CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

5221.0100 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of

codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

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

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 15 SR 124*

5221.0200 AUTHORITY.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0300 PURPOSE.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0400 SCOPE.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0500 EXCESSIVE CHARGES.

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

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

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

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0600 PAYER RESPONSIBILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the 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 176.136; 176.83*

History: *13 SR 2609*

5221.0700 PROVIDER RESPONSIBILITIES.

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

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

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

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

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

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

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

25105 Arthrotomy, wrist joint; for synovectomy

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

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

(2) Modifier number 22 denotes unusual services. This modifier is appropriate where the service provided is significantly greater than what is usually required for the listed procedure, or where service was provided under highly unusual circumstances. Unusual circumstances include major complications or difficulties associated with the patient's condition, the medical facilities, or other causes. Unusual circumstances do not include common differences among services of a kind or magnitude which is typical within a particular code category. This modifier does not exempt a service from the maximum fee for the five-digit code, except where the increased services or unusual circumstances may be reasonably expected to significantly increase the provider's cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 5. **Collection of excessive charges.** No provider shall collect or attempt to collect payment from an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is

excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0800 DISPUTE RESOLUTION.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0900 [Repealed, 13 SR 2609]

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

Subpart 1. **Contents.** This chapter contains the medical fee schedule. The medical fee schedule shall contain codes and descriptions of services compensable under Minnesota Statutes, section 176.135, and dollar amounts equal to the 75th percentile of the usual and customary charges for those services by provider groups in Minnesota during the preceding calendar year.

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

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

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

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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

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

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

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

[For text of subp 2, items D to L, see M.R.]

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 services; new patient; brief service	$ 34.00
90010-00	limited service	42.00
90015-00	intermediate service	51.00
90017-00	extended service	69.50
90020-00	comprehensive service	136.65
90030-00	Office services; established patient; minimal service	17.50
90040-00	brief service	24.50
90050-00	limited service	28.56
90060-00	intermediate service	40.00
90070-00	extended service	60.00
90080-00	comprehensive service	92.50

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
90100-00	Home medical service, new patient; brief service	$ 50.00
90115-00	intermediate service	55.00
90130-00	Home medical service, established patient; minimal service	32.00
90140-00	brief service	42.00
90150-00	limited service	42.10
90160-00	intermediate service	52.00
90170-00	extended service	62.23

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	$ 71.50
90215-00	intermediate	90.00
90220-00	comprehensive	132.50
	Subsequent Hospital Care	
90240-00	Subsequent hospital care; brief service	$29.50
90250-00	limited service	38.50
90260-00	intermediate services	50.00
90270-00	extended service	80.00
90280-00	comprehensive service	90.00
	Hospital Discharge Services	
90292-00	Hospital discharge day management (MD/DO)	$ 52.00

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, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 44.88
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	75.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	90.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.25
90350-00	limited service	32.00
90360-00	intermediate service	35.00
90370-00	extended service	50.00

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	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	$ 35.31
90410-00	limited service	36.00
90415-00	intermediate service	72.70
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	20.75
90440-00	brief service	25.25
90450-00	limited service	35.00
90460-00	intermediate service	50.00
90470-00	extended service	60.20

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	$ 38.00
90505-00	brief service	38.00
90510-00	limited service	50.00
90515-00	intermediate service	71.50
90517-00	extended service	111.90
90520-00	comprehensive service	128.00
90530-00	Emergency department service, established patient; minimal service	22.00
90540-00	brief service	38.50

90550-00	limited service	44.40
90560-00	intermediate service	53.00
90570-00	extended service	73.50
90580-00	comprehensive service	100.00

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

5221.1200 CONSULTATIONS.

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

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

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

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

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

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

(4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical

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

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

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

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

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

Code	Service	Maximum Fee
	Initial Consultation	
90600-00	Initial consultation; limited	$ 61.75
90605-00	intermediate consultation	82.00
90610-00	extensive consultation	100.50
90620-00	comprehensive consultation	145.00
90630-00	complex consultation	189.00
	Follow-up Consultation	
90640-00	Follow-up consultation; brief visit	$ 39.00
90641-00	limited	43.00
90642-00	intermediate	76.51
90643-00	complex	102.00
	Confirmatory (Additional Opinion) Consultation	
90650-00	Confirmatory consultation; limited	$ 64.50
90651-00	intermediate	75.00
90652-00	extensive	90.00
90653-00	comprehensive	142.00
90654-00	complex	197.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

5221.1210 IMMUNIZATION INJECTIONS.

Immunizations are usually given in conjunction with a medical service.

When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include the supply of materials.

Code	Service	Maximum Fee
90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	$ 22.50
90702-00	diphtheria and tetanus toxoids (DT)	12.30
90703-00	tetanus toxoid	11.00
90704-00	mumps virus vaccine, live	25.00
90705-00	measles virus vaccine, live, attenuated	24.00
90706-00	rubella virus vaccine, live	25.00
90707-00	measles, mumps, and rubella virus vaccine, live	35.00
90708-00	measles and rubella virus vaccine, live	29.50
90709-00	rubella and mumps virus vaccine, live	30.50
90712-00	polio virus vaccine, live, oral; any type(s)	17.00
90713-00	poliomyelitis vaccine	22.50
90714-00	typhoid vaccine	12.00
90717-00	yellow fever vaccine	31.00
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD)	11.00
90719-00	diphtheria toxoid	2.00
90724-00	influenza virus vaccine	12.00
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	84.38
90731-00	hepatitis B vaccine	61.00
90732-00	pneumococcal vaccine, polyvalent	18.00
90733-00	meningococcal polysaccharide vaccine; any group(s)	23.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	27.00
90741-00	Immunization, passive; immune serum globulin, human (ISG)	17.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	56.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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	$ 44.00
90781-00	each additional hour, up to eight hours	50.00

Statutory Authority: *MS s 176.136*

History: *14 SR 722*

5221.1220 THERAPEUTIC INJECTIONS.

Code	Service	Maximum Fee
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	$12.00
90783-00	intra-arterial	15.00
90788-00	Intramuscular injection of antibiotic (specify)	14.70
90798-00	Intravenous therapy for severe or intractable allergic disease in physician's office or institution (i.e., theophylines, corticosteroids, antihistamines)	32.82

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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).	$ 125.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	72.00
90830-00	Psychological testing by physician, with written report, per hour	80.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	112.50
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	59.00
90844-00	approximately 45 or 50 minutes	85.00

90847-00	Family medical psychotherapy (conjoint psychotherapy)	84.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	65.00
90853-00	Group medical psychotherapy (other than of a multiple-family group)	40.71
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	55.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	91.00
	Other Psychiatric Therapy	
90880-00	Medical hypnotherapy	$ 48.20
90882-00	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	85.00
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	80.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow	45.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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, codes 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	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient	$ 55.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient, one or more visits	60.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient	43.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient, one or more visits	58.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure)	30.60
	Special Services	
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 36.50
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	28.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	100.00
92081-00	Visual field examination with medical diagnostic evaluation; limited examination (for example, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	36.25
92082-00	intermediate examination (for example, 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)	50.00
92083-00	extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41)	75.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	24.40
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	29.00

	Ophthalmoscopy	
92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial	$ 38.00
92226-00	subsequent	37.69
92230-00	Ophthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	35.00
92235-00	with fluorescein angiography (includes multiframe photography)	155.00
92250-00	with fundus photography	35.00
92260-00	with ophthalmodynamometry	33.20
	Other Specialized Services	
92270-00	Electro-oculography, with medical diagnostic evaluation	$ 71.00
92285-00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (for example, close-up photography, slit lamp photography, goniophotography, stereo-photography	40.00
92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00
92287-00	with fluorescein angiography	45.00
	Contact Lenses	
92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, one eye	$ 80.00
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	16.00
92326-00	Replacement of contact lens	60.00
	Spectacle Services	
92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 30.00
92341-00	bifocal	45.25
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	100.00
92391-00	Supply of contact lenses, except prosthesis for aphakia	55.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	43.00
92508-00	group	35.50
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	61.00
92532-00	Positional nystagmus	22.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	55.14
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	41.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	45.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	73.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	31.00
92545-00	Oscillating tracking test, with recording	26.00
92546-00	Torsion swing test, with recording	31.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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
	Cardiographic Services	
92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external	254.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,200.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	44.00

93005-00	tracing only, without interpretation and/or report	38.50
93010-00	interpretation and report only	17.00
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	59.50
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	201.00
93017-00	tracing only, without interpretation and report	173.00
93018-00	interpretation and report only	97.00
93024-00	Ergonovine provocation test	200.00
93040-00	Rhythm ECG, one to three leads; with interpretation	22.44
93041-00	tracing only, without interpretation and report	23.00
93042-00	Rhythm ECG, tracing with interpretation and report only	20.00
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	75.00
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	125.00
93262-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	226.00
93263-00	without superimposition scanning	236.00
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis)	225.00
93268-00	Patient demand single event ECG recording; presymptom memory loop and transmission	125.00
93269-00	postsymptom memory loop and transmission	75.00
93300-00	Echocardiography, M-mode; complete	72.00
93308-00	Echocardiography, real-time with image documentation (2D); limited	119.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D)	270.25
	Cardiac Catheterization	
93501-00	Right heart catheterization only	$ 750.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography	365.00
93505-00	Endomyocardial biopsy	660.00
93547-00	Combined left heart catheterization, selective coronary angiography and	

	selective left ventricular angiography	850.00
93548-00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, selective left ventriculography, with aortic root aortography	1,200.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography	1,200.00
93552-00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, selective left ventricular cineangiography and visualization of bypass grafts	1,166.00
	Other Vascular Studies	
93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	$ 45.00
93732-00	with reprogramming	66.40
93733-00	telephone analysis	40.50
93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	54.00
93735-00	with reprogramming	56.65
93736-00	telephonic analysis	35.50
Noninvasive Peripheral Vascular Diagnostic Studies Cerebrovascular Arterial Studies		
93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periobital flow direction with arterial compression, periobital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)	$ 85.00
93870-00	Noninvasive studies of carotid artery, 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)	191.90
93890-00	Noninvasive studies of extremity arteries (i.e., segmental blood pressure measurements, continuous wave Doppler analog wave form analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmographic or pulse volume digit	

	wave form analysis, flow velocity signals); upper extremity	80.00
93910-00	lower extremity	108.00
	Venous Studies	
93950-00	Noninvasive studies of extremity veins	$ 75.75

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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 measurements, and/or maximal voluntary ventilation	$ 33.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	56.00
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	66.30
94150-00	Vital capacity, total	18.75
94160-00	Vital capacity screening tests; total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity; maximal voluntary ventilation	28.70
94260-00	Thoric gas volume	12.00
94375-00	Respiratory flow volume loop	25.00
94640-00	Nonpressurized inhalation treatment for acute airway obstruction	25.00
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation	18.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	144.50
94657-00	subsequent days	53.50
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	25.25
94665-00	subsequent	35.00
94681-00	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	102.20

94700-00	Analysis of arterial blood gas (oxygen saturation, pO2, pCO2, CO2, pH); rest only	29.00
94705-00	rest and exercise (including cannulization of artery)	143.60
94750-00	Pulmonary compliance study, any method	20.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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
95001-00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; 31-60 tests	$ 2.25
95002-00	61-90 tests	2.25
95003-00	more than 90 tests	3.00
95021-00	Intracutaneous (intradermal) tests with allergenic extracts, immediate reaction 15-20 minutes; 11-20 tests	4.00
95022-00	21-30 tests	3.45
95023-00	more than 30 tests	2.50
95042-00	Patch or application tests; 21-30 tests	4.00
95043-00	more than 30 tests	5.00
95078-00	Provocative testing	11.00
95115-00	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	8.00
95117-00	multiple injections	9.50
95120-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen	8.75
95125-00	Multiple antigens (specify number of injections)	9.00
95130-00	Single stinging insect venom	23.50

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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
95822-00	Electroencephalogram (EEG); sleep only	$ 160.25
95828-00	Polysomnography (recording, analysis, and interpretation of the multiple simultaneous physiological measurements of sleep)	871.00
95831-00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	32.00
95852-00	hand, with or without comparison with normal side	16.00
95857-00	Tensilon test for myasthenia gravis	80.00
95860-00	Electromyography; one extremity and related paraspinal areas	180.00
95861-00	two extremities and related paraspinal areas	260.00
95863-00	three extremities and related paraspinal areas	250.00
95864-00	four extremities and related paraspinal areas	315.00
95869-00	Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	83.30
95882-00	Assessment of higher cerebral function with medical interpretation; cognitive testing and others	45.65
95900-00	Nerve conduction, velocity, or latency study, motor, each nerve	51.00
95904-00	Nerve conduction, velocity and/or latency study; sensory, each nerve	63.00
95925-00	Somatosensory testing (i.e., cerebral evoked potentials), one or more nerves	170.00
95935-00	"H" reflex, by electrodiagnostic testing	46.00
95937-00	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	88.00
95950-00	Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; electroencephalographic (EEG) recording and interpretation, initial 24 hours	475.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 60.00
96504-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by push technique	37.00
96505-00	by infusion technique	62.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	37.75
96509-00	by infusion technique	83.31
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	90.00
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	110.00
96520-00	Portable pump refilling and maintenance	50.00
96524-00	Chemotherapy injection, complex, administered by physician, arterial infusion technique	72.00
96530-00	Implantable pump filling and maintenance	74.50
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	165.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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 (Geockerman treatment) or petrolatum and ultraviolet B	15.00
96912-00	psoralens and ultraviolet A (PUVA)	35.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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 m musculoskeletal system	$ 31.50
97261-00	each additional area	8.85

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$9.30
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)	9.30
99013-00	Telephone calls for consultation or medical management; simple or brief	6.00
99025-00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit	27.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	25.00
99054-00	Services requested on Sundays and holidays in addition to basic services	30.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	53.00
99058-00	Office services provided on an emergency basis	37.75
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	44.80
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	50.00
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 gasses during surgery); 30 minutes to one hour	$ 120.00
99151-00	more than one hour	296.00
	Medical Conferences	
99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes	$ 75.00
99156-00	approximately 50 minutes	118.00
	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 conver-

sion 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	$ 175.00
99162-00	additional 30 minutes	75.00
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	80.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness	66.35
99172-00	limited examination, evaluation, or treatment for same or new illness	65.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness	80.00
	Other Services	
99175-00	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	$ 73.00
99195-00	Phlebotomy, therapeutic (separate procedure)	40.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

5221.2250 PHYSICIAN SERVICES; SURGERY.

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

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.

[For text of items B to D, see M.R.]

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	
10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 55.00
10003*00	Incision and drainage of infected or	

	noninfected epithelial inclusion cyst (sebaceous cyst) with complete removal of sac and treatment of cavity	65.00
10020*00	Incision and drainage of furuncle	44.00
10060*00	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	57.00
10061-00	complicated	130.00
10080*00	Incision and drainage of piloridial cyst; simple	64.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	55.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple	55.00
10121*00	complicated	105.00
10140*00	Incision and drainage of hematoma; simple	52.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst	46.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	41.00
11040-00	Debridement; skin, partial thickness	49.00
11041-00	full thickness	35.00
11042-00	skin, and subcutaneous tissue	100.00
11044-00	skin, subcutaneous tissue, muscle, and bone	375.00
	Paring or Curettement	
11050*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 30.00
11051-00	two to four lesions	42.00
11052-00	more than four lesions	64.00
	Biopsy	
11100-00	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 67.00
	Excision — Benign Lesions	
11200*00	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 58.25
11400-00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	74.00
11401-00	lesion diameter 0.5 to 1.0 centimeter	86.48
11402-00	lesion diameter 1.0 to 2.0 centimeters	102.20
11403-00	lesion diameter 2.0 to 3.0 centimeters	125.00

11404-00	lesion diameter 3.0 to 4.0 centimeters	150.00
11406-00	lesion diameter over 4.0 centimeters	237.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter (MD/DO)	85.00
11421-00	lesion diameter 0.5 to 1.0 centimeter	100.00
11422-00	lesion diameter 1.0 to 2.0 centimeters	124.00
11423-00	lesion diameter 2.0 to 3.0 centimeters	145.00
11424-00	lesion diameter 3.1 to 4.0 centimeters	200.00
11426-00	lesion diameter over 4.0 centimeters	250.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	95.00
11441-00	lesion diameter 0.5 to 1.0 centimeter	120.00
11442-00	lesion diameter 1.1 to 2.0 centimeters	149.00
11443-00	lesion diameter 2.1 to 3.0 centimeters	120.00
11444-00	lesion diameter 3.1 to 4.0 centimeters	230.00
	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	165.00
11602-00	lesion diameter 1.1 to 2.0 centimeters	200.00
11603-00	lesion diameter 2.1 to 3.0 centimeters	275.00
11604-00	lesion diameter 3.1 to 4.0 centimeters	280.00
11606-00	lesion diameter over 4.0 centimeters	386.50
11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less	165.40
11621-00	lesion diameter 0.6 to 1.0 centimeter	231.50
11622-00	lesion diameter 1.1 to 2.0 centimeters	350.00
11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less	272.70
11641-00	lesion diameter 0.6 to 1.0 centimeter	297.26
11642-00	lesion diameter 1.1 to 2.0 centimeters	400.00
11643-00	lesion diameter 2.1 to 3.0 centimeters	397.33

	Nails	
11700*00	Debridement of nails, manual; 5 or less	$ 29.00
11710*00	Debridement of nails, electric grinder, 5 or less	26.00
11730*00	Avulsion of nail plate, partial or complete, simple; single	68.00
11740-00	Evacuation of subungual hematoma	42.00
11750-00	Excision of nail and nail matrix, partial or complete, (e.g. ingrown or deformed nail) for permanent removal	150.00
	Miscellaneous	
11770-00	Excision of piloridial cyst or sinus; simple	$ 565.00
11771-00	extensive	660.00
11900*00	Injection, intralesional, up to and including seven lesions	35.00
	Introduction	
11901*00	Injection, intralesional; up to and including 7 lesions	$ 68.00
11954-00	Subcutaneous injection of "filling" material (e.g. silicone); over 10 centimeters	100.00
	Repair — Simple	
12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	$ 60.00
12002*00	2.5 to 7.5 centimeters	88.75
12004*00	7.5 to 12.5 centimeters	123.50
12005*00	12.5 to 20.0 centimeters	149.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	88.00
12013*00	2.5 to 5.0 centimeters	120.00
12014-00	5.1 to 7.5 centimeters	120.00
12015-00	7.6 to 12.5 centimeters	132.00
12020-00	Treatment of superficial wound dehiscence; simple closure	110.00
	Repair — Intermediate	
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 88.00
12032*00	2.5 to 7.5 centimeters	122.50
12034-00	7.6 to 12.5 centimeters	170.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	105.00
12042-00	2.5 to 7.5 centimeters	146.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	131.00
12052-00	2.5 to 5.0 centimeters	174.00

12053-00	5.1 to 7.5 centimeters	215.00
	Repair — Complex	
13101-00	Repair, complex, trunk; 2.6 to 7.5 centimeters	$ 267.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters	250.00
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	490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less	220.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters	420.00
13152-00	2.5 to 7.5 centimeters	720.00
	Adjacent Tissue Transfer or Rearrangement	
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	$ 1,000.00
	Free Skin Grafts	
15100-00	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters or less, or each one percent of body area of infants and children	$ 628.00
	Burns, Local Treatment	
16000-00	Initial treatment, first degree burn, when no more than local treatment is required	$ 45.00
16010-00	Dressings and/or debridement, initial or subsequent; under anesthesia, small	44.00
16020*00	without anesthesia, office or hospital, small	47.00
16025*00	without anesthesia, medium, for example, whole face or whole extremity	82.00
	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	$ 49.00
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	46.50
17101-00	second lesion	23.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to	

	15 lesions	45.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	50.00
17250*00	Chemical cauterization of a wound	35.00
17303-00	Chemosurgery (Mohs' technique), first stage, fixed tissue technique, including removal of all gross tumor and application of fixative	53.00
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 5 horizontal, microscopic specimens	505.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)	32.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)	34.00

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

Code	Service	Maximum Fee
	Excision — General	
20205-00	Biopsy, muscle; deep	$ 250.00
20220-00	Biopsy, bone, trocar, or needle; superficial, for example ilium, sternum, spinous process, ribs	157.00
	Introduction or Removal — General	
20520*00	Removal of foreign body in muscle or tendon sheath; simple	$ 50.00
20550*00	Injection, tendon sheath, ligament, or trigger points	48.00
20600*00	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	50.00
20605*00	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa	63.00
20610*00	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa	64.27
20670*00	Removal of implant; superficial, (e.g. buried wire, pin, or rod)	90.00
20680-00	Removal of implant; deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate	350.00
	Head Repair, Revision, or Reconstruction	
21310-00	Treatment of closed or open nasal fracture without manipulation	$ 58.00
21315-00	mandible (includes obtaining graft)	145.00

21320-00	Manipulative treatment, nasal bone fracture; with stabilization	365.00
	Neck (Soft Tissues) and Thorax — Fracture or Dislocation	
21800-00	Treatment of rib fracture; closed, uncomplicated, each	$ 68.00
	Shoulders — Fracture or Dislocation	
23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy)	$ 1,579.00
23450-00	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation	1,575.00
23500-00	Treatment of closed clavicular fracture; without manipulation	125.00
23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	219.00
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	165.00
23655-00	requiring anesthesia	236.25
23700*00	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	154.00
	Humerus (Upper Arm) and Elbow — Fracture or Dislocation	
24105-00	Excision, olecranon bursa	$ 420.00
24500-00	Treatment of closed humeral shaft fracture; without manipulation	220.00
24600-00	Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	199.00
24650-00	Treatment of closed radial head or neck fracture without manipulation	168.75
24685-00	Open treatment of closed or open ulnar fracture proximal end (olecranon process), with or without internal or external skeletal fixation	750.00
	Forearm and Wrist — Incision and Excision	
25111-00	Excision of ganglion, wrist (dorsal or volar); primary	$ 425.00
	Forearm and Wrist — Fracture or Dislocation	
25500-00	Treatment of closed radial shaft fracture; without manipulation	$ 168.50
25505-00	with manipulation	369.00
25560-00	Treatment of closed radial and ulnar shaft fractures; without manipulation	231.00
25565-00	Treatment of closed radial and ulnar shaft fractures; with manipulation	471.00
25600-00	Treatment of closed distal radial fracture (for example, Colles or Smith	

	type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	195.50
25605-00	with manipulation	344.00
25610-00	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning	520.00
25611-00	with external skeletal fixation or percutaneous pinning	637.50
25622-00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	240.00

Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction

26011*00	Drainage of finger abscess; complicated (i.e., felon, etc.)	$ 200.00
26055-00	Tendon sheath incision for trigger finger	401.00
26115-00	Excision, tumor, hand or finger; subcutaneous	307.00
26116-00	deep, subfascial, intramuscular	483.00
26122-00	Fasciectomy, palmar, simple for Dupuytren's contracture; up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,375.00
26160-00	Excision of lesion of tendon sheath or capsule	270.00
26418-00	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	380.00

Hands and Fingers — Fractures or Dislocations

26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 132.00
26605-00	with manipulation, each bone	205.60
26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	89.00
26725-00	with manipulation, each	140.00
26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each	516.00
26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	61.00
26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated	

	soft tissue closure, each	138.00
26770-00	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	71.00
	Hand and Fingers — Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 350.00
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)	$2,001.82
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple	3,199.00
27134-00	Revision of total hip arthroplasty; both components	4,300.00
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	1,764.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,604.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	398.40
	Femur (Thigh Region) and Knee Joint — Introduction or Removal	
27370-00	Injection procedure for knee arthrography	$ 63.00
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27422-00	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	$ 1,350.00
27425-00	Lateral retinacular release, any method	1,235.00
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,496.00
27447-00	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement)	3,200.00
27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,568.00
27570*00	Manipulation of knee joints under general anesthesia (includes application of traction or other fixation devices)	225.60

Amputation

27590-00	Amputation, thigh, through femur, any level	$ 1,100.00

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

27750-00	Treatment of closed tibial shaft fracture; without manipulation	$ 250.00
27752-00	with manipulation	439.00
27760-00	Treatment of closed distal tibial fracture (medial malleolus) without manipulation	215.00
27766-00	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation	854.00
27780-00	Treatment of closed proximal fibula or shaft fracture; without manipulation	178.00
27786-00	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	187.00
27792-00	Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation	766.00
27802-00	with manipulation	640.00
27814-00	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	1,087.00
27822-00	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	1,232.00
27880-00	Amputation leg, through tibia and fibulat	900.00

Foot

28080-00	Excision of Morton neuroma; single each	$ 366.75
28090-00	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot	400.00
28190*00	Removal of foreign body, foot; subcutaneous	53.50
28285-00	Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy)	413.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure)	535.00
28292-00	Keller, McBride or Mayo type procedure	701.25
28296-00	With metatarsal osteotomy (Mitchell, Chevron, or concentric type procedure)	935.00

28470-00	Treatment of closed metatarsal fracture; without manipulation, each	130.00
28490-00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	67.25
28510-00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	60.00
28820-00	Amputation, toe; metatarso-phalangeal joint	244.82

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)	$ 90.00
29075-00	elbow to finger (short arm)	73.00
29085-00	hand and lower forearm (gauntlet)	75.00
	Splints	
29105-00	Application of long arm splint (shoulder to hand)	$ 51.00
29125-00	Application of short arm splint (forearm to hand); static	44.00
29130-00	Application of finger splint; static	29.50
	Strapping — Any Age	
29260-00	Strapping; elbow or wrist	$ 20.00
29345-00	Application of long leg cast (thigh to toes)	113.30
29355-00	walker or ambulatory type	134.00
29365-00	Application of cylinder cast (thigh to ankle)	93.00
29405-00	Application of short leg cast (below knee to toes)	90.00
29425-00	walking or ambulatory type	100.00
29435-00	Application of patellar tendon bearing (PTB) cast	132.00
29440-00	Adding walker to previously applied cast	40.00
29450-00	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	58.00
29455-00	bilateral	112.00
	Splints	
29505-00	Application of long leg splint (thigh to ankle or toes)	$ 67.00
29515-00	Application of short leg splint (calf to foot)	50.00

	Strapping — Any Age	
29530-00	Strapping; knee	$ 48.00
29550-00	toes	26.00
29580-00	Unna boot	35.00
	Removal or Repair	
29700-00	Removal or bivalving; gauntlet, boot or body cast	$ 30.00
29705-00	full arm or full leg cast	25.00
29720-00	Repair of spica, body cast, or jacket	23.00
	Arthroscopy	
29870-00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$ 525.00
29874-00	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body (for example, osteochondritis dissecans fragmentation, chondral fragmentation)	1,350.00
29875-00	synovectomy, limited (for example, plica or shelf resection)	1,254.00
29877-00	debridement/shaving of articular cartilage (chrondroplasty)	1,461.00
29879-00	abrasion arthroplasty (includes chrondroplasty where necessary) or multiple drilling	1,566.00
29880-00	with meniscectomy (medial AND lateral, including any meniscal shaving)	1,732.00
29881-00	with meniscectomy (medial or lateral including any meniscal shaving)	1,511.00

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; unilateral	$ 136.00
30116-00	Excision, nasal polyp(s), extensive; bilateral	620.00
30300*00	Removal foreign body, intranasal; office type procedure	42.00
	Nose — Repair	
30420-00	Rhinoplasty, primary; including major septal repair	$ 2,205.00
30520-00	Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft	1,031.00
30800*00	Cauterization turbinates, unilateral or	

	bilateral (separate procedure); superficial	22.00
	Other Procedures	
30901*00	Control nasal hemorrhage, anterior, simple (cauterization); unilateral	$ 54.00
30902*00	bilateral	68.00
30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral	92.50
31000*00	Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium)	50.00
31001*00	maxillary sinuses, bilateral	85.00
31021-00	Sinusotomy, maxillary (antrotomy); intranasal, bilateral	632.00
31250-00	Nasal endoscopy, diagnostic (includes examination of the medial meatus, infundibulum and sinus ostia)	60.00
	Larynx	
31500-00	Intubation, endotracheal, emergency procedure	$ 130.00
31505-00	Laryngoscopy, indirect; diagnostic	37.75
31525-00	Laryngoscopy, direct; diagnostic, except newborn	250.00
31535-00	Laryngoscopy, direct, operative, with biopsy;	595.00
31536-00	with operating microscope	588.00
31541-00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis	670.00
31575-00	Laryngoscopy, flexible fiberscopic; diagnostic	95.00
	Trachea and Bronchi	
31600-00	Tracheostomy, planned (separate procedure)	$ 510.05
31622-00	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing	458.00
31625-00	with biopsy	492.00
31628-00	with transbronchial lung biopsy, with or without fluoroscopic guidance	525.00
	Lungs	
32000*00	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	$ 125.00
32020-00	Tube thoracotomy with water seal (for example, pneumothorax, hemothorax, empyema)(separate procedure)	420.00

32405-00	Biopsy, lung, percutaneous needle	275.00
32480-00	Lobectomy, total or segmental	1,868.00
32500-00	Wedge resection of lung, single or multiple	1,452.40

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	
33206-00	Insertion of permanent pacemaker with transvenous electrode(s); atrial	$ 1,400.00
33207-00	ventricular	1,577.00
33208-00	AV sequential	1,900.00
33210-00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter	525.00
33212-00	Insertion or replacement of pulse generator only	770.00
33405-00	Replacement, aortic valve, with cardiopulmonary bypass	4,387.00
	Coronary Artery Procedures	
33510-00	Coronary artery bypass, autogenous graft, (e.g., saphenous vein or internal mammary artery); single graft	$ 4,100.00
33511-00	two coronary grafts	4,700.00
33512-00	three coronary grafts	5,535.00
33513-00	four coronary grafts	6,040.00
	Arteries and Veins	
34201-00	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	$ 980.00
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	2,920.00
35301-00	Thromboendarterectomy, with or without patch graft, carotid, vertebral, subclavian, by neck incision	2,123.00
	Vascular Injection Procedures	
36000*00	Introduction of needle or intracatheter, vein; unilateral	$ 44.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery	355.00
36200-00	Introduction of catheter, aorta (arch, abdominal, midstream renal, aortioliac run-off) or selective; initial placement	206.17

36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	40.00
36415*00	Routine venipuncture for collection of specimen(s)	8.00
36430-00	Transfusion, blood or blood components	76.50
36470*00	Injection of sclerosing solution; single vein	50.00
36471*00	Injection of sclerosing solution; multiple veins, same leg	55.00
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age two	140.00
36520-00	Therapeutic apheresis (plasma and/or cell exchange)	115.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	42.00
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	114.00
36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	285.00
36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,200.00
37609-00	Ligation or biopsy, temporal artery	242.00
37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	700.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	1,000.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	850.00
37731-00	bilateral	1,300.00
37785-00	Ligation division, and/or excision of secondary varicose veins (clusters) of leg; unilateral	180.00

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
	Lymphatic	
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	$ 166.00
38510-00	deep cervical nodes	344.00
38525-00	deep axillary node(s)	344.00

Mediastinum and Diaphragm

39400-00	Mediastinoscopy, with or without biopsy	$ 535.00

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	$ 110.00
40808-00	Biopsy, vestibule of mouth	85.00
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	159.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,650.00
42440-00	Excision of submandibular (submaxillary) gland	1,065.00
42700*00	Incision and drainage abscess; peritonsillar	137.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	500.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	491.00
	Esophagus	
43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 345.00
43202-00	for biopsy and/or collection of specimen by brushing or washing	448.00
43204-00	for injection sclerosis of esophageal varices	714.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	500.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, with small diameter flexible fiberscope)	413.00
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	367.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	420.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	508.00
43246-00	for directed placement of percutaneous gastrostomy tube	695.00
43247-00	for removal of foreign body	580.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser	

	photocoagulation)	480.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection	560.00
43262-00	for sphincterotomy/papillotomy	984.50
43450*00	Dilation esophagus, by unguided sound(s) or bougie(s), single or multiple passes; initial session	87.00
43451*00	subsequent session	73.00
43635-00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type	1,750.00
43640-00	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	1,650.00
	Stomach	
43760*00	Change of gastrostomy tube (MD/DO)	$ 75.00
43830-00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure) (MD/DO)	765.00
	Intestines	
44005-00	Enterolysis (freeing of intestinal adhesion) for acute bowel obstruction	$ 1,236.50
44100-00	Biopsy of intestine by capsule, tube, peroral (1 or more specimens)	208.00
44120-00	Enterectomy, resection of small intestine; with anastomosis	1,442.00
44140-00	Colectomy, partial; with anastomosis	1,572.00
44143-00	with end colostomy and closure of distal segment (Hartmann type procedure)	1,652.00
44145-00	with coloproctostomy (low pelvic anastomosis)	2,055.00
44160-00	Colectomy with removal of terminal ileum and ileocolostomy	2,100.00
44625-00	Closure of enterostomy, large or small intestine; with resection and anastomosis	1,249.62
44950-00	Appendectomy	792.00
44960-00	for ruptured appendix with abscesses or generalized peritonitis	994.00
45110-00	Proctectomy; complete, combined abdominoperineal, with colostomy, 1 or 2 stages	2,396.00
45300-00	Proctosigmoidoscopy; diagnostic	65.00
45305-00	for biopsy	100.00
45310-00	Proctosigmoidoscopy; for removal of polyp or papilloma	140.00
45330-00	Sigmoidoscopy, flexible fiberoptic; diagnostic	120.00
45331-00	for biopsy and/or collection of specimen by brushing or washing	168.00
45333-00	Sigmoidoscopy, flexible fiberoptic; for	

	removal of polypoid lesion(s)	232.00
45355-00	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple	135.00
45378-00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure	530.00
45380-00	for biopsy and/or collection of specimen by brushing or washing	612.06
45382-00	Colonoscopy, fiberoptic, beyond splenic flexure; for control of hemorrhage (i.e., electrocoagulation, laser photocoagulation)	525.00
45383-00	Colonoscopy, fiberoptic, beyond splenic flexure; for ablation of tumor or musocal lesion (e.g., electrocoagulation, laser photocoagulation, hop biopsy/fulguration)	574.00
45385-00	for removal of polypoid lesion(s)	685.00
45550-00	Proctopexy combined with sigmoid resection, abdominal approach	770.00
45505-00	Proctoplasty; for prolapse of mucous membrane	825.00
46040-00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	258.50
46050*00	Incision and drainage, perianal abscess, superficial	113.00
46083-00	Incision of thrombosed hemorrhoid, external	75.00
46200-00	Fissurectomy, with or without sphincterotomy	421.00
46221-00	Hemorrhoidectomy, by simple ligature (e.g. rubber band)	111.00
46230-00	Excision of external hemorrhoid tags and/or multiple papillae	100.00
46255-00	Hemorrhoidectomy, internal and external, simple	655.00
46260-00	Hemorrhoidectomy, internal and external, complex or extensive	815.00
46275-00	Fistulectomy; submuscular	825.00
46320*00	Enucleation or excision of external thrombotic hemorrhoid	84.00
46600-00	Anoscopy; diagnostic (separate procedure)	30.25
46900-00	Destruction of lesion(s), anus (i.e., condyloma, papilloma, mossuscum contagiosum, herpetic vesicle), simple; chemical	40.00
46946-00	Ligation of internal hemorrhoids; multiple procedures	100.00
47000*00	Biopsy of liver; percutaneous needle	191.00
47600-00	Cholecystectomy	1,245.00
47605-00	with cholangiography	1,367.00
47610-00	Cholecystectomy with exploration of common duct	1,500.00
49000-00	Exploratory laparotomy, exploratory celiotomy	845.00

49080*00	Peritoneocentesis, abdominal paracentesis; initial	96.00
49505-00	Repair inguinal hernia, age 5 or over	754.00
49515-00	with excision of hydrocele or spermatocele	825.00
49520-00	Repair inguinal hernia; recurrent (MD/DO)	850.00
49525-00	sliding	854.00
49530-00	incarcerated	897.00
49550-00	Repair femoral hernial groin incision	765.00
49560-00	Repair ventral (incisional) hernia (separate procedure)	840.00
49565-00	Repair ventral (incisional) hernia separate procedure); recurrent	978.00
49581-00	Repair umbilical hernia; age 5 or over	656.50

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 trocar or needle	$ 385.00
50230-00	Nephrectomy, including partial ureterectomy, any approach including resection; radical, with regional lymphadenectomy	2,525.00
50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	49.50
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)	35.00
51700*00	Bladder irrigation, simple, lavage and/or instillation	32.00
51705*00	Change of cystostomy tube; simple	40.00
51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	56.11
51725-00	Simple cystometrogram (CMG) (i.e., spinal manometer)	90.30
51726-00	Complex cystometrogram (for example, calibrated electronic equipment)	111.00
51736-00	Simple uroflowmetry (UFR) (i.e., stop-watch flow rate, mechanical uroflowmeter)	42.00
51741-00	Complex uroflowmetry	60.00
51840-00	Anterior vesicourethropexy, or urethropexy; simple	1,270.00
51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,350.00
51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control	

	(e.g., Stamey, Raz, modified Pereyra)	1,405.00
52000-00	Cystourethroscopy (separate procedure)	135.00
52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	244.00
52204-00	Cystourethroscopy with biopsy	216.00
52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery of trigone bladder neck, prostatic fossa, urethra, or periurethral glands)	297.00
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	280.00
52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters)	430.00
52235-00	MEDIUM bladder tumor(s) (2.0 to 5.0 centimeters)	784.47
52240-00	LARGE bladder tumor(s)	1,300.00
52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	227.00
52276-00	Cystourethroscopy with direct vision internal urethrotomy	479.50
52281-00	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office	236.00
52310-00	Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate procedure); simple	326.00
52320-00	Cystourethroscopy; with removal of ureteral calculus	620.00
52332-00	Cystourethroscopy, with insertion of indwelling ureteral stent	363.60
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)	1,350.00
52500-00	Transurethral resection of bladder neck (separate procedure)	750.00
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)	1,392.00
53600*00	Dilation of urethral stricture by passage of sound or urethral dilator,	

	male; initial	36.00
53601*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent	30.00
53620*00	Dilation of urethral stricture by passage of filiform and follower, male; initial	58.18
53621*00	subsequent	44.88
53660*00	Dilation of female urethra including suppository and/or instillation; initial	31.00
53661-00	subsequent	30.00
53670*00	Catheterization; urethral; simple	28.00
53675*00	complicated (may include difficult removal of balloon catheter)	62.00

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 (i.e., condyloma, papilloma, mulloscum contagiosum, herpetic vesicle), simple; chemical	$ 34.00
54055*00	electrodesiccation	68.00
54235-00	Injection of corpora cavernosa with pharmacologic agent(s) (i.e., papaverine, phentolamine, etc.)	60.00
54405-00	Insertion of inflatable (multicomponent) penile prosthesis, including placement of pump, cylinders, and/or reservoir	2,426.00
54521-00	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral	544.00
54640-00	Orchiopexy, any type, with or without hernia repair; unilateral	925.00
55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	40.00
55040-00	Excision of hydrocele; unilateral	620.00
55700-00	Biopsy, prostate; needle or punch, single or multiple, any approach	118.25
55845-00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	2,400.00
	Female Reproductive System	
56420*00	Incision and drainage of Bartholin's gland abscess, unilateral	$ 87.00
56440-00	Marsupialization of Bartholin's gland cyst	378.00
56501-00	Destruction of lesion(s), vulva; simple, any method	51.00
56515-00	extensive, any method	100.00
56600*00	Biopsy of vulva (separate procedure)	85.00
57061-00	Destruction of vaginal lesion(s); simple, any method	45.00
57100*00	Biopsy of vaginal mucosa; simple,	

	(separate procedure)	72.00
57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	20.00
57160*00	Insertion of pessary	30.00
57260-00	Combined anteroposterior colporrhaphy	1,110.00
57452*00	Colposcopy (vaginoscopy); (separate procedure)	130.00
57454*00	with biopsies, or biopsy of the cervix	150.00
57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	75.00
57505-00	Endocervical curettage (not done as part of a dilation and curettage)	115.00
57510-00	Cauterization of cervix; electro or thermal	72.00
57511*00	cryocautery, initial or repeat	99.00
57513-00	laser surgery	475.00
57520-00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair	500.00
57700-00	Cerclage of uterine cervix (tracheloplasty)	511.00
58100*00	Endometrial biopsy, suction type (separate procedure)	83.00
58102-00	Office endometrial curettage	133.00
58120-00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	345.00
58150-00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	1,375.00
58152-00	with clopo-urethrocystopexy (Marshall-Marchetti-Krantz type)	2,000.00
58260-00	Vaginal hysterectomy	1,350.00
58265-00	with plastic repair of vagina, anterior and/or posterior colporrhaphy	1,550.80
58340-00	Injection procedure for hysterosalpingography	109.50
58720-00	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	1,000.00
58925-00	Ovarian cystectomy, unilateral or bilateral	1,013.00
58940-00	Oophorectomy, partial or total, unilateral or bilateral	1,000.00
58980-00	Laparoscopy for visualization of pelvic viscera	625.00
58982-00	with fulguration of oviducts (with or without transection)	700.00
58983-00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	780.00
58984-00	with fulguration of ovarian or peritoneal lesions by any method	769.00
58985-00	with lysis of adhesions	728.00
58986-00	with biopsy (single or multiple)	757.00
58987-00	with aspiration (single or multiple)	725.00
58990-00	Hysteroscopy; diagnostic	400.00

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	$129.50
60220-00	Total thyroid lobectomy, unilateral	1,125.00
60245-00	Thyroidectomy, subtotal or partial	1,428.00

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; unilateral	$ 1,692.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,950.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,725.00
	Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic	$ 110.00
62273*00	Injection lumbar epidural, of blood or clot patch	228.40
62278*00	Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural or caudal single	180.00
62279*00	epidural or caudal, continuous	282.50
62282*00	Injection of neurolytic substance (i.e., alcohol, phenol, iced saline solutions); lumbar or caudal epidural	500.00
62288*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure)	75.00
62289*00	lumbar or caudal epidural	256.00
	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	$ 2,604.00
63017-00	Laminectomy for exploration/ decompression of spinal cord and/or cauda equina, more than two segments; lumbar	2,775.00
63020-00	Laminotomy (hemilaminectomy), for decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral	2,300.00
63030-00	one interspace, lumbar, unilateral	2,200.00

63031-00	one interspace, lumbar, bilateral	2,860.00
63042-00	reexploration; lumbar	2,795.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

64405*00	Injection, anesthetic agent; greater occipital nerve	$ 127.30
64421-00	intercostal nerves, multiple, regional block	165.00
64440*00	paravertebral nerve (thoracic, lumbar, sacral, coccygeal), single vertebral level	50.00
64450*00	Injection, anesthetic agent; other peripheral nerve or branch	65.00
64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	196.00
64550-00	Application of surface (transcutaneous) neurostimulator	42.30
64640-00	Destruction by neurolytic agent; other peripheral nerve or branch	300.00
64718-00	Neurolysis or transposition; ulnar nerve at elbow	989.00
64721-00	median nerve at carpal tunnel	735.00

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	51.00
65220*00	corneal, without slit lamp	55.00
65222*00	corneal, with slit lamp	66.50
65855-00	Trabeculoplasty by laser surgery (1 or more sessions) (defined treatment series)	710.00
66170-00	Fistulization of sclera for glaucoma; trabeculectomy ab externo	1,187.00
66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)	700.00
66802-00	Discission of lens capsule; laser surgery (one or more stages)	600.00
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 (one or more stages)	700.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,641.60
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure)	1,800.00
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,400.00
67101-00	Repair of retinal detachment, one or more sessions; cryotheraphy or diathermy, with or	

	without drainage of subretinal fluid	1,375.00
67105-00	Repair of retinal detachment, 1 or more sessions, same hospitalization; photocoagulation (laser or xenon arc, 1 or more sessions) with drainage of subretinal fluid	612.00
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 (i.e., retinal break, lattice, degeneration) without drainage, one or more sessions; cryotherapy, diathermy	750.00
67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	750.00
67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), 1 or more sessions; photocoagulation (laser or xenon arc)	975.00
67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), 1 or more sessions; cryotherapy, diathermy	900.00
67228-00	photocoagulation (laser or xenon arc)	790.00
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); 1 muscle	975.00
67312-00	2 muscles, 1 or both eyes	1,009.00
67313-00	three or more muscles, one or both eyes	1,000.00
67515*00	Injection of therapeutic agent into Tenon's capsule	52.50
67800-00	Excision of chalazion; single	80.00
67801-00	multiple, same lid	135.00
67820*00	Correction of trichiasis; epilation, by forceps only	35.50
67825*00	epilation, (i.e., by electrosurgery or cryotherapy)	150.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	98.00
67921-00	Repair of entropion; suture	522.00
67938-00	Removal of embedded foreign body; eyelid	40.00
68200*00	Subconjunctival injection	52.02
68760-00	Closure of lacrimal punctum (i.e., thermocauterization, ligation, or laser photocoagulation)	119.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	43.00
68825-00	Probing of nasolacrimal duct, with or	

	without irrigation, unilateral or bilateral; requiring general anesthesia	259.00
68840*00	Probing of lacrimal canaliculi, with or without irrigation	75.00

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

Code	Service	Maximum Fee
69200-00	Removal foreign body from external auditory canal; without general anesthesia	$ 40.28
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	21.10
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	38.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	84.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral	167.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	317.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral	265.00
69437-00	bilateral	378.00
69610-00	Tympanic membrane repair, with or without site preparation or perforation preparation for closure without patch	90.00
69620-00	Myningoplasty	1,385.00
69631-00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	1,958.00
69632-00	with ossicular chain reconstruction (for example, postfenestration)	2,350.00
69641-00	Tympanoplasty with mastoidotomy; without ossicular chain reconstruction	2,707.90
69660-00	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material	2,197.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 124*

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	$ 56.00
70110-00	complete, minimum of four views	78.00
70130-00	Radiologic examination, mastoids; complete, minimum of three views per side	99.00
70140-00	Radiologic exammation, facial bones; less than three views	54.50
70150-00	complete, minimum of three views	76.76
70160-00	Radiologic examination, nasal bones; complete, minimum of three views	53.50
70200-00	Radiologic examination; orbits, complete, minimum of four views	74.55
70210-00	Radiologic examination, sinuses, paranasal, less than three views	39.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views	75.00
70250-00	Radiologic examination, skull, less than four views, with or without stereo	60.00
70320-00	Radiologic examination, teeth; complete, full mouth	59.25
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	150.00
70333-00	Temporomandibular joint arthrography; complete procedure	250.00
70355-00	Orthopantogram	58.00
70360-00	Radiologic examination, neck, soft tissue	40.00
70380-00	Radiologic examination, salivary gland for calculus	58.50

70450-00	Computerized axial tomography, head or brain; without contrast material	353.00
70460-00	with contrast material	414.00
70470-00	without contrast material, followed by contrast material(s) and further sections	450.00
70481-00	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	482.00
70482-00	without contrast material, followed by contrast material(s) and further sections	532.00
70540-00	Magnetic resonance (e.g., proton) imaging; orbit, face, and neck	640.00
70551-00	Magnetic resonance (i.e., proton) imaging brain (including brain stem)	772.00
	Chest	
71010-00	Radiologic examination, chest; single view, frontal	$ 38.00
71015-00	stereo, posteroanterior	38.50
71020-00	Radiologic examination, chest, two views, frontal and lateral	52.50
71021-00	with apical lordotic procedure	46.75
71030-00	Radiological examination, chest, complete, minimum of four views	45.00
71035-00	Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies	25.90
71100-00	Radiologic examination, ribs, unilateral; two views	58.75
71101-00	Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views	65.00
71110-00	Radiologic examination, ribs, bilateral; three views	73.00
71120-00	Radiologic examination; sternum, minimum of two views	54.00
71250-00	Computerized axial tomography, thorax, without contrast materials	408.10
71260-00	with contrast materials	467.50
71270-00	without contrast material, followed by contrast material(s) and further sections	532.00
	Spine and Pelvis	
72010-00	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral	$ 132.10
72020-00	Radiologic examination, spine, single view, specify level	50.90
72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral	57.00
72050-00	minimum of four views	85.60
72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	98.75
72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral	63.00
72072-00	thoracic anteroposterior and lateral,	

	including swimmer's view of the cervicothoracic junction	76.90
72080-00	Radiologic examination, spine; thoracolumbar, anteroposterior and lateral	63.00
72090-00	scoliosis study, including supine and erect studies	52.75
72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	67.00
72114-00	complete, including bending views	95.00
72120-00	Radiologic examination, spine, lumbosacral, bending views only, mmimum of four views	78.75
72125-00	Computerized axial tomography, cervical spine; without contrast material	525.00
72128-00	Computerized axial tomography, thoracic spine;	460.00
72131-00	Computerized axial tomography, lumbar spine; without contrast material	480.00
72132-00	with contrast material	445.00
72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents	801.00
72143-00	thoracic	810.00
72144-00	lumbar	790.00
72170-00	Radiologic examination, pelvis anteroposterior only	46.00
72180-00	stereo	45.00
72190-00	complete, mmimum of three views	65.00
72192-00	Computerized axial tomography, pelvis, without contrast material	223.00
72193-00	with contrast material(s)	460.00
72196-00	Magnetic resonance (i.e., proton) imaging, pelvis	750.00
72200-00	Radiologic examination, sacroiliac joints; less than three views	59.00
72202-00	three or more views	58.00
72220-00	Radiologic examination, sacrum and coccyx, minimum of two views	54.90
72266-00	Myelography, lumbosacral; complete procedure	579.00
	Upper Extremities	
73000-00	Radiologic examination; clavicle, complete	$ 40.50
73010-00	scapula, complete	54.00
73020-00	Radiologic examination, shoulder; one view	38.00
73030-00	complete, minimum of two views	51.01
73041-00	Radiologic examination, shoulder, arthrography; complete procedure	243.50
73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	58.50
73060-00	humerus, minimum of two views	47.00

73070-00	Radiologic examination, elbow; anteroposterior and lateral views	43.50
73080-00	complete, minimum of three views	48.00
73090-00	Radiologic examination; forearm, anteroposterior and lateral views	43.50
73100-00	Radiologic examination, wrist; anteroposterior and lateral views	41.00
73110-00	complete, minimum of three views	47.00
73120-00	Radiologic examination, hand; two views	43.00
73130-00	minimum of three views	47.00
73140-00	Radiologic examination, finger or fingers, minimum of two views	38.00
73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity	665.00
	Lower Extremities	
73500-00	Radiologic examination, hip; unilateral, one view	$ 36.00
73510-00	complete, minimum of two views	59.00
73520-00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	53.07
73550-00	Radiologic examination, femur, anteroposterior and lateral views	51.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	45.00
73562-00	anteroposterior and lateral, with oblique, minimum of three views	57.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	60.00
73581-00	Radiologic examination, knee, arthrography; complete procedure	212.00
73590-00	Radiologic examination, tibia and fibula, anteroposterior and lateral views	47.00
73600-00	Radiologic examination, ankle; anteroposterior and lateral views	40.00
73610-00	complete, minimum of three views	48.50
73620-00	Radiologic examination, foot; anteroposterior and lateral views	40.00
73630-00	complete, minimum of three views	50.00
73650-00	Radiologic examination; calcaneus, minimum of two views	41.25
73660-00	toe or toes, minimum of two views	37.85
73700-00	Computerized axial tomography, lower extremity; without contrast material	470.00
73720-00	Magnetic resonance (e.g., proton) imaging, lower extremity	650.00
	Abdomen	
74000-00	Radiologic examination, abdomen, single anteroposterior view	44.90
74010-00	anteroposterior and additional oblique and cone views	55.00
74020-00	complete, including decubitus and/or erect views	63.00

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	425.00
74160-00	with contrast material(s)	499.00
74170-00	without contrast material, followed by contrast material(s) and further sections	532.00
74181-00	Magnetic resonance (e.g., proton) imaging, abdomen	892.50
	Gastrointestinal Tract	
74210-00	Radiologic examination; pharynx and/or cervical esophogus	$ 74.00
74220-00	esophagus	108.00
74240-00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	122.70
74241-00	with or without delayed films, with KUB	128.00
74245-00	with small bowel, includes multiple serial films	182.20
74246-00	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without delayed films; without KUB	135.00
74247-00	with or without delayed films, with KUB	140.00
74250-00	Radiologic examination, small bowel, includes multiple serial films	155.10
74270-00	Radiologic examination, colon; barium enema	124.20
74280-00	air contrast with specific high density barium, with or without glucagon	173.00
74290-00	Cholecystography, oral contrast	79.00
74291-00	additional or repeat examination or multiple day examination	67.00
74305-00	Cholangiography and/or pancreatography; postoperative	105.25
	Urinary Tract	
74400-00	Urography, (pyelography) intravenous, with or without KUB	$ 145.00
74405-00	with special hypertensive contrast concentration and/or clearance studies	167.00
74410-00	Urography, infusion, drip technique	125.00
74415-00	Urography, infusion, drip technique and/or bolus technique; with nephrotomography	183.50
74420-00	Urography, retrograde, with or without KUB	61.75
74431-00	Cystography, minimum of three views; complete procedure	113.00
74456-00	Corpora cavernosography; complete procedure	154.40

Gynecological and Obstetrical

74710-00	Pelvimetry, with or without placental localization	$ 89.00
74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	47.10
74741-00	Hysterosalpingography; complete procedure	142.50

Veins and Lymphatics

75821-00	Venography, extremity, unilateral; complete procedure	$ 255.00

Miscellaneous

76020-00	Bone age studies	$ 46.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	73.00
76061-00	Radiologic examination, osseous survey: limited (e.g., for metastases)	152.90
76062-00	Radiologic examination, osseous survey; complete	215.10
76066-00	Joint survey, single view, one or more joints (specify)	25.00
76090-00	Mammography; unilateral	58.00
76091-00	bilateral	70.00
76096-00	Localization of breast nodule or calcification before operation, with marker and confirmation of its position with appropriate imaging (i.e., radiologic or ultrasound)	190.00
76098-00	Radiological examination, breast surgical specimen	40.00
76100-00	Radiologic examination, single plane body section	150.00
76101-00	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	103.00
76102-00	bilateral	130.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	523.00
76370-00	Computerized tomography guidance for placement of radiation therapy fields	150.00
76375-00	Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction	60.00

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, spectral analysis with amplitude quantification	$ 139.55
76512-00	contact B-scan	135.00
76516-00	Ophthalmic, biometry; by ultrasound echography, A-mode	155.00
76519-00	intraocular lens power calculation	155.44
76536-00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B-scan and/or real-time with image documentation	203.70
	Chest	
76620-00	Echocardiography, M-mode	$ 144.00
76627-00	Echocardiography, real-time with image documentation (2D); complete	300.00
76629-00	Echocardiography, M-mode and real time with image documentation	275.00
76632-00	Doppler echocardiography	85.00
76700-00	Echography, abdominal, B-scan; and/or real-time with image documentation	165.85
76705-00	limited	135.90
76770-00	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan	227.85
76775-00	limited	103.00
	Pelvis	
76805-00	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete	$ 111.00
76815-00	Echography, pregnant uterus, B-scan and/or real-time with image documentation; limited (fetal growth rate, heart beat, anomalies, placental location)	80.00
76816-00	follow-up or repeat	80.00
76818-00	Fetal biophysical profile	125.00
76855-00	Echography, pelvic area (Doppler)	169.50
76856-00	Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; complete	133.00
76857-00	limited or follow-up (e.g., for follicles)	60.00
76870-00	Echography, scrotum and contents	181.90
76880-00	Echography, extremity, B-scan and/or real-time with image documentation	130.00
76925-00	Imaging, peripheral (e.g., B-scan, Doppler or real-time scan)	140.00
76943-00	Ultrasonic guidance for needle biopsy; complete procedure	286.70
76970-00	Ultrasound study follow-up (specify)	85.00
76991-00	Intraluminal ultrasound study (e.g., transrectal, transvaginal)	200.00

Subp. 4. **Therapeutic radiology.** The following codes, procedures, and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services,

and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

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

Code	Service	Maximum Fee
77262-00	Therapeutic radiology treatment planning; intermediate	$ 329.99
77280-00	Therapeutic radiology simulation-aided field setting; simple	137.50
77285-00	intermediate	220.00
77290-00	complex	271.00
77315-00	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	357.50
77334-00	Treatment devices, design and construction; complex	103.50
77336-00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance	98.00
77400-00	Daily megavoltage treatment management; simple	48.50
77405-00	intermediate	119.00
77410-00	complex	136.00
77415-00	Therapeutic radiology treatment port film interpretation and verification, per treatment course	23.00
77420-00	Weekly megavoltage treatment management; simple	25.00

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	$ 20.00
78001-00	multiple determinations	146.60
78010-00	Thyroid imaging; only	184.85
	Diagnostic - Gastrointestinal System	
78215-00	Liver and spleen imaging	$ 228.10
	Diagnostic - Musculoskeletal System	

78300-00	Bone imaging; limited area (for example, skull, pelvis)	$ 195.00
78305-00	multiple areas	270.00
78306-00	whole body	313.80
78350-00	Bone density (bone mineral content) study; single photon absorptiometry	84.00
78351-00	dual photon absorptiometry	247.30
	Cardiovascular System	
78460-00	Myocardial imaging; resting only, quantitative or qualitative	$720.00
78461-00	exercise and redistribution, qualitative or quantitative, with or without pharmacological intervention	335.00
78465-00	tomographic (SPECT) with exercise and redistribution, qualitative or quantitative, with or without pharmacologic intervention	620.95
	Diagnostic - Nervous System	
78660-00	Dacryocystography (lacrimal flow study)	$ 16.00
	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	$ 131.25
	Therapeutic	
79000-00	Radionuclide therapy, hyperthyroidism; initial, including evaluation of patient	$ 361.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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 1 or 2 clinical chemistry tests	$ 17.00
80003-00	3 clinical chemistry tests	29.10
80004-00	4 clinical chemistry tests	30.00
80005-00	5 clinical chemistry tests	41.00
80006-00	6 clinical chemistry tests	29.00
80007-00	7 clinical chemistry tests	32.00
80008-00	8 clinical chemistry tests	31.90
80009-00	9 clinical chemistry tests	36.00
80010-00	10 clinical chemistry tests	35.50
80011-00	11 clinical chemistry tests	37.00
80012-00	12 clinical chemistry tests	39.70
80016-00	13-16 clinical chemistry tests	40.50
80018-00	17-18 clinical chemistry tests	45.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	30.85
	Therapeutic Drug Monitoring	
80031-00	Therapeutic quantitative drug monitoring in body fluids and/or excreta; measurement one drug	$ 38.00
80032-00	two drugs measured	39.00
80034-00	four or more drugs measured	50.00
	Organ or Disease Oriented Panels	
80050-00	General health screen panel	$ 45.00
80053-00	Executive profile	82.80
80055-00	Obstetric profile	37.00
80056-00	Amenorrhea profile	199.00
80058-00	Hepatic function panel	31.00
80059-00	Hepatitis panel	73.30
80060-00	Hypertension panel	30.00
80061-00	Lipid profile	30.00
80062-00	Cardiac evaluation (including coronary risk) panel	35.00

80064-00	Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination	54.00
80065-00	Metabolic panel	53.50
80070-00	Thyroid panel	37.00
80071-00	with thyrotropin releasing hormone (TRH)	45.00
80072-00	Arthritis panel	43.00
80073-00	Renal panel	28.00
80085-00	Microcytic anemia panel	64.00
80086-00	Macrocytic anemia panel	40.60
80090-00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	84.00
	Consultations (Clinical Pathology)	
80500-00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 27.80
80502-00	comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	30.00

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

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$ 12.75
81002-00	routine, without microscopy	8.00
81004-00	components, single, not otherwise listed, specify	7.50
81005-00	chemical, qualitative, any number of constituents	7.50
81010-00	concentration and dilution test	5.00
81015-00	microscopic only	9.00
81020-00	two or three glass test	10.50

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
82000-00	Acetaldehyde, blood	$ 8.25
82010-00	Acetone; quantitative	6.50
82011-00	Acetylsalicylic acid; quantitative	22.60
82024-00	Adrenocorticotropic hormone (ACTH), RIA	101.00
82040-00	Albumin; serum	11.10
82042-00	urine, quantitative (specify method, e.g., Esbach)	3.25
82055-00	Alcohol (ethanol), blood; chemical	36.00
82085-00	Aldolase, blood; kinetic ultraviolet method	27.50
82137-00	Aminophylline	33.00

82138-00	Amitriptyline	50.00
82140-00	Ammonia; blood	37.50
82150-00	Amylase, serum	21.90
82156-00	Amylase, urine	23.00
82157-00	Androstenedione, RIA	101.00
82164-00	Angiotensin-converting enzyme	38.30
82172-00	Apolipoprotein, immunoassay	24.50
82205-00	Barbiturates; quantitative	34.00
82210-00	quantitative and identification	31.00
82232-00	Beta-2 microglubulin, RIA; serum	60.00
82250-00	Bilirubin; blood, total OR direct	16.75
82251-00	blood, total AND direct	15.10
82270-00	Blood; occult, feces, screening	9.00
82273-00	duodenal, gastric contents, qualitative	8.00
82306-00	Calcifediol (25-OH Vitamin D-3), chromatographic technique	131.10
82308-00	Calcitonin, RIA	72.80
82310-00	Calcium, blood; chemical	12.30
82330-00	fractionated diffusible	26.00
82340-00	Calcium, urine; quantitative, timed specimen	22.00
82355-00	Calculus (stone), qualitative, chemical	32.50
82360-00	Calculus (stone), quantitative; chemical	34.90
82372-00	Carbamazepine, serum	31.50
82374-00	Carbon dioxide, combining power or content	8.80
82375-00	Carbon monoxide, (carboxyhemoglobin); quantitative	39.50
82376-00	qualitative	12.00
82380-00	Carotene, blood	24.00
82382-00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine	63.00
82384-00	fractionated	72.00
82390-00	Ceruloplasmin, chemical (copper oxidase), blood	24.00
82435-00	Chlorides; blood (specify chemical or electrometric)	8.80
82465-00	Cholesterol, serum; total	15.00
82470-00	total and esters	16.00
82480-00	Cholinesterase; serum	24.80
82486-00	Chromatography; gas-liquid, compound and method not elsewhere specified	66.50
82507-00	Citrate	77.00
82512-00	Clonazepam	56.00
82525-00	Copper; blood	29.00
82529-00	Cortisol; fluorometric, plasma	42.60
82533-00	Cortisol; RIA, plasma	42.00
82534-00	RIA, urine	53.00
82540-00	Creatine; blood	18.00
82546-00	Creatine and creatinine	12.00
82550-00	Creatine phosphokinase (CPK), blood; timed kinet ultraviolet method	22.60
82552-00	isoenzymes	35.00
82555-00	Colorimetric	29.20
82565-00	Creatinine; blood	13.00

82570-00	urine	16.35
82575-00	clearance	32.75
82595-00	Cryoglobulin, blood	39.30
82606-00	Cyanocobalamin (Vitamin B-12); bioassay	32.00
82607-00	RIA	36.00
82615-00	Cystine and homocystine, urine; qualitative	55.10
82620-00	quantitative	97.00
82626-00	Dehydroepiandrosterone (DHEA), RIA	86.00
82628-00	Desipramine	56.00
82634-00	Deoxycortisol, 11-(compound S), RIA	49.60
82640-00	Digitoxin (digitalis); blood, RIA	48.50
82643-00	Digoxin, RIA	37.00
82660-00	Drug screen (amphetamines, barbiturates, alkaloids)	45.10
82662-00	Immunoassay technique for drugs	38.70
82670-00	Estradiol, RIA (placental)	74.50
82672-00	total	80.50
82692-00	Ethosuximide	37.75
82705-00	Fat or lipids, feces; screening	20.00
82710-00	quantitative, 24 or 72 hour specimen	70.70
82728-00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)	41.50
82730-00	Fibrinogen, quantitative	28.00
82745-00	Folic acid (folate), blood; bioassay	38.00
82746-00	RIA	42.50
82756-00	Free thyroxine index (T-7)	27.00
82784-00	Gammaglobulin, E (e.g., RIA, EIA)	40.00
82785-00	Gammaglobulin, E	36.00
82792-00	Gasses, blood, oxygen saturation; by calculation from pO2	35.90
82800-00	Gasses, blood; pH only	36.25
82803-00	pH, pC02, p02, simultaneous	65.60
82941-00	Gastrin, RIA	54.00
82946-00	Glucagon tolerance test	15.00
82947-00	Glucose; except urine (for example, blood, spinal fluid, joint fluid)	14.50
82948-00	blood, stick test	11.00
82950-00	post glucose dose (includes glucose)	17.00
82951-00	tolerance test (GTT), three specimens (includes glucose)	40.50
82952-00	tolerance test, each additional beyond three specimens	16.40
82954-00	Glucose, urine	5.00
82977-00	Glutamyl transpeptidase, gamma (GGT)	18.50
83000-00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	47.50
83001-00	RIA	53.00
83002-00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	50.00
83003-00	Growth hormone, human (HGH) (somatotropin); RIA	46.20
83010-00	Haptoglobin; chemical	52.00
83015-00	Heavy metal screen (arsenic, bismuth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)	73.80

83036-00	Hemoglobin; glycosylated	23.90
83150-00	Homovanillic acid (HVA), urine	20.00
83497-00	Hydroxyindolacetic acid, 5-(HIAA), urine	48.40
83498-00	Hydroxyprogesterone, 17-d, RIA	76.00
83523-00	Imipramine	59.40
83525-00	Insulin, RIA	39.90
83540-00	Iron, serum; chemical	16.00
83545-00	automated	16.00
83550-00	Iron binding capacity, serum; chemical	24.00
83555-00	automated	29.80
83565-00	radioactive uptake method	27.50
83582-00	Ketogenic steroids, urine; 17-(17-KGS)	40.80
83589-00	Ketosteroids, 17-(17-KS), urine; total	36.00
83610-00	Lactic dehydrogenase (LDH), RIA	17.10
83615-00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method	17.10
83620-00	Lactic dehydrogenase (LDH), blood colorimetric or fluorometric	16.55
83625-00	isoenzymes, electrophoretic separation and quantitation	30.90
83626-00	isoenzymes, chemical separation	27.40
83645-00	Lead, screening; blood	26.00
83655-00	Lead, quantitative; blood	35.00
83690-00	Lipase, blood	22.75
83700-00	total	22.00
83705-00	fractionated	23.50
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 by precipitation method	20.30
83719-00	Lipoprotein very low density cholesterol (VLDL cholesterol) by ultracentrifugation	16.00
83720-00	Lipoprotein cholesterol fractionation calculation by formula	20.00
83725-00	Lithium, blood, quantitative	22.00
83735-00	Magnesium, blood; chemical	17.30
83750-00	atomic absorption	18.10
83835-00	Metanephrines, urine	45.00
83872-00	Mucin, synovial fluid (Ropes test)	19.00
83915-00	Nucleotidase 5'-	31.10
83916-00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis	65.20
83930-00	Osmolality; blood	20.50
83945-00	Oxalate, urine	37.50
83947-00	Oxybutyric acid, beta	11.00
83970-00	Parathormone, RIA	108.50
83986-00	pH, body fluid, except blood	8.00
84030-00	Phenylalanine (PKU); Guthrie	13.00
84037-00	Phenylketones; urine, qualitative	5.00
84045-00	Phenytoin	33.50
84060-00	Phosphatase, acid; blood	22.00
84065-00	prostatic fraction	21.00
84066-00	prostatic fraction, RIA	45.00
84075-00	Phosphatase, alkaline, blood	18.30

84078-00	heat stable (total not included)	18.15
84080-00	isoenzymes, electrophoretic method	45.00
84100-00	Phosphorus (phosphate); blood	13.70
84105-00	urine	16.35
84121-00	Porphyrins; uro-, copro-, and porphobilinogen, urine	54.40
84126-00	Porphyrins, feces, quantitative	33.00
84132-00	Potassium; blood	15.00
84133-00	urine	18.50
84136-00	Pregnanediol; other method (specify)	15.00
84141-00	Primidone	40.00
84142-00	Procainamide	46.10
84144-00	Progesterone, any method	52.50
84146-00	Prolactin, RIA	52.20
84155-00	Protein, total, serum; chemical	15.10
84165-00	Protein, total, serum; electrophoretic fractionation and quantitation	29.20
84175-00	Protein, other sources, quantitative	22.00
84176-00	Protein, special studies (i.e., monoclonal protein analysis)	125.00
84180-00	Protein, urine; quantitative, 24-hour specimen	19.00
84185-00	Bence-Jones	13.20
84190-00	electrophoretic fractionation and quantitation	29.20
84195-00	Protein, spinal fluid; semiquantitative (Pandy)	20.00
84203-00	Protoporphyrin, RBC; screen	9.00
84207-00	Pyridoxine (Vitamin B-6)	10.00
84208-00	Pyrophosphate vs urate, crystals (polarization)	17.30
84230-00	Quinidine, blood	34.25
84231-00	Radioimmunoassay (RIA) not elsewhere specified	55.00
84238-00	Receptor assay; non-endocrine (e.g., acetylcholine) (specify receptor)	111.30
84244-00	Renin (angiotensin I); (RIA)	71.00
84275-00	Sialic acid, blood	78.00
84295-00	Sodium; blood (MD/DO)	15.50
84300-00	urine	14.40
84403-00	Testosterone, blood, RIA	85.00
84420-00	Theophylline, blood, or saliva	35.00
84435-00	Thyroxine, CPB or resin uptake	16.00
84436-00	Thyroxine, true, RIA	19.40
84439-00	Thyroxine, free, RIA	25.00
84442-00	Thyroxine binding globulin (TBG)	38.00
84443-00	Thyroid stimulating hormone (TSH), RIA	43.00
84445-00	Thyrotropin releasing factor (TRF), RIA; plus long acting (LATS)	150.00
84447-00	Toxicology, screen; general	45.00
84448-00	sedative	46.00
84450-00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method (MD/DO)	19.00
84455-00	colorimetric or fluorometric	17.00
84460-00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	22.00

84478-00	Triglycerides, blood	14.90
84479-00	Triiodothyronine (t-3), resin uptake	21.00
84480-00	Triiodothyronine, true, RIA	50.00
84520-00	Urea nitrogen, blood (BUN); quantitative	13.00
84550-00	Uric acid; blood, chemical	15.00
84555-00	uricase, ultraviolet method	16.00
84560-00	Uric acid, urine	21.00
84585-00	Vanillylmandelic acid (VMA), urine	60.00
84590-00	Vitamin A, blood;	30.50
84630-00	Zinc, quantitative; blood	24.10
84702-00	Gonadotropin, chorionic; quantitative	33.75
84703-00	qualitative	21.00

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke	$ 9.50
85002-00	Ivy or template	23.80
85007-00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)	12.50
85009-00	differential WBC count, buffy coat	20.90
85012-00	eosinophil count, direct	15.00
85014-00	hematocrit	9.00
85018-00	hemoglobin, colorimetric	10.00
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only)	20.00
85022-00	hemogram, automated, and manual differential WBC count (CBC)	26.00
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	32.50
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)	22.70
85027-00	hemogram, and platelet count, automated	16.50
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; 1-3 indices	11.25
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes)	24.50
85041-00	red blood cell (RBC) only	8.10
85044-00	reticulocyte count	14.90
85048-00	White blood cell (WBC)	10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	54.50
85095-00	Bone marrow smear and/or cell block; aspiration only	91.50
85097-00	Bone marrow smear and/or cell block;	

	smear interpretation only	101.50
85100-00	aspiration, staining, and interpretation	84.70
85102-00	Bone marrow needle biopsy	100.00
85103-00	staining and interpretation	145.00
85105-00	interpretation only	91.50
85240-00	factor VII (AHG), one stage factor VIII (AHG), one stage	83.40
85291-00	factor XII (fibrin stabilizing), screen solubility	35.00
85300-00	Clotting inhibitors or anticoagulants; antithrombin III, except antigen assay	101.00
85302-00	protein C assay	59.30
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	15.00
85368-00	Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)	12.00
85376-00	Fibrinogen; thrombin with plasma dilution	28.75
85535-00	Iron stain (RBC or bone marrow smears)	40.10
85540-00	Leukocyte alkaline phosphatase with count	40.00
85544-00	Lupus erythematosus (LE) cell prep	24.00
85548-00	Morphology of red blood cells only	28.00
85580-00	Platelet; count (Rees-Ecker)	15.00
85585-00	estimation on smear only	11.00
85595-00	electronic technique	13.25
85610-00	Prothrombin time	14.00
85618-00	Prothrombin-Proconvertin, P&P (Owren)	19.00
85630-00	Red blood cell size (Price-Jones)	7.80
85650-00	Sedimentation rate (ESR); Wintrobe type	11.00
85651-00	Westergren type	11.00
85660-00	Sickling of RBC, reduction, slide method	11.00
85670-00	Thrombin time; plasma	14.30
85730-00	Thromboplastin time, partial; plasma or whole blood	20.00

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	$ 19.00
86004-00	warm	21.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	18.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	24.00
86012-00	Antibody absorption, cold auto absorption; per serum	18.00
86013-00	differential	10.00
86016-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	37.50
86018-00	enzyme technique, including antihuman globulin	14.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique	26.00

86026-00	RBC antibodies (8-10 cell panel), with enzyme technique including antihuman globulin	74.30
86031-00	Antihuman globulin test; direct, 1-3 dilutins ()	16.50
86032-00	indirect, qualitative	28.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.00
86038-00	Antinuclear antibodies (ANA), RIA	40.00
86060-00	Antistreptolysin O; titer	25.25
86063-00	screen	15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	65.20
86067-00	other method (specify)	39.50
86068-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; first unit	65.00
86069-00	each additional unit	43.00
86080-00	Blood typing; ABO only	11.75
86082-00	ABO and Rho(D)	23.00
86095-00	Blood typing, RBC, antigens other than ABO or Rho(D); antiglobulin technique, each antigen	22.50
86096-00	direct, slide or tube, including Rh subtypes, each antigen	13.50
86100-00	Blood typing; Rho(D) only	15.00
86105-00	Rh genotyping, complete	9.50
86140-00	C-reactive protein	15.00
86149-00	Carcinoembryonic antigen (CEA); gel diffusion	51.00
86151-00	Carcinoembryonic antigen (CEA); RIA or EIA	60.00
86158-00	Complement; C1 esterase	57.00
86162-00	total (CH 50)	53.00
86163-00	Complement; C3 esterase	30.00
86171-00	Complement fixation tests, each (for example, cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis)	17.00
86225-00	Deoxyribonucleic acid (DNA) antibody	39.00
86229-00	Enzyme immunoassay for chemical constituent	36.60
86235-00	Antibody to specific nuclear antigen, any method, each	57.00
86244-00	Feto-protein, alpha-1, RIA or EIA	50.00
86255-00	Fluorescent antibody; screen	33.00
86256-00	titer	40.00
86265-00	Frozen blood, preparation for freezing, each unit, including processing and collection	54.10
86277-00	Growth hormone, human (HGH), antibody, RIA	31.00
86280-00	Hemagglutination inhibition tests (HAI), each (for example, rubella, viral)	19.00
86282-00	Hemolysins and agglutinins, auto, screen, each	22.50

86283-00	incubated with glucose (i.e., ATP)	41.00
86287-00	Hepatitis B surface antigen (HBsAg) Australian antigen, HAA, RIA or EIA	28.00
86288-00	Hepatitis B core antigen (HBcAg), RIA	26.00
86289-00	Hepatitis B core antibody; RIA (HBcAg)	35.30
86291-00	Hepatitis B surface antibody	26.00
86293-00	Hepatitis B antigen	33.00
86296-00	Hepatitis A antibody	37.80
86298-00	IgG antibody	30.00
86299-00	IgM antibody	38.20
86300-00	Heterophile antibodies; screening (includes monotype test), slide or tube	15.25
86305-00	quantitive titer	22.00
86310-00	plus titers after absorption with beef cells and guinea pig kidney	38.20
86312-00	HIV (HTLV-III) antibody detection; immunoassay	24.00
86316-00	Immunoassay for tumor antigen (i.e., prostate specific antigen, cancer antigen)	53.00
86317-00	Immunoassay for infectious agent antigen or antibody, each	16.70
86320-00	Immunoelectrophoresis; serum, each	70.70
86325-00	other fluids (e.g., urine) with concentration, each specimen	70.70
86329-00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify)	42.65
86335-00	Immunoglobulin typing (Gc, Gm, Inv), each	18.00
86353-00	Lymphocyte transformation, spontaneous blastogenesis or phytomitogen (phytohemoglutination, PHA) or other mitogen culture (MC) (i.e., tuberculin, candida)	178.00
86357-00	Insulin antibodies, RIA	133.60
86377-00	other method (specify)	51.50
86382-00	Neutralization test, viral	9.50
86403-00	Particle agglutination, rapid test for infectious agent, each antigen	16.70
86421-00	Radioallergosorbent test, in vitro testing for allergen-specific IgE (i.e., RAST, MAST, FAST, IP, PRIST, etc.); up to five tests	29.00
86422-00	six or more tests	15.50
86423-00	Radioimmunosorbent test IgE, quantitative	35.00
86430-00	Rheumatoid factor, latex fixation	19.50
86455-00	Skin test; anergy testing, 1 or more antigens	10.00
86540-00	mumps	13.00
86580-00	Skin test; tuberculosis or intradermal	10.00
86585-00	tuberculosis, tine test	9.00

86590-00	Streptokinase, antibody	16.00
86592-00	Syphilis, test; qualitative	13.00
86593-00	quantitative	12.00
86594-00	Thyroid autoantibodies	50.40
86600-00	Toxoplasmosis, dye test	27.00
86650-00	Treponema antibodies, fluorescent, absorbed	42.60
86800-00	Thyroglobulin antibody, RIA	40.65
86812-00	Tissue typing; HLA typing, A, B, or C (for example, A10, B7, B27), single antigen	69.30
86813-00	HLA typing, A, B, and/or C (i.e., A10, B7, B27), multiple antigens	309.00
86817-00	HLA typing, DR, multiple antigens	400.00

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)	31.50
87045-00	stool	30.50
87060-00	throat or nose	14.00
87070-00	any other source	25.00
87072-00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	14.50
87075-00	Culture, bacterial, any source; anaerobic (isolation)	30.50
87081-00	Culture, bacterial, screening only, for single organisms	15.00
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083-00	multiple organisms	10.00
87084-00	with colony estimation from density chart	10.50
87085-00	with colony count	25.00
87086-00	Culture, bacterial, urine; quantitative, colony count	20.00
87087-00	commercial kit	12.00
87088-00	identification, in addition to quantitative or commercial kit	23.00
87101-00	Culture, fungi, isolation; skin	18.00
87102-00	other source (except blood)	13.50
87103-00	blood	55.00
87106-00	Culture, fungi, definitive identification of each fungus	29.80
87109-00	Culture, mycoplasma, any source	45.50
87110-00	Culture, Chlamydia	35.50
87116-00	Culture, tubercle or other acid-fast bacilli (for example, TB, AFB, mycobacteria); source, isolation only	35.00
87117-00	concentration plus isolation	39.30

87118-00	Culture, mycobacteria, definitive identification of each organism	19.50
87140-00	Culture, typing; fluorescent method, each antiserum	14.50
87147-00	Serologic method, agglutination grouping, per antiserum	20.00
87151-00	serologic method, speciation	12.00
87158-00	other methods	27.00
87163-00	Culture, any source, additional identification methods required	27.00
87164-00	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection	9.00
87174-00	Endotoxin, bacterial (pyrogens); chemical	40.00
87177-00	Ova and parasites, direct smears, concentration and identification	29.00
87181-00	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	16.00
87184-00	disc method, each plate (12 or less discs)	19.50
87186-00	microtiter, minimum inhibitory concentration (MIC), 8 or less any number of antibiotics	25.20
87188-00	macrotube dilution method, each antibiotic	43.70
87205-00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	15.80
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 (for example, malaria, kala azar, herpes)	29.00
87208-00	direct or concentrated, dry, for ova and parasites	13.00
87210-00	wet mount with simple stain for bacteria, fungi, ova, and/or parasites	13.50
87211-00	wet and dry mount, for ova and parasites	16.00
87220-00	Tissue examination for fungi (for example, KOH slide)	13.11
87230-00	Toxin or antitoxin assay, tissue culture (i.e., Clostridium difficile toxin)	55.40
87250-00	Virus identification; inoculation of embryonated eggs, or small animal, includes observation and dissection	43.40
87252-00	tissue culture inoculation and observation	60.40
87253-00	tissue culture, additional studies (i.e., hemadsorption, neutralization) each isolate	25.00

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 and interpretation	$ 30.80
88106-00	filter method only with interpretation	34.30
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	29.00
88130-00	Sex chromatin identification; Barr bodies	17.75
88150-00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to 3 smears; screen by technical under physician supervision	17.00
88151-00	requiring interpretation by physician	22.00
88155-00	with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index)	13.50
88160-00	Cytopathology, any other source; screening and interpretation	30.50
88161-00	preparation, screening, and interpretation	31.00
88170-00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	97.00
88172-00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	35.00
88173-00	interpretation and report	97.10
88262-00	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	599.60
88267-00	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotope, with banding	577.50

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	$ 32.50
88302-00	Surgical pathology, gross and microscopic; examination of presumptively normal tissue, for identification and record purposes	40.00
88304-00	Surgical pathology, gross and microscopic; diagnostic examination of presumptively abnormal tissue; uncomplicated specimen	43.80
88305-00	single complicated or multiple uncomplicated	

	specimen(s), without complex dissection	77.85
88307-00	single complicated specimen requiring complex dissection or multiple complicated specimens	128.90
88311-00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	26.00
88312-00	Special stains; Group I stains for microorganisms	25.00
88313-00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	23.80
88321-00	Consultation and report on referred slides prepared elsewhere	30.00
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	51.50
88331-00	with frozen section(s); single specimen	100.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	42.00
88342-00	Immunocytochemistry (including tissue immunoperoxidase), each antibody	102.10

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

Code	Service	Maximum Fee
89051-00	Cell count, miscellaneous body fluids (e.g. CSF, joint fluid), except blood, with differential count	$ 16.60
89060-00	Crystal identification by compensated polarizing lens analysis, cynovial fluid	16.00
89125-00	Fat stain, feces, urine, or sputum	26.20
89190-00	Nasal smear for eosinophils	13.00
89205-00	Occult blood, any source except feces	10.00
89300-00	Semen analysis; presence and/or motility of sperm, including Huhner test	32.00
89310-00	motility and count	20.00
89320-00	Semen analysis; complete (volume count, motility and differential)	41.00
89325-00	Sperm antibodies	180.00
89330-00	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkheit test	37.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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	
02140-00	Amalgam; one surface, permanent	$ 30.00
02150-00	two surfaces, permanent	43.00
02160-00	three surfaces, permanent	56.00
02161-00	four or more surfaces, permanent	66.00
	Acrylic or Plastic Restorations	
02330-00	Resin; one surface, anterior	$ 40.00
02331-00	two surfaces, anterior	58.00
02332-00	three surfaces, anterior	77.00
02335-00	four or more surfaces or (involving incisal angle	75.00
	Inlay Restorations	
02540-00	Onlay - metallic; per tooth (in addition to inlay)	$ 390.00
	Crowns - Single Restoration Only	
02740-00	Crown; porcelain/ceramic substrate	$ 425.00
02750-00	porcelain fused to high noble metal	395.00
02751-00	porcelain fused to predominantly base metal	380.00
02752-00	porcelain fused to noble metal	380.00
02790-00	full cast high noble metal	375.00
02791-00	full cast predominantly base metal	325.00
02792-00	full cast noble metal	338.00
02810-00	3/4 cast metallic	400.00
02815-00	Incision and drainage of abscess; intraoral	80.00
02824-00	Removal of tooth; bony impaction presenting unusual difficulties and circumstances	175.00
02825-00	Removal of tooth, soft tissue impaction	105.00
02826-00	partial bony impaction	125.00
02827-00	complete bony impaction	150.00
02829-00	Apicoectomy; performed as separate surgical procedure (per root)	200.00
02830-00	stainless steel	85.00
02832-00	Alveolectomy/alveoloplasty, per quadrant (in conjunction with extractions)	90.00
02848-00	Osseous surgery; per quadrant	400.00
	Other Restorative Services	
02910-00	Recement inlays	$ 29.00
02920-00	Recement crowns	28.00
02940-00	Sedative fillings	25.00
02950-00	Crown buildups, including any pins	85.00
02960-00	Labial veneer (laminate); chairside	175.00
	Endodontics	
03110-00	Pulp cap; direct (excluding final restoration)	$ 20.00
03120-00	indirect (excluding final restoration)	15.00
03220-00	Therapeutic pulpotomy	45.00

	Root Canal Therapy	
03310-00	One canal (excludes final restoration)	$ 203.00
03320-00	Two canals (excludes final restoration)	250.00
03330-00	Three canals (excludes final restoration)	340.00
	Periapical Services	
03410-00	Apicoectomy; (per tooth) first root	$ 225.00
03430-00	Retrograde filling; per root	100.00
	Other Endodontic Procedures	
03950-00	Canal preparation and fitting of preformed dowel or post	$ 85.00
03960-00	Bleaching of discolored tooth	60.00
	Prosthodontics, Removable Complete Dentures - Including Routine Postdelivery Care	
05110-00	Complete upper	$ 500.00
05120-00	Complete lower	500.00
05130-00	Immediate upper	550.00
05140-00	Immediate lower	650.00
	Partial Dentures - Including Routine Postdelivery Care	
05215-00	Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests)	$ 620.00
05216-00	Lower; high noble cast base with acrylic saddles (including any conventional clasps and rests (DDS)	615.00
	Adjustments to Dentures	
05410-00	Adjust complete denture; upper	$ 20.00
05421-00	Adjust partial denture; upper	25.00
05422-00	lower	23.00
	Repairs to Dentures	
05610-00	Repair acrylic saddle or base	$ 50.00
05620-00	Repair cast framework	50.00
05640-00	Replace broken teeth; per tooth	48.00
05650-00	Add tooth to existing partial denture	70.00
05660-00	Add clasp to existing partial denture	120.00
	Denture Relining	
05750-00	Relining complete upper denture (laboratory)	$ 153.00
05760-00	Relining upper partial denture (laboratory)	176.00
	Other Removable Prosthetic Services	
05820-00	Temporary (partial stayplate), denture upper	$ 160.00
05850-00	Tissue conditioning; per denture unit	35.00
	Bridge Pontics	
06210-00	Pontic; cast high noble metal	$ 375.00
06212-00	Pontic; cast noble metal	395.00

06240-00	porcelain fused to high noble metal	390.00
06241-00	porcelain fused to predominantly base metal	375.00
06242-00	porcelain fused to noble metal	360.00

Retainers

06545-00	Cast metal retainer for acid etch bridge	$ 150.00

Prosthodontics, Fixed

06640-00	Replace broken facing with acrylic	$ 80.00

Bridge Retainers — Crowns

06750-00	Crown; porcelain fused to high noble metal	$ 395.00
06751-00	porcelain fused to predominantly base metal	375.00
06752-00	porcelain fused to noble metal	375.00
06790-00	full cast high noble metal	365.00
06791-00	full cast predominantly base metal	340.00
06792-00	full cast noble metal	390.00
06801-00	Diagnostic exam and DXL	25.00
06802-00	Prevention	27.00
06803-00	Restorative	55.00
06804-00	Endodontics	325.00
06808-00	Dental oral surgery	45.00

Other Fixed Prosthetic Services

06930-00	Recement bridge	$ 45.00

Oral Surgery Extractions — Includes Local Anesthesia and Routine Postoperative Care

07110-00	Single tooth	$ 39.00
07120-00	Each additional tooth	35.00

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

07210-00	Surgical removal of tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$ 85.00
07220-00	Removal of impacted tooth; soft tissue	105.00
07230-00	Removal of the impacted tooth; partially bony	130.00
07240-00	Removal of impacted tooth; completely bony	154.00
07241-00	Removal of impacted tooth; completely bony, with unusual surgical complications	175.00
07250-00	Surgical removal of residual tooth roots	85.00

Other Surgical Procedures

07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	$ 150.00

07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	125.00
07286-00	Biopsy of oral tissue; soft	100.00
	Alveoloplasty - Surgical Preparation of Ridge For Dentures	
07310-00	Alveoloplasty (per quadrant) in conjunction with extractions	$ 75.00
	Surgical Incision	
07510-00	Incision and drainage of abscess, intraoral soft tissue	$ 40.00
	Other Repair Procedures	
07960-00	Frenulectomy	$ 100.00
	Adjunctive General Services Unclassified Treatment	
09110-00	Palliative (emergency) treatment of dental pain; minor procedures	$ 25.00
	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 10.00
09211-00	Regional block anesthesia	8.00
09220-00	General; first 30 minutes	105.00
09230-00	Analgesia	12.00
	Professional Consultation	
09310-00	Consultation; per session	$ 35.00
09430-00	Office visit during regularly scheduled office hours	18.00
09440-00	Office visit after regularly scheduled hours	30.00
	Drugs	
09610-00	Therapeutic drug injection, by report	$ 15.00
09630-00	Other drugs and/or medicaments	15.00
	Miscellaneous Services	
09910-00	Application of desensitizing medicaments	$ 15.00
	Surgery	
21110-00	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	$ 420.00
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	3,250.00
21203-00	mandibular ramus (osteotomy)	3,800.00
21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,800.00
40808-00	Biopsy, vestibule of mouth	95.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	106.00

41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	205.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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)	$46.00
06502-00	Bifocal eyeglass lenses (one lens)	70.00
06503-00	Trifocal eyeglass lenses (one lens)	69.00
06504-00	Lenticular eyeglass lenses (one lens)	21.00
06506-00	Eyeglass frames	79.95
06510-00	Tinting for lenses	14.00
06587-00	Contact lenses, soft (one lens)	80.00
06588-00	Contact lenses, hard (one lens)	80.00
06589-00	Dispensing fee; single vision lenses	20.00
06590-00	bifocal lenses	34.00
06593-00	frames for lenses	10.00
09213-00	Eye refraction	27.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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)	$ 51.00
06502-00	Bifocal eyeglass lenses (one lens)	62.00
06503-00	Trifocal eyeglass lenses (one lens)	75.00
06506-00	Eyeglass frames	90.00
06510-00	Tinting for lenses	13.50
06587-00	Contact lenses, soft (one lens)	75.00
06588-00	Contact lenses, hard (one lens)	64.50
06590-00	Dispensing fee; bifocal lenses	65.40
06593-00	frames for lenses	64.05

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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	$ 28.50
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	34.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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. **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	$ 18.75
97012-00	traction, mechanical	17.50
97014-00	electrical stimulation (unattended)	16.00
97016-00	vasopneumatic devices	16.00
97018-00	paraffin bath	20.00
97020-00	microwave	15.00
97022-00	whirlpool	20.00
97024-00	diathermy	16.00
97026-00	infrared	7.50
97028-00	ultraviolet	18.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	$ 28.00
97112-00	neuromuscular reeducation	25.00
97114-00	functional activities	23.50
97116-00	gait training	24.00
97118-00	electrical stimulation (manual)	17.50
97120-00	iontophoresis	23.00
97122-00	traction, manual	18.00
97124-00	massage	19.00
97126-00	contrast baths	20.00
97128-00	ultrasound	19.50
97145-00	Physical medicine treatment to one area, each additional 15 minutes	13.67
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit	36.00
97241-00	each additional 15 minutes, up to one hour	9.50
97500-00	Orthotics training (dynamic bracing, splinting), upper/lower extremities; initial 30 minutes, each visit	25.00
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	32.00
97531-00	each additional 15 minutes	15.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit	30.00

Tests and Measurements

97700-00	Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes a. Orthotic check-out; b. Prosthetic check-out; c. Activities of daily living check-out; d. Follow-up evaluation for testing for strength, dexterity, or stamina	$ 29.50
97701-00	each additional 15 minutes	22.00
97720-00	Initial evaluation for testing for strength, dexterity, or stamina; initial 30 minutes, each visit	33.21
97721-00	each additional 15 minutes	22.00
97752-00	Muscle testing with torque curves during isometric and isokinetic exercise mechanized or computerized evaluations with printout (e.g., by use of cybex or similar type machine); for extremities	70.00
97753-00	for trunk/back	125.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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	
09520-00	New patient; brief examination	$ 27.00
09521-00	intermediate examination	40.00
09522-00	extensive examination	60.00
09530-00	Established patient; brief examination	25.00
09531-00	intermediate examination	40.00
09532-00	extensive examination	65.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office	$ 20.00
09541-00	subsequent; office	22.00
09542-00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00
	Home/Nursing Home Visits	
09550-00	Chiropractic visit with manipulation/adjustment	$ 50.00
09556-00	Visit with cast application to one area; (e.g., long leg, thoracolumbar lumbosocrol, or full-body corset type)	30.00
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	
09560-00	Application of hot pack	$ 11.00
09561-00	Application of cold pack	11.00
09562-00	Diathermy	12.00
09563-00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic	12.00
09564-00	Intersegmental motorized mobilization	14.00
09565-00	Muscle stimulation, manual	12.00
09566-00	Ultrasound therapy	12.00
09567-00	Traction	13.00
09568-00	Acupressure, manual or mechanical	13.00
09569-00	Acupuncture	15.00
09570-00	Whirlpool	10.00
09572-00	Infrared - heat lamp	7.00
09574-00	Trigger point therapy	14.00
09591-00	Nutritional supplement	16.00
09592-00	Exercise consultation or instruction	10.00

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

Code	Service	Maximum Fee
	Spine and Pelvis	
72010-00	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral)	$ 75.00
72020-00	Radiologic examination, spine; single view, (specify level)	35.00
72040-00	Radiologic examination, spine, cervical; limited	45.00
72070-00	Radiologic examination, spine; thoracic	56.00
72080-00	thoracic, limited (anteroposterior and lateral)	60.00
72090-00	scoliosis study, comprehensive	40.00
72100-00	Radiologic examination, spine; lumbosacral; limited (anteroposterior and lateral)	58.00
72110-00	complete, with oblique views	80.00
72114-00	complete, including bending views	110.00
72120-00	bending views only, minimum of four views	80.00
72170-00	Radiologic examination, pelvis; limited (minimum two views)	50.00
	Upper Extremities	
73020-00	Radiologic examination, shoulder; limited (one projection)	$ 30.00
73030-00	complete, minimum of two views	54.00
73070-00	Radiologic examination, elbow; limited (anteroposterior and lateral)	40.00
73100-00	Radiologic examination, wrist; limited (anteroposterior and lateral)	40.00
73120-00	Radiologic examination, hand	33.00
73140-00	Radiologic examination, finger or fingers, minimum of two views	35.00
	Lower Extremities	
73500-00	Radiologic examination, hip; limited (one view)	$ 30.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	44.00
73562-00	anteroposterior and lateral, with oblique(s), minimum of three views	52.50
73600-00	Radiologic examination, ankle; limited (two views)	47.00
73610-00	Radiologic examination, ankle; comprehensive (minimum of three views)	56.00
73620-00	Radiologic examination, foot; anteroposterior and lateral views	40.00
	Miscellaneous	
76140-00	Consultation on x-ray examination made elsewhere, written report	$ 25.00

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
	Automated Multichannel Test	
80019-00	Automated multichannel tests; 19 or more clinical chemistry tests (indicate instrument use and number of tests performed)	$ 58.40
	Urinalysis	
81000-00	Urinalysis; routine (pH, specific gravity, protein tests for reducing substances such as glucose), with microscopy	$ 12.00
81002-00	routine, without microscopy	12.00
81015-00	Urinalysis; microscopic only	12.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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. **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	$ 44.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	52.00
10101*00	multiple or complicated	77.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	23.00
11040-00	Debridement; skin, partial thickness	50.00
11050*00	Paring or curettement of benign lesion with or without chemical cauterization; single lesion	25.00
11051*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions	22.00
11052-00	more than four lesions	30.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), hands, feet; lesion diameter up to 0.5 centimeter	79.00
11421-00	lesion diameter 0.6 - 1.0 centimeters	125.00
11422-00	lesion diameter 1.1 - 2.0 centimeters	136.00
	Nails	
11700*00	Debridement of nails, manual; five or less	$ 20.00

11710*00	Debridement of nails, electric grinder; five or less	27.00
11730*00	Avulsion of nail plate, partial or complete simple; single	75.00
11750-00	Excision of nail and nail matrix, partial or complete, for permanent removal	200.00
11900*00	Injection, intralesional; up to and including seven lesions	30.00
	Other Procedures	
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	$ 23.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	47.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	41.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)	50.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)	55.00
28080-00	Excision of Morton neuroma, single, each	460.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe	375.00
28153-00	Resection, head of phalanx, toe	375.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	425.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)	615.00
28292-00	Keller, McBride, or Mayo type procedure	865.00
29425-00	Application of short leg cast (below knee to toes); walking or ambulatory type	148.00
29540-00	Strapping; ankle	20.00
29550-00	toes	23.00
29580-00	Unna boot	45.00
36415*00	Routine venipuncture for collection of specimens	10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch	36.00
	Patient Visits	
90000-00	New patient; brief service	$ 28.00
90010-00	limited service	35.00
90015-00	intermediate service	39.00
90017-00	extended service	44.50
90020-00	comprehensive service	37.00
90030-00	Established patient; minimal service	17.50

90040-00	brief service	22.00
90050-00	limited service	25.00
90060-00	intermediate services	30.00
90070-00	extended service	35.00
90080-00	comprehensive service	50.00
	Home Medical Services	
90140-00	Home medical service, established patient; brief service	$ 40.00
90160-00	intermediate service	35.00
	Hospital Medical Services	
90200-00	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	$58.00
90215-00	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	40.00
	Skilled Nursing, Intermediate Care, and Long Term Care Facilities	
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	35.00
90350-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; limited service	17.00
90360-00	intermediate service	25.00
	Nursing Home, Boarding Home, Domiciliary, or Custodial Care Medical Services	
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	$ 17.00
90410-00	limited service	20.00
90415-00	intermediate service	40.00
90450-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; limited service	15.00
90460-00	intermediate service	40.00
90600-00	Initial consultation; limited	55.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

5221.3100 [Repealed, 14 SR 722]

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

Code	Service	Maximum Fee
06043-00	Independent behavior and/or other analysts, counselors, and other therapists	$ 75.00
06046-00	Independent social worker services	75.00
09046-00	Initial office visit with evaluation and history; one hour	85.00
09048-00	Initial inpatient hospital visit, including history and evaluation; per hour	90.00
09050-00	Initial consultation; one hour	85.00
09061-00	Psychological testing; one hour	80.00
09062-00	Follow-up office visit; 15 minutes	30.00
09064-00	Biofeedback; per hour	80.00
09065-00	per one-half hour	50.00
09066-00	Psychotherapy (inpatient, outpatient, office or home)	80.00
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)	42.50
09070-00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour	80.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

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
06043-00	Independent behavior and/or other analysts, counselors, and other therapists	$ 80.00
06046-00	Independent social worker services	73.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 R 722*

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

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

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

[For text of items A to P, see M.R.]

Q. Mount Sinai Hospital, Minneapolis
R. North Memorial Medical Center, Robbinsdale
S. Saint Cloud Hospital, Saint Cloud
T. St. John's Hospital Northeast, Saint Paul
U. Saint Joseph's Hospital, Saint Paul
V. Saint Luke's Hospital, Duluth
W. Saint Mary's Hospital, Duluth
X. Saint Mary's Hospital, Minneapolis
Y. The Samaritan Hospital, Saint Paul
Z. United Hospital, Saint Paul
AA. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ 315.20

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

[For text of items A to JJJJJJ, see M.R.]

Service	Maximum Fee
Group 2 semiprivate room charge for one day	$ 235.00

Subp. 4. **Group 3.** The following 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	$ 415.10

Subp. 5. **Group 4.** The following 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	$ 215.80

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722*

5221.3310 [Repealed, 14 SR 722]

5221.3400 [Repealed, 13 SR 2609]

5221.3500 EFFECTIVE DATE.

This chapter is effective October 1, 1989, and applies to all health care services or supplies governed by this chapter provided on and after October 1, 1989.

Statutory Authority: *MS s 176.136*

History: *14 SR 722*