Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Medical Charges and Reimbursement

Rules as Adopted

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. 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

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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.

~~Subp. 16. **Appropriate record.** "Appropriate record" means the following:~~

~~A. for outpatient treatment provided by a physician, osteopath, optometrist, podiatrist, and dentist, legible information that substantiates the nature and necessity of a service or charge in the form of an office note, progress note, chart note, or any other routinely generated medical record;~~

~~B. for inpatient hospital treatment, the discharge summary created by the treating physician;~~

~~C. for outpatient treatment provided by a chiropractor, legible information that substantiates the nature and necessity of a service or charge in the form of an initial evaluation, interim evaluation, or discharge/final evaluation; and~~

~~D. for outpatient treatment provided by other health~~

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~~care-providers-not-specified-in-items-A-to-C,-legible information-that-substantiates-the-nature-and-necessity-of-a service-or-charge-in-the-form-of-an-initial-report,-an-interim report,-or-a-discharge/summary-report.~~

5221.0200 AUTHORITY.

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

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.

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.

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

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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.

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.

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

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(3) request ~~an appropriate record or~~ 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 ~~an appropriate record and~~ the provider's response to the initial request for specific additional information~~, the payer shall make a determination as set forth in this item~~.

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

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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.

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	

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. ~~A provider may not require prepayment for costs of copies of existing medical records.~~

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.

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.

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

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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. **Code modifiers.** 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 items A to T.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. Modifier number 50 denotes bilateral procedures. ~~This modifier does not exempt the secondary services from the maximum fee for the five-digit code.~~ 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.

G. 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.

H. Modifier number 52 denotes reduced services. This

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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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

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O. 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.

P. 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.

Q. 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.

R. 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.

S. 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.

T. 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.

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

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physician.

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

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

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

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

D. to L. [Unchanged.]

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;	

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	brief service (MD/DO)	$ 33.00
90010-00	limited service (MD/DO)	40.00
90015-00	intermediate service (MD/DO)	49.00
90017-00	extended service (MD/DO)	65.00
90020-00	comprehensive service (MD/DO)	130.00
90030-00	Office services; established patient; minimal service (MD/DO)	16.50
90040-00	brief service (MD/DO)	23.50
90050-00	limited service (MD/DO)	26.00
90060-00	intermediate service (MD/DO)	35.70
90070-00	extended service (MD/DO)	55.00
90080-00	comprehensive service (MD/DO)	88.30

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	$ 44.00
90110-00	limited service	48.00
90115-00	intermediate service	50.00
~~90130-00~~		
90140-00	Home medical service, established patient; ~~minimal~~ brief service	~~30.30~~ 42.90
~~90140-00~~	~~--brief service~~	~~42.90~~
90150-00	limited service	45.00
90160-00	intermediate service	50.00
90170-00	extended service	57.80

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 ~~90270~~ 90292.

Code	Service	Maximum Fee
90200-00	Initial hospital care; brief (MD/DO)	$ 66.00
90215-00	intermediate (MD/DO)	87.50
90220-00	comprehensive (MD/DO)	127.00
90240-00	Subsequent hospital care; brief service (MD/DO)	28.00
90250-00	limited service (MD/DO)	35.50
90260-00	intermediate services (MD/DO)	50.00
90270-00	extended service (MD/DO)	69.00
90280-00	comprehensive service (MD/DO)	82.00
	Hospital Discharge Services	
90292-00	Hospital discharge day management (MD/DO)	$ 50.00

Subp. 5. **Skilled nursing, intermediate care, and long-term**

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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	$ 45.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	70.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	96.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.00
90350-00	limited service	27.25
90360-00	intermediate service	40.00
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
90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	$ ~~50.00~~ 37.00
90415-00	intermediate service	81.50
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	25.00
90450-00	limited service	33.00
90460-00	intermediate service	44.00
90470-00	extended service	55.00

Subp. 7. **Emergency department services.** The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department. They do not apply when physicians elect to use the emergency room as a substitute for their office and an actual emergency situation does not exist.

Code	Service	Maximum Fee

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90500-00	Emergency department service new patient; minimal service (MD/DO)	$ 31.50
90505-00	brief service (MD/DO)	37.50
90510-00	limited service (MD/DO)	47.00
90515-00	intermediate service (MD/DO)	65.00
90517-00	extended service (MD/DO)	95.00
90520-00	comprehensive service (MD/DO)	120.00
90530-00	Emergency department service, established patient; minimal service (MD/DO)	23.49
90540-00	brief service (MD/DO)	37.00
90550-00	limited service (MD/DO)	42.00
90560-00	intermediate service (MD/DO)	49.00
90570-00	extended service (MD/DO)	65.00
90580-00	comprehensive service	86.00

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	$ 112.00

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

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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,

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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
90600-00	Initial consultation; limited (MD/DO)	$ 58.00
90605-00	intermediate consultation (MD/DO)	76.50
90610-00	extensive consultation (MD/DO)	93.50
90620-00	comprehensive consultation (MD/DO)	139.50
90630-00	complex consultation (MD/DO)	160.00
	Follow-up Consultation	

90640-00	Follow-up consultation; brief visit (MD/DO)	$ 39.50
90641-00	limited	48.50
90642-00	intermediate	82.00
90643-00	complex	100.00

Confirmatory (Additional Opinion) Consultation

90650-00	Confirmatory consultation; limited (MD/DO)	$ 63.00
90651-00	intermediate (MD/DO)	75.00
90652-00	extensive (MD/DO)	80.00
90653-00	comprehensive (MD/DO)	120.00
90654-00	complex (MD/DO)	193.00

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) (MD/DO)	$ 20.00
90702-00	diphtheria and tetanus toxoids (DT) (MD/DO)	11.00
90703-00	tetanus toxoid (MD/DO)	10.50
90704-00	mumps virus vaccine, live (MD/DO)	19.00
90705-00	measles virus vaccine, live, attenuated (MD/DO)	16.50
90706-00	rubella virus vaccine, live (MD/DO)	17.00
90707-00	measles, mumps, and rubella virus vaccine, live (MD/DO)	26.75
90708-00	measles and rubella virus vaccine, live	24.00
90712-00	polio virus vaccine, live, oral; any type(s) (MD/DO)	15.00
90713-00	poliomyelitis vaccine (MD/DO)	15.00
90714-00	typhoid vaccine	11.00
90717-00	yellow fever vaccine	30.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD) (MD/DO)	10.00
90719-00	diphtheria toxoid (MD/DO)	9.50
90724-00	influenza virus vaccine (MD/DO)	11.25
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	115.52
90731-00	hepatitis B vaccine	61.25
90732-00	pneumococcal vaccine, polyvalent (MD/DO)	17.00
90733-00	meningococcal polysaccharide vaccine; any group(s) (MD/DO)	16.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	16.00
90741-00	Immunization, passive; immune serum globulin, human (ISG)	15.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	50.00

5221.1220 THERAPEUTIC INJECTIONS.

Code	Service	Maximum Fee
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	10.00

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90788-00 Intramuscular injection of antibiotic (specify) 14.25

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.

General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
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). (MD/DO)	$ 112.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	70.00
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	111.50
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 (MD/DO)	55.00
90844-00	approximately 45 or 50 minutes (MD/DO)	85.00
90847-00	Family medical psychotherapy (conjoint psychotherapy) (MD/DO)	85.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	57.00
90853-00	Group medical psychotherapy (other than of a multiple-family group) (MD/DO)	40.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	~~120.00~~ 50.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	120.00

Other Psychiatric Therapy

90880-00	Medical hypnotherapy (MD/DO)	$ 75.00
90882-00	Environmental intervention for medical	

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	management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	70.00
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 (MD/DO)	78.00

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

Code	Service	Maximum Fee
	General Services	
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient (MD/DO)	$ 51.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient, one or more visits (MD/DO)	58.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient (MD/DO)	40.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient, one or more visits (MD/DO)	55.00
92019-00	limited	26.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure) (MD/DO)	29.30
	Special Services	
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 37.00
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	41.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	140.00
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)	31.31
92082-00	intermediate examination (for example, multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel,	

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	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) (MD/DO)	59.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day (MD/DO)	24.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography (MD/DO)	25.00
	Ophthalmoscopy	
92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial (MD/DO)	$ 37.00
92226-00	subsequent (MD/DO)	30.00
92230-00	Opthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	34.00
92235-00	with fluorescein angiography (includes multiframe photography) (MD/DO)	150.00
92250-00	with fundus photography	33.00
92260-00	with opthalmodynamometry	30.00
	Other Specialized Services	
92275-00	Electroretinography, with medical diagnostic evaluation	$ 154.00
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
	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
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	30.00
92326-00	Replacement of contact lens	65.00
	Spectacle Services	
92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	147.35
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

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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 (MD/DO)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	42.00
92508-00	Speech, language, or hearing therapy with continuing medical supervision; group (MD/DO)	16.00
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	58.00
92512-00	Nasal function studies, for example, rhinomanometry	71.50
92532-00	Positional nystagmus	21.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	30.00
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	43.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (MD/DO)	55.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (MD/DO)	26.00
92545-00	Oscillating tracking test, with recording (MD/DO)	26.00
92546-00	Torsion swing test, with recording	31.00

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

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92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external (MD/DO)	244.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,080.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads (MD/DO)	42.50
93005-00	tracing only, without interpretation and/or report (MD/DO)	37.00
93010-00	interpretation and report only (MD/DO)	17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	50.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report (MD/DO)	195.00
93017-00	tracing only, without interpretation and report (MD/DO)	99.00
93018-00	interpretation and report only (MD/DO)	100.00
93024-00	Ergonovine provocation test	175.00
93040-00	Rhythm ECG, one to three leads; with interpretation (MD/DO)	22.00
93041-00	tracing only without interpretation and report (MD/DO)	12.00
93042-00	Rhythm ECG, tracing with interpretation and report only (MD/DO)	18.00
93210-00	Phonocardiogram, intracardiac	45.50
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report (MD/DO)	105.00
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	185.70
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	200.00
	without superimposition scanning	219.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis)	215.75
93268-00	Patient demand single event ECG recording; pre-symptom memory loop and transmission	34.00
93269-00	post-symptom memory loop and transmission	30.00
93300-00	Echocardiography, M-mode; complete	79.00
93308-00	Echocardiograph, real-time with image documentation (2D); limited (MD/DO)	105.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D) (MD/DO)	250.00
93320-00	Doppler echocardiography (MD/DO)	105.00

Cardiac Catheterization

93501-00	Right heart catheterization only	$ 685.00
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 (MD/DO)	351.00
93505-00	Endomyocardial biopsy	330.00
93547-00	Combined left heart catheterization, selective coronary angiography and	

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	selective left ventricular angiography (MD/DO)	760.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (MD/DO)	1,166.00
93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	79.00
	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	$ 54.00
93732-00	with reprogramming	45.00
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	40.00
93735-00	with reprogramming	50.00
93736-00	telephonic analysis	35.50
93784-00	Ambulatory blood pressure monitoring, using a system such as magnetic tape and/or computer disc, for 24 hours; including recording, scanning analysis, interpretation and report	225.00
	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)	$ 79.00
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) (MD/DO)	185.20
	Venous Studies	
93950-00	Noninvasive studies of extremity veins; (MD/DO)	$ 80.00
93960-00	Quantitative venous flow studies (e.g., capacitance and outflow measurement or calf, measurement of calf venous reflux, quantitative photoplethysmography)	100.00

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

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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	$ 30.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after broncodilator (aerosol or parenteral) or exercise	50.00
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	65.70
94150-00	Vital capacity, total	18.00
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	20.00
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	79.00
94260-00	Thoric gas volume	11.00
94350-00	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including a alveolar nitrogen or helium equilibration time	46.45
94360-00	Determination of resistance to airflow, oscillatory or plethysmographic methods	10.00
94375-00	Respiratory flow volume loop	24.00
94640-00	Nonpressurized inhalation treatment for acute airway obstruction (MD/DO)	22.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (MD/DO)	20.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	128.50
94657-00	subsequent days	56.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	20.50
94665-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	21.50
94680-00	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	35.00
94681-00	including CO2 output, percentage oxygen extracted	94.60
94700-00	Analysis of arterial blood gas (oxygen saturation, pO2, pCO2, CO2, pH); rest only	33.30

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

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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 90000-90699.)

Code	Service	Maximum Fee
95000-00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; up to 30 tests	$ 2.50
95001-00	31-60 tests	2.05
95002-00	61-90 tests	2.00
95007-00	Percutaneous tests (scratch, puncture, prick) with antibiotics, biologicals, stinging insects; 11-15 tests	22.50
95011-00	more than 15 tests	50.00
95014-00	Intracutaneous (intradermal) tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 1-5 tests	15.00
95017-00	Intracutaneous (intradermal tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 11-15 tests	45.00
95021-00	Intracutaneous (intradermal tests with allergenic extracts, immediate reaction 15-20 minutes; 11-20 tests	4.00
95022-00	21-30 tests	3.30
95023-00	more than 30 tests	2.25
95027-00	Skin and point titration	6.00
95030-00	Intracutaneous (intradermal) tests with allergenic extracts, delayed reaction 24-72 hours, including reading; 2 tests	11.00
95031-00	3-4 tests	10.00
95042-00	Patch or application tests; 21-30 tests	3.33
95043-00	more than 30 tests	4.00
95070-00	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds	110.00
95078-00	Provocative testing (MD/DO)	14.00
95105-00	Medical conference services (e.g., use of mechanical and electric devices, climatotherapy, breathing exercises and/or postural drainage)	35.00
95120-00	Professional services for allergen immunotherapy in prescribing physician's	

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	office or institution, including provision of allergenic extract; single antigen (MD/DO)	8.00
95125-00	Multiple antigens (specify number of injections) (MD/DO)	9.00
95130-00	Single stinging insect venom (MD/DO)	23.50
95131-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 2 stinging insect venoms	22.00
95132-00	3 stinging insect venoms	27.50
95180-00	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, horse serum)	6.70

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
95821-00	Electroencephalogram (EEG); sleep only	$ 145.00
95823-00	physical or pharmacological activation only	100.00
95827-00	all night sleep recording only	300.00
95831-00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	25.00
95851-00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	50.00
95852-00	hand, with or without comparison with normal side	16.00
95857-00	Tensilon test for myasthenia gravis	57.00
95860-00	Electromyography; one extremity and related paraspinal areas (MD/DO)	175.00
95861-00	two extremities and related paraspinal areas (MD/DO)	250.00
95863-00	three extremities and related paraspinal areas (MD/DO)	165.00
95864-00	four extremities and related paraspinal areas (MD/DO)	226.00
95869-00	Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	77.80
95882-00	Assessment of higher cerebral function with medical interpretation; cognitive testing and others (MD/DO)	45.00
95900-00	Nerve conduction, velocity, or latency study, motor, each nerve (MD/DO)	50.00
95904-00	Nerve conduction, velocity and/or latency study; sensory, each nerve	59.50
95935-00	"H" reflex, by electrodiagnostic testing	45.00
95950-00	Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; electroencephalographic (EEG) recording	

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	and interpretation, initial 24 hours	380.00
95951-00	combined electroencephalographic (EEG) and video recording and interpretation, initial 24 hours	1,000.00

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
96505-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by infusion technique	55.00
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	37.00
96509-00	by infusion technique	90.00
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	81.50
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	321.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	48.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	217.30
96540-00	Chemotherapy injection, intrathecal via reservoir, single or multiple agents, administered by physician	107.00

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)	$ 7.50
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	25.00
96912-00	psoralens and ultraviolet A (PUVA)	30.00

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, socroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	$ 30.00
97261-00	each additional area (MD/DO)	8.40

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 (MD/DO)	$ 9.25
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) (MD/DO)	11.00
99014-00	Telephone calls for consultation or medical management; intermediate	15.00
99025-00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit (MD/DO)	25.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	27.10
99054-00	Services requested on Sundays and holidays in addition to basic services	25.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	55.00
99058-00	Office services provided on an emergency basis (MD/DO)	40.00
99062-00	Emergency care facility services; when the nonhospital-based physician	

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	is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	52.00
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
99065-00	during regular office hours	50.50
99075-00	Medical testimony (MD/DO)	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 (MD/DO)	Reasonableness of charges reviewable by commissioner
99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00

Prolonged Services

99150-00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour (MD/DO)	$ 114.00
99151-00	more than one hour	191.00

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 (MD/DO)	73.70
99156-00	approximately 50 minutes	100.00

Critical Care Services

Critical care services (codes 99162-00 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,

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but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
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 (MD/DO)	$ 151.50
99162-00	additional 30 minutes (MD/DO)	76.50
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	75.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness (MD/DO)	60.00
99172-00	limited examination, evaluation, or treatment for same or new illness (MD/DO)	53.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness (MD/DO)	78.00
99174-00	Extended reexamination, reevaluation and/or treatment, same or new illness (MD/DO)	150.00
	Other Services	
99195-00	Phlebotomy, therapeutic (separate procedure)	35.00

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. [Unchanged.]

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. The surgical package includes the assistant surgeons if any are

used. Reimbursement for the assistant surgeon is made from the fee collected for the surgical package and is the responsibility of the primary physician. For the purposes of this definition, preoperative care does not include any care administered before the provider determines that surgery is required.

B. to D. [Unchanged.]

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.

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(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 65 <u>75</u> 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

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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 to 11441) 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 to 16030) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001 to 12014) 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 to 12052) 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 13120 to 13152) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

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

(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.

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Code	Service	Maximum Fee
	Incision	
10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion (MD/DO)	$ 53.00
10003*00	Incision and drainage of infected or noninfected epithelial inclusion cyst (sebaceous cyst) with complete removal of sac and treatment of cavity (MD/DO)	60.00
10020*00	Incision and drainage of furuncle (MD/DO)	40.00
~~10040*00~~	~~Acne surgery (e.g. marsupialization, opening or removal of multiple milia, comedones, cysts, pustules~~	~~23.00~~
10060*00	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple (MD/DO)	54.00
10061-00	complicated	130.00
10080*00	Incision and drainage of piloridial cyst; simple (MD/DO)	60.00
10100*00	Incision and drainage of onychia or paronychia single or simple (MD/DO)	47.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple (MD/DO)	52.50
10121*00	complicated	112.20
10140*00	Incision and drainage of hematoma; simple	50.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst (MD/DO)	45.00
10180-00	Incision and drainage, complex, postoperative wound infection	100.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	35.00
~~11041-00~~		
11040-00	Debridement; skin, ~~full~~ partial thickness	35.00
11041-00	full thickness	35.00
11042-00	skin, and subcutaneous tissue	80.00
	Paring or Curettement	
11050*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 28.00
11051-00	two to four lesions	40.00
11052-00	more than four lesions	52.00
	Biopsy	
11100-00	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion (MD/DO)	$ 63.00
	Excision -- Benign Lesions	
11200*00	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions (MD/DO)	$ 55.00
11400-00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter (MD/DO)	70.40
11401-00	lesion diameter 0.5 to 1.0 centimeter	82.00
11402-00	lesion diameter 1.0 to 2.0 centimeters	100.00
11403-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	115.00
11404-00	lesion diameter 3.0 to 4.0 centimeters (MD/DO)	150.00

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11406-00	lesion diameter over 4.0 centimeters	200.00
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)	77.00
11421-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	96.60
11422-00	lesion diameter 1.0 to 2.0 centimeters (MD/DO)	120.00
11423-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	144.00
11424-00	lesion diameter 3.1 to 4.0 centimeters	160.00
11426-00	lesion diameter over 4.0 centimeters	300.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter (MD-DO)	90.00
11441-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	113.00
11442-00	lesion diameter 1.1 to 2.0 centimeters	135.00
11443-00	lesion diameter 2.1 to 3.0 centimeters	89.00

Excision -- Malignant Lesions

~~16000-00~~		
11600-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	$ 111.00
11601-00	lesion diameter 0.6 to 1.0 centimeter	145.00
11602-00	lesion diameter 1.1 to 2.0 centimeters	204.00
11603-00	lesion diameter 2.1 to 3.0 centimeters	260.00
11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less	171.00
11621-00	lesion diameter 0.6 to 1.0 centimeter	220.00
11622-00	lesion diameter 1.1 to 2.0 centimeters	280.43
11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less	243.00
11641-00	lesion diameter 0.6 to 1.0 centimeter	292.90

Nails

11700*00	Debridement of nails, manual; 5 or less	$ 29.00
11710*00	Debridement of nails, electric grinder, 5 or less	25.00
11730*00	Avulsion of nail plate, partial or complete, simple; single (MD/DO)	64.00
11740-00	Evacuation of subungual hematoma (MD/DO)	36.50
11750-00	Excision of nail and nail matrix, partial or complete, (e.g. ingrown or deformed nail) for permanent removal	125.00
11760-00	Reconstruction of nail bed; simple	77.00

Miscellaneous

11770-00	Excision of piloridial cyst or sinus; simple	$ 550.00
11771-00	extensive	600.00
11900*00	Injection, intralesional, up to and including seven lesions (MD/DO)	35.00

Introduction

11901*00	Injection, intralesional; up to and including 7 lesions	$ 71.00
11954-00	Subcutaneous injection of "filling" material (e.g. silicone); over 10 centimeters	50.00

Repair -- Simple

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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 (MD/DO)	$ 55.50
12002*00	2.5 to 7.5 centimeters (MD/DO)	82.00
12004*00	7.5 to 12.5 centimeters (MD/DO)	120.00
12005*00	12.5 to 20.0 centimeters (MD/DO)	175.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters (MD/DO)	83.00
12013*00	2.5 to 5.0 centimeters	115.00
12014-00	5.1 to 7.5 centimeters	75.00
	Repair -- Intermediate	
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters (MD/DO)	$ 84.00
12032*00	2.5 to 7.5 centimeters (MD/DO)	118.00
12034-00	7.6 to 12.5 centimeters (MD/DO)	168.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters (MD/DO)	98.00
12042-00	2.5 to 7.5 centimeters (MD/DO)	140.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters (MD/DO)	112.00
12052-00	2.5 to 5.0 centimeters (MD/DO)	160.00
	Repair -- Complex	
13100-00	Repair, complex, trunk; 1.1 to 2.5 centimeters	$ 140.00
13101-00	2.6 to 7.5 centimeters	275.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters	280.00
13121-00	2.6 to 7.5 centimeters	234.00
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	210.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters (MD/DO)	420.00
13152-00	2.5 to 7.5 centimeters (MD/DO)	630.00
	Adjacent Tissue Transfer or Rearrangement	
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters (MD/DO)	$ 725.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters (MD/DO)	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 (MD/DO)	$ 635.00
	Burns, Local Treatment	

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16000-00	Initial treatment, first degree burn, when no more than local treatment is required (MD/DO)	$ 47.50
16020*00	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small (MD/DO)	42.50
16025*00	without anesthesia, medium, for example, whole face or whole extremity (MD/DO)	71.00
	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 (MD/DO)	$ 46.50
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (MD/DO)	43.00
17101-00	second lesion (MD/DO)	22.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	40.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions (MD/DO)	50.00
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	460.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2) (MD/DO)	30.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)	31.00

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	
20220-00	Biopsy, bone, trocar, or needle; superficial, for example ilium, sternum, spinous process, ribs	$ 175.00
	Introduction or Removal -- General	
20550*00	Injection, tendon sheath, ligament, or trigger points (MD/DO)	46.00
20600*00	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes (MD/DO)	50.00
20605*00	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa (MD/DO)	60.25

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20610*00	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa (MD/DO)	61.00
20670*00	Removal of implant; superficial, (e.g. buried wire, pin, or rod)	86.50
20680-00	Removal of implant; deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate (MD/DO)	344.00

Head Repair, Revision, or Reconstruction

21116-00	Injection procedure for temporomandibular joint arthrography	$162.00
21310-00	Treatment of closed or open nasal fracture without manipulation (MD/DO)	55.00
21315-00	mandible (includes obtaining graft)	120.00
21320-00	Manipulative treatment, nasal bone fracture; with stabilization (MD/DO)	300.00

Neck (Soft Tissues) and Thorax -- Fracture or Dislocation

21800-00	Treatment of rib fracture; closed, uncomplicated, each	$ 65.00

Spine

22555-00	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) (MD/DO)	$ 2,300.00

Shoulders -- Fracture or Dislocation

23350-00	Injection procedure for shoulder arthrography (MD/DO)	$ 58.00
23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) (MD/DO)	1,515.00
23450-00	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation (MD/DO)	1,359.00
23500-00	Treatment of closed clavicular fracture; without manipulation (MD/DO)	100.00
23540-00	Treatment of closed acromioclavicular dislocation; without manipulation	75.00
23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	202.25
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia (MD/DO)	138.00
23655-00	requiring anesthesia (MD/DO)	213.00

Humerus (Upper Arm) and Elbow -- Fracture or Dislocation

24500-00	Treatment of closed humeral shaft fracture; without manipulation	$233.70
24600-00	Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	168.00
24650-00	Treatment of closed radial head or neck fracture without manipulation (MD/DO)	160.00

Forearm and Wrist -- Incision and Excision

25000-00	Tendon sheath incision; at radial styloid for de Quervain's disease	$395.00
25111-00	Excision of ganglion, wrist (dorsal or volar); primary (MD/DO)	400.00

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		Forearm and Wrist -- Fracture or Dislocation	
25505-00		Treatment of closed radial shaft fracture; with manipulation (MD/DO)	$ 345.00
25560-00		Treatment of closed radial and ulnar shaft fractures; without manipulation	211.50
25565-00		Treatment of closed radial and ulnar shaft fractures; with manipulation (MD/DO)	435.00
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 (MD/DO)	176.00
25605-00		with manipulation (MD/DO)	322.00
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 (MD/DO)	460.00
25611-00		with external skeletal fixation or percutaneous pinning (MD/DO)	643.00
25622-00		Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	185.00
		Hand and Fingers -- Incision, Excision, Repair, Revision, or Reconstruction	
26010*00		Draining of finger abscess; simple	$ 55.00
26055-00		Tendon sheath incision for trigger finger (MD/DO)	400.00
26115-00		Excision, tumor, hand or finger; subcutaneous	315.00
26116-00		deep, subfascial, intramuscular	537.50
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	1,309.00
26160-00		Excision of lesion of tendon sheath or capsule (MD/DO)	231.00
26418-00		Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon (MD/DO)	333.00
		Hands and Fingers -- Fractures or Dislocations	
26600-00		Treatment of closed metacarpal fracture, single; without manipulation, each bone (MD/DO)	$ 116.00
26605-00		with manipulation, each bone (MD/DO)	196.00
26720-00		Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (MD/DO)	77.00
26725-00		with manipulation, each (MD/DO)	150.00
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	400.00
26750-00		Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each (MD/DO)	55.50
26755-00		with manipulation, each	112.00
26760-00		Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	100.00
26770-00		Treatment of closed interphalangeal	

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	joint dislocation, single, with manipulation; without anesthesia (MD/DO)	65.00
	Hand and Fingers -- Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (MD/DO)	$ 295.50
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)	$2,098.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple (MD/DO)	3,050.00
27134-00	Revision of total hip arthroplasty; both components	4,100.00
27235-00	Treatment of closed or open femoral fracture, in situ pinning of undisplaced or impacted fracture	1,493.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (MD/DO)	1,700.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation (MD/DO)	1,496.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	381.00
	Femur (Thigh Region) and Knee Joint -- Introduction or Removal	
27370-00	Injection procedure for knee arthrography (MD/DO)	$ 55.64
	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)	$ 1,203.00
27425-00	Lateral retinacular release, any method	1,235.00
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,400.00
27447-00	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement) (MD/DO)	3,000.00
27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation (MD/DO)	1,482.00
	Amputation	
27590-00	Amputation, thigh, through femur, any level	$1,050.40
	Leg (Tibula and Fibula) and Ankle Joint -- Fractures or Dislocations	
27750-00	Treatment of closed tibial shaft fracture; without manipulation	$275.00

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27760-00	Treatment of closed distal tibial fracture (medial malleolus) without manipulation	190.00
27780-00	Treatment of closed proximal fibula or shaft fracture; without manipulation (MD/DO)	141.00
27786-00	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation (MD/DO)	176.00
27800-00	Treatment of closed tibia and fibula fractures, shafts; without manipulation	315.00
27802-00	with manipulation (MD/DO)	540.00
27814-00	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation (MD/DO)	950.00
27822-00	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only (MD/DO)	1,153.00
27880-00	Amputation leg, through tibia and fibulat (MD/DO)	918.00

Foot

28080-00	Excision of Morton neuroma; single each (MD/DO)	$ 381.00
28090-00	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot (MD/DO)	316.30
28114-00	Ostectomy, complete excision; all metatarsal heads, with proximal phalangectomy, excluding first metatarsal (Clayton type procedure)	40.00
28190*00	Removal of foreign body, foot; subcutaneous	65.00
28285-00	Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy) (MD/DO)	394.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure) (MD/DO)	478.50
28292-00	Keller, McBride or Mayo type procedure	675.00
28296-00	With metatarsal osteotomy (Mitchell, Chevron, or concentric type procedure)	840.00
28470-00	Treatment of closed metatarsal fracture; without manipulation, each (MD/DO)	128.25
28490-00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation (MD/DO)	66.00
28510-00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each (MD/DO)	55.90
28820-00	Amputation, toe; metatarso phalangeal joint	247.00

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

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physician.

Code	Service	Maximum Fee
	Body and Upper Extremity Casts	
29065-00	Application; shoulder to hand (long arm) (MD/DO)	$ 84.00
29075-00	elbow to finger (short arm) (MD/DO)	70.00
29085-00	hand and lower forearm (gauntlet) (MD/DO)	70.00
	Splints	
29105-00	Application of long arm splint (shoulder to hand) (MD/DO)	$ 49.00
29125-00	Application of short arm splint (forearm to hand); static (MD/DO)	42.00
29130-00	Application of finger splint; static	26.00
	Strapping -- Any Age	
29220-00	Strapping; low back (MD/DO)	$ 30.00
~~29240-00~~	~~--shoulder (e.g. Velpeau)~~	~~50.00~~
29260-00	elbow or wrist (MD/DO)	20.00
29345-00	Application of long leg cast (thigh to toes) (MD/DO)	111.00
29355-00	walker or ambulatory type (MD/DO)	127.00
29365-00	Application of cylinder cast (thigh to ankle) (MD/DO)	87.50
29405-00	Application of short leg cast (below knee to toes) (MD/DO)	85.00
29425-00	walking or ambulatory type (MD/DO)	96.00
29435-00	Application of patellar tendon bearing (PTB) cast (MD/DO)	124.00
29440-00	Adding walker to previously applied cast (MD/DO)	34.00
29450-00	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral (MD/DO)	56.00
29455-00	bilateral	103.00
	Splints	
29505-00	Application of long leg splint (thigh to ankle or toes) (MD/DO)	$ 62.00
29515-00	Application of short leg splint (calf to foot) (MD/DO)	50.00
	Strapping -- Any Age	
29530-00	Strapping; knee	$ 48.00
29540-00	ankle (MD/DO)	25.00
29550-00	toes	20.00
29580-00	Unna boot (MD/DO)	34.00
	Removal or Repair	
29700-00	Removal or bivalving; gauntlet, boot or body cast	$33.20
29705-00	full arm or full leg cast	30.00
29720-00	Repair of spica, body cast, or jacket (MD/DO)	21.00
	Arthroscopy	
29870-00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$ 500.00
29874-00	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body	

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		(for example, osteochondritis dissecans fragmentation, chondral fragmentation) (MD/DO)	1,310.00
29875-00		synovectomy, limited (for example, plica or shelf resection) (MD/DO)	1,225.00
29877-00		debridement/shaving of articular cartilage (chondroplasty) (MD/DO)	1,416.00
29879-00		abrasion arthroplasty (includes chrondroplasty where necessary) or multiple drilling	~~15.25~~ 1,525.00
29881-00		with meniscectomy (medial or lateral including any meniscal shaving) (MD/DO)	1,450.00

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

Code	Service	Maximum Fee
30100-00	Biopsy, intranasal	$ 88.50
30110-00	Excision, nasal polyp(s), simple; unilateral	120.00
30116-00	Excision, nasal polyp(s), extensive; bilateral	505.00
30200*00	Injection into turbinate(s), therapeutic	40.50
30300*00	Removal foreign body, intranasal; office type procedure (MD/DO)	39.00
	Nose -- Repair	
30420-00	Rhinoplasty, primary; including major septal repair (MD/DO)	$ 2,250.00
30520-00	Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft (MD/DO)	970.00
30800*00	Cauterization turbinates, unilateral or bilateral (separate procedure); superficial	30.00
	Other Procedures	
30901*00	Control nasal hemorrhage, anterior, simple (cauterization); unilateral (MD/DO)	$ 50.00
30902*00	bilateral	70.00
30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral (MD/DO)	90.00
31000*00	Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium)	47.00
31021-00	Sinusotomy, maxillary (antrotomy); intranasal, bilateral	550.00
	Larynx	
31500-00	Intubation, endotracheal, emergency procedure (MD/DO)	$ 119.00
31505-00	Laryngoscopy, indirect; diagnostic (MD/DO)	37.00
31525-00	Laryngoscopy, direct; diagnostic, except newborn (MD/DO)	106.00
31536-00	Laryngoscopy, direct, operative, with biopsy; with operating microscope	560.50
31541-00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis	660.00
31575-00	Laryngoscopy, flexible fiberscopic; diagnostic (MD/DO)	75.00

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	Trachea and Bronchi	
31600-00	Tracheostomy, planned (separate procedure) (MD/DO)	$ 505.00
31622-00	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing (MD/DO)	465.00
31625-00	with biopsy (MD/DO)	470.00
31628-00	with transbronchial lung biopsy, with or without fluoroscopic guidance	555.00
	Lungs	
32000*00	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (MD/DO)	$ 120.00
32020-00	Tube thoracotomy with water seal (for example, pneumothorax, hemothorax, empyema)(separate procedure) (MD/DO)	399.00
32100-00	Thoracotomy, major; with exploration and biopsy	1,600.00
32405-00	Biopsy, lung, percutaneous needle	313.00
32480-00	Lobectomy, total or segmental (MD/DO)	1,840.00
32500-00	Wedge resection of lung, single or multiple	1,480.00

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

Code	Service	Maximum Fee
	Heart	
33206-00	Insertion of permanent pacemaker with transvenous electrode(s); atrial	$ 1,480.00
33207-00	ventricular	1,552.00
33210-00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter (MD/DO)	506.00
33212-00	Insertion or replacement of pulse generator only	770.00
33405-00	Replacement, aortic valve, with cardiopulmonary bypass	4,259.00
	Coronary Artery Procedures	
33511-00	Coronary artery bypass, autogenous graft (e.g. saphenous vein or internal mammary artery); two coronary grafts (MD/DO)	$ 4,900.00
33512-00	three coronary grafts (MD/DO)	~~4,900.00~~ 5,400.00
33513-00	four coronary grafts	5,570.00
33514-00	five coronary grafts	6,224.00

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Vascular Injection Procedures

36000*00	Introduction of needle or intracatheter, vein; unilateral (MD/DO)	$ 63.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery (MD/DO)	331.00
36140-00	Introduction of needle or intracatheter; extremity artery	274.61
36200-00	Introduction of catheter, aorta (arch, abdominal, midstream renal, aortioliac run-off) or selective; initial placement	330.50
36215-00	each additional selective thoracic and/or cerebral artery catheter placement (e.g. vertebral or carotid)	448.00
36230-00	coronary artery, selective, unilateral or bilateral	449.28
36245-00	each additional selective abdominal artery catheter placement (e.g. celiac artery, gastroduodenal artery, inferior mesenteric artery, renal artery)	441.00
36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	44.10
36415*00	Routine venipuncture for collection of specimen(s) (MD/DO)	7.60
36430-00	Transfusion, blood or blood components (MD/DO)	70.50
36470*00	Injection of sclerosing solution; single vein	42.00
36471*00	Injection of sclerosing solution; multiple veins, same leg (MD/DO)	50.00
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 2	133.20
36520-00	Therapeutic apheresis (plasma and/or cell exchange) (MD/DO)	156.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	47.00
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	117.00
36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	410.00
36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,255.00
37609-00	Ligation or biopsy, temporal artery	280.00
37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	650.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	921.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	830.00
37731-00	bilateral	1,256.00

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

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38100-00	Splenectomy; total	$ 1,500.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	180.00
38510-00	deep cervical nodes	366.00

Mediastinum and Diaphragm

39400-00	Mediastinoscopy, with or without biopsy	$ 540.00

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

Code	Service	Maximum Fee
40490-00	Biopsy of lip	$ 102.00
40808-00	Biopsy, vestibule of mouth	70.00
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	151.50
41010-00	Incision of lingual frenum (frenotomy)	41.50
42330-00	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	120.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,795.00
42700*00	Incision and drainage abscess; peritonsillar	103.75
42809-00	Removal of foreign body from pharynx	72.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	462.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	475.00

Esophagus

43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 304.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	490.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	439.16
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	350.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	406.00
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	500.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	473.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with	

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	or without specimen collection	536.00
43262-00	for sphincterotomy/papillotomy	1,023.00
43450*00	Dilation esophagus, by unguided sounds(s) or bougie(s), single or multiple passes; initial session	84.00
43451*00	subsequent session	70.00
43520-00	Pyloromyotomy, cutting of pyloric muscle (Fredet-Tamstedt type operation)	965.00
43635-00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type	1,750.00
	Stomach	
43760*00	Change of gastrostomy tube (MD/DO)	$ 50.00
43830-00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure) (MD/DO)	700.00
43846-00	Gastric bypass with Roux-en-Y gastroenterostomy for morbid obesity (MD/DO)	2,593.00
	Intestines	
44005-00	Enterolysis (freeing of intestinal adhesion) for acute bowel obstruction	$ 1,056.00
44100-00	Biopsy of intestine by capsule, tube, peroral (1 or more specimens)	208.00
44120-00	Enterectomy, resection of small intestine; with anastomosis	1,480.00
44140-00	Colectomy, partial; with anastomosis (MD/DO)	1,550.00
44143-00	with end colostomy and closure of distal segment (Hartmann type procedure	1,544.00
44145-00	with coloproctostomy (low pelvic anastomosis)	1,901.00
44160-00	Colectomy with removal of terminal ileum and ileocolostomy	1,992.00
44950-00	Appendectomy (MD/DO)	741.00
44960-00	for ruptured appendix with abscesses or generalized peritonitis (MD/DO)	890.00
45110-00	Proctectomy; complete, combined abdominoperineal, with colostomy, 1 or 2 stages	2,179.40
45300-00	Proctosigmoidoscopy; diagnostic (MD/DO)	60.00
45305-00	for biopsy	100.00
45310-00	Proctosigmoidoscopy; for removal of polyp or papilloma	130.00
45315-00	for removal of multiple excrescences, papillomata or polyps	150.00
45330-00	Sigmoidoscopy, flexible fiberoptic; diagnostic (MD/DO)	103.00
45331-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	159.00
45333-00	Sigmoidoscopy, flexible fiberoptic; for removal of polypoid lesions(s)	193.50
45355-00	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple	120.00
45378-00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure (MD/DO)	500.00
45380-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	601.00
45383-00	Colonoscopy, fiberoptic, beyond splenic flexure; for ablation of tumor or musocal lesion (e.g., electrocoagulation, laser	

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	photocoagulation, hop biopsy/fulguration)	572.00
45385-00	for removal of polypoid lesion(s) (MD/DO)	657.00
45505-00	Proctoplasty; for prolapse of mucous membrane (MD/DO)	750.00
46040-00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	280.00
46050*00	Incision and drainage, perianal abscess, superficial	105.00
46083-00	Incision of thrombosed hemorrhoid, external	66.00
46220-00	Papillectomy or excision of single tag, anus (separate procedure)	90.00
46221-00	Hemorrhoidectomy, by simple ligature (e.g. rubber band)	97.00
46230-00	Excision of external hemorrhoid tags and/or multiple papillae	96.00
46255-00	Hemorrhoidectomy, internal and external, simple (MD/DO)	609.50
46260-00	Hemorrhoidectomy, internal and external, complex or extensive	700.00
46275-00	Fistulectomy; submuscular (MD/DO)	760.00
46320*00	Enucleation or excision of external thrombotic hemorrhoid	81.00
46500*00	Injection of sclerosing solution, hemorrhoids	55.00
46600-00	Anoscopy; diagnostic (separate procedure)	29.00
46910*00	Destruction of lesion(s), anus (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	85.00
46945-00	Ligation of internal hemorrhoids; single procedure	91.00
46946-00	multiple procedures	73.00
47000*00	Biopsy of liver; percutaneous needle (MD/DO)	182.00
47600-00	Cholecystectomy	1,185.00
47605-00	with cholangiography (MD/DO)	1,296.00
47610-00	Cholecystectomy with exploration of common duct (MD/DO)	1,400.00
49000-00	Exploratory laparotomy, exploratory celiotomy (MD/DO)	790.00
49080*00	Peritoneocentesis, abdominal paracentesis; initial	100.00
49505-00	Repair inguinal hernia, age 5 or over (MD/DO)	728.00
49520-00	Repair inguinal hernia; recurrent (MD/DO)	895.00
49525-00	sliding	920.50
49530-00	incarcerated	870.00
49550-00	Repair femoral hernial groin incision (MD/DO)	700.00
49560-00	Repair ventral (incisional) hernia (separate procedure) (MD/DO)	805.00
49565-00	Repair ventral (incisional) hernia separate procedure); recurrent (MD/DO)	1,020.00
49580-00	Repair umbilical hernia; under age 5 years	510.00
49581-00	Repair umbilical hernia; age 5 or over	640.00

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 (MD/DO)	$ 353.50
50230-00	Nephrectomy, including partial ureterectomy, any approach including resection; radical, with regional lymphadenectomy	1,821.00
50360-00	Renal homotransplantation, implantation	

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		of graft; excluding donor and recipient nephrectomy	3,094.00
	50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	50.00
	50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
	50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure	30.50
	51600*00	Injection procedure for cystography or voiding urethrocystography (MD/DO)	18.56
	51605-00	Injection procedure and placement of chain for contrast and/or chain urethrocystrography	49.51
	51610-00	Injection procedure for retrograde urethrocystography	29.00
	51700*00	Bladder irrigation, simple, lavage and/or instillation	34.00
	51705*00	Change of cystostomy tube; simple (MD/DO)	39.40
	51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	81.20
	51726-00	Complex cystometrogram (for example, calibrated electronic equipment) (MD/DO)	104.00
	51741-00	Complex uroflowmetry	60.00
	51840-00	Anterior vesicourethropexy, or urethropexy; simple	1,113.00
	51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,250.00
	51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,400.00
	52000-00	Cystourethroscopy (separate procedure) (MD/DO)	131.00
	52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	250.00
	52204-00	Cystourethroscopy with biopsy	186.00
	52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of 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	290.00
	52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters)	~~530.00~~ 430.00
	52235-00	MEDIUM bladder tumor(s) (2.0 to 5.0 centimeters)	820.00
	52240-00	LARGE bladder tumor(s)	1,200.00
	52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	216.00
	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 (MD/DO)	227.00
	52310-00	Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate	

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	procedure); simple	322.00
52320-00	Cystourethroscopy; with removal of ureteral calculus (MD/DO)	517.00
52332-00	Cystourethroscopy, with insertion of indwelling ureteral stent (MD/DO)	360.00
52336-00	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method; with removal or manipulation of calculus) (ureteral catheterization is included)	1,300.00
52340-00	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic musocal folds)	500.00
52500-00	Transurethral resection of bladder neck (separate procedure)	785.00
52601-00	Transurethral resection of prostate, including control of post-operative bleeding, complete (vasectomy, meatotomy, cysto-urethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	1,325.50
53600*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial (MD/DO)	36.00
53601*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent	27.80
53620*00	Dilation of urethral stricture by passage of filiform and follower, male; initial	57.60
53621*00	subsequent	35.35
53660*00	Dilation of female urethra including suppository and/or instillation; initial (MD/DO)	28.00
53661-00	subsequent (MD/DO)	30.00
53670*00	Catheterization; urethral; simple	25.00

Subp. ~~10~~ 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	
54055*00	Destruction of lesions(s), penis (e.g., condyloma, papilloma molluscum contagiosum, herpetic vesical), simple electrodesiccation	$ 65.00
54240-00	Penile plethysmography	80.00
54521-00	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral	550.00
54640-00	Orchiopexy, any type, with or without hernia repair; unilateral (MD/DO)	890.00
54840-00	Excision of spermatocele, with or without epididymectomy	600.00
55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	39.00
55040-00	Excision of hydrocele; unilateral (MD/DO)	550.00
55700-00	Biopsy, prostate; needle or punch, single or multiple, any approach	134.00
55845-00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	2,500.00
	Female Reproductive System	

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56420*00	Incision and drainage of Bartholin's gland abscess, unilateral	$ 104.00
56440-00	Marsupialization of Bartholin's gland cyst	347.00
56501-00	Destruction of lesion(s), vulva; simple, any method	40.00
56600*00	Biopsy of vulva (separate procedure)	77.00
57061-00	Destruction of vaginal lesion(s); simple, any method	48.00
57100*00	Biopsy of vaginal mucosa; simple, (separate procedure)	70.00
57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	18.00
57160*00	Insertion of pessary	25.00
57260-00	Combined anteroposterior colporrhaphy	1,030.00
57265-00	with enterocele repair	1,065.00
57452*00	Colposcopy (vaginoscopy); (separate procedure)	118.00
57454*00	with biopsies, or biopsy of the cervix	140.00
57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	72.00
57510-00	Cauterization of cervix; electro or thermal	72.00
57511*00	cryocautery, initial or repeat	81.00
57513-00	laser surgery	450.00
57520-00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair	466.00
57700-00	Cerclage of uterine cervix (tracheloplasty)	499.00
58100*00	Endometrial biopsy, suction type (separate procedure)	76.00
58102-00	Office endometrial curettage	103.00
58120-00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	320.00
58150-00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) (MD/DO)	1,280.00
58152-00	with clopo-urethrocystopexy (Marshall-Marchetti-Krantz type)	1,875.00
58260-00	Vaginal hysterectomy (MD/DO)	1,250.00
58265-00	with plastic repair of vagina, anterior and/or posterior colporrhaphy (MD/DO)	1,450.00
58340-00	Injection procedure for hysterosalpinography	85.30
58720-00	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (MD/DO)	905.00
58925-00	Ovarian cystectomy, unilateral or bilateral	931.00
58940-00	Oophorectomy, partial or total, unilateral or bilateral	950.00
58980-00	Laparoscopy for visualization of pelvic viscera (MD/DO)	585.00
58982-00	with fulguration of oviducts (with or without transection)	675.00
58983-00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	773.00
58984-00	with fulguration of ovarian or peritoneal lesions by any method	750.00
58985-00	with lysis of adhesions	686.00
58987-00	with aspiration (single or multiple)	926.00

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	$ 123.50

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60220-00	Total thyroid lobectomy, unilateral	1,100.00
60245-00	Thyroidectomy, subtotal or partial	1,223.00
60500-00	Parathyroidectomy or exploration of parathyroid(s)	1,602.00

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

Code	Service	Maximum Fee
61310-00	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial (MD/DO)	$ 2,625.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,845.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,690.00
	Spine and Spinal Cord -- Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic (MD/DO)	$ 100.00
62273*00	Injection lumbar epidural, of blood or clot patch (MD/DO)	240.00
62274*00	Injection of anesthetic substance diagnostic or therapeutic; subarachnoid or subdural simple (MD/DO)	100.00
62278*00	epidural or caudal single (MD/DO)	195.00
62279*00	epidural or caudal, continuous	275.00
62284*00	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa (MD/DO)	135.20
62289*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal (MD/DO)	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 (MD/DO)	$ 2,420.00
63020-00	Laminotomy (hemilaminectomy), for decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral (MD/DO)	2,075.00
63030-00	one interspace, lumbar, unilateral (MD/DO)	2,005.00
63042-00	reexploration; lumbar (MD/DO)	2,586.00
	Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System	
64405*00	Injection, anesthetic agent; greater occipital nerve	$ 114.00
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	130.00
64442-00	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level	120.00

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64450*00	Injection, anesthetic agent; other peripheral nerve or branch (MD/DO)	84.00
64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	255.00
64520*00	lumbar or thoracic (paravertebral sympathetic)	169.70
64550-00	Application of surface (transcutaneous) neurostimulator (MD/DO)	45.00
64640-00	Destruction by neurolytic agent; other peripheral nerve or branch	324.00
64718-00	Neurolysis or transposition; ulnar nerve at elbow (MD/DO)	1,015.00
64721-00	median nerve at carpal tunnel (MD/DO)	728.00

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 (MD/DO)	$ 45.00
65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating (MD/DO)	50.00
65220*00	corneal, without slit lamp (MD/DO)	52.00
65222*00	corneal, with slit lamp (MD/DO)	61.80
65420-00	Excision or transposition of pterygium; without graft (MD/DO)	545.00
65435*00	Removal of corneal epithelium; with or without chemo-cauterization (abrasion, curettage)	51.90
65855-00	Trabeculoplasty by laser surgery, (1 or more sessions) (defined treatment series)	693.00
66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)	650.00
66762-00	Coreoplasty by photocoagulation (1 or more sessions) (e.g., for improvement of vision)	600.00
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)	547.00
66821-00	laser surgery (one or more stages)	700.00
66940-00	Extraction of lens with or without iridectomy; extracapsular	1,682.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,770.00
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) (MD/DO)	1,763.50
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,287.50
67036-00	Vitrectomy, mechanical, pars plana approach	3,025.00
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	556.00
67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,080.00
67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration)	

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	without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	700.00
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	818.00
67228-00	photocoagulation (laser or xenon arc)	778.00
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	900.00
67312-00	2 muscles, 1 or both eyes	968.00
67515*00	Injection of therapeutic agent into Tenon's capsule	49.00
67700*00	Blepharotomy, drainage of abscess, eyelid	57.00
67800-00	Excision of chalazion; single	75.00
67801-00	multiple, same lid	110.00
67805-00	multiple, different lids	135.00
67810*00	Biopsy of eyelid	106.00
67820*00	Correction of trichiasis; epilation, by forceps only	31.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	87.00
67921-00	Repair of entropion; suture	700.00
67938-00	Removal of embedded foreign body; eyelid	40.00
68200*00	Subconjunctival injection	48.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral (MD/DO)	37.00
68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring general anesthesia	260.00

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

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 55.00
69200-00	Removal foreign body from external auditory canal; without general anesthesia	27.24
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	20.75
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 (MD/DO)	150.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	240.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral (MD/DO)	252.00
69437-00	bilateral (MD/DO)	350.00
69440-00	Middle ear exploration through postauricular or ear canal incision (MD/DO)	897.00

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69610-00	Tympanic membrane repair, with or without site preparation or perforation preparation for closure without patch	90.00
69620-00	Myningoplasty (MD/DO)	1,305.00
69631-00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction (MD/DO)	1,950.00
69632-00	with ossicular chain reconstruction (for example, postfenestration) (MD/DO)	2,115.00
69641-00	Tympanoplasty with mastoidotomy; without ossicular chain reconstruction (MD/DO)	2,100.00
69660-00	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material (MD/DO)	1,985.00

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 (MD/DO)	$ 47.25
70120-00	Radiologic examination, mastoids; less than three views per side (MD/DO)	72.00
70130-00	complete, minimum of three views per side (MD/DO)	90.00
70140-00	Radiologic examination, facial bones; less than three views (MD/DO)	41.70
70150-00	complete, minimum of three views (MD/DO)	55.00
70160-00	Radiologic examination, nasal bones; complete, minimum of three views (MD/DO)	47.00
70200-00	Radiologic examination; orbits, complete, minimum of four views (MD/DO)	46.30
70210-00	Radiologic examination, sinuses, paranasal, less than three views (MD/DO)	37.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views (MD/DO)	69.50
70240-00	Radiologic examination, sella ~~turcia~~ turcica (MD/DO)	48.25
70250-00	Radiologic examination, skull, less than four views, with or without stereo (MD/DO)	48.00
70260-00	complete, minimum of four views, with or without stereo (MD/DO)	74.00
70300-00	Radiologic examination, teeth; single view	14.20
70310-00	partial examination, less than full mouth	18.90
70320-00	complete, full mouth	55.00
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	81.00
70332-00	Temporomandibular joint arthrography; supervision and interpretation only	250.00
70333-00	complete procedure	180.00
70355-00	Orthopantogram	35.00
70360-00	Radiologic examination, neck, soft	

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	tissue (MD/DO)	33.75
70380-00	Radiologic examination, salivary gland for calculus	48.50
70390-00	Sialography; supervision and interpretation only	99.00
~~70450-00~~	~~Computerized axial tomography, head or brain (MD/DO)~~	~~120.90~~
~~70480-00~~	~~Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear, without contrast material~~	~~150.00~~
~~70481-00~~	~~--with contrast material~~	~~139.00~~
~~70486-00~~	~~Computerized axial tomography, maxillofacial area, without contrast material~~	~~91.40~~
~~70491-00~~	~~Computerized axial tomography, soft tissue neck, with contrast material(s)~~	~~132.00~~
70540-00	Magnetic resonance (e.g., proton) imaging; orbit, face, and neck	600.00

Chest

71010-00	Radiologic examination, chest; single view, frontal (MD/DO)	$ 34.00
71015-00	stereo, posteroanterior (MD/DO)	35.00
71020-00	Radiologic examination, chest, two views, frontal and lateral (MD/DO)	47.25
71021-00	with apical lordotic procedure (MD/DO)	44.00
71022-00	with oblique projections (MD/DO)	22.50
71030-00	Radiological examination, chest, complete, minimum of four views (MD/DO)	45.00
71034-00	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy	56.00
71035-00	Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies	23.50
71100-00	Radiologic examination, ribs, unilateral; two views (MD/DO)	53.00
71101-00	Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views	60.00
71110-00	Radiologic examination, ribs, bilateral; three views (MD/DO)	62.00
71111-00	Radiologic examination, ribs, bilateral; including postero-anterior chest, minimum of four views	73.00
71120-00	Radiologic examination; sternum, minimum of two views (MD/DO)	38.00
71130-00	Radiologic examination; sternoclavicular joint or joints, minimum of three views	60.00
~~71260-00~~	~~--with contrast material~~	~~142.20~~

Spine and Pelvis

72010-00	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral (MD/DO)	$ 86.00
72020-00	Radiologic examination, spine, single view, specify level (MD/DO)	37.00
72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral (MD/DO)	50.50
72050-00	minimum of four views (MD/DO)	80.40
72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	89.00
72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral (MD/DO)	57.50
72072-00	Thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction (MD/DO)	58.50
72074-00	Radiologic examination, spine; thoracic, complete, including obliques, minimum of	

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		four views	65.00
	72080-00	thoracolumbar, anteroposterior and lateral (MD/DO)	58.00
	72090-00	scoliosis study, including supine and erect studies (MD/DO)	50.75
	72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral (MD/DO)	62.00
	72114-00	complete, including bending views (MD/DO)	95.00
	72120-00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	61.20
	~~72126-00~~	~~Computerized axial tomography, cervical spine; with contrast material (MD/DO)~~	~~174.40~~
	~~72132-00~~	~~---with contrast material (MD/DO)~~	~~163.00~~
	72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents	790.00
	72170-00	Radiologic examination, pelvis anteroposterior only (MD/DO)	41.00
	72180-00	stereo (MD/DO)	42.00
	72190-00	complete, minimum of three views (MD/DO)	65.00
	~~72192-00~~	~~Computerized axial tomography, pelvis; without contrast material (MD/DO)~~	~~212.50~~
	~~72193-00~~	~~--with contrast material(s) (MD/DO)~~	~~106.00~~
	72200-00	Radiologic examination, sacroiliac joints; less than three views (MD/DO)	52.40
	72202-00	three or more views (MD/DO)	58.75
	72220-00	Radiologic examination, sacrum and coccyx, minimum of two views (MD/DO)	50.00
	72240-00	Myelography, cervical; supervision and interpretation only	213.90
	72241-00	Myelography, cervical, complete procedure (MD/DO)	590.00
	~~72266-00~~	~~--complete procedure (MD/DO)~~	~~216.00~~
	72270-00	Myelography, entire spinal canal; supervision and interpretation only (MD/DO)	205.44
	72271-00	complete procedure (MD/DO)	340.30
		Upper Extremities	
	73000-00	Radiologic examination; clavicle, complete (MD/DO)	$ 37.50
	73010-00	scapula, complete (MD/DO)	42.75
	73020-00	Radiologic examination, shoulder; one view (MD/DO)	37.00
	73030-00	complete, minimum of two views (MD/DO)	48.00
	~~73041-00~~	~~--complete procedure (MD/DO)~~	~~154.00~~
	73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (MD/DO)	54.00
	73060-00	humerus, minimum of two views (MD/DO)	42.75
	73070-00	Radiologic examination, elbow; anteroposterior and lateral views (MD/DO)	41.00
	73080-00	complete, minimum of three views (MD/DO)	44.00
	73090-00	Radiologic examination; forearm, anteroposterior and lateral views (MD/DO)	41.00
	73100-00	Radiologic examination, wrist; anteroposterior and lateral views (MD/DO)	40.00
	73110-00	complete, minimum of three views (MD/DO)	44.00
	73115-00	Radiologic examination, wrist, arthography; supervision and interpretation only	49.00
	73120-00	Radiologic examination, hand; two views (MD/DO)	40.00
	73130-00	minimum of three views (MD/DO)	44.24
	73140-00	Radiologic examination, finger or fingers, minimum of two views (MD/DO)	35.00
	73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity	700.00

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	Lower Extremities	
73500-00	Radiologic examination, hip; unilateral, one view (MD/DO)	$ 34.00
73510-00	complete, minimum of two views (MD/DO)	51.00
73520-00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis (MD/DO)	50.00
73530-00	Radiologic examination, hip, during operative procedure (MD/DO)	26.30
73560-00	Radiologic examination, knee; anteroposterior and lateral views (MD/DO)	42.00
73562-00	anteroposterior and lateral, with oblique, minimum of three views (MD/DO)	54.00
73580-00	Radiologic examination, knee, arthography; supervision and interpretation only (MD/DO)	130.00
~~73581-00~~	~~--complete procedure (MD/DO)~~	~~154.00~~
73590-00	Radiologic examination, tibia and fibula, anteroposterior and lateral views (MD/DO)	43.70
73600-00	Radiologic examination, ankle; anteroposterior and lateral views (MD/DO)	38.00
73610-00	complete, minimum of three views (MD/DO)	45.60
73620-00	Radiologic examination, foot; anteroposterior and lateral views (MD/DO)	39.00
73630-00	complete, minimum of three views (MD/DO)	45.00
73650-00	Radiologic examination; calcaneus, minimum of two views (MD/DO)	38.00
73660-00	toe or toes, minimum of two views (MD/DO)	35.00
~~73700-00~~	~~Computerized axial tomography, lower extremity, without contrast material~~	~~130.00~~
73720-00	Magnetic resonance (e.g., proton) imaging, lower extremity	665.00
	Abdomen	
74000-00	Radiologic examination, abdomen, single anteroposterior view (MD/DO)	37.00
74010-00	anteroposterior and additional oblique and cone views (MD/DO)	40.00
74020-00	complete, including decubitus ~~or~~ and/or erect views (MD/DO)	41.00
74022-00	Complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest (MD/DO)	34.00
~~74150-00~~	~~Computerized axial tomography, abdomen; without contrast material (MD/DO)~~	~~212.50~~
~~74160-00~~	~~--with contrasts (MD/DO)~~	~~129.50~~
74181-00	Magnetic resonance (e.g., proton) imaging, abdomen	790.00
	Gastrointestinal Tract	
74220-00	Radiologic examination; esophagus (MD/DO)	$ 78.00
74230-00	Swallowing function, ~~paraynx~~ pharynx and/or esophagus, with cineradiography and/or video	56.00
74240-00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB (MD/DO)	103.00
74241-00	with or without delayed films, with KUB (MD/DO)	68.40
74245-00	with small bowel, includes multiple serial films (MD/DO)	142.50
74246-00	Radiologic examination, gastrointestinal	

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		tract, upper, air contrast, with specific high density barium, effervescent agent, with or without delayed films; without KUB	103.00
	74247-00	with or without delayed films, with KUB (MD/DO)	125.00
	74250-00	Radiologic examination, small bowel, includes multiple serial films (MD/DO)	97.50
	74270-00	Radiologic examination, colon; barium enema (MD/DO)	101.00
	74280-00	air contrast with specific high density barium, with or without glucagon (MD/DO)	152.00
	74290-00	Cholecystography, oral contrast (MD/DO)	73.00
	74300-00	Cholangiography and/or pancreatography; during surgery (MD/DO)	41.50
	74305-00	Cholangiography and/or pancreatography; postoperative	59.50
	74328-00	Endoscopic catheterization of the biliary ductal system, fluoroscopic monitoring and radiography	43.75
	74329-00	Endoscopic catheterization of the pancreatic ductal system, fluoroscopic monitoring and radiography	53.00
	74330-00	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography (MD/DO)	62.00
	74340-00	Introduction of long gastrointestinal tube (e.g., Miller-Abbott) with multiple fluoroscopies and films	49.25
		Urinary Tract	
	74400-00	Urography, (pyelography) intravenous, with or without KUB (MD/DO)	$ 112.00
	74405-00	with special hypertensive contrast concentration and/or or clearance studies (MD/DO)	161.70
	74410-00	Urography, infusion, drip technique (MD/DO)	90.00
	74415-00	Urography, infusion, drip technique and/or bolus technique; with nephrotomography	161.70
	~~74420-00~~	~~Urography, retrograde, with or without kidneys, ureters, and bladder (MD/DO)~~	~~55.00~~
	74425-00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); supervision and interpretation only (MD/DO)	43.75
	74426-00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); complete procedure	145.60
	74430-00	Cystography, minimum of three views; supervision and interpretation only (MD/DO)	46.00
	74431-00	Cystography, minimum of three views; complete procedure	91.00
	74451-00	Urethrocystography, retrograde; complete procedure	97.40
	74455-00	Urethrocystography, voiding; supervision and interpretation only (MD/DO)	69.50
	74456-00	complete procedure (MD/DO)	87.50
	74475-00	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, with fluoroscopic monitoring and radiography; supervision and interpretation only	155.00
		Gynecological and Obstetrical	
	74710-00	Pelvimetry, with or without placental	

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		localization	$ 83.10
	74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	42.00
	74740-00	Hysterosalpingography; supervision and interpretation only	101.00
	74741-00	complete procedure	137.20
		Vascular System	
	75550-00	Angiocardiography by cineradiography; supervision and interpretation only	$144.50
	75605-00	Aortography, thoracic, by serialography; supervision and interpretation only	106.00
	75627-00	Aortography, abdominal catheter, by serialography; supervision and interpretation only	84.50
	~~75628-00~~	~~Aortography, abdominal, catheter by serialography (MD/DO)~~	~~288.00~~
	75630-00	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; supervision and interpretation only	168.00
	75631-00	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography (MD/DO)	436.25
	75650-00	Angiography, cervicocerebral, catheter, including vessel origin; supervision and interpretation only	284.50
	75655-00	Angiography, cerviocerebral, selective catheter, including vessel origin; two vessels, complete procedure (MD/DO)	503.00
	75656-00	Angiography, cervicocerebral, selective catheter, including vessel origin, three or four vessels, supervision and interpretation only	250.00
	75657-00	three or four vessels, complete procedure (MD/DO)	603.80
	75671-00	Angiography, carotid, cerebral, bilateral; supervision and interpretation only	238.00
	75673-00	Angiography, carotid cerebral, bilateral; catheter, complete procedure (MD/DO)	498.00
	75710-00	Angiography, extremity, unilateral, supervision and interpretation only	77.50
	75712-00	Angiography, extremity, unilateral; by serialography, complete procedure (MD/DO)	334.80
	75716-00	Angiography, extremity, bilateral; supervision and intrepretation only	95.50
	75718-00	by serialography, complete procedure	267.00
	75750-00	Angiography, coronary, root injection (MD/DO)	83.80
	75752-00	Angiography, coronary, unilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only	50.00
	75754-00	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording (MD/DO)	171.00
	75762-00	Angiography, coronary bypass, unilateral selective injection; supervision and interpretation only	50.50
	75766-00	Angiography, coronary bypass, multiple selective injection; supervision and interpretation only	74.00
		Veins and Lymphatics	

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75820-00	Venography, extremity, unilateral; supervision and interpretation only	$ 98.50
75821-00	Venography, extremity, unilateral; complete procedure (MD/DO)	130.15
75897-00	Transcatheter therapy, infusion (e.g., thrombolysis other than coronary), including angiography; complete procedure	375.00
75962-00	Percutaneous transluminal angioplasty, peripheral artery; supervision and interpretation only	68.00
75985-00	Change of percutaneous drainage catheter with contrast monitoring (i.e., biliary tract, urinary tract); complete procedure	199.00
	Miscellaneous	
76000-00	Fluoroscopy (separate procedure), up to one hour physician time	$ 40.00
76020-00	Bone age studies	36.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	69.00
76061-00	Radiologic examination, osseous survey: limited (e.g., for metastases)	139.00
76062-00	Radiologic examination, osseous survey; complete (MD/DO)	195.50
76066-00	Joint survey, single view, one or more joints (specify)	23.00
76080-00	Radiologic examination, fistula or sinus tract study; supervision and interpretation only	61.00
76081-00	Radiologic examination, fistula or sinus tract study; complete procedure (MD/DO)	76.70
76100-00	Radiologic examination, single plane body section (MD/DO)	101.30
76101-00	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	93.60
76102-00	bilateral	100.00
76150-00	Xeroradiography	50.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	436.00
~~76370-00~~	~~Computerized tomography guidance for placement of radiation therapy fields~~	~~74.25~~
~~76375-00~~	~~Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction~~	~~45.00~~

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.

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Code	Service	Maximum Fee
	Head and Neck	
76506-00	Echoencephalography, B-scan and/or real-time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	$ 140.00
76511-00	Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification (MD/DO)	150.00
76516-00	Ophthalmic, biometry; by ultrasound echography, A-mode (MD/DO)	153.90
76519-00	intraocular lens power calculation (MD/DO)	175.00
76536-00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B-scan and/or real-time with image documentation	118.00
	Chest	
76604-00	Echography, chest B-scan (includes Mediastinum) and/or real time with image documentation (MD/DO)	$ 68.00
76620-00	Echocardiography, M-mode (MD/DO)	120.00
76627-00	Echocardiography, real-time with image documentation (2D); complete	163.00
76629-00	Echocardiography, M-mode and real time with image documentation (MD/DO)	225.00
76632-00	Doppler echocardiography	70.50
76700-00	Echography, abdominal, B-scan; and/or real-time with image documentation (MD/DO)	110.00
76705-00	limited (MD/DO)	98.00
76770-00	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan (MD/DO)	123.50
76775-00	limited (MD/DO)	67.50
	Pelvis	
76805-00	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (MD/DO)	$ 98.80
76815-00	Echography, pregnant uterus, B-scan and/or real-time with image documentation; limited (fetal growth rate, heart beat, anomalies, placental location)	73.00
76816-00	follow-up or repeat	65.00
76818-00	Fetal biophysical profile	106.00
76855-00	Echography, pelvic area (Doppler)	90.00
76856-00	Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; complete	90.00
76857-00	limited or follow-up (e.g., for follicles)	65.00
76870-00	Echography, scrotum and contents	137.40
76880-00	Echography, extremity, B-scan and/or real-time with image documentation	88.00
76925-00	Imaging, peripheral (e.g., B-scan, Doppler or real-time scan	110.00
76943-00	Ultrasonic guidance for needle biopsy; complete procedure	249.25
76970-00	Ultrasound study follow-up (specify)	50.00
76986-00	Echography, intraoperative	62.00
76991-00	Intraluminal ultrasound study (e.g., transrectal, transvaginal)	200.00

Subp. 4. Therapeutic radiology. The following codes,

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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	$ 295.00
77263-00	complex	345.00
77280-00	Therapeutic radiology simulation-aided field setting; simple (MD/DO)	100.04
77285-00	intermediate	125.00
77290-00	complex	175.00
77300-00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment (MD/DO)	60.00
77305-00	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	125.00
77310-00	intermediate (three or more treatment ports directed to a single area of interest)	150.00
77315-00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	280.00
77334-00	Treatment devices, design and construction; complex (MD/DO)	150.00
77336-00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance (MD/DO)	61.50
77400-00	Daily megavoltage treatment	

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	management; simple (MD/DO)	42.40
77405-00	intermediate	50.00
77410-00	complex (MD/DO)	70.00
77415-00	Therapeutic radiology treatment port film interpretation and verification, per treatment course	22.00
77420-00	Weekly megavoltage treatment management; simple (MD/DO)	25.00
77425-00	intermediate	95.83
77465-00	Daily kilovoltage treatment management (MD/DO)	31.50

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
78000-00	Thyroid uptake; single determination (MD/DO)	$ 21.00
78001-00	Thyroid uptake; multiple determinations	113.90
78003-00	stimulation, suppression or discharge (not including initial uptake studies)	65.25
78006-00	Thyroid imaging, with uptake; single determination (MD/DO)	63.00
78007-00	Thyroid imaging, with uptake; multiple determinations	88.00
78010-00	Thyroid imaging; only (MD/DO)	81.40
	Diagnostic - Gastrointestinal System	
78201-00	Liver imaging; static only (MD/DO)	$ 69.75
78215-00	Liver and spleen imaging (MD/DO)	207.40
78216-00	with vascular flow (MD/DO)	90.00
78220-00	Liver function study with hepatobiliary agents, with serial images (MD/DO)	86.50
78223-00	Hepatobiliary ductal system imaging, including gallbladder (MD/DO)	90.00
78264-00	Gastric emptying study	65.25
78278-00	Acute gastrointestinal blood loss imaging	118.50
78290-00	Bowel imaging (for example, ectopic gastric mucosa, Meckel's localization, volvulus (MD/DO)	78.00
	Diagnostic - Musculoskeletal System	
78300-00	Bone imaging; limited area (for, example, skull, pelvis) (MD/DO)	$ 80.00
78305-00	multiple areas	87.50
78350-00	Bone density (bone mineral content) study; single photon absorptiometry	78.00
	Respiratory System	
78580-00	Pulmonary perfusion imaging; particulate (MD/DO)	$ 81.50
78581-00	gaseous (MD/DO)	80.00
78582-00	gaseous, with ventilation, rebreathing and washout (MD/DO)	68.50
78585-00	rebreathing and washout, with or without single breath	114.75
78587-00	Pulmonary ventilation imaging; multiple projections (MD/DO)	100.00

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78593-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection (MD/DO)	98.00
78594-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views)	81.50
	Nervous System	
78660-00	Dacryocystography (lacrimal flow study)	$ 15.00
	Genitourinary System	
78700-00	Kidney imaging; static only	$ 68.00
78704-00	Kidney imaging; with function study (e.g., imaging renogram) (MD/DO)	81.00
78715-00	Kidney vascular flow only	54.60
78725-00	Kidney function study only	152.00
78727-00	Kidney transplant evaluation	95.00
78740-00	Ureteral reflux study (radionuclide voiding cystogram)	80.00
78805-00	Radionuclide localization of abscess; limited area	483.80
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	121.50

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 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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

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

Code	Service	Maximum Fee
	Automated Multichannel Tests	
80002-00	Automated multichannel test 1 or 2 clinical chemistry tests (MD/DO)	$ 15.50
80003-00	3 clinical chemistry tests (MD/DO)	30.00
80004-00	4 clinical chemistry tests (MD/DO)	25.70
80005-00	5 clinical chemistry tests (MD/DO)	45.00
80006-00	6 clinical chemistry tests (MD/DO)	26.50
80007-00	7 clinical chemistry tests (MD/DO)	29.25
80008-00	8 clinical chemistry tests (MD/DO)	30.00
80009-00	9 clinical chemistry tests (MD/DO)	33.50
80010-00	10 clinical chemistry tests (MD/DO)	33.50
80011-00	11 clinical chemistry tests (MD/DO)	35.50
80012-00	12 clinical chemistry tests (MD/DO)	36.80
80016-00	13-16 clinical chemistry tests (MD/DO)	40.00
80018-00	17-18 clinical chemistry tests (MD/DO)	44.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed) (MD/DO)	32.00
	Therapeutic Drug Monitoring	
80031-00	Therapeutic quantitative drug monitoring in body fluids and/or excreta; measurement one drug (MD/DO)	$ 33.00
80032-00	two drugs measured	39.00
	Organ or Disease Oriented Panels	
80050-00	General health screen panel	$ 42.75
80053-00	Executive profile (MD/DO)	60.00
80055-00	Obstetric profile (MD/DO)	35.00
80058-00	Hepatic function panel (MD/DO)	29.50
80059-00	Hepatitis panel (MD/DO)	76.00
80060-00	Hypertension panel (MD/DO)	30.00
80061-00	Lipid profile (MD/DO)	30.00
80062-00	Cardiac evaluation (including coronary risk) panel (MD/DO)	30.00
80063-00	Cardiac injury panel	51.00
80064-00	Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination (MD/DO)	25.00
80065-00	Metabolic panel (MD/DO)	50.25
80070-00	Thyroid panel (MD/DO)	30.50
80071-00	with thyrotropin releasing hormone (TRH) (MD/DO)	49.50
80072-00	Arthritis panel (MD/DO)	43.00
80073-00	Renal panel	28.00
80085-00	Microcytic anemia panel	62.00
80086-00	Macrocytic anemia panel (MD/DO)	37.60
80090-00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	74.00
	Consultations (Clinical Pathology)	
80500-00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 18.00

Subp. 3. **Urinalysis.** The following codes, service

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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 (MD/DO)	$ 12.00
81002-00	routine, without microscopy (MD/DO)	7.00
81004-00	components, single, not otherwise listed, specify (MD/DO)	6.00
81005-00	chemical, qualitative, any number of constituents (MD/DO)	6.50
81010-00	concentration and dilution test (MD/DO)	5.00
81015-00	microscopic only (MD/DO)	8.00
81020-00	two or three glass test	10.00

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

Code	Service	Maximum Fee
82009-00	Acetone, qualitative	$ 7.25
82010-00	quantitative	6.00
82011-00	Acetylsalicylic acid; quantitative (MD/DO)	20.50
82024-00	Adrenocorticotropic hormone (ACTH), RIA	101.20
82042-00	Albumin; urine, quantitative (specify method, e.g., Esbach)	2.90
82070-00	Alcohol (ethanol), urine; by gas-liquid chromatography	46.50
82085-00	Aldolase, blood; kinetic ultraviolet method	27.00
82088-00	Aldosterone; RIA, blood	132.30
82130-00	Amino acids, urine or plasma, chromatographic fractionation and quantitation; one or more	176.90
82137-00	Aminophylline (MD/DO)	35.00
82138-00	Amitriptyline	51.40
82140-00	Ammonia; blood	31.50
82143-00	Amniotic fluic scan (spectrophotometric)	58.00
82150-00	Amylase, serum (MD/DO)	20.30
82156-00	Amylase, urine (MD/DO)	21.30
82157-00	Androstenedione, RIA	90.00
82164-00	Angiotensin-converting enzyme	35.50
82172-00	Apolipoprotein, immunoassay	25.00
82205-00	Barbiturates; quantitative (MD/DO)	28.00
82210-00	quantitative and identification (MD/DO)	31.00
82250-00	Bilirubin; blood, total OR direct (MD/DO)	15.00
82251-00	blood, total AND direct	22.00
82270-00	Blood; occult, feces, screening	8.00
82273-00	duodenal, gastric contents, qualitative	6.00
82306-00	Calcifediol (25-OH Vitamin D-3), chromatographic technique	133.50
82310-00	Calcium, blood; chemical (MD/DO)	14.95
82330-00	fractionated diffusible	24.00
82340-00	Calcium, urine; quantitative, timed specimen (MD/DO)	17.50
82355-00	Calculus (stone), qualitative, chemical	30.50
82360-00	Calculus (stone, quantitative; chemical	31.50
82372-00	Carbamazepine, serum (MD/DO)	32.00
82374-00	Carbon dioxide, combining power	

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		or content	19.15
	82375-00	Carbon monoxide, (carboxyhemoglobin); quantitative	42.10
	82376-00	qualitative	10.00
	82380-00	Carotene, blood	28.00
	82382-00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine	66.00
	82384-00	fractionated	77.00
	82390-00	Ceruloplasmin, chemical (copper oxidase), blood	29.00
	82435-00	Chlorides; blood (specify chemical or electrometric) (MD/DO)	18.00
	82465-00	Cholesterol, serum; total (MD/DO)	15.00
	82470-00	total and esters	15.35
	82480-00	Cholinesterase; serum (MD/DO)	39.00
	82486-00	Chromatography; gas-liquid, compound and method not elsewhere specified	61.50
	82507-00	Citrate	69.20
	82512-00	Clonazepam (MD/DO)	49.00
	82525-00	Copper; blood	33.00
	82529-00	Cortisol; fluorometric, plasma	39.85
	82533-00	Cortisol; RIA, plasma (MD/DO)	40.00
	82534-00	RIA, urine	47.00
	82540-00	Creatine; blood (MD/DO)	15.00
	82546-00	Creatine and creatinine	12.00
	82550-00	Creatine phosphokinase (CPK), blood; timed kinet ultraviolet method	20.90
	82552-00	isoenzymes	34.00
	82555-00	Colorimetric (MD/DO)	16.00
	82565-00	Creatinine; blood (MD/DO)	14.00
	82570-00	urine	15.00
	82575-00	clearance (MD/DO)	30.50
	82595-00	Cryoglobulin, blood	25.70
	82607-00	RIA (MD/DO)	34.50
	82615-00	Cystine and homocystine, urine; qualitative	51.00
	82626-00	Dehydroepiandrosterone (DHEA), RIA	75.00
	82628-00	Desipramine	50.00
	82640-00	Digitoxin (digitalis); blood, RIA	33.00
	82643-00	Digoxin, RIA	37.10
	82660-00	Drug screen (amphetamines, barbiturates, alkaloids) (MD/DO)	40.00
	82662-00	Immunoassay technique for drugs	31.50
	82664-00	Electrophoretic technique, not elsewhere specified	110.00
	82670-00	Estradiol, RIA (placental)	62.00
	82671-00	Estrogens; fractionated	15.00
	82672-00	total	70.50
	82677-00	Estriol; RIA	49.00
	82692-00	Ethosuximide	37.75
	82705-00	Fat orllipids, feces; screening	19.50
	82728-00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)	37.25
	82730-00	Fibrinogen, quantitative	28.50
	82745-00	Folic acid (folate), blood; bioassay	44.50
	82746-00	RIA	40.00
	82756-00	Free thyroxine index (T-7) (MD/DO)	28.50
	82784-00	Gammaglobulin, E (e.g., RIA, EIA)	44.00
	82785-00	Gammaglobulin, E (MD/DO)	32.50
	82792-00	Gases, blood, oxygen saturation; by calculation from pO2 (MD/DO)	35.90
	82801-00	Gasses, blood; pCO2	10.50
	82941-00	Gastrin, RIA	35.00
	82946-00	Glucagon tolerance test	20.00
	82947-00	Glucose; except urine (for example, blood, spinal fluid, joint fluid) (MD/DO)	14.00
	82948-00	blood, stick test	10.50
	82949-00	fermentation (MD/DO)	10.25
	82950-00	post glucose dose (includes glucose)	16.00

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82951-00	tolerance test (GTT), three specimens (includes glucose) (MD/DO)	40.50
82952-00	tolerance test, each additional beyond three specimens	23.25
82954-00	Glucose, urine	7.00
82977-00	Glutamyl transpeptidase, gamma (GGT)	16.30
83000-00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	45.00
83001-00	RIA (MD/DO)	45.90
83002-00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	50.00
83003-00	Growth hormone, human (HGH) (somatotropin); RIA	48.00
83010-00	Haptoglobin; chemical	37.00
83015-00	Heavy metal screen (arsenic, bismurth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)	90.00
83020-00	Hemoglobin; electrophoresis (includes A2, S, C, etc.)	10.00
83036-00	Hemoglobin; glycosylated	22.50
83050-00	methemoglobin, quantitative	12.50
83051-00	plasma	14.55
83150-00	Homovanillic acid (HVA), urine	16.00
83497-00	Hydroxyindolacetic acid, 5-(HIAA), urine	44.80
83498-00	Hydroxyprogesterone, 17-d, RIA	68.95
83523-00	Imipramine (MD/DO)	50.00
83540-00	Iron, serum; chemical (MD/DO)	16.40
83550-00	Iron binding capacity, serum; chemical	21.25
83555-00	automated	27.60
83565-00	radioactive uptake method	27.50
83582-00	Ketogenic steroids, urine; 17-(17-KGS)	43.90
83589-00	Ketosteroids, 17-(17-KS), urine; total	42.00
83615-00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method	20.50
83620-00	Lactic dehydrogenase (LDH), blood colorimetric or fluorometric (MD/DO)	16.50
83625-00	isoenzymes, electrophoretic separation and quantitation	28.00
83631-00	Lactic dehydrogenase (LDH), CSF	11.00
83645-00	Lead, screening; blood	11.00
83655-00	Lead, quantitative; blood	35.00
83690-00	Lipase, blood (MD/DO)	22.00
83700-00	total	20.00
83705-00	fractionated	23.00
83715-00	Lipoprotein, blood; electrophoretic separation and quantitation (phenotyping)	30.00
83718-00	Lipoprotein high density cholesterol by precipitation method	18.80
83719-00	Lipoprotein very low density cholesterol VLDL cholesterol) by ultracentrifugation	24.00
83720-00	Lipoprotein cholesterol fractionation calculation by formula	19.00
83725-00	Lithium, blood, quantitative (MD/DO)	20.85
83735-00	Magnesium, blood; chemical (MD/DO)	17.55
83750-00	atomic absorption	20.00
83835-00	Metanephrines, urine (MD/DO)	49.00
83916-00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis	61.75
83930-00	Osmolality; blood (MD/DO)	10.30
83945-00	Oxalate, urine	35.00
83947-00	Oxybutyric acid, beta	15.20
83970-00	Parathormone, RIA (MD/DO)	108.50
84035-00	Phenylketones; blood, qualitative	15.00
84045-00	Phenytoin (MD/DO)	31.00
84060-00	Phosphatase, acid; blood (MD/DO)	22.00
84065-00	prostatic fraction (MD/DO)	25.00
84066-00	prostatic fraction, RIA	48.00
84075-00	Phosphatase, alkaline, blood (MD/DO)	15.80
84078-00	heat stable (total not included)	16.80
84080-00	isoenzymes, electrophoretic method (MD/DO)	41.00

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84100-00	Phosphorus (phosphate); blood (MD/DO)	14.00
84105-00	urine (MD/DO)	15.50
84126-00	Porphyrins, feces, quantitative	33.50
84132-00	Potassium; blood (MD/DO)	14.25
84133-00	urine	11.00
84136-00	Pregnanediol; other method (specify)	15.00
84141-00	Primidone (MD/DO)	40.50
84142-00	Procainamide	43.00
84144-00	Progesterone, any method (MD/DO)	50.00
84146-00	Prolactin, RIA (MD/DO)	50.00
84155-00	Protein, total, serum; chemical	14.10
84165-00	Protein, total, serum; electrophoretic fractionation and quantitation (MD/DO)	27.00
84175-00	Protein, other sources, quantitative (MD/DO)	19.50
84180-00	Protein, urine; quantitative, 24-hour specimen (MD/DO)	18.00
84185-00	Bence-Jones	12.20
84190-00	electrophoretic fractionation and quantitation (MD/DO)	27.35
84195-00	Protein, spinal fluid; semi-quantitative (Pandy)	19.00
84202-00	Protoporphyrin, RBC; quantitative (MD/DO)	13.00
84203-00	screen (MD/DO)	9.00
84207-00	Pyridoxine (Vitamin B-6)	6.00
84208-00	Pyrophosphate vs urate, crystals (polarization)	15.50
84220-00	Pyruvic Kinase, RBC	41.90
84230-00	Quinidine, blood	31.00
84231-00	Radioimmunoassay (RIA) not elsewhere specified	52.00
84233-00	Receptor assay; estrogen (estradiol)	58.00
84238-00	non-endocrine (e.g., acetylcholine) (specify receptor)	103.10
84244-00	Renin (angiotensin I); (RIA)	65.70
84275-00	Sialic acid, blood	78.00
84295-00	Sodium; blood (MD/DO)	14.75
84300-00	urine	15.50
84403-00	Testosterone, blood, RIA (MD/DO)	79.30
84408-00	Tetrahydrocannabinol THC (marijuana)	30.00
84420-00	Theophylline, blood, or saliva (MD/DO)	32.00
84435-00	Thyroxine, CPB or resin uptake (MD/DO)	16.00
84436-00	Thyroxine, true, RIA (MD/DO)	19.25
84439-00	Thyroxine, free, RIA (MD/DO)	20.00
84442-00	Thyroxine binding globulin (TBG) (MD/DO)	35.20
84443-00	Thyroid stimulating hormone (TSH), RIA (MD/DO)	40.00
84447-00	Toxicology, screen; general (MD/DO)	68.30
84448-00	sedative (MD/DO)	40.00
84450-00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method (MD/DO)	16.00
84455-00	coloraimetric or fluorometric (MD/DO)	14.00
84460-00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method (MD/DO)	16.00
84465-00	colorimetric or fluorometric	15.50
84478-00	Triglycerides, blood (MD/DO)	15.00
84479-00	Triiodothyronine (t-3), resin uptake	19.80
84480-00	Triiodothyronine, true, RIA (MD/DO)	50.00
84520-00	Urea nitrogen, blood (BUN); quantitative (MD/DO)	14.50
84550-00	Uric acid; blood, chemical (MD/DO)	15.00
84555-00	uricase, ultraviolet method (MD/DO)	17.40
84560-00	Uric acid, urine (MD/DO)	20.00
84580-00	Urobilinogen, urine; quantitative, timed specimen	12.00
84585-00	Vanillymandelic acid (VMA), urine	53.60

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84630-00	Zinc, quantitative; blood	28.10
84702-00	Gonadotropin, chorionic; quantitative	28.30
84703-00	qualitative	20.00
84999-00	Unlisted chemistry or toxicology procedure	34.00

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke (MD/DO)	$ 8.00
85002-00	Ivy or template (MD/DO)	21.40
85007-00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation) (MD/DO)	11.25
85009-00	differential WBC count, buffy coat	19.00
85012-00	eosinophil count, direct (MD/DO)	14.00
85014-00	hematocrit (MD/DO)	9.00
85018-00	hemoglobin, colorimetric (MD/DO)	9.50
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only) (MD/DO)	19.00
85022-00	hemogram, automated, and manual differential WBC count (CBC) (MD/DO)	24.25
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	31.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	23.00
85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	27.20
85027-00	hemogram, and platelet count, automated (MD/DO)	15.25
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	10.50
85030-00	4 or more indices	15.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes) (MD/DO)	22.00
85041-00	red blood cell (RBC) only	8.00
85044-00	reticulocyte count (MD/DO)	13.50
85048-00	White blood cell (WBC) (MD/DO)	10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	50.50
85095-00	Bone marrow smear and/or cell block; aspiration only	87.00
85097-00	Bone marrow smear and/or cell block; smear interpretation only MD/DO)	75.00
85100-00	aspiration, staining, and interpretation (MD/DO)	114.00
85102-00	Bone marrow needle biopsy (MD/DO)	94.00
85103-00	staining and interpretation (MD/DO)	115.00
85105-00	interpretation only (MD/DO)	81.50
85210-00	Clotting; factor II, prothrombin, specific	14.00
85240-00	factor VIII (AHG), 1 stage	77.20
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	14.00
85368-00	Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)	11.00
85540-00	Leukocyte alkaline phosphatase with count	27.00
85544-00	Lupus erythematosus (LE) cell prep (MD/DO)	20.00
85548-00	Morphology of red blood cells only	

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	(MD/DO)	27.00
85575-00	Platelet; adhesiveness (in vivo)	11.00
85580-00	count (Rees-Ecker) (MD/DO)	14.00
85585-00	estimation on smear only (MD/DO)	9.00
85590-00	phase microscopy (MD/DO)	15.00
85595-00	electronic technique (MD/DO)	14.00
85610-00	Prothrombin time (MD/DO)	13.00
85618-00	Prothrombin-Proconvertin, P&P (Owren)	9.80
85630-00	Red blood cell size (Price-Jones)	12.00
85650-00	Sedimentation rate (ESR); Wintrobe type (MD/DO)	11.00
85651-00	Westergren type (MD/DO)	10.00
85660-00	Sickling of RBC, reduction, slide method (MD/DO)	12.00
85670-00	Thrombin time; plasma	25.00
85730-00	Thromboplastin time, partial; plasma or whole blood (MD/DO)	19.00

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 (MD/DO)	$ 19.00
86004-00	warm	15.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube (MD/OD)	16.00
86007-00	each additional antigen (MD/DO)	25.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	20.00
86009-00	each additional antigen	37.00
86012-00	Antibody absorption, cold auto absorption; per serum	15.50
86013-00	Antibody absorption, cold auto absorption; differential (MD/DO)	8.00
86016-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	27.00
86017-00	with ABO+Rh(D) typing (for blood instead of complete crossmatch	15.00
86018-00	enzyme technique, including antihuman globulin	10.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique (MD/DO)	26.00
86028-00	Saline or high protein, each (MD/DO)	27.50
86031-00	Antihuman globulin test; direct, 1-3 dilutins (MD/DO)	15.25
86032-00	indirect, qualitative (MD/DO)	17.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.00
86038-00	Antinuclear antibodies (ANA), RIA	30.00
86060-00	Antistreptolysin O; titer (MD/DO)	23.00
86063-00	screen (MD/DO)	15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	21.00
86067-00	other method (specify)	54.50
86069-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; each additional unit	35.50
86075-00	Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening first unit	18.25
86080-00	Blood typing; ABO only (MD/DO)	11.75
86082-00	ABO and Rho(D) (MD/DO)	21.30
86095-00	Blood typing, RBC, antigens other	

		than ABO or Rho(D); antiglobulin technique, each antigen (MD/DO)	20.00
	86096-00	direct, slide or tube, including Rh subtypes, each antigen	13.50
	86100-00	Blood typing; Rho(D) only	12.50
	86105-00	Blood typing; Rh genotyping, complete (MD/DO)	8.50
	86115-00	anti-Rh immunoglobulin testing (RhoGAM type)	45.00
	86128-00	Blood autotransfusion, including collection, processing, and storage	19.05
	86140-00	C-reactive protein (MD/DO)	14.00
	86149-00	Carcinoembryonic antigen (CEA); gel diffusion	51.00
	86151-00	Carcinoembryonic antigen (CEA); RIA or EIA (MD/DO)	60.00
	86158-00	Complement; $C^1$1 esterase	44.00
	86162-00	total (CH 50)	56.60
	86163-00	Complement; $C^1$3 esterase (MD/DO)	30.00
	86164-00	$C^1$4 esterase	28.00
	86171-00	Complement fixation tests, each (for example, cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis) (MD/DO)	16.50
	86225-00	Deoxyribonucleic acid (DNA) antibody (MD/DO)	40.00
	86229-00	Enzyme immunoassay for chemical constituent	15.80
	86235-00	Antibody to specific nuclear antigen, any method, each	65.50
	86244-00	Feto-protein, alpha-1, RIA or EIA	49.70
	86255-00	Fluorescent antibody; screen (MD/DO)	28.00
	86256-00	titer (MD/DO)	34.00
	86265-00	Frozen blood, preparation for freezing, each unit, including processing and collection	50.10
	86277-00	Growth hormone, human (HGH), antibody, RIA	17.00
	86280-00	Hemagglutination inhibition tests (HAI), each (for example, rubella, viral) (MD/DO)	19.00
	86282-00	Hemolysins and agglutinins, auto, screen, each	21.25
	86287-00	Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA, RIA or EIA	26.70
	86288-00	Hepatitis B core antigen (HBcAg), RIA	27.00
	86289-00	Hepatitis B core antibody; RIA (HBcAg) (MD/DO)	35.00
	86291-00	Hepatitis B surface antibody (MD/DO)	26.70
	86293-00	Hepatitis Be antigen (MD/DO)	33.00
	86296-00	Hepatitis A antibody (MD/DO)	33.74
	86298-00	IgG antibody	40.00
	86299-00	IgM antibody	35.40
	86300-00	Heterophile antibodies; screening (includes monotype test), slide or tube (MD/DO)	15.00
	86305-00	quantitive titer (MD/DO)	20.00
	86312-00	HIV (HTLV-III) antibody detection; immunoassay	22.00
	86314-00	confirmatory test (e.g., Western blot)	47.00
	86320-00	Immunoelectrophoresis; serum, each	65.50
	86325-00	other fluids (e.g., urine) with concentration, each specimen	65.50
	86329-00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify) (MD/DO)	50.00
	86335-00	Immunoglobulin typing (Gc, Gm,	

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	Inv), each	15.00
86357-00	Insulin antibodies, RIA	123.70
86376-00	Microsomal antibody (thyroid); RIA	29.40
86377-00	other method (specify)	47.70
86382-00	Neutralization test, viral	9.50
86403-00	Particle agglutination, rapid test for infectious agent, each antigen	14.00
86422-00	Radioallergosorbent test, in vitro testing for allergen-specific IgE (for example, RAST, MAST, FAST, IP, PRIST, etc.); 6 or more tests	15.50
86423-00	Radioimmunosorbent test IgE, quantitative (MD/DO)	35.00
86430-00	Rheumatoid factor, latex fixation	18.40
86455-00	Skin test; anergy testing, 1 or more antigens	25.00
86490-00	coccidioidomycosis	14.00
86510-00	histoplasmosis	16.00
86580-00	Skin test; tuberculosis or intradermal (MD/DO)	9.50
86585-00	tuberculosis, tine test (MD/DO)	8.00
86590-00	Streptokinase, antibody	16.00
86592-00	Syphilis, test; qualitative	12.75
86593-00	quantitative	12.00
86594-00	Thyroid autoantibodies	48.00
86595-00	Tissue culture	62.55
86600-00	Toxoplasmosis, dye test	16.00
86650-00	Treponema antibodies, fluorescent, absorbed (MD/DO)	39.40
86800-00	Thyroglobulin antibody, RIA	42.40
86812-00	Tissue typing; HLA typing, A, B, or C (for example, A10, B7, B27), single antigen	65.00

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)	27.00
87045-00	stool	28.40
87060-00	throat or nose	12.50
87070-00	any other source	23.00
87072-00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	16.20
87075-00	Culture, bacterial, any source; anaerobic (isolation)	29.00
87081-00	Culture, bacterial, screening only, for single organisms	14.50
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083-00	multiple organisms	17.25
87084-00	with colony estimation from density chart	10.00
87085-00	with colony count	29.00
87086-00	Culture, bacterial, urine; quantitative, colony count (MD/DO)	19.00
87087-00	commercial kit	11.25
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
87106-00	Culture, fungi, definitive identification of each fungus	27.60
87109-00	Culture, mycoplasma, any source	43.50

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87116-00	Culture, tubercle or other acid-fast bacilli (for example, TB, AFB, mycobacteria); source, isolation only	31.00
87117-00	concentration plus isolation	36.40
87118-00	Culture, mycobacteria, definitive identification of each organism	25.00
87140-00	Culture, typing; fluorescent method, each antiserum	14.50
87147-00	Serologic method, agglutination grouping, per antiserum (MD/DO)	20.00
87151-00	serologic method, speciation	19.00
87158-00	other methods	52.40
87163-00	Culture, any source, additional identification methods required (MD/DO)	25.00
87164-00	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection (MD/DO)	8.00
87174-00	Endotoxin, bacterial (pyrogens); chemical	40.00
87177-00	Ova and parasites, direct smears, concentration and identification (MD/DO)	25.30
87181-00	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic (MD/DO)	15.00
87184-00	disc method, each plate (12 or less discs)	18.75
87186-00	microtiter, minimum inhibitory concentration (MIC), 8 or less any number of antibiotics (MD/DO)	22.50
87188-00	macrotube dilution method, each antibiotic	16.50
87205-00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types (MD/DO)	14.60
87206-00	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	30.00
87207-00	special stain for inclusion bodies or intracellular parasites (for example, malaria, kala azar, herpes)	31.00
87208-00	direct or concentrated, dry, for ova and parasites (MD/DO)	13.00
87210-00	wet mount with simple stain for bacteria, fungi, ova, and/or parasites (MD/DO)	12.25
87211-00	wet and dry mount, for ova and parasites (MD/DO)	12.00
87220-00	Tissue examination for fungi (for example, KOH slide) (MD/DO)	12.50
87250-00	Virus identification; inoculation of embryonated eggs, or small animal, includes observation and dissection	39.00

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 (MD/DO)	$ 30.00
88106-00	filter method only with interpretation	31.70
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	37.00

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88130-00	Sex chromatin identification; Barr bodies	15.50
88150-00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to 3 smears; screen by technical under physician supervision	16.75
88151-00	requiring interpretation by physician	19.25
88155-00	with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index)	13.50
88160-00	Cytopathology, any other source; screening and interpretation (MD/DO	28.50
88161-00	preparation, screening, and interpretation (MD/DO)	40.90
88162-00	extended study involving over 5 slides and/or multiple stains	55.00
88170-00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	90.00
88172-00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	27.50
88173-00	interpretation and report	88.00
88260-00	Chromosome analysis; count 5 cells, screening, with banding	400.00
88262-00	count 15-20 cells, 2 karyotypes, with banding	363.40
88267-00	Chromosone analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotope, with banding	453.00

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

Code	Service	Maximum Fee
88300-00	Surgical pathology, gross examination only	$ 25.00
88302-00	Surgical pathology, gross and microscopic; examination of presumptively normal tissue, for identification and record purposes (MD/DO)	36.00
88304-00	Surgical pathology, gross and microscopic; diagnostic examination of presumptively abnormal tissue; uncomplicated specimen (MD/DO)	45.00
88305-00	single complicated or multiple uncomplicated specimen(s), without complex dissection	73.90
88307-00	single complicated specimen requiring complex dissection or multiple complicated specimens	128.90
88309-00	Complex diagnostic problem with or without extensive dissection (MD/DO)	185.60
88311-00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	20.90
88312-00	Special stains; Group I stains for microorganisms (MD/DO)	25.00
88313-00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	18.50
88314-00	histochemical staining with frozen section(s)	10.00

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88321-00	Consultation and report on referred slides prepared elsewhere	67.95
88323-00	Consultation and report on referred material requiring preparation of slides	52.50
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	48.00
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

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

Code	Service	Maximum Fee
89050-00	Cell count, miscellaneous body fluids (e.g., CSFm joint fluid), except blood	20.40
89051-00	Cell count, miscellaneous body fluids (e.g. CSF, joint fluid), except blood, with differential count	15.50
89060-00	Crystal identification by compensated polarizing lens analysis, cynovial fluid	16.00
89125-00	Fat stain, feces, urine, or sputum	24.30
89130-00	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology (MD/DO)	61.00
89190-00	Nasal smear for eosinophils (MD/DO)	12.00
89205-00	Occult blood, any source except feces	11.00
89300-00	Semen analysis; presence and/or motility of sperm, including Huhner test	32.00
89310-00	motility and count	19.00
89320-00	Semen analysis; complete (volume count, motility and differential) (MD/DO)	39.00
89325-00	Sperm antibodies	109.00
89330-00	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkheit test	32.00
89350-00	Sputum, obtaining specimen, aerosol induced technique (MD/DO)	17.10
89360-00	Sweat collection by iontophoresis	41.00

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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 (DDS)	$ 28.00
02150-00	two surfaces, permanent (DDS)	40.00
02160-00	three surfaces, permanent (DDS)	53.00
02161-00	four or more surfaces, permanent (DDS)	64.00
	Acrylic or Plastic Restorations	
02330-00	Resin; one surface, anterior (DDS)	$ 38.00

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02331-00	two surfaces, anterior (DDS)	54.00
02332-00	three surfaces, anterior (DDS)	70.00
02335-00	four or more surfaces or (involving incisal angle (DDS)	70.00
	Inlay Restorations	
02530-00	Inlay - metallic; three surfaces	310.00
02540-00	Onlay - metallic; per tooth (in addition to inlay)	395.00
	Crowns - Single Restoration Only	
02711-00	Plastic, prefabricated	$ 135.00
02740-00	Crown; porcelain/ceramic substrate	420.00
02750-00	porcelain fused to high noble metal	375.00
02751-00	porcelain fused to predominantly base metal	360.00
02752-00	porcelain fused to noble metal	360.00
02790-00	full cast high noble metal	355.00
02791-00	full cast predominantly base metal	310.00
02792-00	full cast noble metal	305.00
02810-00	3/4 cast metallic	380.00
02815-00	Incision and drainage of abscess; intraoral	90.00
02824-00	Removal of tooth; bony impaction presenting unusual difficulties and circumstances	160.00
02825-00	Removal of tooth, soft tissue impaction (DDS)	90.00
02826-00	partial bony impaction (DDS)	115.00
02827-00	complete bony impaction (DDS)	140.00
02828-00	Dental root resection	96.00
02829-00	Apicoectomy; performed as separate surgical procedure (per root)	200.00
02830-00	stainless steel (DDS)	85.00
02848-00	Osseous surgery; per quadrant	350.00
	Other Restorative Services	
02910-00	Recement inlays (DDS)	28.00
02920-00	Recement crowns (DDS)	25.00
02940-00	Sedative fillings (DDS)	25.00
02950-00	Crown buildups, including any pins (DDS)	80.00
02960-00	Labial veneer (laminate); chairside	165.00
	Endodontics	
03110-00	Pulp cap; direct (excluding final restoration)	$ 20.00
03120-00	indirect (excluding final restoration)	12.00
03220-00	Therapeutic pulpotomy	40.00
	Root Canal Therapy	
03310-00	One canal (excludes final restoration) (DDS)	$ 195.00
03320-00	Two canals (excludes final restoration) (DDS)	238.00
03330-00	Three canals (excludes final restoration) (DDS)	325.00
	Periapical Services	
03410-00	Apicoectomy; (per tooth) first root (DDS)	$ 200.00
	Other Endodontic Procedures	
03950-00	Canal preparation and fitting of preformed dowel or post	$ 85.00
03960-00	Bleaching of discolored tooth	40.00

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		Prosthodontics, Removable Complete Dentures - Including Routine Post-Delivery Care	
05110-00		Complete upper (DDS)	$ 495.00
05120-00		Complete lower (DDS)	500.00
05130-00		Immediate upper (DDS)	537.00
05140-00		Immediate lower (DDS)	550.00
		Partial Dentures - Including Routine Post-Delivery Care	
05212-00		Lower, partial; acrylic base (including any conventional clasps and rests	537.00
05213-00		Upper partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests	565.00
05214-00		Lower partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests) ~~575.00~~	565.00
05215-00		Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests ~~565.00~~	575.00
05216-00		Lower; high noble cast base with acrylic saddles (including any conventional clasps and rests (DDS)	595.00
		Adjustments to Dentures	
05410-00		Adjust complete denture; upper	25.00
05421-00		Adjust partial denture; upper	30.00
05422-00		lower	25.00
		Repairs to Dentures	
05610-00		Repair acrylic saddle or base	48.00
05620-00		Repair (DDS)	50.00
05630-00		Repair or replace broken clasp (DDS)	45.00
05640-00		Replace broken teeth; per tooth (DDS)	48.00
05650-00		Add tooth to existing partial denture (DDS)	65.00
05660-00		Add clasp to existing partial denture (DDS)	90.00
		Denture Relining	
05730-00		Relining complete upper denture (chairside) (DDS)	$ 135.00
05750-00		Relining complete upper denture (laboratory) (DDS)	158.00
05760-00		Relining upper partial denture (laboratory) (DDS)	160.00
		Other Removable Prosthetic Services	
05820-00		Temporary (partial stayplate), denture upper (DDS)	$ 200.00
05850-00		Tissue conditioning; per denture unit (DDS)	39.00
		Bridge Pontics	
06210-00		Pontic; cast high noble metal $ ~~135.00~~	350.00
06240-00		porcelain fused to high noble metal	363.00
06241-00		porcelain fused to predominantly base metal	355.00
06242-00		porcelain fused to noble metal	350.00
		Retainers	

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06545-00	Cast metal retainer for acid etch bridge	$ 132.00
	Prosthodontics, Fixed	
06640-00	Replace broken facing with acrylic (DDS)	$ 70.00
	Bridge Retainers -- Crowns	
06750-00	Crown; porcelain fused to high noble metal	$ 377.00
06751-00	porcelain fused to predominantly base metal	360.00
06752-00	porcelain fused to noble metal	355.00
06790-00	full cast high noble metal	355.00
06791-00	full cast predominantly base metal	295.00
06792-00	full cast noble metal	300.00
06801-00	Diagnostic exam and DXL	20.00
06802-00	Prevention	25.00
06803-00	Restorative	52.50
06804-00	Endodontics	285.00
06808-00	Dental oral surgery	45.00
06809-00	Unlisted dental procedures	24.00
	Other Fixed Prosthetic Services	
06930-00	Recement bridge (DDS)	$ 40.00
	Oral Surgery Extractions -- Includes Local Anesthesia and Routine Postoperative Care	
07110-00	Single tooth (DDS)	$ 35.00
07120-00	Each additional tooth (DDS)	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 (DDS)	$ 75.00
07220-00	Removal of impacted tooth; soft tissue (DDS)	86.00
07230-00	Removal of the impacted tooth; partially bony (DDS)	119.00
07240-00	Removal of impacted tooth; completely bony (DDS)	140.00
07241-00	Removal of impacted tooth; completely bony, with unusual surgical complications (DDS)	150.00
07250-00	Surgical removal of residual tooth roots (DDS)	75.00
	Other Surgical Procedures	
07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments) (DDS)	$ 125.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	140.00
07286-00	Biopsy of oral tissue; soft	90.00
	Alveoplasty - Surgical Preparation of Ridge For Dentures	
07310-00	Alveoloplasty (per quadrant) in conjunction with extractions (DDS)	$ 75.00
	Surgical Incision	
07510-00	Incision and drainage of	

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		abscess, intraoral soft tissue (DDS)	$ 45.00
		Other Repair Procedures	
	07960-00	Frenulectomy	$ 90.00
		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	$ 8.00
	09211-00	Regional block anesthesia	10.00
	09220-00	General; first 30 minutes (DDS)	90.00
	09230-00	Analgesia (DDS)	12.00
		Professional Consultation	
	09310-00	Consultation; per session	35.00
	09420-00	Hospital call	14.00
	09430-00	Office visit during regularly scheduled office hours	15.00
		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 (DDS)	$ 15.00
	~~09991-00~~		~~25.00~~
	~~09993-00~~		~~30.00~~
		Surgery	
	21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	2,960.00
	21203-00	mandibular ramus (osteotomy)	2,950.00
	21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,400.00
	40808-00	Biopsy, vestibule of mouth	107.00
	40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	100.00
	41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	150.00
	~~42115-00~~		
	42150-00	Removal of exostosis, bony palate	280.00
		Radiology -- Dental	
	70320-00	Radiologic examination, teeth; complete, full mouth	45.00
	70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	35.00
	70330-00	bilateral	90.00
	70350-00	Caphalogram, orthodontic	40.00
	70355-00	Orthopantogram	35.00
	76100-00	Radiologic examination, single plane body section (e.g., tomography)	73.00
		Surgical Pathology -- Dental	
	88304-00	Surgical pathology, gross and microscopic	

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	examination of presumptively abnormal tissue(s); uncomplicated specimen	40.00
	Office Dental Services	
90000-00	Office dental service, new patient; brief service	25.00
90010-00	limited service	33.00
90020-00	comprehensive service	75.20
90030-00	Office dental service, established patient; minimal service	24.00
90040-00	brief service	25.00
90050-00	limited service	34.00
90060-00	intermediate service	44.00
90070-00	extended service	55.00
	Hospital Dental Services	
90240-00	Subsequent hospital care, each day; brief services	$ 35.00
90250-00	limited services	41.75
90260-00	intermediate services	60.00
	Dental Consultations	
90600-00	Initial consultation; limited	$ 35.00
90605-00	intermediate	62.00
90620-00	comprehensive	95.00
	Dental Injections	
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	$ 15.00
	Cardiovascular -- Dental	
93000-00	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	$ 15.00
97010-00	Physical-dental medicine treatment to one area; hot or cold packs	25.00
97110-00	Physical-dental medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	28.50
97128-00	ultrasound	25.00

5221.2600 OPTOMETRISTS~~,-OPTICIANS~~.

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.

~~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"-have-the meanings-given-them-in-part-5221.1100.~~

~~B.--"Level-of-service"-for-the-purpose-of-this-rule has-the-following-meanings:~~

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~~(1) "Minimal service" means a level of service that may be provided by paraoptometric personnel but supervised by a doctor of optometry. For example, determination of visual acuity or verification of a prescription.~~

~~(2) "Brief service" means a level of service pertaining to the evaluation and treatment of a condition requiring only any abbreviated history and examination, and involving less time or skill than a limited optometric service. For example, examination of a patient with subconjunctival hemmorrhage or evaluation and replacement of a lost contact lens.~~

~~(3) "Limited service" means a level of service pertaining to the evaluation of an acute problem or the periodic re-evaluation of a problem, including an interval history and examination, the review of the effectiveness of past treatment, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings or optometric management. For example, progress evaluation of a treatment program involving contact lenses, low vision, or vision therapy, or periodic re-evaluation of an intraocular lens implant.~~

~~(4) "Intermediate service" means a level of service that usually involves an optometric eye health examination that may include but is not limited to history, general observation, external ocular and adnexal examination, and other diagnostic procedures as warranted. Intermediate services do not usually include determination of the refractive state, but may do so in an established patient who is under continuing active treatment.~~

~~(5) "Extended level of service" means a level of service requiring an unusual amount of effort or judgment, including a detailed history, review of medical records, examination, and a formal conference with patient, family, or staff, or a comparable optometric diagnostic or therapeutic service.~~

~~(6) "Comprehensive service" means a level of service in which a general evaluation of the complete visual~~

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system is made. The comprehensive services constitute a single service entity, but need not be performed in one session. When indicated in the doctor's professional judgment, this service may include, but is not limited to history, general health observation, external examination of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination, biomicroscopy, tonometry, gross visual fields, and blood pressure screening. It may include initiation of diagnostic and treatment programs, or referral, as indicated. The treatment services include the prescription of lenses, other therapy, or arranging for special optometric diagnostic or treatment services, consultation, or laboratory procedures, as may be indicated.

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$48.00
06502-00	Bifocal eyeglass lenses (one lens)	70.20
06503-00	Trifocal eyeglass lenses (one lens)	90.00
06504-00	Lenticular eyeglass lenses (one lens)	21.00
06506-00	Eyeglass frames	67.00
06510-00	Tinting for lenses	15.00
06587-00	Contact lenses, soft (one lens)	80.00
06588-00	Contact lenses, hard (one lens)	70.00
06589-00	Dispensing fee; single vision lenses	25.00
06590-00	bifocal lenses	30.00
06591-00	trifocal lenses	32.00
09201-00	Eye examination with complete visual fields included	44.00
09213-00	Eye refraction	29.00
	Office Services	
90000-00	New patient, brief service	$22.00
90010-00	limited service	28.00
90015-00	intermediate service	38.00
90017-00	extended service	50.00
90020-00	comprehensive service	50.00
90030-00	Established patient, minimal service	15.00
90040-00	brief service	19.00
90050-00	limited service	25.00
90060-00	intermediate service (does not include determination of the refractive state)	31.00
90070-00	extended service	45.00
90080-00	comprehensive service	49.00
92002-00	New patient, intermediate service	39.00
92004-00	comprehensive service, one or more visits	50.00
92012-00	Established patient, intermediate service (includes determination of the refractive state)	38.00
92014-00	comprehensive service, one or more visits	44.00
92060-00	Sensorimotor examination with diagnostic evaluation	50.00
92065-00	Orthoptic and/or pleoptic training, with continuing direction and evaluation	40.00

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~~92081-00~~	~~Visual field examination with medical diagnostic evaluation, tangent screen, autoplot or equivalent~~	~~20.00~~
~~92082-00~~	~~quantitative perimetry (for example, several isopters on Goldmann perimeter or equivalent~~	~~42.50~~
~~92083-00~~	~~static and kinetic perimetry, or equivalent~~	~~60.00~~
~~92100-00~~	~~Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day~~	~~10.00~~
~~92140-00~~	~~Provocative tests for glaucoma, with medical diagnostic evaluation~~	~~15.00~~
~~92225-00~~	~~Opthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomocroscopy), with medical diagnostic evaluation, initial~~	~~22.20~~
~~92250-00~~	~~Ophthalmoscopy, with medical diagnostic evaluation, with fundus photography~~	~~15.00~~
~~92285-00~~	~~Extended ocular photography for documentation of progress~~	~~10.00~~
~~92287-00~~	~~Specular endothelial microscopy with photographic documentation, evaluation and report, with flouroscein antiography~~	~~38.00~~
~~92310-00~~	~~Prescription and management of corneal contact lens, both eyes, except for aphakia~~	~~50.00~~
~~92312-00~~	~~corneal lens for aphakia, two eyes~~	~~130.00~~
~~92325-00~~	~~Modification of contact lens~~	~~20.00~~
~~92326-00~~	~~Replacement of contact lens~~	~~58.00~~
~~92340-00~~	~~Treatment with spectacles, except for aphakia, monofocal~~	~~49.00~~
~~92341-00~~	~~bifocal~~	~~64.00~~
~~92342-00~~	~~multifocal, other than bifocal~~	~~84.00~~
~~92370-00~~	~~Repair and adjusting spectacles, except for aphakia~~	~~68.95~~
~~92390-00~~	~~Supply of all spectacle lenses, except for aphakia and low vision aids (all combinations, nonspecific), one lens only (enter two units for a pair)~~	~~79.00~~
~~92391-00~~	~~Supply of contact lenses, except prosthesis for aphakia, one lens only (enter two units for a pair)~~	~~108.00~~
~~99056-00~~	~~Services provided at request of patient in a location other than optometrist's office that are normally provided in the office~~	~~6.00~~

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)	$ 53.00
06502-00	Bifocal eyeglass lenses (one lens)	69.95
06503-00	Trifocal eyeglass lenses (one lens)	85.00
06504-00	Lenticular eyeglass lenses (one lens)	24.00
06506-00	Eyeglass frames	80.00
06510-00	Tinting for lenses	12.00
06587-00	Contact lenses, soft (one lens)	109.00
06588-00	Contact lenses, hard (one lens)	61.00
06593-00	Dispensing fee, frames for lenses	70.20

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Office Services

92004-00	New patient; comprehensive service	$ 34.00
92012-00	Established patient; intermediate service	40.00
92340-00	Treatment with spectacles, except for aphakia; monofocal	50.00

5221.2700 AUDIOLOGISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to audiologists holding a certificate of clinical competency (CCC-A) or to audiologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

Code	Service	Maximum Fee
06665-00	Monaural dispensing fee (CCC-A/CFY)	190.00
21010-00	Basic hearing evaluation (CCC-A/CFY)	40.00
21020-00	Basic hearing evaluation (CCC-A/CFY)	45.00
21021-00	Limited hearing evaluation (CCC-A/CFY)	32.00
21022-00	Extended hearing evaluation (CCC-A/CFY)	64.00
21031-00	Limited site of auditory lesion evaluation (CCC-A/CFY)	16.00
21032-00	Extended site of auditory lesion evaluation (CCC-A/CFY)	32.00
21050-00	Basic prescription hearing aid evaluation (CCC-A/CFY)	40.00
21052-00	Extended prescription hearing aid evaluation (CCC-A/CFY)	45.00
21053-00	Performance evaluation of specific hearing aid (CCC-A/CFY)	20.00
21081-00	Hearing screening group (CCC-A/CFY)	9.50
22010-00	Basic speech, language, or voice evaluation (CCC-A/CFY)	80.00
92551-00	Screening test, pure tone, air only (CCC-A/CFY)	18.50
92553-00	air and bone (CCC-A/CFY)	33.00
92556-00	threshold and discrimination (CCC-A/CFY)	44.25
92557-00	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination) (CCC-A/CFY)	60.00
92566-00	Impedance testing (CCC-A/CFY)	18.00
92567-00	Tympanometry (CCC-A/CFY)	22.00
92582-00	Conditioning play audiomety (CCC-A/CFY)	30.00
~~92585-00~~	~~Brainstem evoked response recording (CCC-A/CFY)~~	~~.....~~
92590-00	Hearing ~~and~~ aid examination and selection; monaural (CCC-A/CFY)	50.00
~~92591-00~~	~~binaural (CCC-A/CFY)~~	~~.....~~
92592-00	Hearing aid check; monaural (CCC-A//CFY)	53.50
~~92593-00~~	~~binaural~~	~~30.00~~ ~~.....~~

5221.2750 SPEECH PATHOLOGISTS.

The following codes, service description, and maximum fees apply to speech pathologists holding a certificate of clinical

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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
~~06045-00~~	~~(CCC-SP/CFY)~~	~~35.00~~
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual (CCC-SP/CFY)	34.00
92508-00	group (CCC-SP/CFY)	21.00

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subp. 2. **~~Physical therapy.~~ 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) 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 re-education" (code 97112) 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) 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) means teaching individuals with neurological or musculoskeletal disorders to

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ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240) 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) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how to prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

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

H. "Kinetic activities" (code 97530) means services when there are neuromusculoskeletal dysfunction which limit the patient's performing the activities that are ordinarily prescribed under therapeutic exercise. ~~Time is spent developing specific, individualized therapeutic exercise and instructing the patient in how to perform them.~~

~~I. "Functional capacity evaluation" (code 97705) means an objective, directly observed, measurement of workers' ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator.~~

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. ~~The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.~~

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

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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. **Scope** 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~~,~~ ~~a hospital satellite clinic, or hospital out-patient setting~~.

Code	Service	Maximum Fee
	Modalities	
97010-00	Physical medicine treatment to one area; hot or cold packs ~~(RPT/OTR)~~	$ 17.00
97012-00	traction, mechanical ~~(RPT/OTR)~~	16.00
97014-00	electrical stimulation (unattended) ~~(RPT/OTR)~~	15.00
97016-00	vasopneumatic devices ~~(RPT/OTR)~~	16.00
97018-00	paraffin bath ~~(RPT/OTR)~~	20.00
97022-00	whirlpool ~~(RPT/OTR)~~	17.00
97024-00	diathermy ~~(RPT/OTR)~~	16.00
97028-00	ultraviolet ~~(RPT/OTR)~~	25.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises ~~(RPT/OTR)~~	$ 22.00
97112-00	neuromuscular reeducation ~~(RPT/OTR)~~	25.00
97114-00	functional activities ~~(RPT/OTR)~~	19.00
97116-00	gait training ~~(RPT/OTR)~~	23.00
97118-00	electrical stimulation (manual) ~~(RPT/OTR)~~	16.25
97120-00	iontophoresis ~~(RPT/OTR)~~	20.00
97122-00	traction, manual ~~(RPT/OTR)~~	18.00
97124-00	massage ~~(RPT/OTR)~~	17.25
97126-00	contrast baths	18.00
97128-00	ultrasound ~~(RPT/OTR)~~	16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	13.00
97220-00	Hubbard tank; initial 30 minutes each visit ~~(RPT/OTR)~~	45.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit ~~(RPT/OTR)~~	30.00
97500-00	Orthotics training (dynamic bracing, splinting), ~~upper~~ upper/lower extremities; initial 30 minutes, each visit ~~(RPT/OTR)~~	21.00
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 ~~(RPT/OTR)~~	25.00
97531-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit ~~(RPT/OTR)~~	20.00
97541-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50

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		Tests and Measurements	
97700-00		Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes ~~(RPT/OTR)~~	
	a.	Orthotic check-out;	
	b.	Prosthetic check-out;	
	c.	Activities of daily living check-out;	
	d.	Follow-up evaluation for extremity testing for strength, dexterity, or stamina	$ 21.00
97701-00		each additional 15 minutes	21.00
97720-00		Initial evaluation for ~~extremity~~ testing for strength, dexterity, or stamina; initial 30 minutes, each visit ~~(RPT/OTR)~~	32.00
97721-00		each additional 15 minutes (RPT/OTR)	25.00
97752-00		Muscle testing with torque curves during isometric and isokinetic exercise mechanized or computerized ~~evalators~~ evaluations with printout (e.g., by use of cybex or similar type machine); for extremities ~~(RPT/OTR)~~	55.00
97753-00		for trunk/back	134.40

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.

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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 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 ~~on-the-same-day~~.

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 (CHIRO/DC)	$ 30.00
09521-00	intermediate examination (CHIRO/DC)	40.00
09522-00	extensive examination (CHIRO/DC)	60.00
09530-00	Established patient; brief examination (CHIRO/DC)	25.00
09531-00	intermediate examination (CHIRO/DC)	40.00
09532-00	extensive examination (CHIRO/DC)	60.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office (CHIRO/DC)	$ 20.00
09541-00	subsequent; office (CHIRO/DC)	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 (CHIRO/DC)	$ 40.00
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00

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09556-00	(e.g., long leg, thoracolumbar lumbosocrol, or full-body corset type)	28.50
	Conjunctive Therapy/Modality - Office, Home, or Nursing Home	
09560-00	Application of hot pack (CHIRO/DC)	$ 10.00
09561-00	Application of cold pack (CHIRO/DC)	11.00
09562-00	Diathermy (CHIRO/DC)	12.00
09563-00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic (CHIRO/DC)	12.00
09564-00	Intersegmental motorized mobilization (CHIRO/DC)	12.00
09565-00	Muscle stimulation, manual (CHIRO/DC)	12.00
09566-00	Ultrasound therapy (CHIRO/DC)	11.00
09567-00	Traction (CHIRO/DC)	12.00
09568-00	Acupressure, manual or mechanical (CHIRO/DC)	12.00
09569-00	Acupuncture (CHIRO/DC)	15.00
09570-00	Whirlpool	10.00
09572-00	Infrared - heat lamp (CHIRO/DC)	7.00
09573-00	Ultraviolet (CHIRO/DC)	10.00
09574-00	Trigger point therapy (CHIRO/DC)	13.00
09591-00	Nutritional supplement	15.00
09592-00	Exercise consultation or instruction	~~25.00~~ 20.00
09593-00	Diet consultation/instruction (CHIRO/DC)	25.00

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

Code	Service	Maximum Fee
	Chest	
71010CHR	Radiologic examination, chest; (single view, posteroanterior) (CHIRO/DC)	$ 30.00
	Spine and Pelvis	
72010CHR	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral) (CHIRO/DC)	$ 60.00
72020CHR	Radiologic examination, spine; single view, (specify level) (CHIRO/DC)	38.00
72040CHR	Radiologic examination, spine, cervical; limited (CHIRO/DC)	44.00
72070CHR	Radiologic examination, spine; thoracic (CHIRO/DC)	55.00
72080CHR	thoracic, limited (anteroposterior and lateral) (CHIRO/DC)	52.00
72090CHR	scoliosis study, comprehensive (CHIRO/DC)	52.00
72100CHR	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral) (CHIRO/DC)	55.00
72120CHR	Radiologic exam, spine, lumbosacral, bending views only, minimum of four views	80.00
72170CHR	Radiologic examination, pelvis; limited (minimum two views) (CHIRO/DC)	44.00
72190CHR	complete; (minimum of three views) (CHIRO/DC)	90.00
	Upper Extremities	
73020CHR	Radiologic examination, shoulder;	

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	limited (one projection) (CHIRO/DC)	$ 30.00
73030-00	complete, minimum of two views	54.00
73070CHR	Radiologic examination, elbow; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73100CHR	Radiologic examination, wrist; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73110-00	complete, minimum of three views	50.00
73120CHR	Radiologic examination, hand (CHIRO/DC)	36.00
	Lower Extremities	
73500CHR	Radiologic examination, hip; limited (one view) (CHIRO/DC)	$ 35.00
73510CHR	Radiologic examination, hip; complete, minimum of two views (CHIRO/DC)	53.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	40.00
73562CHR	anteroposterior and lateral, with oblique(s), minimum of three views (CHIRO/DC)	55.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	70.00
73600CHR	Radiologic examination, ankle; limited (two views) (CHIRO/DC)	35.00
73610CHR	Radiologic examination, ankle; comprehensive (minimum of three views (CHIRO/DC)	50.00
73620-00	Radiologic examination; foot; anteroposterior and lateral views	32.00
73630-00	complete, minimum of three views	55.00
	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	
80019CHR	Automated multichannel tests; 19 or more clinical chemistry tests (indicate instrument use and number of tests performed) (CHIRO/DC)	$ 60.00
	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
81015CHR	Urinalysis; microscopic only (CHIRO/DC)	12.00
	Hematology	
85022CHR	Blood count; hemogram, automated, and differential WBC count (CBC)	$ 29.00
85031CHR	hemogram, manual, complete CBC	

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		(RBC, WBC, Hgb, HcT, differential and indices) (CHIRO/DC)	~~15.00~~ 20.00
	85548-00	Morphology of red blood cells, only	42.00

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	
~~02229-00~~	~~.....~~	~~$ 200.00~~
10060-00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	$ 50.00
10100*00	Incision and drainage of onychia or paronychia; single or simple (POD/DPM)	55.00
10101*00	multiple or complicated	75.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	20.00
11040-00	Debridement; skin, partial thickness	50.00
11050*00	Paring or curettement of benign lesion with or without chemical cauterization; single lesion (POD/DPM)	25.00
11051*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions	21.00
11052-00	more than four lesions (POD/DPM)	28.85
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), hands, feet; lesion diameter up to 0.5 centimeter (POD/DPM)	85.00
11421-00	lesion diameter 0.6 - 1.0 centimeters	99.00
11422-00	lesion diameter 1.1 - 2.0 centimeters	125.00
	Nails	
11700*00	Debridement of nails, manual; five or less (POD/DPM)	$ 20.00
11701-00	each additional, five or less (POD/DPM)	15.00
11710*00	Debridement of nails, electric grinder; five or less (POD/DPM)	26.00
11711-00	each additional, five or less (POD/DPM)	9.00
11730*00	Avulsion of nail plate, partial or complete simple; single	68.00
11750-00	Excision of nail and nail matrix, partial or complete, for permanent removal (POD/DPM)	200.00
11900*00	Injection, intralesional; up to and including seven lesions	35.00
	Other Procedures	

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17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (POD/DPM)	$ 28.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions (POD/DPM)	30.00
17340*00	Cryotherapy (CO2 slush, liquid N2)	22.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	42.00
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)	45.00
28080-00	Excision of Morton neuroma, single, each	465.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe	325.00
28126-00	Concylectomy, phalangeal base, single toe, each	350.00
28153-00	Resection, head of phalanx, toe	375.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	400.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)	593.00
28292-00	Keller, McBride, or Mayo type procedure	930.00
28308-00	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal	614.00
29405-00	Application of short leg cast (below knee to toes) (POD/DPM)	100.00
29425-00	Application of short leg case (below knee to toes); walking or ambulatory type	125.00
29540-00	Strapping; ankle (POD/DPM)	22.00
29550-00	toes (POD/DPM)	23.00
29580-00	Unna boot (POD/DPM)	35.00
29590-00	Dennis Browne splint strapping	25.00
36415*00	Routine venipuncture for collection of specimens	10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch (POD/DPM)	30.00

Radiology

73600-00	Radiologic examination, ankle; anteroposterior and lateral views (POD/DPM)	$ 40.00
73610-00	complete, minimum of three views	45.00
73620-00	Radiologic examination, foot; anteroposterior and lateral views (POD/DPM)	35.00
73630-00	complete, minimum of three views (POD/DPM)	51.00
73650-00	Radiologic examination; calcaneus, minimum of two views	30.00
73660-00	toe or toes, minimum of two views (POD/DPM)	30.00
80012-00	Automated multichannel test; 12 clinical chemistry tests	40.00
81000-00	Urinalysis; routine (pH, specify gravity, protein, tests for reducing substances such as glucose), with microscopy	11.00

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81002-00	routine, without microscopy	~~13.00~~	10.00
82947-00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid) (POD/DPM)		13.00
82948-00	blood stick test		12.00
85000-00	Bleeding time; Duke		6.00
85014-00	Blood count; hematocrit		9.00
85018-00	Blood count; hemoglobin, colorimetric (POD/DPM)		8.00
85022-00	hemogram, automated, and manual differential WBC count		40.00
85345-00	Coagulation time; Lee and White		7.50
87075-00	Culture, bacterial, any source; anaerobic (isolation)		14.00
87101-00	Culture, fungi, isolation; skin		18.00
88302-00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes		35.00
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen		40.00

Patient Visits

90000POD	New patient; brief service (POD/DPM)	$ 27.00
90010POD	limited service (POD/DPM)	35.00
90015POD	intermediate service (POD/DPM)	38.00
90017POD	extended service (POD/DPM)	45.00
90020POD	comprehensive service (POD/DPM)	35.00
90030POD	Established patient; minimal service (POD/DPM)	17.00
90040POD	brief service (POD/DPM)	22.00
90050POD	limited service (POD/DPM)	25.00
90060POD	intermediate services (POD/DPM)	29.00
90070POD	extended service (POD/DPM)	27.00
90080POD	comprehensive service (POD/DPM)	40.00

Hospital Medical Services

90115-00	Home medical service, new patient; intermediate service	$ 25.00
90140POD	Home medical service, established patient; brief service (POD/DPM)	15.00
90200POD	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	70.00
90215POD	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	40.00
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	15.00
90360-00	intermediate service	25.00
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	16.00
90410-00	limited service	15.00

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90440-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient, brief service	13.00
90450-00	limited service	12.00
90600-00	Initial consultation; limited	55.00
90610-00	extensive	35.00
	Therapeutic Injections	
90782POD	Therapeutic injection of medication (specify); subcutaneous or intramuscular (POD/DPM)	~~$ 30.00~~ $ 20.00
90784-00	intravenous	20.00
90788POD	Intramuscular injection of antibiotic (specify) (POD/DPM)	15.00
	Physical Medicine	
95851POD	Range of motion measurements and report (separate procedure); each extremity (POD/DPM)	$ 40.00
97022POD	whirlpool (POD/DPM)	20.00
97128POD	ultrasound (POD/DPM)	16.00
~~L3010POD~~	~~Foot, insert, removable, molded to patient model, longitudinal arch support, each (POD/DPM)~~	~~.....~~
	Other Procedures	
~~X1229POD~~	~~Radical excision of nail (POD/DPM)~~	~~$.....~~
97700-00	Office visit, including one of the following tests or measurements, with report: a. Orthotic "check-out" b. Prosthetic "check-out" c. Activities of daily living "check-out"; initial 30 minutes, each visit	$ 25.00
99000-00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	10.00
99025-00	Initial (new patient) visit when asterisked (*) surgical procedure constitutes major service at that visit	20.00

5221.3100 PSYCHOLOGISTS AND RULE 29 FACILITIES.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to licensed psychologists and Rule 29 facilities (mental health centers and clinics).

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 psychologist (PSYCH).

Code	Service	Maximum Fee
09046-00	Initial office visit with evaluation and history, one hour (PSYCH)	$ 80.00
09048-00	Initial inpatient hospital visit, including history and evaluation, per hour (POD/DPM)	90.00
09050-00	Initial consultation, one hour (POD/DPM)	85.00
09064-00	Biofeedback, per hour (PSYCH)	80.00

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09065-00	Biofeedback, per half hour (PSYCH)	47.00
09066-00	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed psychologist, one hour (PSYCH)	80.00
09067-00	Psychotherapy, group (maximum ten persons per group), 1-1/2 hours per person (PSYCH)	40.00
09068-00	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour (PSYCH)	45.00
09070-00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge) (PSYCH)	75.00

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
06042-00	Day treatment program (LCP)	$ 33.00
06043-00	Independent behavior and/or other analyst, counselors, and other therapists (LCP)	75.00
06046-00	Independent social worker services (LCP)	66.00
09046-00	Initial office visit with evaluation and history; one hour (LCP)	80.00
09048-00	Initial inpatient hospital visit, including history and evaluation; per hour (LCP)	90.00
09050-00	Initial consultation; one hour (LCP)	85.00
09051-00	Follow-up consultation; 15 minutes (LCP)	30.00
09061-00	Psychological testing; one hour (LCP)	78.00
09062-00	Follow-up office visit; 15 minutes (LCP)	30.00
09064-00	Biofeedback; per hour (LCP)	80.00
09065-00	per one-half hour (LCP)	47.00
09066-00	Psychotherapy (inpatient, outpatient, office or home) (LCP)	80.00
09067-00	Psychotherapy, group (maximum ten persons per group); per session (LCP)	40.00
09068-00	Psychotherapy, individual one-half hour inpatient, outpatient, office, or home) (LCP)	45.00
09070-00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (LCP)	75.00

5221.3160 SOCIAL WORKERS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees of this part apply to social workers with a master

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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 (MSW)	$ 45.00
06046-00	Independent social worker services (MSW)	70.00

~~5221.3170~~ 5221.1410 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider ~~certified by the Biofeedback Certification Institute of America (BCIA). Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP)~~ 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) (BCIA/LCP)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow (BCIA/LCP)	45.00

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. [Unchanged.]

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

A. to P. [Unchanged.]

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

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Z. United Hospital, Saint Paul

AA. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ 293.10

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

A. to JJJJJJ. [Unchanged.]

Service	Maximum Fee
Group 2 semiprivate room charge for one day	$ 216.00

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	$ 400.18

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	$ 180.80

5221.3310 EFFECTIVE DATE.

The amendments to the rules in this chapter adopted at .. State Register, page ..., on ....., ... are effective five working days after publication of the notice of adoption in the State Register, and apply to all health care services or providers governed by parts 5221.0100 to 5221.3200 provided after that effective date.

REPEALER. Minnesota Rules, parts 5221.0900 ~~and~~, 5221.1400, 5221.1700, and 5221.3400, are repealed.

RENUMBER. Minnesota Rules, part 5221.1000, subpart 7, is renumbered as part 5221.0700, subpart 3, item C, subitems (1) to

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