system	2.04	010

68825	A	Explore tear duct system	3.06	010
68830	A	Reopen tear duct channel	4.09	010
68840	A	Explore/irrigate tear ducts	1.73	010
68850	A	Injection for tear sac X–ray	1.33	000
69000	A	Drain external ear lesion	1.77	010
69005	A	Drain external ear lesion	3.29	010
69020	A	Drain outer ear canal lesion	1.90	010
69100	A	Biopsy of external ear	1.46	000
69105	A	Biopsy of external ear canal	1.70	000
69110	A	Partial removal external ear	6.18	090
69120	A	Removal of external ear	4.78	090
69140	A	Remove ear canal lesion(s)	16.15	090
69145	A	Remove ear canal lesion(s)	5.20	090
69150	A	Extensive ear canal surgery	24.16	090
69155	A	Extensive ear/neck surgery	33.79	090
69200	A	Clear outer ear canal	1.21	000
69205	A	Clear outer ear canal	2.28	010
69210	A	Remove impacted ear wax	0.85	000
69220	A	Clean out mastoid cavity	1.36	000
69222	A	Clean out mastoid cavity	2.14	010
69300	A	Revise external ear	11.77	YYY
69310	A	Rebuild outer ear canal	21.01	090
69320	A	Rebuild outer ear canal	32.15	090
69400	A	Inflate middle ear canal	1.31	000
69401	A	Inflate middle ear canal	0.90	000
69405	A	Catheterize middle ear canal	3.09	010
69410	A	Inset middle ear baffle	0.97	000
69420	A	Incision of eardrum	2.02	010
69421	A	Incision of eardrum	2.89	010
69424	A	Remove ventilating tube	1.48	000
69433	A	Create eardrum opening	2.88	010
69436	A	Create eardrum opening	4.16	010
69440	A	Exploration of middle ear	16.48	090
69450	A	Eardrum revision	14.16	090
69501	A	Mastoidectomy	20.32	090
69502	A	Mastoidectomy	26.08	090
69505	A	Remove mastoid structures	29.60	090
69511	A	Extensive mastoid surgery	30.83	090
69530	A	Extensive mastoid surgery	35.65	090
69535	A	Remove part of temporal bone	61.34	090
69540	A	Remove ear lesion	2.49	010
69550	A	Remove ear lesion	26.31	090
69552	A	Remove ear lesion	36.57	090
69554	A	Remove ear lesion	50.08	090
69601	A	Mastoid surgery revision	27.63	090
69602	A	Mastoid surgery revision	30.34	090
69603	A	Mastoid surgery revision	31.92	090
69604	A	Mastoid surgery revision	34.78	090
69605	A	Mastoid surgery revision	34.03	090
69610	A	Repair of eardrum	5.38	010
69620	A	Repair of eardrum	14.71	090
69631	A	Repair eardrum structures	22.75	090
69632	A	Rebuild eardrum structures	29.19	090
69633	A	Rebuild eardrum structures	27.76	090
69635	A	Repair eardrum structures	30.68	090

69636		A	Rebuild eardrum structures	35.03	090
69637		A	Rebuild eardrum structures	34.85	090
69641		A	Revise middle ear and mastoid	29.02	090
69642		A	Revise middle ear and mastoid	38.13	090
69643		A	Revise middle ear and mastoid	35.14	090
69644		A	Revise middle ear and mastoid	39.00	090
69645		A	Revise middle ear and mastoid	37.38	090
69646		A	Revise middle ear and mastoid	40.57	090
69650		A	Release middle ear bone	22.12	090
69660		A	Revise middle ear bone	27.52	090
69661		A	Revise middle ear bone	34.76	090
69662		A	Revise middle ear bone	34.07	090
69666		A	Repair middle ear structures	23.07	090
69667		A	Repair middle ear structures	22.85	090
69670		A	Remove mastoid air cells	21.80	090
69676		A	Remove middle ear nerve	18.21	090
69700		A	Close mastoid fistula	16.27	090
69711		A	Remove/repair hearing aid	18.74	090
69720		A	Release facial nerve	32.69	090
69725		A	Release facial nerve	34.44	090
69740		A	Repair facial nerve	28.19	090
69745		A	Repair facial nerve	32.83	090
69801		A	Incise inner ear	21.60	090
69802		A	Incise inner ear	24.33	090
69805		A	Explore inner ear	25.90	090
69806		A	Explore inner ear	30.68	090
69820		A	Establish inner ear window	19.53	090
69840		A	Revise inner ear window	18.77	090
69905		A	Remove inner ear	26.40	090
69910		A	Remove inner ear and mastoid	32.37	090
69915		A	Incise inner ear nerve	38.70	090
69930		A	Implant cochlear device	38.97	090
69950		A	Incise inner ear nerve	40.43	090
69955		A	Release facial nerve	43.61	090
69960		A	Release inner ear canal	38.63	090
69970		A	Remove inner ear lesion	43.22	090

F. Procedure code numbers 70010 to 79440 relate to radiology procedures.

CPT/ HCPCS Proce- dure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
70010		A	Contrast X-ray of brain	5.98	XXX
70010	26	A	Contrast X-ray of brain	1.76	XXX
70010	TC	A	Contrast X-ray of brain	4.22	XXX
70015		A	Contrast X-ray of brain	3.08	XXX
70015	26	A	Contrast X-ray of brain	1.76	XXX
70015	TC	A	Contrast X-ray of brain	1.32	XXX
70030		A	X-ray eye for foreign body	0.67	XXX
70030	26	A	X-ray eye for foreign body	0.26	XXX
70030	TC	A	X-ray eye for foreign body	0.41	XXX
70100		A	X-ray exam of jaw	0.79	XXX

70100	26	A	X–ray exam of jaw	0.28	XXX
70100	TC	A	X–ray exam of jaw	0.51	XXX
70110		A	X–ray exam of jaw	0.99	XXX
70110	26	A	X–ray exam of jaw	0.38	XXX
70110	TC	A	X–ray exam of jaw	0.60	XXX
70120		A	X–ray exam of mastoids	0.88	XXX
70120	26	A	X–ray exam of mastoids	0.28	XXX
70120	TC	A	X–ray exam of mastoids	0.60	XXX
70130		A	X–ray exam of mastoids	1.28	XXX
70130	26	A	X–ray exam of mastoids	0.51	XXX
70130	TC	A	X–ray exam of mastoids	0.77	XXX
70134		A	X–ray exam of middle ear	1.23	XXX
70134	26	A	X–ray exam of middle ear	0.51	XXX
70134	TC	A	X–ray exam of middle ear	0.72	XXX
70140		A	X–ray exam of facial bones	0.89	XXX
70140	26	A	X–ray exam of facial bones	0.29	XXX
70140	TC	A	X–ray exam of facial bones	0.60	XXX
70150		A	X–ray exam of facial bones	1.16	XXX
70150	26	A	X–ray exam of facial bones	0.39	XXX
70150	TC	A	X–ray exam of facial bones	0.77	XXX
70160		A	X–ray exam of nasal bones	0.77	XXX
70160	26	A	X–ray exam of nasal bones	0.26	XXX
70160	TC	A	X–ray exam of nasal bones	0.51	XXX
70170		A	X–ray exam of tear duct	1.37	XXX
70170	26	A	X–ray exam of tear duct	0.45	XXX
70170	TC	A	X–ray exam of tear duct	0.92	XXX
70190		A	X–ray exam of eye sockets	0.92	XXX
70190	26	A	X–ray exam of eye sockets	0.32	XXX
70190	TC	A	X–ray exam of eye sockets	0.60	XXX
70200		A	X–ray exam of eye sockets	1.19	XXX
70200	26	A	X–ray exam of eye sockets	0.42	XXX
70200	TC	A	X–ray exam of eye sockets	0.77	XXX
70210		A	X–ray exam of sinuses	0.86	XXX
70210	26	A	X–ray exam of sinuses	0.26	XXX
70210	TC	A	X–ray exam of sinuses	0.60	XXX
70220		A	X–ray exam of sinuses	1.15	XXX
70220	26	A	X–ray exam of sinuses	0.38	XXX
70220	TC	A	X–ray exam of sinuses	0.77	XXX
70240		A	X–ray exam pituitary saddle	0.70	XXX
70240	26	A	X–ray exam pituitary saddle	0.29	XXX
70240	TC	A	X–ray exam pituitary saddle	0.41	XXX
70250		A	X–ray exam of skull	0.97	XXX
70250	26	A	X–ray exam of skull	0.36	XXX
70250	TC	A	X–ray exam of skull	0.60	XXX
70260		A	X–ray exam of skull	1.38	XXX
70260	26	A	X–ray exam of skull	0.51	XXX
70260	TC	A	X–ray exam of skull	0.87	XXX
70300		A	X–ray exam of teeth	0.41	XXX
70300	26	A	X–ray exam of teeth	0.16	XXX
70300	TC	A	X–ray exam of teeth	0.26	XXX
70310		A	X–ray exam of teeth	0.65	XXX
70310	26	A	X–ray exam of teeth	0.24	XXX
70310	TC	A	X–ray exam of teeth	0.41	XXX
70320		A	Full mouth X–ray of teeth	1.10	XXX
70320	26	A	Full mouth X–ray of teeth	0.33	XXX

70320	TC	A	Full mouth X–ray of teeth	0.77	XXX
70328		A	X–ray exam of jaw joint	0.76	XXX
70328	26	A	X–ray exam of jaw joint	0.28	XXX
70328	TC	A	X–ray exam of jaw joint	0.48	XXX
70330		A	X–ray exam of jaw joints	1.18	XXX
70330	26	A	X–ray exam of jaw joints	0.36	XXX
70330	TC	A	X–ray exam of jaw joints	0.82	XXX
70332		A	X–ray exam of jaw joint	2.86	XXX
70332	26	A	X–ray exam of jaw joint	0.81	XXX
70332	TC	A	X–ray exam of jaw joint	2.05	XXX
70336		A	Magnetic image jaw joint	12.32	XXX
70336	26	A	Magnetic image jaw joint	1.42	XXX
70336	TC	A	Magnetic image jaw joint	10.91	XXX
70350		A	X–ray head for orthodontia	0.62	XXX
70350	26	A	X–ray head for orthodontia	0.26	XXX
70350	TC	A	X–ray head for orthodontia	0.37	XXX
70355		A	Panoramic X–ray of jaws	0.85	XXX
70355	26	A	Panoramic X–ray of jaws	0.30	XXX
70355	TC	A	Panoramic X–ray of jaws	0.56	XXX
70360		A	X–ray exam of neck	0.67	XXX
70360	26	A	X–ray exam of neck	0.26	XXX
70360	TC	A	X–ray exam of neck	0.41	XXX
70370		A	Throat X–ray and fluoroscopy	1.75	XXX
70370	26	A	Throat X–ray and fluoroscopy	0.48	XXX
70370	TC	A	Throat X–ray and fluoroscopy	1.27	XXX
70371		A	Speech evaluation, complex	3.30	XXX
70371	26	A	Speech evaluation, complex	1.26	XXX
70371	TC	A	Speech evaluation, complex	2.05	XXX
70373		A	Contrast X–ray of larynx	2.40	XXX
70373	26	A	Contrast X–ray of larynx	0.66	XXX
70373	TC	A	Contrast X–ray of larynx	1.74	XXX
70380		A	X–ray exam of salivary gland	0.91	XXX
70380	26	A	X–ray exam of salivary gland	0.26	XXX
70380	TC	A	X–ray exam of salivary gland	0.65	XXX
70390		A	X–ray exam of salivary duct	2.31	XXX
70390	26	A	X–ray exam of salivary duct	0.57	XXX
70390	TC	A	X–ray exam of salivary duct	1.74	XXX
70450		A	CAT scan of head or brain	5.87	XXX
70450	26	A	CAT scan of head or brain	1.27	XXX
70450	TC	A	CAT scan of head or brain	4.60	XXX
70460		A	Contrast CAT scan of head	7.19	XXX
70460	26	A	Contrast CAT scan of head	1.68	XXX
70460	TC	A	Contrast CAT scan of head	5.51	XXX
70470		A	Contrast CAT scans of head	8.77	XXX
70470	26	A	Contrast CAT scans of head	1.89	XXX
70470	TC	A	Contrast CAT scans of head	6.89	XXX
70480		A	CAT scan of skull	6.51	XXX
70480	26	A	CAT scan of skull	1.91	XXX
70480	TC	A	CAT scan of skull	4.60	XXX
70481		A	Contrast CAT scan of skull	7.56	XXX
70481	26	A	Contrast CAT scan of skull	2.05	XXX
70481	TC	A	Contrast CAT scan of skull	5.51	XXX
70482		A	Contrast CAT scans of skull	9.04	XXX
70482	26	A	Contrast CAT scans of skull	2.15	XXX
70482	TC	A	Contrast CAT scans of skull	6.89	XXX

70486		A	CAT scan of face, jaw	6.29	XXX
70486	26	A	CAT scan of face, jaw	1.69	XXX
70486	TC	A	CAT scan of face, jaw	4.60	XXX
70487		A	Contrast CAT scan, face/jaw	7.44	XXX
70487	26	A	Contrast CAT scan, face/jaw	1.93	XXX
70487	TC	A	Contrast CAT scan, face/jaw	5.51	XXX
70488		A	Contrast CAT scans face/jaw	9.00	XXX
70488	26	A	Contrast CAT scans face/jaw	2.11	XXX
70488	TC	A	Contrast CAT scans face/jaw	6.89	XXX
70490		A	CAT scan of neck tissue	6.51	XXX
70490	26	A	CAT scan of neck tissue	1.91	XXX
70490	TC	A	CAT scan of neck tissue	4.60	XXX
70491		A	Contrast CAT of neck tissue	7.56	XXX
70491	26	A	Contrast CAT of neck tissue	2.05	XXX
70491	TC	A	Contrast CAT of neck tissue	5.51	XXX
70492		A	Contrast CAT of neck tissue	9.04	XXX
70492	26	A	Contrast CAT of neck tissue	2.15	XXX
70492	TC	A	Contrast CAT of neck tissue	6.89	XXX
70540		A	Magnetic image, face, neck	13.11	XXX
70540	26	A	Magnetic image, face, neck	2.20	XXX
70540	TC	A	Magnetic image, face, neck	10.91	XXX
70541		A	Magnetic image, head (MRA)	13.44	XXX
70541	26	A	Magnetic image, head (MRA)	2.53	XXX
70541	TC	A	Magnetic image, head (MRA)	10.91	XXX
70551		A	Magnetic image, brain (MRI)	13.11	XXX
70551	26	A	Magnetic image, brain (MRI)	2.20	XXX
70551	TC	A	Magnetic image, brain (MRI)	10.91	XXX
70552		A	Magnetic image, brain (MRI)	15.74	XXX
70552	26	A	Magnetic image, brain (MRI)	2.65	XXX
70552	TC	A	Magnetic image, brain (MRI)	13.09	XXX
70553		A	Magnetic image, brain	27.76	XXX
70553	26	A	Magnetic image, brain	3.53	XXX
70553	TC	A	Magnetic image, brain	24.23	XXX
71010		A	Chest X–ray	0.73	XXX
71010	26	A	Chest X–ray	0.27	XXX
71010	TC	A	Chest X–ray	0.46	XXX
71015		A	X–ray exam of chest	0.83	XXX
71015	26	A	X–ray exam of chest	0.32	XXX
71015	TC	A	X–ray exam of chest	0.51	XXX
71020		A	Chest X–ray	0.93	XXX
71020	26	A	Chest X–ray	0.33	XXX
71020	TC	A	Chest X–ray	0.60	XXX
71021		A	Chest X–ray	1.12	XXX
71021	26	A	Chest X–ray	0.40	XXX
71021	TC	A	Chest X–ray	0.72	XXX
71022		A	Chest X–ray	1.18	XXX
71022	26	A	Chest X–ray	0.46	XXX
71022	TC	A	Chest X–ray	0.72	XXX
71023		A	Chest X–ray and fluoroscopy	1.34	XXX
71023	26	A	Chest X–ray and fluoroscopy	0.57	XXX
71023	TC	A	Chest X–ray and fluoroscopy	0.77	XXX
71030		A	Chest X–ray	1.23	XXX
71030	26	A	Chest X–ray	0.46	XXX
71030	TC	A	Chest X–ray	0.77	XXX
71034		A	Chest X–ray and fluoroscopy	2.09	XXX

71034	26	A	Chest X–ray and fluoroscopy	0.69	XXX
71034	TC	A	Chest X–ray and fluoroscopy	1.40	XXX
71035		A	Chest X–ray	0.78	XXX
71035	26	A	Chest X–ray	0.27	XXX
71035	TC	A	Chest X–ray	0.51	XXX
71036		A	X–ray guidance for biopsy	2.35	XXX
71036	26	A	X–ray guidance for biopsy	0.81	XXX
71036	TC	A	X–ray guidance for biopsy	1.54	XXX
71038		A	X–ray guidance for biopsy	2.46	XXX
71038	26	A	X–ray guidance for biopsy	0.81	XXX
71038	TC	A	X–ray guidance for biopsy	1.64	XXX
71040		A	Contrast X–ray of bronchi	2.30	XXX
71040	26	A	Contrast X–ray of bronchi	0.87	XXX
71040	TC	A	Contrast X–ray of bronchi	1.42	XXX
71060		A	Contrast X–ray of bronchi	3.26	XXX
71060	26	A	Contrast X–ray of bronchi	1.11	XXX
71060	TC	A	Contrast X–ray of bronchi	2.15	XXX
71090		A	X–ray and pacemaker insertion	2.46	XXX
71090	26	A	X–ray and pacemaker insertion	0.81	XXX
71090	TC	A	X–ray and pacemaker insertion	1.64	XXX
71100		A	X–ray exam of ribs	0.89	XXX
71100	26	A	X–ray exam of ribs	0.33	XXX
71100	TC	A	X–ray exam of ribs	0.56	XXX
71101		A	X–ray exam of ribs, chest	1.07	XXX
71101	26	A	X–ray exam of ribs, chest	0.41	XXX
71101	TC	A	X–ray exam of ribs, chest	0.65	XXX
71110		A	X–ray exam of ribs	1.18	XXX
71110	26	A	X–ray exam of ribs	0.41	XXX
71110	TC	A	X–ray exam of ribs	0.77	XXX
71111		A	X–ray exam of ribs, chest	1.35	XXX
71111	26	A	X–ray exam of ribs, chest	0.48	XXX
71111	TC	A	X–ray exam of ribs, chest	0.87	XXX
71120		A	X–ray exam of breastbone	0.93	XXX
71120	26	A	X–ray exam of breastbone	0.30	XXX
71120	TC	A	X–ray exam of breastbone	0.63	XXX
71130		A	X–ray exam of breastbone	1.01	XXX
71130	26	A	X–ray exam of breastbone	0.33	XXX
71130	TC	A	X–ray exam of breastbone	0.68	XXX
71250		A	Cat scan of chest	7.47	XXX
71250	26	A	Cat scan of chest	1.72	XXX
71250	TC	A	Cat scan of chest	5.75	XXX
71260		A	Contrast CAT scan of chest	8.73	XXX
71260	26	A	Contrast CAT scan of chest	1.84	XXX
71260	TC	A	Contrast CAT scan of chest	6.89	XXX
71270		A	Contrast CAT scans of chest	10.65	XXX
71270	26	A	Contrast CAT scans of chest	2.05	XXX
71270	TC	A	Contrast CAT scans of chest	8.60	XXX
71550		A	Magnetic image, chest	13.30	XXX
71550	26	A	Magnetic image, chest	2.39	XXX
71550	TC	A	Magnetic image, chest	10.91	XXX
71555		A	Magnetic imaging/chest (MRA)	13.51	XXX
71555	26	A	Magnetic imaging/chest (MRA)	2.60	XXX
71555	TC	A	Magnetic imaging/chest (MRA)	10.91	XXX
72010		A	X–ray exam of spine	1.67	XXX
72010	26	A	X–ray exam of spine	0.67	XXX

72010	TC	A	X-ray exam of spine	1.00	XXX
72020		A	X-ray exam of spine	0.64	XXX
72020	26	A	X-ray exam of spine	0.23	XXX
72020	TC	A	X-ray exam of spine	0.41	XXX
72040		A	X-ray exam of neck spine	0.91	XXX
72040	26	A	X-ray exam of neck spine	0.33	XXX
72040	TC	A	X-ray exam of neck spine	0.59	XXX
72050		A	X-ray exam of neck spine	1.33	XXX
72050	26	A	X-ray exam of neck spine	0.46	XXX
72050	TC	A	X-ray exam of neck spine	0.87	XXX
72052		A	X-ray exam of neck spine	1.65	XXX
72052	26	A	X-ray exam of neck spine	0.54	XXX
72052	TC	A	X-ray exam of neck spine	1.10	XXX
72069		A	X-ray exam of trunk spine	0.81	XXX
72069	26	A	X-ray exam of trunk spine	0.33	XXX
72069	TC	A	X-ray exam of trunk spine	0.48	XXX
72070		A	X-ray exam of thorax spine	0.96	XXX
72070	26	A	X-ray exam of thorax spine	0.33	XXX
72070	TC	A	X-ray exam of thorax spine	0.63	XXX
72072		A	X-ray exam of thoracic spine	1.04	XXX
72072	26	A	X-ray exam of thoracic spine	0.33	XXX
72072	TC	A	X-ray exam of thoracic spine	0.72	XXX
72074		A	X-ray exam of thoracic spine	1.22	XXX
72074	26	A	X-ray exam of thoracic spine	0.33	XXX
72074	TC	A	X-ray exam of thoracic spine	0.89	XXX
72080		A	X-ray exam of trunk spine	0.98	XXX
72080	26	A	X-ray exam of trunk spine	0.33	XXX
72080	TC	A	X-ray exam of trunk spine	0.65	XXX
72090		A	X-ray exam of trunk spine	1.08	XXX
72090	26	A	X-ray exam of trunk spine	0.42	XXX
72090	TC	A	X-ray exam of trunk spine	0.65	XXX
72100		A	X-ray exam of lower spine	0.98	XXX
72100	26	A	X-ray exam of lower spine	0.33	XXX
72100	TC	A	X-ray exam of lower spine	0.65	XXX
72110		A	X-ray exam of lower spine	1.35	XXX
72110	26	A	X-ray exam of lower spine	0.46	XXX
72110	TC	A	X-ray exam of lower spine	0.89	XXX
72114		A	X-ray exam of lower spine	1.70	XXX
72114	26	A	X-ray exam of lower spine	0.54	XXX
72114	TC	A	X-ray exam of lower spine	1.15	XXX
72120		A	X-ray exam of lower spine	1.20	XXX
72120	26	A	X-ray exam of lower spine	0.33	XXX
72120	TC	A	X-ray exam of lower spine	0.87	XXX
72125		A	CAT scan of neck spine	7.47	XXX
72125	26	A	CAT scan of neck spine	1.72	XXX
72125	TC	A	CAT scan of neck spine	5.75	XXX
72126		A	Contrast CAT scan of neck	8.69	XXX
72126	26	A	Contrast CAT scan of neck	1.80	XXX
72126	TC	A	Contrast CAT scan of neck	6.89	XXX
72127		A	Contrast CAT scans of neck	10.49	XXX
72127	26	A	Contrast CAT scans of neck	1.89	XXX
72127	TC	A	Contrast CAT scans of neck	8.60	XXX
72128		A	CAT scan of thorax spine	7.47	XXX
72128	26	A	CAT scan of thorax spine	1.72	XXX
72128	TC	A	CAT scan of thorax spine	5.75	XXX

72129		A	Contrast CAT scan of thorax	8.69	XXX
72129	26	A	Contrast CAT scan of thorax	1.80	XXX
72129	TC	A	Contrast CAT scan of thorax	6.89	XXX
72130		A	Contrast CAT scans of thorax	10.49	XXX
72130	26	A	Contrast CAT scans of thorax	1.89	XXX
72130	TC	A	Contrast CAT scans of thorax	8.60	XXX
72131		A	CAT scan of lower spine	7.47	XXX
72131	26	A	CAT scan of lower spine	1.72	XXX
72131	TC	A	CAT scan of lower spine	5.75	XXX
72132		A	Contrast CAT of lower spine	8.69	XXX
72132	26	A	Contrast CAT of lower spine	1.80	XXX
72132	TC	A	Contrast CAT of lower spine	6.89	XXX
72133		A	Contrast CAT scans, low spine	10.49	XXX
72133	26	A	Contrast CAT scans, low spine	1.89	XXX
72133	TC	A	Contrast CAT scans, low spine	8.60	XXX
72141		A	Magnetic image, neck spine	13.30	XXX
72141	26	A	Magnetic image, neck spine	2.39	XXX
72141	TC	A	Magnetic image, neck spine	10.91	XXX
72142		A	Magnetic image, neck spine	15.95	XXX
72142	26	A	Magnetic image, neck spine	2.86	XXX
72142	TC	A	Magnetic image, neck spine	13.09	XXX
72146		A	Magnetic image, chest spine	14.50	XXX
72146	26	A	Magnetic image, chest spine	2.39	XXX
72146	TC	A	Magnetic image, chest spine	12.11	XXX
72147		A	Magnetic image, chest spine	15.95	XXX
72147	26	A	Magnetic image, chest spine	2.86	XXX
72147	TC	A	Magnetic image, chest spine	13.09	XXX
72148		A	Magnetic image, lumbar spine	14.31	XXX
72148	26	A	Magnetic image, lumbar spine	2.20	XXX
72148	TC	A	Magnetic image, lumbar spine	12.11	XXX
72149		A	Magnetic image, lumbar spine	15.74	XXX
72149	26	A	Magnetic image, lumbar spine	2.65	XXX
72149	TC	A	Magnetic image, lumbar spine	13.09	XXX
72156		A	Magnetic image, neck spine	28.05	XXX
72156	26	A	Magnetic image, neck spine	3.82	XXX
72156	TC	A	Magnetic image, neck spine	24.23	XXX
72157		A	Magnetic image, chest spine	28.05	XXX
72157	26	A	Magnetic image, chest spine	3.82	XXX
72157	TC	A	Magnetic image, chest spine	24.23	XXX
72158		A	Magnetic image, lumbar spine	27.76	XXX
72158	26	A	Magnetic image, lumbar spine	3.53	XXX
72158	TC	A	Magnetic image, lumbar spine	24.23	XXX
72159		A	Magnetic imaging/spine (MRA)	14.63	XXX
72159	26	A	Magnetic imaging/spine (MRA)	2.52	XXX
72159	TC	A	Magnetic imaging/spine (MRA)	12.11	XXX
72170		A	X–ray exam of pelvis	0.76	XXX
72170	26	A	X–ray exam of pelvis	0.25	XXX
72170	TC	A	X–ray exam of pelvis	0.51	XXX
72190		A	X–ray exam of pelvis	0.97	XXX
72190	26	A	X–ray exam of pelvis	0.32	XXX
72190	TC	A	X–ray exam of pelvis	0.65	XXX
72192		A	CAT scan of pelvis	7.37	XXX
72192	26	A	CAT scan of pelvis	1.61	XXX
72192	TC	A	CAT scan of pelvis	5.75	XXX
72193		A	Contrast CAT scan of pelvis	8.38	XXX

72193	26	A	Contrast CAT scan of pelvis	1.72	XXX
72193	TC	A	Contrast CAT scan of pelvis	6.66	XXX
72194		A	Contrast CAT scans of pelvis	10.06	XXX
72194	26	A	Contrast CAT scans of pelvis	1.80	XXX
72194	TC	A	Contrast CAT scans of pelvis	8.26	XXX
72196		A	Magnetic image, pelvis	13.30	XXX
72196	26	A	Magnetic image, pelvis	2.39	XXX
72196	TC	A	Magnetic image, pelvis	10.91	XXX
72198		A	Magnetic imaging/pelvis(MRA)	13.50	XXX
72198	26	A	Magnetic imaging/pelvis(MRA)	2.59	XXX
72198	TC	A	Magnetic imaging/pelvis(MRA)	10.91	XXX
72200		A	X–ray exam sacroiliac joints	0.77	XXX
72200	26	A	X–ray exam sacroiliac joints	0.26	XXX
72200	TC	A	X–ray exam sacroiliac joints	0.51	XXX
72202		A	X–ray exam sacroiliac joints	0.89	XXX
72202	26	A	X–ray exam sacroiliac joints	0.29	XXX
72202	TC	A	X–ray exam sacroiliac joints	0.60	XXX
72220		A	X–ray exam of tailbone	0.81	XXX
72220	26	A	X–ray exam of tailbone	0.26	XXX
72220	TC	A	X–ray exam of tailbone	0.56	XXX
72240		A	Contrast X–ray of neck spine	5.98	XXX
72240	26	A	Contrast X–ray of neck spine	1.36	XXX
72240	TC	A	Contrast X–ray of neck spine	4.62	XXX
72255		A	Contrast X–ray thorax spine	5.58	XXX
72255	26	A	Contrast X–ray thorax spine	1.36	XXX
72255	TC	A	Contrast X–ray thorax spine	4.22	XXX
72265		A	Contrast X–ray lower spine	5.21	XXX
72265	26	A	Contrast X–ray lower spine	1.25	XXX
72265	TC	A	Contrast X–ray lower spine	3.97	XXX
72270		A	Contrast X–ray of spine	7.91	XXX
72270	26	A	Contrast X–ray of spine	1.98	XXX
72270	TC	A	Contrast X–ray of spine	5.94	XXX
72285		A	X–ray of neck spine disk	9.41	XXX
72285	26	A	X–ray of neck spine disk	1.25	XXX
72285	TC	A	X–ray of neck spine disk	8.16	XXX
72295		A	X–ray of lower spine disk	8.89	XXX
72295	26	A	X–ray of lower spine disk	1.25	XXX
72295	TC	A	X–ray of lower spine disk	7.64	XXX
73000		A	X–ray exam of collarbone	0.75	XXX
73000	26	A	X–ray exam of collarbone	0.24	XXX
73000	TC	A	X–ray exam of collarbone	0.51	XXX
73010		A	X–ray exam of shoulder blade	0.77	XXX
73010	26	A	X–ray exam of shoulder blade	0.26	XXX
73010	TC	A	X–ray exam of shoulder blade	0.51	XXX
73020		A	X–ray exam of shoulder	0.69	XXX
73020	26	A	X–ray exam of shoulder	0.23	XXX
73020	TC	A	X–ray exam of shoulder	0.46	XXX
73030		A	X–ray exam of shoulder	0.82	XXX
73030	26	A	X–ray exam of shoulder	0.27	XXX
73030	TC	A	X–ray exam of shoulder	0.56	XXX
73040		A	Contrast X–ray of shoulder	2.86	XXX
73040	26	A	Contrast X–ray of shoulder	0.81	XXX
73040	TC	A	Contrast X–ray of shoulder	2.05	XXX
73050		A	X–ray exam of shoulders	0.95	XXX
73050	26	A	X–ray exam of shoulders	0.30	XXX

73050	TC	A	X–ray exam of shoulders	0.65	XXX
73060		A	X–ray exam of humerus	0.81	XXX
73060	26	A	X–ray exam of humerus	0.26	XXX
73060	TC	A	X–ray exam of humerus	0.56	XXX
73070		A	X–ray exam of elbow	0.74	XXX
73070	26	A	X–ray exam of elbow	0.23	XXX
73070	TC	A	X–ray exam of elbow	0.51	XXX
73080		A	X–ray exam of elbow	0.81	XXX
73080	26	A	X–ray exam of elbow	0.26	XXX
73080	TC	A	X–ray exam of elbow	0.56	XXX
73085		A	Contrast X–ray of elbow	2.86	XXX
73085	26	A	Contrast X–ray of elbow	0.81	XXX
73085	TC	A	Contrast X–ray of elbow	2.05	XXX
73090		A	X–ray exam of forearm	0.75	XXX
73090	26	A	X–ray exam of forearm	0.24	XXX
73090	TC	A	X–ray exam of forearm	0.51	XXX
73092		A	X–ray exam of arm, infant	0.72	XXX
73092	26	A	X–ray exam of arm, infant	0.24	XXX
73092	TC	A	X–ray exam of arm, infant	0.48	XXX
73100		A	X–ray exam of wrist	0.72	XXX
73100	26	A	X–ray exam of wrist	0.24	XXX
73100	TC	A	X–ray exam of wrist	0.48	XXX
73110		A	X–ray exam of wrist	0.78	XXX
73110	26	A	X–ray exam of wrist	0.26	XXX
73110	TC	A	X–ray exam of wrist	0.52	XXX
73115		A	Contrast X–ray of wrist	2.35	XXX
73115	26	A	Contrast X–ray of wrist	0.81	XXX
73115	TC	A	Contrast X–ray of wrist	1.54	XXX
73120		A	X–ray exam of hand	0.72	XXX
73120	26	A	X–ray exam of hand	0.24	XXX
73120	TC	A	X–ray exam of hand	0.48	XXX
73130		A	X–ray exam of hand	0.78	XXX
73130	26	A	X–ray exam of hand	0.26	XXX
73130	TC	A	X–ray exam of hand	0.52	XXX
73140		A	X–ray exam of finger(s)	0.61	XXX
73140	26	A	X–ray exam of finger(s)	0.20	XXX
73140	TC	A	X–ray exam of finger(s)	0.41	XXX
73200		A	CAT scan of arm	6.45	XXX
73200	26	A	CAT scan of arm	1.61	XXX
73200	TC	A	CAT scan of arm	4.83	XXX
73201		A	Contrast CAT scan of arm	7.47	XXX
73201	26	A	Contrast CAT scan of arm	1.72	XXX
73201	TC	A	Contrast CAT scan of arm	5.75	XXX
73202		A	Contrast CAT scans of arm	9.03	XXX
73202	26	A	Contrast CAT scans of arm	1.80	XXX
73202	TC	A	Contrast CAT scans of arm	7.23	XXX
73220		A	Magnetic image, arm, hand	13.11	XXX
73220	26	A	Magnetic image, arm, hand	2.20	XXX
73220	TC	A	Magnetic image, arm, hand	10.91	XXX
73221		A	Magnetic image, joint of arm	12.32	XXX
73221	26	A	Magnetic image, joint of arm	1.42	XXX
73221	TC	A	Magnetic image, joint of arm	10.91	XXX
73225		A	Magnetic imaging/upper (MRA)	13.36	XXX
73225	26	A	Magnetic imaging/upper (MRA)	2.45	XXX
73225	TC	A	Magnetic imaging/upper (MRA)	10.91	XXX

73500		A	X–ray exam of hip	0.72	XXX
73500	26	A	X–ray exam of hip	0.26	XXX
73500	TC	A	X–ray exam of hip	0.46	XXX
73510		A	X–ray exam of hip	0.87	XXX
73510	26	A	X–ray exam of hip	0.32	XXX
73510	TC	A	X–ray exam of hip	0.56	XXX
73520		A	X–ray exam of hips	1.05	XXX
73520	26	A	X–ray exam of hips	0.39	XXX
73520	TC	A	X–ray exam of hips	0.65	XXX
73525		A	Contrast X–ray of hip	2.86	XXX
73525	26	A	Contrast X–ray of hip	0.81	XXX
73525	TC	A	Contrast X–ray of hip	2.05	XXX
73530		A	X–ray exam of hip	0.94	XXX
73530	26	A	X–ray exam of hip	0.43	XXX
73530	TC	A	X–ray exam of hip	0.51	XXX
73540		A	X–ray exam of pelvis and hips	0.86	XXX
73540	26	A	X–ray exam of pelvis and hips	0.31	XXX
73540	TC	A	X–ray exam of pelvis and hips	0.56	XXX
73550		A	X–ray exam of thigh	0.81	XXX
73550	26	A	X–ray exam of thigh	0.26	XXX
73550	TC	A	X–ray exam of thigh	0.56	XXX
73560		A	X–ray exam of knee	0.76	XXX
73560	26	A	X–ray exam of knee	0.25	XXX
73560	TC	A	X–ray exam of knee	0.51	XXX
73562		A	X–ray exam of knee	0.83	XXX
73562	26	A	X–ray exam of knee	0.28	XXX
73562	TC	A	X–ray exam of knee	0.56	XXX
73564		A	X–ray exam of knee	0.94	XXX
73564	26	A	X–ray exam of knee	0.33	XXX
73564	TC	A	X–ray exam of knee	0.60	XXX
73565		A	X–ray exam of knee	0.73	XXX
73565	26	A	X–ray exam of knee	0.25	XXX
73565	TC	A	X–ray exam of knee	0.48	XXX
73580		A	Contrast X–ray of knee joint	3.38	XXX
73580	26	A	Contrast X–ray of knee joint	0.81	XXX
73580	TC	A	Contrast X–ray of knee joint	2.56	XXX
73590		A	X–ray exam of lower leg	0.76	XXX
73590	26	A	X–ray exam of lower leg	0.25	XXX
73590	TC	A	X–ray exam of lower leg	0.51	XXX
73592		A	X–ray exam of leg, infant	0.72	XXX
73592	26	A	X–ray exam of leg, infant	0.24	XXX
73592	TC	A	X–ray exam of leg, infant	0.48	XXX
73600		A	X–ray exam of ankle	0.72	XXX
73600	26	A	X–ray exam of ankle	0.24	XXX
73600	TC	A	X–ray exam of ankle	0.48	XXX
73610		A	X–ray exam of ankle	0.78	XXX
73610	26	A	X–ray exam of ankle	0.26	XXX
73610	TC	A	X–ray exam of ankle	0.52	XXX
73615		A	Contrast X–ray of ankle	2.86	XXX
73615	26	A	Contrast X–ray of ankle	0.81	XXX
73615	TC	A	Contrast X–ray of ankle	2.05	XXX
73620		A	X–ray exam of foot	0.72	XXX
73620	26	A	X–ray exam of foot	0.24	XXX
73620	TC	A	X–ray exam of foot	0.48	XXX
73630		A	X–ray exam of foot	0.78	XXX

73630	26	A	X–ray exam of foot	0.26	XXX
73630	TC	A	X–ray exam of foot	0.52	XXX
73650		A	X–ray exam of heel	0.70	XXX
73650	26	A	X–ray exam of heel	0.24	XXX
73650	TC	A	X–ray exam of heel	0.46	XXX
73660		A	X–ray exam of toe(s)	0.61	XXX
73660	26	A	X–ray exam of toe(s)	0.20	XXX
73660	TC	A	X–ray exam of toe(s)	0.41	XXX
73700		A	CAT scan of leg	6.45	XXX
73700	26	A	CAT scan of leg	1.61	XXX
73700	TC	A	CAT scan of leg	4.83	XXX
73701		A	Contrast CAT scan of leg	7.47	XXX
73701	26	A	Contrast CAT scan of leg	1.72	XXX
73701	TC	A	Contrast CAT scan of leg	5.75	XXX
73702		A	Contrast CAT scans of leg	9.03	XXX
73702	26	A	Contrast CAT scans of leg	1.80	XXX
73702	TC	A	Contrast CAT scans of leg	7.23	XXX
73720		A	Magnetic image, leg, foot	13.11	XXX
73720	26	A	Magnetic image, leg, foot	2.20	XXX
73720	TC	A	Magnetic image, leg, foot	10.91	XXX
73721		A	Magnetic image, joint of leg	12.32	XXX
73721	26	A	Magnetic image, joint of leg	1.42	XXX
73721	TC	A	Magnetic image, joint of leg	10.91	XXX
73725		A	Magnetic imaging/lower (MRA)	13.45	XXX
73725	26	A	Magnetic imaging/lower (MRA)	2.54	XXX
73725	TC	A	Magnetic imaging/lower (MRA)	10.91	XXX
74000		A	X–ray exam of abdomen	0.78	XXX
74000	26	A	X–ray exam of abdomen	0.27	XXX
74000	TC	A	X–ray exam of abdomen	0.51	XXX
74010		A	X–ray exam of abdomen	0.91	XXX
74010	26	A	X–ray exam of abdomen	0.35	XXX
74010	TC	A	X–ray exam of abdomen	0.56	XXX
74020		A	X–ray exam of abdomen	1.02	XXX
74020	26	A	X–ray exam of abdomen	0.41	XXX
74020	TC	A	X–ray exam of abdomen	0.60	XXX
74022		A	X–ray exam series, abdomen	1.20	XXX
74022	26	A	X–ray exam series, abdomen	0.48	XXX
74022	TC	A	X–ray exam series, abdomen	0.72	XXX
74150		A	CAT scan of abdomen	7.27	XXX
74150	26	A	CAT scan of abdomen	1.76	XXX
74150	TC	A	CAT scan of abdomen	5.51	XXX
74160		A	Contrast CAT scan of abdomen	8.55	XXX
74160	26	A	Contrast CAT scan of abdomen	1.89	XXX
74160	TC	A	Contrast CAT scan of abdomen	6.66	XXX
74170		A	Contrast CAT scans, abdomen	10.34	XXX
74170	26	A	Contrast CAT scans, abdomen	2.08	XXX
74170	TC	A	Contrast CAT scans, abdomen	8.26	XXX
74181		A	Magnetic image, abdomen (MRI	13.30	XXX
74181	26	A	Magnetic image, abdomen (MRI	2.39	XXX
74181	TC	A	Magnetic image, abdomen (MRI	10.91	XXX
74185		A	Magnetic image/abdomen (MRA)	13.50	XXX
74185	26	A	Magnetic image/abdomen (MRA)	2.59	XXX
74185	TC	A	Magnetic image/abdomen (MRA)	10.91	XXX
74190		A	X–ray exam of peritoneum	1.89	XXX
74190	26	A	X–ray exam of peritoneum	0.62	XXX

74190	TC	A	X–ray exam of peritoneum	1.27	XXX
74210		A	Contrast X–ray exam of throat	1.69	XXX
74210	26	A	Contrast X–ray exam of throat	0.53	XXX
74210	TC	A	Contrast X–ray exam of throat	1.15	XXX
74220		A	Contrast X–ray exam, esophagus	1.84	XXX
74220	26	A	Contrast X–ray exam, esophagus	0.69	XXX
74220	TC	A	Contrast X–ray exam, esophagus	1.15	XXX
74230		A	Cinema X–ray throat/esophagus	2.07	XXX
74230	26	A	Cinema X–ray throat/esophagus	0.80	XXX
74230	TC	A	Cinema X–ray throat/esophagus	1.27	XXX
74235		A	Remove esophagus obstruction	4.32	XXX
74235	26	A	Remove esophagus obstruction	1.76	XXX
74235	TC	A	Remove esophagus obstruction	2.56	XXX
74240		A	X–ray exam upper GI tract	2.46	XXX
74240	26	A	X–ray exam upper GI tract	1.04	XXX
74240	TC	A	X–ray exam upper GI tract	1.42	XXX
74241		A	X–ray exam upper GI tract	2.49	XXX
74241	26	A	X–ray exam upper GI tract	1.04	XXX
74241	TC	A	X–ray exam upper GI tract	1.45	XXX
74245		A	X–ray exam upper GI tract	3.68	XXX
74245	26	A	X–ray exam upper GI tract	1.36	XXX
74245	TC	A	X–ray exam upper GI tract	2.32	XXX
74246		A	Contrast X–ray upper GI tract	2.65	XXX
74246	26	A	Contrast X–ray upper GI tract	1.04	XXX
74246	TC	A	Contrast X–ray upper GI tract	1.60	XXX
74247		A	Contrast X–ray upper GI tract	2.68	XXX
74247	26	A	Contrast X–ray upper GI tract	1.04	XXX
74247	TC	A	Contrast X–ray upper GI tract	1.64	XXX
74249		A	Contrast X–ray upper GI tract	3.86	XXX
74249	26	A	Contrast X–ray upper GI tract	1.36	XXX
74249	TC	A	Contrast X–ray upper GI tract	2.51	XXX
74250		A	X–ray exam of small bowel	1.97	XXX
74250	26	A	X–ray exam of small bowel	0.70	XXX
74250	TC	A	X–ray exam of small bowel	1.27	XXX
74251		A	X–ray exam of small bowel	2.19	XXX
74251	26	A	X–ray exam of small bowel	0.92	XXX
74251	TC	A	X–ray exam of small bowel	1.27	XXX
74260		A	X–ray exam of small bowel	2.20	XXX
74260	26	A	X–ray exam of small bowel	0.75	XXX
74260	TC	A	X–ray exam of small bowel	1.45	XXX
74270		A	Contrast X–ray exam of colon	2.70	XXX
74270	26	A	Contrast X–ray exam of colon	1.04	XXX
74270	TC	A	Contrast X–ray exam of colon	1.66	XXX
74280		A	Contrast X–ray exam of colon	3.66	XXX
74280	26	A	Contrast X–ray exam of colon	1.48	XXX
74280	TC	A	Contrast X–ray exam of colon	2.18	XXX
74283		A	Contrast X–ray exam of colon	5.50	XXX
74283	26	A	Contrast X–ray exam of colon	3.01	XXX
74283	TC	A	Contrast X–ray exam of colon	2.50	XXX
74290		A	Contrast X–ray, gallbladder	1.20	XXX
74290	26	A	Contrast X–ray, gallbladder	0.48	XXX
74290	TC	A	Contrast X–ray, gallbladder	0.72	XXX
74291		A	Contrast X–rays, gallbladder	0.71	XXX
74291	26	A	Contrast X–rays, gallbladder	0.30	XXX
74291	TC	A	Contrast X–rays, gallbladder	0.41	XXX

74300	26	A	X–ray bile ducts, pancreas	0.54	XXX
74301	26	A	Additional X–rays at surgery	0.32	XXX
74305		A	X–ray bile ducts, pancreas	1.40	XXX
74305	26	A	X–ray bile ducts, pancreas	0.63	XXX
74305	TC	A	X–ray bile ducts, pancreas	0.77	XXX
74320		A	Contrast X–ray of bile ducts	3.88	XXX
74320	26	A	Contrast X–ray of bile ducts	0.81	XXX
74320	TC	A	Contrast X–ray of bile ducts	3.07	XXX
74327		A	X–ray for bile stone removal	2.77	XXX
74327	26	A	X–ray for bile stone removal	1.05	XXX
74327	TC	A	X–ray for bile stone removal	1.72	XXX
74328		A	X–ray for bile duct endoscopy	4.12	XXX
74328	26	A	X–ray for bile duct endoscopy	1.05	XXX
74328	TC	A	X–ray for bile duct endoscopy	3.07	XXX
74329		A	X–ray for pancreas endoscopy	4.12	XXX
74329	26	A	X–ray for pancreas endoscopy	1.05	XXX
74329	TC	A	X–ray for pancreas endoscopy	3.07	XXX
74330		A	X–ray bile/pancreas endoscopy	4.12	XXX
74330	26	A	X–ray bile/pancreas endoscopy	1.05	XXX
74330	TC	A	X–ray, bile/pancreas endoscopy	3.07	XXX
74340		A	X–ray guide for GI tube	3.38	XXX
74340	26	A	X–ray guide for GI tube	0.81	XXX
74340	TC	A	X–ray guide for GI tube	2.56	XXX
74350		A	X–ray guide, stomach tube	4.21	XXX
74350	26	A	X–ray guide, stomach tube	1.14	XXX
74350	TC	A	X–ray guide, stomach tube	3.07	XXX
74355		A	X–ray guide, intestinal tube	3.70	XXX
74355	26	A	X–ray guide, intestinal tube	1.14	XXX
74355	TC	A	X–ray guide, intestinal tube	2.56	XXX
74360		A	X–ray guide, GI dilation	3.88	XXX
74360	26	A	X–ray guide, GI dilation	0.81	XXX
74360	TC	A	X–ray guide, GI dilation	3.07	XXX
74363		A	X–ray, bile duct dilation	7.25	XXX
74363	26	A	X–ray, bile duct dilation	1.32	XXX
74363	TC	A	X–ray, bile duct dilation	5.94	XXX
74400		A	Contrast X–ray urinary tract	2.37	XXX
74400	26	A	Contrast X–ray urinary tract	0.73	XXX
74400	TC	A	Contrast X–ray urinary tract	1.64	XXX
74405		A	Contrast X–ray urinary tract	2.67	XXX
74405	26	A	Contrast X–ray urinary tract	0.73	XXX
74405	TC	A	Contrast X–ray urinary tract	1.94	XXX
74410		A	Contrast X–ray urinary tract	2.63	XXX
74410	26	A	Contrast X–ray urinary tract	0.73	XXX
74410	TC	A	Contrast X–ray urinary tract	1.90	XXX
74415		A	Contrast X–ray urinary tract	2.79	XXX
74415	26	A	Contrast X–ray urinary tract	0.73	XXX
74415	TC	A	Contrast X–ray urinary tract	2.07	XXX
74420		A	Contrast X–ray urinary tract	3.09	XXX
74420	26	A	Contrast X–ray urinary tract	0.53	XXX
74420	TC	A	Contrast X–ray urinary tract	2.56	XXX
74425		A	Contrast X–ray urinary tract	1.80	XXX
74425	26	A	Contrast X–ray urinary tract	0.53	XXX
74425	TC	A	Contrast X–ray urinary tract	1.27	XXX
74430		A	Contrast X–ray of bladder	1.51	XXX
74430	26	A	Contrast X–ray of bladder	0.48	XXX

74430	TC	A	Contrast X–ray of bladder	1.03	XXX
74440		A	X–ray exam male genital tract	1.67	XXX
74440	26	A	X–ray exam male genital tract	0.57	XXX
74440	TC	A	X–ray exam male genital tract	1.10	XXX
74445		A	X–ray exam of penis	2.79	XXX
74445	26	A	X–ray exam of penis	1.69	XXX
74445	TC	A	X–ray exam of penis	1.10	XXX
74450		A	X–ray exam urethra/bladder	1.91	XXX
74450	26	A	X–ray exam urethra/bladder	0.49	XXX
74450	TC	A	X–ray exam urethra/bladder	1.42	XXX
74455		A	X–ray exam urethra/bladder	2.03	XXX
74455	26	A	X–ray exam urethra/bladder	0.49	XXX
74455	TC	A	X–ray exam urethra/bladder	1.54	XXX
74470		A	X–ray exam of kidney lesion	2.03	XXX
74470	26	A	X–ray exam of kidney lesion	0.81	XXX
74470	TC	A	X–ray exam of kidney lesion	1.22	XXX
74475		A	X–ray control catheter insert	4.78	XXX
74475	26	A	X–ray control catheter insert	0.81	XXX
74475	TC	A	X–ray control catheter insert	3.97	XXX
74480		A	X–ray control catheter insert	4.78	XXX
74480	26	A	X–ray control catheter insert	0.81	XXX
74480	TC	A	X–ray control catheter insert	3.97	XXX
74485		A	X–ray guide, GU dilation	3.88	XXX
74485	26	A	X–ray guide, GU dilation	0.81	XXX
74485	TC	A	X–ray guide, GU dilation	3.07	XXX
74710		A	X–ray measurement of pelvis	1.54	XXX
74710	26	A	X–ray measurement of pelvis	0.51	XXX
74710	TC	A	X–ray measurement of pelvis	1.03	XXX
74740		A	X–ray female genital tract	1.84	XXX
74740	26	A	X–ray female genital tract	0.57	XXX
74740	TC	A	X–ray female genital tract	1.27	XXX
74742		A	X–ray fallopian tube	3.95	XXX
74742	26	A	X–ray fallopian tube	0.88	XXX
74742	TC	A	X–ray fallopian tube	3.07	XXX
74775		A	X–ray exam of perineum	2.36	XXX
74775	26	A	X–ray exam of perineum	0.93	XXX
74775	TC	A	X–ray exam of perineum	1.42	XXX
75552		A	Magnetic image, myocardium	13.30	XXX
75552	26	A	Magnetic image, myocardium	2.39	XXX
75552	TC	A	Magnetic image, myocardium	10.91	XXX
75553		A	Magnetic image, myocardium	13.70	XXX
75553	26	A	Magnetic image, myocardium	2.79	XXX
75553	TC	A	Magnetic image, myocardium	10.91	XXX
75554		A	Cardiac MRI/function	13.53	XXX
75554	26	A	Cardiac MRI/function	2.62	XXX
75554	TC	A	Cardiac MRI/function	10.91	XXX
75555		A	Cardiac MRI/limited study	13.44	XXX
75555	26	A	Cardiac MRI/limited study	2.53	XXX
75555	TC	A	Cardiac MRI/limited study	10.91	XXX
75600		A	Contrast X–ray exam of aorta	12.99	XXX
75600	26	A	Contrast X–ray exam of aorta	0.73	XXX
75600	TC	A	Contrast X–ray exam of aorta	12.26	XXX
75605		A	Contrast X–ray exam of aorta	13.95	XXX
75605	26	A	Contrast X–ray exam of aorta	1.69	XXX
75605	TC	A	Contrast X–ray exam of aorta	12.26	XXX

75625		A	Contrast X–ray exam of aorta	13.95	XXX
75625	26	A	Contrast X–ray exam of aorta	1.69	XXX
75625	TC	A	Contrast X–ray exam of aorta	12.26	XXX
75630		A	X–ray aorta, leg arteries	14.73	XXX
75630	26	A	X–ray aorta, leg arteries	1.95	XXX
75630	TC	A	X–ray aorta, leg arteries	12.78	XXX
75650		A	Artery X–rays, head and neck	14.48	XXX
75650	26	A	Artery X–rays, head and neck	2.21	XXX
75650	TC	A	Artery X–rays, head and neck	12.26	XXX
75658		A	X–ray exam of arm arteries	14.21	XXX
75658	26	A	X–ray exam of arm arteries	1.95	XXX
75658	TC	A	X–ray exam of arm arteries	12.26	XXX
75660		A	Artery X–rays, head and neck	14.21	XXX
75660	26	A	Artery X–rays, head and neck	1.95	XXX
75660	TC	A	Artery X–rays, head and neck	12.26	XXX
75662		A	Artery X–rays, head and neck	14.73	XXX
75662	26	A	Artery X–rays, head and neck	2.47	XXX
75662	TC	A	Artery X–rays, head and neck	12.26	XXX
75665		A	Artery X–rays, head and neck	14.21	XXX
75665	26	A	Artery X–rays, head and neck	1.95	XXX
75665	TC	A	Artery X–rays, head and neck	12.26	XXX
75671		A	Artery X–rays, head and neck	14.73	XXX
75671	26	A	Artery X–rays, head and neck	2.47	XXX
75671	TC	A	Artery X–rays, head and neck	12.26	XXX
75676		A	Artery X–rays, neck	14.21	XXX
75676	26	A	Artery X–rays, neck	1.95	XXX
75676	TC	A	Artery X–rays, neck	12.26	XXX
75680		A	Artery X–rays, neck	14.73	XXX
75680	26	A	Artery X–rays, neck	2.47	XXX
75680	TC	A	Artery X–rays, neck	12.26	XXX
75685		A	Artery X–rays, spine	14.21	XXX
75685	26	A	Artery X–rays, spine	1.95	XXX
75685	TC	A	Artery X–rays, spine	12.26	XXX
75705		A	Artery X–rays, spine	15.52	XXX
75705	26	A	Artery X–rays, spine	3.25	XXX
75705	TC	A	Artery X–rays, spine	12.26	XXX
75710		A	Artery X–rays, arm/leg	13.95	XXX
75710	26	A	Artery X–rays, arm/leg	1.69	XXX
75710	TC	A	Artery X–rays, arm/leg	12.26	XXX
75716		A	Artery X–rays, arms/legs	14.21	XXX
75716	26	A	Artery X–rays, arms/legs	1.95	XXX
75716	TC	A	Artery X–rays, arms/legs	12.26	XXX
75722		A	Artery X–rays, kidney	13.95	XXX
75722	26	A	Artery X–rays, kidney	1.69	XXX
75722	TC	A	Artery X–rays, kidney	12.26	XXX
75724		A	Artery X–rays, kidneys	14.48	XXX
75724	26	A	Artery X–rays, kidneys	2.21	XXX
75724	TC	A	Artery X–rays, kidneys	12.26	XXX
75726		A	Artery X–rays, abdomen	13.95	XXX
75726	26	A	Artery X–rays, abdomen	1.69	XXX
75726	TC	A	Artery X–rays, abdomen	12.26	XXX
75731		A	Artery X–rays, adrenal gland	13.95	XXX
75731	26	A	Artery X–rays, adrenal gland	1.69	XXX
75731	TC	A	Artery X–rays, adrenal gland	12.26	XXX
75733		A	Artery X–rays, adrenal glands	14.21	XXX

75733	26	A	Artery X–rays, adrenal glands	1.95	XXX
75733	TC	A	Artery X–rays, adrenal glands	12.26	XXX
75736		A	Artery X–rays, pelvis	13.95	XXX
75736	26	A	Artery X–rays, pelvis	1.69	XXX
75736	TC	A	Artery X–rays, pelvis	12.26	XXX
75741		A	Artery X–rays, lung	14.21	XXX
75741	26	A	Artery X–rays, lung	1.95	XXX
75741	TC	A	Artery X–rays, lung	12.26	XXX
75743		A	Artery X–rays, lungs	14.73	XXX
75743	26	A	Artery X–rays, lungs	2.47	XXX
75743	TC	A	Artery X–rays, lungs	12.26	XXX
75746		A	Artery X–rays, lung	13.95	XXX
75746	26	A	Artery X–rays, lung	1.69	XXX
75746	TC	A	Artery X–rays, lung	12.26	XXX
75756		A	Artery X–rays, chest	13.95	XXX
75756	26	A	Artery X–rays, chest	1.69	XXX
75756	TC	A	Artery X–rays, chest	12.26	XXX
75774		A	Artery X–ray, each vessel	12.80	XXX
75774	26	A	Artery X–ray, each vessel	0.53	XXX
75774	TC	A	Artery X–ray, each vessel	12.26	XXX
75790		A	Visualize A–V shunt	4.07	XXX
75790	26	A	Visualize A–V shunt	2.74	XXX
75790	TC	A	Visualize A–V shunt	1.32	XXX
75801		A	Lymph vessel X–ray, arm/leg	6.48	XXX
75801	26	A	Lymph vessel X–ray, arm/leg	1.21	XXX
75801	TC	A	Lymph vessel X–ray, arm/leg	5.27	XXX
75803		A	Lymph vessel X–ray, arms/legs	7.00	XXX
75803	26	A	Lymph vessel X–ray, arms/legs	1.73	XXX
75803	TC	A	Lymph vessel X–ray, arms/legs	5.27	XXX
75805		A	Lymph vessel X–ray, trunk	7.15	XXX
75805	26	A	Lymph vessel X–ray, trunk	1.21	XXX
75805	TC	A	Lymph vessel X–ray, trunk	5.94	XXX
75807		A	Lymph vessel X–ray, trunk	7.67	XXX
75807	26	A	Lymph vessel X–ray, trunk	1.73	XXX
75807	TC	A	Lymph vessel X–ray, trunk	5.94	XXX
75809		A	Nonvascular shunt, X–ray	1.45	XXX
75809	26	A	Nonvascular shunt, X–ray	0.68	XXX
75809	TC	A	Nonvascular shunt, X–ray	0.77	XXX
75810		A	Vein X–ray, spleen/liver	13.95	XXX
75810	26	A	Vein X–ray, spleen/liver	1.69	XXX
75810	TC	A	Vein X–ray, spleen/liver	12.26	XXX
75820		A	Vein X–ray, arm/leg	1.97	XXX
75820	26	A	Vein X–ray, arm/leg	1.05	XXX
75820	TC	A	Vein X–ray, arm/leg	0.92	XXX
75822		A	Vein X–ray, arms/legs	3.01	XXX
75822	26	A	Vein X–ray, arms/legs	1.57	XXX
75822	TC	A	Vein X–ray, arms/legs	1.44	XXX
75825		A	Vein X–ray, trunk	13.95	XXX
75825	26	A	Vein X–ray, trunk	1.69	XXX
75825	TC	A	Vein X–ray, trunk	12.26	XXX
75827		A	Vein X–ray, chest	13.95	XXX
75827	26	A	Vein X–ray, chest	1.69	XXX
75827	TC	A	Vein X–ray, chest	12.26	XXX
75831		A	Vein X–ray, kidney	13.95	XXX
75831	26	A	Vein X–ray, kidney	1.69	XXX

75831	TC	A	Vein X–ray, kidney	12.26	XXX
75833		A	Vein X–ray, kidneys	14.48	XXX
75833	26	A	Vein X–ray, kidneys	2.21	XXX
75833	TC	A	Vein X–ray, kidneys	12.26	XXX
75840		A	Vein X–ray, adrenal gland	13.95	XXX
75840	26	A	Vein X–ray, adrenal gland	1.69	XXX
75840	TC	A	Vein X–ray, adrenal gland	12.26	XXX
75842		A	Vein X–ray, adrenal glands	14.48	XXX
75842	26	A	Vein X–ray, adrenal glands	2.21	XXX
75842	TC	A	Vein X–ray, adrenal glands	12.26	XXX
75860		A	Vein X–ray, neck	13.95	XXX
75860	26	A	Vein X–ray, neck	1.69	XXX
75860	TC	A	Vein X–ray, neck	12.26	XXX
75870		A	Vein X–ray, skull	13.95	XXX
75870	26	A	Vein X–ray, skull	1.69	XXX
75870	TC	A	Vein X–ray, skull	12.26	XXX
75872		A	Vein X–ray, skull	13.95	XXX
75872	26	A	Vein X–ray, skull	1.69	XXX
75872	TC	A	Vein X–ray, skull	12.26	XXX
75880		A	Vein X–ray, eye socket	1.97	XXX
75880	26	A	Vein X–ray, eye socket	1.05	XXX
75880	TC	A	Vein X–ray, eye socket	0.92	XXX
75885		A	Vein X–ray, liver	14.41	XXX
75885	26	A	Vein X–ray, liver	2.14	XXX
75885	TC	A	Vein X–ray, liver	12.26	XXX
75887		A	Vein X–ray, liver	14.41	XXX
75887	26	A	Vein X–ray, liver	2.14	XXX
75887	TC	A	Vein X–ray, liver	12.26	XXX
75889		A	Vein X–ray, liver	13.95	XXX
75889	26	A	Vein X–ray, liver	1.69	XXX
75889	TC	A	Vein X–ray, liver	12.26	XXX
75891		A	Vein X–ray, liver	13.95	XXX
75891	26	A	Vein X–ray, liver	1.69	XXX
75891	TC	A	Vein X–ray, liver	12.26	XXX
75893		A	Venous sampling by catheter	13.08	XXX
75893	26	A	Venous sampling by catheter	0.81	XXX
75893	TC	A	Venous sampling by catheter	12.26	XXX
75894		A	X–rays, transcatheter therapy	25.43	XXX
75894	26	A	X–rays, transcatheter therapy	1.95	XXX
75894	TC	A	X–rays, transcatheter therapy	23.49	XXX
75896		A	X–rays, transcatheter therapy	22.37	XXX
75896	26	A	X–rays, transcatheter therapy	1.95	XXX
75896	TC	A	X–rays, transcatheter therapy	20.42	XXX
75898		A	Follow–up angiogram	3.48	XXX
75898	26	A	Follow–up angiogram	2.46	XXX
75898	TC	A	Follow–up angiogram	1.03	XXX
75900		A	Arterial catheter exchange	21.16	XXX
75900	26	A	Arterial catheter exchange	0.74	XXX
75900	TC	A	Arterial catheter exchange	20.42	XXX
75940		A	X–ray placement, vein filter	13.08	XXX
75940	26	A	X–ray placement, vein filter	0.81	XXX
75940	TC	A	X–ray placement, vein filter	12.26	XXX
75960		A	Transcatheter intro, stent	15.72	XXX
75960	26	A	Transcatheter intro, stent	1.23	XXX
75960	TC	A	Transcatheter intro, stent	14.50	XXX

75961		A	Retrieval, broken catheter	16.54	XXX
75961	26	A	Retrieval, broken catheter	6.32	XXX
75961	TC	A	Retrieval, broken catheter	10.22	XXX
75962		A	Repair arterial blockage	16.13	XXX
75962	26	A	Repair arterial blockage	0.81	XXX
75962	TC	A	Repair arterial blockage	15.32	XXX
75964		A	Repair artery blockage, each	8.70	XXX
75964	26	A	Repair artery blockage, each	0.53	XXX
75964	TC	A	Repair artery blockage, each	8.17	XXX
75966		A	Repair arterial blockage	17.26	XXX
75966	26	A	Repair arterial blockage	1.95	XXX
75966	TC	A	Repair arterial blockage	15.32	XXX
75968		A	Repair artery blockage, each	8.70	XXX
75968	26	A	Repair artery blockage, each	0.53	XXX
75968	TC	A	Repair artery blockage, each	8.17	XXX
75970		A	Vascular biopsy	12.48	XXX
75970	26	A	Vascular biopsy	1.25	XXX
75970	TC	A	Vascular biopsy	11.23	XXX
75978		A	Repair venous blockage	16.36	XXX
75978	26	A	Repair venous blockage	1.04	XXX
75978	TC	A	Repair venous blockage	15.32	XXX
75980		A	Contrast X–ray exam bile duct	7.42	XXX
75980	26	A	Contrast X–ray exam bile duct	2.14	XXX
75980	TC	A	Contrast X–ray exam bile duct	5.27	XXX
75982		A	Contrast X–ray exam bile duct	8.08	XXX
75982	26	A	Contrast X–ray exam bile duct	2.14	XXX
75982	TC	A	Contrast X–ray exam bile duct	5.94	XXX
75984		A	X–ray control catheter change	2.98	XXX
75984	26	A	X–ray control catheter change	1.08	XXX
75984	TC	A	X–ray control catheter change	1.90	XXX
75989		A	Abscess drainage under X–ray	4.82	XXX
75989	26	A	Abscess drainage under X–ray	1.76	XXX
75989	TC	A	Abscess drainage under X–ray	3.07	XXX
75992		A	Atherectomy, X–ray exam	16.13	XXX
75992	26	A	Atherectomy, X–ray exam	0.81	XXX
75992	TC	A	Atherectomy, X–ray exam	15.32	XXX
75993		A	Atherectomy, X–ray exam	8.70	XXX
75993	26	A	Atherectomy, X–ray exam	0.53	XXX
75993	TC	A	Atherectomy, X–ray exam	8.17	XXX
75994		A	Atherectomy, X–ray exam	17.26	XXX
75994	26	A	Atherectomy, X–ray exam	1.95	XXX
75994	TC	A	Atherectomy, X–ray exam	15.32	XXX
75995		A	Atherectomy, X–ray exam	17.26	XXX
75995	26	A	Atherectomy, X–ray exam	1.95	XXX
75995	TC	A	Atherectomy, X–ray exam	15.32	XXX
75996		A	Atherectomy, X–ray exam	8.70	XXX
75996	26	A	Atherectomy, X–ray exam	0.53	XXX
75996	TC	A	Atherectomy, X–ray exam	8.17	XXX
76000		A	Fluoroscope examination	1.51	XXX
76000	26	A	Fluoroscope examination	0.25	XXX
76000	TC	A	Fluoroscope examination	1.27	XXX
76001		A	Fluoroscope exam, extensive	3.57	XXX
76001	26	A	Fluoroscope exam, extensive	1.01	XXX
76001	TC	A	Fluoroscope exam, extensive	2.56	XXX
76003		A	Needle localization by X–ray	2.08	XXX

76003	26	A	Needle localization by X–ray	0.81	XXX
76003	TC	A	Needle localization by X–ray	1.27	XXX
76010		A	X–ray, nose to rectum	0.78	XXX
76010	26	A	X–ray, nose to rectum	0.27	XXX
76010	TC	A	X–ray, nose to rectum	0.51	XXX
76020		A	X–rays for bone age	0.80	XXX
76020	26	A	X–rays for bone age	0.29	XXX
76020	TC	A	X–rays for bone age	0.51	XXX
76040		A	X–rays, bone evaluation	1.18	XXX
76040	26	A	X–rays, bone evaluation	0.41	XXX
76040	TC	A	X–rays, bone evaluation	0.77	XXX
76061		A	X–rays, bone survey	1.64	XXX
76061	26	A	X–rays, bone survey	0.67	XXX
76061	TC	A	X–rays, bone survey	0.97	XXX
76062		A	X–rays, bone survey	2.22	XXX
76062	26	A	X–rays, bone survey	0.81	XXX
76062	TC	A	X–rays, bone survey	1.40	XXX
76065		A	X–rays, bone evaluation	1.14	XXX
76065	26	A	X–rays, bone evaluation	0.42	XXX
76065	TC	A	X–rays, bone evaluation	0.72	XXX
76066		A	Joint(s) survey, single film	1.55	XXX
76066	26	A	Joint(s) survey, single film	0.46	XXX
76066	TC	A	Joint(s) survey, single film	1.08	XXX
76070		A	CT scan, bone density study	3.25	XXX
76070	26	A	CT scan, bone density study	0.38	XXX
76070	TC	A	CT scan, bone density study	2.87	XXX
76075		A	Dual energy X–ray study	3.45	XXX
76075	26	A	Dual energy X–ray study	0.43	XXX
76075	TC	A	Dual energy X–ray study	3.02	XXX
76080		A	X–ray exam of fistula	1.84	XXX
76080	26	A	X–ray exam of fistula	0.81	XXX
76080	TC	A	X–ray exam of fistula	1.03	XXX
76086		A	X–ray of mammary duct	3.10	XXX
76086	26	A	X–ray of mammary duct	0.54	XXX
76086	TC	A	X–ray of mammary duct	2.56	XXX
76088		A	X–ray of mammary ducts	4.23	XXX
76088	26	A	X–ray of mammary ducts	0.67	XXX
76088	TC	A	X–ray of mammary ducts	3.57	XXX
76090		A	Mammogram, one breast	1.41	XXX
76090	26	A	Mammogram, one breast	0.38	XXX
76090	TC	A	Mammogram, one breast	1.03	XXX
76091		A	Mammogram, both breasts	1.88	XXX
76091	26	A	Mammogram, both breasts	0.61	XXX
76091	TC	A	Mammogram, both breasts	1.27	XXX
76093		A	Magnetic image, breast	19.57	XXX
76093	26	A	Magnetic image, breast	2.42	XXX
76093	TC	A	Magnetic image, breast	17.16	XXX
76094		A	Magnetic image, both breasts	25.69	XXX
76094	26	A	Magnetic image, both breasts	2.42	XXX
76094	TC	A	Magnetic image, both breasts	23.27	XXX
76095		A	Stereotactic breast biopsy	9.34	XXX
76095	26	A	Stereotactic breast biopsy	2.37	XXX
76095	TC	A	Stereotactic breast biopsy	6.98	XXX
76096		A	X–ray of needle wire, breast	2.11	XXX
76096	26	A	X–ray of needle wire, breast	0.84	XXX

76096	TC	A	X–ray of needle wire, breast	1.27	XXX
76098		A	X–ray exam, breast specimen	0.65	XXX
76098	26	A	X–ray exam, breast specimen	0.24	XXX
76098	TC	A	X–ray exam, breast specimen	0.41	XXX
76100		A	X–ray exam of body section	2.09	XXX
76100	26	A	X–ray exam of body section	0.87	XXX
76100	TC	A	X–ray exam of body section	1.22	XXX
76101		A	Complex body section X–ray	2.26	XXX
76101	26	A	Complex body section X–ray	0.87	XXX
76101	TC	A	Complex body section X–ray	1.38	XXX
76102		A	Complex body section X–rays	2.56	XXX
76102	26	A	Complex body section X–rays	0.87	XXX
76102	TC	A	Complex body section X–rays	1.69	XXX
76120		A	Cinematic X–rays	1.59	XXX
76120	26	A	Cinematic X–rays	0.57	XXX
76120	TC	A	Cinematic X–rays	1.03	XXX
76125		A	Cinematic X–rays	1.17	XXX
76125	26	A	Cinematic X–rays	0.40	XXX
76125	TC	A	Cinematic X–rays	0.77	XXX
76150		A	X–ray exam, dry process	0.41	XXX
76355		A	CAT scan for localization	9.82	XXX
76355	26	A	CAT scan for localization	1.79	XXX
76355	TC	A	CAT scan for localization	8.04	XXX
76360		A	CAT scan for needle biopsy	9.74	XXX
76360	26	A	CAT scan for needle biopsy	1.71	XXX
76360	TC	A	CAT scan for needle biopsy	8.04	XXX
76365		A	CAT scan for cyst aspiration	9.74	XXX
76365	26	A	CAT scan for cyst aspiration	1.71	XXX
76365	TC	A	CAT scan for cyst aspiration	8.04	XXX
76370		A	CAT scan for therapy guide	4.14	XXX
76370	26	A	CAT scan for therapy guide	1.27	XXX
76370	TC	A	CAT scan for therapy guide	2.87	XXX
76375		A	CAT scans, other planes	3.68	XXX
76375	26	A	CAT scans, other planes	0.24	XXX
76375	TC	A	CAT scans, other planes	3.44	XXX
76380		A	CAT scan follow–up study	4.87	XXX
76380	26	A	CAT scan follow–up study	1.46	XXX
76380	TC	A	CAT scan follow–up study	3.41	XXX
76400		A	Magnetic image, bone marrow	13.30	XXX
76400	26	A	Magnetic image, bone marrow	2.39	XXX
76400	TC	A	Magnetic image, bone marrow	10.91	XXX
76506		A	Echo exam of head	2.33	XXX
76506	26	A	Echo exam of head	0.94	XXX
76506	TC	A	Echo exam of head	1.38	XXX
76511		A	Echo exam of eye	2.44	XXX
76511	26	A	Echo exam of eye	1.22	XXX
76511	TC	A	Echo exam of eye	1.22	XXX
76512		A	Echo exam of eye	2.48	XXX
76512	26	A	Echo exam of eye	0.99	XXX
76512	TC	A	Echo exam of eye	1.49	XXX
76513		A	Echo exam of eye, water bath	2.48	XXX
76513	26	A	Echo exam of eye, water bath	0.99	XXX
76513	TC	A	Echo exam of eye, water bath	1.49	XXX
76516		A	Echo exam of eye	2.03	XXX
76516	26	A	Echo exam of eye	0.81	XXX

76516	TC	A	Echo exam of eye	1.22	XXX
76519		A	Echo exam of eye	2.03	XXX
76519	26	A	Echo exam of eye	0.81	XXX
76519	TC	A	Echo exam of eye	1.22	XXX
76529		A	Echo exam of eye	2.19	XXX
76529	26	A	Echo exam of eye	0.85	XXX
76529	TC	A	Echo exam of eye	1.33	XXX
76536		A	Echo exam of head and neck	2.23	XXX
76536	26	A	Echo exam of head and neck	0.84	XXX
76536	TC	A	Echo exam of head and neck	1.38	XXX
76604		A	Echo exam of chest	2.10	XXX
76604	26	A	Echo exam of chest	0.83	XXX
76604	TC	A	Echo exam of chest	1.27	XXX
76645		A	Echo exam of breast	1.84	XXX
76645	26	A	Echo exam of breast	0.81	XXX
76645	TC	A	Echo exam of breast	1.03	XXX
76700		A	Echo exam of abdomen	3.13	XXX
76700	26	A	Echo exam of abdomen	1.21	XXX
76700	TC	A	Echo exam of abdomen	1.92	XXX
76705		A	Echo exam of abdomen	2.27	XXX
76705	26	A	Echo exam of abdomen	0.88	XXX
76705	TC	A	Echo exam of abdomen	1.38	XXX
76770		A	Echo exam abdomen back wall	3.03	XXX
76770	26	A	Echo exam abdomen back wall	1.11	XXX
76770	TC	A	Echo exam abdomen back wall	1.92	XXX
76775		A	Echo exam abdomen back wall	2.26	XXX
76775	26	A	Echo exam abdomen back wall	0.87	XXX
76775	TC	A	Echo exam abdomen back wall	1.38	XXX
76778		A	Echo exam kidney transplant	3.03	XXX
76778	26	A	Echo exam kidney transplant	1.11	XXX
76778	TC	A	Echo exam kidney transplant	1.92	XXX
76800		A	Echo exam spinal canal	3.06	XXX
76800	26	A	Echo exam spinal canal	1.68	XXX
76800	TC	A	Echo exam spinal canal	1.38	XXX
76805		A	Echo exam of pregnant uterus	3.53	XXX
76805	26	A	Echo exam of pregnant uterus	1.48	XXX
76805	TC	A	Echo exam of pregnant uterus	2.05	XXX
76810		A	Echo exam of pregnant uterus	7.01	XXX
76810	26	A	Echo exam of pregnant uterus	2.93	XXX
76810	TC	A	Echo exam of pregnant uterus	4.08	XXX
76815		A	Echo exam of pregnant uterus	2.36	XXX
76815	26	A	Echo exam of pregnant uterus	0.97	XXX
76815	TC	A	Echo exam of pregnant uterus	1.38	XXX
76816		A	Echo exam follow–up or repeat	1.94	XXX
76816	26	A	Echo exam follow–up or repeat	0.85	XXX
76816	TC	A	Echo exam follow–up or repeat	1.08	XXX
76818		A	Fetal biophysical profile	2.73	XXX
76818	26	A	Fetal biophysical profile	1.15	XXX
76818	TC	A	Fetal biophysical profile	1.58	XXX
76825		A	Echo exam of fetal heart	3.28	XXX
76825	26	A	Echo exam of fetal heart	1.36	XXX
76825	TC	A	Echo exam of fetal heart	1.92	XXX
76826		A	Echo exam of fetal heart	2.22	XXX
76826	26	A	Echo exam of fetal heart	1.53	XXX
76826	TC	A	Echo exam of fetal heart	0.69	XXX

76827		A	Echo exam of fetal heart	2.99	XXX
76827	26	A	Echo exam of fetal heart	1.29	XXX
76827	TC	A	Echo exam of fetal heart	1.69	XXX
76828		A	Echo exam of fetal heart	1.95	XXX
76828	26	A	Echo exam of fetal heart	0.85	XXX
76828	TC	A	Echo exam of fetal heart	1.10	XXX
76830		A	Echo exam, transvaginal	2.53	XXX
76830	26	A	Echo exam, transvaginal	1.04	XXX
76830	TC	A	Echo exam, transvaginal	1.49	XXX
76856		A	Echo exam of pelvis	2.53	XXX
76856	26	A	Echo exam of pelvis	1.04	XXX
76856	TC	A	Echo exam of pelvis	1.49	XXX
76857		A	Echo exam of pelvis	1.59	XXX
76857	26	A	Echo exam of pelvis	0.57	XXX
76857	TC	A	Echo exam of pelvis	1.03	XXX
76870		A	Echo exam of scrotum	2.44	XXX
76870	26	A	Echo exam of scrotum	0.95	XXX
76870	TC	A	Echo exam of scrotum	1.49	XXX
76872		A	Echo exam, transrectal	2.53	XXX
76872	26	A	Echo exam, transrectal	1.04	XXX
76872	TC	A	Echo exam, transrectal	1.49	XXX
76880		A	Echo exam of extremity	2.27	XXX
76880	26	A	Echo exam of extremity	0.88	XXX
76880	TC	A	Echo exam of extremity	1.38	XXX
76930		A	Echo guide for heart sac tap	2.50	XXX
76930	26	A	Echo guide for heart sac tap	1.01	XXX
76930	TC	A	Echo guide for heart sac tap	1.49	XXX
76932		A	Echo guide for heart biopsy	2.50	XXX
76932	26	A	Echo guide for heart biopsy	1.01	XXX
76932	TC	A	Echo guide for heart biopsy	1.49	XXX
76934		A	Echo guide for chest tap	2.50	XXX
76934	26	A	Echo guide for chest tap	1.01	XXX
76934	TC	A	Echo guide for chest tap	1.49	XXX
76936		A	Echo guide for artery repair	8.29	XXX
76936	26	A	Echo guide for artery repair	2.16	XXX
76936	TC	A	Echo guide for artery repair	6.13	XXX
76938		A	Echo exam for drainage	2.50	XXX
76938	26	A	Echo exam for drainage	1.01	XXX
76938	TC	A	Echo exam for drainage	1.49	XXX
76941		A	Echo guide for transfusion	3.50	XXX
76941	26	A	Echo guide for transfusion	2.01	XXX
76941	TC	A	Echo guide for transfusion	1.49	XXX
76942		A	Echo guide for biopsy	2.50	XXX
76942	26	A	Echo guide for biopsy	1.01	XXX
76942	TC	A	Echo guide for biopsy	1.49	XXX
76945		A	Echo guide, villus sampling	2.83	XXX
76945	26	A	Echo guide, villus sampling	1.34	XXX
76945	TC	A	Echo guide, villus sampling	1.49	XXX
76946		A	Echo guide for amniocentesis	2.06	XXX
76946	26	A	Echo guide for amniocentesis	0.57	XXX
76946	TC	A	Echo guide for amniocentesis	1.49	XXX
76948		A	Echo guide, ova aspiration	2.06	XXX
76948	26	A	Echo guide, ova aspiration	0.57	XXX
76948	TC	A	Echo guide, ova aspiration	1.49	XXX
76950		A	Echo guidance radiotherapy	2.14	XXX

76950	26	A	Echo guidance radiotherapy	0.87	XXX
76950	TC	A	Echo guidance radiotherapy	1.27	XXX
76960		A	Echo guidance radiotherapy	2.14	XXX
76960	26	A	Echo guidance radiotherapy	0.87	XXX
76960	TC	A	Echo guidance radiotherapy	1.27	XXX
76970		A	Ultrasound exam follow–up	1.62	XXX
76970	26	A	Ultrasound exam follow–up	0.60	XXX
76970	TC	A	Ultrasound exam follow–up	1.03	XXX
76975		A	GI endoscopic ultrasound	2.67	XXX
76975	26	A	GI endoscopic ultrasound	1.18	XXX
76975	TC	A	GI endoscopic ultrasound	1.49	XXX
76986		A	Echo exam at surgery	4.34	XXX
76986	26	A	Echo exam at surgery	1.78	XXX
76986	TC	A	Echo exam at surgery	2.56	XXX
77261		A	Radiation therapy planning	2.06	XXX
77262		A	Radiation therapy planning	3.14	XXX
77263		A	Radiation therapy planning	4.66	XXX
77280		A	Set radiation therapy field	4.43	XXX
77280	26	A	Set radiation therapy field	1.05	XXX
77280	TC	A	Set radiation therapy field	3.38	XXX
77285		A	Set radiation therapy field	6.98	XXX
77285	26	A	Set radiation therapy field	1.55	XXX
77285	TC	A	Set radiation therapy field	5.43	XXX
77290		A	Set radiation therapy field	8.66	XXX
77290	26	A	Set radiation therapy field	2.33	XXX
77290	TC	A	Set radiation therapy field	6.33	XXX
77295		A	Set radiation therapy field	33.97	XXX
77295	26	A	Set radiation therapy field	6.77	XXX
77295	TC	A	Set radiation therapy field	27.21	XXX
77300		A	Radiation therapy dose plan	2.23	XXX
77300	26	A	Radiation therapy dose plan	0.92	XXX
77300	TC	A	Radiation therapy dose plan	1.31	XXX
77305		A	Radiation therapy dose plan	2.86	XXX
77305	26	A	Radiation therapy dose plan	1.05	XXX
77305	TC	A	Radiation therapy dose plan	1.81	XXX
77310		A	Radiation therapy dose plan	3.83	XXX
77310	26	A	Radiation therapy dose plan	1.55	XXX
77310	TC	A	Radiation therapy dose plan	2.27	XXX
77315		A	Radiation therapy dose plan	4.92	XXX
77315	26	A	Radiation therapy dose plan	2.33	XXX
77315	TC	A	Radiation therapy dose plan	2.59	XXX
77321		A	Radiation therapy port plan	5.35	XXX
77321	26	A	Radiation therapy port plan	1.42	XXX
77321	TC	A	Radiation therapy port plan	3.93	XXX
77326		A	Radiation therapy dose plan	3.69	XXX
77326	26	A	Radiation therapy dose plan	1.39	XXX
77326	TC	A	Radiation therapy dose plan	2.30	XXX
77327		A	Radiation therapy dose plan	5.45	XXX
77327	26	A	Radiation therapy dose plan	2.06	XXX
77327	TC	A	Radiation therapy dose plan	3.38	XXX
77328		A	Radiation therapy dose plan	7.94	XXX
77328	26	A	Radiation therapy dose plan	3.11	XXX
77328	TC	A	Radiation therapy dose plan	4.83	XXX
77331		A	Special radiation dosimetry	1.79	XXX
77331	26	A	Special radiation dosimetry	1.30	XXX

77331	TC	A	Special radiation dosimetry	0.49	XXX
77332		A	Radiation treatment aid(s)	2.12	XXX
77332	26	A	Radiation treatment aid(s)	0.81	XXX
77332	TC	A	Radiation treatment aid(s)	1.31	XXX
77333		A	Radiation treatment aid(s)	3.11	XXX
77333	26	A	Radiation treatment aid(s)	1.26	XXX
77333	TC	A	Radiation treatment aid(s)	1.85	XXX
77334		A	Radiation treatment aid(s)	4.99	XXX
77334	26	A	Radiation treatment aid(s)	1.83	XXX
77334	TC	A	Radiation treatment aid(s)	3.16	XXX
77336		A	Radiation physics consult	2.90	XXX
77370		A	Radiation physics consult	3.40	XXX
77401		A	Radiation treatment delivery	1.73	XXX
77402		A	Radiation treatment delivery	1.73	XXX
77403		A	Radiation treatment delivery	1.73	XXX
77404		A	Radiation treatment delivery	1.73	XXX
77406		A	Radiation treatment delivery	1.73	XXX
77407		A	Radiation treatment delivery	2.04	XXX
77408		A	Radiation treatment delivery	2.04	XXX
77409		A	Radiation treatment delivery	2.04	XXX
77411		A	Radiation treatment delivery	2.04	XXX
77412		A	Radiation treatment delivery	2.27	XXX
77413		A	Radiation treatment delivery	2.27	XXX
77414		A	Radiation treatment delivery	2.27	XXX
77416		A	Radiation treatment delivery	2.27	XXX
77417		A	Radiology port film(s)	0.58	XXX
77419		A	Weekly radiation therapy	5.35	XXX
77420		A	Weekly radiation therapy	2.40	XXX
77425		A	Weekly radiation therapy	3.64	XXX
77430		A	Weekly radiation therapy	5.35	XXX
77431		A	Radiation therapy management	2.69	XXX
77432		A	Stereotactic radiation treatment	13.08	XXX
77470		A	Special radiation treatment	13.95	XXX
77470	26	A	Special radiation treatment	3.11	XXX
77470	TC	A	Special radiation treatment	10.84	XXX
77600		A	Hyperthermia treatment	5.29	ZZZ
77600	26	A	Hyperthermia treatment	2.33	ZZZ
77600	TC	A	Hyperthermia treatment	2.96	ZZZ
77605		A	Hyperthermia treatment	7.06	ZZZ
77605	26	A	Hyperthermia treatment	3.11	ZZZ
77605	TC	A	Hyperthermia treatment	3.96	ZZZ
77610		A	Hyperthermia treatment	5.29	ZZZ
77610	26	A	Hyperthermia treatment	2.33	ZZZ
77610	TC	A	Hyperthermia treatment	2.96	ZZZ
77615		A	Hyperthermia treatment	7.06	ZZZ
77615	26	A	Hyperthermia treatment	3.11	ZZZ
77615	TC	A	Hyperthermia treatment	3.96	ZZZ
77620		A	Hyperthermia treatment	5.29	ZZZ
77620	26	A	Hyperthermia treatment	2.33	ZZZ
77620	TC	A	Hyperthermia treatment	2.96	ZZZ
77750		A	Infuse radioactive materials	8.12	090
77750	26	A	Infuse radioactive materials	6.82	090
77750	TC	A	Infuse radioactive materials	1.30	090
77761		A	Radioelement application	7.74	090
77761	26	A	Radioelement application	5.29	090

77761	TC	A	Radioelement application	2.45	090
77762		A	Radioelement application	11.47	090
77762	26	A	Radioelement application	7.95	090
77762	TC	A	Radioelement application	3.52	090
77763		A	Radioelement application	16.27	090
77763	26	A	Radioelement application	11.89	090
77763	TC	A	Radioelement application	4.37	090
77776		A	Radioelement application	9.06	XXX
77776	26	A	Radioelement application	6.94	XXX
77776	TC	A	Radioelement application	2.12	XXX
77777		A	Radioelement application	14.52	090
77777	26	A	Radioelement application	10.39	090
77777	TC	A	Radioelement application	4.13	090
77778		A	Radioelement application	20.55	090
77778	26	A	Radioelement application	15.56	090
77778	TC	A	Radioelement application	5.00	090
77781		A	High intensity brachytherapy	22.07	090
77781	26	A	High intensity brachytherapy	2.31	090
77781	TC	A	High intensity brachytherapy	19.76	090
77782		A	High intensity brachytherapy	23.24	090
77782	26	A	High intensity brachytherapy	3.48	090
77782	TC	A	High intensity brachytherapy	19.76	090
77783		A	High intensity brachytherapy	24.94	090
77783	26	A	High intensity brachytherapy	5.18	090
77783	TC	A	High intensity brachytherapy	19.76	090
77784		A	High intensity brachytherapy	27.55	090
77784	26	A	High intensity brachytherapy	7.79	090
77784	TC	A	High intensity brachytherapy	19.76	090
77789		A	Radioelement application	1.99	090
77789	26	A	Radioelement application	1.55	090
77789	TC	A	Radioelement application	0.44	090
77790		A	Radioelement handling	2.04	XXX
77790	26	A	Radioelement handling	1.55	XXX
77790	TC	A	Radioelement handling	0.49	XXX
78000		A	Thyroid, single uptake	1.23	XXX
78000	26	A	Thyroid, single uptake	0.29	XXX
78000	TC	A	Thyroid, single uptake	0.94	XXX
78001		A	Thyroid, multiple uptakes	1.66	XXX
78001	26	A	Thyroid, multiple uptakes	0.39	XXX
78001	TC	A	Thyroid, multiple uptakes	1.27	XXX
78003		A	Thyroid suppress/stimul	1.43	XXX
78003	26	A	Thyroid suppress/stimul	0.49	XXX
78003	TC	A	Thyroid suppress/stimul	0.94	XXX
78006		A	Thyroid, imaging with uptake	3.05	XXX
78006	26	A	Thyroid, imaging with uptake	0.73	XXX
78006	TC	A	Thyroid, imaging with uptake	2.32	XXX
78007		A	Thyroid, image, mult uptakes	3.25	XXX
78007	26	A	Thyroid, image, mult uptakes	0.75	XXX
78007	TC	A	Thyroid, image, mult uptakes	2.51	XXX
78010		A	Thyroid imaging	2.35	XXX
78010	26	A	Thyroid imaging	0.58	XXX
78010	TC	A	Thyroid imaging	1.77	XXX
78011		A	Thyroid imaging with flow	3.02	XXX
78011	26	A	Thyroid imaging with flow	0.68	XXX
78011	TC	A	Thyroid imaging with flow	2.34	XXX

78015		A	Thyroid met imaging	3.52	XXX
78015	26	A	Thyroid met imaging	1.01	XXX
78015	TC	A	Thyroid met imaging	2.51	XXX
78016		A	Thyroid met imaging/studies	4.63	XXX
78016	26	A	Thyroid met imaging/studies	1.24	XXX
78016	TC	A	Thyroid met imaging/studies	3.39	XXX
78017		A	Thyroid met imaging, mult	4.92	XXX
78017	26	A	Thyroid met imaging, mult	1.30	XXX
78017	TC	A	Thyroid met imaging, mult	3.62	XXX
78018		A	Thyroid, met imaging, body	6.70	XXX
78018	26	A	Thyroid, met imaging, body	1.42	XXX
78018	TC	A	Thyroid, met imaging, body	5.28	XXX
78070		A	Parathyroid nuclear imaging	2.53	XXX
78070	26	A	Parathyroid nuclear imaging	0.76	XXX
78070	TC	A	Parathyroid nuclear imaging	1.77	XXX
78075		A	Adrenal nuclear imaging	6.39	XXX
78075	26	A	Adrenal nuclear imaging	1.11	XXX
78075	TC	A	Adrenal nuclear imaging	5.28	XXX
78102		A	Bone marrow imaging, ltd	2.81	XXX
78102	26	A	Bone marrow imaging, ltd	0.82	XXX
78102	TC	A	Bone marrow imaging, ltd	1.99	XXX
78103		A	Bone marrow imaging, mult	4.21	XXX
78103	26	A	Bone marrow imaging, mult	1.12	XXX
78103	TC	A	Bone marrow imaging, mult	3.08	XXX
78104		A	Bone marrow imaging, body	5.17	XXX
78104	26	A	Bone marrow imaging, body	1.20	XXX
78104	TC	A	Bone marrow imaging, body	3.97	XXX
78110		A	Plasma volume, single	1.21	XXX
78110	26	A	Plasma volume, single	0.29	XXX
78110	TC	A	Plasma volume, single	0.92	XXX
78111		A	Plasma volume, multiple	2.84	XXX
78111	26	A	Plasma volume, multiple	0.33	XXX
78111	TC	A	Plasma volume, multiple	2.51	XXX
78120		A	Red cell mass, single	2.04	XXX
78120	26	A	Red cell mass, single	0.35	XXX
78120	TC	A	Red cell mass, single	1.69	XXX
78121		A	Red cell mass, multiple	3.31	XXX
78121	26	A	Red cell mass, multiple	0.48	XXX
78121	TC	A	Red cell mass, multiple	2.83	XXX
78122		A	Blood volume	5.16	XXX
78122	26	A	Blood volume	0.67	XXX
78122	TC	A	Blood volume	4.49	XXX
78130		A	Red cell survival study	3.69	XXX
78130	26	A	Red cell survival study	0.91	XXX
78130	TC	A	Red cell survival study	2.78	XXX
78135		A	Red cell survival kinetics	5.70	XXX
78135	26	A	Red cell survival kinetics	0.95	XXX
78135	TC	A	Red cell survival kinetics	4.75	XXX
78140		A	Red cell sequestration	4.75	XXX
78140	26	A	Red cell sequestration	0.91	XXX
78140	TC	A	Red cell sequestration	3.83	XXX
78160		A	Plasma iron turnover	4.06	XXX
78160	26	A	Plasma iron turnover	0.49	XXX
78160	TC	A	Plasma iron turnover	3.57	XXX
78162		A	Iron absorption exam	3.78	XXX

78162	26	A	Iron absorption exam	0.67	XXX
78162	TC	A	Iron absorption exam	3.11	XXX
78170		A	Red cell iron utilization	5.78	XXX
78170	26	A	Red cell iron utilization	0.61	XXX
78170	TC	A	Red cell iron utilization	5.17	XXX
78172	26	A	Total body iron estimation	0.80	XXX
78185		A	Spleen imaging	2.90	XXX
78185	26	A	Spleen imaging	0.60	XXX
78185	TC	A	Spleen imaging	2.30	XXX
78190		A	Platelet survival, kinetics	7.18	XXX
78190	26	A	Platelet survival, kinetics	1.61	XXX
78190	TC	A	Platelet survival, kinetics	5.57	XXX
78191		A	Platelet survival	8.05	XXX
78191	26	A	Platelet survival	0.91	XXX
78191	TC	A	Platelet survival	7.14	XXX
78195		A	Lymph system imaging	5.02	XXX
78195	26	A	Lymph system imaging	1.05	XXX
78195	TC	A	Lymph system imaging	3.97	XXX
78201		A	Liver imaging	2.95	XXX
78201	26	A	Liver imaging	0.65	XXX
78201	TC	A	Liver imaging	2.30	XXX
78202		A	Liver imaging with flow	3.57	XXX
78202	26	A	Liver imaging with flow	0.76	XXX
78202	TC	A	Liver imaging with flow	2.81	XXX
78205		A	Liver imaging (3D)	6.83	XXX
78205	26	A	Liver imaging (3D)	1.07	XXX
78205	TC	A	Liver imaging (3D)	5.75	XXX
78215		A	Liver and spleen imaging	3.58	XXX
78215	26	A	Liver and spleen imaging	0.73	XXX
78215	TC	A	Liver and spleen imaging	2.86	XXX
78216		A	Liver and spleen image, flow	4.25	XXX
78216	26	A	Liver and spleen image, flow	0.85	XXX
78216	TC	A	Liver and spleen image, flow	3.39	XXX
78220		A	Liver function study	4.35	XXX
78220	26	A	Liver function study	0.73	XXX
78220	TC	A	Liver function study	3.62	XXX
78223		A	Hepatobiliary imaging	4.82	XXX
78223	26	A	Hepatobiliary imaging	1.26	XXX
78223	TC	A	Hepatobiliary imaging	3.57	XXX
78230		A	Salivary gland imaging	2.80	XXX
78230	26	A	Salivary gland imaging	0.68	XXX
78230	TC	A	Salivary gland imaging	2.12	XXX
78231		A	Serial salivary imaging	3.87	XXX
78231	26	A	Serial salivary imaging	0.78	XXX
78231	TC	A	Serial salivary imaging	3.08	XXX
78232		A	Salivary gland function exam	4.15	XXX
78232	26	A	Salivary gland function exam	0.71	XXX
78232	TC	A	Salivary gland function exam	3.44	XXX
78258		A	Esophageal motility study	3.92	XXX
78258	26	A	Esophageal motility study	1.11	XXX
78258	TC	A	Esophageal motility study	2.81	XXX
78261		A	Gastric mucosa imaging	5.04	XXX
78261	26	A	Gastric mucosa imaging	1.04	XXX
78261	TC	A	Gastric mucosa imaging	4.00	XXX
78262		A	Gastroesophageal reflux exam	5.16	XXX

78262	26	A	Gastroesophageal reflux exam	1.02	XXX
78262	TC	A	Gastroesophageal reflux exam	4.14	XXX
78264		A	Gastric emptying study	5.19	XXX
78264	26	A	Gastric emptying study	1.17	XXX
78264	TC	A	Gastric emptying study	4.02	XXX
78270		A	Vit B–12 absorption exam	1.81	XXX
78270	26	A	Vit B–12 absorption exam	0.31	XXX
78270	TC	A	Vit B–12 absorption exam	1.51	XXX
78271		A	Vit B–12 absorp exam, IF	1.91	XXX
78271	26	A	Vit B–12 absorp exam, IF	0.31	XXX
78271	TC	A	Vit B–12 absorp exam, IF	1.60	XXX
78272		A	Vit B–12 absorp, combined	2.68	XXX
78272	26	A	Vit B–12 absorp, combined	0.41	XXX
78272	TC	A	Vit B–12 absorp, combined	2.26	XXX
78278		A	Acute GI blood loss imaging	6.23	XXX
78278	26	A	Acute GI blood loss imaging	1.48	XXX
78278	TC	A	Acute GI blood loss imaging	4.75	XXX
78282	26	A	GI protein loss exam	0.57	XXX
78290		A	Meckel's divert exam	3.98	XXX
78290	26	A	Meckel's divert exam	1.02	XXX
78290	TC	A	Meckel's divert exam	2.96	XXX
78291		A	LeVeen/shunt patency exam	4.29	XXX
78291	26	A	LeVeen/shunt patency exam	1.31	XXX
78291	TC	A	LeVeen/shunt patency exam	2.98	XXX
78300		A	Bone imaging, limited area	3.36	XXX
78300	26	A	Bone imaging, limited area	0.93	XXX
78300	TC	A	Bone imaging, limited area	2.43	XXX
78305		A	Bone imaging, multiple areas	4.81	XXX
78305	26	A	Bone imaging, multiple areas	1.25	XXX
78305	TC	A	Bone imaging, multiple areas	3.57	XXX
78306		A	Bone imaging, whole body	5.45	XXX
78306	26	A	Bone imaging, whole body	1.29	XXX
78306	TC	A	Bone imaging, whole body	4.16	XXX
78315		A	Bone imaging, 3 phase	6.16	XXX
78315	26	A	Bone imaging, 3 phase	1.51	XXX
78315	TC	A	Bone imaging, 3 phase	4.65	XXX
78320		A	Bone imaging (3D)	7.30	XXX
78320	26	A	Bone imaging (3D)	1.54	XXX
78320	TC	A	Bone imaging (3D)	5.75	XXX
78350		A	Bone mineral, single photon	1.07	XXX
78350	26	A	Bone mineral, single photon	0.33	XXX
78350	TC	A	Bone mineral, single photon	0.74	XXX
78351		A	Bone mineral, dual photon	0.50	XXX
78414	26	A	Nonimaging heart function	0.67	XXX
78428		A	Cardiac shunt imaging	3.37	XXX
78428	26	A	Cardiac shunt imaging	1.17	XXX
78428	TC	A	Cardiac shunt imaging	2.20	XXX
78445		A	Vascular flow imaging	2.56	XXX
78445	26	A	Vascular flow imaging	0.75	XXX
78445	TC	A	Vascular flow imaging	1.81	XXX
78455		A	Venous thrombosis study	4.97	XXX
78455	26	A	Venous thrombosis study	1.09	XXX
78455	TC	A	Venous thrombosis study	3.88	XXX
78457		A	Venous thrombosis imaging	3.74	XXX
78457	26	A	Venous thrombosis imaging	1.15	XXX

78457	TC	A	Venous thrombosis imaging	2.59	XXX
78458		A	Ven thrombosis images, bilateral	5.25	XXX
78458	26	A	Ven thrombosis images, bilateral	1.34	XXX
78458	TC	A	Ven thrombosis images, bilateral	3.91	XXX
78460		A	Heart muscle blood single	3.59	XXX
78460	26	A	Heart muscle blood single	1.29	XXX
78460	TC	A	Heart muscle blood single	2.30	XXX
78461		A	Heart muscle blood multiple	6.42	XXX
78461	26	A	Heart muscle blood multiple	1.82	XXX
78461	TC	A	Heart muscle blood multiple	4.60	XXX
78464		A	Heart image (3D) single	8.50	XXX
78464	26	A	Heart image (3D) single	1.61	XXX
78464	TC	A	Heart image (3D) single	6.89	XXX
78465		A	Heart image (3D) multiple	13.65	XXX
78465	26	A	Heart image (3D) multiple	2.17	XXX
78465	TC	A	Heart image (3D) multiple	11.48	XXX
78466		A	Heart infarct image	3.60	XXX
78466	26	A	Heart infarct image	1.04	XXX
78466	TC	A	Heart infarct image	2.56	XXX
78468		A	Heart infarct image, EF	4.76	XXX
78468	26	A	Heart infarct image, EF	1.19	XXX
78468	TC	A	Heart infarct image, EF	3.57	XXX
78469		A	Heart infarct image (3D)	6.46	XXX
78469	26	A	Heart infarct image (3D)	1.37	XXX
78469	TC	A	Heart infarct image (3D)	5.09	XXX
78472		A	Gated heart, resting	6.83	XXX
78472	26	A	Gated heart, resting	1.46	XXX
78472	TC	A	Gated heart, resting	5.37	XXX
78473		A	Gated heart, multiple	10.22	XXX
78473	26	A	Gated heart, multiple	2.18	XXX
78473	TC	A	Gated heart, multiple	8.04	XXX
78478		A	Heart wall motion (add–on)	2.44	XXX
78478	26	A	Heart wall motion (add–on)	0.92	XXX
78478	TC	A	Heart wall motion (add–on)	1.52	XXX
78480		A	Heart function, (add–on)	2.44	XXX
78480	26	A	Heart function, (add–on)	0.92	XXX
78480	TC	A	Heart function, (add–on)	1.52	XXX
78481		A	Heart first pass single	6.55	XXX
78481	26	A	Heart first pass single	1.46	XXX
78481	TC	A	Heart first pass single	5.09	XXX
78483		A	Heart first pass multiple	9.84	XXX
78483	26	A	Heart first pass multiple	2.18	XXX
78483	TC	A	Heart first pass multiple	7.66	XXX
78580		A	Lung perfusion imaging	4.45	XXX
78580	26	A	Lung perfusion imaging	1.11	XXX
78580	TC	A	Lung perfusion imaging	3.34	XXX
78584		A	Lung V/Q image single breath	4.60	XXX
78584	26	A	Lung V/Q image single breath	1.48	XXX
78584	TC	A	Lung V/Q image single breath	3.11	XXX
78585		A	Lung V/Q imaging	7.10	XXX
78585	26	A	Lung V/Q imaging	1.61	XXX
78585	TC	A	Lung V/Q imaging	5.49	XXX
78586		A	Aerosol lung image, single	3.12	XXX
78586	26	A	Aerosol lung image, single	0.60	XXX
78586	TC	A	Aerosol lung image, single	2.53	XXX

78587		A	Aerosol lung image, multiple	3.46	XXX
78587	26	A	Aerosol lung image, multiple	0.73	XXX
78587	TC	A	Aerosol lung image, multiple	2.73	XXX
78591		A	Vent image, 1 breath, 1 proj	3.38	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.60	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	2.78	XXX
78593		A	Vent image, 1 proj, gas	4.09	XXX
78593	26	A	Vent image, 1 proj, gas	0.73	XXX
78593	TC	A	Vent image, 1 proj, gas	3.36	XXX
78594		A	Vent image, mult proj, gas	5.66	XXX
78594	26	A	Vent image, mult proj, gas	0.80	XXX
78594	TC	A	Vent image, mult proj, gas	4.85	XXX
78596		A	Lung differential function	8.77	XXX
78596	26	A	Lung differential function	1.89	XXX
78596	TC	A	Lung differential function	6.89	XXX
78600		A	Brain imaging, ltd static	3.47	XXX
78600	26	A	Brain imaging, ltd static	0.66	XXX
78600	TC	A	Brain imaging, ltd static	2.81	XXX
78601		A	Brain ltd imaging and flow	4.08	XXX
78601	26	A	Brain ltd imaging and flow	0.77	XXX
78601	TC	A	Brain ltd imaging and flow	3.31	XXX
78605		A	Brain imaging, complete	4.11	XXX
78605	26	A	Brain imaging, complete	0.80	XXX
78605	TC	A	Brain imaging, complete	3.31	XXX
78606		A	Brain imaging comp and flow	4.72	XXX
78606	26	A	Brain imaging comp and flow	0.95	XXX
78606	TC	A	Brain imaging comp and flow	3.77	XXX
78607		A	Brain imaging (3D)	8.20	XXX
78607	26	A	Brain imaging (3D)	1.82	XXX
78607	TC	A	Brain imaging (3D)	6.38	XXX
78610		A	Brain flow imaging only	1.99	XXX
78610	26	A	Brain flow imaging only	0.45	XXX
78610	TC	A	Brain flow imaging only	1.54	XXX
78615		A	Cerebral blood flow imaging	4.38	XXX
78615	26	A	Cerebral blood flow imaging	0.63	XXX
78615	TC	A	Cerebral blood flow imaging	3.75	XXX
78630		A	Cerebrospinal fluid scan	5.93	XXX
78630	26	A	Cerebrospinal fluid scan	1.02	XXX
78630	TC	A	Cerebrospinal fluid scan	4.91	XXX
78635		A	CSF ventriculography	3.39	XXX
78635	26	A	CSF ventriculography	0.91	XXX
78635	TC	A	CSF ventriculography	2.48	XXX
78645		A	CSF shunt evaluation	4.20	XXX
78645	26	A	CSF shunt evaluation	0.85	XXX
78645	TC	A	CSF shunt evaluation	3.34	XXX
78647		A	Cerebrospinal fluid scan	7.10	XXX
78647	26	A	Cerebrospinal fluid scan	1.35	XXX
78647	TC	A	Cerebrospinal fluid scan	5.75	XXX
78650		A	CSF leakage imaging	5.43	XXX
78650	26	A	CSF leakage imaging	0.91	XXX
78650	TC	A	CSF leakage imaging	4.52	XXX
78655		A	Nuclear exam of eye lesion	5.70	XXX
78655	26	A	Nuclear exam of eye lesion	0.84	XXX
78655	TC	A	Nuclear exam of eye lesion	4.85	XXX
78660		A	Nuclear exam of tear flow	2.87	XXX

78660	26	A	Nuclear exam of tear flow	0.80	XXX
78660	TC	A	Nuclear exam of tear flow	2.07	XXX
78700		A	Kidney imaging, static	3.63	XXX
78700	26	A	Kidney imaging, static	0.67	XXX
78700	TC	A	Kidney imaging, static	2.96	XXX
78701		A	Kidney imaging with flow	4.19	XXX
78701	26	A	Kidney imaging with flow	0.73	XXX
78701	TC	A	Kidney imaging with flow	3.46	XXX
78704		A	Imaging renogram	4.96	XXX
78704	26	A	Imaging renogram	1.11	XXX
78704	TC	A	Imaging renogram	3.85	XXX
78707		A	Kidney flow and function image	5.75	XXX
78707	26	A	Kidney flow and function image	1.40	XXX
78707	TC	A	Kidney flow and function image	4.35	XXX
78710		A	Kidney imaging (3D)	6.75	XXX
78710	26	A	Kidney imaging (3D)	0.99	XXX
78710	TC	A	Kidney imaging (3D)	5.75	XXX
78715		A	Renal vascular flow exam	1.99	XXX
78715	26	A	Renal vascular flow exam	0.45	XXX
78715	TC	A	Renal vascular flow exam	1.54	XXX
78725		A	Kidney function study	2.31	XXX
78725	26	A	Kidney function study	0.57	XXX
78725	TC	A	Kidney function study	1.74	XXX
78726		A	Kidney function with intervent	4.18	XXX
78726	26	A	Kidney function with intervent	1.30	XXX
78726	TC	A	Kidney function with intervent	2.88	XXX
78727		A	Kidney transplant evaluation	5.37	XXX
78727	26	A	Kidney transplant evaluation	1.48	XXX
78727	TC	A	Kidney transplant evaluation	3.88	XXX
78730		A	Urinary bladder retention	1.95	XXX
78730	26	A	Urinary bladder retention	0.53	XXX
78730	TC	A	Urinary bladder retention	1.42	XXX
78740		A	Ureteral reflux study	2.92	XXX
78740	26	A	Ureteral reflux study	0.85	XXX
78740	TC	A	Ureteral reflux study	2.07	XXX
78760		A	Testicular imaging	3.60	XXX
78760	26	A	Testicular imaging	0.98	XXX
78760	TC	A	Testicular imaging	2.61	XXX
78761		A	Testicular imaging and flow	4.18	XXX
78761	26	A	Testicular imaging and flow	1.07	XXX
78761	TC	A	Testicular imaging and flow	3.11	XXX
78800		A	Tumor imaging, limited area	4.28	XXX
78800	26	A	Tumor imaging, limited area	0.97	XXX
78800	TC	A	Tumor imaging, limited area	3.31	XXX
78801		A	Tumor imaging, mult areas	5.30	XXX
78801	26	A	Tumor imaging, mult areas	1.18	XXX
78801	TC	A	Tumor imaging, mult areas	4.12	XXX
78802		A	Tumor imaging, whole body	6.68	XXX
78802	26	A	Tumor imaging, whole body	1.29	XXX
78802	TC	A	Tumor imaging, whole body	5.39	XXX
78803		A	Tumor imaging (3D)	7.99	XXX
78803	26	A	Tumor imaging (3D)	1.61	XXX
78803	TC	A	Tumor imaging (3D)	6.38	XXX
78805		A	Abscess imaging, ltd area	4.40	XXX
78805	26	A	Abscess imaging, ltd area	1.09	XXX

78805	TC	A	Abscess imaging, ltd area	3.31	XXX
78806		A	Abscess imaging, whole body	7.41	XXX
78806	26	A	Abscess imaging, whole body	1.15	XXX
78806	TC	A	Abscess imaging, whole body	6.26	XXX
78807		A	Nuclear localization/abscess	7.99	XXX
78807	26	A	Nuclear localization/abscess	1.61	XXX
78807	TC	A	Nuclear localization/abscess	6.38	XXX
78890		B	Nuclear medicine data proc	1.34	XXX
78890	26	B	Nuclear medicine data proc	0.07	XXX
78890	TC	B	Nuclear medicine data proc	1.27	XXX
78891		B	Nuclear med data proc	2.72	XXX
78891	26	B	Nuclear med data proc	0.16	XXX
78891	TC	B	Nuclear med data proc	2.56	XXX
79000		A	Initial hyperthyroid therapy	5.25	XXX
79000	26	A	Initial hyperthyroid therapy	2.68	XXX
79000	TC	A	Initial hyperthyroid therapy	2.56	XXX
79001		A	Repeat hyperthyroid therapy	2.82	XXX
79001	26	A	Repeat hyperthyroid therapy	1.55	XXX
79001	TC	A	Repeat hyperthyroid therapy	1.27	XXX
79020		A	Thyroid ablation	5.26	XXX
79020	26	A	Thyroid ablation	2.69	XXX
79020	TC	A	Thyroid ablation	2.56	XXX
79030		A	Thyroid ablation, carcinoma	5.69	XXX
79030	26	A	Thyroid ablation, carcinoma	3.13	XXX
79030	TC	A	Thyroid ablation, carcinoma	2.56	XXX
79035		A	Thyroid metastatic therapy	6.32	XXX
79035	26	A	Thyroid metastatic therapy	3.75	XXX
79035	TC	A	Thyroid metastatic therapy	2.56	XXX
79100		A	Hematopoietic nuclear therapy	4.52	XXX
79100	26	A	Hematopoietic nuclear therapy	1.96	XXX
79100	TC	A	Hematopoietic nuclear therapy	2.56	XXX
79200		A	Intracavitary nuclear treatment	5.53	XXX
79200	26	A	Intracavitary nuclear treatment	2.97	XXX
79200	TC	A	Intracavitary nuclear treatment	2.56	XXX
79300	26	A	Interstitial nuclear therapy	2.38	XXX
79400		A	Nonhemato nuclear therapy	5.47	XXX
79400	26	A	Nonhemato nuclear therapy	2.91	XXX
79400	TC	A	Nonhemato nuclear therapy	2.56	XXX
79420	26	A	Intravascular nuc therapy	2.24	XXX
79440		A	Nuclear joint therapy	5.53	XXX
79440	26	A	Nuclear joint therapy	2.97	XXX
79440	TC	A	Nuclear joint therapy	2.56	XXX

G. Procedure code numbers 90780 to 99440 relate to medical services and evaluation and management services.

CPT/ HCPCS Proce– dure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
90780		A	IV infusion therapy, 1 hour	1.09	XXX
90781		A	IV infusion, additional hour	0.55	XXX
90782		T	Injection (SC)/(IM)	0.10	XXX

90783		T	Injection (IA)	0.40	XXX
90784		T	Injection (IV)	0.47	XXX
90788		T	Injection of antibiotic	0.11	XXX
90801		A	Psychiatric interview	2.92	XXX
90820		A	Diagnostic interview	2.67	XXX
90825		A	Evaluation of tests/records	1.31	XXX
90830		A	Psychological testing	1.78	XXX
90835		A	Special interview	3.37	XXX
90841		B	Psychotherapy	0.00	XXX
90842		A	Psychotherapy, 75–80 min.	3.87	XXX
90843		A	Psychotherapy 20–30 min.	1.48	XXX
90844		A	Psychotherapy 45–50 min.	2.31	XXX
90845		A	Medical psychoanalysis	2.22	XXX
90846		A	Special family therapy	2.49	XXX
90847		A	Special family therapy	2.82	XXX
90849		A	Special family therapy	0.87	XXX
90853		A	Special group therapy	0.71	XXX
90855		A	Individual psychotherapy	2.46	XXX
90857		A	Special group therapy	0.59	XXX
90862		A	Medication management	1.35	XXX
90870		A	Electroconvulsive therapy	2.48	000
90871		A	Electroconvulsive therapy	3.63	000
90880		A	Medical hypnotherapy	2.87	XXX
90887		A	Consultation with family	1.84	XXX
90889		B	Preparation of report	0.00	XXX
90900		A	Biofeedback, electromyogram	1.83	000
90902		A	Biofeedback, nerve impulse	1.55	000
90904		A	Biofeedback, blood pressure	1.26	000
90906		A	Biofeedback, blood flow	2.54	000
90908		A	Biofeedback, brain waves	1.78	000
90910		A	Biofeedback, oculogram	1.62	000
90911		A	Anorectal biofeedback	3.45	000
90915		A	Biofeedback, unspecified	1.68	000
90918		A	ESRD related services, month	12.05	XXX
90919		A	ESRD related services, month	9.39	XXX
90920		A	ESRD related services, month	8.12	XXX
90921		A	ESRD related services, month	5.30	XXX
90922		A	ESRD related services, day	0.18	XXX
90935		A	Hemodialysis, one evaluation	2.75	000
90937		A	Hemodialysis, repeated eval.	4.84	000
90945		A	Dialysis, one evaluation	2.58	000
90947		A	Dialysis, repeated eval.	4.31	000
90997		A	Hemoperfusion	4.26	000
91000		A	Esophageal intubation	1.68	000
91000	26	A	Esophageal intubation	1.61	000
91000	TC	A	Esophageal intubation	0.08	000
91010		A	Esophagus motility study	4.01	000
91010	26	A	Esophagus motility study	3.20	000
91010	TC	A	Esophagus motility study	0.80	000
91011		A	Esophagus motility study	4.72	000
91011	26	A	Esophagus motility study	3.71	000
91011	TC	A	Esophagus motility study	1.01	000
91012		A	Esophagus motility study	5.14	000
91012	26	A	Esophagus motility study	4.01	000
91012	TC	A	Esophagus motility study	1.13	000

91020		A	Esophagogastric study	4.47	000
91020	26	A	Esophagogastric study	3.71	000
91020	TC	A	Esophagogastric study	0.76	000
91030		A	Acid perfusion of esophagus	1.79	000
91030	26	A	Acid perfusion of esophagus	1.57	000
91030	TC	A	Acid perfusion of esophagus	0.22	000
91032		A	Esophagus, acid reflux test	3.62	000
91032	26	A	Esophagus, acid reflux test	2.89	000
91032	TC	A	Esophagus, acid reflux test	0.74	000
91033		A	Prolonged acid reflux test	4.80	000
91033	26	A	Prolonged acid reflux test	3.47	000
91033	TC	A	Prolonged acid reflux test	1.33	000
91052		A	Gastric analysis test	2.57	000
91052	26	A	Gastric analysis test	2.24	000
91052	TC	A	Gastric analysis test	0.33	000
91055		A	Gastric intubation for smear	2.11	000
91055	26	A	Gastric intubation for smear	1.81	000
91055	TC	A	Gastric intubation for smear	0.30	000
91060		A	Gastric saline load test	1.19	000
91060	26	A	Gastric saline load test	0.97	000
91060	TC	A	Gastric saline load test	0.22	000
91065		A	Breath hydrogen test	1.30	000
91065	26	A	Breath hydrogen test	0.95	000
91065	TC	A	Breath hydrogen test	0.35	000
91100		A	Pass intestine bleeding tube	1.67	000
91105		A	Gastric intubation treatment	0.85	000
91122		A	Anal pressure record	3.62	000
91122	26	A	Anal pressure record	2.90	000
91122	TC	A	Anal pressure record	0.72	000
92002		A	Eye exam, new patient	1.51	XXX
92004		A	Eye exam, new patient	2.19	XXX
92012		A	Eye exam established pt	1.27	XXX
92014		A	Eye exam and treatment	1.61	XXX
92015		A	Refraction	0.71	XXX
92018		A	New eye exam and treatment	2.00	XXX
92019		A	Eye exam and treatment	1.80	XXX
92020		A	Special eye evaluation	0.66	XXX
92060		A	Special eye evaluation	0.90	XXX
92060	26	A	Special eye evaluation	0.71	XXX
92060	TC	A	Special eye evaluation	0.18	XXX
92065		A	Orthoptic/pleoptic training	0.73	XXX
92065	26	A	Orthoptic/pleoptic training	0.57	XXX
92065	TC	A	Orthoptic/pleoptic training	0.16	XXX
92070		A	Fitting of contact lens	1.92	XXX
92081		A	Visual field examination(s)	0.68	XXX
92081	26	A	Visual field examination(s)	0.53	XXX
92081	TC	A	Visual field examination(s)	0.15	XXX
92082		A	Visual field examination(s)	0.94	XXX
92082	26	A	Visual field examination(s)	0.74	XXX
92082	TC	A	Visual field examination(s)	0.19	XXX
92083		A	Visual field examination(s)	1.34	XXX
92083	26	A	Visual field examination(s)	1.06	XXX
92083	TC	A	Visual field examination(s)	0.28	XXX
92100		A	Serial tonometry exam(s)	1.18	XXX
92120		A	Tonography and eye evaluation	1.13	XXX

92130		A	Water provocation tonography	1.31	XXX
92140		A	Glaucoma provocative tests	0.80	XXX
92225		A	Special eye exam, initial	1.04	XXX
92226		A	Special eye exam, subsequent	0.91	XXX
92230		A	Eye exam with photos	1.31	XXX
92235		A	Eye exam with photos	2.42	XXX
92235	26	A	Eye exam with photos	1.41	XXX
92235	TC	A	Eye exam with photos	1.01	XXX
92250		A	Eye exam with photos	0.87	XXX
92250	26	A	Eye exam with photos	0.69	XXX
92250	TC	A	Eye exam with photos	0.17	XXX
92260		A	Ophthalmoscopy/dynamometry	1.05	XXX
92265		A	Eye muscle evaluation	1.11	XXX
92265	26	A	Eye muscle evaluation	0.88	XXX
92265	TC	A	Eye muscle evaluation	0.23	XXX
92270		A	Electro–oculography	1.50	XXX
92270	26	A	Electro–oculography	1.20	XXX
92270	TC	A	Electro–oculography	0.31	XXX
92275		A	Electroretinography	1.93	XXX
92275	26	A	Electroretinography	1.53	XXX
92275	TC	A	Electroretinography	0.40	XXX
92280		A	Special eye evaluation	1.20	XXX
92280	26	A	Special eye evaluation	0.95	XXX
92280	TC	A	Special eye evaluation	0.25	XXX
92283		A	Color vision examination	0.55	XXX
92283	26	A	Color vision examination	0.43	XXX
92283	TC	A	Color vision examination	0.12	XXX
92284		A	Dark adaptation eye exam	0.83	XXX
92284	26	A	Dark adaptation eye exam	0.65	XXX
92284	TC	A	Dark adaptation eye exam	0.17	XXX
92285		A	Eye photography	0.49	XXX
92285	26	A	Eye photography	0.38	XXX
92285	TC	A	Eye photography	0.11	XXX
92286		A	Internal eye photography	1.90	XXX
92286	26	A	Internal eye photography	1.51	XXX
92286	TC	A	Internal eye photography	0.40	XXX
92287		A	Internal eye photography	2.36	XXX
92310		A	Contact lens fitting	2.47	XXX
92311		A	Contact lens fitting	1.99	XXX
92312		A	Contact lens fitting	2.42	XXX
92313		A	Contact lens fitting	1.81	XXX
92314		A	Prescription of contact lens	1.46	XXX
92315		A	Prescription of contact lens	1.12	XXX
92316		A	Prescription of contact lens	1.64	XXX
92317		A	Prescription of contact lens	0.85	XXX
92325		A	Modification of contact lens	0.38	XXX
92326		A	Replacement of contact lens	1.57	XXX
92330		A	Fitting of artificial eye	2.25	XXX
92335		A	Fitting of artificial eye	2.46	XXX
92340		A	Fitting of spectacles	0.78	XXX
92341		A	Fitting of spectacles	0.99	XXX
92342		A	Fitting of spectacles	1.12	XXX
92352		A	Special spectacles fitting	0.67	XXX
92353		A	Special spectacles fitting	0.90	XXX
92354		A	Special spectacles fitting	8.33	XXX

92355		A	Special spectacles fitting	4.05	XXX
92358		A	Eye prosthesis service	0.93	XXX
92370		A	Repair and adjust spectacles	0.67	XXX
92371		A	Repair and adjust spectacles	0.59	XXX
92392		A	Supply of low vision aids	3.78	XXX
92393		A	Supply of artificial eye	12.16	XXX
92395		A	Supply of spectacles	1.35	XXX
92396		A	Supply of contact lenses	2.20	XXX
92502		A	Ear and throat examination	2.70	000
92504		A	Ear microscopy examination	0.45	XXX
92506		A	Speech and hearing evaluation	1.41	XXX
92507		A	Speech/hearing therapy	0.87	XXX
92508		A	Speech/hearing therapy	0.45	XXX
92511		A	Nasopharyngoscopy	1.74	000
92512		A	Nasal function studies	1.05	XXX
92516		A	Facial nerve function test	0.84	XXX
92520		A	Laryngeal function studies	1.32	XXX
92531		B	Spontaneous nystagmus study	0.00	XXX
92532		B	Positional nystagmus study	0.00	XXX
92533		B	Caloric vestibular test	0.00	XXX
92534		B	Optokinetic nystagmus	0.00	XXX
92541		A	Spontaneous nystagmus test	1.11	XXX
92541	26	A	Spontaneous nystagmus test	0.88	XXX
92541	TC	A	Spontaneous nystagmus test	0.23	XXX
92542		A	Positional nystagmus test	0.98	XXX
92542	26	A	Positional nystagmus test	0.71	XXX
92542	TC	A	Positional nystagmus test	0.27	XXX
92543		A	Caloric vestibular test	1.25	XXX
92543	26	A	Caloric vestibular test	0.83	XXX
92543	TC	A	Caloric vestibular test	0.42	XXX
92544		A	Optokinetic nystagmus test	0.76	XXX
92544	26	A	Optokinetic nystagmus test	0.55	XXX
92544	TC	A	Optokinetic nystagmus test	0.21	XXX
92545		A	Oscillating tracking test	0.65	XXX
92545	26	A	Oscillating tracking test	0.44	XXX
92545	TC	A	Oscillating tracking test	0.21	XXX
92546		A	Torsion swing recording	0.84	XXX
92546	26	A	Torsion swing recording	0.61	XXX
92546	TC	A	Torsion swing recording	0.24	XXX
92547		A	Supplemental electrical test	0.56	XXX
92552		A	Pure tone audiometry, air	0.44	XXX
92553		A	Audiometry, air and bone	0.66	XXX
92555		A	Speech threshold audiometry	0.38	XXX
92556		A	Speech audiometry, complete	0.57	XXX
92557		A	Comprehensive hearing test	1.19	XXX
92561		A	Bekesy audiometry, diagnosis	0.71	XXX
92562		A	Loudness balance test	0.41	XXX
92563		A	Tone decay hearing test	0.38	XXX
92564		A	SISI hearing test	0.47	XXX
92565		A	Stenger test, pure tone	0.40	XXX
92567		A	Tympanometry	0.53	XXX
92568		A	Acoustic reflex testing	0.38	XXX
92569		A	Acoustic reflex decay test	0.41	XXX
92571		A	Filtered speech hearing test	0.39	XXX
92572		A	Staggered spondaic word test	0.09	XXX

92573		A	Lombard test	0.35	XXX
92574		A	Swinging story test	1.20	XXX
92575		A	Sensorineural acuity test	0.30	XXX
92576		A	Synthetic sentence test	0.45	XXX
92577		A	Stenger test, speech	0.72	XXX
92578		A	Delayed auditory feedback	0.54	XXX
92580		A	Electrodermal audiometry	0.67	XXX
92582		A	Conditioning play audiometry	0.72	XXX
92583		A	Select picture audiometry	0.89	XXX
92584		A	Electrocochleography	2.48	XXX
92585		A	Brain stem evoked audiometry	3.89	XXX
92585	26	A	Brain stem evoked audiometry	2.06	XXX
92585	TC	A	Brain stem evoked audiometry	1.84	XXX
92587		A	Evoked auditory test	1.54	XXX
92587	26	A	Evoked auditory test	0.25	XXX
92587	TC	A	Evoked auditory test	1.30	XXX
92588		A	Evoked auditory test	2.13	XXX
92588	26	A	Evoked auditory test	0.67	XXX
92588	TC	A	Evoked auditory test	1.47	XXX
92589		A	Auditory function test(s)	0.54	XXX
92596		A	Ear protector evaluation	0.59	XXX
92950		A	Heart/lung resuscitation(CPR)	6.16	000
92953		A	Temporary external pacing	1.42	000
92960		A	Heart electroconversion	4.21	000
92970		A	Cardioassist, internal	7.21	000
92971		A	Cardioassist, external	2.92	000
92975		A	Dissolve clot, heart vessel	13.16	000
92977		A	Dissolve clot, heart vessel	7.88	XXX
92980		A	Insert intracoronary stent	31.80	000
92981		A	Insert intracoronary stent	9.88	ZZZ
92982		A	Coronary artery dilation	25.61	000
92984		A	Coronary artery dilation	7.51	ZZZ
92986		A	Revision of aortic valve	32.84	090
92990		A	Revision of pulmonary valve	26.17	090
92995		A	Coronary atherectomy	28.12	000
92996		A	Coronary atherectomy	7.96	ZZZ
93000		A	Electrocardiogram, complete	0.78	XXX
93005		A	Electrocardiogram, tracing	0.44	XXX
93010		A	Electrocardiogram report	0.33	XXX
93012		A	Transmission of ECG	2.35	XXX
93014		A	Report on transmitted ECG	0.95	XXX
93015		A	Cardiovascular stress test	3.20	XXX
93016		A	Cardiovascular stress test	0.85	XXX
93017		A	Cardiovascular stress test	1.65	XXX
93018		A	Cardiovascular stress test	0.69	XXX
93024		A	Cardiac drug stress test	3.84	XXX
93024	26	A	Cardiac drug stress test	2.73	XXX
93024	TC	A	Cardiac drug stress test	1.11	XXX
93040		A	Rhythm ECG with report	0.43	XXX
93041		A	Rhythm ECG, tracing	0.14	XXX
93042		A	Rhythm ECG, report	0.29	XXX
93201		A	Phonocardiogram and ECG lead	1.49	XXX
93202		A	Phonocardiogram and ECG lead	0.78	XXX
93204		A	Phonocardiogram and ECG lead	0.71	XXX
93205		A	Special phonocardiogram	1.37	XXX

93208		A	Special phonocardiogram	0.34	XXX
93209		A	Special phonocardiogram	1.03	XXX
93210		A	Intracardiac phonocardiogram	2.71	XXX
93210	26	A	Intracardiac phonocardiogram	1.77	XXX
93210	TC	A	Intracardiac phonocardiogram	0.94	XXX
93220		A	Vectorcardiogram	1.22	XXX
93221		A	Vectorcardiogram tracing	0.59	XXX
93222		A	Vectorcardiogram report	0.62	XXX
93224		A	ECG monitor/report, 24 hrs	4.60	XXX
93225		A	ECG monitor/record, 24 hrs	1.22	XXX
93226		A	ECG monitor/report, 24 hrs	2.14	XXX
93227		A	ECG monitor/review, 24 hrs	1.24	XXX
93230		A	ECG monitor/report, 24 hrs	4.98	XXX
93231		A	EXG monitor/record, 24 hrs	1.49	XXX
93232		A	ECG monitor/report, 24 hrs	2.13	XXX
93233		A	ECG monitor/review, 24 hrs	1.36	XXX
93235		A	ECG monitor/report, 24 hrs	3.71	XXX
93236		A	ECG monitor/report, 24 hrs	2.56	XXX
93237		A	ECG monitor/review, 24 hrs	1.15	XXX
93268		A	ECG record/review	4.52	XXX
93270		A	ECG recording	1.22	XXX
93271		A	ECG/monitoring and analysis	2.35	XXX
93272		A	ECG/review, interpret only	0.95	XXX
93278		A	ECG/signal–averaged	2.09	XXX
93278	26	A	ECG/signal–averaged	0.93	XXX
93278	TC	A	ECG/signal–averaged	1.16	XXX
93307		A	Echo exam of heart	5.61	XXX
93307	26	A	Echo exam of heart	1.82	XXX
93307	TC	A	Echo exam of heart	3.79	XXX
93308		A	Echo exam of heart	3.14	XXX
93308	26	A	Echo exam of heart	1.23	XXX
93308	TC	A	Echo exam of heart	1.91	XXX
93312		A	Echo exam of heart	6.73	XXX
93312	26	A	Echo exam of heart	2.98	XXX
93312	TC	A	Echo exam of heart	3.75	XXX
93313		A	Echo exam of heart	1.65	XXX
93314		A	Echo exam of heart	5.40	XXX
93314	26	A	Echo exam of heart	1.65	XXX
93314	TC	A	Echo exam of heart	3.75	XXX
93320		A	Doppler echo exam, heart	2.62	XXX
93320	26	A	Doppler echo exam, heart	0.93	XXX
93320	TC	A	Doppler echo exam, heart	1.68	XXX
93321		A	Doppler echo exam, heart	1.48	XXX
93321	26	A	Doppler echo exam, heart	0.38	XXX
93321	TC	A	Doppler echo exam, heart	1.10	XXX
93325		A	Doppler color flow	2.98	XXX
93325	26	A	Doppler color flow	0.12	XXX
93325	TC	A	Doppler color flow	2.86	XXX
93350		A	Echo exam of heart	4.50	XXX
93350	26	A	Echo exam of heart	2.76	XXX
93350	TC	A	Echo exam of heart	1.74	XXX
93501		A	Right heart catheterization	23.38	000
93501	26	A	Right heart catheterization	6.80	000
93501	TC	A	Right heart catheterization	16.58	000
93503		A	Insert/place heart catheter	5.01	000

93505		A	Biopsy of heart lining	9.71	000
93505	26	A	Biopsy of heart lining	7.74	000
93505	TC	A	Biopsy of heart lining	1.97	000
93510		A	Left heart catheterization	43.76	000
93510	26	A	Left heart catheterization	7.50	000
93510	TC	A	Left heart catheterization	36.26	000
93511		A	Left heart catheterization	43.05	000
93511	26	A	Left heart catheterization	7.76	000
93511	TC	A	Left heart catheterization	35.30	000
93514		A	Left heart catheterization	47.10	000
93514	26	A	Left heart catheterization	11.80	000
93514	TC	A	Left heart catheterization	35.30	000
93524		A	Left heart catheterization	57.89	000
93524	26	A	Left heart catheterization	11.77	000
93524	TC	A	Left heart catheterization	46.12	000
93526		A	Rt and Lt heart catheters	59.01	000
93526	26	A	Rt and Lt heart catheters	11.62	000
93526	TC	A	Rt and Lt heart catheters	47.39	000
93527		A	Rt and Lt heart catheters	60.77	000
93527	26	A	Rt and Lt heart catheters	14.64	000
93527	TC	A	Rt and Lt heart catheters	46.12	000
93528		A	Rt and Lt heart catheters	59.73	000
93528	26	A	Rt and Lt heart catheters	13.61	000
93528	TC	A	Rt and Lt heart catheters	46.12	000
93529		A	Rt, Lt heart catheterization	53.96	000
93529	26	A	Rt, Lt heart catheterization	7.84	000
93529	TC	A	Rt, Lt heart catheterization	46.12	000
93536		A	Insert circulation assist	11.60	000
93539		A	Injection, cardiac cath	1.86	000
93540		A	Injection, cardiac cath	2.00	000
93541		A	Injection for lung angiogram	1.55	000
93542		A	Injection for heart X–rays	1.55	000
93543		A	Injection for heart X–rays	1.23	000
93544		A	Injection for aortography	1.22	000
93545		A	Injection for coronary X–rays	2.19	000
93555		A	Imaging, cardiac cath	7.22	XXX
93555	26	A	Imaging, cardiac cath	1.11	XXX
93555	TC	A	Imaging, cardiac cath	6.11	XXX
93556		A	Imaging, cardiac cath	10.95	XXX
93556	26	A	Imaging, cardiac cath	1.32	XXX
93556	TC	A	Imaging, cardiac cath	9.62	XXX
93561		A	Cardiac output measurement	2.49	000
93561	26	A	Cardiac output measurement	1.95	000
93561	TC	A	Cardiac output measurement	0.54	000
93562		A	Cardiac output measurement	1.18	000
93562	26	A	Cardiac output measurement	0.86	000
93562	TC	A	Cardiac output measurement	0.32	000
93600		A	Bundle of His recording	6.86	000
93600	26	A	Bundle of His recording	4.95	000
93600	TC	A	Bundle of His recording	1.92	000
93602		A	Intra–atrial recording	5.05	000
93602	26	A	Intra–atrial recording	3.96	000
93602	TC	A	Intra–atrial recording	1.09	000
93603		A	Right ventricular recording	6.03	000
93603	26	A	Right ventricular recording	4.38	000

93603	TC	A	Right ventricular recording	1.65	000
93607		A	Right ventricular recording	7.02	000
93607	26	A	Right ventricular recording	5.55	000
93607	TC	A	Right ventricular recording	1.46	000
93609		A	Mapping of tachycardia	16.73	000
93609	26	A	Mapping of tachycardia	14.07	000
93609	TC	A	Mapping of tachycardia	2.66	000
93610		A	Intra–atrial pacing	6.74	000
93610	26	A	Intra–atrial pacing	5.41	000
93610	TC	A	Intra–atrial pacing	1.33	000
93612		A	Intraventricular pacing	7.03	000
93612	26	A	Intraventricular pacing	5.44	000
93612	TC	A	Intraventricular pacing	1.59	000
93615		A	Esophageal recording	1.66	000
93615	26	A	Esophageal recording	1.35	000
93615	TC	A	Esophageal recording	0.31	000
93616		A	Esophageal recording	3.19	000
93616	26	A	Esophageal recording	2.88	000
93616	TC	A	Esophageal recording	0.31	000
93618		A	Heart rhythm pacing	13.81	000
93618	26	A	Heart rhythm pacing	9.92	000
93618	TC	A	Heart rhythm pacing	3.89	000
93619		A	Electrophysiology evaluation	24.87	000
93619	26	A	Electrophysiology evaluation	17.32	000
93619	TC	A	Electrophysiology evaluation	7.55	000
93620		A	Electrophysiology evaluation	34.30	000
93620	26	A	Electrophysiology evaluation	25.54	000
93620	TC	A	Electrophysiology evaluation	8.77	000
93621	26	A	Electrophysiology evaluation	28.10	000
93622	26	A	Electrophysiology evaluation	27.96	000
93623	26	A	Stimulation, pacing heart	5.72	000
93624		A	Electrophysiologic study	9.85	000
93624	26	A	Electrophysiologic study	7.90	000
93624	TC	A	Electrophysiologic study	1.94	000
93631		A	Heart pacing, mapping	19.94	000
93631	26	A	Heart pacing, mapping	13.73	000
93631	TC	A	Heart pacing, mapping	6.21	000
93640		A	Evaluation heart device	16.67	000
93640	26	A	Evaluation heart device	9.65	000
93640	TC	A	Evaluation heart device	7.02	000
93641		A	Electrophysiology evaluation	20.26	000
93641	26	A	Electrophysiology evaluation	13.23	000
93641	TC	A	Electrophysiology evaluation	7.02	000
93642		A	Electrophysiology evaluation	18.70	000
93642	26	A	Electrophysiology evaluation	11.68	000
93642	TC	A	Electrophysiology evaluation	7.02	000
93650		A	Ablate heart dysrhythm focus	25.34	000
93651		A	Ablate heart dysrhythm focus	34.69	000
93652		A	Ablate heart dysrhythm focus	36.13	000
93660	26	A	Tilt table evaluation	3.42	000
93720		A	Total body plethysmography	1.13	XXX
93721		A	Plethysmography tracing	0.70	XXX
93722		A	Plethysmography report	0.43	XXX
93724		A	Analyze pacemaker system	11.77	000
93724	26	A	Analyze pacemaker system	7.88	000

93724	TC	A	Analyze pacemaker system	3.89	000
93731		A	Analyze pacemaker system	1.27	XXX
93731	26	A	Analyze pacemaker system	0.79	XXX
93731	TC	A	Analyze pacemaker system	0.49	XXX
93732		A	Analyze pacemaker system	1.87	XXX
93732	26	A	Analyze pacemaker system	1.36	XXX
93732	TC	A	Analyze pacemaker system	0.51	XXX
93733		A	Telephone analysis, pacemaker	1.12	XXX
93733	26	A	Telephone analysis, pacemaker	0.40	XXX
93733	TC	A	Telephone analysis, pacemaker	0.72	XXX
93734		A	Analyze pacemaker system	1.05	XXX
93734	26	A	Analyze pacemaker system	0.71	XXX
93734	TC	A	Analyze pacemaker system	0.34	XXX
93735		A	Analyze pacemaker system	1.63	XXX
93735	26	A	Analyze pacemaker system	1.19	XXX
93735	TC	A	Analyze pacemaker system	0.44	XXX
93736		A	Telephone analysis, pacemaker	1.01	XXX
93736	26	A	Telephone analysis, pacemaker	0.39	XXX
93736	TC	A	Telephone analysis, pacemaker	0.63	XXX
93737		A	Analyze cardio/defibrillator	1.22	XXX
93737	26	A	Analyze cardio/defibrillator	0.73	XXX
93737	TC	A	Analyze cardio/defibrillator	0.49	XXX
93738		A	Analyze cardio/defibrillator	1.83	XXX
93738	26	A	Analyze cardio/defibrillator	1.33	XXX
93738	TC	A	Analyze cardio/defibrillator	0.51	XXX
93740		A	Temperature gradient studies	0.63	XXX
93740	26	A	Temperature gradient studies	0.47	XXX
93740	TC	A	Temperature gradient studies	0.15	XXX
93770		A	Measure venous pressure	0.37	XXX
93770	26	A	Measure venous pressure	0.34	XXX
93770	TC	A	Measure venous pressure	0.03	XXX
93797		A	Cardiac rehab	0.49	000
93798		A	Cardiac rehab/monitor	0.77	000
93875		A	Extracranial study	1.75	XXX
93875	26	A	Extracranial study	0.64	XXX
93875	TC	A	Extracranial study	1.11	XXX
93880		A	Extracranial study	4.76	XXX
93880	26	A	Extracranial study	1.01	XXX
93880	TC	A	Extracranial study	3.75	XXX
93882		A	Extracranial study	3.16	XXX
93882	26	A	Extracranial study	0.68	XXX
93882	TC	A	Extracranial study	2.49	XXX
93886		A	Intracranial study	5.63	XXX
93886	26	A	Intracranial study	1.39	XXX
93886	TC	A	Intracranial study	4.24	XXX
93888		A	Intracranial study	3.75	XXX
93888	26	A	Intracranial study	0.92	XXX
93888	TC	A	Intracranial study	2.83	XXX
93922		A	Extremity study	1.74	XXX
93922	26	A	Extremity study	0.57	XXX
93922	TC	A	Extremity study	1.17	XXX
93923		A	Extremity study	3.26	XXX
93923	26	A	Extremity study	1.05	XXX
93923	TC	A	Extremity study	2.21	XXX
93924		A	Extremity study	3.56	XXX

93924	26	A	Extremity study	1.15	XXX
93924	TC	A	Extremity study	2.41	XXX
93925		A	Lower extremity study	4.76	XXX
93925	26	A	Lower extremity study	0.99	XXX
93925	TC	A	Lower extremity study	3.77	XXX
93926		A	Lower extremity study	3.18	XXX
93926	26	A	Lower extremity study	0.67	XXX
93926	TC	A	Lower extremity study	2.51	XXX
93930		A	Upper extremity study	4.87	XXX
93930	26	A	Upper extremity study	0.88	XXX
93930	TC	A	Upper extremity study	3.99	XXX
93931		A	Upper extremity study	3.24	XXX
93931	26	A	Upper extremity study	0.59	XXX
93931	TC	A	Upper extremity study	2.66	XXX
93965		A	Extremity study	1.94	XXX
93965	26	A	Extremity study	0.83	XXX
93965	TC	A	Extremity study	1.11	XXX
93970		A	Extremity study	5.27	XXX
93970	26	A	Extremity study	1.11	XXX
93970	TC	A	Extremity study	4.16	XXX
93971		A	Extremity study	3.51	XXX
93971	26	A	Extremity study	0.74	XXX
93971	TC	A	Extremity study	2.77	XXX
93975		A	Vascular study	6.98	XXX
93975	26	A	Vascular study	2.25	XXX
93975	TC	A	Vascular study	4.72	XXX
93976		A	Vascular study	4.67	XXX
93976	26	A	Vascular study	1.51	XXX
93976	TC	A	Vascular study	3.16	XXX
93978		A	Vascular study	4.95	XXX
93978	26	A	Vascular study	1.07	XXX
93978	TC	A	Vascular study	3.88	XXX
93979		A	Vascular study	3.30	XXX
93979	26	A	Vascular study	0.72	XXX
93979	TC	A	Vascular study	2.58	XXX
93980		A	Penile vascular study	6.20	XXX
93980	26	A	Penile vascular study	2.68	XXX
93980	TC	A	Penile vascular study	3.52	XXX
93981		A	Penile vascular study	4.30	XXX
93981	26	A	Penile vascular study	1.06	XXX
93981	TC	A	Penile vascular study	3.25	XXX
93990		A	Doppler flow testing	2.96	XXX
93990	26	A	Doppler flow testing	0.45	XXX
93990	TC	A	Doppler flow testing	2.51	XXX
94010		A	Breathing capacity test	0.87	XXX
94010	26	A	Breathing capacity test	0.46	XXX
94010	TC	A	Breathing capacity test	0.41	XXX
94060		A	Evaluation of wheezing	1.62	XXX
94060	26	A	Evaluation of wheezing	0.70	XXX
94060	TC	A	Evaluation of wheezing	0.91	XXX
94070		A	Evaluation of wheezing	2.42	XXX
94070	26	A	Evaluation of wheezing	1.00	XXX
94070	TC	A	Evaluation of wheezing	1.43	XXX
94150		A	Vital capacity test	0.32	XXX
94150	26	A	Vital capacity test	0.23	XXX

94150	TC	A	Vital capacity test	0.09	XXX
94160		A	Vital capacity screening	0.56	XXX
94160	26	A	Vital capacity screening	0.37	XXX
94160	TC	A	Vital capacity screening	0.18	XXX
94200		A	Lung function test (MBC/MVV)	0.50	XXX
94200	26	A	Lung function test (MBC/MVV)	0.25	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.25	XXX
94240		A	Residual lung capacity	1.17	XXX
94240	26	A	Residual lung capacity	0.50	XXX
94240	TC	A	Residual lung capacity	0.67	XXX
94250		A	Expired gas collection	0.39	XXX
94250	26	A	Expired gas collection	0.25	XXX
94250	TC	A	Expired gas collection	0.13	XXX
94260		A	Thoracic gas volume	0.88	XXX
94260	26	A	Thoracic gas volume	0.34	XXX
94260	TC	A	Thoracic gas volume	0.54	XXX
94350		A	Lung nitrogen washout curve	1.01	XXX
94350	26	A	Lung nitrogen washout curve	0.47	XXX
94350	TC	A	Lung nitrogen washout curve	0.54	XXX
94360		A	Measure airflow resistance	1.40	XXX
94360	26	A	Measure airflow resistance	0.45	XXX
94360	TC	A	Measure airflow resistance	0.94	XXX
94370		A	Breath airway closing volume	0.67	XXX
94370	26	A	Breath airway closing volume	0.41	XXX
94370	TC	A	Breath airway closing volume	0.27	XXX
94375		A	Respiratory flow volume loop	0.99	XXX
94375	26	A	Respiratory flow volume loop	0.52	XXX
94375	TC	A	Respiratory flow volume loop	0.47	XXX
94400		A	CO2 breathing response curve	1.28	XXX
94400	26	A	CO2 breathing response curve	0.95	XXX
94400	TC	A	CO2 breathing response curve	0.33	XXX
94450		A	Hypoxia response curve	1.03	XXX
94450	26	A	Hypoxia response curve	0.65	XXX
94450	TC	A	Hypoxia response curve	0.38	XXX
94620		A	Pulmonary stress testing	2.99	XXX
94620	26	A	Pulmonary stress testing	1.60	XXX
94620	TC	A	Pulmonary stress testing	1.39	XXX
94640		A	Airway inhalation treatment	0.40	XXX
94650		A	Pressure breathing (IPPB)	0.38	XXX
94651		A	Pressure breathing (IPPB)	0.37	XXX
94652		A	Pressure breathing (IPPB)	0.46	XXX
94656		A	Initial ventilator mgmt	2.41	XXX
94657		A	Cont. ventilator	1.47	XXX
94660		A	Pos airway pressure, CPAP	1.50	XXX
94662		A	Neg pressure ventilation, CNP	1.07	XXX
94664		A	Aerosol or vapor inhalations	0.52	XXX
94665		A	Aerosol or vapor inhalations	0.48	XXX
94667		A	Chest wall manipulation	0.57	XXX
94668		A	Chest wall manipulation	0.35	XXX
94680		A	Exhaled air analysis: O2	1.13	XXX
94680	26	A	Exhaled air analysis: O2	0.60	XXX
94680	TC	A	Exhaled air analysis: O2	0.53	XXX
94681		A	Exhaled air analysis: O2, CO2	1.92	XXX
94681	26	A	Exhaled air analysis: O2, CO2	0.54	XXX
94681	TC	A	Exhaled air analysis: O2, CO2	1.38	XXX

94690		A	Exhaled air analysis	0.65	XXX
94690	26	A	Exhaled air analysis	0.12	XXX
94690	TC	A	Exhaled air analysis	0.53	XXX
94720		A	Monoxide diffusing capacity	1.32	XXX
94720	26	A	Monoxide diffusing capacity	0.50	XXX
94720	TC	A	Monoxide diffusing capacity	0.82	XXX
94725		A	Membrane diffusion capacity	2.16	XXX
94725	26	A	Membrane diffusion capacity	0.44	XXX
94725	TC	A	Membrane diffusion capacity	1.71	XXX
94750		A	Pulmonary compliance study	1.08	XXX
94750	26	A	Pulmonary compliance study	0.52	XXX
94750	TC	A	Pulmonary compliance study	0.57	XXX
94760		A	Measure blood oxygen level	0.26	XXX
94761		A	Measure blood oxygen level	0.67	XXX
94762		A	Measure blood oxygen level	1.12	XXX
94770		A	Exhaled carbon dioxide test	0.67	XXX
94770	26	A	Exhaled carbon dioxide test	0.33	XXX
94770	TC	A	Exhaled carbon dioxide test	0.34	XXX
95004		A	Allergy skin tests	0.09	XXX
95010		A	Sensitivity skin tests	0.27	XXX
95015		A	Sensitivity skin tests	0.27	XXX
95024		A	Allergy skin tests	0.14	XXX
95027		A	Skin end point titration	0.14	XXX
95028		A	Allergy skin tests	0.22	XXX
95044		A	Allergy patch tests	0.19	XXX
95052		A	Photo patch test	0.24	XXX
95056		A	Photosensitivity tests	0.17	XXX
95060		A	Eye allergy tests	0.34	XXX
95065		A	Nose allergy test	0.19	XXX
95070		A	Bronchial allergy tests	2.14	XXX
95071		A	Bronchial allergy tests	2.73	XXX
95075		A	Ingestion challenge test	2.90	XXX
95078		A	Provocative testing	0.25	XXX
95115		A	Immunotherapy, one injection	0.38	XXX
95117		A	Immunotherapy injections	0.48	XXX
95144		A	Antigen therapy services	0.19	XXX
95145		A	Antigen therapy services	0.41	XXX
95146		A	Antigen therapy services	0.68	XXX
95147		A	Antigen therapy services	0.97	XXX
95148		A	Antigen therapy services	0.97	XXX
95149		A	Antigen therapy services	1.20	XXX
95165		A	Antigen therapy services	0.16	XXX
95170		A	Antigen therapy services	0.42	XXX
95180		A	Rapid desensitization	2.16	XXX
95805		A	Multiple sleep latency test	7.59	XXX
95805	26	A	Multiple sleep latency test	2.49	XXX
95805	TC	A	Multiple sleep latency test	5.10	XXX
95807		A	Sleep study	8.65	XXX
95807	26	A	Sleep study	3.54	XXX
95807	TC	A	Sleep study	5.10	XXX
95808		A	Polysomnography, 1–3	9.64	XXX
95808	26	A	Polysomnography, 1–3	4.54	XXX
95808	TC	A	Polysomnography, 1–3	5.10	XXX
95810		A	Polysomnography, 4 or more	10.53	XXX
95810	26	A	Polysomnography, 4 or more	5.42	XXX

95810	TC	A	Polysomnography, 4 or more	5.10	XXX
95812		A	Electroencephalogram (EEG)	3.00	XXX
95812	26	A	Electroencephalogram (EEG)	1.60	XXX
95812	TC	A	Electroencephalogram (EEG)	1.40	XXX
95813		A	Electroencephalogram (EEG)	3.65	XXX
95813	26	A	Electroencephalogram (EEG)	2.26	XXX
95813	TC	A	Electroencephalogram (EEG)	1.40	XXX
95816		A	Electroencephalogram (EEG)	2.68	XXX
95816	26	A	Electroencephalogram (EEG)	1.38	XXX
95816	TC	A	Electroencephalogram (EEG)	1.30	XXX
95819		A	Electroencephalogram (EEG)	2.94	XXX
95819	26	A	Electroencephalogram (EEG)	1.60	XXX
95819	TC	A	Electroencephalogram (EEG)	1.34	XXX
95822		A	Sleep electroencephalogram	3.44	XXX
95822	26	A	Sleep electroencephalogram	1.66	XXX
95822	TC	A	Sleep electroencephalogram	1.78	XXX
95824		A	Electroencephalography	1.75	XXX
95824	26	A	Electroencephalography	1.34	XXX
95824	TC	A	Electroencephalography	0.41	XXX
95827		A	Night electroencephalogram	4.24	XXX
95827	26	A	Night electroencephalogram	1.99	XXX
95827	TC	A	Night electroencephalogram	2.25	XXX
95829		A	Surgery electrocorticogram	6.85	XXX
95829	26	A	Surgery electrocorticogram	6.70	XXX
95829	TC	A	Surgery electrocorticogram	0.15	XXX
95830		A	Insert electrodes for EEG	2.52	XXX
95831		A	Limb muscle testing, manual	0.59	XXX
95832		A	Hand muscle testing, manual	0.55	XXX
95833		A	Body muscle testing, manual	0.88	XXX
95834		A	Body muscle testing, manual	1.24	XXX
95851		A	Range of motion measurements	0.53	XXX
95852		A	Range of motion measurements	0.35	XXX
95857		A	Tensilon test	1.05	XXX
95858		A	Tensilon test and myogram	2.63	XXX
95858	26	A	Tensilon test and myogram	2.23	XXX
95858	TC	A	Tensilon test and myogram	0.40	XXX
95860		A	Muscle test, one limb	2.09	XXX
95860	26	A	Muscle test, one limb	1.72	XXX
95860	TC	A	Muscle test, one limb	0.37	XXX
95861		A	Muscle test, two limbs	3.58	XXX
95861	26	A	Muscle test, two limbs	2.86	XXX
95861	TC	A	Muscle test, two limbs	0.73	XXX
95863		A	Muscle test, three limbs	4.25	XXX
95863	26	A	Muscle test, three limbs	3.33	XXX
95863	TC	A	Muscle test, three limbs	0.92	XXX
95864		A	Muscle test, four limbs	5.56	XXX
95864	26	A	Muscle test, four limbs	3.81	XXX
95864	TC	A	Muscle test, four limbs	1.75	XXX
95867		A	Muscle test, head or neck	1.79	XXX
95867	26	A	Muscle test, head or neck	1.22	XXX
95867	TC	A	Muscle test, head or neck	0.57	XXX
95868		A	Muscle test, head or neck	3.49	XXX
95868	26	A	Muscle test, head or neck	2.81	XXX
95868	TC	A	Muscle test, head or neck	0.68	XXX
95869		A	Muscle test, limited	0.92	XXX

95869	26	A	Muscle test, limited	0.72	XXX
95869	TC	A	Muscle test, limited	0.21	XXX
95872		A	Muscle test, one fiber	2.81	XXX
95872	26	A	Muscle test, one fiber	2.21	XXX
95872	TC	A	Muscle test, one fiber	0.59	XXX
95875		A	Limb exercise test	2.00	XXX
95875	26	A	Limb exercise test	1.59	XXX
95875	TC	A	Limb exercise test	0.41	XXX
95880		A	Cerebral aphasia testing	1.78	XXX
95881		A	Cerebral developmental test	1.78	XXX
95882		A	Cognitive function testing	1.78	XXX
95883		A	Neuropsychological testing	1.78	XXX
95900		A	Motor nerve conduction test	1.06	XXX
95900	26	A	Motor nerve conduction test	0.79	XXX
95900	TC	A	Motor nerve conduction test	0.28	XXX
95904		A	Sense nerve conduction test	0.91	XXX
95904	26	A	Sense nerve conduction test	0.69	XXX
95904	TC	A	Sense nerve conduction test	0.22	XXX
95920		A	Intraoperative nerve testing	4.87	XXX
95920	26	A	Intraoperative nerve testing	3.60	XXX
95920	TC	A	Intraoperative nerve testing	1.27	XXX
95925		A	Somatosensory testing	3.17	XXX
95925	26	A	Somatosensory testing	1.81	XXX
95925	TC	A	Somatosensory testing	1.37	XXX
95933		A	Blink reflex test	1.88	XXX
95933	26	A	Blink reflex test	1.11	XXX
95933	TC	A	Blink reflex test	0.77	XXX
95935		A	""H" or "F" reflex study"	1.16	XXX
95935	26	A	""H" or "F" reflex study"	0.95	XXX
95935	TC	A	""H" or "F" reflex study"	0.21	XXX
95937		A	Neuromuscular junction test	1.40	XXX
95937	26	A	Neuromuscular junction test	1.07	XXX
95937	TC	A	Neuromuscular junction test	0.33	XXX
95950		A	Ambulatory EEG monitoring	9.02	XXX
95950	26	A	Ambulatory EEG monitoring	2.77	XXX
95950	TC	A	Ambulatory EEG monitoring	6.25	XXX
95951		A	EEG monitoring/video record	12.90	XXX
95951	26	A	EEG monitoring/video record	5.36	XXX
95951	TC	A	EEG monitoring/video record	7.53	XXX
95953		A	EEG monitoring/computer	10.60	XXX
95953	26	A	EEG monitoring/computer	4.35	XXX
95953	TC	A	EEG monitoring/computer	6.25	XXX
95954		A	EEG monitoring/giving drugs	4.92	XXX
95954	26	A	EEG monitoring/giving drugs	4.44	XXX
95954	TC	A	EEG monitoring/giving drugs	0.48	XXX
95955		A	EEG during surgery	4.06	XXX
95955	26	A	EEG during surgery	2.10	XXX
95955	TC	A	EEG during surgery	1.96	XXX
95956		A	EEG monitoring/cable/radio	10.89	XXX
95956	26	A	EEG monitoring/cable/radio	4.64	XXX
95956	TC	A	EEG monitoring/cable/radio	6.25	XXX
95957		A	EEG digital analysis	4.31	XXX
95957	26	A	EEG digital analysis	2.64	XXX
95957	TC	A	EEG digital analysis	1.67	XXX
95958		A	EEG monitoring/function test	9.41	XXX

95958	26	A	EEG monitoring/function test	7.69	XXX
95958	TC	A	EEG monitoring/function test	1.72	XXX
95961		A	Electrode stimulation, brain	5.73	XXX
95961	26	A	Electrode stimulation, brain	4.47	XXX
95961	TC	A	Electrode stimulation, brain	1.27	XXX
95962		A	Electrode stimulation, brain	5.98	XXX
95962	26	A	Electrode stimulation, brain	4.71	XXX
95962	TC	A	Electrode stimulation, brain	1.27	XXX
96400		A	Chemotherapy, (SC)/(IM)	0.13	XXX
96405		A	Intralesional chemo admin	0.91	000
96406		A	Intralesional chemo admin	1.38	000
96408		A	Chemotherapy, push technique	0.94	XXX
96410		A	Chemotherapy, infusion method	1.50	XXX
96412		A	Chemotherapy, infusion method	1.13	XXX
96414		A	Chemotherapy, infusion method	1.30	XXX
96420		A	Chemotherapy, push technique	1.23	XXX
96422		A	Chemotherapy, infusion method	1.21	XXX
96423		A	Chemotherapy, infusion method	0.47	XXX
96425		A	Chemotherapy, infusion method	1.39	XXX
96440		A	Chemotherapy, intracavitary	3.22	000
96445		A	Chemotherapy, intracavitary	3.23	000
96450		A	Chemotherapy, into CNS	2.79	000
96520		A	Pump refilling, maintenance	0.87	XXX
96530		A	Pump refilling, maintenance	1.04	XXX
96542		A	Chemotherapy injection	2.58	XXX
96545		B	Provide chemotherapy agent	0.00	XXX
96900		A	Ultraviolet light therapy	0.39	XXX
96910		A	Photo chemotherapy with UV–B	0.57	XXX
96912		A	Photo chemotherapy with UV–A	0.65	XXX
96913		A	Photo chemotherapy, UV–A or B	1.33	XXX
98925		A	Osteopathic manipulation	0.71	000
98926		A	Osteopathic manipulation	1.07	000
98927		A	Osteopathic manipulation	1.27	000
98928		A	Osteopathic manipulation	1.47	000
98929		A	Osteopathic manipulation	1.60	000
99000		B	Specimen handling	0.00	XXX
99001		B	Specimen handling	0.00	XXX
99002		B	Device handling	0.00	XXX
99024		B	Postop follow–up visit	0.00	XXX
99025		B	Initial surgical evaluation	0.00	XXX
99050		B	Medical services after hrs	0.00	XXX
99052		B	Medical services at night	0.00	XXX
99054		B	Medical services, unusual hrs	0.00	XXX
99056		B	Nonoffice medical services	0.00	XXX
99058		B	Office emergency care	0.00	XXX
99070		B	Special supplies	0.00	XXX
99071		B	Patient education materials	0.00	XXX
99078		B	Group health education	0.00	XXX
99080		B	Special reports or forms	0.00	XXX
99090		B	Computer data analysis	0.00	XXX
99100		B	Special anesthesia service	0.00	XXX
99116		B	Anesthesia with hypothermia	0.00	XXX
99135		B	Special anesthesia procedure	0.00	XXX
99140		B	Emergency anesthesia	0.00	XXX
99175		A	Induction of vomiting	1.37	XXX

99183	A	Hyperbaric oxygen therapy	4.06	XXX
99185	A	Regional hypothermia	0.62	XXX
99186	A	Total body hypothermia	2.02	XXX
99195	A	Phlebotomy	0.43	XXX
99201	A	Office/outpatient visit, new	0.77	XXX
99202	A	Office/outpatient visit, new	1.23	XXX
99203	A	Office/outpatient visit, new	1.70	XXX
99204	A	Office/outpatient visit, new	2.54	XXX
99205	A	Office/outpatient visit, new	3.18	XXX
99211	A	Office/outpatient visit, est	0.37	XXX
99212	A	Office/outpatient visit, est	0.67	XXX
99213	A	Office/outpatient visit, est	0.95	XXX
99214	A	Office/outpatient visit, est	1.46	XXX
99215	A	Office/outpatient visit, est	2.31	XXX
99217	A	Observation care discharge	1.63	XXX
99218	A	Observation care	1.79	XXX
99219	A	Observation care	2.85	XXX
99220	A	Observation care	3.60	XXX
99221	A	Initial hospital care	1.76	XXX
99222	A	Initial hospital care	2.93	XXX
99223	A	Initial hospital care	3.74	XXX
99231	A	Subsequent hospital care	0.90	XXX
99232	A	Subsequent hospital care	1.35	XXX
99233	A	Subsequent hospital care	1.88	XXX
99238	A	Hospital discharge day	1.59	XXX
99241	A	Office consultation	1.22	XXX
99242	A	Office consultation	1.93	XXX
99243	A	Office consultation	2.49	XXX
99244	A	Office consultation	3.52	XXX
99245	A	Office consultation	4.74	XXX
99251	A	Initial inpatient consult	1.25	XXX
99252	A	Initial inpatient consult	1.94	XXX
99253	A	Initial inpatient consult	2.57	XXX
99254	A	Initial inpatient consult	3.53	XXX
99255	A	Initial inpatient consult	4.79	XXX
99261	A	Follow–up inpatient consult	0.71	XXX
99262	A	Follow–up inpatient consult	1.22	XXX
99263	A	Follow–up inpatient consult	1.85	XXX
99271	A	Confirmatory consultation	1.07	XXX
99272	A	Confirmatory consultation	1.60	XXX
99273	A	Confirmatory consultation	2.27	XXX
99274	A	Confirmatory consultation	3.01	XXX
99275	A	Confirmatory consultation	4.14	XXX
99281	A	Emergency dept visit	0.56	XXX
99282	A	Emergency dept visit	0.86	XXX
99283	A	Emergency dept visit	1.58	XXX
99284	A	Emergency dept visit	2.41	XXX
99285	A	Emergency dept visit	3.80	XXX
99288	B	Direct advanced life support	0.00	XXX
99291	A	Critical care, first hour	5.13	XXX
99292	A	Critical care, add'l 30 min	2.49	XXX
99295	A	Neonatal critical care	22.13	XXX
99296	A	Neonatal critical care	10.37	XXX
99297	A	Neonatal critical care	5.32	XXX
99301	A	Nursing facility care	1.54	XXX

99302	A	Nursing facility care	2.19	XXX
99303	A	Nursing facility care	3.28	XXX
99311	A	Nursing facility care, subseq	0.90	XXX
99312	A	Nursing facility care, subseq	1.32	XXX
99313	A	Nursing facility care, subseq	1.67	XXX
99321	A	Rest home visit, new patient	1.10	XXX
99322	A	Rest home visit, new patient	1.55	XXX
99323	A	Rest home visit, new patient	2.04	XXX
99331	A	Rest home visit, established pat.	0.89	XXX
99332	A	Rest home visit, established pat.	1.18	XXX
99333	A	Rest home visit, established pat.	1.45	XXX
99341	A	Home visit, new patient	1.68	XXX
99342	A	Home visit, new patient	2.21	XXX
99343	A	Home visit, new patient	2.89	XXX
99351	A	Home visit, established patient	1.30	XXX
99352	A	Home visit, established patient	1.67	XXX
99353	A	Home visit, established patient	2.12	XXX
99354	A	Prolonged service, office	2.31	XXX
99355	A	Prolonged service, office	2.31	XXX
99356	A	Prolonged service, inpatient	2.33	XXX
99357	A	Prolonged service, inpatient	2.33	XXX
99358	B	Prolonged serv, w/o contact	0.00	XXX
99359	B	Prolonged serv, w/o contact	0.00	XXX
99361	B	Physician/team conference	0.00	XXX
99362	B	Physician/team conference	0.00	XXX
99371	B	Physician phone consultation	0.00	XXX
99372	B	Physician phone consultation	0.00	XXX
99373	B	Physician phone consultation	0.00	XXX
99375	A	Care plan oversight/30–60	1.59	XXX
99376	B	Care plan oversight/over 60	0.00	XXX
99381	A	Preventive visit, new, infant	2.45	XXX
99382	A	Preventive visit, new, age 1–4	2.81	XXX
99383	A	Preventive visit, new, age 5–11	2.81	XXX
99384	A	Preventive visit, new, 12–17	3.16	XXX
99385	A	Preventive visit, new, 18–39	2.97	XXX
99386	A	Preventive visit, new, 40–64	3.64	XXX
99387	A	Prevent. visit, new, 65 and over	3.99	XXX
99391	A	Preventive visit, est, infant	2.11	XXX
99392	A	Preventive visit, est, age 1–4	2.45	XXX
99393	A	Preventive visit, est, age 5–11	2.45	XXX
99394	A	Preventive visit, est, 12–17	2.81	XXX
99395	A	Preventive visit, est, 18–39	2.64	XXX
99396	A	Preventive visit, est, 40–64	2.97	XXX
99397	A	Prev. visit, est, 65 and over	3.31	XXX
99401	A	Preventive counseling, individual	0.94	XXX
99402	A	Preventive counseling, individual	1.89	XXX
99403	A	Preventive counseling, individual	2.83	XXX
99404	A	Preventive counseling, individual	3.78	XXX
99431	A	Initial care, normal newborn	2.41	XXX
99432	A	Newborn care not in hospital	2.60	XXX
99433	A	Normal newborn care, hospital	1.28	XXX
99440	A	Newborn resuscitation	6.05	XXX

H. Procedure code numbers A4190 to V2520 relate to miscellaneous services and supplies.

CPT/ HCPCS Procedure Code	Tech/ Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
A4190		P	Transparent film each	0.00	XXX
A4200		P	Gauze pad medicated/nonmedical	0.00	XXX
A4202		P	Elastic gauze roll	0.00	XXX
A4203		P	Nonelastic gauze roll	0.00	XXX
A4204		P	Absorptive dressing	0.00	XXX
A4205		P	Nonabsorptive dressing	0.00	XXX
A4206		P	1 CC sterile syringe and needle	0.00	XXX
A4207		P	2 CC sterile syringe and needle	0.00	XXX
A4208		P	3 CC sterile syringe and needle	0.00	XXX
A4209		P	5+ CC sterile syringe and needle	0.00	XXX
A4211		P	Supp. for self administered inj.	0.00	XXX
A4212		P	Noncoring needle or stylet	0.00	XXX
A4213		P	20+ CC syringe only	0.00	XXX
A4214		P	30 CC sterile water/saline	0.00	XXX
A4215		P	Sterile needle	0.00	XXX
A4220		P	Infusion pump refill kit	0.00	XXX
A4244		P	Alcohol or peroxide per pint	0.00	XXX
A4245		P	Alcohol wipes per box	0.00	XXX
A4246		P	Betadine/pHisoHex solution	0.00	XXX
A4247		P	Betadine/iodine swabs/wipes	0.00	XXX
A4253		P	Blood glucose/reagent strips	0.00	XXX
A4256		P	Calibrator solution/chips	0.00	XXX
A4259		P	Lancets per box	0.00	XXX
A4262		B	Temporary tear duct plug	0.00	XXX
A4263		A	Permanent tear duct plug	0.93	XXX
A4265		P	Paraffin	0.00	XXX
A4270		B	Disposable endoscope sheath	0.00	XXX
A4300		A	Catheter impl vasc access portal	0.93	XXX
A4305		P	Drug delivery system >=50 ML	0.00	XXX
A4306		P	Drug delivery system <=5 ML	0.00	XXX
A4310		P	Insert tray without bag/catheter	0.00	XXX
A4311		P	Catheter without bag 2–way latex	0.00	XXX
A4312		P	Catheter without bag 2–way silic.	0.00	XXX
A4313		P	Catheter with bag 3–way	0.00	XXX
A4314		P	Catheter w/drainage 2–way latex	0.00	XXX
A4315		P	Catheter w/drainage 2–way silic.	0.00	XXX
A4316		P	Catheter with drainage 3–way	0.00	XXX
A4320		P	Irrigation tray	0.00	XXX
A4322		P	Irrigation syringe	0.00	XXX
A4323		P	Saline irrigation solution	0.00	XXX
A4326		P	Male external catheter	0.00	XXX
A4327		P	Female urinary collect dev. cup	0.00	XXX
A4328		P	Female urinary collect pouch	0.00	XXX
A4329		P	External catheter start set	0.00	XXX
A4330		P	Stool collection pouch	0.00	XXX

A4335	P	Incontinence supply	0.00	XXX
A4338	P	Indwelling catheter latex	0.00	XXX
A4340	P	Indwelling catheter special	0.00	XXX
A4344	P	Cath. indwell. foley 2–way silic.	0.00	XXX
A4346	P	Catheter indwelling foley 3–way	0.00	XXX
A4347	P	Male external catheter	0.00	XXX
A4351	P	Straight tip urine catheter	0.00	XXX
A4352	P	Coude tip urinary catheter	0.00	XXX
A4354	P	Catheter insertion tray with bag	0.00	XXX
A4355	P	Bladder irrigation tubing	0.00	XXX
A4356	P	External ureth clmp or compr dvc.	0.00	XXX
A4357	P	Bedside drainage bag	0.00	XXX
A4358	P	Urinary leg bag	0.00	XXX
A4359	P	Urinary suspensory w/o leg bag	0.00	XXX
A4361	P	Ostomy face plate	0.00	XXX
A4362	P	Solid skin barrier	0.00	XXX
A4363	P	Liquid skin barrier	0.00	XXX
A4364	P	Ostomy/catheter adhesive	0.00	XXX
A4367	P	Ostomy belt	0.00	XXX
A4397	P	Irrigation supply sleeve	0.00	XXX
A4398	P	Irrigation supply bags	0.00	XXX
A4399	P	Irrigation supply cone/catheter	0.00	XXX
A4400	P	Ostomy irrigation set	0.00	XXX
A4402	P	Lubricant per ounce	0.00	XXX
A4404	P	Ostomy ring each	0.00	XXX
A4421	P	Ostomy supply miscellaneous	0.00	XXX
A4454	P	Tape all types all sizes	0.00	XXX
A4455	P	Adhesive remover per ounce	0.00	XXX
A4460	P	Elastic compression bandage	0.00	XXX
A4465	P	Nonelastic extremity binder	0.00	XXX
A4470	P	Gravlee jet washer	0.00	XXX
A4480	P	Vabra aspirator	0.00	XXX
A4550	A	Surgical trays	0.93	XXX
A4556	P	Electrodes	0.00	XXX
A4557	P	Lead wires	0.00	XXX
A4558	P	Conductive paste or gel	0.00	XXX
A4647	B	Supp– paramagnetic contr mat	0.00	XXX
A4649	B	Surgical supplies	0.00	XXX
A5051	P	Pouch clsd w barr attached	0.00	XXX
A5052	P	Clsd ostomy pouch without barr	0.00	XXX
A5053	P	Clsd ostomy pouch faceplate	0.00	XXX
A5054	P	Clsd ostomy pouch with flange	0.00	XXX
A5055	P	Stoma cap	0.00	XXX
A5061	P	Pouch drainable with barrier at.	0.00	XXX
A5062	P	Drnble ostomy pouch w/o barr	0.00	XXX
A5063	P	Drain ostomy pouch with flange	0.00	XXX
A5064	P	Drain ostomy pouch with faceplate	0.00	XXX
A5065	P	Drain ostomy pouch on faceplate	0.00	XXX
A5071	P	Urinary pouch with barrier	0.00	XXX
A5072	P	Urinary pouch without barrier	0.00	XXX
A5073	P	Urinary pouch on barr with flng	0.00	XXX
A5074	P	Urinary pouch with faceplate	0.00	XXX
A5075	P	Urinary pouch on faceplate	0.00	XXX
A5081	P	Continent stoma plug	0.00	XXX
A5082	P	Continent stoma catheter	0.00	XXX

A5093		P	Ostomy accessory convex inse	0.00	XXX
A5102		P	Bedside bottle rigid/expandable	0.00	XXX
A5105		P	Urinary suspensory	0.00	XXX
A5112		P	Urinary leg bag	0.00	XXX
A5113		P	Latex leg strap	0.00	XXX
A5114		P	Foam/fabric leg strap	0.00	XXX
A5119		P	Skin barrier wipes box per 50	0.00	XXX
A5121		P	Solid skin barrier 6x6	0.00	XXX
A5122		P	Solid skin barrier 8x8	0.00	XXX
A5123		P	Skin barrier with flange	0.00	XXX
A5126		P	Adhesive disc/foam pad	0.00	XXX
A5131		P	Appliance cleaner	0.00	XXX
A5149		P	Incontinence/ostomy supply	0.00	XXX
G0002		A	Temporary urinary catheter	1.20	000
G0004		A	ECG transm phys review and int	8.12	XXX
G0005		A	ECG 24–hour recording	1.22	XXX
G0006		A	ECG transmission and analysis	5.95	XXX
G0007		A	ECG phy review and interpret	0.95	XXX
G0015		A	Post symptom ECG tracing	5.95	XXX
G0016		A	Post symptom ECG md review	0.95	XXX
G0025		A	Collagen skin test kit	0.93	XXX
M0064		A	Visit for drug monitoring	0.58	XXX
M0101		A	Cutting or removal of corns	0.73	XXX
Q0035		A	Cardiokymography	0.68	XXX
Q0035	26	A	Cardiokymography	0.30	XXX
Q0035	TC	A	Cardiokymography	0.38	XXX
Q0068		A	Extracorpeal plasmapheresis	3.03	000
Q0091		A	Obtaining screen pap smear	0.67	XXX
Q0092		A	Set up port X–ray equipment	0.30	XXX
V2520		P	Contact lens hydrophilic	0.00	XXX

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530*

5221.4032 PROFESSIONAL/TECHNICAL COMPONENTS FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **General.** Fees for certain services which are a combination of professional and technical care shall be adjusted when the professional and technical components of the service are performed by different individuals or entities. The professional component of the service represents the care rendered by the health care provider, such as examination of the patient, performance and supervision of the procedure, and consultation with other providers. The technical component of the service represents all other costs associated with the service, such as the cost of equipment, the salary of technicians, and supplies normally used in delivering the service. Services subject to this distinction are identified in part 5221.4030, subpart 2a, by modifiers appearing in column 3 alongside the service codes. Modifier TC indicates relative RVUs for the technical component of the service and modifier 26 indicates RVUs for the professional component of the service. The maximum fee for either component of the service is calculated using the RVUs for the component provided and the formula in part 5221.4020.

Subp. 2. **Separate billing for both components.** If the professional component is split from the technical component and both are billed separately, the total cost for both cannot exceed the maximum fee allowed for the complete service, unless there are extenuating circumstances and there is documented justification for the additional cost.

Subp. 3. **One billing for both components.** If the same health care provider renders both the professional and technical components of the service, the maximum fee is calcu-

lated for the complete service by using the RVUs corresponding to the service code listed without a modifier in part 5221.4030, subpart 2a, and the formula in part 5221.4020.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4033 OUTPATIENT LIMITATION FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **Limitation.** Procedures whose codes are listed below are predominantly performed in office settings and, therefore, no additional facility fees are payable when the procedure is performed by the employee's treating health care provider, unless it is an emergency or medically necessary to perform the procedure in a nonoffice setting or after normal office hours. This part does not preclude payment of a facility fee where the employee is treated by emergency room or urgent care staff.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. **Procedure codes subject to limitation.**

CPT/HCPCS Procedure Code	CPT/HCPCS Description
10040	Acne surgery
10060	Drainage of skin abscess
10061	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10081	Drainage of pilonidal cyst
10120	Remove foreign body
10121	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
11000	Surgical cleansing of skin
11001	Additional cleansing of skin
11040	Surgical cleansing, abrasion
11041	Surgical cleansing of skin
11050	Trim skin lesion
11051	Trim 2 to 4 skin lesions
11052	Trim over 4 skin lesions
11100	Biopsy of skin lesion
11101	Biopsy, each added lesion
11200	Removal of skin tags
11201	Removal of added skin tags
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11400	Removal of skin lesion
11401	Removal of skin lesion
11402	Removal of skin lesion
11403	Removal of skin lesion
11420	Removal of skin lesion

11421	Removal of skin lesion
11422	Removal of skin lesion
11423	Removal of skin lesion
11440	Removal of skin lesion
11441	Removal of skin lesion
11442	Removal of skin lesion
11443	Removal of skin lesion
11600	Removal of skin lesion
11601	Removal of skin lesion
11602	Removal of skin lesion
11603	Removal of skin lesion
11620	Removal of skin lesion
11621	Removal of skin lesion
11622	Removal of skin lesion
11623	Removal of skin lesion
11640	Removal of skin lesion
11641	Removal of skin lesion
11642	Removal of skin lesion
11643	Removal of skin lesion
11700	Scraping of 1 to 5 nails
11701	Scraping of additional nails
11710	Scraping of 1 to 5 nails
11711	Scraping of additional nails
11730	Removal of nail plate
11731	Removal of second nail plate
11732	Remove additional nail plate
11740	Drain blood from under nail
11750	Removal of nail bed
11752	Remove nail bed/finger tip
11760	Reconstruction of nail bed
11762	Reconstruction of nail bed
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesion injections
12031	Layer closure of wound(s)
12032	Layer closure of wound(s)
12041	Layer closure of wound(s)
12042	Layer closure of wound(s)
12051	Layer closure of wound(s)
12052	Layer closure of wound(s)
15780	Abrasion treatment of skin
15781	Abrasion treatment of skin
15782	Abrasion treatment of skin
15783	Abrasion treatment of skin
15786	Abrasion treatment of lesion
15787	Abrasion, added skin lesions
15851	Removal of sutures
15852	Dressing change, not for burn
16000	Initial treatment of burn(s)
16010	Treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
17000	Destroy benign/premal lesion
17001	Destruction of additional lesions
17002	Destruction of additional lesions

17010	Destruction skin lesion(s)
17100	Destruction of skin lesion
17101	Destruction of 2nd lesion
17102	Destruction of additional lesions
17104	Destruction of skin lesions
17105	Destruction of skin lesions
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17110	Destruction of skin lesions
17200	Electrocautery of skin tags
17201	Electrocautery added lesions
17250	Chemical cautery, tissue
17260	Destruction of skin lesions
17261	Destruction of skin lesions
17262	Destruction of skin lesions
17263	Destruction of skin lesions
17264	Destruction of skin lesions
17266	Destruction of skin lesions
17270	Destruction of skin lesions
17271	Destruction of skin lesions
17272	Destruction of skin lesions
17273	Destruction of skin lesions
17274	Destruction of skin lesions
17276	Destruction of skin lesions
17280	Destruction of skin lesions
17281	Destruction of skin lesions
17282	Destruction of skin lesions
17283	Destruction of skin lesions
17284	Destruction of skin lesions
17286	Destruction of skin lesions
17304	Chemosurgery of skin lesion
17305	2nd stage chemosurgery
17306	3rd stage chemosurgery
17307	Follow–up skin lesion therapy
17310	Extensive skin chemosurgery
17340	Cryotherapy of skin
17360	Skin peel therapy
19000	Drainage of breast lesion
19001	Drain added breast lesion
20000	Incision of abscess
20500	Injection of sinus tract
20520	Removal of foreign body
20550	Inject tendon/ligament/cyst
20600	Drain/inject joint/bursa
20605	Drain/inject joint/bursa
20610	Drain/inject joint/bursa
20615	Treatment of bone cyst
20974	Electrical bone stimulation
21029	Contour of face bone lesion
21030	Removal of face bone lesion
21031	Remove exostosis, mandible
21032	Remove exostosis, maxilla
21079	Prepare face/oral prosthesis
21080	Prepare face/oral prosthesis
21081	Prepare face/oral prosthesis

21082	Prepare face/oral prosthesis
21083	Prepare face/oral prosthesis
21084	Prepare face/oral prosthesis
21085	Prepare face/oral prosthesis
21086	Prepare face/oral prosthesis
21087	Prepare face/oral prosthesis
21088	Prepare face/oral prosthesis
21089	Prepare face/oral prosthesis
21110	Interdental fixation
23031	Drain shoulder bursa
24200	Removal of arm foreign body
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Repair wrist bone fracture
26010	Drainage of finger abscess
26600	Treat metacarpal fracture
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
28001	Drainage of bursa of foot
28010	Incision of toe tendon
28011	Incision of toe tendons
28022	Exploration of a foot joint
28024	Exploration of a toe joint
28052	Biopsy of foot joint lining
28108	Removal of toe lesions
28124	Partial removal of toe
28126	Partial removal of toe
28153	Partial removal of toe
28160	Partial removal of toe
28190	Removal of foot foreign body
28220	Release of foot tendon
28230	Incision of foot tendon(s)
28232	Incision of toe tendon
28234	Incision of foot tendon
28270	Release of foot contracture
28272	Release of toe joint, each
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28455	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation

29015	Application of body cast
29020	Application of body cast
29025	Application of body cast
29035	Application of body cast
29049	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29220	Strapping of low back
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29450	Application of leg cast
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle
29550	Strapping of toes
29580	Application of paste boot
29590	Application of foot splint
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29715	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast
29850	Knee arthroscopy/surgery
30000	Drainage of nose lesion
30020	Drainage of nose lesion
30100	Intranasal biopsy
30110	Removal of nose polyp(s)
30200	Injection treatment of nose
30210	Nasal sinus therapy
30220	Insert nasal septal button
30300	Remove nasal foreign body
30901	Control of nosebleed
31000	Irrigation maxillary sinus
31002	Irrigation sphenoid sinus
31505	Diagnostic laryngoscopy
31575	Diagnostic laryngoscopy

31579	Diagnostic laryngoscopy
36000	Place needle in vein
36400	Drawing blood
36405	Drawing blood
36406	Drawing blood
36410	Drawing blood
36430	Blood transfusion service
36450	Exchange transfusion service
36470	Injection therapy of vein
36471	Injection therapy of veins
36510	Insertion of catheter, vein
40490	Biopsy of lip
40800	Drainage of mouth lesion
40804	Removal foreign body, mouth
40808	Biopsy of mouth lesion
40810	Excision of mouth lesion
40812	Excise/repair mouth lesion
41100	Biopsy of tongue
41108	Biopsy of floor of mouth
41825	Excision of gum lesion
41826	Excision of gum lesion
42100	Biopsy roof of mouth
42330	Removal of salivary stone
42400	Biopsy of salivary gland
42650	Dilation of salivary duct
42660	Dilation of salivary duct
42800	Biopsy of throat
45300	Proctosigmoidoscopy
45303	Proctosigmoidoscopy
45330	Sigmoidoscopy, diagnostic
45520	Treatment of rectal prolapse
46083	Incise external hemorrhoid
46221	Ligation of hemorrhoid(s)
46230	Removal of anal tabs
46320	Removal of hemorrhoid clot
46500	Injection into hemorrhoids
46600	Diagnostic anoscopy
46604	Anoscopy and dilation
46606	Anoscopy and biopsy
46614	Anoscopy; control bleeding
46615	Anoscopy
46900	Destruction, anal lesion(s)
46910	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
46917	Laser surgery, anal lesion(s)
46934	Destruction of hemorrhoids
46935	Destruction of hemorrhoids
46936	Destruction of hemorrhoids
46940	Treatment of anal fissure
46942	Treatment of anal fissure
46945	Ligation of hemorrhoids
46946	Ligation of hemorrhoids
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion

52265	Cystoscopy and treatment
53270	Removal of urethra gland
53600	Dilate urethra stricture
53601	Dilate urethra stricture
53620	Dilate urethra stricture
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53670	Insert urinary catheter
54050	Destruction, penis lesion(s)
54055	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54230	Prepare penis study
54235	Penile injection
55000	Drainage of hydrocele
55250	Removal of sperm duct(s)
56420	Drainage of gland abscess
56501	Destruction, vulva lesion(s)
56606	Biopsy of vulva/perineum
57061	Destruction vagina lesion(s)
57100	Biopsy of vagina
57150	Treat vagina infection
57160	Insertion of pessary
57170	Fitting of diaphragm/cap
57452	Examination of vagina
57454	Vagina examination and biopsy
57460	LEEP procedure
57500	Biopsy of cervix
57505	Endocervical curettage
57510	Cauterization of cervix
57511	Cryocautery of cervix
58100	Biopsy of uterus lining
58301	Remove intrauterine device
59200	Insert cervical dilator
59300	Episiotomy or vaginal repair
59425	Antepartum care only
59426	Antepartum care only
59430	Care after delivery
60100	Biopsy of thyroid
61001	Remove cranial cavity fluid
63690	Analysis of neuroreceiver
63691	Analysis of neuroreceiver
64400	Injection for nerve block
64405	Injection for nerve block
64408	Injection for nerve block
64412	Injection for nerve block
64413	Injection for nerve block
64418	Injection for nerve block
64435	Injection for nerve block
64440	Injection for nerve block
64441	Injection for nerve block
64445	Injection for nerve block
64450	Injection for nerve block
64505	Injection for nerve block

64508	Injection for nerve block
64550	Apply neurostimulator
64553	Implant neuroelectrodes
64555	Implant neuroelectrodes
64560	Implant neuroelectrodes
64565	Implant neuroelectrodes
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65286	Repair of eye wound
65430	Corneal smear
65435	Curette/treat cornea
65436	Curette/treat cornea
65600	Revision of cornea
65772	Correction of astigmatism
65855	Laser surgery of eye
65860	Incise inner eye adhesions
66761	Revision of iris
66770	Removal of inner eye lesion
67145	Treatment of retina
67210	Treatment of retinal lesion
67228	Treatment of retinal lesion
67345	Destroy nerve of eye muscle
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67710	Incision of eyelid
67800	Remove eyelid lesion
67801	Remove eyelid lesions
67805	Remove eyelid lesions
67810	Biopsy of eyelid
67820	Revise eyelashes
67825	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
67915	Repair eyelid defect
67922	Repair eyelid defect
67930	Repair eyelid wound
67938	Remove eyelid foreign body
68020	Incise/drain eyelid lining
68040	Treatment of eyelid lesions
68100	Biopsy of eyelid lining
68110	Remove eyelid lining lesion
68135	Remove eyelid lining lesion
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68420	Incise/drain tear sac
68440	Incise tear duct opening
68530	Clearance of tear duct
68705	Revise tear duct opening
68760	Close tear duct opening
68761	Close tear duct opening

68770	Close tear system fistula
68800	Dilate tear duct opening(s)
68820	Explore tear duct system
68830	Reopen tear duct channel
68840	Explore/irrigate tear ducts
69000	Drain external ear lesion
69005	Drain external ear lesion
69020	Drain outer ear canal lesion
69100	Biopsy of external ear
69105	Biopsy of external ear canal
69200	Clear outer ear canal
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
69222	Clean out mastoid cavity
69400	Inflate middle ear canal
69401	Inflate middle ear canal
69405	Catheterize middle ear canal
69410	Inset middle ear baffle
69420	Incision of eardrum
69433	Create eardrum opening
69540	Remove ear lesion
69610	Repair of eardrum
92002	Eye exam, new patient
92004	Eye exam, new patient
92012	Eye exam, established patient
92014	Eye exam and treatment
92019	Eye exam and treatment
92020	Special eye evaluation
92070	Fitting of contact lens
92100	Serial tonometry exam(s)
92120	Tonography and eye evaluation
92130	Water provocation tonography
92140	Glaucoma provocative tests
92225	Special eye exam, initial
92226	Special eye exam, subsequent
92230	Eye exam with photos
92260	Ophthalmoscopy/dynamometry
92287	Internal eye photography
92311	Contact lens fitting
92312	Contact lens fitting
92313	Contact lens fitting
92315	Prescription of contact lens
92316	Prescription of contact lens
92317	Prescription of contact lens
92330	Fitting of artificial eye
92335	Fitting of artificial eye
92352	Special spectacles fitting
92353	Special spectacles fitting
92354	Special spectacles fitting
92371	Repair and adjust spectacles
92504	Ear microscopy examination
92506	Speech and hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92511	Nasopharyngoscopy

92512	Nasal function studies
92516	Facial nerve function test
92520	Laryngeal function studies
92565	Stenger test, pure tone
92571	Filtered speech hearing test
92575	Sensorineural acuity test
92576	Synthetic sentence test
92577	Stenger test, speech
92582	Conditioning play audiometry
93205	Special phonocardiogram
93221	Vectorcardiogram tracing
93721	Plethysmography tracing
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95010	Sensitivity skin tests
95015	Sensitivity skin tests
95056	Photosensitivity tests
95065	Nose allergy test
95075	Ingestion challenge test
95144	Antigen therapy services
95145	Antigen therapy services
95146	Antigen therapy services
95147	Antigen therapy services
95148	Antigen therapy services
95149	Antigen therapy services
95165	Antigen therapy services
95170	Antigen therapy services
95180	Rapid desensitization
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
95857	Tensilon test
95880	Cerebral aphasia testing
95881	Cerebral developmental test
96405	Intralesional chemotherapy administration
96406	Intralesional chemotherapy administration
96445	Chemotherapy, intracavitary
96450	Chemotherapy, into central nervous system
96542	Chemotherapy injection
99201	Office/outpatient visit, new
99202	Office/outpatient visit, new
99203	Office/outpatient visit, new
99204	Office/outpatient visit, new
99205	Office/outpatient visit, new
99211	Office/outpatient visit, established
99212	Office/outpatient visit, established
99213	Office/outpatient visit, established
99214	Office/outpatient visit, established
99215	Office/outpatient visit, established
99241	Office consultation
99242	Office consultation
99243	Office consultation

99244	Office consultation
99245	Office consultation
99271	Confirmatory consultation
99272	Confirmatory consultation
99273	Confirmatory consultation
99274	Confirmatory consultation
99354	Prolonged service, office
99355	Prolonged service, office
A2000	Chiropractor manipulation of spine
G0020	Prepare face/oral prosthesis
G0021	Prepare face/oral prosthesis
H5300	Occupational therapy
M0101	Cutting/removal of corns/calluses

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530*

5221.4034 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **Global surgery fee.** Except as described in item B, codes for surgical procedures and their corresponding maximum fees include all services normally furnished by the surgeon or the surgeon's designee before, during, and after the procedure within a predetermined postoperative period. This concept is referred to as the "global surgery package" or "global surgery fee." Services included in the global surgery package for a given procedure include: Preoperative visits related to the surgery on the day before surgery and the day of surgery; the hospital admission workup; the primary operation; local infiltration, digital block or topical anesthesia when used; immediate postoperative care including conferences with the family and other health care providers and evaluations of the patient in the recovery room; postoperative hospital and office visits, as well as all additional medical or surgical services required of the surgeon because of complications, which do not require additional trips to the operating room. Also included in the global surgery fee are all written reports and records normally maintained by the surgeon during the preoperative, intraoperative, and postoperative periods.

All coded procedures have been placed into a specific surgical category, listed and described in items A to F. Rules for the application of the global surgery policy are included in each category description. The category symbol for each procedure appears in part 5221.4030, subpart 2a, in column 6. The symbol also indicates the number of days included in the global fee period for the procedure.

A. 090, major surgical procedures: the global surgery policy applies, as described above, and the calculated fee includes care provided on the day before surgery, on the day of surgery, and care provided during the 90–day postoperative period beginning the day after surgery.

B. 010, minor surgical procedures: the global surgery policy applies, and the calculated maximum fee includes care provided on the day of surgery and care provided during the ten–day postoperative period beginning the day after surgery.

C. 000, minor/endoscopic procedures: the global surgery policy applies, and the calculated maximum fee includes care provided on the day of surgery only.

D. XXX: the global surgery policy does not apply to these procedures.

E. ZZZ: these procedures are part of other services and fall within the global definition of the major service.

F. MMM, maternity related procedures: the global surgery policy does not apply to these procedures.

Subp. 2. **Exclusions from the global surgery package.** The services in items A to E are not included in the global surgery package.

A. For purposes of the global surgery package, preoperative care does not include any care administered before the provider determines that surgery is required, nor does it in-

clude an initial evaluation or consultation by the surgeon during which the decision to have surgery is made. These visits shall be paid separately at maximum fees calculated according to the formula in part 5221.4020.

B. If the surgeon performs a significant, separately identifiable service during the global surgery period that is not a usual part of the global surgery package, then separate payment for the service may be made, according to the guidelines in subitems (1) to (3).

(1) If the surgeon performed an evaluation and management service during the global period, for reasons unrelated to the original procedure, then the surgeon may bill for this additional service by using the correct procedure code, plus the modifier 24. Evaluation and management services include office visits, hospital visits, and other related services and have been assigned CPT procedure code numbers 99201 to 99499. Maximum fees for these additional services are calculated using the RVUs for the coded service and the formula in part 5221.4020.

(2) If the surgeon performed an evaluation and management service on the day of a procedure, that was above and beyond the usual care associated with the procedure, then the surgeon may bill for this additional service by using the correct procedure code, plus the modifier 25. Evaluation and management services include office visits, hospital visits, and other related services and have been assigned CPT procedure code numbers 99210 to 99499. Maximum fees for these additional services are calculated using the RVUs for the coded service and the formula in part 5221.4020.

(3) If during the global period, the surgeon performed an additional related procedure which required a return trip to the operating room, this additional procedure, referred to as a reoperation, may be separately billed and paid for, as provided in this subitem.

Some reoperations have been assigned separate, distinct procedure codes and RVUs, which are included in part 5221.4030. The surgeon may bill for the reoperation using the correct code. The maximum fee for these procedures is calculated using the RVUs for the coded reoperation and the formula in part 5221.4020. For example:

Original surgery: Coronary artery bypass; billing code number 33516; Reoperation: billing code number 33530. The maximum fee for each is calculated using the formula in part 5221.4020 and the RVUs corresponding to each code.

Maximum fee for 33516: 72.51 (total RVUs) x $52.05 (CF) = $3,774.15

Maximum fee for the reoperation, 33530: 19.51 (total RVUs) x $52.05 (CF) = $1,015.50

Reoperations which have not been assigned separate, distinct codes and RVUs must be identified on the bill with the original procedure code plus the modifier 78. The maximum fee for a reoperation without a separate distinct procedure code is calculated according to the following formula: Maximum fee = .43 x (total RVUs for original procedure x CF). No additional preoperative and postoperative payments shall be made, because they are included in the original global fee. For example:

Original surgery: Hemilaminectomy with decompression of nerve root(s) and excision of herniated intervertebral disc, cervical; billing code number 63020; Reoperation: no separate procedure code.

The maximum payment for the original surgery is calculated using the formula in part 5221.4020 and the RVUs corresponding to the service code.

Maximum fee for the original surgery, 63020: 33.83 (total RVUs) x $52.05 (CF) = $1,760.85

The maximum fee for the reoperation is calculated at 43 percent of the maximum fee for the original surgery.

The maximum fee for the reoperation, 63020–78: .43 x 33.83 (total RVUs) x $52.50 (CF) = $757.17

(4) If the surgeon performed a procedure or service during the global period that was unrelated to the original procedure and that does not fit into subitems (1) to (3), the surgeon may bill for this additional service by using the correct procedure code for the service plus the modifier 79. Maximum fees for these additional services are calculated using the RVUs for the coded service and the formula in part 5221.4020.

C. Except as provided in part 5221.0410, subpart 7, the physician may separately bill a reasonable amount for supplementary reports and services directly related to the em-

ployee's ability to return to work, fitness for job offers, and opinions as to whether or not the condition was related to a work–related injury. Fees for these services are governed by parts 5221.0410, subpart 7, 5221.0420, subpart 3, and 5221.0500, subpart 2.

D. The global fees for transplant surgeries do not include organ acquisition services and postoperative immunosuppressive therapy. Organ acquisition services are considered hospital costs, and no separate payment to the surgeon is allowed. Separate billing and payment to the surgeon for postoperative immunosuppressive therapy is allowed at maximum fees calculated according to the formula in part 5221.4020.

E. Physical and occupational therapy services are not included in the global surgery package. Separate billing and payment for these services is allowed at maximum fees calculated according to the formula in part 5221.4020.

Subp. 3. **Multiple surgery fee reduction.**

A. Except as provided in item B, maximum fees for multiple procedures performed on the same patient on the same day are determined according to the following payment schedule: 100 percent of the global fee for the most expensive procedure only; 50 percent of the global fee for the second most expensive procedure; 25 percent of the global fee for all additional procedures.

The most expensive procedure is coded using the correct procedure code listed in part 5221.4030. The additional, less expensive procedures are coded by adding modifier 51 to the correct procedure code.

Example:

On the same day, the surgeon performed three procedures on the same patient: removal of foreign body, knee area, procedure code number 27372, total RVUs: 8.74; repair of torn ligament, knee, procedure code number 27405, total RVUs: 19.56; and removal of foreign body, foot, complicated, procedure code number 28193, total RVUs: 8.16.

The most expensive procedure is the repair of the torn ligament, because of the three procedures it has the highest number of RVUs, 19.56. The maximum fee for this procedure is calculated according to the formula in part 5221.4020, using total RVUs for procedure code number 27405.

The second most expensive procedure is the removal of foreign body, knee area, total RVUs of 8.74. The maximum fee for this procedure is calculated according to the following formula:

.50 x 8.74 (total RVUs) x $52.05 (CF) = $227.45.

Procedure code number 27372–51 is used for billing.

The third most expensive procedure is removal of the foreign body, foot, complicated, total RVUs 8.16. The maximum fee for this procedure is calculated according to the following formula:

.25 x 8.16 (total RVUs) x $52.05 (CF) = $106.18.

Procedure code number 28193–51 is used for billing.

B. Services whose codes are listed below are not subject to the multiple surgery fee reduction described in item A. Maximum fees for these services are calculated according to the formula in part 5221.4020.

(1) 11001, 11101, 11201, 11700, 11701, 11711, 11731, 11732, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 11975, 11976, 15000, 15101, 15121, 15201, 15221, 15241, 15261, 15410, 15412, 15414, 15416, 15500, 15505, 15510, 15515, 15540, 15545, 15550, 15555, 15700, 15710, 15720, 15730, 15775, 15776, 15787, 15824, 15825, 15826, 15828, 15829, 15850, 15876, 15877, 15878, 15879, 15954, 15955, 15960, 15961, 15964, 15965, 15966, 15967, 15970, 15971, 15972, 15973, 15974, 15975, 15980, 15981, 15982, 15983, 17001, 17002, 17101, 17102, 17201, 17303, 17304, 17305, 17306, 17307, 17310, 17380, 19001, 19340, 19360,

(2) 20690, 20692, 20974, 20975, 22145, 22148, 22230, 22585, 22650, 22820, 22840, 22842, 22845, 26861, 26863, 27358, 27692,

(3) 33471, 33480, 33481, 33482, 33483, 33485, 33490, 33492, 33520, 33525, 33528, 33530, 33930, 33940, 33960, 33972, 35681, 36218, 36248, 36415, 36430, 36468, 36469, 36490, 36495, 36496, 36497, 36660,

(4) 40842, 40843, 40844, 40845, 41820, 41821, 41822, 41823, 41828, 41830, 41850, 41870, 41872, 41874, 44015, 44131, 44955, 47001, 47133, 48160,

(5) 50300, 50320, 51725, 51726, 51736, 51739, 51741, 51772, 51785, 51792, 51795, 51797, 53800, 54240, 54250, 55970, 55980, 56680, 56685, 58611, 59020, 59025, 59050, 59412, 59525,

(6) 61106, 61130, 61712, 61795, 63035, 63048, 63057, 63066, 63076, 63078, 63082, 63096, 63088, 63091, 63308, 64550, 64623, 64727, 64778, 64783, 64787, 64830, 64832, 64837, 64859, 64872, 64874, 64876, 64901, 64902, 65760, 65765, 65767, 65771, 66702, 67335, 67907, 69090, 69300, 69710,

(7) 93501, 93505, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93546, 93547, 93548, 93549, 93550, 93552, 93553.

Subp. 4. **Bilateral procedures.** When a procedure which normally is done on only one side of the body is performed on both sides of the body, payment for the complete bilateral procedure is made at the rate of 150 percent of the global fee for one procedure. Modifier 50 is added to the correct procedure code in these instances.

If a procedure is normally performed on both sides of the body, and this is noted in the procedure code description, the maximum payment for the complete bilateral procedure is calculated using the RVUs listed for the applicable procedure code. Modifier 50 must not be used with these codes.

Subp. 5. **Cosurgeons.** When the procedure is performed by two physicians, acting as cosurgeons, the amount paid for the procedure is 125 percent of the global fee, divided equally between the two surgeons. For purposes of this part, a physician is considered a cosurgeon if the physician performed a discrete function during the operative procedure. If the cosurgeons have agreed to a different payment distribution, payments will be made accordingly, if the agreed–upon distribution is documented and explained on the bill for the procedure, and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p). Modifier 62 must be used to identify procedures performed by cosurgeons.

Subp. 6. **Assistant–at–surgery.**

A. Except as described in item B, the maximum fee allowed for an assistant–at–surgery is 16 percent of the global fee for the procedure. For purposes of this part, a physician is considered an assistant–at–surgery if the physician did not perform a discrete function but merely assisted the primary surgeon during the operative procedure. Modifier 80, 81, or 82, as appropriate, must be used to identify services of an assistant–at–surgery.

B. No payment will be made for an assistant–at–surgery for procedures listed below, unless an unusual, documented need is present.

(1) 10000, 10001, 10002, 10003, 10020, 10040, 10060, 10061, 10080, 10100, 10101, 10120, 10121, 10140, 10141, 10160, 10180, 11000, 11001, 11040, 11041, 11042, 11043, 11044, 11050, 11051, 11052, 11100, 11101, 11200, 11201, 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11450, 11451, 11462, 11463, 11470, 11471, 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 11700, 11701, 11710, 11711, 11730, 11731, 11732, 11740, 11750, 11752, 11760, 11762, 11765, 11770, 11771, 11772, 11900, 11901, 11920, 11950, 11951, 11952, 11954, 11960, 11970, 11971, 12001, 12002, 12004, 12005, 12006, 12007, 12011, 12013, 12014, 12015, 12016, 12017, 12018, 12020, 12021, 12031, 12032, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13100, 13101, 13120, 13121, 13131, 13132, 13150, 13151, 13152, 13160, 13300, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 15000, 15050, 15100, 15200, 15201, 15220, 15240, 15241, 15260, 15261, 15400, 15416, 15505, 15510, 15515, 15555, 15580, 15600, 15610, 15620, 15625, 15630, 15700, 15720, 15730, 15734, 15736, 15738, 15740, 15760, 15775, 15780, 15781, 15782, 15783, 15786, 15787, 15790, 15791, 15810, 15811, 15819, 15820, 15821, 15822, 15823, 15824, 15825, 15828, 15833, 15834, 15836, 15837, 15838, 15839, 15841, 15842, 15850, 15851, 15852, 15860, 15875, 15879, 15920, 15931, 15940, 15950, 15960, 15961, 15964, 15966, 15967, 15970, 15972, 15973, 15975, 15980, 15982, 15983, 16000, 16010, 16015, 16020, 16025, 16030,

16035, 16040, 16041, 16042, 17000, 17001, 17002, 17010, 17100, 17101, 17102, 17104, 17105, 17110, 17200, 17201, 17250, 17300, 17303, 17304, 17305, 17306, 17307, 17310, 17340, 17360, 17380, 19000, 19001, 19020, 19030, 19100, 19101, 19110, 19112, 19120, 19290, 19291, 19324, 19350, 19355, 19370, 19396;

(2) 20000, 20005, 20010, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 20250, 20500, 20505, 20520, 20525, 20550, 20600, 20605, 20610, 20615, 20660, 20661, 20662, 20663, 20665, 20670, 20690, 20804, 20805, 20806, 20816, 20820, 20824, 20826, 20827, 20828, 20832, 20834, 20910, 20912, 20926, 20950, 20969, 20970, 20974, 20976, 21010, 21011, 21025, 21026, 21030, 21031, 21032, 21040, 21041, 21070, 21071, 21100, 21110, 21116, 21230, 21245, 21246, 21248, 21249, 21254, 21260, 21261, 21267, 21275, 21282, 21300, 21310, 21315, 21320, 21325, 21330, 21335, 21336, 21337, 21339, 21344, 21345, 21348, 21355, 21356, 21366, 21386, 21387, 21400, 21401, 21408, 21421, 21423, 21433, 21436, 21440, 21445, 21450, 21451, 21452, 21453, 21455, 21480, 21485, 21495, 21501, 21510, 21550, 21555, 21556, 21800, 21805, 21810, 21820, 21920, 21925, 21930, 22120, 22200, 22212, 22222, 22305, 22310, 22315, 22330, 22345, 22360, 22505, 23030, 23031, 23035, 23065, 23066, 23075, 23076, 23140, 23146, 23156, 23170, 23172, 23221, 23330, 23331, 23350, 23406, 23500, 23505, 23510, 23520, 23525, 23530, 23540, 23545, 23570, 23575, 23600, 23605, 23620, 23625, 23650, 23655, 23658, 23665, 23675, 23700, 23921, 23930, 23931, 23935, 24065, 24066, 24075, 24076, 24105, 24120, 24126, 24153, 24200, 24201, 24220, 24305, 24330, 24351, 24362, 24495, 24500, 24505, 24530, 24535, 24536, 24540, 24542, 24560, 24565, 24570, 24576, 24577, 24578, 24580, 24581, 24600, 24605, 24620, 24625, 24640, 24650, 24655, 24660, 24670, 24675, 24680, 24802, 24930, 24935, 24940, 25000, 25005, 25020, 25023, 25028, 25031, 25035, 25040, 25065, 25066, 25075, 25076, 25077, 25100, 25101, 25110, 25111, 25112, 25125, 25126, 25130, 25145, 25246, 25248, 25251, 25260, 25270, 25290, 25301, 25316, 25335, 25355, 25370, 25392, 25393, 25444, 25450, 25455, 25490, 25491, 25492, 25500, 25505, 25510, 25530, 25535, 25540, 25560, 25565, 25600, 25605, 25610, 25611, 25615, 25622, 25624, 25626, 25628, 25630, 25635, 25640, 25650, 25660, 25665, 25675, 25680, 25690, 25905, 25907, 25920, 25922, 25924, 25927, 25931, 26010, 26011, 26020, 26025, 26030, 26034, 26040, 26045, 26055, 26060, 26070, 26075, 26080, 26100, 26105, 26110, 26115, 26116, 26117, 26130, 26145, 26160, 26170, 26180, 26200, 26205, 26210, 26230, 26235, 26236, 26250, 26260, 26261, 26320, 26350, 26356, 26357, 26370, 26410, 26415, 26416, 26418, 26420, 26428, 26432, 26433, 26434, 26437, 26440, 26442, 26449, 26450, 26455, 26474, 26476, 26478, 26479, 26489, 26497, 26500, 26504, 26517, 26550, 26552, 26555, 26557, 26560, 26562, 26568, 26585, 26587, 26590, 26591, 26593, 26600, 26605, 26607, 26610, 26615, 26641, 26645, 26655, 26660, 26670, 26675, 26676, 26680, 26700, 26705, 26706, 26710, 26715, 26720, 26725, 26727, 26730, 26735, 26740, 26742, 26744, 26746, 26750, 26755, 26756, 26760, 26765, 26770, 26775, 26776, 26780, 26785, 26863, 26910, 26951, 26952, 26989, 26990, 26991, 27010, 27040, 27041, 27086, 27093, 27095, 27158, 27175, 27190, 27195, 27196, 27200, 27201, 27202, 27210, 27212, 27220, 27222, 27230, 27232, 27238, 27246, 27250, 27252, 27256, 27259, 27265, 27266, 27275, 27301, 27315, 27323, 27324, 27327, 27340, 27370, 27374, 27397, 27500, 27502, 27508, 27510, 27517, 27518, 27520, 27530, 27532, 27534, 27538, 27550, 27552, 27554, 27560, 27562, 27564, 27570, 27603, 27604, 27605, 27613, 27614, 27618, 27626, 27630, 27648, 27664, 27732, 27734, 27750, 27752, 27754, 27760, 27762, 27780, 27781, 27782, 27786, 27788, 27790, 27800, 27802, 27808, 27810, 27816, 27818, 27830, 27840, 27842, 27844, 27860, 27884, 28001, 28002, 28003, 28004, 28005, 28008, 28010, 28011, 28022, 28024, 28043, 28088, 28092, 28102, 28107, 28126, 28150, 28153, 28160, 28190, 28192, 28193, 28222, 28232, 28261, 28264, 28272, 28307, 28313, 28340, 28341, 28345, 28360, 28400, 28405, 28406, 28430, 28435, 28440, 28450, 28455, 28456, 28460, 28470, 28475, 28476, 28480, 28490, 28495, 28496, 28500, 28505, 28510, 28520, 28525, 28530, 28540, 28545, 28546, 28570, 28575, 28580, 28600, 28605, 28610, 28630, 28635, 28640, 28665, 28670, 28675, 28810, 28820, 28825, 29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29105, 29125, 29126, 29130, 29131, 29200, 29220, 29240, 29260, 29280, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29450, 29505, 29515, 29520, 29530, 29540, 29550, 29580, 29590, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, 29830, 29847, 29871, 29872, 29886, 29890;

(3) 30000, 30020, 30100, 30110, 30115, 30117, 30120, 30124, 30125, 30130, 30140, 30200, 30210, 30220, 30300, 30310, 30320, 30400, 30410, 30420, 30430, 30435, 30450, 30520, 30540, 30545, 30560, 30580, 30600, 30620, 30630, 30800, 30805, 30820, 30901, 30903, 30905, 30906, 30915, 30920, 30930, 31000, 31002, 31020, 31030, 31032, 31033, 31050, 31051, 31070, 31090, 31200, 31201, 31250, 31252, 31254, 31255, 31256, 31258, 31260, 31263, 31265, 31267, 31268, 31270, 31275, 31277, 31500, 31505, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579, 31580, 31582, 31585, 31586, 31590, 31595, 31600, 31601, 31603, 31605, 31611, 31612, 31613, 31614, 31615, 31622, 31625, 31628, 31629, 31630, 31631, 31635, 31640, 31641, 31645, 31646, 31656, 31659, 31700, 31708, 31710, 31715, 31717, 31719, 31720, 31725, 31766, 31781, 31820, 31825, 31830, 32000, 32002, 32005, 32020, 32400, 32405, 32420, 32700, 32705, 32810, 32960, 33010, 33011, 33015, 33207, 33208, 33210, 33212, 33216, 33218, 33219, 33222, 33232, 33250, 33471, 33478, 33694, 33738, 33739, 33762, 33764, 33774, 33779, 33780, 33786, 33803, 33813, 33851, 33940, 33971, 33972, 34471, 35450, 36000, 36010, 36100, 36101, 36120, 36140, 36145, 36160, 36200, 36215, 36230, 36245, 36261, 36262, 36400, 36405, 36406, 36410, 36415, 36420, 36425, 36430, 36440, 36450, 36455, 36470, 36471, 36488, 36489, 36490, 36491, 36495, 36496, 36497, 36500, 36510, 36520, 36600, 36620, 36625, 36640, 36660, 36680, 36800, 36810, 36815, 36832, 36840, 36845, 36860, 36861, 37565, 37606, 37609, 37616, 37785, 38200, 38230, 38240, 38300, 38305, 38308, 38500, 38505, 38510, 38520, 38525, 38790, 38794, 39400;

(4) 40490, 40500, 40510, 40520, 40525, 40527, 40530, 40650, 40652, 40654, 40700, 40701, 40702, 40720, 40761, 40801, 40804, 40805, 40806, 40808, 40810, 40812, 40814, 40816, 40818, 40819, 40820, 40830, 40831, 40840, 40843, 40844, 41000, 41005, 41006, 41007, 41008, 41009, 41010, 41015, 41016, 41017, 41018, 41100, 41105, 41108, 41110, 41112, 41113, 41114, 41115, 41116, 41250, 41251, 41252, 41500, 41510, 41520, 41800, 41805, 41806, 41820, 41821, 41822, 41823, 41825, 41826, 41827, 41828, 41830, 41850, 41870, 41872, 41874, 42000, 42100, 42104, 42106, 42107, 42140, 42145, 42160, 42180, 42182, 42200, 42205, 42215, 42226, 42227, 42235, 42250, 42260, 42280, 42281, 42300, 42305, 42310, 42320, 42325, 42326, 42330, 42335, 42340, 42400, 42405, 42408, 42409, 42450, 42500, 42505, 42507, 42509, 42550, 42600, 42650, 42660, 42700, 42720, 42725, 42800, 42802, 42804, 42806, 42808, 42809, 42810, 42820, 42821, 42825, 42826, 42830, 42831, 42836, 42842, 42860, 42870, 42880, 42900, 42960, 42961, 42962, 42970, 42971, 42972, 43200, 43202, 43204, 43215, 43217, 43219, 43220, 43226, 43227, 43228, 43234, 43235, 43239, 43241, 43243, 43245, 43246, 43247, 43251, 43255, 43258, 43260, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43420, 43450, 43451, 43453, 43455, 43456, 43460, 43600, 43750, 43760, 44100, 44360, 44361, 44363, 44364, 44366, 43369, 44372, 44373, 44380, 44382, 44385, 44386, 44388, 44389, 44391, 44392, 44393, 45005, 45020, 45100, 45150, 45300, 45302, 45303, 45305, 45307, 45310, 45315, 45317, 45320, 45321, 45330, 45331, 45332, 45333, 45334, 45336, 45337, 45355, 45378, 45379, 45380, 45382, 45383, 45385, 45386, 45500, 45520, 45521, 45900, 45905, 45910, 45915, 46000, 46030, 46040, 46045, 46050, 46060, 46070, 46080, 46083, 46200, 46210, 46211, 46220, 46221, 46230, 46250, 46255, 46257, 46258, 46260, 46270, 46275, 46280, 46285, 46320, 46500, 46600, 46602, 46604, 46606, 46608, 46610, 46612, 46614, 46705, 46715, 46730, 46751, 46753, 46754, 46900, 46910, 46916, 46917, 46922, 46924, 46934, 46935, 46936, 46937, 46938, 46940, 46942, 46845, 46946, 47000, 47490, 47510, 47525, 47530, 47716, 48102, 48160, 49080, 49081, 49085, 49180, 49300, 49301, 49302, 49303, 49400, 49401, 49420, 49421, 49611;

(5) 50080, 50200, 50390, 50392, 50393, 50394, 50395, 50396, 50398, 50551, 50553, 50555, 50557, 50559, 50561, 50570, 50572, 50574, 50576, 50590, 50684, 50686, 50688, 50690, 50951, 50953, 50955, 50957, 50959, 50961, 50970, 50972, 50974, 50976, 50978, 50980, 51000, 51005, 51010, 51065, 51600, 51605, 51610, 51700, 51705, 51710, 51720, 51725, 51726, 51727, 51736, 51739, 51741, 51772, 51785, 51792, 51795, 51797, 51820, 51940, 52000, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52550, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52283, 52285, 52290, 52300, 52305, 52310, 52315, 52317, 52318, 52320, 52325, 52330, 52332, 52334, 52335, 52336, 52337, 52338, 52340, 52500, 52601, 52606, 52612, 52614, 52620, 52630, 52640,

52650, 52700, 53000, 53010, 53020, 53025, 53040, 53060, 53080, 53200, 53220, 53235, 53240, 53250, 53260, 53265, 53270, 53275, 53420, 53450, 53460, 53502, 53520, 53600, 53601, 53605, 53621, 53640, 53660, 53661, 53665, 53670, 53675, 54000, 54001, 54015, 54050, 54055, 54056, 54057, 54060, 54065, 54100, 54105, 54150, 54152, 54160, 54161, 54200, 54220, 54230, 54235, 54240, 54250, 54300, 54308, 54318, 54328, 54332, 54336, 54340, 54344, 54348, 54352, 54380, 54385, 54435, 54450, 54500, 54505, 54520, 54600, 54620, 54660, 54670, 54700, 54800, 54860, 54900, 55000, 55100, 55120, 55180, 55200, 55250, 55450, 55600, 55651, 55700, 55705, 55720, 55740, 55980, 56000, 56100, 56400, 56405, 56420, 56440, 56501, 56600, 56605, 56606, 56685, 56700, 56710, 56720, 56740, 57000, 57010, 57020, 57061, 57065, 57100, 57105, 57135, 57150, 57160, 57170, 57180, 57291, 57311, 57400, 57410, 57415, 57450, 57451, 57452, 57454, 57500, 57505, 57510, 57511, 57513, 57520, 57700, 57800, 57820, 58100, 58101, 58102, 58120, 58300, 58301, 58310, 58320, 58340, 58345, 58820, 58970, 58980, 58982, 58983, 58986, 58987, 58988, 58990, 58992, 58994, 59000, 59015, 59020, 59025, 59030, 59050, 59130, 59135, 59140, 59150, 59151, 59160, 59200, 59300, 59325, 59400, 59410, 59412, 59420, 59430, 59812, 59820, 59840, 59841, 59850, 59851, 59852;

(6) 60000, 60100, 61000, 61001, 61020, 61026, 61050, 61055, 61070, 61105, 61107, 61108, 61120, 61151, 61334, 61470, 61535, 61541, 61542, 61553, 61690, 61710, 61790, 61791, 61795, 61850, 61865, 61870, 61885, 61888, 62194, 62256, 62268, 62269, 62270, 62272, 62273, 62274, 62276, 62277, 62278, 62279, 62280, 62282, 62284, 62288, 62289, 62290, 62291, 62292, 62294, 63196, 63198, 63306, 63307, 63600, 63650, 63652, 63656, 63657, 63660, 63688, 63780, 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64440, 64441, 64442, 64443, 64445, 64450, 64505, 64508, 64510, 64520, 64530, 64550, 64553, 64555, 64560, 64565, 64573, 64575, 64577, 64580, 64585, 64595, 64600, 64605, 64610, 64620, 64622, 64623, 64630, 64640, 64680, 64721, 64726, 64727, 64732, 64734, 64736, 64738, 64761, 64774, 64778, 64783, 64795, 64831, 64832, 64834, 64837, 64840, 64858, 64861, 64870, 64895, 64896, 64898, 64901, 64905, 64907, 65140, 65150, 65205, 65210, 65220, 65222, 65230, 65235, 65240, 65245, 65260, 65270, 65272, 65275, 65280, 65286, 65300, 65400, 65410, 65420, 65426, 65430, 65435, 65436, 65450, 65600, 65772, 65775, 65800, 65805, 65810, 65815, 65820, 65825, 65830, 65855, 65860, 66020, 66030, 66130, 66155, 66165, 66600, 66625, 66630, 66700, 66701, 66720, 66721, 66761, 66762, 66770, 66800, 66801, 66802, 66820, 66821, 66825, 66830, 66840, 66850, 66915, 66983, 67031, 67105, 67141, 67145, 67208, 67210, 67227, 67228, 67345, 67350, 67415, 67430, 67500, 67505, 67515, 67700, 67710, 67715, 67800, 67801, 67805, 67808, 67810, 67820, 67825, 67830, 67835, 67840, 67850, 67880, 67882, 67906, 67909, 67914, 67915, 67916, 67921, 67922, 67923, 67930, 67935, 67938, 67975, 67999, 68020, 68040, 68100, 68110, 68115, 68130, 68135, 68200, 68328, 68330, 68340, 68360, 68400, 68420, 68440, 68500, 68510, 68530, 68700, 68705, 68760, 68761, 68770, 68800, 68820, 68825, 68830, 68840, 68850, 69000, 69005, 69020, 69090, 69100, 69105, 69110, 69120, 69140, 69145, 69200, 69205, 69210, 69220, 69221, 69222, 69300, 69310, 69320, 69400, 69401, 69405, 69410, 69420, 69421, 69424, 69425, 69433, 69436, 69440, 69450, 69501, 69502, 69505, 69511, 69530, 69540, 69550, 69554, 69601, 69602, 69603, 69604, 69610, 69611, 69620, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69646, 69650, 69660, 69661, 69662, 69667, 69676, 69700, 69710, 69725, 69801, 69802, 69805, 69806, 69820, 69905, 69910, 69930, 69955, 69960, 69970, 92995, 92996.

Subp. 7. **Multiple physicians.** If more than one physician provides services that are part of a global surgery package, maximum fees for each physician's portion of the package are calculated according to items A to E.

A. If a surgeon who performs surgery in an inpatient hospital cares for the patient only until discharged from the hospital, then the maximum fee for this surgeon's services are calculated according to the following formula:

Maximum fee = .86 x (total RVUs x CF).

Modifier 54 is used to identify these services.

B. If a health care provider who did not perform the surgery assumes surgical follow–up care of a patient after discharge from the inpatient hospital, then the maximum fee for this practitioner's services is calculated according to the following formula:

Maximum fee = .14 x (total RVUs x CF).
Modifier 55 is used to identify these services.

C. If several health care providers furnish postoperative care, the maximum fee for the postoperative period is divided among the practitioners based on the number of days for which each health care provider was primarily responsible for care of the patient. Both modifiers 55 and 52 are used to identify postoperative services furnished by more than one provider.

D. If the providers have agreed to a payment distribution of the global fee that differs from the distributions set forth in items A to C, then payments will be made accordingly, if the agreed–upon distribution is documented and explained on the bill for the procedure and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

E. The sum of the fees allowed for all practitioners providing care included in the global surgery package shall not exceed the amount of the global fee for the procedure, calculated according to the formula in part 5221.4020, for a single practitioner.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4040 PATHOLOGY AND LABORATORY PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.**

A. Column 1 in subpart 2a is labeled "CPT/HCPCS procedure code." This is the specific code intended to identify the health care service described in column 2.

B. Column 2 in subpart 2a is labeled "CPT/HCPCS description." This is a short narrative description of the procedure code. A complete description of the service appears in the CPT or HCPCS Manual in effect on the date the service was rendered.

C. Column 3 in subpart 2a is labeled "total RVU." These are the total relative value units for the service.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. **List of pathology and laboratory procedure codes.**

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
80007	7 Clinical chemistry tests	0.74
80500	Lab pathology consultation	0.48
80502	Lab pathology consultation	1.40
81000	Urinalysis with microscopy	0.22
81002	Urinalysis without scope	0.12
82565	Assay blood creatinine	0.09
82947	Assay body fluid, glucose	0.35
84132	Assay blood potassium	0.22
84295	Assay blood sodium	0.28
85007	Differential white blood cell count	0.26
85014	Hematocrit	0.14
85018	Hemoglobin, colorimetric	0.17
85021	Automated hemogram	0.23
85022	Automated hemogram	0.40
85023	Automated hemogram	0.50
85024	Automated hemogram	0.43
85025	Automated hemogram	0.61
85031	Manual hemogram, complete CBC	0.44
85048	White blood cell (WBC) count	0.15
85060	Blood smear interpretation	0.57
85095	Bone marrow aspiration	1.48
85097	Bone marrow interpretation	1.20
85100	Bone marrow examination	2.83

85101	Aspirate, stain bond marrow	1.61
85102	Bone marrow biopsy	1.83
85103	Bone marrow biopsy and exam	1.27
85105	Bone marrow, interpretation	0.90
85109	Bone marrow preparation	0.98
85580	Blood platelet count	0.34
85610	Prothrombin time	0.25
85651	RBC sedimentation rate	0.17
85730	Thromboplastin time, partial	0.34
86068	Blood compatibility test	0.55
86077	Physician blood bank service	0.57
86078	Physician blood bank service	1.08
86079	Physician blood bank service	0.59
86083	Blood typing; antibody screen	0.75
86455	Reduced allergy skin test	0.33
86490	Coccidioidomycosis skin test	0.24
86510	Histoplasmosis skin test	0.26
86540	Mumps skin test	0.21
86580	TB intradermal test	0.21
86585	TB tine test	0.16
87040	Blood culture for bacteria	0.89
87070	Culture specimen, bacteria	0.45
88104	Microscopic exam of cells	0.85
88106	Microscopic exam of cells	0.79
88107	Microscopic exam of cells	1.04
88108	Cytopathology	0.88
88125	Forensic cytopathology	0.31
88160	Cytopathology	0.71
88161	Cytopathology	0.76
88162	Cytopathology, extensive	1.31
88170	Fine needle aspiration	1.28
88171	Fine needle aspiration	2.04
88172	Evaluation of smear	1.11
88173	Interpretation of smear	1.65
88180	Cell marker study	0.59
88182	Cell marker study	1.41
88300	Surg. path, gross	0.24
88302	Tissue exam by pathologist	0.48
88304	Tissue exam by pathologist	0.71
88305	Tissue exam by pathologist	1.52
88307	Tissue exam by pathologist	2.64
88309	Tissue exam by pathologist	3.56
88311	Decalcify tissue	0.38
88312	Special stains	0.67
88313	Special stains	0.38
88314	Histochemical stain	0.91
88318	Chemical histochemistry	0.55
88319	Enzyme histochemistry	0.87
88321	Microslide consultation	1.44
88323	Microslide consultation	1.75
88325	Comprehensive review of data	2.27
88329	Pathology consult in surgery	0.88
88331	Pathology consult in surgery	1.94
88332	Pathology consult in surgery	0.98
88342	Immunocytochemistry	1.26

88346	Immunofluorescent study	1.22
88347	Immunofluorescent study	1.09
88348	Electron microscopy	3.22
88349	Scanning electron microscopy	1.97
88355	Analysis, skeletal muscle	3.05
88356	Analysis, nerve	4.81
88358	Analysis, tumor	4.35
88362	Nerve teasing preparations	3.50
88365	Tissue hybridization	1.42
89100	Sample intestinal contents	0.86
89105	Sample intestinal contents	0.76
89130	Sample stomach contents	0.73
89132	Sample stomach contents	0.33
89135	Sample stomach contents	1.16
89136	Sample stomach contents	0.37
89140	Sample stomach contents	1.49
89141	Sample stomach contents	1.34
89350	Sputum specimen collection	0.34
89360	Collect sweat for test	0.37

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530; 20 SR 1163*

5221.4041 FEE ADJUSTMENTS FOR PROFESSIONAL/TECHNICAL COMPONENTS FOR PATHOLOGY/LABORATORY SERVICES.

Subpart 1. **General.** Fees for pathology and laboratory services shall be adjusted when the professional and technical components of the service are performed by different individuals or entities. The professional component of the service represents the care rendered by the health care provider, such as examination of the patient, performance and supervision of the procedure, and consultation with other practitioners. The technical component of the service represents all other costs associated with the service, such as the cost of equipment, the salary of technicians, and supplies normally used in delivering the service. The maximum fee for the professional component of the service is calculated according to the following formula:

Maximum fee = .75 x (total RVUs x CF). The billing code for the professional component of the service is the specific procedure code plus the modifier 26. The maximum fee for the technical component of the service is calculated according to the following formula: Maximum fee = .25 x (total RVUs x CF). The billing code for the technical component of the service is the specific procedure code plus the modifier TC.

Subp. 2. **Services provided to hospital inpatients.** The maximum fee for a service rendered by a provider to an employee while hospitalized as an inpatient is that calculated for the professional component of the service only. Charges for the technical component of the service for an inpatient may be included in the separate billing by hospital and are limited by Minnesota Statutes, section 176.136, subdivision 1b.

Subp. 3. **Separate billing for each component.** If the professional component is split from the technical component and both are billed separately, the total cost for both shall not exceed the maximum fee allowed for the complete service, unless there are extenuating circumstances and there is documented justification for the additional cost.

Subp. 4. **One billing for both components.** If the same health care provider renders both the professional and technical components of the service, the maximum fee is calculated according to the formula in part 5221.4020.

Subp. 5. **Services performed in an independent laboratory.** The maximum fee for physician pathology services performed in an independent laboratory is that calculated for

the complete service, using the RVUs corresponding to the service code listed without a modifier in part 5221.4040, subpart 2a, and the formula in part 5221.4020.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.**

A. Column 1 in subpart 2a is labeled "CPT/HCPCS procedure code." This is the specific code intended to identify the health care service described in column 2.

B. Column 2 in subpart 2a is labeled "CPT/HCPCS description." This is a short narrative description of the procedure code. A complete description of the service appears in the CPT or HCPCS Manual in effect on the date the service was rendered.

C. Column 3 in subpart 2a is labeled "total RVU." These are the total relative value units for the service.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. **List of physical medicine and rehabilitation procedure codes.**

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
97010	Hot or cold packs therapy	0.27
97012	Mechanical traction therapy	0.37
97014	Electric stimulation therapy	0.32
97016	Vasopneumatic device therapy	0.36
97018	Paraffin bath therapy	0.30
97020	Microwave therapy	0.26
97022	Whirlpool therapy	0.37
97024	Diathermy treatment	0.27
97026	Infrared therapy	0.25
97028	Ultraviolet therapy	0.32
97032	Electrical stimulation, each 15 minutes	0.32
97033	Electric current therapy, each 15 minutes	0.33
97034	Contrast bath therapy, each 15 minutes	0.26
97035	Ultrasound therapy, each 15 minutes	0.26
97036	Hydrotherapy, each 15 minutes	0.49
97039	Physical therapy treatment	0.44
97110	Therapeutic exercises	0.48
97112	Neuromuscular reeducation	0.47
97113	Aquatic therapy/exercises	0.53
97116	Gait training therapy	0.42
97122	Manual traction therapy	0.46
97124	Massage therapy	0.38
97139	Physical medicine procedure	0.31
97150	Group therapeutic procedures	0.39
97250	Myofascial release	0.67
97260	Regional manipulation	0.32
97261	Supplemental manipulations	0.19
97265	Joint mobilization	0.67
97500	Orthotics training, initial 30 minutes	0.49
97501	Supplemental training, each 15 minutes	0.27
97520	Prosthetic training, initial 30 minutes	0.56
97521	Supplemental training, each 15 minutes	0.32

97530	Therapeutic activities, each 15 minutes	0.50
97540	Training for daily living, initial 30 minutes	0.67
97541	Supplemental training, each 15 minutes	0.30
97700	Training check–out, initial 30 minutes	0.62
97701	Supplemental check–out, each 15 minutes	0.30
97750	Physical performance test, each 15 minutes	0.57
97770	Cognitive skills development, each 15 minutes	0.60
H5300	Occupational therapy	0.47
Q0103	Physical therapy evaluation	1.16
Q0104	Physical therapy reevaluation	0.44
Q0109	Occupational therapy evaluation	1.16
Q0110	Occupational therapy reevaluation	0.44

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530; 20 SR 858*

5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES.

Maximum fees for the physical medicine and rehabilitation modalities in the following list are determined according to the following payment schedule when more than one modality is provided to the same patient on the same day: 100 percent of the fee calculated according to the formula in part 5221.4020 for the most expensive procedure and 75 percent of the fee calculated according to the formula in part 5221.4020 for each additional procedure. All modalities after the first, most expensive modality shall be coded by adding modifier 51 to the applicable procedure code.

97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97014	Electric stimulation therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97020	Microwave therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation (manual)
97033	Iontophoresis
97034	Contrast baths
97035	Ultrasound
97036	Hydrotherapy
97039	Physical therapy treatment
97113	Aquatic therapy with exercises
97122	Manual traction therapy
97124	Massage therapy
97139	Physical medicine procedure

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530*

5221.4060 CHIROPRACTIC PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.**

A. Column 1 in subpart 2a is labeled "CPT/HCPCS procedure code." This is the specific code intended to identify the health care service described in column 3.

B. Column 2 in subpart 2a is labeled "CPT/HCPCS description." This is a short narrative description of the procedure code. Complete descriptions of included chiropractic

services appear either in the CPT or HCPCS manual in effect on the date the service was rendered or in subpart 3.

C. Column 3 in subpart 2a is labeled "total RVU." These are the total relative value units for the service.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. **List of chiropractic procedure codes.**

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
72010	X–ray exam of spine	1.05
72020	X–ray exam of spine	0.52
72040	X–ray exam of neck spine	0.84
72050	X–ray exam of neck spine	0.78
72052	X–ray exam of neck spine	0.96
72070	X–ray exam of thorax spine	1.05
72074	X–ray exam of thoracic spine	0.72
72080	X–ray exam of trunk spine	1.05
72090	X–ray exam of trunk spine	0.63
72100	X–ray exam of lower spine	0.58
72110	X–ray exam of lower spine	1.69
72114	X–ray exam of lower spine	0.99
72120	X–ray exam of lower spine	0.70
72170	X–ray exam of pelvis	0.44
72190	X–ray exam of pelvis	0.57
73020	X–ray exam of shoulder	0.41
73030	X–ray exam of shoulder	0.49
73070	X–ray exam of elbow	0.43
73100	X–ray exam of wrist	0.42
73500	X–ray exam of hip	0.42
73562	X–ray exam of knee	0.49
73610	X–ray exam of ankle	0.46
81000	Urinalysis with microscopy	0.12
81002	Without microscopy	0.07
X2005	Chiropractic visit with manipulation/adjustment, initial; office	0.39
X2006	Chiropractic visit with manipulation/adjustment, subsequent; office	0.42
X2009	Each additional manipulation/adjustment on same day; office, home, or nursing	0.26
X2100	New patient; brief examination	0.43
X2120	Extensive examination	1.14
X2125	Established patient; brief examination	0.52
X2130	Intermediate examination	0.70
X2135	Extensive examination	1.05
X2201	Application of hot pack	0.21
X2202	Application of cold pack	0.19
X2205	Diathermy	0.26
X2210	Electrical stimulation	0.21
X2212	Intersegmental motorized mobilization	0.25
X2214	Muscle stimulation, manual	0.22
X2220	Ultrasound therapy	0.21
X2225	Traction	0.23

X2230	Acupressure, manual or mechanical	0.25
X2245	Infrared – heat lamp	0.21
X2255	Trigger point therapy	0.25
X2392	Exercise consultation/instruction	0.26
X9557	Medical conference up to 25 minutes	0.88

Subp. 3. **Select chiropractic procedure code descriptions.**

X9198 Special chiropractic report. Review of medical and vocational data and preparation of a report to clarify the patient's status, which report includes more information than that contained in the usual chiropractic communication or standard reporting form.

X9199 Unlisted special chiropractic service. Chiropractic services specifically related to planning and coordinating the employee's return to work, including but not limited to office visits, telephone calls, or conferences with the employee, the employer, the insurer, the qualified rehabilitation consultant, and/or other health care providers.

X9557 Conference. Conference by a chiropractor with the patient and/or the patient's representative and/or additional health care providers to coordinate activities of patient care; up to 25 minutes.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530*

5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

Maximum fees for the chiropractic modalities in the following list are determined according to the following payment schedule when more than one modality is provided to the same patient on the same day: 100 percent of the fee calculated according to the formula in part 5221.4020 for the most expensive procedure and 75 percent of the fee calculated according to the formula in part 5221.4020 for each additional procedure. All modalities after the first, most expensive modality shall be coded by adding modifier 51 to the applicable procedure code.

X2201	Application of hot pack
X2202	Application of cold pack
X2205	Diathermy
X2210	Electrical stimulation
X2212	Intersegmental motorized mobilization
X2214	Muscle stimulation, manual
X2220	Ultrasound therapy
X2225	Traction
X2230	Acupressure, manual or mechanical
X2245	Infrared – heat lamp
X2250	Ultraviolet
X2255	Trigger point therapy

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.4070 PHARMACY.

Subpart 1. **Substitution of generically equivalent drugs.** A generically equivalent drug as defined in Minnesota Statutes, section 151.21, subdivision 2, must be dispensed in place of the ordered drug if:

A. the generically equivalent drug is approved by the United States Food and Drug Administration and is also determined as therapeutically equivalent by the United States Food and Drug Administration;

B. in the professional judgment of the pharmacist, the substituted drug is therapeutically equivalent to the ordered drug; and

C. the charge for the substituted generically equivalent drug is less than the charge for the drug originally ordered.

However, a substitution shall not be made if the ordering provider has written in his or her own handwriting "Dispense as written" or "DAW" on the prescription, as provided in the Minnesota Drug Selection Act, Minnesota Statutes, section 151.21. The dispensing provider must notify the recipient and the payer when a generically equivalent drug is dispensed. The notice to the recipient may be given orally or by appropriate labeling on the medication's container. The notice to the payer must be in writing on a claim form prescribed in part 5221.0700, subpart 2.

Subp. 2. **Procedure code.** The procedure code for a medication is the current HCPCS code which correctly describes the medication as provided or the prescription number. Procedure codes are not required for nonprescription medications.

Subp. 3. **Maximum fee.**

A. The employer's liability for compensable prescription medications shall be limited to the sum of the average wholesale price (AWP) of the medication on the date the medication was dispensed, and a professional dispensing fee of $5.14 per medication.

B. The employer's liability for compensable nonprescription medications shall be the lower of the actual retail price of the medication or the sum of the average wholesale price (AWP) of the medication, on the date the medication was dispensed, and a professional dispensing fee of $5.14 per medication.

Statutory Authority: *MS s 175.171; 176.101; 176.135; 176.136; 176.231; 176.83*

History: *18 SR 1472*

5221.6010 AUTHORITY.

Parts 5221.6010 to 5221.8900 are adopted under the authority of Minnesota Statutes, sections 176.83, subdivisions 1, 3, 4, and 5, and 176.103, subdivision 2.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6020 PURPOSE AND APPLICATION.

Subpart 1. **Purpose.** Parts 5221.6010 to 5221.6600 establish parameters for reasonably required treatment of employees with compensable workers' compensation injuries to prevent excessive services under Minnesota Statutes, sections 176.135 and 176.136, subdivision 2. Parts 5221.6010 to 5221.6600 do not affect any determination of liability for an injury under Minnesota Statutes, chapter 176, and are not intended to expand or restrict a health care provider's scope of practice under any other statute.

Subp. 2. **Application.** All treatment must be medically necessary as defined in part 5221.6040, subpart 10. In the absence of a specific parameter, any applicable general parameters govern. A departure from a parameter that limits the duration or type of treatment may be appropriate in any one of the circumstances specified in part 5221.6050, subpart 8. Parts 5221.6010 to 5221.6600 apply to all treatment provided after January 4, 1995, regardless of the date of injury. All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after January 4, 1995. However, consideration may be given to treatment initiated under the emergency rules (parts 5221.6050 to 5221.6500 [Emergency]). Parts 5221.6010 to 5221.6600 do not apply to treatment of an injury after an insurer has denied liability for the injury. However, in such cases

the rules do apply to treatment initiated after liability has been established. References to days and weeks in parts 5221.6050 to 5221.6600 mean calendar days and weeks unless specified otherwise.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6030 INCORPORATION BY REFERENCE.

The ICD–9–CM diagnostic codes referenced in parts 5221.6010 to 5221.6600 are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6040 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5221.6010 to 5221.6600 have the meanings given them in this part.

Subp. 2. **Active treatment.** "Active treatment" means treatment specified in parts 5221.6200, subpart 4; 5221.6205, subpart 4; 5221.6210, subpart 4; 5221.6300, subpart 4; and 5221.6305, subpart 2, item C, which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.

Subp. 3. **Chronic pain syndrome.** "Chronic pain syndrome" means any set of verbal or nonverbal behaviors that:

A. involve the complaint of enduring pain;

B. differ significantly from the patient's preinjury behavior;

C. have not responded to previous appropriate treatment;

D. are not consistent with a known organic syndrome which has remained untreated; and

E. interfere with physical, psychological, social, or vocational functioning.

Subp. 4. **Condition.** A patient's "condition" means the symptoms, physical signs, clinical findings, and functional status that characterize the complaint, illness, or injury related to a current claim for compensation.

Subp. 5. **Emergency treatment.** "Emergency treatment" means treatment that is:

A. required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or

B. immediately necessary to alleviate severe pain.

Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

Subp. 6. **Etiology.** "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality which is considered a cause of the patient's condition.

Subp. 7. **Functional status.** "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.

Subp. 8. **Initial nonsurgical management or treatment.** "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment under parts 5221.6200, subparts 3, 4, 5, and 8; 5221.6205, subparts 3, 4, 5, and 8; 5221.6210, subparts 3, 4, 5, and 8; 5221.6300, subparts 3, 4, 5, and 8; and 5221.6305, subpart 2. Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under part 5221.6600.

Subp. 9. **Medical imaging procedures.** A "medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X–rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.

Subp. 10. **Medically necessary treatment.** "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter in parts 5221.6050 to 5221.6600. Where parts 5221.6050 to 5221.6600 do not govern, the treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

Subp. 11. **Neurologic deficit.** "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder, or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

A. "Static neurologic deficit" means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.

B. "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or noted by repeated examination since onset.

Subp. 12. **Passive treatment.** "Passive treatment" is any treatment modality specified in parts 5221.6200, subpart 3; 5221.6205, subpart 3; 5221.6210, subpart 3; 5221.6300, subpart 3; and 5221.6305, subpart 2, item B. Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

Subp. 13. **Therapeutic injection.** "Therapeutic injection" is any injection modality specified in parts 5221.6200, subpart 5; 5221.6205, subpart 5; 5221.6210, subpart 5; 5221.6300, subpart 5; and 5221.6305, subpart 2, item A. Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT; PRIOR NOTIFICATION.

Subpart 1. **General.**

A. All treatment must be medically necessary treatment, as defined in part 5221.6040, subpart 10. The health care provider must evaluate the medical necessity of all treatment under item B on an ongoing basis.

Parts 5221.6050 to 5221.6600 do not require or permit any more frequent examinations than would normally be required for the condition being treated, but do require ongoing evaluation of the patient that is medically necessary, consistent with accepted medical practice.

B. The health care provider must evaluate at each visit whether initial nonsurgical treatment for the low back, cervical, thoracic, and upper extremity conditions specified in parts 5221.6200, 5221.6205, 5221.6210, and 5221.6300, is effective according to subitems (1) to (3). No later than any applicable treatment response time in parts 5221.6200 to 5221.6300, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in subitems (1) to (3):

(1) the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

(2) the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

Except as otherwise provided under parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B, if there is not progressive improvement in at least two of subitems (1) to (3), the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider who ordered the treatment.

C. The health care provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

Subp. 2. **Documentation.** A health care provider must maintain an appropriate record, as defined in part 5221.0100, subpart 1a, of any treatment provided to a patient.

Subp. 3. **Nonoperative treatment.** Health care providers shall provide a trial of nonoperative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

Subp. 4. **Chemical dependency.** The health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the employee's condition. In cases of incipient or actual dependency, the health care provider shall refer the employee for appropriate evaluation and treatment of the dependency.

Subp. 5. **Referrals between health care providers.** The primary health care provider directing the course of treatment shall make timely and appropriate referrals for consultation for opinion or for the transfer of care if the primary health care provider does not have any reasonable alternative treatment to offer and there is a reasonable likelihood that the consultant may offer or recommend a reasonable alternative treatment plan. This subpart does not prohibit a referral for consultation in other circumstances based on accepted medical practice and the patient's condition.

A. Referrals from consulting health care provider. If the consultant has reasonable belief that another consultation is appropriate, that consultant must coordinate further referral with the original treating health care provider unless the consultant has been approved as the employee's treating health care provider. The consultant is under no obligation to provide or recommend treatment or further referral, if in the consultant's opinion, all reasonable and necessary treatment has been rendered. The consultant shall in this situation refer the employee back to the original treating health care provider for further follow–up.

B. Information sent to consultant. When a referring health care provider arranges for consultation or transfer of care, except in cases of emergency, the referring health care provider shall, with patient authorization, summarize for the consultant orally or in writing the conditions of injury, the working diagnosis, the treatment to date, the patient's response to treatment, all relevant laboratory and medical imaging studies, return to work considerations, and any other information relevant to the consultation. In addition, the referring health care provider shall make available to the consultant, with patient authorization, a copy of all medical records relevant to the employee's injury.

Subp. 6. **Communication between health care providers and consideration of prior care.**

A. Information requested by new health care provider. Upon accepting for treatment a patient with a workers' compensation injury, the health care provider shall ask the patient if treatment has been previously given for the injury by another health care provider. If the patient reports that treatment has been previously given for the injury by another health care provider and if the medical records for the injury have not been transferred, the new health care provider shall request authorization from the employee for relevant medical records. Upon receipt of the employee authorization, the new health care provider shall request relevant medical records from the previous health care providers. Upon receipt of the request

for medical records and employee authorization, the previous health care providers shall provide the records within seven working days.

B. Treatment by prior health care provider. If the employee has reported that care for an injury has been previously given:

(1) Where a previous health care provider has performed diagnostic imaging, a health care provider may not repeat the imaging or perform alternate diagnostic imaging for the same condition except as permitted in part 5221.6100.

(2) When a therapeutic modality employed by a health care provider was no longer improving the employee's condition under subpart 1, item B, or has been used for the maximum duration allowed under parts 5221.6050 to 5221.6600, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies under subpart 8, after surgery, or for treatment of reflex sympathetic dystrophy under part 5221.6305.

(3) It is also inappropriate for two health care providers to use the same treatment modality concurrently.

C. Employee refusal. An employee's refusal to provide authorization for release of medical records does not justify repeat treatment or diagnostic testing. An insurer is not liable for repeat diagnostic testing or other duplicative treatment prohibited by this subpart.

Subp. 7. **Determinations of excessive treatment; notice of denial to health care providers and employee; expedited processing of medical requests.**

A. In addition to services deemed excessive under part 5221.0500 and Minnesota Statutes, section 176.136, subdivision 2, treatment is excessive if:

(1) the treatment is inconsistent with an applicable parameter or other rule in parts 5221.6050 to 5221.6600; or

(2) the treatment is consistent with the parameters in parts 5221.6050 to 5221.6600, but is not medically necessary treatment.

B. If the insurer denies payment for treatment that departs from a parameter under parts 5221.6050 to 5221.6600, the insurer must provide the employee and health care provider with written notice of the reason for the denial and that the treatment rules permit departure from the parameters in specified circumstances. If the insurer denies authorization for proposed treatment after prior notification has been given under subpart 9, the insurer must provide the employee and health care provider in writing with notice of the reason why the information given by the health care provider does not support the proposed treatment and notice of the right to review of the denial under subpart 9, item C. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days' notice of intent to apply any of the chronic management parameters in part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

C. If the insurer denies authorization or payment for treatment governed by parts 5221.6050 to 5221.6600, the health care provider or the employee may request a determination from the commissioner or compensation judge by filing a medical request or petition under chapter 5220 and Minnesota Statutes, sections 176.106, 176.2615, and 176.305. The medical request may not be filed before completion of the managed care plan's dispute resolution process, if applicable. If the health care provider has notified the insurer of proposed treatment requiring prior notification under subpart 9, the health care provider or employee must describe or attach a copy of the notification, and any response from the insurer, to the medical request filed with the department. The insurer may, but is not required to, file a medical response where the insurer's response to prior notification under subpart 9 has been attached to the medical request. If the insurer elects to file a medical response in such cases, it must be received within ten working days of the date the medical request was filed with the department. The commissioner or compensation judge may issue a decision based on written submissions no earlier than ten working days after receipt of the medical request, unless a medical response has been filed sooner.

D. A determination of the compensability of medical treatment under Minnesota Statutes, chapter 176, must include consideration of the following factors:

(1) whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;

(2) if a specific or general parameter applies, whether the treatment is consistent with the treatment parameter and whether the treatment was medically necessary as defined in part 5221.6040, subpart 10; and

(3) whether a departure from the applicable parameter is or was necessary because of any of the factors in subpart 8.

Subp. 8. **Departures from parameters.** A departure from a parameter that limits the duration or type of treatment in parts 5221.6050 to 5221.6600 may be appropriate in any one of the circumstances specified in items A to E. The health care provider must provide prior notification of the departure as required by subpart 9.

A. Where there is a documented medical complication.

B. Where previous treatment did not meet the accepted standard of practice and the requirements of parts 5221.6050 to 5221.6600 for the health care provider who ordered the treatment.

C. Where the treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee's response to the treatment, and efforts to promote employee independence in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

D. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

(1) the employee's subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

(2) the employee's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activity, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

E. Where there is an incapacitating exacerbation of the employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts 5221.6050 to 5221.6600.

Subp. 9. **Prior notification; health care provider and insurer responsibilities.** Prior notification is the responsibility of the health care provider who wants to provide the treatment in item A. Prior notification need not be given in any case where emergency treatment is required.

A. The health care provider must notify the insurer of proposed treatment in subitems (1) to (4) at least seven working days before the treatment is initiated, except as otherwise provided in subitem (4):

(1) for chronic management modalities where prior notification is required under part 5221.6600;

(2) for durable medical equipment requiring prior notification in parts 5221.6200, subpart 8; 5221.6205, subpart 8; 5221.6210, subpart 8; and 5221.6300, subpart 8;

(3) for any nonemergency inpatient hospitalization or nonemergency inpatient surgery. A surgery or hospitalization is considered inpatient if the patient spends at least one night in the facility; and

(4) for treatment that departs from a parameter limiting the duration or type of treatment in parts 5221.6050 to 5221.6600. The health care provider must notify the insurer

within two business days after initiation of treatment if the departure from a parameter is for an incapacitating exacerbation or an emergency.

B. The health care provider's prior notification required by item A may be made orally, or in writing, and shall provide the following information, when relevant:

(1) the diagnosis;

(2) when giving prior notification for chronic management modalities, durable medical equipment, or inpatient hospitalization or surgery required by item A, subitems (1) to (3), whether the proposed treatment is consistent with the applicable treatment parameter;

(3) when giving prior notification for treatment that departs from a treatment parameter, or notification of treatment for an incapacitating exacerbation or emergency, the basis for departure from any applicable treatment parameter specified in subpart 8; the treatment plan, including the nature and anticipated length of the proposed treatment; and the anticipated effect of treatment on the employee's condition.

C. The insurer must provide a toll–free facsimile and telephone number for health care providers to provide prior notification. The insurer must respond orally or in writing to the requesting health care provider's prior notification of proposed treatment in item A within seven working days of receipt of the request. Within the seven days, the insurer must either approve the request, deny authorization, request additional information, request that the employee obtain a second opinion, or request an examination by the employer's physician. A denial must include notice to the employee and health care provider of the reason why the information given by the health care provider in item B does not support the treatment proposed, along with notice of the right to review of the denial under subitem (3).

(1) If the health care provider does not receive a response from the insurer within the seven working days, authorization is deemed to have been given.

(2) If the insurer authorizes the treatment, the insurer may not later deny payment for the treatment authorized.

(3) If the insurer denies authorization, the health care provider or employee may orally or in writing request that the insurer review its denial of authorization.

The insurer's review of its denial must be made by a currently licensed registered nurse, medical doctor, doctor of osteopathy, doctor of chiropractic, or a person credentialled by a program approved by the commissioner of Labor and Industry. The insurer may also delegate the review to a certified managed care plan under subpart 10. In lieu of or in addition to the insurer's review under this subitem, the insurer may request an examination of the employee under subitem (4), (5), or (6) and the requirements of those subitems apply to the proposed treatment. Unless an examination of the employee is requested under subitem (4), (5), or (6), the insurer's determination following review must be communicated orally or in writing to the requestor within seven working days of receipt of the request for review.

Instead of requesting a review, or if the insurer maintains its denial after the review, the health care provider or the employee may file with the commissioner a medical request or a petition for authorization of the treatment under subpart 7, item C, or except as specified in subitem (4), (5), or (6), may proceed with the proposed treatment subject to a later determination of compensability by the commissioner or compensation judge.

(4) If the insurer requests an examination of the employee by the employer's physician, the health care provider may elect to provide the treatment subject to a determination of compensability by the commissioner or compensation judge under subpart 7, item B. However, the health care provider may not provide nonemergency surgery where the insurer has requested an examination for surgery except as provided in subitems (5) and (6), and may not provide continued passive care modalities where prior approval by the insurer, commissioner, or compensation judge is required under parts 5221.6200, subpart 3, item B, subitem (2); 5221.6205, subpart 3, item B, subitem (2); 5221.6210, subpart 3, item B, subitem (2); and 5221.6300, subpart 3, item B, subitem (2).

(5) If prior notification of surgery is required under item A, subitem (3), the insurer may require that the employee obtain a second opinion from a physician of the employee's choice under Minnesota Statutes, section 176.135, subdivision 1a. If within seven working days of the prior notification the insurer notifies the employee and health care pro-

vider that a second opinion is required, the health care provider may not perform the nonemergency surgery until the employee provides the second opinion to the insurer. Except as otherwise provided in parts 5221.6200, subpart 6, items B and C; 5221.6205, subpart 6, items B and C; 5221.6300, subpart 6, item B; and 5221.6305, subpart 3, item B, if the insurer denies authorization within seven working days of receiving the second opinion, the health care provider may elect to perform the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(6) In any case where prior notification of proposed surgery is required, the insurer may elect to obtain an examination of the employee by the employer's physician under Minnesota Statutes, section 176.155, sometimes referred to as an "independent medical examination." If the insurer notifies the employee and health care provider of the examination within seven working days of the provider's notification, the proposed nonemergency surgery may not be provided pending the examination. However, after 45 days following the insurer's request for an examination, the health care provider may elect to proceed with the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(7) The insurer's request for additional information must be directed to the requesting health care provider and must specify the additional information required that is necessary to respond to the health care provider's notification of proposed treatment. The proposed treatment may not be given until the provider provides reasonable additional information. Once the additional information has been received, the insurer must respond within seven working days according to subitems (1) to (6).

Subp. 10. **Certified managed care plans.** The insurer may delegate responsibility for the notices required in subpart 7, item B, and the response to prior notification under subpart 9, to the certified managed care plan with which the insurer has contracted to manage the employee's medical treatment under Minnesota Statutes, section 176.135, subdivision 1f. Alternatively, the managed care plan may act as an intermediary between the treating health care provider and the insurer. In either case, the notices and time periods in subparts 7, 8, and 9 also apply to the managed care plan. Where the insurer has delegated responsibility to the managed care plan, the insurer may not later deny treatment authorized by the plan.

Subp. 11. **Outcome studies.** The commissioner shall perform outcome studies on the treatment modalities in parts 5221.6200 to 5221.6600. The modalities to be studied shall be selected in consultation with the Workers' Compensation Medical Services Review Board. The commissioner may require health care providers who use these modalities to prospectively gather and report outcome information on patients treated, with necessary consent of the employee. The health care providers shall report the outcome information on the modalities in parts 5221.6200 to 5221.6600 on a form prescribed by the commissioner, which may include:

A. the name of the health care provider;

B. the name of the patient, date of injury, date of birth, gender, and, with patient permission, level of education and social security number;

C. the name of the workers' compensation insurer and managed care plan, if any;

D. the pretreatment and posttreatment employment status;

E. the nature of treatment given before and after the treatment being studied for the same condition;

F. the diagnosis, symptoms, physical findings, and functional status before and after the treatment being studied for the same condition; and

G. the presence or absence of preexisting or concurrent conditions.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6100 PARAMETERS FOR MEDICAL IMAGING.

Subpart 1. **General principles.** All medical imaging must comply with items A to E. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study.

A. Effective imaging. A health care provider should initially order the single most effective imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is indicated except for repeat and alternative imaging allowed under items D and E.

B. Appropriate imaging. Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not indicated.

C. Routine imaging. Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

D. Repeat imaging. Repeat imaging, of the same views of the same body part with the same imaging modality is not indicated except as follows:

(1) to diagnose a suspected fracture or suspected dislocation;

(2) to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment;

(3) to follow up a surgical procedure;

(4) to diagnose a change in the patient's condition marked by new or altered physical findings;

(5) to evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study; or

(6) when the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.

E. Alternative imaging.

(1) Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

(2) Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

(3) Alternative imaging is allowed to follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding is one that does not provide an adequate basis for accurate diagnosis.

Subp. 2. **Specific imaging procedures for low back pain.** Except for the emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

A. Computed tomography (CT) scanning is indicated any time that one of the following conditions is met:

(1) when cauda equina syndrome is suspected;

(2) for evaluation of progressive neurologic deficit; or

(3) when bony lesion is suspected on the basis of other tests or imaging procedures.

Except as specified in subitems (1) to (3), CT scanning is not indicated in the first eight weeks after an injury.

Computed tomography scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

B. Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following conditions is met:

(1) when cauda equina syndrome is suspected;

(2) for evaluation of progressive neurologic deficit;

(3) when previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage; or

(4) suspected discitis.

Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first eight weeks after an injury.

Magnetic resonance imaging scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

C. Myelography is indicated in the following circumstances:

(1) may be substituted for otherwise indicated CT scanning or MRI scanning in accordance with items A and B, if those imaging modalities are not locally available;

(2) in addition to CT scanning or MRI scanning, if there are progressive neurologic deficits or changes and CT scanning or MRI scanning has been negative; or

(3) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

D. Computed tomography myelography is indicated in the following circumstances:

(1) the patient's condition is predominantly sciatica, and there has been previous spinal surgery, and tumor is suspected;

(2) the patient's condition is predominantly sciatica and there has been previous spinal surgery and MRI scanning is equivocal;

(3) when spinal stenosis is suspected and the CT or MRI scanning is equivocal;

(4) in addition to CT scanning or MRI scanning, if there are progressive neurologic symptoms or changes and CT scanning or MRI scanning has been negative; or

(5) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

E. Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for CT–myelography is contraindicated and MRI scanning is not available or is also contraindicated.

F. Gadolinium enhanced MRI scanning is indicated when:

(1) there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor;

(2) hemorrhage is suspected;

(3) tumor or vascular malformation is suspected;

(4) infection or inflammatory disease is suspected; or

(5) unenhanced MRI scanning was equivocal.

G. Discography is indicated when:

(1) all of the following are present:

(a) back pain is the predominant complaint;

(b) the patient has failed to improve with initial nonsurgical management;

(c) other imaging has not established a diagnosis; and

(d) lumbar fusion surgery is being considered as a therapy; or

(2) there has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected.

H. Computed tomography discography is indicated when:

(1) sciatica is the predominant complaint and lateral disc herniation is suspected; or

(2) if appropriately performed discography is equivocal or paradoxical, with a normal X–ray pattern but a positive pain response, and an annular tear or intra–annular injection is suspected.

I. Nuclear isotope imaging (including technicium, indium, and gallium scans) are not indicated unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

J. Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in part 5221.6200, subpart 1, item A.

K. Anterior–posterior (AP) and lateral X–rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) when there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected;

(b) when the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion;

(c) for postoperative follow–up of lumbar fusion surgery;

(d) when the patient is more than 50 years of age;

(e) before beginning a course of treatment with spinal adjustment or manipulation; or

(f) eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

(2) They are not indicated in the following circumstances:

(a) to verify progress during initial nonsurgical treatment; or

(b) to evaluate a successful initial nonsurgical treatment program.

L. Oblique X–rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) to follow up abnormalities detected on anterior–posterior or lateral X–ray;

(b) for postoperative follow–up of lumbar fusion surgery; or

(c) to follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures.

(2) They are not indicated as part of a package of X–rays including anterior–posterior and lateral X–rays of the lumbosacral spine.

M. Electronic X–ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions in part 5221.6200, subpart 1, item A.

Statutory Authority: *MS s 176.103; 176.83*

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5221.6200 LOW BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of low back injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the knee, or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This part does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee, including, but not limited to, ICD–9–CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

(2) Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including, but not limited to, the ICD–9–CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subitem (2), however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

(4) Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, ICD–9–CM codes 344.6, 344.60, and 344.61.

B. Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except in any of the following circumstances:

(1) when a patient's history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subparts 1 and 2. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional low back pain as defined in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome as defined in item A, subitems (2) to (4), after the first three weeks of radicular symptoms. Repeat EMG and nerve conduction studies for radicular pain and cauda equina syndrome are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

E. The use of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in item A:

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X–ray analysis of plain radiographs;

(5) diagnostic ultrasound of the lumbar spine; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychosocial evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain before surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

(2) These injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management functional capacity assessment or evaluation is indicated in either of the following circumstances:

(a) activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

(4) Only one completed functional capacity evaluation is indicated per injury.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. **General treatment parameters for low back pain.**

A. All medical care for low back pain, appropriately assigned to a clinical category in subpart 1, item A, is determined by the clinical category to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

(1) subpart 11 governs regional low back pain;

(2) subpart 12 governs radicular pain with no or static neurologic deficits; and

(3) subpart 13 governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment, or injection modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or cauda equina syndrome may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow–up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin–mediated analgesic therapy includes classic acupuncture and acupressure:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement–restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

(2) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, three weeks unless patient is status post-fusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities can extend past the 12–week limitation on passive treatment modalities so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow–up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the lumbosacral spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self–management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, and should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections can extend past the 12–week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections, including injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots, and peripheral nerves. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Sacroiliac joint injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only two injections are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(3) Facet joint or nerve injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, three injections to any one site.

(4) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(5) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of low back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it also meets the specific parameters specified in subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following lumbar decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500, and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. The following surgical therapies have very limited application and require a second opinion that confirms that the treatment is indicated and within the parameters listed,

and a personality or psychosocial evaluation that indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of low back pain must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

A. Lumbar braces, corsets, or supports are indicated as specified in subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification must be provided to the insurer for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification must be provided to the insurer for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for low back conditions:

(1) whirlpools, Jacuzzi, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical treatment is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

A. the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of the injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive imitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified, or the provider must reconsider the diag-

nosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under Minnesota Statutes, section 152.02, including without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional low back pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and that the most cost–effective regimen is used.

Subp. 11. **Specific treatment parameters for regional low back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional low back pain under subpart 1, item A, subitem (1).

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise specified in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation, if indicated, may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedures indicated for patients with regional low back pain only are decompression of a lumbar nerve root or lumbar arthrodesis, with or with-

out instrumentation, which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, items A and C. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated; their use must meet the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management according to the parameters of part 5221.6600.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management which must be provided according to the parameters of part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain, with or without regional low back pain, with no or static neurologic deficits.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks, and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be indicated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It must be provided within the parameters of subpart 11, item B.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with static neurologic deficits must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for cauda equina syndrome and for radicular pain, with or without regional low back pain, with progressive neurologic deficits.**

A. Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, except that surgical evaluation and surgical therapy may begin at any time.

B. If the health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for

patients with radicular pain, with or without regional back pain, with foot drop or progressive neurologic changes at first presentation must meet the parameters of part 5221.6600.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6205 NECK PAIN.

Subpart 1. **Diagnostic procedures for treatment of neck injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the shoulder. This part does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which affects the cervical region, with or without referral to the upper back or shoulder, including, but not limited to, ICD–9–CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

(2) Radicular pain, with or without regional neck pain, with no or static neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including, but not limited to, the ICD–9–CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00. In these cases neurologic findings on history and examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional neck pain, with progressive neurologic deficit, which includes the same diagnoses as subitem (2); however, in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.

(4) Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

B. Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain, except:

(1) when a patient's history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care

provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in item A, subitems (2) to (4), after the first three weeks of radicular or myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

E. The use of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in item A:

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X–ray analysis of plain radiographs;

(5) diagnostic ultrasound of the spine; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors, such as those in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

(2) These blocks and injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not necessarily limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not reimbursable during the period of initial nonoperative care.

(2) Functional capacity assessment or evaluation is reimbursable in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

J. Consultations with other health care providers may be initiated at any time by the treating health care provider, consistent with accepted medical practice.

Subp. 2. **General treatment parameters for neck pain.**

A. All medical care for neck pain appropriately assigned to a clinical category in subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 14, as follows:

(1) subpart 11 governs regional neck pain;

(2) subpart 12 governs radicular pain with static neurologic deficits;

(3) subpart 13 governs radicular pain with progressive neurologic deficits; and

(4) subpart 14 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical care which may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice, and subparts 6 and 11 to 14, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

(c) Surgery must follow the parameters in subparts 6 and 11 to 14, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow–up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin–mediated analgesic therapy includes classic acupuncture and acupressure:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Cervical collars, spinal braces, and other movement–restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

(2) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, up to three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12–week limitation on passive treatment modalities, so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow–up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the cervical spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, it must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self–management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, decreasing in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12–week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection no sooner than two weeks after the previous injection if a positive response to the first injection. No more than three blocks are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of neck problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 14 and part 5221.6500. The health care provider must provide prior notification for nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 14 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

C. The following surgical therapies have very limited application and require a second opinion which confirms that the treatment is indicated and within the parameters listed, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of neck disorders must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only as specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

A. Cervical collars, braces, or supports and home cervical traction devices may be indicated within the parameters of subpart 3, items F and K.

B. For patients using electrical stimulation at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification must be given for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification must be given to the insurer before purchase of the home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for neck pain conditions:

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and shall evaluate whether initial nonsurgical management is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality has resulted in progressive improvement as specified in items A to C:

A. the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under Minnesota Statutes, section 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional neck pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost–effective regimen is used.

Subp. 11. **Specific treatment parameters for regional neck pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional neck pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation if indicated may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100, subpart 1.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be de-

termined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedure indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain, with or without regional neck pain, with no or static neurologic deficits.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It must be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with static neurologic changes must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for radicular pain, with or without regional neck pain, with progressive neurologic changes.**

A. Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, or cervical arthrodesis, with or without instrumentation. For

patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with progressive neurologic changes at first presentation must meet all of the parameters of part 5221.6600.

Subp. 14. **Specific treatment parameters for myelopathy.**

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the parameters of part 5221.6600.

Statutory Authority: *MS s 176.103; 176.83*

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5221.6210 THORACIC BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of thoracic back injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the consistency appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This part does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which effects the thoracic region, including, but not limited to, ICD–9–CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

(2) Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of in-

tervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine, including, but not limited to, the ICD–9–CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

(3) Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

B. Laboratory tests are not indicated in the evaluation of a patient with regional thoracic back pain, or radicular pain, except when a patient's history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications. Laboratory tests may also be ordered as part of a preoperative evaluation.

C. Medical imaging evaluation of the thoracic spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional thoracic back pain and radicular pain under item A, subitems (1) to (3).

E. The use of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in item A:

(1) surface electromyography or surface paraspinal EMG;

(2) thermography;

(3) plethysmography;

(4) electronic X–ray analysis of plain radiographs;

(5) diagnostic ultrasound of the spine; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not reimbursable during the period of initial nonsurgical care, but may be reimbursable during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonoperative care computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors, such as those listed in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonoperative care.

(2) These blocks and injections are invasive and when done as diagnostic procedures only are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not reimbursable during the period of initial nonoperative care.

(2) Functional capacity assessment or evaluation is reimbursable in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with standard medical practice.

Subp. 2. **General treatment parameters for thoracic back pain.**

A. All medical care for thoracic back pain, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

(1) subpart 11 governs regional thoracic back pain;

(2) subpart 12 governs radicular pain; and

(3) subpart 13 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in items C to F, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with thoracic back problems, except patients with myelopathy under subpart 1, item A, subitem (3), must be given initial nonoperative care which may include active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10.

The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date in light of new clinical information.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may also include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) maximum time for patient education and training, up to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow–up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) maximum time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin–mediated analgesic therapy includes classic acupuncture and acupressure:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement–restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

(2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, three weeks unless patient is status post-fusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12–week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow–up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, back, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the thoracic spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment this shall not be the primary focus of the exercise program.

Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self–management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks and should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, one to three visits for instruction and monitoring; and

(b) there is no limit on the duration and frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12–week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first block. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) optimum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of thoracic back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. The surgical therapies in subitems (1) and (2) have very limited application and require a second opinion which confirms that the treatment is indicated and within the parameters listed, and a personality or psychosocial evaluation which indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of thoracic back pain must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in certain specific situations, as specified in items A to D. The health care provider must provide the insurer with prior notification as required by items B and C, according to part 5221.6050, subpart 9.

A. Braces or supports may be indicated within the parameters of subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for thoracic back pain conditions:

(1) whirlpools, Jacuzzis, hot tubs, special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, or loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical management is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

A. the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under Minnesota Statutes, section 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional thoracic back pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost–effective regimen is used.

Subp. 11. **Specific treatment parameters for regional thoracic back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional thoracic back pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical management must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and objective physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

(6) The only surgical procedure indicated for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which must meet the parameters of subpart 6, and part 5221.6500, subpart 2, item C. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of parts 5221.6010 to 5221.6500 for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to the parameters of part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It shall be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional thoracic back pain, must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for myelopathy.**

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the parameters of part 5221.6600.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6300 UPPER EXTREMITY DISORDERS.

Subpart 1. **Diagnostic procedures for treatment of upper extremity disorders (UED).** A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category according to subitems (1) to (6). The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This part does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

(1) Epicondylitis. This clinical category includes medial epicondylitis and lateral epicondylitis, ICD–9–CM codes 726.31 and 726.32.

(2) Tendonitis of the forearm, wrist, and hand. This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including, but not limited to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including, but not limited to, ICD–9–CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.2.

(3) Nerve entrapment syndromes. This clinical category encompasses any compression or entrapment of the radial, ulnar, or median nerves, or any of their branches, including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including, but not limited to, ICD–9–CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

(4) Muscle pain syndromes. This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including, but not limited to, the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syn-

drome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including, but not limited to, ICD–9–CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

(5) Shoulder impingement syndromes, including tendonitis, bursitis, and related conditions. This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including, but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including, but not limited to, ICD–9–CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6, 840.8, and 840.9.

(6) Traumatic sprains or strains of the upper extremity. This clinical category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including, without limitation, ICD–9–CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subitem (4). Injuries with complete tissue disruption are not subject to this parameter.

B. Certain laboratory tests may be indicated in the evaluation of a patient with upper extremity disorder to rule out infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of upper extremity disorders must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

E. The following diagnostic procedures or tests are not indicated for diagnosis of upper extremity disorders:

(1) surface electromyography;

(2) thermography; or

(3) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:

(1) vibrometry;

(2) neurometry;

(3) Semmes–Weinstein monofilament testing; or

(4) algometry.

G. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and are not reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

H. Personality or psychosocial evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. The treating health care provider may perform this evaluation or may refer the patient for consultation

with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

I. Diagnostic analgesic blocks or injection studies.

(1) These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management.

(2) Selection of patients, choice of procedure, and localization of the site of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(3) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

J. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the required information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not indicated during the first 12 weeks of initial nonsurgical treatment.

(2) Functional capacity assessment or evaluation is indicated after the first 12 weeks of care in either of the following circumstances:

(a) activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to return to do a specific job.

(3) A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

(4) Only one completed functional capacity evaluation is indicated per injury.

K. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. **General treatment parameters for upper extremity disorders.**

A. All medical care for upper extremity disorders, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 16 as follows:

(1) subpart 11 governs epicondylitis;

(2) subpart 12 governs tendonitis of the forearm, wrist, and hand;

(3) subpart 13 governs upper extremity nerve entrapment syndromes;

(4) subpart 14 governs upper extremity muscle pain syndromes;

(5) subpart 15 governs shoulder impingement syndromes; and

(6) subpart 16 governs traumatic sprains and strains of the upper extremity.

The health care provider must at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category and these changes must be recorded in the medical record. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality should be applied simultaneously, if possible, to all indicated areas.

B. In general, a course of treatment must be divided into three phases:

(1) First, all patients with an upper extremity disorder must be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subparts 3, 4, 5, 8, and 10, appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 16, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy can be in addition to any received during the period of initial nonsurgical management.

(b) Surgery must follow the parameters in subparts 6 and 11 to 16, and part 5221.6500.

(c) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment is described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to H is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to H are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

F. Acupuncture treatments. Endorphin–mediated analgesic therapy includes classic acupuncture and acupressure:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

G. Phoresis includes phonopheresis and iontophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and

(3) maximum treatment duration is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

H. Manual therapy includes soft tissue and joint mobilization and therapeutic massage:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Splints, braces, and other movement–restricting appliances. Bracing required for longer than two weeks must be accompanied by active motion exercises to avoid stiffness and prolonged disability:

(1) time for treatment response, ten days;

(2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, eight weeks. Prophylactic use is allowed indefinitely.

J. Rest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part should not be prescribed for more than two weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints should begin no later than two weeks after application of the immobilization.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12–week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which include an initial education and training session, and two follow–up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment this must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may

objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the testing sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self–management of the condition must be promoted:

(a) maximum treatment frequency, up to three times per week for three weeks. Should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

Subp. 5. **Therapeutic injections.** Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections may extend past the 12–week limitation on passive modalities, so long as the maximum treatment for injections in items A to C is not exceeded.

A. Trigger point injections:

(1) time for treatment response, within 30 minutes;

(2) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, four injections to any one site over the course of treatment.

B. Soft tissue injections include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, once per month to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, three injections to any one site over the course of treatment.

C. Injections for median nerve entrapment at the carpal tunnel:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, can repeat injection in one month if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, two injections to any one site over the course of treatment.

Subp. 6. **Surgery.** Surgery may only be performed if it meets applicable parameters in subparts 11 to 16 and part 5221.6500.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this part which requires joint reconstruction, 16 weeks; or

(2) for all other surgery for clinical categories in this part, eight weeks.

The health care provider must provide the insurer with prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

B. Repeat surgery must also meet the parameters of subparts 11 to 16 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

Subp. 7. **Chronic management.** Chronic management of upper extremity disorders must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide the insurer with prior notification as required in items B and C and part 5221.6050, subpart 9.

A. Splints, braces, straps, or supports may be indicated as specified in subpart 3, item I.

B. For patients using an electrical stimulation device at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide the equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for the upper extremity disorders specified in subparts 11 to 16:

(1) whirlpools, Jacuzzi, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

A. the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

B. the objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items in items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under Minnesota Statutes, section 152.02, including, without

limitation, narcotics, is indicated only for the treatment of severe acute pain. Therefore, these medications are not routinely indicated in the treatment of patients with upper extremity disorders. The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost–effective regimen is used.

Subp. 11. **Specific treatment parameters for epicondylitis.**

A. Initial nonsurgical management is appropriate for all patients with epicondylitis and must be the first phase of treatment.

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care must at all times include active treatment modalities according to subpart 4.

(2) Initial nonsurgical management must be provided in the least intensive setting consistent with quality health care practices.

(3) Except as provided in subpart 3, use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not indicated.

(4) Use of home–based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. The purpose and goal of surgical evaluation is to determine whether surgery is indicated for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

(1) Surgical evaluation, if indicated, must begin no later than 12 months after beginning initial nonsurgical management.

(2) Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the parameters of subpart 1, if not already obtained during the initial evaluation. Repeat testing is not indicated unless there has been an objective change in the patient's condition which in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

(3) Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general parameters in part 5221.6100, subpart 1. Other medical imaging studies are not indicated.

(4) Surgical evaluation may also include personality or psychological evaluation consistent with the parameters of subpart 1, item H.

(5) Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition. Consultation is governed by part 5221.6050, subpart 6.

(6) If surgery is indicated, it may not be performed until 12 months after initial nonsurgical management was begun except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain. In this instance, a second surgical opinion must confirm the need for surgery sooner than 12 months after initial nonsurgical management was begun.

(7) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

C. If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to part 5221.6600.

Subp. 12. **Specific treatment parameters for tendonitis of forearm, wrist, and hand.**

A. Except as provided in item B, subitem (3), initial nonsurgical management is appropriate for all patients with tendonitis and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if indicated, may begin after only two months of initial nonsurgical management.

(2) For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

(3) For patients with a locked finger or thumb, surgery may be indicated immediately without any preceding nonsurgical management.

C. If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with tendonitis must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for nerve entrapment syndromes.**

A. Initial nonsurgical management is appropriate for all patients with nerve entrapment syndromes, except as specified in subitem (2), and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, with the following modifications: nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two–point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be indicated.

B. If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation may begin, and surgical therapy may be provided, if indicated, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is indicated under item A.

(2) Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least seven days with local injection.

(3) If there is neither a confirming EMG or appropriate response to local injection, or if surgery has been previously performed at the same site, surgery is not indicated unless a second opinion confirms the need for surgery.

C. If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of dai-

ly life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with nerve entrapment syndromes must meet all of the parameters of part 5221.6600.

Subp. 14. **Specific treatment parameters for muscle pain syndromes.**

A. Initial nonsurgical management is appropriate for all patients with muscle pain syndromes and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. Surgery is not indicated for the treatment of muscle pain syndrome.

C. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with muscle pain syndrome must meet all of the parameters of part 5221.6600.

Subp. 15. **Specific treatment parameters for shoulder impingement syndromes.**

A. Initial nonsurgical management is appropriate for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, except as follows:

(1) continued nonsurgical management may be inappropriate, and early surgical evaluation may be indicated, for patients with:

(a) clinical findings of rotator cuff tear; or

(b) acute rupture of the proximal biceps tendon;

(2) use of home–based treatment modalities with monitoring by the health care provider may continue for up to six months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after six months of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation must begin no later than six months after beginning initial nonsurgical management.

(2) Diagnostic injection, arthrography, CT–arthrography, or MRI scanning may be indicated as part of the surgical evaluation.

(3) The only surgical procedures indicated for patients with shoulder impingement syndrome and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion, or repair of proximal biceps tendon, all of which must meet the parameters of part 5221.6500, subpart 3.

C. If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with shoulder impingement syndrome must meet the parameters of part 5221.6600.

Subp. 16. **Specific treatment parameters for traumatic sprains and strains of the upper extremity.**

A. Initial nonsurgical management must be the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11.

B. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

C. If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must meet all of the parameters of part 5221.6600.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6305 REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER AND LOWER EXTREMITIES.

Subpart 1. **Scope.**

A. This clinical category encompasses any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions: edema; local skin color change of red or purple; osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on bone scan. This clinical category includes, but is not limited to, the diagnoses of reflex sympathetic dystrophy, causalgia, Sudek's atrophy, algoneurodystrophy, and shoulder–hand syndrome, and including, but not limited to, ICD–9–CM codes 337.9, 354.4, and 733.7.

B. Reflex sympathetic dystrophy occurs as a complication of another preceding injury. The treatment parameters of this part refer to the treatment of the body part affected by the reflex sympathetic dystrophy. The treatment for any condition not affected by reflex sympathetic dystrophy continues to be subject to whatever treatment parameters otherwise apply. Any treatment under this part for the reflex sympathetic dystrophy may be in addition to treatment received for the original condition.

C. Thermography may be used in the diagnosis of reflex sympathetic dystrophy, but is considered an adjunct to physical examination and is not reimbursed separately from the office visit.

Subp. 2. **Initial nonsurgical management.** Initial nonsurgical management is appropriate for all patients with reflex sympathetic dystrophy and must be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in items A to D.

A. Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

(1) Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the employee remains disabled as a result of the reflex sympathetic dystrophy.

(a) Time for treatment response: within 30 minutes.

(b) Maximum treatment frequency: can repeat an injection at a site if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more than three injections to different sites are reimbursable per patient visit.

(c) Maximum treatment duration: may be continued as long as injections control symptoms and facilitate objective functional gains, if the period of improvement is progressively longer with each injection.

(2) Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

B. Only the passive treatment modalities set forth in subitems (1) to (4) are indicated. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy.

(1) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subpart.

(b) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without professional assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(2) Desensitizing procedures, such as stroking or friction massage, stress loading, and contrast baths:

(a) time for treatment response, three to five treatments;

(b) maximum treatment frequency in a clinical setting, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(c) maximum treatment duration in a clinical setting, 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(3) Electrical stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(b) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

i. time for patient education and training, one to three sessions; and

ii. patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(4) Acupuncture treatments. Endorphin–mediated analgesic therapy includes classic acupuncture and acupressure:

(a) time for treatment response, three to five sessions;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks.

C. Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise is essential for a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must be specifically aimed at the involved musculature. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation, and monthly thereafter.

(1) Supervised exercise. One goal of a supervised exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self–management of the condition must be promoted:

(a) maximum treatment frequency, up to five times per week for three weeks. Should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

D. Oral medications may be indicated in accordance with accepted medical practice.

Subp. 3. **Surgery.**

A. Surgical sympathectomy may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks by injection.

B. Dorsal column stimulator or morphine pump may be indicated for a patient with neuropathic pain unresponsive to all other treatment modalities who is not a candidate for any other therapy and has had a favorable response to a trial screening period. Use of these devices is indicated only if a second opinion confirms that this treatment is indicated, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from this treatment.

Subp. 4. **Chronic management.** If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must satisfy all of the treatment parameters of part 5221.6600.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6400 INPATIENT HOSPITALIZATION PARAMETERS.

Subpart 1. **General principles.**

A. The health care provider must provide prior notification of inpatient hospital admission for nonemergency care according to part 5221.6050, subpart 9. Hospitalization is characterized as inpatient if the patient spends at least one night in the hospital.

B. Treatment for emergency conditions, including incapacitating pain, should not be delayed to provide the insurer with prior notification. The admitting health care provider should notify the insurer within two business days following an emergency admission, or within two business days after the health care provider learns that it is a workers' compensation injury. The medical necessity for the emergency hospitalization is subject to retrospective review, based on the information available at the time of the emergency hospitalization.

C. Unless the patient's condition requires special care, only ward or semiprivate accommodations are indicated. The admitting health care provider must document the special care needs.

D. Admissions before the day of surgery are indicated only if they are medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any or all of a preoperative work–up which could have been completed as an outpatient is not indicated.

E. Inpatient hospitalization solely for physical therapy, bedrest, or administration of injectable drugs is indicated only if the treatment is otherwise indicated and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self–care.

F. Discharge from the hospital must be at the earliest possible date consistent with proper health care.

G. If transfer to a convalescent center or nursing home is indicated, prior notification is required as provided for inpatient hospitalization.

Subp. 2. **Specific requirements for hospital admission of patients with low back pain.** Hospitalization for low back pain is indicated in the circumstances in items A to D.

A. When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and in addition, the intensity of service during admission meets the criteria in subitems (1) and (2).

(1) Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion.

(2) Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of three injections in 24 hours. Need for parenteral analgesics is determined by:

(a) an inability to take oral medications or diet (N.P.O.); or

(b) an inability to achieve relief with aggressive oral analgesics.

B. For surgery which is otherwise indicated according to part 5221.6500 and is appropriately scheduled as an inpatient procedure.

C. For evaluation and treatment of cauda equina syndrome, according to part 5221.6200, subpart 13.

D. For evaluation and treatment of foot drop or progressive neurologic deficit, according to part 5221.6200, subpart 13.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6500 PARAMETERS FOR SURGICAL PROCEDURES.

Subpart 1. **General.**

A. The health care provider must provide prior notification according to part 5221.6050, subpart 9, before proceeding with any elective inpatient surgery.

B. Emergency surgery may proceed without prior notification. The reasonableness and necessity for the emergency surgery is subject to retrospective review based on the information available at the time of the emergency surgery.

Subp. 2. **Spinal surgery.** Initial nonsurgical, surgical, and chronic management parameters are also included in parts 5221.6200, low back pain; 5221.6205, neck pain; and 5221.6210, thoracic back pain.

A. Surgical decompression of a lumbar nerve root or roots includes, but is not limited to, the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a lumbar nerve root may be performed for the following diagnoses:

(a) intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc which impinges significantly on a nerve root or the thecal sac, ICD–9–CM code 722.10;

(b) sciatica, ICD–9–CM code 724.3; or

(c) lumbosacral radiculopathy or radiculitis, ICD–9–CM code 724.4.

(2) Indications: both of the following conditions in units (a) and (b) must be satisfied to indicate that the surgery is reasonably required.

(a) Response to nonsurgical care: the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care; or

ii. cauda equina syndrome, ICD–9–CM code 344.6, 344.60, or 344.61; or

iii. progressive neurological deficits.

(b) Clinical findings: the employee exhibits one of the findings of subunit i in combination with the test results of subunit ii or, in the case of diagnosis in subitem

(1), unit (a), a second opinion confirms that decompression of the lumbar nerve root is the appropriate treatment for the patient's condition:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including, but not limited to, foot drop or quadriceps weakness, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Repeat surgical decompression of a lumbar nerve root is not indicated at the same nerve root unless a second opinion, if requested by the insurer, confirms that surgery is indicated.

B. Surgical decompression of a cervical nerve root. Surgical decompression of a cervical nerve root or roots includes, but is not limited to, the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a cervical nerve root may be performed for the following diagnoses:

(a) displacement of cervical intervertebral disc, ICD–9–CM code 722.0, excluding fracture; or

(b) cervical radiculopathy or radiculitis, ICD–9–CM code 723.4, excluding fracture.

(2) Indications: the requirements in units (a) and (b) must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care, the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care;

ii. cervical compressive myelopathy; or

iii. progressive neurologic deficits;

(b) clinical findings: the employee exhibits one of the findings of subunit i, in combination with the test results of subunit ii:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Second opinions: surgical decompression of a cervical nerve root is not indicated for the following conditions, unless a second opinion, if requested by the insurer, confirms that the surgery is indicated:

(a) repeat surgery at same level; or

(b) request for surgery at the C3–4 level.

C. Lumbar arthrodesis with or without instrumentation.

(1) Indications: one of the following conditions must be satisfied to indicate that the surgery is reasonably required:

(a) unstable lumbar vertebral fracture, ICD–9–CM codes 805.4, 805.5, 806.4, and 806.5; or

(b) for a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD–9–CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD–9–CM code 724.4. Documentation under this item must include an MRI or CT scan or a myelogram; or

(c) traumatic spinal deformity including a history of compression (wedge) fracture or fractures, ICD–9–CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD–9–CM codes 737.1, 737.10, 737.30, 737.41, and 737.43; or

(d) incapacitating low back pain, ICD–9–CM code 724.2, for longer than three months, and one of the following conditions involving lumbar segments L–3 and below is present:

i. for the first surgery only, degenerative disc disease, ICD–9–CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or two levels; or

ii. pseudoarthrosis, ICD–9–CM code 733.82;

iii. for the second or third surgery only, previously operated disc; or

iv. spondylolisthesis.

(2) Contraindications: lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(3) Retrospective review: when lumbar arthrodesis is performed to correct instability created during a decompression, laminectomy, or discectomy, approval for the arthrodesis will be based on a retrospective review of the operative report.

Subp. 3. **Upper extremity surgery.** Initial nonsurgical, surgical, and chronic management parameters for upper extremity disorders are found in part 5221.6300, subparts 1 to 16.

A. Rotator cuff repair:

(1) Diagnoses: rotator cuff surgery may be performed for the following diagnoses:

(a) rotator cuff syndrome of the shoulder, ICD–9–CM code 726.1, and allied disorders: unspecified disorders of shoulder bursae and tendons, ICD–9–CM code 726.10, calcifying tendinitis of shoulder, ICD–9–CM code 726.11, bicipital tenosynovitis, ICD–9–CM code 726.12, and other specified disorders, ICD–9–CM code 726.19; or

(b) tear of rotator cuff, ICD–9–CM code 727.61.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), both of the following conditions must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care: the employee's condition has failed to improve with adequate initial nonsurgical treatment; and

(b) clinical findings: the employee exhibits:

i. severe shoulder pain and inability to elevate the shoulder; or

ii. weak or absent abduction and tenderness over rotator cuff, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial; and

iii. positive findings in arthrogram, MRI, or ultrasound, or positive findings on previous arthroscopy, if performed.

B. Acromioplasty:

(1) Diagnosis: acromioplasty may be performed for acromial impingement syndrome, ICD–9–CM codes 726.0 to 726.2.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for acromioplasty:

(a) response to nonsurgical care: the employee's condition has failed to improve after adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits pain with active elevation from 90 to 130 degrees and pain at night, and a positive impingement test.

C. Repair of acromioclavicular or costoclavicular ligaments:

(1) Diagnosis: surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation, ICD–9–CM codes 831.04 to 831.14.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the requirements of units (a) and (b) must be satisfied for repair of acromioclavicular or costoclavicular ligaments:

(a) response to nonsurgical care: the employee's condition includes:

i. failure to improve after at least a one–week trial period in a support brace; or

ii. separation cannot be reduced and held in a brace; or

iii. grade III separation has occurred; and

(b) clinical findings: the employee exhibits localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

D. Excision of distal clavicle:

(1) Diagnosis: excision of the distal clavicle may be performed for the following conditions:

(a) acromioclavicular separation, ICD–9–CM codes 831.01 to 831.14;

(b) osteoarthrosis of the acromioclavicular joint, ICD–9–CM codes 715.11, 715.21, and 715.31; or

(c) shoulder impingement syndrome.

(2) Criteria and indications: in addition to one of the diagnosis in subitem (1), the following conditions must be satisfied for excision of distal clavicle:

(a) response to nonsurgical care: the employee's condition fails to improve with adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits:

i. pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight;

ii. confirmation that separation of AC joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial; and

iii. separation at the acromioclavicular joint with weight–bearing films, or severe degenerative joint disease at the acromioclavicular joint noted on X–rays.

E. Repair of shoulder dislocation or subluxation (any procedure):

(1) Diagnosis: surgical repair of a shoulder dislocation may be performed for the following diagnoses:

(a) recurrent dislocations, ICD–9–CM code 718.31;

(b) recurrent subluxations; or

(c) persistent instability following traumatic dislocation.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following clinical findings must exist for repair of a shoulder dislocation:

(a) the employee exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living; and

(b) X–ray findings are consistent with multiple dislocations or subluxations.

F. Repair of proximal biceps tendon:

(1) Diagnosis: surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps, ICD–9–CM code 727.62 or 840.8.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for repair of proximal biceps tendon:

(a) the procedure may be done alone or in conjunction with another indicated repair of the rotator cuff; and

(b) clinical findings: the employee exhibits:

i. complaint of pain that does not resolve with attempt to use arm; and

ii. palpation of "bulge" in upper aspect of arm.

G. Epicondylitis. Specific requirements for surgery for epicondylitis are included in part 5221.6300, subpart 11.

H. Tendinitis. Specific requirements for surgery for tendinitis are included in part 5221.6300, subpart 12.

I. Nerve entrapment syndromes. Specific requirements for nerve entrapment syndromes are included in part 5221.6300, subpart 13.

J. Muscle pain syndromes. Surgery is not indicated for muscle pain syndromes.

K. Traumatic sprains and strains. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

Subp. 4. **Lower extremity surgery.**

A. Anterior cruciate ligament (ACL) reconstruction:

(1) Diagnoses: surgical repair of the anterior cruciate ligament, including arthroscopic repair, may be performed for the following diagnoses:

(a) old disruption of anterior cruciate ligament, ICD–9–CM code 717.83; or

(b) sprain of cruciate ligament of knee, ICD–9–CM code 844.2.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1) the conditions in units (a) to (c) must be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication:

(a) the employee gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred;

(b) there are objective clinical findings of positive Lachman's sign, positive pivot shift, and/or positive anterior drawer; and

(c) there are positive diagnostic findings with arthrogram, MRI, or arthroscopy and there is no evidence of severe compartmental arthritis.

B. Patella tendon realignment or Maquet procedure:

(1) Diagnosis: patella tendon realignment may be performed for dislocation of patella, open, ICD–9–CM code 836.3, or closed, ICD–9–CM code 836.4, or chronic residuals of dislocation.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), all of the following conditions must be satisfied for a patella tendon realignment:

(a) the employee gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation; and

(b) there are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

C. Knee joint replacement:

(1) Diagnoses: knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee, ICD–9–CM codes 717.1 to 717.4.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the following conditions must be satisfied for a knee joint replacement:

(a) clinical findings: the employee exhibits limited range of motion, night pain in the joint or pain with weight–bearing, and no significant relief of pain with an adequate course of initial nonsurgical care; and

(b) diagnostic findings: there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis and joint destruction with standing films, MRI, or arthroscopy.

D. Fusion; ankle, tarsal, metatarsal:

(1) Diagnoses: fusion may be performed for the following conditions:

(a) malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD–9–CM code 733.81 or 733.82; or

(b) traumatic arthritis (arthropathy), ICD–9–CM code 716.17.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for an ankle, tarsal, or metatarsal fusion:

(a) initial nonsurgical care: the employee must have failed to improve with an adequate course of initial nonsurgical care which included:

i. immobilization which may include casting, bracing, shoe modification, or other orthotics; and

ii. anti–inflammatory medications;

(b) clinical findings:

i. the employee gives a history of pain which is aggravated by activity and weight–bearing, and relieved by xylocaine injection; and

ii. there are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion; and

(c) diagnostic findings: there are medical imaging studies confirming the presence of:

i. loss of articular cartilage and joint space narrowing;

ii. bone deformity with hypertrophic spurring and sclerosis; or

iii. nonunion or malunion of a fracture.

E. Lateral ligament ankle reconstruction:

(1) Diagnoses: ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions:

(a) chronic ankle instability, ICD–9–CM code 718.87; or

(b) grade III sprain, ICD–9–CM codes 845.0 to 845.09.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for a lateral ligament ankle reconstruction:

(a) initial nonsurgical care: the employee must have received an adequate course of initial nonsurgical care including, at least:

i. immobilization with support, cast, or ankle brace, followed by

ii. a physical rehabilitation program; and

(b) clinical findings:

i. the employee gives a history of ankle instability and swelling; and

ii. there is a positive anterior drawer sign on examination; or

iii. there are positive stress X–rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X–ray, or ligamentous injury is shown on MRI scan.

(3) Prosthetic ligaments: prosthetic ligaments are not indicated.

(4) Implants: requests for any plastic implant must be confirmed by a second opinion.

(5) Calcaneus osteotomy: requests for calcaneus osteotomies must be confirmed by a second opinion.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.6600 CHRONIC MANAGEMENT.

Subpart 1. **Scope.** This part applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by parts 5221.6200 to 5221.6500. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The purpose of chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient should be returned to the highest functional status reasonably possible.

A. Personality or psychological evaluation may be indicated for patients who are candidates for chronic management. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to

obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

B. Any of the chronic management modalities of subpart 2 may be used singly or in combination as part of a program of chronic management.

C. No further passive treatment modalities or therapeutic injections are indicated, except as otherwise provided in parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B.

D. No further diagnostic evaluation is indicated unless there is the development of symptoms or physical findings which would in themselves warrant diagnostic evaluation.

E. A program of chronic management must include appropriate means by which use of scheduled medications can be discontinued or severely limited.

Subp. 2. **Chronic management modalities.** The health care provider must provide prior notification of the chronic management modalities in items B to F according to part 5221.6050, subpart 9. Prior notification is not required for home–based exercises in item A, unless durable medical equipment is prescribed for home use. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days' notice of intent to apply any of the chronic management parameters in part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

A. Home–based exercise programs consist of aerobic conditioning, stretching and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed and reimbursed within any applicable treatment parameters in parts 5221.6200 to 5221.6305.

(1) Indications: exercise is necessary on a long–term basis to maintain function.

(2) Requirements: the patient should receive specific instruction and training in the exercise program. Repetitions, durations, and frequencies of exercises must be specified. Any durable medical equipment needed must be prescribed in advance and the insurer must be given prior notification of proposed purchase.

(3) Treatment period, one to three visits for instruction and monitoring.

B. Health clubs:

(1) Indications: the patient is deconditioned and requires a structured environment to perform prescribed exercises. The health care provider must document the reasons why reconditioning cannot be accomplished with a home–based program of exercise.

(2) Requirements: the program must have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency of attendance and the patient must maintain adequate documentation of attendance. There must be a prescribed duration of attendance.

(3) Treatment period, 13 weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment at a health club are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

C. Computerized exercise programs utilize computer controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility, and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

(1) Indications: the patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. The health care provider must document the reasons why reconditioning cannot be accomplished with a home–based program of exercise.

(2) Requirements: the program must have specific goals stated in objective terms, for example "improve strength of back extensors 50 percent." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency and duration of attendance.

(3) Treatment period, six weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment.

D. Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs must include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility, and motor control, and cardiopulmonary function. Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral, and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances, and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical, and functional needs of the individual.

(1) Indications: the patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. The health care provider must document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is indicated where only physical and functional needs are identified. Work hardening is indicated where, in addition to physical and functional needs, behavioral and vocational needs are also identified that are not otherwise being addressed.

(2) Requirements: the program must have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There must be an individualized program of activities and the activities must be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There must be a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance. Activity restrictions must be identified at completion of the program.

(3) Treatment period, six weeks. Additional periods of treatment require prior notification of the insurer. Additional periods of treatment at a work hardening program or work conditioning program are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job which necessitates a redesign of the program.

E. Chronic pain management programs consist of multidisciplinary teams who provide coordinated, goal–oriented services to reduce pain disability, improve functional status, promote return to work, and decrease dependence on the health system of persons with chronic pain syndrome. Pain management programs must provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and, if indicated, chemical dependency evaluation. The program of treatment must be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

(1) Indications: the patient is diagnosed as having a chronic pain syndrome.

(2) Requirements: an admission evaluation must be performed by a doctor, and a licensed mental health professional, each with at least two years experience in evaluation of chronic pain patients and chronic pain treatment, or one year of formal training in a pain fellowship program. The evaluation must confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There must be a specific set of prescribed activities and treatments, and a specific timetable of progression in those activities. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance.

(3) Treatment period: for initial treatment, a maximum of 20 eight–hour days, though fewer or shorter days can be used, and a maximum duration of four weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is indicated for an injury.

F. Individual or group psychological or psychiatric counseling.

(1) Indications: a personality or psychosocial evaluation has revealed one or more of the problems listed in subpart 1, item A, which interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

(2) Requirements: there must be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals within the prescribed number of treatment or therapy sessions. There must be a prescribed frequency of attendance and the treating health care provider must maintain adequate documentation of attendance. There must be a prescribed duration of treatment.

(3) Treatment period: a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is indicated for an injury.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

5221.8900 DISCIPLINARY ACTION; PENALTIES.

Subpart 1. **Discipline.** A health care provider is subject to disciplinary action under Minnesota Statutes, section 176.103, for failure to comply with the requirements in parts 5221.6010 to 5221.6600 or the violation of any of the provisions of Minnesota Statutes, chapter 176, or other rules or orders issued pursuant thereto.

Subp. 2. **Complaints.** Complaints about professional behavior or services of health care providers relating to noncompliance with established workers' compensation laws, rules, or orders shall be made in writing to the commissioner. The commissioner or a designee shall assist a person in filing a complaint, if necessary. A complaint may be submitted by any person who becomes aware of a violation, including designees of the commissioner, administrative law judges, and presiding officials at judicial proceedings.

Subp. 3. **Review and investigation.** The commissioner shall investigate all complaints to determine whether there has been a violation of established workers' compensation laws, rules, or orders. The commissioner may refer a matter to another agency that has jurisdiction over the provider's license or conduct, or to an agency that has prosecuting authority in the event of suspected theft or fraud or to a peer review organization for an opinion. Absent suspected theft or fraud, providing treatment outside a parameter set forth in parts 5221.6020 to 5221.6500 shall not in itself result in a referral to a prosecuting authority.

If an investigation indicates that discipline may be warranted, the commissioner shall determine whether the violation involves inappropriate, unnecessary, or excessive treatment, or whether the violation involves other statutes or rules. The commissioner shall take appropriate action according to subpart 6, 7, or 8.

Subp. 4. **Cooperation with disciplinary proceedings.** A health care provider who is the subject of a complaint investigated by the commissioner under Minnesota Statutes, section 176.103, shall cooperate fully with the investigation. Cooperation includes, but is not limited to, responding fully and promptly to any questions raised by the commissioner relating to the subject of the investigation and providing copies of records, reports, logs, data, and cost information as requested by the commissioner to assist in the investigation. The health care provider shall not charge for services but may charge for the cost of copies of medical records, at the rate set in part 5219.0300, subpart 2, for this investigation. Cooperation includes attending, in person, a meeting scheduled by the commissioner for the purposes of subpart 5. This subpart does not limit the health care provider's right to be represented by an attorney.

Subp. 5. **In-person meeting.** When conferring with the parties to a complaint is deemed appropriate, the commissioner shall schedule a meeting for the purpose of clarification of issues, obtaining information, instructing parties to the complaint, or for the purpose of resolving disciplinary issues.

Subp. 6. **Resolution by instruction or written agreement.** The commissioner may resolve a complaint through instruction of a provider, or may enter into stipulated consent agreements regarding discipline with a provider in lieu of initiating a contested case or medical services review board proceeding.

Subp. 7. **Inappropriate, unnecessary, or excessive treatment.**

A. Except as otherwise provided in subparts 3 and 6, if the suspected violation involves a treatment standard set forth in parts 5221.6020 to 5221.6500 the commissioner must refer the health care provider to the medical services review board for review under Minnesota Statutes, section 176.103, subdivision 2, if:

(1) the situation requires medical expertise in matters beyond the department's general scope;

(2) wherever possible under Minnesota Statutes, chapter 176, a final determination has been made by a workers' compensation presiding official, or provider licensing or registration body that the medical treatment in issue was inappropriate, unnecessary, or excessive; and

(3) a pattern of consistently providing inappropriate, unnecessary, or excessive services exists for three or more employees.

B. Where the medical service review board's report to the commissioner indicates a violation of treatment standards or other inappropriate, unnecessary, or excessive treatment the commissioner shall order a sanction. Sanctions may include, but are not limited to, a warning; a fine of up to $200 per violation; a restriction on providing treatment; requiring preauthorization by the board, the payor, or the commissioner for a plan of treatment; and suspension from receiving compensation for the provision of treatment.

C. Within 30 days of receipt of the order of sanction, the health care provider may request in writing a review by the commissioner of the sanction in accordance with the procedure set forth in Minnesota Statutes, section 176.103, subdivision 2a. Within 30 days following receipt of the compensation judge's decision reviewing the sanction, a provider may petition the workers' compensation court of appeals for review according to the procedures in Minnesota Statutes, section 176.103, subdivision 2a.

Subp. 8. **Violations of statutes and rules other than those involving inappropriate, unnecessary, or excessive treatment.** If the suspected violation warranting discipline involves a statute or rule other than treatment standards, the commissioner shall initiate a contested case hearing for disciplinary action under Minnesota Statutes, section 176.103, subdivision 3, paragraph (b), and the administrative procedure act in Minnesota Statutes, chapter 14.

A. Upon petition of the commissioner and following receipt of the recommendation of the administrative law judge, the medical services review board may issue a fine of up

to $200 for each violation, or disqualify or suspend the health care provider from receiving payment for services, according to Minnesota Statutes, section 176.103, subdivision 3, paragraph (b).

B. Within 30 days after service of the board's decision, a provider may petition the workers' compensation court of appeals for review according to Minnesota Statutes, section 176.421.

Subp. 9. **Penalties.** In addition to disciplinary action under subparts 1 to 8, the commissioner may assess a penalty under part 5220.2810 if a health care provider fails to release existing written medical data according to Minnesota Statutes, section 176.138. A penalty may also be assessed under part 5220.2830 and Minnesota Statutes, section 176.231, subdivision 10, if a health care provider fails to provide reports required by part 5221.0410.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*