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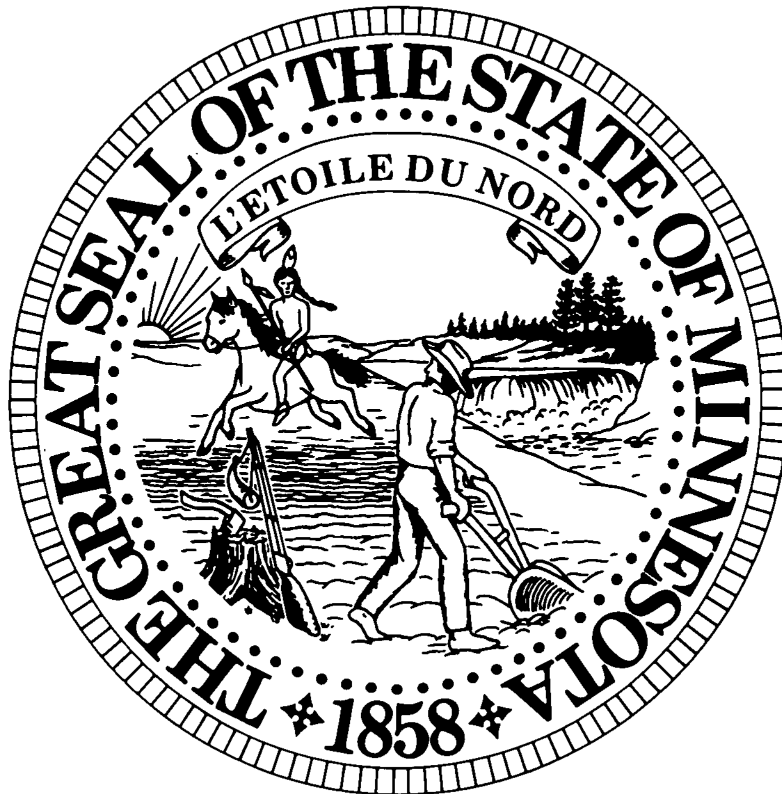
State Register

Department of Administration—Print Communications Division



Rules edition
Published every Monday
(Tuesday if Monday is a holiday)

Monday 21 June 1993

Volume 17, Number 51

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State Register

Judicial Notice Shall Be Taken of Material Published in the *State Register*

The *State Register* is the official publication of the State of Minnesota, containing executive and commissioners' orders, proposed and adopted rules, official and revenue notices, professional, technical and consulting contracts, non-state bids and public contracts, contract awards, grants, and a monthly calendar of cases to be heard by the state supreme court.

***A Contracts Supplement* is published Tuesday, Wednesday and Friday and contains bids and proposals, including printing bids.**

Printing Schedule and Submission Deadlines

Vol. 17 Issue Number	*Submission deadline for Adopted and Proposed Rules, Commissioners' Orders**	*Submission deadline for Executive Orders, Contracts, and Official Notices**	Issue Date
51	Monday 7 June	Monday 14 June	Monday 21 June
52	Monday 14 June	Monday 21 June	Monday 28 June
1 FY 94	Monday 21 June	Monday 28 June	Tuesday 6 July
2	Monday 28 June	Friday 2 July	Monday 12 July

*Deadline extensions may be possible at the editor's discretion; however, none will be made beyond the second Wednesday (12 calendar days) preceding the issue date for rules, proposed rules and executive orders, or beyond the Wednesday (5 calendar days) preceding the issue date for official notices. Requests for deadline extensions should be made only in valid emergency situations.

**Notices of public hearings on proposed rules and notices of intent to adopt rules without a public hearing are published in the Proposed Rules section and must be submitted two weeks prior to the issue date.

Instructions for submission of documents may be obtained from the ***State Register*** editorial offices, 117 University Ave., St. Paul, Minnesota 55155, (612) 297-7963, TDD (Minnesota Relay Service), Metro Area (612) 297-5353, Greater MN 1-800-627-3529.

The ***State Register*** is published every Monday (Tuesday when Monday is a holiday) by the State of Minnesota, Department of Administration, Print Communications Division, 117 University Avenue, St. Paul, Minnesota 55155, pursuant to *Minnesota Statutes* § 14.46. A ***State Register Contracts Supplement*** is published every Tuesday, Wednesday and Friday. The Monday edition is the vehicle for conveying all information about state agency rulemaking, including official notices; hearing notices; proposed, adopted and emergency rules. It also contains executive orders of the governor; commissioners' orders; state contracts and advertised bids; professional, technical and consulting contracts; non-state public contracts; state grants; decisions of the supreme court; a monthly calendar of scheduled cases before the supreme court; and other announcements. The *State Register* Contracts Supplement contains additional state contracts and advertised bids.

In accordance with expressed legislative intent that the ***State Register*** be self-supporting, the following subscription rates have been established: the Monday edition costs $150.00 per year and includes an index issue published in August (single issues are available at the address listed above for $3.50 per copy); the combined four editions cost $195.00 (subscriptions are not available for just the *Contracts Supplement*); trial subscriptions are available for $60.00, includes four editions, last for 13 weeks, and may be converted to a full subscription anytime by making up the price difference. No refunds will be made in the event of subscription cancellation.

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FOR LEGISLATIVE NEWS

Publications containing news and information from the Minnesota Senate and House of Representatives are available free to concerned citizens and the news media. To be placed on the mailing list, write or call the offices listed below:

SENATE

Briefly-Preview—Senate news and committee calendar; published weekly during legislative sessions.

Perspectives—Publication about the Senate.

Session Review—Summarizes actions of the Minnesota Senate.

Contact: Senate Public Information Office
Room 231 State Capitol, St. Paul, MN 55155
(612) 296-0504

HOUSE

Session Weekly—House committees, committee assignments of individual representatives; news on committee meetings and action. House action and bill introductions

This Week—weekly interim bulletin of the House.

Session Summary—Summarizes all bills that both the Minnesota House of Representatives and Minnesota Senate passed during their regular and special sessions.

Contact: House Information Office
Room 175 State Office Building, St. Paul, MN 55155
(612) 296-2146

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NOTICE: How to Follow State Agency Rulemaking in the *State Register*

The ***State Register*** is the official source, and only complete listing, for all state agency rulemaking in its various stages. State agencies are required to publish notice of their rulemaking action in the ***State Register***. Published every Monday, the ***State Register*** makes it easy to follow and participate in the important rulemaking process. Approximately 75 state agencies have the authority to issue rules. Each agency is assigned specific ***Minnesota Rule*** chapter numbers. Every odd-numbered year the ***Minnesota Rules*** are published. This is a ten-volume bound collection of all adopted rules in effect at the time. Supplements are published to update this set of rules. Proposed and adopted emergency rules do not appear in this set because of their short-term nature, but are published in the ***State Register***.

If an agency seeks outside opinion before issuing new rules or rule amendments, it must publish a NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION in the ***Official Notices*** section of the ***State Register***. When rules are first drafted, state agencies publish them as **Proposed Rules**, along with a notice of hearing, or notice of intent to adopt rules without a hearing in the case of noncontroversial rules. This notice asks for comment on the rules as proposed. Proposed emergency rules and withdrawn proposed rules are also published in the ***State Register***. After proposed rules have gone through the comment period, and have been rewritten into their final form, they again appear in the ***State Register*** as **Adopted Rules**. These final adopted rules are not printed in their entirety in the ***State Register***, only the changes made since their publication as Proposed Rules. To see the full rule, as adopted and in effect, a person simply needs two issues of the ***State Register***, the issue the rule appeared in as proposed, and later as adopted. For a more detailed description of the rulemaking process, see the ***Minnesota Guidebook to State Agency Services***.

The ***State Register*** features partial and cumulative listings of rules in this section on the following schedule: issues 1-13 inclusive; issues 14-25 inclusive; issue 26, cumulative for issues 1-26; issues 27-38 inclusive; issue 39, cumulative for 1-39; issues 40-51 inclusive; and issue 52, cumulative for 1-52. An annual subject matter index for rules appears in August. For copies of the ***State Register***, a subscription, the annual index, the ***Minnesota Rules*** or the ***Minnesota Guidebook to State Agency Services***, contact the Print Communications Division, 117 University Avenue, St. Paul, MN 55155 (612) 297-3000 or toll-free in Minnesota 1-800-657-3757.

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Proposed Rules

Pursuant to Minn. Stat. §§ 14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted.

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§ 14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register*.

Pursuant to Minn. Stat. §§ 14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Labor and Industry

Proposed Permanent Rules Relating to Boilers and Boats for Hire

Notice of Intent to Amend a Rule Without a Public Hearing

The Department of Labor and Industry, Code Administration and Inspection Services intends to adopt a permanent rule amendment without a public hearing following the procedures set forth in the Administrative Procedure Act, *Minnesota Statutes*, sections 14.22 to 14.28. You have 30 days to submit written comments on the proposed rule and may also submit a written request that a hearing be held on the rule amendment.

Agency Contact Person. Comments or questions on the rule and written requests for a public hearing on the rule must be submitted to:

Jerry Schnobrich
Code Administration and Inspection Services
Chief Boiler Inspector
443 Lafayette Road North
St. Paul, MN 55155-4304
(612) 296-1098

Subject of Rule and Statutory Authority. The proposed rule is about boats for hire—their inspection, equipment, passenger capacity, navigation and pilots licensing. The statutory authority to adopt this rule is specifically *Minnesota Statutes*, sections 183.41, subd. 2, 183.44, subd. 2 and generally 183.41, 183.42, 183.44 and 183.62 as well as Chapter 183 and *Minnesota Statutes*, section 175.71. A copy of the proposed rule is published in the *State Register*. A free copy of the rule is available upon request from the agency contact person listed above.

Comments. You have until 4:30 p.m. July 21, 1993 to submit written comment in support of or in opposition to the proposed rule and any part or subpart of the rule. Your comment must be in writing and received by the agency contact person by the due date. Comment is encouraged. Your comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Request for a Hearing. In addition to submitting comments, you may also request that a hearing be held on the rule. Your request for a public hearing must be in writing and must be received by the agency contact person by 4:30 p.m. on July 21, 1993. Your written request for a public hearing must include your name and address. You are encouraged to identify the portion of the proposed rule which caused your request, the reason for the request, and any changes you want made to the proposed rule. If 25 or more persons submit a written request for a hearing, a public hearing will be held unless a sufficient number withdraw their request in writing. If a public hearing is required the agency will follow the procedures in *Minnesota Statutes*, section 14.131 to 14.20.

Modifications. The proposed rule may be modified as a result of public comment. The modifications must be supported by data and views submitted to the agency and may not result in a substantial change in the proposed rule as printed in the *State Register*. If the proposed rule affects you in any way, you are encouraged to participate in the rulemaking process.

Statement of Need and Reasonableness. A statement of need and reasonableness is now available from the agency contact person. This statement describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule.

Small Business Considerations. The proposed rule will have a positive impact on small business because regulation is minimized and the clarity of the rule is enhanced.

Adoption and Review of Rule. If no hearing is required, after the end of the comment period the agency may adopt the rule. The rule and supporting documents will then be submitted to the attorney general for review as to legality and form to the extent form relates to legality. You may request to be notified of the date the rule is submitted to the attorney general and be notified of the attorney general's decision on the rule. If you wish to be so notified, or wish to receive a copy of the adopted rule, submit your request to the agency contact person listed above.

Dated: 4 June 1993

John B. Lennes, Jr., Commissioner
Department of Labor and Industry

Rules as Proposed

5225.0100 APPLICATION FOR ~~STEAM~~ BOILER OPERATING ENGINEER ~~OR PILOT~~ LICENSE.

Any person desiring to take an examination for a license as a ~~steam~~ boiler operating engineer ~~or pilot~~ shall make written application ~~therefor~~ under oath, on blanks furnished by the boiler inspector. The application shall be accompanied by a corroborating affidavit of at least one employer or a ~~steam~~ boiler operating engineer possessing not less than a second class engineer's license~~, or pilot, as the case may be,~~ certifying to the applicant's experience as stated in ~~his~~ the application. If ~~such~~ affidavits are not obtainable, satisfactory evidence of the applicant's experience must be furnished.

5225.0300 EXPIRATION AND RENEWALS.

Subpart 1. **Timing.** Licenses for engineers ~~and pilots~~, unless revoked, are valid for ~~a period of~~ one year from the date of issuance, with privilege of renewal without examination upon application to the Department of Labor and Industry, Boiler Inspection Division, and payment of a renewal fee within ten calendar days of the expiration date. The renewal license must be given a consecutive issue number and the same monthly date as the original issue. An application for renewal may not be presented before 30 days preceding the expiration date of the license. Engineers who fail to renew their licenses before the ten-day grace period has expired are subject to subparts 2 and 3.

[For text of subps 2 and 3, see M.R.]

5225.0500 EXAMINATIONS.

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

Subp. 3. **Effect of failure.** Applicants who fail to pass an examination shall not be eligible to take another examination for the same class of license within the following periods:

A. special engineer's~~,~~ or hobby~~, or pilot's~~ license, ten days;

[For text of items B and C, see M.R.]

5225.0550 DOCUMENTATION OF EXPERIENCE REQUIREMENTS FOR LICENSURE AS A BOILER OPERATOR.

Subpart 1. **Compliance requirements.** All applicants must comply with chapter 5225 and *Minnesota Statutes*, sections 183.375 to 183.62. Applicants with previous experience in a jurisdiction requiring licensure must show proof of compliance with the licensure requirements of that jurisdiction in order to receive credit for the experience. All applicants for licensure as a ~~pilot,~~ hobby boiler operator~~,~~ or boiler operator shall provide documentation of operating experience for the level of class/grade applied for in accordance with subparts 2 to 9.

[For text of subps 2 to 6, see M.R.]

Subp. 7. [See repealer.]

[For text of subps 8 to 10, see M.R.]

5225.0900 DISPLAY OF LICENSE.

Licenses granted must be placed in a glassed frame and be displayed in a conspicuous place in the engine or boiler room~~, or pilot's station~~. Boiler plants operated by a contract boiler operator must have a copy of the engineer's license of each person who may be operating the boiler posted in each boiler room.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

5225.6000 SCOPE.

Parts 5225.6000 to ~~5225.7200 shall be followed by vessels navigating the lakes and rivers of Minnesota~~ 5225.8600 govern boats, as defined by part 5225.6100, subpart 2, and their pilots.

5225.6050 INCORPORATION BY REFERENCE.

Subpart 1. **Code of Federal Regulations, title 33.** To the extent referred to in parts 5225.6350 and 5225.6500, *Code of Federal Regulations,* title 33, section 86.01, and United States Code, title 33, sections 2002 to 2019, are incorporated by reference.

Subp. 2. **Code of Federal Regulations, title 46.** To the extent referred to in parts 5225.6140, 5225.6500, and 5225.7200, and not in its entirety, the *Code of Federal Regulations,* title 46, as revised on October 1, 1991, is incorporated by reference. Amendments subsequent to October 1991 are not incorporated.

Subp. 3. **Use of terms.** For the purpose of parts 5225.6000 to 5225.8600, the following terms in incorporated sections of *Code of Federal Regulations,* have the meanings given in items A and B.

A. "Officer in charge, marine inspection," or "officer in charge" means a "chief boiler inspector."

B. "Marine inspector" means a "designated boat inspector" and is used in this chapter to mean a boat inspector who is designated by the chief boiler inspector of the Department of Labor and Industry.

5225.6100 DEFINITIONS.

Subpart 1. [See repealer.]

Subp. 1a. **Scope.** To the extent referred to in parts 5225.6000 to 5225.8600, the terms in this part have the meanings given them.

Subp. 2. **Boat.** "Boat" means any vessel navigating inland waters of the state~~,~~ which is propelled by machinery or sails, is carrying passengers ~~or cargo~~ for hire, and ~~operated by a licensed pilot~~ is 21 feet or more in length.

Subp. 2a. **Length.** "Length" means the straight-line distance from the foremost part of the boat (bow) to the rear most part of the boat (stern).

Subp. 2b. **Passengers for hire.** "Passengers for hire" means the carriage of any persons by a boat for a valuable consideration, whether directly or indirectly flowing to the owner, charterer, agent, or any other person interested in the boat. Passengers for hire does not include the pilot, the crew, or other persons employed or engaged in any capacity on board a boat in the business of that boat.

Subp. 3. **Under way.** ~~A vessel is~~ "Under way" ~~within the meaning of these rules~~ means a boat when it is not at anchor~~, or~~ and is not made fast to the shore or ground.

Subp. 4. **Visible.** ~~The word~~ "Visible," ~~in these rules,~~ when applied to lights, ~~shall mean~~ means visible on a dark night with a clear atmosphere.

5225.6140 INSPECTION OF BOATS.

Subpart 1. **Inspections required.** Annual inspection by the Department of Labor and Industry is required of any boat that is not under the jurisdiction of the Coast Guard.

Subp. 2. **Inspections optional.** Boats that are less than 21 feet in length may be inspected by the Department of Labor and Industry at the owner's request if the owner pays for the inspection.

Subp. 3. **Inspection standards.** The Department of Labor and Industry, Division of Boiler Inspection, shall conduct the inspection according to *Code of Federal Regulations,* title 46, subparts 175.20, 176.05-5, 176.05-10, and 176.25, and the requirements in parts 5225.6000 to 5225.8600.

5225.6145 PILOT REQUIREMENTS.

All pilots must comply with parts 5225.0600, 5225.0700, and 5225.6000 to 5225.8600 and *Minnesota Statutes*, sections 183.41 to 183.62. The chief boiler inspector may revoke the license of any pilot who violates these provisions. In that event, the procedures of part 5225.0880 apply.

5225.6150 LICENSE REQUIREMENTS.

Subpart 1. **General.** The operation of a boat requires a valid, current Minnesota pilot's license issued by the Department of Labor and Industry, Division of Boiler Inspection.

Subp. 2. **Requirements for licensure.** An applicant for a pilot's license must:

A. fill out an application on forms provided by the Department of Labor and Industry;

B. submit an affidavit from a person who can attest to the piloting experience of the applicant as provided in subpart 3;

C. pass an examination prepared by the chief boiler inspector as described in part 5225.0500, subpart 1, with a score of at least 75 percent; and

D. pay the license fee as provided in part 5225.8600.

Subp. 3. **Experience documentation.** An applicant must have at least 15 hours of training experience operating a boat. The training experience must be supervised by a licensed pilot. The applicant must submit an affidavit completed by the supervising licensed pilot attesting to the applicant's training experience. The applicant must submit the affidavit before taking the examination.

Subp. 4. **Exemptions from affidavit and examination requirement.** The affidavit and examination requirement shall be waived for an applicant possessing a valid, unlimited, current United States Coast Guard pilot's license. An applicant possessing a valid, unlimited, current United States Coast Guard pilot's license must complete an application and pay the fee set by part 5225.8600. The affidavit and examination requirement must not be waived for those holding a limited United States Coast Guard license.

Subp. 5. **Effect of failure of examination.** An applicant who fails to pass the examination is not eligible to take another examination for ten days. The fee paid for the examination shall not be refunded.

5225.6160 LICENSE EXPIRATION AND RENEWAL.

Subpart 1. **Timing.** Licenses for pilots, unless revoked, are valid for one year from the date of issuance, with privilege of renewal without examination upon application to the Department of Labor and Industry, Boiler Inspection Division, and payment of a renewal fee within ten calendar days of the expiration date. The renewal license must be given a consecutive issue number and the same monthly date as the original issue. An application for renewal may not be submitted before 30 days preceding the expiration date of the license. Pilots who fail to renew their licenses before the ten-day grace period has expired are subject to the requirements in subparts 2 and 3.

Subp. 2. **Application for renewal within one year of expiration.** A license that has expired may be renewed within one year of expiration without an examination by filing an application for renewal and submitting the expired renewal fee required in part 5225.8600, subpart 2, item C.

Subp. 3. **Renewal application after one year of expiration.** A license that has expired more than one year before submitting an application for renewal may be renewed by submitting an application for renewal, passing the examination described in part 5225.6150, subpart 2, item C, and paying the fee required in part 5225.8600, subpart 2, item C.

5225.6170 DISPLAY OF LICENSE.

Licenses must be placed in a glass or plexiglass frame and be displayed in a conspicuous place in the pilot's station.

5225.6350 RULES FOR NAVIGATION.

Subpart 1. ***Code of Federal Regulations* requirements; jurisdiction.** All boats must comply with United States Code, title 33, sections 2002 to 2019.

Subp. 2. **Towing rowboats.** Every boat that tows a rowboat shall provide oars on the rowboat regardless of whether the rowboat is equipped with an outboard motor.

5225.6500 EQUIPMENT.

Subpart 1. **Generally.** When ~~in use~~ under way, every ~~vessel subject to these rules~~ boat shall carry oars or pole, an anchor, a fire extinguisher, and at least one approved life preserver for each passenger. If a pole is used, it must be at least 12 feet in length and have a hook attached to one end.

Subp. 2. ***Code of Federal Regulations* requirements.** In addition to the requirements of subpart 1, all boats must comply with the following equipment requirements:

A. fire extinguisher, *Code of Federal Regulations,* title 46, subpart 181.30;

B. bilge pumps, *Code of Federal Regulations,* title 46, subpart 182.25-10;

C. life preservers, *Code of Federal Regulations,* title 46, section 180.25, except subpart 180.25-20;

D. ring life buoys, *Code of Federal Regulations,* title 46, subpart 180.30;

E. distress signals, *Code of Federal Regulations,* title 46, subpart 180.35;

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F. whistles, *Code of Federal Regulations,* title 33, subpart 86.01;

G. ventilation systems, *Code of Federal Regulations,* title 46, subparts 177.20 and 182.15-45; and

H. anchors, *Code of Federal Regulations,* title 46, subpart 184.10.

Subp. 3. **First aid kit.** Each boat must have a first aid kit on board that is approved by the American Red Cross or an equivalent entity. The American Red Cross First Aid Kit for Car and Home is recommended, and is available from the American Red Cross, 11 Del Place, Minneapolis, Minnesota 55403.

Subp. 4. **First aid handbook.** All boats must have a first aid handbook on board. The American Red Cross Standard First Aid and Safety Handbook is recommended, and is available from the American Red Cross, 11 Del Place, Minneapolis, Minnesota 55403.

Subp. 5. **Battery covers.** All batteries must be covered with battery covers to eliminate sparking or arcing.

5225.6700 REPORTS OF DAMAGE.

Pilots of motor boats A pilot of a boat shall report in writing to the office of the chief boiler inspector of the Division of Boiler Inspection Department of Labor and Industry any accident causing either death, an injury that requires hospitalization, or damage in excess of $100 $1,000. They In the event of a death, the report must be made within 48 hours. In the event of an injury or property damage, the report must be made within five days. The pilot shall also promptly report any other pilot who does not properly discharge the duties of a pilot and any person who flashes a light into the face of a pilot or otherwise commits an act that endangers the safety of a motor pilot or passengers of a boat.

5225.6940 DESIGN CHANGES.

Subpart 1. **Approval of design.** The Division of Boiler Inspection must be notified before any design change is made to a boat that changes the length, draft, center of gravity, or superstructure of the boat. Drawings, sketches, or written specifications of the changes must be reviewed and approved by a marine architect designated by the boiler division. The marine architect shall make a report regarding the proposed design changes to the chief boiler inspector. Final approval or disapproval of design changes will be made by the chief boiler inspector. All costs of the review by the architect must be paid by the boat owner.

Subp. 2. **Stability test.** A stability test is required before the boat is placed back in service when a boat's length or draft is changed, its superstructure increased, or its center of gravity is changed. The stability test must be witnessed by an inspector of the boiler division. The cost of the stability test must be paid by the boat owner.

5225.6975 ISSUANCE OF CERTIFICATE.

A certificate of inspection shall be issued to a boat owner upon the boat passing the yearly inspection required by part 5225.6140, and the payment of the fee described in part 5225.8600, subpart 7. The certificate of inspection is valid for one year beginning on the day of issuance. A person operating a boat without a certificate of inspection is guilty of a misdemeanor and is subject to a penalty in the amount of the cost of inspection up to a maximum of $1,000.

5225.6980 REVOCATION OF CERTIFICATE; PENALTIES.

Any violation of parts 5225.6000 to 5225.8600 shall be grounds to revoke the certificate of inspection. A person in charge of operating the boat who willfully, or from ignorance or gross neglect, creates or allows to be created any condition endangering human life is subject to the disciplinary procedures in part 5225.0880, and a boat owner who has knowledge of the condition, or of circumstances that would cause such a condition, is guilty of a gross misdemeanor under *Minnesota Statutes*, section 183.62.

5225.7200 PASSENGER CAPACITY.

The passenger capacity of ~~all steam and gasoline vessels not otherwise provided for~~ each boat shall be ~~determined~~ designated by the ~~following rules, to wit: multiply the length (in feet), the breadth of the planking or plating, and the depth inside at the place of minimum depth. The product of these dimensions multiplied by .6, excluding fractional part of such product, shall be deemed the capacity of cubic feet. To determine the number of persons a boat is permitted to carry on the inland waters of this state, divide such product by eight and drop any resulting fraction~~ chief boiler inspector under *Code of Federal Regulations*, title 46, subpart 176.01-25.

~~Example: The carrying capacity of a boat 18 feet in length, 5-1/2 feet in breadth, and 2-1/4 feet in depth shall be determined as follows:~~

~~18 x 5-1/2 x 2-1/4 x .6 = 134 = 16 persons~~
~~8 8~~

~~Then estimate the weight of all equipment and machinery and divide by 150. To this quotient add one and subtract this sum from the number secured by the above formula.~~

~~Example: Weight of equipment and machinery, 450 lbs.~~

~~450~~ E ~~150~~ = ~~3~~ + ~~1~~ = 4
~~16~~ - 4 = ~~12 passengers~~

5225.8600 FEES.

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

Subp. 2. **Engineer licenses.**

A. The fees for a new boiler operating engineer or pilot license, application, and examination are as follows:

[For text of subitems (1) to (4), see M.R.]

(5) hobby engineer, $50; ~~and~~

(6) pilot, $30; and

(7) pilot who possesses a valid, unlimited, current United States Coast Guard pilot's license, $15.

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

[For text of subps 3 to 8, see M.R.]

REPEALER. *Minnesota Rules*, parts 5225.0550, subpart 7; 5225.6100, subpart 1; 5225.6300; 5225.6400; 5225.6600; 5225.6800; 5225.7000; and 5225.7100, are repealed.

Department of Labor and Industry

Proposed Permanent Rules Relating to Workers' Compensation: Managed Care; Independent Medical Examination Fees; Rules of Practice; Relative Value Medical Fee Schedule and Medical Rules of Practice; Independent Contractors

Notice of Hearing

NOTICE IS HEREBY GIVEN that a public hearing will be held pursuant to *Minnesota Statutes* § 14.14, subdivision 1 in the above-captioned matter. The hearing will be held at 9:00 a.m. on July 27, 1993, Room C-1 and C-2, St. Paul Civic Center, 143 West 4th Street (Kellogg Boulevard at West 7th Street), St. Paul, Minnesota, and continuing until all interested persons and groups have had an opportunity to be heard concerning the proposed rule. The proposed rules may be modified as a result of the hearing process. You are encouraged to participate if you are in any way affected by these rules.

Managed Care Rules; Chapter 5218.

The statutory authority to adopt the rule is *Minnesota Statute* § 176.1351, subd. 6. The rules govern criteria and standards for certification and operation of a workers' compensation managed care plan. Topics include, but are not limited to, the following: required health care services and providers; procedures for referral and treatment of employees with work related injuries; coverage responsibility of the managed care plan after notice of an injury; disclosure of a plan's affiliation with a workers' compensation employer, insurer or third party administrator; notice of coverage to employees; participating provider education; annual reporting requirements; contracts with health care providers; services by nonparticipating providers, including providers who have previously treated the employee; payment to participating providers; dispute resolution, utilization review, peer review and case management requirements; trade secret status of applications; and procedures for suspending or revoking certification of a managed care plan.

The rules will affect small business health care providers. However, the requirements of *Minnesota Statute* § 14.115 related to the impact on small business do not apply because the rules regulate health care providers for standards and costs, under subdivision 7(c) of that statute.

A fiscal note is not required under *Minnesota Statute*, section 14.11 because the rules do not require the expenditure of public money greater than $100,000 in either of the two years following adoption.

Independent Medical Examination Fees; Chapter 5219.

A rule setting maximum charges for or in connection with independent or adverse medical examinations is proposed pursuant to *Minnesota Statute* § 176.136, subd. 1(c) (1992).

The rule defines "for or in connection with adverse or independent medical examinations" and sets forth components of the charges for examination related fees, including, but not limited to, review of records and diagnostic tests, taking patient history, preparing reports, travel expenses (if any), and cancellations. The rule also prescribes maximum charges for the adverse or independent medical examiner related to depositions, attorney conferences, and trial appearances.

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The rules do not impact small businesses subject to *Minnesota Statute* § 14.115; the subd. 7 (c) exemption applies.

The rules do not require the expenditure of public monies by local public bodies. The rules limit the charges payable by local public bodies.

Workers' Compensation Rules of Practice; Chapter 5220

The general statutory authority for the Workers' Compensation Rules of Practice is contained in *Minnesota Statutes* § 175.17 (2), 175.171 (2), and 176.83, subd. 1. Other statutory authority for specific portions of the proposed rules is set out in the Statement of Need and Reasonableness.

The rules update workers' compensation procedural and benefit rules; delete obsolete and unnecessary provisions and repeal some rules which will be proposed in other chapters; revise form filing and reporting procedures; clarify procedures; provide greater specificity concerning eligibility for certain benefits; add criteria for assessing a penalty following a frivolous or nonspecific denial of liability; add procedures for recovery of benefit overpayments; add an expedited procedure for determining workers' compensation coverage issues such as independent contractor status; update administrative conference procedures; modify discontinuance of benefit procedures, including provisions governing when benefits may be discontinued prior to an administrative conference or a discontinuance notice; include small claims court procedures; modify penalty rules; establish parameters of Department interim notices and orders to be published for the guidance of Department constituents concerning matters within the Department's authority; and expand the attorney fee rule to include verification of the benefits genuinely disputed, a standard notice to the employee regarding fees in excess of the amount presumed reasonable, procedures to report defense fees and costs, and other miscellaneous changes.

The majority of the rules do not directly affect small businesses. The attorney fee rule affects small attorney firms by requiring additional information to be reported or collected, and by altering the attorney fee request procedures. Attorney firms are service providers exempt from consideration under *Minnesota Statute* § 14.115. Nevertheless, a description of the Department's consideration of the impact on small businesses is more fully described in the Statement of Need and Reasonableness.

The rules do not require additional expenditures of public monies by local public bodies.

Medical Rules of Practice and Medical Fee Schedule; Chapter 5221.

The statutory authority for the Medical Rules of Practice and Medical Fee Schedule is *Minnesota Statute* § 175.171 (2), 176.101, subd. 3e, 176.135, subdivisions 2 and 7, 176.136, 176.231, and 176.83, subdivisions 1, 4, 5, 8, and 15.

The proposed Medical Rules of Practice prescribe health care provider forms to replace the current physician report form and the maximum medical improvement and permanent partial disability report form; require a new report of work ability form to be completed by health care providers and provided by the employee to other parties; set standards for health care provider cooperation with return to work planning by the employer and qualified rehabilitation consultant; define primary treating doctor and set standards and procedures for a change of doctor; set criteria for determining when maximum medical improvement has been reached, including specific criteria for musculoskeletal injuries; specify the manner in which an insurer must file the health care provider reports with the agency; and require insurers to collect, retain and report to the agency specified medical data.

The rules also govern the reimbursement for medical services and a new relative value fee schedule is proposed. The rules define excessive charges for medical services including without limitation services in violation of *Minnesota Statute* § 256B.0644 and 62J.23; specify limitations on payer liability under *Minnesota Statute* § 176.136; define usual and customary and prevailing charges; require services, articles and supplies to be billed to the insurer directly; specify health care provider coding and billing procedures and adopt the HCFA 1500 and UB93 uniform billing claim forms; adopt a relative value fee schedule, based on the federal Medicare relative value schedule, to achieve a 15 percent overall reduction from the Minnesota Medical Fee Schedule most recently in effect, with distinct classifications for medical/surgical, pathology/laboratory, chiropractic and physical/occupational medicine services; and establish procedures for prescribing and determining maximum fees for medication.

The rules affect small business health care providers. However, the requirements of *Minnesota Statute* § 14.115 concerning impact on small business do not apply because the rules regulate health care providers for standards and costs under subd. 7(c) of that statute. Nonetheless, the Department has considered methods for reducing the impact of the rules on health care providers. A discussion of the considerations is set forth in the Statement of Need and Reasonableness. The rules also affect workers' compensation insurers, who are not generally small businesses, and who can be expected to benefit from the legislative medical cost controls implemented by the rules.

The rules are not expected to require any local public body to spend more than $100,000 in either of the next two years. Therefore, a fiscal note is not required under *Minnesota Statute* § 14.11, subd. 1.

Independent Contractor Amendment; Chapter 5224.

The statutory authority for this amendment is *Minnesota Statute* § 176.83, subdivision 1 and 11. The amendment clarifies application of the rules; a repealed statutory citation is updated.

The amendment does not have an adverse impact on small businesses.

The amendment does not require additional expenditures of public monies by local public bodies.

How to Obtain a Copy of the Rules

The proposed rules follow this notice in the *State Register*. Copies will also by available at the door on the date of hearing. One free copy of the proposed rules may also be obtained in any of the following ways:

Downloading: If you have a personal computer with a modem and communication software, you may download an unofficial reproduction of any of the rules directly off the Department of Labor and Industry bulletin board by dialing (612) 282-2265. The official published version of the proposed or adopted rules should be consulted in the event of discrepancies, if any, with unofficial reproductions obtained by downloading.

Send in a Request: You may mail or fax a request to Janis Keesling, Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155-4316. The fax number is (612) 296-9634.

Please check the rule(s) you request:

- ☐ Permanent Managed Care Rules
- ☐ Independent Medical Examination Rules
- ☐ Workers' Compensation Rules of Practice
- ☐ Relative Value Medical Fee Schedule
- ☐ Medical Rules of Practice
- ☐ Independent Contractor Rules
- ☐ All of the Above

Please specify how you would like the rules:

- ☐ 3.5" computer disc (ASCII format)
- ☐ Paper Copy

Name and Address you would like the rules mailed to: ________________________________

____

____

Personal Contact: You may obtain a paper or computer disc (3.5" ASCII format) copy of the rules in person from Janis Keesling at the above address or by phoning her at (612) 296-8213 from 8:00 a.m.-4:30 p.m., Monday-Friday.

Statement of Need and Reasonableness

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness for each of the above proposed rules is now available for review at the agency and at the Office of Administrative Hearings. This Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the Department of Labor and Industry or the Office of Administrative Hearings and copies may be obtained at the cost of reproduction.

Public Comment and Hearing Procedures

Any person may present views on the proposed rules in one or more of the following ways: by submitting written data to the administrative law judge at any time before the hearing; by submitting oral or written data at the hearing; and by submitting written material to the adminstrative law judge during the comment period following the hearing. Statements may be submitted without appearing at the hearing.

Written material may be submitted and recorded in the hearing record for five working days after the public hearing ends. This comment period may be extended for a longer period not to exceed twenty calendar days if so ordered by the administrative law judge at the hearing. The written material received during this period shall be available for review at the Office of Administrative Hearings. The Department of Labor and Industry and any interested persons may respond in writing within five business days after the comment period ends to any new information submitted. Any written material or responses submitted must be received at the Office of Administrative Hearings no later than 4:30 p.m. on the final day. No additional evidence may be submitted during this five-day period.

The Department of Labor and Industry requests that any persons submitting written views or data to the administrative law judge

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prior to the hearing or during the comment period also submit a copy of the written information to Penny Johnson, Legal Services, Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155-4310.

The rule hearings procedure is governed by *Minnesota Statutes*, section 14.14 to 14.20 and by parts 1400.0200 to 1400.1200 of *Minnesota Rules*. Questions regarding procedure may be directed to the administrative law judge. The administrative law judge assigned to preside over the hearings is:

Barbara L. Neilson
Administrative Law Judge
Office of Administrative Hearings
100 Washington Square, Suite 1700
Minneapolis, MN 55401-2138
Phone: (612) 341-7604

NOTICE: Any person may request notification of the date on which the administrative law judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the administrative law judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day that the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

Lobbyist Registration

Minnesota Statutes, Chapter 10A requires each lobbyist to register with the State Ethical Practices Board.

Questions should be directed to the Ethical Practices Board, First Floor South, Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155, telephone (612) 296-5148.

Dated: 7 June 1993

John B. Lennes., Commissioner
Department of Labor and Industry

Proposed Permanent Rules Relating to Managed Care

Rules as Proposed (all new material)

5218.0010 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0010 to 5218.0900 have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exits.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a personal injury under *Minnesota Statutes*, section 176.135.

Subp. 5. **Health care provider.** "Health care provider" has the meaning given in *Minnesota Statutes*, section 176.011, subdivision 24.

Subp. 6. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by *Minnesota Statutes*, chapter 176, and includes a self-insured employer and third party administrator for the employer or insurer.

Subp. 7. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the delivery and management of treatment to injured employees under *Minnesota Statutes*, sections 176.135 and 176.1351.

Subp. 8. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other arrangements for the delivery of medical services or supplies to injured employees.

Subp. 9. **Payer.** "Payer" refers to any entity responsible for payment and administration of a workers' compensation claim under *Minnesota Statutes*, chapter 176.

Subp. 10. **Primary treating health care provider.** "Primary treating health care provider" means a physician, chiropractor, osteopath, podiatrist, or dentist directing and coordinating the course of medical care to the employee.

Subp. 11. **Revocation.** "Revocation" means the termination of a managed care plan's certification to provide services under parts 5218.0010 to 5218.0900.

Subp. 12. **Suspension.** "Suspension" means the managed care plan's authority to enter into new or amended contracts with insurers has been suspended by the commissioner for a specified period of time.

5218.0020 AUTHORITY.

Parts 5218.0010 to 5218.0900 are adopted under the commissioner's rulemaking authority under *Minnesota Statutes*, section 176.1351, subdivision 6.

5218.0030 PURPOSE AND SCOPE.

The purpose of parts 5218.0010 to 5218.0900 is to establish procedures and requirements for certification as a managed care plan relating to the management and delivery of medical services to injured employees within the workers' compensation system under *Minnesota Statutes*, sections 176.135, subdivision 1, paragraph (f), and 176.1351. No health care provider, network of providers, employer, insurer, or any other person may suggest to an employee, or state in any name, contract, or literature that an entity constitutes workers' compensation managed care unless the entity is a certified managed care plan under this chapter.

5218.0040 PROVISIONAL CERTIFICATION.

A managed care plan provisionally certified under the emergency rules may continue to operate with the provisional certification under parts 5218.0010 to 5218.0900, provided that the managed care plan must submit a new application within 60 days after the effective date of this chapter. To maintain certification, a certified managed care plan must submit an annual report required by part 5218.0300, subpart 2.

5218.0100 APPLICATION FOR CERTIFICATION.

Subpart 1. **Certification.** Except as provided in part 5218.0200, subpart 4, any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under *Minnesota Statutes*, chapter 176, under a plan certified by the commissioner. To obtain certification of a plan, an application shall be submitted on a form provided by the commissioner which shall include items A to N, and other matters related to parts 5218.0010 to 5218.0900.

A. The original plus one identical copy of the application must be submitted. Portions of the application which the managed care plan believes is subject to trade secret protection under *Minnesota Statutes*, section 13.37, must be clearly marked, separated and justified in accordance with part 5218.0800, subpart 2, item B.

B. The plan must provide the information in subitems (1) to (7). An individual may act in more than one capacity:

(1) the names of all directors and officers of the managed care plan;

(2) the title and name of the person to be the day-to-day administrator of the managed care plan;

(3) the title and name of the person to be the administrator of the financial affairs of the managed care plan;

(4) the name, and medical specialty, if any, of the medical director;

(5) the name, address, and telephone number of a communication liaison for the department, the insurer, the employer, and the employee;

(6) the nature of any affiliation specified in part 5218.0200, subpart 4, between the managed care plan, or its parent, subsidiary, or other related organization, and an employer, insurer, or third party administrator; and

(7) the name of any entity, other than individual health care providers, with whom the managed care plan has a joint venture or other agreement to perform any of the functions of the managed care plan, and a description of the specific functions to be performed by each entity.

C. Each application for certification or application following revocation must be accompanied by a nonrefundable fee of $1,500. If a plan has been provisionally certified under chapter 5218 [Emergency], the application fee shall be $600. Fees for the annual report and changes to the plan as certified are in part 5218.0300.

D. The managed care plan must ensure provision of quality services that meet all uniform treatment standards adopted by the commissioner under *Minnesota Statutes*, section 176.83, subdivision 5, and all medical and health care services that may be required by *Minnesota Statutes*, chapter 176.

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E. The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a statement describing how the plan will ensure an adequate number of each category of health care providers is available to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, in accordance with this chapter and *Minnesota Statutes*, section 176.1351, subdivisions 1, clauses (1) and (2), and 10.

(1) The managed care plan must include at a minimum, and provide to an employee when necessary under *Minnesota Statutes*, section 176.135, subdivision 1, the following types of health care services and providers, unless the managed care plan provides evidence that a particular service or type of provider is not available in the community:

(a) medical doctors, including the following specialties:

i. specialists in at least one of the following fields: family practice, internal medicine, occupational medicine, or emergency medicine;

ii. orthopedic surgeons, including specialists in hand and upper extremity surgery;

iii. neurologists and neurosurgeons; and

iv. general surgeons;

(b) chiropractors;

(c) podiatrists;

(d) osteopaths;

(e) physical and occupational therapists;

(f) psychologists or psychiatrists;

(g) diagnostic pathology and laboratory services;

(h) radiology services; and

(i) hospital, outpatient surgery, and urgent care services.

The managed care plan must submit copies of all types of agreements with providers who will deliver services under the managed care plan, and a description of any other relationships with providers who may deliver services to a covered employee. The managed care plan must attach to each standard document a corresponding list of names, clinics, addresses, and types of license and specialties for the health care providers. The managed care plan must also submit a statement that all licensing requirements for the providers are current and in good standing in Minnesota or the state in which the provider is practicing.

(2) The managed care plan must provide for referral for specialty services that are not specified in subitem (1) and that may be reasonable and necessary to cure or relieve an employee of the effects of the injury under *Minnesota Statutes*, section 176.135, subdivision 1. The insurer remains liable for any health service required under *Minnesota Statutes*, section 176.135, that the managed care plan does not provide.

F. The managed care plan must include procedures to ensure that employees will receive services in accordance with subitems (1) to (7):

(1) Employees must receive initial evaluation by a participating licensed health care provider within 24 hours of the employee's request for treatment, following a work injury.

(2) In cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.0500, subpart 1, item A, the employee must receive initial evaluation or treatment by a participating licensed health care provider within five working days of the employee's request for a change of doctor, or referral to the managed care plan.

(3) Following the initial evaluation, upon request, the employee must be allowed to receive ongoing treatment from any participating health care provider in one of the disciplines in units (a) to (e), if the provider is available within the mileage limitations in subitem (7) and the treatment is required under *Minnesota Statutes*, section 176.135, subdivision 1, is within the provider's scope of practice, and is appropriate under the standards of treatment adopted by the managed care plan or the standards of treatment adopted by the commissioner under *Minnesota Statutes*, section 176.83, subdivision 5:

(a) medical doctors;

(b) chiropractors;

(c) podiatrists;

(d) osteopaths; or

(e) dentists.

An evaluating provider may also be offered as a primary treating provider.

(4) Employees must receive any necessary treatment, diagnostic tests, or specialty services in a manner that is timely, effective, and convenient for the employee.

(5) Employees must be allowed to change primary treating providers within the managed care plan at least once without proceeding through the managed care plan's dispute resolution process. A change of providers from the evaluating health care provider to a primary treating doctor for ongoing treatment is not considered a change of doctor, unless the employee has received treatment from the evaluating health care provider more than once for the injury.

(6) Employees must be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under unit (a).

(7) Employees must have access to the evaluating and primary treating health care provider within 30 miles of either the employee's place of employment or residence if either the residence or place of employment is within the seven county metropolitan area. The seven county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. If both the employee's residence and place of employment are outside the seven county metropolitan area, the allowable distance is 50 miles. If the employee requires specialty services that are not available within the stated mileage restriction, the managed care plan may refer the employee to a provider outside of the stated mileage restriction.

G. The managed care plan must designate the procedures for approval of services from a health care provider outside the managed care plan according to part 5218.0500.

H. The managed care plan must include a procedure for peer review and utilization review as specified in part 5218.0750.

I. The managed care plan must include a procedure for internal dispute resolution according to part 5218.0700 and *Minnesota Statutes*, section 176.1351, subdivision 2, clause (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

J. The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers. The plan must submit a proposed notice to employees, which may be customized according to the needs of the employer, but which must include the information in part 5218.0250.

K. The managed care plan must describe how aggressive medical case management will be provided according to part 5218.0760 for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

L. The managed care plan must describe a procedure or program through which participating health care providers may obtain information on the following topics:

(1) treatment parameters adopted by the commissioner;

(2) maximum medical improvement;

(3) permanent partial disability rating;

(4) return to work and disability management;

(5) health care provider obligations in the workers' compensation system; and

(6) other topics the managed care plan deems necessary to obtain cost effective medical treatment and appropriate return to work for an injured employee.

The medical director or a designee must document attendance for a minimum of 12 hours of education during the first year, and four hours each year thereafter, covering any of the topics listed in subitems (1) to (6). The documentation shall be submitted to the commissioner upon request. The medical director or designee must be available as a consultant on these topics to any health care provider delivering services under the managed care plan.

M. The managed care plan must specify any medical treatment standards it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation

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injuries. The managed care plan shall make the standards available for review by the commissioner upon request. All managed care plan health care providers and those providing services under part 5218.0500 shall be governed by these treatment standards and by the standards adopted by the commissioner under *Minnesota Statutes*, section 176.83, subdivision 5. A managed care plan may not prescribe treatment standards that disallow, in all cases, treatment that is permitted by the commissioner's standards. However, this item does not require ongoing treatment in individual cases if the treatment is not medically necessary, even though the maximum amount of treatment permitted under any standard has not been given.

N. The managed care plan must provide other information as the commissioner considers necessary to determine compliance with this chapter.

Subp. 2. **Notification; approval or denial.** Within 30 days of receipt of an application the commissioner must notify an applicant for certification of any additional information required or modification that must be made. The commissioner must notify the applicant in writing of the approval or denial of certification within 30 days of receipt of the additional information or modification. If the certification is denied, the applicant must be provided, in writing, with the reason for the denial.

Subp. 3. **Review of decision.** Any person aggrieved by a denial of certification by the commissioner may request in writing, within 30 days of the date the denial is served and filed, the initiation of a contested case proceeding under *Minnesota Statutes*, chapter 14. Following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with *Minnesota Statutes*, section 14.62. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to *Minnesota Statutes*, sections 176.421 and 176.442.

5218.0200 COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and *Minnesota Statutes*, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Contracts and coverage.** A managed care plan must contract with the insurer liable for coverage of employees with a personal injury under *Minnesota Statutes*, chapter 176. Contracts with the insurer must include the provisions required by part 5218.0300, subpart 1, and are subject to the conditions of coverage in subparts 3 to 6.

Subp. 3. **Multiple plans.** Insurers may contract with multiple managed care plans to provide coverage for employers. When an insurer contracts with multiple managed care plans to cover the same employer, each employee shall have the initial choice within a reasonable time designated by the employer and insurer to select the managed care plan that will manage the employee's care. The employee must select a managed care plan from those that have a contract with the insurer liable for the personal injury under *Minnesota Statutes*, chapter 176, and that provide services within the mileage restrictions under part 5218.0100, subpart 1, item F, subitem (7).

Subp. 4. **Restrictions on employer or insurer formed plans.**

A. A workers' compensation insurer may not own, form, or operate a certified managed care plan. A health maintenance organization or preferred provider organization that is self-insured for workers' compensation is not precluded from applying for certification. An employee of a certified managed care plan shall not be required to obtain services under the plan.

B. A managed care plan, in its application for certification, must disclose to the commissioner the existence of any of the factors in subitems (1) to (4), and any equivalent interest the managed care plan has in an insurer. The commissioner shall consider these factors and any other relevant information in determining whether a managed care plan is owned, operated, or formed by an insurer or employer liable for services under *Minnesota Statutes*, section 176.1351, subdivision 1:

(1) when an insurer or employer, or any member of its staff, directly participates in the formation or certification of the plan;

(2) when an insurer or employer, or any member of its staff assumes a position as a director, or other governing member, officer, agent, or employee of the plan;

(3) when an insurer or employer, or any member of its staff has any ownership interest or similar financial or investment interest in the managed care plan; or

(4) when an insurer or employer, or any member of its staff, enters into any contract with the plan that limits the ability of the plan to accept business from any other insurer or any other source.

This item is not intended to limit cooperative efforts between a managed care plan, employer, and insurer to accomplish the purposes of *Minnesota Statutes*, section 176.1351.

C. For purposes of this subpart, the following definitions apply.

(1) "Staff" means any person who is a regular employee of an insurer or other employer under this rule, or who is a regular employee of any parent or subsidiary entity of an insurer or employer.

(2) "Insurer" includes any subsidiary, parent, or other related entity affiliated with the insurer or employer, including a third party administrator.

Subp. 5. **Coverage.**

A. An employee who gives notice to an employer of a compensable personal injury under *Minnesota Statutes*, chapter 176, on or after the effective date of the managed care plan contract with the insurer liable for the injury under *Minnesota Statutes*, chapter 176, shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract. An employee may not be required to receive medical services under the managed care plan until the notice required by part 5218.0250 is given to the employee.

B. The requirements established in parts 5218.0010 to 5218.0900 do not apply to an employee with a compensable injury under *Minnesota Statutes*, chapter 176, if the employer received notice of the injury before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan according to part 5218.0100, subpart 1, item F, subitems (2) and (3). Services by health care providers who are not participating providers must be delivered according to part 5218.0500.

C. Except as provided in part 5218.0500, an employer may elect to require an employee who has notified the employer of a claimed workers' compensation injury to receive treatment from a certified managed care plan before the employer accepts or denies liability for the injury. In such cases, the employer is liable for the cost of any treatment related to the claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury. If liability is denied, the employer cannot pursue reimbursement from the employee. This item does not limit the employer's right to pursue any other applicable subrogation or reimbursement rights it may have against another entity.

D. The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer, after notice of a claimed injury, does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee from the health care provider. If the employer admits liability for the claimed injury within 14 days after receiving notice of the injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.0500, before the injury. If liability is admitted or determined later than 14 days after notice of the injury and the employee has been receiving treatment from a nonparticipating provider under this item, the employee is not required to receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.0500, subpart 2.

Subp. 6. **Termination of coverage.** To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract or a contract with a health care provider terminates. When a contract with a health care provider terminates, or when managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the health care provider under the terminated contract until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures in part 5218.0100, subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.0500.

5218.0250 NOTICE TO EMPLOYEE BY EMPLOYER.

An employee who is otherwise covered by a certified managed care plan is not required to receive services under a managed care plan until the employer gives the employee notice of items A to E. This individual notice must be given at the time of enrollment and offered again when the employer receives notice of the injury. In addition, the employer must post a notice of items A to E at a prominent location on the employer's premises. The posted notice shall remain posted as long as the employees are covered by the managed care plan. The posted and individual notices must include the information in items A to E:

A. that the employer has enrolled with the specified managed care plan to provide all necessary medical treatment for workers' compensation injuries after a specified date. An employee with an injury prior to enrollment is covered only if the employee changes doctors. The specified date must be later than the date the notice is posted;

B. the contact person and telephone number of the employer and the managed care plan who can answer questions about managed care;

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C. that the employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist, if the treatment is available within the community and is appropriate for the injury or illness;

D. how the employee can access care under the managed care plan and the 24 hour telephone number of the managed care plan that informs employees of available services;

E. that the employee is required to receive services from a health care provider who is a member of the managed care plan, except in the following circumstances:

(1) if the employee has established a relationship with a health care provider who is able to treat the injury and who has treated the employee at least two times within the previous two years before the injury, except that if the employee changes doctors it must be to a doctor within the managed care plan;

(2) in an emergency; and

(3) if the employee's place of employment and residence are beyond the mileage parameters set forth in part 5218.0100, subpart 1, item F, subitem (7); and

F. the St. Paul, Duluth, and toll-free telephone numbers of the Department of Labor and Industry for questions.

5218.0300 REPORTING REQUIREMENTS FOR CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of the following contracts.

A. Contracts between the managed care plan and any insurer or self-insured employer, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts must include a list of signatories and a listing of all employers covered by each contract including the employer's names, unemployment insurance identification number, and estimated number of employees governed by the managed care plan contract. Amendments and addendums to the contracts must be submitted to the commissioner within 30 days of execution. Contract provisions must be consistent with parts 5218.0010 to 5218.0900 and *Minnesota Statutes*, section 176.1351. The contract must specify the billing and payment procedures and how the medical case management and return to work functions will be coordinated.

B. New types of agreements between participating health care providers and the managed care plan, which shall not be effective until approved by the commissioner.

C. Contracts between the managed care plan and any entity, other than individual participating providers, that performs some of the functions of the managed care plan.

Subp. 2. **Annual reporting.** In order to maintain certification, each managed care plan shall provide on the first working day following each anniversary of certification the following information in items A to D. The annual report must be accompanied by a nonrefundable fee of $400:

A. a current listing of participating health care providers, including provider names, specialty, business address, and telephone number, and for any new health care provider the information required by part 5218.0100, subpart 1, item D;

B. a summary of any sanctions or punitive actions taken by the managed care plan against its participating providers;

C. a report that summarizes peer review, utilization review, reported complaints and dispute resolution proceedings showing cases reviewed, issued involved, and any action taken; or

D. a report of educational opportunities offered to participating providers and a summary of attendance.

Subp. 3. **Plan amendments.** Any of the proposed changes to the certified managed care plan in items A to D, other than changes to the health care provider list, must be reported and may not be implemented under the plan until approved by the commissioner. Submitted changes must be accompanied by a nonrefundable fee of $150:

A. amendments to any contract with participating health care providers;

B. amendments to contracts between the managed care plan and another entity performing functions of the managed care plan;

C. changes in the managed care plan's ownership, organizational status or affiliation with an insurer, employer, or third party administration under part 5218.0200, subpart 3; and

D. any other amendments to the managed care plan as certified.

Subp. 4. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies related to the workers' compensation claim required by the insurer to determine compensability in accordance with *Minnesota Statutes*, sections 176.135, subdivision 7, and 176.138, and any other data required by rule.

Subp. 5. **Monitoring.** The commissioner shall require additional information from the managed care plan if the information is relevant to determining the managed care plan's compliance with parts 5218.0100 to 5218.0900 and *Minnesota Statutes*, section 176.1351.

5218.0400 COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota or other applicable state of practice.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in accordance with part 5218.0200, subpart 6.

5218.0500 HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** A health care provider who is not a participating health care provider may provide medical services to an employee covered by a managed care plan in any of the circumstances in items A to D. The employer or insurer must notify the managed care plan of treatment under items A, B, and D and the managed care plan, employer, or insurer must initiate the contact with the nonparticipating provider.

A. A nonparticipating provider may deliver services to an employee if the health care provider maintains the employee's medical records, has a documented history of treatment of that employee at least twice in the two years before the date of injury, whether for a work-related condition or not, and so long as the provider complies with *Minnesota Statutes*, section 176.1351, subdivision 2, clause (8). A documented history of treatment does not include evaluations for no or minimal compensation or treatment of an injury before notice of the injury is given to the employer. The employee must promptly provide the insurer with copies of medical records documenting the previous treatment. The insurer must treat the medical records as private data. If the employee requests a change of doctor, further services shall be provided by the managed care plan according to part 5218.0100, subpart 1, item F, subitems (2) and (3).

B. A nonparticipating provider may deliver services to an employee for emergency treatment.

C. A nonparticipating provider may deliver services to an employee when the employee is referred to the provider by the managed care plan.

D. A nonparticipating provider may deliver services to an employee when the employee has received treatment for a claimed injury from a nonparticipating provider under part 5218.0200, subpart 5, item D, and liability for the injury is admitted or established later than 14 days after the employer received notice of the injury.

Subp. 2. **Requirements.** To deliver services to an employee under subpart 1, items A and D, a health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized services, including without limitation physical therapy and diagnostic testing, except for minor diagnostic testing that may be done in the nonparticipating provider's office. The nonparticipating provider referring the employee may continue to act as the primary treating provider.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.0700. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.0700. A health care provider who has been informed that an injured employee is covered by a managed care plan and who does not comply with the requirements in subpart 2 is subject to denial of payment for the services in accordance with the procedures in part 5218.0700 and sanctions under *Minnesota Statutes*, section 176.103.

5218.0600 CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and *Minnesota Statutes*, section 176.135, subdivision 6, and shall be the amount allowed under part 5221.0500 and *Minnesota Statutes*, section 176.136, subdivisions 1a and

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1b. A managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

5218.0700 DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to the delivery of health services under this chapter shall first be processed without charge to the employee or health care provider through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a written request. If the dispute cannot be resolved, the parties may proceed under *Minnesota Statutes*, sections 176.106 and 176.305 or 176.2615.

5218.0750 UTILIZATION REVIEW AND PEER REVIEW.

Subpart 1. **Peer review.** The managed care plan must implement a system for peer review to improve patient care and cost effectiveness of treatment. Peer review must include at least one health care provider of the same discipline being reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review, and how the results will be used.

Subp. 2. **Utilization review.** The managed care organization must implement a program for utilization review. The program must include the collection, review, and analysis of group data to improve overall quality of care and efficient use of resources. In its application for certification, the managed care plan must specify the data that will be collected, how the data will be analyzed, and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

5218.0760 MEDICAL CASE MANAGEMENT.

Subpart 1. **Role of case manager.** The medical case manager must monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment, and other health services needed by an injured employee, and must promote an appropriate, prompt return to work. Medical case managers must facilitate communication between the employee, employer, insurer, health care provider, managed care plan, and any assigned qualified rehabilitation consultant to achieve these goals. The managed care plan must describe in its application for certification how employees will be selected for case management, the services to be provided, and who will provide the services.

Subp. 2. **Qualifications of medical case manager.** Case management for an employee covered by a managed care plan must be provided by a licensed or registered health care professional. Case managers must have at least one year's experience in workers' compensation.

5218.0800 MONITORING RECORDS.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.**

A. All records of the managed care plan and its participating health care providers relevant to determining compliance with parts 5218.0010 to 5218.0900 and *Minnesota Statutes*, section 176.1351, shall be disclosed within a reasonable time after request by the commissioner. Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

B. The release of records filed with the commissioner is subject to *Minnesota Statutes*, sections 13.37, 145.61 to 145.67, 176.231, subdivisions 8 and 9, 176.234, and 176.138. If a managed care plan believes that portions of its application are nonpublic trade secret data under *Minnesota Statutes*, section 13.37, subdivisions 2 and 3, the plan's application must clearly identify the portions of the application it identifies as trade secret in a separate appendix or appendices.

The plan must also submit with the application an analysis of how each section of the appendix it has characterized as trade secret satisfies each of the three parts of the statutory definition of trade secret under *Minnesota Statutes*, section 13.37, subdivision 2. Absent a clear indication to the contrary, a written opinion submitted by an attorney identifying and analyzing portions of the application as meeting the statutory requirements for a trade secret under *Minnesota Statutes*, section 13.37, subdivision 2, shall be considered prima facie showing of a trade secret.

5218.0900 SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0010 to 5218.0900 or *Minnesota Statutes*, section 176.1351, by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the investigation reveals reasonable cause to believe that there has been a violation warranting suspension or revocation of certification, the commissioner shall initiate a contested case proceeding under *Minnesota Statutes*, chapter 14.

Subp. 2. **Criteria.** Under *Minnesota Statutes*, section 176.1351, subdivision 5, the certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0010 to 5218.0900 or *Minnesota Statutes*, section 176.1351;

C. the managed care plan fails to comply with parts 5218.0010 to 5218.0900 and *Minnesota Statutes*, section 176.1351, or requirements of utilization and treatment standards adopted under *Minnesota Statutes*, section 176.83;

D. any false or misleading information is submitted by the managed care plan or participating provider;

E. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked, or under *Minnesota Statutes*, section 176.103, or who is ineligible to provide treatment to an injured employee under *Minnesota Statutes*, section 256B.0644; or

F. the managed care plan is formed, owned, or operated by an insurer.

Subp. 3. **Effects.** No employee is covered by a contract between a managed care plan and insurer if the managed care plan's certification is revoked. The managed care plan may reapply for certification as specified in the order of revocation. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under *Minnesota Statutes*, section 176.135.

Proposed Permanent Rules Relating to Independent Medical Examination Fees

Rules as Proposed (all new material)

5219.0500 INDEPENDENT MEDICAL EXAMINATION FEES.

Subpart 1. **Authority.** This part is adopted under the authority of *Minnesota Statutes*, section 176.136, subdivision 1c.

Subp. 2. **Definition.** For purposes of this part, the language contained in *Minnesota Statutes*, section 176.136, subdivision 1c: "for, or in connection with, independent or adverse medical examinations requested by any party" means charges by a health care provider as defined by *Minnesota Statutes*, section 176.011, subdivision 24, with regard to examinations conducted pursuant to *Minnesota Statutes*, section 176.155, subdivision 1, for:

A. review of medical records;

B. obtaining history from and examination of an employee;

C. reading, interpretation, and analysis of X-rays or other diagnostic imaging or tests;

D. diagnosis, analysis, treatment recommendations, and preparation of written report;

E. travel expenses and charges;

F. preparation of postexamination supplemental reports;

G. reserve time and cancellation fees;

H. depositions and court appearances;

I. conferences with attorneys; and

J. mental health professionals' hourly charges.

Subp. 3. **Charges.** Charges by a health care provider as defined by *Minnesota Statutes*, section 176.011, subdivision 24, for or in connection with independent medical examinations pursuant to *Minnesota Statutes*, section 176.155, must not exceed the cost specified in items A to J.

A. The charge for review of medical records is as follows:

(1) for all or part of the first 50 pages, $175; and

(2) for all or part of each additional 50 pages, $100.

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B. The charge for obtaining a history from and examination of an employee is $275.

C. The charge for reading, interpretation, and analysis of X-rays and other diagnostic imaging or tests is $75.

D. The charge for a diagnosis, analysis, treatment recommendations, and a written report is $250.

E. The charge for travel expenses is as follows:

(1) the cost of actual travel expenses incurred. If appropriate, mileage at the maximum rate allowed for deductions by the Internal Revenue Service may be charged in lieu of air, bus, train, or other fare or the actual expenses incurred for the use of one's automobile; and

(2) travel surcharge:

(a) within the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties), no charge; and

(b) outside of the seven-county metropolitan area, $75.

F. The charge for postexamination supplemental reports is as follows:

(1) for postexamination supplemental reports within six months of date of examination, $150; and

(2) an additional charge for reviewing additional records for postsupplemental reports of more than 25 pages, $100.

G. The charge for reserve time charges and cancellation fees. In the event a scheduled examination is canceled or the employee does not appear for the examination:

(1) if canceled at least three business days before the examination date, no charge;

(2) if the employee fails to appear for the examination, or the examination is canceled less than three business days before the examination date, $400.

These charges are in lieu of the amounts specified in items A to E.

H. The charge for depositions and court appearances are as follows:

(1) for the first review of new or additional medical records in preparation for a deposition or court appearance, the same charge as in item A;

(2) for the review of previously studied records in preparation for a deposition or court appearance, $75 for a review of up to 50 pages, and $37.50 for each additional 50 pages or part thereof;

(3) deposition, including predeposition attorney conferences, $400 per hour for a minimum of two hours;

(4) court appearance, $400 per hour for a minimum of three hours;

(5) cancellation fees for depositions and court appearances are as follows:

(a) if canceled six business days before the deposition or appearance, no charge;

(b) if canceled on the fifth, fourth, or third business day before the deposition or appearance, $500;

(c) if canceled two business days before the deposition or appearance, $700; and

(d) if canceled one business day before or on the same day as the deposition or appearance, $800.

I. The charge for attorney conference, other than at the time of deposition is $200 per hour with a one hour minimum.

J. The charge for psychiatrists or psychologists is $200 per hour for review and analysis of medical data, in lieu of the charges in items A to E.

Subp. 4. **Adjustments.** On October 1, 1994, and on October 1 of each succeeding year, the fees in this part must be adjusted by the percentage determined under *Minnesota Statutes*, section 176.645, in the same manner as the conversion factor of the relative value fee schedule is adjusted under *Minnesota Statutes*, section 176.136. This provision does not apply to expenses under subpart 3, item E, subitem (1).

Proposed Permanent Rules Relating to Workers' Compensation; Rules of Practice

Rules as Proposed

5220.0105 INCORPORATION BY REFERENCE.

The following documents are incorporated by reference only to the extent specifically referenced in ~~parts 5220.0100 to 5220.1910~~ chapter 5220. The documents in items A and B are not subject to frequent change, although new editions may occasionally be

published. The documents in item C are revised annually. All documents are available through the Minitex interlibrary loan system.

A. The Dictionary of Occupational Titles, fourth edition, ~~1977~~ 1991, United States Department of Labor, is available for purchase through the Superintendent of Documents, United States Government Printing Office, Washington, DC 20402. ~~A revised edition is planned for late 1991.~~

[For text of items B and C, see M.R.]

5220.2510 SCOPE AND PURPOSE.

~~Parts 5220.2510 to 5220.2950 together with parts 5220.0100 to 5220.1910 govern~~ Chapter 5220 governs all workers' compensation matters before the commissioner of the Department of Labor and Industry ~~except matters which are governed by the joint rules of practice of the Workers' Compensation Division~~ and the Office of Administrative Hearings ~~in parts 1415.0100 to 1415.3600~~. The Joint Rules of Practice of the Workers' Compensation Division and the Office of Administrative Hearings in chapter 1415 also govern workers' compensation matters.

5220.2520 DEFINITIONS.

Subpart 1. **Scope.** Terms used in parts 5220.2510 to ~~5220.2950,~~ 5220.2960 have the meanings given them in part 1415.0300 and this part and *Minnesota Statutes*, section 176.011.

[For text of subps 2 to 8, see M.R.]

Subp. 9. [See repealer.]

Subp. 10. [See repealer.]

5220.2530 FIRST REPORT OF INJURY.

The first report of injury must be fully completed and submitted ~~in duplicate~~ to the division within the time limits established by *Minnesota Statutes*, section 176.231. It must be on a form prescribed by the commissioner, containing substantially the following:

A. information identifying the employee, employer, insurer, and any adjusting company, including numbers identifying the employer, insurer, adjusting company, and insurer class code;

B. claim numbers ~~or codes~~ and Occupational Safety and Health log number;

[For text of item C, see M.R.]

D. information regarding employment status and ~~the job held at the time of injury~~ occupation, including date of hire;

E. information regarding the circumstances of the injury, including the date, place, time, persons or objects involved, and the date notice was received by the employer~~,~~ and ~~the name of the person who received notice~~ insurer;

[For text of item F, see M.R.]

G. information regarding lost time from work; and

H. information identifying the treating physician~~;~~.

~~I. information identifying the employee's next of kin if the injury or disease has resulted in the death of the employee; and~~

~~J. verification by the employer or the employer's authorized representative and the date of submission to the insurer.~~

Failure to file the report in a timely manner may result in the assessment against the employer or insurer of the penalty set out in part 5220.2820 and against the insurer of the penalty set out in part 5220.2770.

5220.2540 PAYMENT OF TEMPORARY TOTAL, TEMPORARY PARTIAL, OR PERMANENT TOTAL COMPENSATION.

Subpart 1. **Time of payment.** Payment of compensation must be commenced within 14 days of:

[For text of items A and B, see M.R.]

C. an order by the division, compensation judge, or workers' compensation court of appeals requiring payment of benefits which is not appealed. A party's consideration of an appeal does not excuse payment beyond the 14-day time limit. When an appeal is not filed, payments made after the 14th day are subject to penalties and interest under parts 5220.2760 and 5220.2780.

Once temporary total or permanent total disability benefits have been commenced, they must continue to be paid on a regular basis~~.~~ ~~Payments are due on the date~~ at the intervals the employee would have received wages from the employer had the employee continued

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working. Less frequent payments may be arranged by written agreement of the parties. With the initial payment of temporary total or permanent total disability benefits, the insurer must notify the employee in writing of the day of the week that further payments will be made and the frequency with which payments will be made.

The same time limits apply to payments of temporary partial disability benefits. If the current wage varies so that wage documentation for calculation of temporary partial disability benefits is necessary, payment is due ten days following the date the employee or employer sends wage verification to the insurer.

[For text of subp 2, see M.R.]

Subp. 2a. **Suitable employment.** If a rehabilitation plan has been completed, the employee is ineligible for rehabilitation services, or the employee has not requested rehabilitation services, a job which pays at least 50 percent of the gross weekly wage on the date of injury is economically suitable under *Minnesota Statutes*, section 176.101, subdivision 3e, if the job represents the employee's current earning capacity and that earning capacity cannot reasonably be expected to significantly change.

Subp. 3. **Notice to division.** The insurer must keep the division advised of all payments of compensation and amounts withheld and amounts paid for attorney fees ~~by the filing of interim status reports 60 days after commencement of payment or an R-1 form, and thereafter each year on the anniversary date of the injury unless another time interval is specified~~ upon request by the division.

The insurer must also file with the division proof of payment which must indicate the amount of compensation paid and the date when the first payment was made, at each of the following times:

A. when the insurer makes the first payment to the employee following the injury;

B. when payments are reinstated after they have been previously discontinued by a notice of ~~discontinuance~~ intention to discontinue benefits or an order of the division under part 5220.2640, subpart 7;

C. when monitoring period compensation is commenced under *Minnesota Statutes*, section 176.101, subdivision 3i; ~~or~~ and

D. when payments are commenced by order of the division, a compensation judge, the workers' compensation court of appeals, or the Minnesota Supreme Court.

[For text of subp 4, see M.R.]

Subp. 5. **Removal from the labor market.** An employee who voluntarily removes himself or herself from the labor market is no longer entitled to temporary total, temporary partial, or permanent total disability benefits. A removal from the labor market has occurred when the employee is released to return to work by a health care provider and the employee retires or the employee's opportunities for gainful employment or suitable employment are significantly diminished due to the employee's move to another labor market.

Subp. 6. **Permanent total disability.** An employee shall not be found to be permanently and totally disabled within the meaning of *Minnesota Statutes*, section 176.101, subdivision 5, clause (2), unless the employee has not refused a suitable job under *Minnesota Statutes*, section 176.101, subdivision 3e, and the employee:

A. has a permanent partial disability rating of at least 20 percent of the whole body;

B. has a permanent partial disability rating of at least 17 percent of the whole body, and:

(1) is over 45 years old;

(2) has not earned a high school diploma or its equivalent; or

(3) has been employed during the three years immediately preceding the disability only in jobs classified by the Dictionary of Occupational Titles, fourth edition, 1991, at specific vocational preparation level three or below;

C. has a permanent partial disability rating of at least 14 percent of the whole body and has two of the following three characteristics:

(1) is over 45 years old;

(2) has not earned a high school diploma or its equivalent;

(3) has been employed during the three years immediately preceding the disability only in jobs classified by the Dictionary of Occupational Titles, fourth edition, 1991, at specific vocational preparation level three or below;

D. has a permanent partial disability rating of at least ten percent of the whole body, and:

(1) is over 45 years old;

(2) has not earned a high school diploma or its equivalent; and

(3) has been employed during the three years immediately preceding the disability only in jobs classified by the Dictionary of Occupational Titles, fourth edition, 1991, at specific vocational preparation level three or below;

E. has been evaluated by the vocational rehabilitation unit of the division and it has been found by that unit that the employee would be unlikely to be able to secure anything more than sporadic employment resulting in an insubstantial income even after the employee had received all appropriate services under *Minnesota Statutes*, section 176.102; or

F. has diligently searched for employment for a period of at least two years and has been unable to secure anything more than sporadic employment resulting in an insubstantial income. To show that a diligent search has been made, the employee must keep a detailed record of the job search if the employee is capable of doing so. As time progresses, the employee must expand the area in which a job is sought. If there are no jobs available in the occupation in which the employee has training or experience, the employee must expand the job search to include jobs outside of the employee's training or experience but which have been identified by the vocational rehabilitation unit of the division or the employee's qualified rehabilitation consultant as jobs the employee is physically able to perform and which would provide or be consistent with a rehabilitation plan to eventually provide an economically suitable wage under part 5220.2540, subpart 2a.

Subp. 7. **Apprentices, temporary partial disability benefits.** An apprentice, upon return to the same apprenticeship program in the same position or a similar position to that held on the date of injury, has not suffered a loss of earning capacity where the wage upon return to the apprenticeship program is the same or greater than the wage on the date of injury. Temporary partial disability benefits are not owing where there is no loss in earning capacity.

5220.2550 PAYMENT OF PERMANENT PARTIAL DISABILITY, INCLUDING IMPAIRMENT COMPENSATION AND ECONOMIC RECOVERY COMPENSATION.

Subpart 1. **Time of payment.** Permanent partial disability must be paid at the time specified in *Minnesota Statutes*, sections 176.021 and 176.101. When permanent partial disability compensation is being paid periodically following the payment of temporary total benefits or following or concurrent with the payment of temporary partial benefits, the payments must be continued without interruption at the same intervals that the temporary benefits were paid. When the employee reaches maximum medical improvement, the insurer must request an initial assessment of any permanent partial disability from the employee's physician.

A. When the extent of permanent partial disability is not disputed, upon receipt of a medical report containing a permanency rating or medical information from which the insurer may determine a rating, the employer or insurer must, within 30 days:

[For text of subitems (1) and (2), see M.R.]

B. When the extent of permanent partial disability is disputed, upon receipt of a medical report containing a permanency rating or medical information from which the insurer may determine a rating, the employer or insurer must, within 30 days:

(1) make a minimum lump sum payment or begin periodic payments based on ~~no less than the lowest available medically documented rating~~ the minimum undisputed permanent partial disability ascertainable; and

[For text of subitem (2), see M.R.]

C. If permanent partial disability benefits are not currently payable under *Minnesota Statutes*, section 176.101, inform the employee in writing of the disability rating and the time when the permanent partial disability payment will be payable by statute.

Subp. 2. **Notice ~~to division~~ of benefit payment.**

[For text of item A, see M.R.]

B. For injuries on or after January 1, 1984, when the insurer makes a lump sum payment of permanent partial disability benefits or begins periodic payment, the employer or insurer shall fully complete, serve on the employee, and file with the division a notice of permanent partial disability benefits which must be on a form prescribed by the commissioner, containing substantially the following information:

[For text of subitems (1) to (5), see M.R.]

(6) instructions to the employee concerning any disagreement about the payment;

[For text of subitems (7) and (8), see M.R.]

(9) copies of medical reports containing disability ratings or medical information upon which the insurer bases the rating;

[For text of subitems (10) and (11), see M.R.]

Subp. 2a. **Inability to return to former employment.** An employee is not "unable to return to former employment" within the

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meaning of *Minnesota Statutes*, section 176.101, subdivision 3t, paragraph (b), when the employee returns to suitable employment with the employer.

[For text of subps 3 and 4, see M.R.]

5220.2555 RETRAINING COMPENSATION.

An employee who has been approved for retraining under *Minnesota Statutes*, section 176.102, subdivision 11, may petition the commissioner or a compensation judge for additional compensation, not to exceed 25 percent of the compensation otherwise payable, if the employee will incur a special, unusual, or unique circumstance during the retraining period that would otherwise reduce the likelihood that the retraining plan will be successfully completed. Additional compensation is not warranted under this subpart if the circumstance on which the request is based is compensable as a cost of the rehabilitation plan under *Minnesota Statutes*, section 176.102, subdivision 9. The commissioner or a compensation judge may order an award of additional compensation and specify the amount to be awarded. When the employee is entitled to additional compensation for retraining, the compensation shall begin on the first day the special, unusual, or unique circumstance of the retraining is present but not before the start of the retraining program, and shall stop at any time the special, unusual, or unique circumstance is no longer present. The commissioner or compensation judge may determine the date of commencement and the date of discontinuance of the additional compensation.

5220.2560 ATTACHMENT AND GARNISHMENT OF BENEFITS.

Workers' compensation benefits are not subject to attachment or garnishment, although they may be withheld under *Minnesota Statutes*, sections 518.54, subdivision 6, and 518.611, and paid for child support or spousal maintenance, if the other requirements of those statutes are met. Upon request, the insurer shall file with the division a statement of the amount being withheld from the employee's benefits and paid to the county or obligee, a copy of the order for withholding of income, and verification of payments made.

5220.2570 DENIALS OF LIABILITY.

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

Subp. 2. **Denial of liability form.** A denial of primary liability under *Minnesota Statutes*, section 176.221, subdivision 1 (, except a letter denial under subpart 4 or 5), must be fully completed and on a form prescribed by the commissioner, containing substantially the following:

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

E. a specific reason for the denial which must be in language easily readable and understandable to a person of average intelligence and education and clearly state a clear statement of the facts forming the basis for the denial. A denial which states only that the injury did not arise out of and in the course and scope of employment or that the injury was denied for lack of a medical report, for example, is not specific within the meaning of this item; and

F. a copy of a medical report or summary of any health care provider contact which forms a basis for the denial; and

G. instructions to the employee if the employee disagrees, including the availability of rehabilitation benefits, the statute of limitations for filing a workers' compensation claim, and the address and telephone numbers of division offices the employee may contact for information.

Subp. 3. **Notice of intention to discontinue benefits.** A denial of primary liability filed more than 30 days after notice to or knowledge by the employer of a work-related injury which is required to be reported to the commissioner under *Minnesota Statutes*, section 176.231, subdivision 1, and for which benefits have been are being paid must be made by a notice of intention to discontinue benefits under part 5220.2630 and must clearly indicate that its purpose is to deny liability for the entire claim.

Subp. 4. **Letter denial for new period of temporary total.** A denial of liability for temporary total disability benefits for a new period of lost time due to a previous work-related injury must be in writing and include:

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

E. a specific reason for the denial in language easily readable and understandable to a person of average intelligence and education and clearly state a clear statement of the facts forming the basis for the denial.

Subp. 5. **Letter denial for other benefits.** A denial of liability for a portion of benefits or any other compensation where primary liability has been accepted, must be in writing and include:

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

E. a specific reason for the denial in language easily readable and understandable to a person of average intelligence and education and clearly state a clear statement of the facts forming the basis for the denial.

Subp. 6. **Service.** The employer or insurer shall, as provided in part 5220.2890, serve on the employee the form or letter under subparts 1 to 5 with any relevant medical or other reports attached and file a copy to with the division.

[For text of subp 7, see M.R.]

Subp. 8. [See repealer.]

Subp. 9. **Penalty; timeliness.** Failure to pay or deny in a timely manner may result in the assessment of the penalties set out in parts 5220.2770 and 5220.2790.

Subp. 10. **Penalty; frivolous denial.**

A. A frivolous denial under *Minnesota Statutes*, section 176.225, subdivision 1, clause (a), includes one which:

(1) does not state facts indicating that an investigation has been completed or that a good faith effort to investigate has been attempted; or

(2) states a basis which is a clearly inaccurate statement of fact or the applicable law.

B. In addition to any workers' compensation benefits due and a penalty under subpart 9, a penalty may be assessed by the division or compensation judge under parts 5220.2760 and 5220.2770 and *Minnesota Statutes*, sections 176.221, subdivision 3a, and 176.225, subdivision 1, for a frivolous denial.

Subp. 11. **Penalty; nonspecific denial.** A nonspecific denial as defined in subpart 2, item E; 4, item E; or 5, item E, may result in the assessment of a penalty in the amount of $300 under *Minnesota Statutes*, section 176.84, subdivision 2. A penalty for a nonspecific denial may be assessed without regard to the substantive validity of the denial of benefits. A penalty under this subpart may be assessed in addition to the penalties described in subparts 9 and 10 and is payable to the special compensation fund.

5220.2580 CLAIM FOR REFUND FROM EMPLOYEE OR DEPENDENT; OVERPAYMENTS.

Subpart 1. **Request for refund.** All requests for refunds or reimbursements by an insurer for payments made under a mistake of fact or law, which were allegedly not received by an employee or dependent in good faith, must be made in writing to the employee with a copy immediately mailed to the attorney representing the employee or dependent, if any, and upon request to the division.

Subp. 2. **Contents of request.** All requests must ~~clearly indicate the basis for believing payments were not received in good faith, and set forth~~ contain the following information:

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

D. the mistake of fact or law which forms the basis for the claimed overpayment; ~~and~~

E. the reason the insurer believes the payments were not received in good faith; and

F. a statement informing the employee that, if the employee has any questions regarding the legal obligations to repay any claims for overpayment alleged to have not been received in good faith, the employee should contact either a private attorney or the division.

Subp. 3. **Overpayments.** The insurer that overpaid benefits that were received by the employee in good faith may take the credit allowed under *Minnesota Statutes*, section 176.179, after giving notice to the employee of the information in subpart 2, items A to F. Benefits paid pursuant to *Minnesota Statutes*, section 176.239, subdivision 3, are not overpaid benefits unless so ordered by a compensation judge under *Minnesota Statutes*, section 176.239, subdivision 9.

5220.2605 DISPOSITION OF COVERAGE ISSUES.

Subpart 1. **Motion.** If an answer filed under *Minnesota Statutes*, section 176.321, raises an issue related to independent contractor or employment status, a party may move to bifurcate the issue or issues for immediate and expedited resolution upon affidavit or, if requested by any party, an oral hearing.

Subp. 2. **Filing.** The motion must be filed with the division, or the office if the matter has been certified to the office, within ten days after the filing of the answer. The motion, which must be served upon the petitioner or petitioner's attorney and other parties to the proceedings, must include (1) an affidavit of service; (2) evidence relied on in support of the motion by verified affidavits; (3) any request and reasons for an oral hearing; and (4) if desired, a written brief not exceeding 25 pages in support of the motion. Other parties to the proceeding may respond to the motion within 20 days after the service of the motion under this part by submission of affidavits and, in its discretion, a written brief not exceeding 20 pages. The movant will have ten days from service of a response to the motion to file affidavits and, if desired, a written brief not exceeding ten pages in rebuttal to any issue raised in opposition to the motion.

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Subp. 3. **Decision; hearing.** The judge may determine the motion on the basis of the written matter submitted, or may, on the judge's own motion or upon motion of a party, schedule a hearing. If a hearing is scheduled, the parties must be served with notice of hearing at least 20 days before the hearing. The parties may present the issues fully, including the right to introduce evidence supplementing that presented by affidavit and the right to cross-examine adverse witnesses.

Subp. 4. **Appeal.** Whether or not a hearing is held, the judge shall issue a decision based on the facts presented. This decision may be appealed to the Workers' Compensation Court of Appeals.

Subp. 5. **Hearing on the merits.** The commissioner or compensation judge shall schedule a hearing on other issues not decided under this subpart, if needed, following a final decision on the motion under this subpart and any related appeal.

5220.2610 ADMINISTRATIVE CONFERENCES.

Subpart 1. **Scope.** This part governs administrative conferences conducted under *Minnesota Statutes*, sections ~~176.102, 176.103, 176.242, 176.2421, and 176.243, and applies to all medical, rehabilitation, discontinuance, and return to work conferences conducted by the division~~ 176.106 and 176.239.

Subp. 2. **Notice.** Unless the issue will be decided on the basis of written submissions, or unless the parties agree on a shorter notice period, the division must ~~promptly~~ notify the parties and intervenors or potential intervenors under *Minnesota Statutes*, section 176.361, of the date, time, and place of the conference at least ten working days before the conference date. The qualified rehabilitation consultant, if one is assigned, must be notified of a rehabilitation conference. The special compensation fund must be notified of all administrative conferences where the fund is reimbursing benefits to an insurer or self-insurer under *Minnesota Statutes*, section 176.131 or 176.132, or a claim has been made under the above referenced statutes against the fund for benefits by any of the parties, or the fund is paying benefits under *Minnesota Statutes*, section 176.191. The notice must ~~explain~~ include the ~~purpose of~~ statutory authority to hold the conference and indicate whether issues from another petition or request form have been joined for consideration at the conference. Telephone notice of the conference at least three working days before the conference date is sufficient for a discontinuance or ~~return to work~~ other expedited conference if timely service of notice by mail cannot be made.

Subp. 3. **Appearances.** All parties and the qualified rehabilitation consultant, if the conference is conducted under *Minnesota Statutes*, section ~~176.102,~~ 176.106 concerning rehabilitation services, must be given notice and the opportunity to attend administrative conferences or, at their option, to present documents on their behalf. ~~Intervenors or a representative of the special compensation fund~~ A person who has an interest in the outcome of the conference such that the person may either gain or lose by the decision may attend the conference. A party may be represented by an attorney. The employee and insurer or designated person having authority to act on behalf of the party regarding the matter in dispute is required to attend an administrative conference under *Minnesota Statutes*, section ~~176.242, 176.2421, or 176.243~~ 176.239, unless health reasons, distances, or other good cause prevents attendance. If absent because of distance, the employee and insurer or authorized designee of the employee and insurer must be available by telephone at the scheduled conference time.

Subp. 4. [See repealer.]

Subp. 5. **Information considered.** The presiding official shall permit the parties to ~~state~~ present their positions and ~~to present~~ reports or other documents or exhibits relevant to the issues involved. ~~There is no provision in the statute for costs for testimony at a medical administrative conference.~~ Reasonable opportunity for parties to refute statements or other information submitted ~~at the conference~~ must be allowed. Copies of documents submitted ~~at the conference~~ must be simultaneously supplied to the other parties.

Subp. 6. **Concurrent litigation.** When the same or a nearly identical issue in the same case is pending with the office, the workers' compensation court of appeals, or another court, the division must decline to issue a decision and defer to the office or court to avoid inconsistent determinations.

Subp. 7. **Continuance.** Continuances are disfavored and will be granted only upon a showing of good cause for the inability or failure to appear at a conference. Good cause generally means that circumstances beyond the control of the party or party's representative prevent attendance at the scheduled time. Before a continuance is granted, the division must consider receiving written arguments and supporting documentation in place of the scheduled conference.

Subp. 8. **Intervenors.** If, at the time of the conference, the division determines that a potential party has not been notified of the conference, the conference must be canceled or continued, the parties may enter into an agreement which does not compromise the rights of the potential party, or the division must issue a decision which does not compromise the rights of the potential party. A potential party is a person who has an interest in the outcome of the conference under *Minnesota Statutes*, section 176.361, such that the person may either gain or lose by the decision to be made following the conference.

Subp. 9. **Decision.** The decision following an administrative conference shall include a determination concerning the rights an intervenor or potential intervenor under *Minnesota Statutes*, section 176.361, may have in the dispute. The decision must include a statement indicating the right to request a formal hearing and explain how to initiate the request.

Subp. 10. **Testimony cost.** The division shall not order reimbursement of costs for testimony at an administrative conference.

5220.2620 MEDICAL ~~CONFERENCES~~ DISPUTES.

Subpart 1. **~~Definitions~~ Definition.** For purposes of this part, the following ~~terms have~~ term has the ~~meanings~~ meaning given ~~them~~.

"Medical issues" ~~refers to~~ means all health care rendered under *Minnesota Statutes*, sections 176.135 and 176.136, and determinations by the division under *Minnesota Statutes*, ~~section~~ sections 176.103 and 176.106, and includes:

A. ~~the reasonableness of a fee for health care services~~ whether the charge is a reasonable charge as described and allowed by chapter 5221 and *Minnesota Statutes*, section 176.136;

B. the reasonableness and necessity of ~~medications, health supplies, articles, and equipment~~ a medical service or treatment as described and allowed by chapter 5221 and *Minnesota Statutes*, sections 176.135 and 176.136;

C. ~~the failure to pay a bill for health care services, treatment, equipment or supplies, or other health care under *Minnesota Statutes*, section 176.135, subdivision 1;~~

~~D. the reasonableness and necessity of treatment;~~

~~E.~~ the need for a second opinion prior to surgery;

~~F.~~ D. a request for change of ~~physician~~ primary health care provider;

~~G.~~ E. the employee's cooperation with medical treatment;

~~H.~~ F. the inability to secure a health care provider report;

~~I. the reasonableness and necessity of nursing services;~~

~~J. the appropriateness of a medical service;~~

~~K.~~ G. the relationship of the health care to the work injury;

~~L. whether treatment for a medical condition is required as a result of a work-related injury;~~

~~M.~~ H. the assessment of penalties or interest for untimely response to medical billings~~;~~ and failure to provide at an administrative conference a specific reason for nonpayment of the items in dispute;

I. the availability of medical services from a managed care organization under *Minnesota Statutes*, section 176.1351; and

~~N.~~ J. other problems related to medical treatment and supplies.

Subp. 2. **Medical claim, request.** An employee~~,~~ or insurer~~, or health care provider as defined by *Minnesota Statutes*, section 176.011, subdivision 24,~~ may initiate a medical claim by filing ~~an M-4 "request for assistance in resolving a workers' compensation medical issue"~~ a medical request form ~~or an M-10 "change of physician" form~~ with the ~~section and~~ division. A medical request form may be filed by a health care provider as defined by *Minnesota Statutes*, section 176.011, subdivision 24, where the insurer has denied payment on the basis that a charge is excessive under *Minnesota Statutes*, section 176.136, subdivision 2. A claim is not denied based on excessiveness where the insurer asserts that the injury did not arise out of and in the course of employment or where the disputed treatment is for a condition which the insurer asserts is not wholly or partly casually related to the work injury. The requesting party shall serve the medical request form and attachments on the other parties, including the employee, insurer, employer, and any health care provider ~~directly involved in the dispute, specifying~~ and other person having an interest in the outcome such that the person may either gain or lose by the resulting decision. The requesting party shall specify the medical issues in dispute and ~~whether an administrative conference is requested~~ attach supporting documents. A health care provider filing a medical request form must attach evidence of the insurer's denial of payment based on excessiveness, an itemized statement of charges, and the appropriate record as defined in part 5221.0100, subpart 1a. The requesting party must also specify the name and address of any third party who has paid or has been ordered to pay to reimburse medical or treatment expense, and the claim or policy number, if known. At the time the ~~M-4~~ medical request form is filed, the requesting party must mail a copy of the ~~M-4~~ medical request form to third parties who have paid benefits. A claim petition containing medical issues only ~~or a referral of a medical issue from the office will~~ may be treated in the same manner as ~~an M-4~~ a medical request form under this subpart if the insurer is not disputing that the injury arose out of and in the course of employment.

Subp. 3. **Medical claims response.** If the employee or health care provider has filed ~~an M-4 or M-10~~ a medical request form, the insurer must file ~~an M-1 medical status report~~ a medical response form with the ~~section~~ division and ~~send~~ serve copies ~~to~~ on the other parties no later than 20 days after service of the ~~M-4 or M-10~~ medical request form. ~~The insurer must respond on an M-10 form to~~

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an M-10 request to change physicians, file the response with the section, and send copies to the other parties no later than 20 days after service of the request to change physicians. Failure to file a required form will be considered in the determination of disputed issues, penalties, and interest charges, and may result in a determination based solely on the written submissions of the requester when an administrative conference is not scheduled.

Subp. 4. [See repealer.]

Subp. 5. **Medical claim; denial of liability.** If an M-4 a medical request form has been mistakenly filed in a case in which initial issues of liability within the jurisdiction of the office exist, the matter will be certified to the office for hearing if the petitioner has standing to file a litigated claim. The date of filing of the form with the section is used by the office to determine when the hearing will be held. After initial issues over which the division does not have jurisdiction have been resolved, any remaining medical issues shall be scheduled for an administrative conference in accordance with this part may be set for a settlement conference before a judge of the division under *Minnesota Statutes*, section 176.305, or the requester will be instructed to file a claim petition, intervene in another proceeding, or other procedure as the division directs.

Subp. 6. [See repealer.]

Subp. 7. [See repealer.]

Subp. 8. [See repealer.]

Subp. 9. [See repealer.]

Subp. 10. [See repealer.]

Subp. 11. [See repealer.]

Subp. 12. **Penalties.** Where payment of medical charges is not made in compliance with part 5221.0600 and *Minnesota Statutes*, section 176.135, a penalty may be assessed under part 5220.2740.

5220.2630 DISCONTINUANCE OF COMPENSATION.

Subpart 1. **Generally.** When an insurer proposes or intends to reduce, suspend, or discontinue an employee's benefits, it shall file one of the following documents described in this part. A form need not be filed when an insurer increases or decreases an employee's periodic temporary partial benefit due to changes in the employee's earnings while employed.

Subp. 2. **Petition.**

A. The filing of a petition to discontinue compensation with the division under part 1415.1000 and *Minnesota Statutes*, section 176.238, subdivision 5, commences a formal action to reduce, suspend, or discontinue compensation. A petition is required to reduce, suspend, or discontinue permanent total benefits if a judicial or administrative order finding permanent total status was previously issued.

B. The petition must include substantially all the items listed in part 1415.1000, subpart 1, except that items H to J must list the benefits which the insurer wishes to discontinue. In addition, it must contain a clear and concise statement of the facts upon which the proposed discontinuance is based. Service and filing of the petition must be in accordance with part 1415.1000, subpart 2.

C. Following the filing of a petition to discontinue benefits, the insurer must continue paying compensation until the matter is resolved by agreement or until a judge orders otherwise.

D. The division shall refer the matter to the office under *Minnesota Statutes*, section 176.241 176.238.

Subp. 3. **Notice of discontinuance benefit payment.**

A. The employer or insurer may discontinue make a lump sum or final payment of the benefit indicated by the filing of a notice of discontinuance benefit payment with the division and service of the notice on the other parties at the time that the payment or return to work occurs when the discontinuance results from payment represents:

(1) a return to work;

(2) a lump sum payment of full permanent partial disability compensation;

(3) (2) a final periodic payment of impairment compensation or economic recovery compensation;

(4) (3) a final payment under an award, order, or stipulation; or

(5) (4) for injuries occurring before August 1, 1975, where the employee is not permanently totally disabled, a final payment of temporary total disability or for injuries occurring before May 28, 1977, a final payment of temporary partial disability based on a statutory maximum number of weekly payments; or

(5) a final payment of monitoring period compensation.

B. A notice of ~~discontinuance~~ benefit payment must be fully completed and on the form prescribed by the commissioner, containing substantially the ~~following:~~ relevant information described in part 5220.2550, subpart 2.

~~(1) information identifying the employee, employer, insurer, and any adjusting company;~~

~~(2) the date of the injury or disease;~~

~~(3) claim numbers or codes;~~

~~(4) the type of benefits being reduced or discontinued;~~

~~(5) the effective date of the discontinuance;~~

~~(6) the reason for the discontinuance, stated in language easily readable and understandable to a person of average intelligence and education and in sufficient detail to inform the employee of the factual basis for the discontinuance;~~

~~(7) information regarding previous benefits paid and previous awards of benefits;~~

~~(8) information regarding attorney fees;~~

~~(9) information regarding permanent partial disability ratings received;~~

~~(10) the date the notice was served on the employee;~~

~~(11) verification and information identifying the person making the decision to discontinue benefits;~~

~~(12) instructions to the employee including who to contact for information regarding the discontinuance and how to request a formal hearing before a compensation judge;~~

~~(13) copies of relevant medical reports; and~~

~~(14) copies of any other relevant documents.~~

~~Supporting documents must be attached to all copies of the discontinuance notice served.~~

~~C. If the reason for the discontinuance is the employee's return to work and the employee has received temporary total or temporary partial compensation for 45 workdays prior to the return to work and no approved rehabilitation plan is in effect at the time the 14-day check under *Minnesota Statutes*, section 176.243, subdivision 1, is due, a 14-day check must be made and an administrative conference may be requested under part 5220.2650.~~

~~D. The employee may object to the discontinuance by filing an objection to discontinuance under *Minnesota Statutes*, section 176.241, with the division. This commences a formal action. The case will then be referred to the office and scheduled for hearing under part 1415.2100. The burden of establishing the basis for the discontinuance is on the party proposing the discontinuance.~~

Subp. 4. **Notice of intention to discontinue benefits.**

A. To discontinue temporary total, temporary partial, or permanent total benefits in situations not specified in subpart 3, the employer or insurer must serve upon the employee and file with the division a notice of intention to discontinue benefits or a petition under subpart 2. The insurer may serve and file a notice of intention to discontinue permanent total benefits under this subpart only where no judicial or administrative decision finding permanent total status was previously issued. The notice of intention to discontinue benefits must be accompanied by a form prescribed by the commissioner with which to request an administrative conference on the proposed discontinuance ~~which contains~~. The form must contain the employer's name, the date of the injury or disease, and the name, social security number, and address of the employee and a space for the employee to indicate the reason the employee objects to the proposed discontinuance.

B. A notice of intention to discontinue benefits must be fully completed and on the form prescribed by the commissioner, containing substantially the following:

[For text of subitems (1) to (3), see M.R.]

(4) the type of benefits being reduced or discontinued;

(5) the legal reason or reasons for the proposed discontinuance, stated in language which may easily be read and understood by a person of average intelligence and education, and in sufficient detail to inform the employee of the factual basis for the discontinuance;

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[For text of subitems (6) to (8), see M.R.]

(9) ~~information regarding permanent partial disability ratings;~~

~~(10)~~ the date the notice was served on the employee and the employee's attorney;

~~(11)~~ (10) verification and information identifying the person making the proposal to discontinue benefits;

~~(12)~~ (11) instructions to the employee, including who to contact for more information and how to request a conference or hearing;

~~(13)~~ (12) copies of relevant medical reports; and

~~(14)~~ (13) copies of any other relevant documents.

Supporting documents must be attached to all copies of the discontinuance notice when served.

C. The liability of the insurer to make compensation payments continues at least until the notice of intention to discontinue benefits is received by the division and served on the employee and the employee's attorney, except that benefits may be discontinued on the date the employee returned to work and temporary partial benefits may be discontinued as of the date the employee ceased employment. Where benefit amounts are difficult to determine because the employee's circumstances have changed, payments up to the date of the notice may be averaged based on benefit payments in the 26 weeks before the change. Continuation of benefits following service and filing of a notice of intention to discontinue benefits is set out in part 5220.2640, subpart 3.

~~D. An employee may request a conference under part 5220.2640, subpart 2 following the filing of a notice of intention to discontinue benefits. If a notice of intention to discontinue benefits was required but was not filed, the commissioner may schedule a conference. At the conference the issue of jurisdiction shall be resolved prior to dealing with discontinuance issues. An insurer or employer may request a conference under part 5220.2640, subpart 2 at any time to discuss a proposed discontinuance of benefits.~~

~~E. Instead of requesting a conference under item D or after the conference determination, the employee may object to a proposed or allowed discontinuance by filing with the division an objection to discontinuance under *Minnesota Statutes*, section 176.241.~~

Subp. 5. [See repealer.]

Subp. 6. **Penalties.** Where compensation is discontinued, reduced, or suspended in violation of this part, a penalty may be assessed under parts 5220.2720, 5220.2760, and 5220.2790.

5220.2640 DISCONTINUANCE CONFERENCES.

Subpart 1. **Purpose.** The purpose of an administrative conference under *Minnesota Statutes*, section ~~176.242~~ 176.239, is to determine whether reasonable grounds exist for a discontinuance of weekly benefits. The conference is an informal procedure to encourage discussion and clarify issues. If the parties do not reach an agreement on the issues, they will be resolved by a decision of the division. If all affected parties consent, or if notice of joinder of rehabilitation or medical issues has been given under part 5220.2610, subpart 2, rehabilitation and medical issues may also be discussed and clarified and decisions issued under *Minnesota Statutes*, sections 176.102 ~~and~~, 176.103, and 176.106.

Subp. 2. **Request.** The employee may request that the division schedule an administrative conference to discuss a proposed discontinuance of benefits. If the proposed discontinuance is based on a reason other than a return to work, the employee's request for a conference must be personally delivered, ~~mailed~~ received by, or telephoned to the department no later than ~~ten~~ 12 calendar days from the date a notice of intention to discontinue benefits, which was served on the employee and the employee's attorney, was received by the division. ~~The request is presumed mailed on the date indicated by the United States postmark. A request which does not include a legible United States postmark is presumed timely requested if received by the division no later than 13 days from the date a notice of intention to discontinue benefits was received by the division.~~ If the proposed discontinuance is based on a return to work, the employee's request must be received by the division within 30 days of the reported date of the employee's return to work. Allowance will be made, if appropriate, for nonreceipt or delay under *Minnesota Statutes*, section 176.285.

If the insurer discontinues, reduces, or suspends benefits without properly serving and filing a notice of intention to discontinue benefits and with the required attachments in a situation in which a notice of intention to discontinue benefits was required under part 5220.2630~~, subpart 8~~ and *Minnesota Statutes*, section 176.238, the employee may request an administrative conference ~~at any time after the discontinuance or reduction~~ within 40 days after the employee received the last payment but no later than ~~ten~~ 12 days after a notice of intention to discontinue benefits is properly served and filed, or 30 days after the employee returned to work if the notice is properly served and filed within 14 days after the insurer has notice of the employee's return to work.

The employee's request should be on the form provided by the insurer ~~which must include the employee's name, address, and social security number; the date of injury or disease; and the employer's name~~ under part 5220.2630, subpart 4, item A.

Subp. 3. **Continuation of benefits.**

A. If an employee requests an administrative conference within the time set out in this part, benefits must be paid through the date of the conference unless:

(1) the employee has withdrawn the request for a conference ~~or~~;

(2) the commissioner determines that no conference is necessary ~~subject to items B and C.~~ and allows the discontinuance;

(3) the employee fails to appear at the conference without good cause and no continuance is allowed;

(4) the employee has returned to work in which case benefits are due through the date of the employee's return to work;

(5) the employee is receiving temporary partial benefits and the employee is no longer employed;

(6) the employee dies;

(7) no plausible information is presented by the employee to dispute the proposed discontinuance of the benefits;

(8) notice of maximum medical improvement was served more than 90 days before the administrative conference;

(9) an approved retraining plan ended more than 90 days before the administrative conference;

(10) the employee has failed to make a good faith effort to participate in the rehabilitation plan before the administrative conference, but is making a good faith effort at the time of the conference, in which case benefits may be discontinued between the date the notice of intention to discontinue benefits was served and filed and the administrative conference date;

(11) the workers' compensation claim was mistakenly accepted by the insurer and primary liability for the entire injury is now denied;

(12) the employee has received temporary partial benefits for the maximum period allowed under *Minnesota Statutes*, section 176.101, subdivision 2;

(13) the employee has completely recovered from the injury; or

(14) the employee has voluntarily retired from the labor market.

B. ~~If an employee does not request an administrative conference or fails to appear at the conference without good cause and no continuance of the conference is allowed, benefits may terminate at the time stated in the notice of intention to discontinue benefits. The date for compensation to end must be no earlier than the day the notice of intention to discontinue benefits is served upon the employee and received by the division.~~

~~C.~~ If an employee's request for a continuance under part 5220.2610, subpart ~~5~~ 7, is granted and the employee is awarded ongoing benefits, benefits must be paid through the date of the conference and continuing. If the employee's request for a continuance is granted and the employee is not awarded benefits, benefits need not be paid during the period of continuance. If the employer or insurer requested the continuance, benefits must be paid during the period of continuance. If the employee and insurer's joint request for a continuance is granted, benefits must be paid during the period of continuance unless the employee agrees in writing to waive the interim payment and await a decision regarding payment under subpart 7 following the administrative conference.

Subp. 4. **Scheduling.** Subject to part 5220.2610, subpart ~~5~~ 7, a discontinuance conference must be set within the time limits set by this subpart. Following a notice of intention to discontinue benefits, the division shall schedule an administrative conference no later than ten calendar days after the division's receipt of a timely request for a conference. If no notice of intention to discontinue benefits was filed as required by part 5220.2630 and the employee requests a conference, the division shall schedule a conference no later than ten calendar days after the division's receipt of the employee's request if the conference request is received within 40 days from the date the employee's last benefit payment was received. ~~If no notice of intention to discontinue benefits has been filed where an employer or insurer requests a conference, the division shall schedule an administrative conference to be held no later than 30 days after receipt of the request.~~

Subp. 5. [See repealer.]

[For text of subp 6, see M.R.]

Subp. 7. **The decision.** The decision must be based on information presented at the conference and information from the division file ~~if the parties have been notified that file information will be reviewed and are given an opportunity to comment on those items considered. A written decision must be issued and must include notice of the right to have the matter heard by a compensation judge~~

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~~if a party is dissatisfied with the decision and the procedure for doing so and notice of the right to be represented by an attorney at a hearing before a compensation judge~~ relating to the department's authority to decide the issue, and information contained in the notice of intention to discontinue benefits and any attachments. The division shall mail a copy of the decision to the parties no later than five working days from the date of the conference. ~~The decision is deemed notice of rights under *Minnesota Statutes*, section 176.241, to those parties served.~~

Subp. 8. [See repealer.]

Subp. 9. **Penalties.** Penalties may be imposed for an improper discontinuance of compensation under part 5220.2720 and *Minnesota Statutes*, section ~~176.242~~ 176.238, subdivision 10, ~~and part 5220.2720~~ and for unreasonable or inexcusable delay or other grounds under parts 5220.2760 and 5220.2790 and *Minnesota Statutes*, section 176.225, subdivisions 1 and 5~~,~~ ~~and parts 5220.2760 and 5220.2790~~.

5220.2655 SMALL CLAIMS COURT OPERATIONS.

Subpart 1. **Jurisdiction.** Only claims within the jurisdictional limits of *Minnesota Statutes*, section 176.2615, as described in items A to D, may be brought in small claims court. The claim may be heard in small claims court if all parties agree to submit the claim to the jurisdiction of the small claims court and:

A. the claim is for rehabilitation benefits only under *Minnesota Statutes*, section 176.102;

B. the claim is for medical benefits only under *Minnesota Statutes*, section 176.135;

C. the claim in its total amount does not equal more than $5,000; or

D. where the claim is for apportionment or for contribution and reimbursement, no counterclaim in excess of $5,000 is asserted.

Subp. 2. **Statement of claim.** An employee, employer, insurer, self-insured employer, or claims service agent for a self-insured employer or insurer may file a statement of claim in a format or form prescribed by the commissioner which has been signed by all parties or with signed attachments of the parties consenting to the jurisdiction of the small claims court. The statement of claim must provide:

A. the name and social security number of the employee;

B. the address and telephone number of the employee;

C. the name, title, address, and telephone number of the insurer's claim representative and claim number;

D. the name, address, and telephone number of the potential intervenor or other payor or provider of benefits received by an employee following an alleged work-related injury;

E. a statement of the benefits claimed, including, if appropriate, value in dollars;

F. attached supporting documentation;

G. defenses to the claim and supporting documentation;

H. the statement that the judge's award or order determining the dispute is final and that the matter may not be appealed, used as evidence, or further considered in any other forum or proceeding; and

I. a statement providing for mutual waiver of representation by attorneys if the parties agree.

Subp. 3. **Notice.** The department shall notify all parties by mail of the date, time, and place of the small claims court hearing.

Subp. 4. **Hearing.** All parties must appear at the hearing fully prepared with the witnesses, exhibits, and evidence the parties choose to present to the presiding judge. Parties may agree to appear without representation by attorneys. Participation of attorneys is permitted to the extent that the judge determines is helpful to the resolution of the case. Attorney's fees shall be awarded subject to the limitations of *Minnesota Statutes*, section 176.081, only if the judge determines that the attorney's participation was significantly instrumental in the disposition of the case.

Subp. 5. **Decision.** The judge shall issue findings and an order deciding the issues within three working days of the completion of the hearing. No appeals can be taken. In the event of a settlement, the judge shall issue a settlement order within three working days of receipt of a settlement agreement.

5220.2670 MEDIATION.

Subpart 1. **Evaluation for mediation.** The commissioner may refer, or any party to a workers' compensation matter or dispute may, at any stage of the proceedings, request evaluation of a disputed matter by the mediation unit to determine suitability of the ~~dispute~~ matter for further action by the unit. If the ~~dispute~~ matter is found to be suitable for resolution by the mediation process, the mediation unit will contact the parties ~~to the dispute~~ or their attorneys, if they are represented, to attempt conciliation or schedule a mediation session.

Subp. 2. **Conciliation.** Conciliation is the resolution of a ~~dispute~~ matter through informal means without conducting a full conference. If the ~~dispute~~ matter is appropriate for conciliation, the mediation unit may conciliate an agreement of the parties.

[For text of subps 3 to 5, see M.R.]

5220.2680 SECOND INJURY LAW.

Subpart 1. [See repealer.]

Subp. 2. [See repealer.]

Subp. 3. [See repealer.]

Subp. 4. [See repealer.]

Subp. 5. **Notice of intention to claim reimbursement.** Notice of intention to claim reimbursement under *Minnesota Statutes*, section 176.131, subdivision 6, must be on forms prescribed by the division. In a claim under *Minnesota Statutes*, section 176.131, subdivision 1, forms must be filed within one year after the payment of sufficient weekly benefits or medical expenses to make claim against the special compensation fund. In a claim under *Minnesota Statutes*, section 176.131, subdivision 2, forms must be filed within one year from the first payment of weekly benefits or medical expense. The insurer must file with the division the original and one copy of the notice of intention to claim reimbursement.

Subp. 6. **Claim for reimbursement.** Reimbursement will be made by an order of the division or workers' compensation court of appeals from the special compensation fund on a yearly basis upon application for reimbursement on forms prescribed by the division. The insurer must file the original and one copy of the claim for reimbursement with the division. The application must be verified, set out in detail expenditures made and expenditures for which reimbursement is claimed, and must be supported by medical reports, showing the nature and extent of disability and relationship to the injury and physical impairment for which reimbursement is claimed. ~~The insurer must file the original and one copy of notice of intention to claim reimbursement and claim for reimbursement with the division.~~

5220.2690 SUBROGATION INTEREST IN THIRD-PARTY RECOVERY.

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

Subp. 3. **Determination of subrogation interest.** The insurer or employee must comply with the procedures in this part in submitting a petition to the workers' compensation division for an order determining subrogation interest and credit.

A. The petition must be on the form prescribed by the commissioner and contain substantially the following:

[For text of subitems (1) to (4), see M.R.]

(5) the name, address, and telephone number of the attorney for each party if any; and

(6) calculation of the subrogation interest, including the future credit amount and the sum payable to the employee.

[For text of items B and C, see M.R.]

D. If a party disagrees with the petitioner's request, the disagreeing party shall serve an answer on all parties to the third-party action and parties to the workers' compensation proceeding within 20 days of service of the petition. If the answering party disagrees with the petitioner's calculation of the subrogation interest, future credit, or sum payable to the employee, the answering party must propose alternative calculations. The answer and a proof of service must be filed with the division within 20 days of service of the petition.

E. Upon receipt of the petition and any answer to the petition, the division will issue an order containing the following:

[For text of subitems (1) to (4), see M.R.]

~~E.~~ F. If an appeal of the order is not received by the division within 30 days, the order will become the final order.

[For text of subp 4, see M.R.]

5220.2720 IMPROPER DISCONTINUANCES; PENALTY.

Subpart 1. **Basis.** A penalty assessment for improper discontinuance will be made by the division, if appropriate where:

A. benefits were discontinued without ~~the~~ timely notice to the employee and the employee's attorney as required under part 5220.2630 and *Minnesota Statutes*, section ~~176.241 and part 5220.2630~~ 176.238;

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B. the discontinuance occurred despite an administrative determination denying a request to discontinue under part 5220.2640 and *Minnesota Statutes*, section ~~176.242 and part 5220.2640~~ 176.239;

[For text of item C, see M.R.]

D. an administrative conference was requested and the request was not withdrawn, the discontinuance occurred before the date of the administrative conference ~~was held~~, except where ~~the employee requests a continued conference date and ongoing benefits are not awarded~~ allowed by part 5220.2640, subpart 3; or

E. when a notice of intention to discontinue benefits is required to be filed but the discontinuance is retroactive, taking effect prior to the date that the notice of intention to discontinue benefits is served and filed with the division or served on the employee, except as allowed by part 5220.2630.

Subp. 2. **Amount.** When the division makes a determination under subpart 1, notice will be given and fines assessed as follows:

A. (1) If an insurer has not had a penalty assessed in the two-year period before the assessment for violation of a particular item in subpart 1, the division will send a warning notice to the insurer that the division has determined the discontinuance is improper. The warning notice will direct the insurer to pay the improperly discontinued benefits and serve and file any required notice of discontinuance within ten days of service of notice or a penalty will be assessed.

(2) If the improperly discontinued benefits are not paid and any proper discontinuance filed within the ~~ten days allowed~~ following time periods after the warning notice is served, the division will send notice that a ~~$100~~ penalty is imposed~~.~~ as follows:

(a) 11 to 20 days late, $100;

(b) 21 to 30 days late, $300;

(c) 31 to 60 days late, $400; and

(d) over 60 days late, $500.

~~(3) If these actions are still not taken within 20 days after service of the warning notice, a penalty of an additional $200 will be imposed.~~

~~(4) In addition to the penalties assessed under subitems (2) and (3), if these actions are not taken within 30 days after service of the warning notice, a penalty of an additional $200 will be imposed.~~

B. If an insurer has had a penalty assessed in the two-year period before the assessment for violation of an item in subpart 1 and again violates the same item, the following penalties apply if the improperly discontinued benefit is not paid and a discontinuance notice is not filed when required:

(1) ~~The division will send notice that a $100 penalty is imposed.~~ one to ten days late, $200;

(2) ~~If the improperly discontinued benefits are not paid and any required notice of discontinuance served and filed within ten days after service of the first penalty assessment on that file, a penalty of an additional $200 will be imposed.~~ 11 to 20 days late, $300;

(3) ~~If these actions are still not taken within 20 days after service of the first penalty assessment, a penalty of an additional $200 will be imposed~~ 21 to 30 days late, $400; and

(4) over 30 days late, $500.

[For text of item C, see M.R.]

D. ~~An additional~~ Alternatively, a penalty may be assessed under *Minnesota Statutes*, section 176.221, subdivision 3, payable to the assigned risk safety account, of up to 100 percent of the amount of compensation to which the employee is entitled.

E. In addition to a penalty payable to the special compensation fund or the assigned risk safety account under this part, a penalty may be assessed under part 5220.2760.

[For text of subp 3, see M.R.]

5220.2740 FAILURE TO ~~MAKE TIMELY PAYMENT OF~~ PAY OR DENY MEDICAL CHARGES; PENALTY.

Subpart 1. **Basis.** Under *Minnesota Statutes*, section 176.221, subdivision 6a, a penalty may be assessed where payment or denial of medical charges is not made in a timely manner as provided in part 5221.0600 and *Minnesota Statutes*, section 176.135.

Subp. 2. **Amount.** Under *Minnesota Statutes*, section 176.221, subdivision ~~3~~ 3a, a penalty of up to ~~100 percent of the amount owing shall be assessed unless the commissioner determines, pursuant to subpart 3, that either no penalty or a lesser amount should be assessed. Upon receipt of information that payment of a medical charge has not been made in a timely manner, the commissioner shall notify the payer of the complaint and provide warning that a penalty may be assessed. If notice is given on an M-4 or M-10 form, the commissioner need not provide additional notice or warning.~~ $1,000 shall be assessed as follows:

A. one to 15 days late, $250;

B. 16 to 30 days late, $500;

C. 31 to 60 days late, $750; and

D. over 60 days late, $1,000.

~~Alternatively, a penalty of up to $1,000 under *Minnesota Statutes*, section 176.221, subdivision 3a, for failure to make payment may be assessed.~~

Subp. 3. [See repealer.]

Subp. 4. **Payable to.** Penalties assessed under this part are payable to the ~~special compensation fund~~ assigned risk safety account.

Subp. 5. **Interest.** Interest on the sums owed under *Minnesota Statutes*, section 176.221, subdivision 8, is payable to the health care provider.

5220.2750 FAILURE TO MAKE TIMELY PAYMENT OF ECONOMIC RECOVERY COMPENSATION OR IMPAIRMENT COMPENSATION; PENALTY.

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

Subp. 2. **Amount.** Under *Minnesota Statutes*, section 176.221, subdivisions 3 and 6a, a penalty of up to 100 percent of the amount owing may be assessed. ~~Where payment is less than ten days late, a penalty of 25 percent may be assessed. Where payment is at least ten but less than 20 days late, a penalty of 50 percent may be assessed. Where payment is at least 20 but less than 30 days late, a penalty of 75 percent may be assessed. Payment 30 or more days late may result in the 100 percent penalty assessment.~~

Subp. 3. **Payable to.** The penalty is payable to the ~~special compensation fund~~ assigned risk safety account.

5220.2760 ADDITIONAL AWARD AS PENALTY.

Subpart 1. **Basis.** Penalties under *Minnesota Statutes*, section 176.225, subdivision 1, in an amount up to 25 percent of the total amount of the compensation award may be assessed by the division on the grounds listed in that section, including:

A. underpaying, delaying payment of, or refusing to pay within 14 days of the filing of an order by the division or a compensation judge the workers' compensation court of appeals or the Minnesota Supreme Court unless the order is appealed within the time limits for an appeal. If the payor does not appeal the order, payments made more than 14 days after the order is served and filed are late, however, the division shall not issue a penalty under this part unless payment is made after the 30th day following a final order. A penalty may be issued, however, for a payment after the 14th day and through the 30th day following a settlement award under *Minnesota Statutes*, section 176.521. Payments made after the 14th day must include interest to the payee;

[For text of item B, see M.R.]

C. ~~any~~ other ~~violation~~ violations under *Minnesota Statutes*, section 176.225, subdivision 1, ~~for which no other penalty is provided under the act~~ paragraph (a), (b), (d), or (e).

This part does not affect the employee's independent right to seek penalties by filing a claim petition under *Minnesota Statutes*, section 176.271.

Subp. 2. **Amount.** A penalty assessed under this part will be for at least ~~ten~~ five percent of the compensation owing and shall be assessed as follows:

A. one to five days late, five percent;

B. six to 15 days late, ten percent;

C. 16 to 30 days late, 15 percent;

D. 31 to 60 days late, 20 percent; and

E. over 60 days late, 25 percent.

[For text of subp 3, see M.R.]

5220.2770 FAILURE TO PAY OR DENY; PENALTY.

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

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Subp. 2. **Amount.** The commissioner's designee must use the following procedure to determine the amount of the penalty.

[For text of item A, see M.R.]

B. Calculation of the amount of the penalty will be in the following manner:

[For text of subitems (1) and (2), see M.R.]

(3) the ~~compensation~~ penalty due for the number of days late is calculated~~;~~ under *Minnesota Statutes*, section 176.221, subdivision 3.

~~(4) amount:~~

~~(a) If payment is two or more weeks late the penalty is calculated at 100 percent of the compensation to which the employee is entitled at the time of payment or at the time of assessment if payment has not yet been made.~~

~~(b) If payment is less than two weeks late the penalty is calculated at 50 percent of the compensation to which the employee is entitled at the time of payment or at the time of assessment if payment has not yet been made.~~

[For text of item C, see M.R.]

D. Where no compensation has been paid but the insurer has failed to file a denial of liability within the statutory 14- or 30-day limit on a claim required to be reported to the division, a penalty of up to $1,000 ~~for violations occurring after April 24, 1984,~~ may be assessed under *Minnesota Statutes*, section 176.221, subdivision 3a, as follows:

(1) one to 15 days late, $100;

(2) 16 to 30 days late, $150;

(3) 31 to 60 days late, $350; and

(4) over 60 days late, $500.

~~In considering the amount of the assessment, the commissioner's designee shall take into consideration at least the following factors:~~

~~(1) the length of the delay;~~

~~(2) the amount of the claim;~~

~~(3) efforts made to comply;~~

~~(4) the past record of payment by this insurer; and~~

~~(5) the complexity of the issues involved.~~

If the insurer has been assessed five or more penalties for violation of this item in the two-year period before the assessment, a penalty of $1,000 shall be assessed for a subsequent violation.

E. Where the insurer has filed a frivolous denial under part 5220.2570, subpart 10, a penalty may be assessed under *Minnesota Statutes*, section 176.221, subdivision 3a, as follows:

(1) one to five violations in the two-year period before the assessment, $500; and

(2) six or more violations in the two-year period before the assessment, $1,000.

Subp. 3. **Payable to.** This penalty is payable to the ~~special compensation fund~~ assigned risk safety account.

[For text of subp 4, see M.R.]

5220.2780 FAILURE TO PAY UNDER ORDER ~~OR PROVIDE REHABILITATION~~; PENALTY.

Subpart 1. **Basis.** Where payment of compensation or expenses is not made within 14 days following an order as required by *Minnesota Statutes*, section 176.221, subdivisions 6a and 8, the division may assess the penalties provided in *Minnesota Statutes*, section 176.221, ~~subdivisions~~ subdivision 3 ~~and~~ or 3a~~. Where rehabilitation services are not provided as required by *Minnesota Statutes*, sections 176.102, 176.221, subdivision 6a, and parts 5220.0130, subpart 2 and 5220.0410, subpart 2, the division may assess the penalty provided in *Minnesota Statutes*, section 176.221, subdivision 3a.~~, however, the division shall not issue a penalty under this part unless payment is made after the 30th day following a final order. A penalty may be issued, however, for a payment after the 14th day and through the 30th day following a settlement award under *Minnesota Statutes*, section 176.521. Payments made after the 14th day must include interest to the payee.

Subp. 2. **Amount.** The ~~maximum~~ penalty available under *Minnesota Statutes*, section 176.221, subdivision 3 or 3a, shall be assessed where there has been a failure to pay under an order which has not been appealed. ~~Less than the maximum penalty available~~ If the payor chooses not to appeal the order, payments made more than 14 days after the order is served and filed are late. Each day after the 14th day is considered a day late. Penalties under *Minnesota Statutes*, section 176.221, subdivision ~~3~~ 3a, ~~may~~ shall be assessed ~~where immediate assessment is necessary~~ as follows:

A. 17 to 30 days late, $500;

B. 31 to 60 days late, $750; and

C. over 60 days late, $1,000.

Subp. 3. **Payable to.** The penalty is payable to the ~~special compensation fund~~ assigned risk safety account.

5220.2790 INEXCUSABLE DELAY IN MAKING PAYMENT, INCREASE IN PAYMENT.

Subpart 1. **Basis.**

[For text of item A, see M.R.]

B. Where other payment of temporary total, temporary partial, permanent total, or permanent partial disability benefits is not made within ~~ten~~ three business days of the date provided by statute or rule on more than three occasions in any 12-month period, the failure is deemed inexcusable.

[For text of subps 2 and 3, see M.R.]

Subp. 4. **Assessment.**

A. The procedure for assessment of a penalty under subpart 1, item A, must be made as provided in part 5220.2770 except that only ten percent of ~~that~~ the amount delayed shall be assessed as a penalty under this part.

B. The calculation of a penalty under subpart 1, item B, for late payment of temporary total, temporary partial, or permanent total disability benefits must be as follows:

[For text of subitems (1) to (3), see M.R.]

(4) The penalty is calculated at ten percent of the sum ~~due at the time of the assessment or ten percent of the sum~~ paid in an untimely manner.

C. The calculation of a penalty for late payment of permanent partial disability benefits, including economic recovery compensation and impairment compensation under subpart 1, item B, must be as follows:

[For text of subitem (1), see M.R.]

(2) if payment of the sum due is not made within ~~ten~~ three business days of the due date on more than three occasions in any 12-month period, a penalty of ten percent of the sum ~~due at the time of the assessment or ten percent of the sum~~ paid in an untimely manner is assessed.

5220.2810 FAILURE TO RELEASE MEDICAL DATA; PENALTY.

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

Subp. 3. **Amount.**

A. If a collector or a possessor of medical data was not issued a warning under this part in the preceding year, the division must send a warning letter before a monetary penalty is assessed. The warning letter must advise the collector or possessor against whom the penalty is sought of the obligation to provide medical data under *Minnesota Statutes*, section 176.138, and that a penalty will be assessed if it fails to provide the requested data within seven working days after the warning letter and to file written verification of the release of the data or a copy of the data with the division within that time.

B. If the requested data is not provided and written verification filed with the division within seven working days after receipt of ~~the~~ a required warning letter or the division's request where no warning letter is required, a penalty of ~~$50~~ $100 shall be imposed. If that ~~party or health care provider~~ collector or possessor has had more than three penalties assessed or warning letters sent for violation of this part in the preceding 12 months, the penalty will be $200 as well as further penalties under items C and D.

C. If the requested data is not provided and written verification filed with the division within 30 days after the date of ~~the~~ a required warning letter or the division's request where no warning letter is required, a penalty of ~~$100~~ $150 will be imposed.

D. If the requested data is not provided and written verification filed with the division within 60 days after the date of ~~the~~ a required warning letter or the division's request where no warning letter is required, a penalty of $200 will be imposed.

Subp. 4. **Payable to.** The amount of any penalty assessed under this part is payable to the ~~special compensation fund~~ assigned risk safety account.

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5220.2820 FAILURE TO MAKE TIMELY REPORT OF INJURY; PENALTY.

Subpart 1. **Basis.** A penalty ~~shall~~ may be assessed under *Minnesota Statutes*, section 176.231, subdivision 10~~, against the employer~~:

A. against the employer, if a work-related death or serious injury occurs to an employee and the commissioner is not notified within 48 hours; ~~or~~

B. against the employer, if any other injury which must be reported to the division occurs and the first report of injury is received by the ~~division~~ insurer more than ~~14~~ ten days after the first day of lost time due to the injury or ~~14~~ ten days after the date when notice of lost time due to the injury was received by the employer, whichever is later~~.~~; or

C. against the insurer, if:

(1) an injury which must be reported to the division occurs;

(2) the first report of injury is received by the insurer within the ten-day period described in item B; and

(3) the report is received by the division more than 14 days after the first day of lost time due to the injury, or 14 days after the date when notice of lost time due to the injury was received by the employer, whichever is later.

Subp. 2. **Amount.** If the employer or insurer has violated subpart 1 and has had no similar violations in the 12-month period prior to the assessment, an advisory letter informing the employer or insurer of the violation and the statutory requirement must be sent. If the employer or insurer has had one violation of subpart 1 in the past 12 months, a penalty of $50 must be assessed. If the employer or insurer has had two violations in the past 12 months, a penalty of $100 must be assessed. If the employer or insurer has had three violations in the past 12 months, a penalty of $150 must be assessed. If the employer or insurer has had four or more violations in the past 12 months, a penalty of $200 must be assessed.

Subp. 3. **Assessment.** The penalty must be assessed by letter informing the employer or insurer of the number of violations in the past 12 months on record and the amount of the penalty. The letter must contain instructions for payment.

Subp. 4. **Payable to.** The penalty is payable to the ~~special compensation fund~~ assigned risk safety account.

Subp. 5. [See repealer.]

5220.2830 OTHER FAILURE TO FILE REPORT IN MANNER OR WITHIN TIME LIMITS PROVIDED; PENALTY.

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

Subp. 2. **Amount.** If, after a letter request from the commissioner or authorized designee, a report under this part is not received by the division within 21 days, a penalty of $50 must be assessed. A failure to file a report after a second request will result in ~~a~~ an additional penalty assessment of $150. A subsequent failure will result in penalty assessments of $200.

Subp. 3. **Payable to.** The penalty is payable to the ~~special compensation fund~~ assigned risk safety account.

5220.2840 FAILURE TO MAKE PAYMENT OR REPORT TO SPECIAL FUND; PENALTY.

Subpart 1. **Due date.** For workers' compensation benefits paid from January 1 through June 30, the due date of the completed assessment form and corresponding assessment amount is August 15 of the same calendar year.

For workers' compensation benefits paid from July 1 through December 31, the due date of the corresponding assessment amount is March 1 of the following calendar year.

Notice of the assessment rate and instructions for payment will be issued by the fund 45 or more days before the due date.

Insurers no longer licensed to provide, or no longer providing workers' compensation insurance in Minnesota, and employers no longer self-insured to provide workers' compensation benefits must continue to file the assessment form until five years have elapsed since a policy of workers' compensation insurance or self-insurance was provided, or three years after the last indemnity payment was made, whichever is later. Insurers not owing an assessment must report zero liability during the required reporting years.

Subp. 2. **Basis.** A penalty will be assessed under *Minnesota Statutes*, section 176.129, subdivision 10, where either:

[For text of item A, see M.R.]

B. written certification that the assessment report and assessment payment will not be made by the due date because of reasons beyond the control of the insurer or because no assessment is owing, is not received by the special compensation fund on or before the due date.

Subp. 3. **Amount.** Within 30 days of the due date, the special compensation fund will give notice of penalty to those who have neither filed the completed assessment form and paid the assessment amount, nor submitted a certified reason for nonpayment by the due date as follows:

A. Either:

(1) 2.5 percent of the assessment amount due if the assessment payment is received at the fund within five days after the due date; ~~or~~

(2) five percent of the assessment amount due if the assessment payment is received at the fund within six to 30 days after the due date; ~~or~~

(3) ten percent of the assessment amount due if the assessment payment is received at the fund within 31 to 60 days after the due date; or

(4) 15 percent of the assessment amount due if the assessment payment is received at the fund 61 or more days after the due date; ~~or~~

B. $500, whichever is greater; or

C. $200 for failure to timely report under subpart 2, item B, that no assessment is due.

Subp. 4. **Payable to.** Both the assessment amount and any penalty due under this part are payable to the ~~special compensation fund~~ assigned risk safety account.

[For text of subp 5, see M.R.]

5220.2850 FAILURE OF UNINSURED OR SELF-INSURED TO PAY; PENALTY.

The fund director, through an authorized designee or representative, will ~~make referrals to the attorney general's office to~~ seek reimbursement of benefits paid from the special fund and the penalties provided under *Minnesota Statutes*, ~~section~~ sections 176.181, subdivision 3, and 176.183, subdivision ~~1 or 1a. Punitive damages of up to 50 percent of all benefits and other expenditures on the claim may also be assessed in the court action initiated by the attorney general's office~~ 2, by filing petitions for contribution and reimbursement or recovery, and through other collection mechanisms or remedies available in the civil courts.

5220.2860 FAILURE TO INSURE; PENALTY.

Penalties for failure to insure will be assessed by the commissioner as provided by *Minnesota Statutes*, section 176.181, subdivision 3. ~~Referrals to the attorney general's office shall also be made as provided in that section.~~ The employer may object to the penalty as provided in part 5220.2870, except that the objection must be served and filed within ten working days from the date the notice of assessment was served on the employer.

5220.2870 PENALTY OBJECTION AND HEARING.

A party to whom notice of assessment has been issued may object to the penalty assessment by filing a written objection with the division on the form prescribed by the commissioner. The objection must be served on the special compensation fund if the penalty is payable to the special compensation fund or the assigned risk safety account in addition to filing the objection with the division, and on the employee if the penalty is payable to the employee~~, the insurer and the employer~~. The objection must be filed and served within 30 days after the date the notice of assessment was served on that party by the division. The written objection must contain a detailed statement explaining the legal or factual basis for the objection and including any documentation supporting the objection. Upon receipt of a timely objection, unresolved issues shall be referred for a hearing to determine the amount and conditions of any penalty. Objections which are not served and filed within the 30-day objection period must be dismissed by a compensation judge.

5220.2920 ATTORNEY FEES.

Subpart 1. **Applicable principles.** Attorney fees shall be awarded in accordance with this part and *Minnesota Statutes*, section 176.081 ~~and the following principles~~, after resolution of a disputed benefit or service issue, whether the matter is settled or a decision is issued.

~~A. No fee will be awarded unless the attorney is successful in obtaining workers' compensation benefits or services for the employee.~~

~~B. If the attorney is successful in obtaining benefits or services, the attorney is entitled to a reasonable fee for the services rendered.~~

~~C. In general, each party shall be responsible for its own fees, except as provided by *Minnesota Statutes*, section 176.081, subdivisions 7, 7a, and 8, or 176.191.~~

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~~D. Attorney fees shall not be awarded piecemeal where to do so would result in a double recovery. Where more than one type of benefit is resolved simultaneously, all benefits resolved shall be considered in determining fees.~~

~~E. Attorney fees for recovery of medical or rehabilitation benefits or services shall be assessed against the employer or insurer only to the extent that the fee computed under *Minnesota Statutes*, section 176.081, subdivision 1, in connection with all benefits currently in dispute which resolve simultaneously with such benefits is not sufficient to provide a reasonable fee to the attorney.~~

~~F. In determining what amount of fee is reasonable for services rendered in connection with rehabilitation and medical services, the factors of *Minnesota Statutes*, section 176.081, subdivision 5, must be applied.~~

A contingent fee provided by *Minnesota Statutes*, section 176.081, must not be based on the time an attorney spends on a case. It must be based on the amount awarded to a client which was genuinely in dispute. The contingent fee provided by *Minnesota Statutes*, section 176.081, subdivision 1, is presumed reasonable. If measured on an hourly basis, a contingent fee may seem unreasonably high or unreasonably low. On average, however, the attorney is reasonably compensated but not excessively compensated, on a contingent basis. It is contrary to the legislature's protective policy of administrative regulation of attorney fees in workers' compensation cases under *Minnesota Statutes*, section 176.081, to allow a contingent fee to stand when it provides a high hourly rate, but to routinely grant excess fees under *Minnesota Statutes*, section 176.081, subdivision 2, when the contingent fee provides a low hourly rate. The attorney fee in a particular case is not unreasonable simply because the hourly rate is below the attorney's usual billing rate. An attorney who enters into a retainer agreement with an employee or dependent under which the attorney agrees to accept a fee that is less than the fee presumed reasonable by *Minnesota Statutes*, section 176.081, subdivision 1, may not claim a higher fee unless a new retainer agreement providing a higher fee is executed. If, during the course of representation involving a pending claim, an attorney requests that the client sign a new retainer agreement, the attorney must notify the client by conspicuous notice in the new retainer agreement that the client is not required by law to agree to a fee higher than a fee already negotiated and agreed upon by the attorney and client.

Subp. 2. **Withholding of attorney fees.** Upon receipt of the notice of representation, the employer and insurer may withhold attorney fees on genuinely disputed portions of claims under subpart 5 and *Minnesota Statutes*, section 176.081. Attorney fees must be withheld on genuinely disputed portions of claims if the employee's attorney so requests.

Subp. 3. **Statement of fees, petition for disputed or excess attorney fees.** The following procedures must be followed in claiming fees.

A. If the claim for attorney fees does not exceed the fees allowed by *Minnesota Statutes*, section 176.081, subdivision 1, clause (a), the party claiming fees shall fully complete and file a statement of attorney fees on a form prescribed by the commissioner, including:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) claim numbers or codes;

(3) the date of injury or disease;

(4) in the format provided in subpart 5, a list of benefits obtained which were genuinely in dispute and which would not have been recovered without the attorney's involvement, and the total dollar amount of benefits obtained;

(5) information concerning any retainer received from the employee;

(6) information concerning expense advancement;

(7) information regarding the withholding of attorney fees, ~~if known~~, and the amount of attorney fees previously paid for the same injury;

(8) the specific dollar amount claimed for attorney fees;

(9) information regarding the attorney's license to practice law in the state;

(10) a statement of the statutory basis or other legal authority for attorney fees;

(11) a notice regarding how to object to the requested fees; ~~and~~

(12) information identifying the employee's attorney; and

(13) the number of hours spent in the employee's representation and the attorney's hourly fee.

The statement must be accompanied by the retainer agreement, if not previously filed, and proof of service on the employer or insurer, and employee.

B. If ~~a party~~ an attorney claims fees in excess of the amount listed in *Minnesota Statutes*, section 176.081, subdivision 1, clause (a), or an objection to the statement under item A is filed, or it is requested that fees be assessed against the employer or insurer for refusal to pay rehabilitation or medical benefits or provide rehabilitation or medical services or the requested fees were incurred

in connection with an administrative conference under *Minnesota Statutes*, section ~~176.242, 176.2421, 176.243, or 176.244~~ 176.102, 176.135, 176.136, or 176.239, the ~~party~~ attorney shall fully complete and file a petition for disputed or excess attorney fees on a form prescribed by the commissioner, including:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) claim numbers or codes;

(3) date of the injury or disease;

(4) an exhibit showing specific legal services performed, the date performed, and the time spent;

(5) the number of hours spent in the employee's representation and the attorney's hourly fee;

(6) a statement of expertise and experience in workers' compensation matters;

(7) a ~~brief~~ complete description of the factual, medical, and legal issues in dispute;

(8) the nature of proof required in the case;

(9) in the format provided by subpart 5, a list of the benefits obtained which were genuinely in dispute and which would not have been recovered without the attorney's involvement, and the total dollar amount of benefits obtained;

(10) information concerning any retainer;

(11) the amount the employee advanced for expenses;

(12) the specific dollar amount claimed in fees;

(13) information regarding the withholding of attorney fees, ~~if known~~ and the amount of attorney fees previously paid for the same injury;

(14) a list of the disbursements incurred and if the disbursement has been paid, by whom;

(15) information regarding the attorney's license to practice law in the state;

(16) a statement of the statutory basis or other legal authority for attorney fees;

(17) whether or not a hearing on attorney fees is requested; ~~and~~

(18) information identifying the employee's attorney; and

(19) where all or a portion of the fee may be payable by the employee, the prescribed notice to the employee requesting that the employee return the attached form within ten days of the employees's receipt of the notice, indicating whether or not the employee agrees that the requested fee should be awarded and notifying the employee of the relevant factors in determining the attorney fee.

The petition must be accompanied by a copy of the retainer agreement, if not previously filed, ~~and~~ proof of service on the employer or insurer, and employee, and a form prescribed by the commissioner upon which the employee indicates agreement or disagreement with the claim for excess fees.

Subp. 4. **Fees, objection.** If a timely objection to the statement of attorney fees or petition for excess fees is filed, the compensation judge or settlement judge shall use this part and *Minnesota Statutes*, section 176.081, subdivision 5, to determine whether the fee is justified.

Subp. 5. **Genuinely disputed portions of claims.** The following information must be included in the statement of attorney fees or petition for excess attorney fees. Items A and B are the applicable principles for the commissioner, compensation judge, or workers' compensation court of appeals to determine whether the benefit paid or payable was genuinely disputed for the purpose of calculation of a contingent fee under *Minnesota Statutes*, section 176.081, subdivision 1.

A. The statement of attorney fees or petition for excess attorney fees must include, for each benefit paid or awarded for which an attorney fee is sought:

(1) whether the rate or amount of each benefit was disputed and if so, the amount disputed;

(2) whether the duration of each benefit was disputed and if so, the period for which the benefit was disputed;

(3) whether eligibility for each benefit was disputed;

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(4) the rate or amount, duration, and period of eligibility for each benefit which was admitted and paid by the insurer at or before the date payment was due;

(5) the nature of the dispute, containing sufficient detail to allow the parties to agree or disagree with the characterization of the dispute;

(6) whether the insurer denied primary liability for the claim; and

(7) in the case of a lump sum award pursuant to an award on stipulation or mediated agreement, subitems (1) to (6) and if the stipulation for settlement or mediated agreement does not allocate the sums awarded to specific benefits, an allocation of the sums awarded to the various types of compensation.

B. The principles applicable to determine whether a benefit was genuinely disputed are as follows:

(1) If primary liability had been denied for the claim, all compensation paid or awarded to the employee or dependent other than payment of medical and rehabilitation expenses, is used to compute the attorney's fee.

(2) If there was no dispute concerning the rate, amount, duration, or eligibility for a benefit and the benefit was timely paid, the benefit may not be used to compute the fee.

(3) The fee may not be computed on the entire amount of a benefit where only a portion of the benefit is disputed. Only the disputed portion of the benefit may be used to compute the fee.

(4) If eligibility for the benefit is disputed, the entire benefit during the period for which eligibility was disputed is used to compute the fee.

(5) If the rate of the benefit is disputed, only the amount paid or awarded above the rate admitted and timely paid is used to compute the fee.

(6) If the duration of the benefit is disputed, only the portion of the benefit not conceded and not timely paid is used to compute the fee.

(7) Benefits allegedly admitted but not timely paid may be used to compute the fee.

(8) Benefits timely paid may not be used to compute the fee except where primary liability for the entire claim or eligibility for the benefit had been generally denied.

(9) The difference between the compensation eventually paid or awarded and the amount admitted and timely paid is used to compute the fee.

(10) The following benefits may be used to compute the fee:

(a) remodeling compensation pursuant to *Minnesota Statutes*, section 176.137, which was in dispute under this subpart;

(b) a penalty sum awarded to the employee or dependent for a benefit which was in dispute under this subpart;

(c) interest on a benefit which was in dispute under this subpart; and

(d) a benefit which was in dispute under this subpart although reimbursable to an intervenor.

(11) Generally, each benefit is evaluated separately, however, if the rate, duration, or eligibility for economic recovery compensation is disputed, the difference between the impairment compensation which was conceded and timely paid and the amount of disputed economic recovery compensation eventually paid or awarded is used to compute the fee.

(12) Following an allocation of a lump sum award under item A, subitem (7), the principles of this item apply to each portion of the settlement sum to arrive at the total disputed compensation awarded to compute the fee. The portion of the lump sum award allocated to medical or rehabilitation expenses must not be used to compute the fee unless the hourly fee associated with the service exceeds the contingent fee available under *Minnesota Statutes*, section 176.081, subdivision 1, for all other disputed benefits under this subpart that are resolved pursuant to the award. Benefits that have not yet become due and are not in dispute under this subpart may not be used to compute the fee.

Subp. 6. **Waiver of objection period.** The parties may not waive by stipulation for settlement or mediation agreement the right to object within ten days to the requested attorney fee. An agreement by a party in a stipulation for settlement, mediation agreement, or similar document to waive the ten-day period in which to object to an attorney's fee is not binding on the party. The party may, despite the agreement, file an objection to the requested fee in any manner provided by *Minnesota Statutes*, section 176.081. The objection to attorney fees does not render the party's consent to other terms of the agreement ineffective.

Subp. 7. **Defense attorney fees.** On August 1 of each year, every insurer and self-insured employer must file with the department its annual statement of attorney fees containing the information required by this subpart for the previous 12-month period from July 1 to June 31. The insurer or self-insured employer must include fees and costs incurred by itself and its agents and representatives, including but not limited to adjusting companies, third-party administrators, and contract service providers such as surveillance

companies and transcription service organizations. For the purpose of this subpart, "paid" includes sums billed or due but not yet paid.

A. The annual defense attorney fees and defense costs statement must include:

(1) Total attorney fees paid to outside and in-house counsel for representation and advice concerning workers' compensation cases. This includes general advice as well as work connected with specific cases. If in-house counsel spends 100 percent of work time on workers' compensation cases, the attorney's full gross wage plus the cost of the employee's benefit package is reported as attorney fees paid. If a portion of the attorney's time is attributable to the defense of workers' compensation cases, the wages and benefits may be prorated by the respective percentage of wages and benefits attributable to the general workers' compensation duties and defense of workers' compensation cases. The outside counsel fees reported must be the total fee paid to all firms for representation and advice concerning workers' compensation cases.

(2) Total paralegal fees paid or cost incurred in connection with workers' compensation cases. Wages and benefits of in-house paralegals may be prorated as provided in subitem (1).

(3) Deposition costs are reported in this subitem. Other deposition costs such as court reporter fees for time, preparation of a deposition transcript, and copies of depositions, and any costs paid to the deponent must be included in this subitem. Expert witness fees are included under subitem (4). The attorney's fee for a deposition is reported in subitem (1).

(4) Expert witness fees, including fees paid to expert witnesses in connection with hearings, depositions, or other workers' compensation proceedings.

(5) Independent medical evaluation fees, including all sums paid for health care provider opinions sought by the insurer or self-insured employer under *Minnesota Statutes*, section 176.155, subdivision 1.

(6) Fees for the generation of a medical report not already included in another category of this item.

(7) Cost of copies of medical and other data such as personnel files and medical treatment charts.

(8) Court filing fees.

(9) Transcript costs, including fees for preparation and copies of hearing transcripts.

(10) Investigation costs not otherwise reported under this item, including surveillance costs and other services and fees connected with investigations related to litigated claims.

(11) Travel and mileage costs, including reimbursement for travel costs associated with litigated cases when these sums are not already reported under another subitem.

(12) The total number of injuries to which the fees and costs included on the report are attributable.

(13) Other litigation costs not included in subitems (1) to (12) are reported in a miscellaneous category.

B. The insurer must collect and make available for review by the department as needed individual case information relating to defense attorney fees and defense costs as provided in this item. This individual case fee information need not be reported annually except as provided by item A. The information specified under this item must be made available to the department upon request and to parties to the claim. The fees listed in item A, subitems (1) and (2), must be collected for individual employee claims by date of injury. All other costs and fees in item A, subitems (3) to (13), may be collected in the aggregate without regard to individual claims. The data collected under item A, subitems (1) and (2), must include:

(1) the employee's social security number;

(2) the date of injury;

(3) the Minnesota supreme court registration numbers for all attorneys providing services relating to the injury;

(4) the hourly rate, if any, charged by all attorneys and paralegals providing services relating to the injury;

(5) the lump sum attorney fees paid for all attorneys providing services relating to the injury; and

(6) a sum representing all in-house attorney and paralegal time spent providing services relating to the injury. For the purpose of this subitem, the employer of the in-house attorney or paralegal may establish an hourly rate for the paralegal or attorney's time based on the gross wages and fringe benefits which closely represents the actual payment for the services rendered.

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C. The attorney fees paid to in-house or outside counsel as reported in this subpart must be approved under *Minnesota Statutes*, section 176.081, subdivision 2, if the payment exceeds $13,000 for any injury.

Subp. 8. **Contingent fee limitations.** The contingent fee presumed reasonable under *Minnesota Statutes*, section 176.081, subdivision 1, applies to fees paid to the attorney or attorneys for the employee. It does not apply to each attorney individually, but begins to run from the first claim concerning the injury and continues until the $13,000 sum is reached without regard to the number of attorneys or claims initiated concerning the same injury. The $13,000 fee which is presumed reasonable applies separately to fees payable to the attorney or attorneys for the employee, and fees payable to the attorney or attorneys for the insurer. The maximum fee presumed reasonable per injury is $26,000, half to the attorney or attorneys for the employee and half to the attorney or attorneys for the insurer. Where the only issues in dispute are medical or rehabilitation benefits or services and it was not reasonable to join the rehabilitation or medical issue with other disputed benefit issues, the attorney fee payable for recovery of the benefit or service is payable by the insurer on an hourly basis. If the hourly fee associated with medical or rehabilitation issues exceeds the available contingent fee under *Minnesota Statutes*, section 176.081, subdivision 1, the available contingent fee shall be awarded as well as a fee payable by the insurer such that the two fees combined compensate the attorney at a reasonable hourly rate.

Subp. 9. **Determinations without a hearing.** If an objection to the requested fee has been filed and the interested parties waive their right to a hearing, the fees may be determined without a hearing. A hearing must be scheduled if an objection has been filed and all interested parties have not waived their right to a hearing. Where no objection to the requested fee has been filed, the commissioner, judge, or court before whom the matter is pending shall determine, without a hearing, the amount of attorney fees owing under this part and *Minnesota Statutes*, section 176.081.

5220.2930 DEPENDENT'S BENEFITS.

Subpart 1. **Allocation of compensation by judge.**

A. A party may petition for an allocation of benefits under *Minnesota Statutes*, section 176.111, subdivision 10. The petition may contain a proposed allocation. The petition must be served on all parties and filed with the division within one year after the date of death ~~or one year after March 9, 1987, whichever is later~~. If a petition for allocation is not filed in a timely manner and the death occurred after June 30, 1981, the allocation will be as provided in subpart 2.

[For text of items B and C, see M.R.]

[For text of subp 2, see M.R.]

Subp. 3. [See repealer.]

[For text of subps 4 and 5, see M.R.]

5220.2960 COMMISSIONER INTERIM NOTICES AND ORDERS.

The commissioner may develop and publish commissioner interim notices and orders concerning matters within the authority of the department. Interim notices and orders do not have the force and effect of law, except where specifically authorized by statute, but may be relied upon by the public until revoked or modified to bind the department. The purpose of an interim notice or order is to provide uniform information and guidance to the public concerning department action. An interim notice or order may be relied upon to bind the department until a statute, appellate court decision, rule, or subsequent commissioner's notice or order conflicts with the notice or order, until the date stated in the notice or order, or until one year after publication, whichever occurs first. An interim notice or order under this part binds the department only if the published notice or order is clearly identified as an interim notice or order and is given an indexing number.

REPEALER. *Minnesota Rules*, parts 5220.2520, subparts 9 and 10; 5220.2570, subpart 8; 5220.2590; 5220.2610, subpart 4; 5220.2620, subparts 4, 6, 7, 8, 9, 10, and 11; 5220.2630, subpart 5; 5220.2640, subparts 5 and 8; 5220.2650; 5220.2660; 5220.2680, subparts 1, 2, 3, and 4; 5220.2730; 5220.2740, subpart 3; 5220.2820, subpart 5; 5220.2880, subpart 2; 5220.2890; 5220.2910; 5220.2930, subpart 3; 5220.2940; and 5220.2950, are repealed.

Proposed Permanent Rules Relating to Workers' Compensation; Medical Services and Fees

The five-digit numeric codes and descriptions included in the Minnesota Department of Labor and Industry, Workers' Compensation Handbook are obtained from the Physicians' Current Procedural Terminology, Copyright 1991, by the American Medical Association (CPT). CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

This publication includes only CPT numeric identifying codes and modifiers for reporting medical services and procedures that were selected by the Minnesota Department of Labor and Industry. Any use of CPT outside the fee schedule should refer to the Physicians' Current Procedural Terminology, copyright 1991 American Medical Association and any update thereto. These CPT publications contain the complete and most current listings of CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

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Rules as Proposed

5221.0100 DEFINITIONS.

[For text of subps 1 to 3, see M.R.]

Subp. 4. **Code.** "Code" means the alphabetic ~~or~~, numeric ~~designation, including code modifiers if appropriate, for a particular type of~~, or alphanumeric symbol used to identify a specific health care service~~, or supply, to categorize provider charges on a bill.~~ place of service, or diagnosis as follows:

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

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

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

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

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

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

[For text of subps 5 and 6, see M.R.]

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

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

Subp. 7. [See repealer.]

Subp. 8. [See repealer.]

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[For text of subp 9, see M.R.]

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~~ 5221.4000 to ~~5221.3500~~ 5221.4070.

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

[For text of subp 11, see M.R.]

Subp. 11a. **Physician.** "Physician" means a person who is authorized by law to practice the medical profession within the United States, is in good standing in the profession, and includes only those persons holding the degree D.O. (Doctor of Osteopathy) or M.D. (Doctor of Medicine), as defined in *Minnesota Statutes*, sections 176.011, subdivision 17, and 176.135, subdivision 2a.

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

Subp. 13. [See repealer.]

Subp. 14. [See repealer.]

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

[For text of subp 15, see M.R.]

5221.0200 AUTHORITY.

This chapter is adopted under the authority of *Minnesota Statutes*, sections 175.171; 176.101, subdivision 3e; 176.135, subdivisions 2 and 7; 176.136; 176.231; and 176.83~~, 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.~~ the payer's maximum liability for medical services, articles, and supplies. This chapter also governs health care provider communication with parties; required reporting of medical, disability, and billing information under *Minnesota Statutes*, chapter 176; change of health care provider; and criteria for determining, serving, and filing maximum medical improvement.

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; and employees as defined in *Minnesota Statutes*, section 176.011, subdivision 9. This chapter shall be applied in all relevant determinations made by compensation judges at the department and the Office of Administrative Hearings, and by the commissioner.

5221.0405 INCORPORATIONS BY REFERENCE.

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

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

B. The Federal Health Care Financing Administration claim form (HCFA-1500)(U2)(12-90). It is not subject to frequent change. It is developed by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

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

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

E. The alphanumeric HCFA Common Procedural Coding System (HCPCS manual), January 1989 edition. It is subject to frequent change. It is published by the HCPCS subcommittee of Minnesota under the authority of the federal Health Care Financing Administration and may be obtained from the Minnesota Department of Human Services, Claims Processing Section, 444 Lafayette Road, Saint Paul, Minnesota 55155-3849. It is available through the Minitex interlibrary loan system.

5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.

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

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

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

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

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

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

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

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

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

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

H. information regarding any surgery that has been performed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. When more than one year has elapsed since the date of a musculoskeletal injury that falls within any category under parts 5223.0070 to 5223.0170, the only factors in determining maximum medical improvement shall be whether a decrease is anticipated in the employee's estimated permanent partial disability rating or a significant improvement is anticipated in the employee's work ability as documented on the report of work ability described in subpart 6. If there is no decrease in the employee's estimated permanent partial disability or no significant improvement in the employee's work ability in any three-month period later than one year after the injury, the employee is presumed to have reached maximum medical improvement. This presumption can only be rebutted by a showing that a decrease in the employee's permanent partial disability rating or significant improvement in the work ability has occurred or is likely to occur beyond this three-month period.

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

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

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

(2) information identifying the employer and insurer;

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

(4) a statement that the attached report indicates that in the opinion of the health care provider, the employee reached maximum medical improvement by the specified date;

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

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

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

The health care provider may refer the employee to another health care provider for an opinion of the employee's permanent partial

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

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

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

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

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

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

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

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

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

(2) the date of the most recent examination;

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

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

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

(6) the date of the next scheduled visit;

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

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

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

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

Subp. 7. **Charge for required reporting.** No charge may be assessed for completion of a health care provider report or report of

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work ability required by subparts 2 and 6, or for a narrative or other report prepared in lieu of a health care provider report or report of work ability. A provider may charge a reasonable amount for requested supplementary reports using CPT codes 99080 (special reports); or X9198 (special chiropractic reports).

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

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

5221.0420 HEALTH CARE PROVIDER PARTICIPATION WITH RETURN TO WORK PLANNING.

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

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

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

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

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

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

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

(3) when a job search is initiated; or

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

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

A. 99080, special reports;

B. 99199, unlisted special service;

C. X9198, special chiropractic reports; or

D. X9199, unlisted special chiropractic service.

5221.0430 CHANGE OF HEALTH CARE PROVIDER.

Subpart 1. **Primary health care provider.** The individual health care provider directing and coordinating medical care to the

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

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

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

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

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

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

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

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

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

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

5221.0500 EXCESSIVE CHARGES; LIMITATION OF PAYER LIABILITY.

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

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, article, or supply, such that the charge has been paid or will be paid in response to another billing; or

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

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

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

D. the service does not comply with the treatment standards and requirements adopted under *Minnesota Statutes*, section

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176.83, subdivision 5, concerning the reasonableness and necessity, quality, coordination, level, duration, frequency, and cost of services; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Under *Minnesota Statutes*, section 176.136, subdivision 1b, paragraph (b), payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital with more than 100 licensed beds shall be 85 percent of the hospital's usual and customary charge as defined in item B, or 85 percent of the prevailing charge as defined in item B, whichever is lower. Outpatient charges for hospitals with more than 100 beds are limited by the maximum fees for any service set forth in parts 5221.4000 to 5221.4070. A hospital charge is considered an inpatient charge if the employee spent either the night before or the night after the service in the hospital, and there is an overnight room charge.

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

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

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

5221.0600 PAYER RESPONSIBILITIES.

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

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~~ compensable by evaluating the charge and service according to the conditions of excessiveness and payer liability specified in ~~parts~~ part 5221.0500 ~~and 5221.0550~~, subparts 1 and 2, and *Minnesota Statutes*, section 176.136, subdivision 2. If the payer determines that the provider has assigned an incorrect code for a service, the payer may determine the correct code for the service and evaluate liability for payment on the basis of the correct code.

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

~~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 or noncompensable under *Minnesota Statutes*, section 176.136, subdivision 2; or part 5221.0500, subparts 1 and 2; or the charges are not submitted on the appropriate billing form prescribed in part 5221.0700; ~~and/or~~ or

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

~~B. If a service is not included in the a 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:

[For text of item A, see M.R.]

B. the basis for denial or reduction of each charge and the specific amounts being denied or reduced for each charge meeting the conditions of an excessive or noncompensable charge under part 5221.0500, subparts 1 and 2, or *Minnesota Statutes*, section 176.136, subdivision 2;

C. ~~the basis for denial of each charge meeting the conditions of an excessive service under part 5221.0500~~ denial of a charge for failure to submit it on the billing form prescribed in part 5221.0700, subpart 2; ~~and/or~~ and

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

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

[For text of subps 5 and 6, see M.R.]

5221.0650 DATA COLLECTION, RETENTION, AND REPORTING REQUIREMENTS.

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

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

Subp. 3. **Retention period.** Data described in subpart 4 shall be collected and stored by the parties listed in subpart 1 for all medical services and supplies provided to an employee under *Minnesota Statutes*, chapter 176, for ten years from the date the service or supply was provided.

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

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

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

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

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

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

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

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

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

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

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

5221.0700 PROVIDER RESPONSIBILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) 11 = office;

(b) 21 = hospital inpatient;

(c) 22 = hospital outpatient;

(d) 23 = emergency room - hospital; and

(e) 24 = ambulatory surgical center.

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

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

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

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

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

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

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

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

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

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

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

(a) type of facility - 1st digit

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

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

IP	1 or 2
OP	3

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

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

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

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

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

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

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

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

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

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

1	Emergency
2	Urgent
3	Elective

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Where a code is assigned to a service, article, or supply, the approved procedure codes and modifiers appropriate for the service, in accordance with subpart 3.

(ii) The charge for each service.

(iii) The number of units of each service provided.

(iv) The date each service was provided.

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

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

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

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

(16) The ICD-9-CM or CPT-4 code that indicates the principal procedure performed during the period covered by this bill and the date on which the principal procedure was performed must appear in form locator field 80. Enter codes for procedures other than the principal procedure in form locator field 81.

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

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

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

Subp. 2c. **Submission of pharmacy charges.** Except as provided in subpart 2b, itemized charges for all medications provided for a claimed workers' compensation injury must be submitted to the payer on a claim form which includes the following information:

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

B. the employee's name and address;

C. the insurer's name and address;

D. the date of the injury;

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

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

G. the name and quantity of each medication provided;

H. the procedure code for the medication;

I. the date the medication was provided;

J. the total charge for each medication provided; and

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

Subp. 3. **Billing code.** The provider shall undertake professional judgment to assign the correct approved billing code for the service rendered using the appropriate provider group designation, and according to the instructions and guidelines in this chapter and in the CPT or HCPCS manual in effect on the date the service was rendered.

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

B. ~~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.~~

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

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

~~25105~~	~~Arthrotomy, wrist joint; for synovectomy~~	

~~C.~~ The codes for services in parts ~~5221.1100~~ 5221.4030 to ~~5221.2400~~ 5221.4070 may be submitted with two-digit or two-letter suffixes~~,~~ called "modifiers." Modifiers indicate that ~~a~~ the service rendered differs in some material respect from the ~~service's basic description~~ service as described in this chapter or in the CPT or HCPCS manual. ~~Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in subitems (1) to (20).~~ Modifiers used must be those listed and described in the CPT manual in effect on the date the service was rendered.

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

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

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

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

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

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

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

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

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

~~(10) Modifier number 55 denotes postoperative management only. This modifier is appropriate to services where the~~

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~~physician provides postoperative management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.~~

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

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

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

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

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

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

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

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

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

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

C. Provider group designation.

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

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

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

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

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osteopathic physician, a physical therapist, or an occupational therapist are listed in part 5221.4050.

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

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

[For text of subp 4, see M.R.]

Subp. 5. [See repealer.]

Rules as proposed (all new material)

5221.4000 APPLICATION SCHEDULE; INSTRUCTIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5221.4030 MEDICAL/SURGICAL PROCEDURE CODES.

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

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

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

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

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

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

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

(a) If the item or service is provided incident to the services of a licensed provider, on the same day as the licensed provider service, payment for it is bundled into the payment for the licensed provider service to which it is incident. For example, an elastic bandage, procedure code number A4202, is a "P" code. If a provider furnished an employee an elastic bandage while treating the employee for a tibia fracture, the cost of the bandage is included in the cost of the treatment, procedure code number 27750. No separate payment for the bandage is allowed.

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

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

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

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

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

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

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

A. Procedure code numbers 10040 to 19380 relate to skin procedures.

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
10040		A	Acne surgery	1.70	010
10060		A	Drainage of skin abscess	1.61	010
10061		A	Drainage of skin abscess	3.22	010
10080		A	Drainage of pilonidal cyst	2.20	010
10081		A	Drainage of pilonidal cyst	3.67	010
10120		A	Remove foreign body	1.72	010
10121		A	Remove foreign body	3.79	010
10140		A	Drainage of hematoma	2.04	010
10160		A	Puncture drainage of lesion	1.59	010
10180		A	Complex drainage, wound	3.42	010
11000		A	Surgical cleansing of skin	1.36	000
11001		A	Additional cleansing of skin	.74	ZZZ
11040		A	Surgical cleansing, abrasion	.95	000
11041		A	Surgical cleansing of skin	1.45	000
11042		A	Cleansing of skin/tissue	1.85	000
11043		A	Cleansing of tissue/muscle	3.92	010
11044		A	Cleansing tissue/muscle/bone	5.53	010
11050		A	Trim skin lesion	.82	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
11051		A	Trim 2 to 4 skin lesions	1.22	000
11052		A	Trim over 4 skin lesions	1.32	000
11100		A	Biopsy of skin lesion	1.37	000
11101		A	Biopsy, each added lesion	.72	ZZZ
11200		A	Removal of skin tags	1.17	010
11201		A	Removal of added skin tags	.44	ZZZ
11300		A	Shave skin lesion	1.10	000
11301		A	Shave skin lesion	1.58	000
11302		A	Shave skin lesion	2.02	000
11303		A	Shave skin lesion	2.76	000
11305		A	Shave skin lesion	1.25	000
11306		A	Shave skin lesion	1.77	000
11307		A	Shave skin lesion	2.18	000
11308		A	Shave skin lesion	2.97	000
11310		A	Shave skin lesion	1.48	000
11311		A	Shave skin lesion	1.97	000
11312		A	Shave skin lesion	2.42	000
11313		A	Shave skin lesion	3.26	000
11400		A	Removal of skin lesion	1.45	010
11401		A	Removal of skin lesion	2.01	010
11402		A	Removal of skin lesion	2.55	010
11403		A	Removal of skin lesion	3.17	010
11404		A	Removal of skin lesion	3.70	010
11406		A	Removal of skin lesion	4.90	010
11420		A	Removal of skin lesion	1.59	010
11421		A	Removal of skin lesion	2.28	010
11422		A	Removal of skin lesion	2.76	010
11423		A	Removal of skin lesion	3.58	010
11424		A	Removal of skin lesion	4.14	010
11426		A	Removal of skin lesion	5.85	010
11440		A	Removal of skin lesion	1.85	010
11441		A	Removal of skin lesion	2.50	010
11442		A	Removal of skin lesion	3.05	010
11443		A	Removal of skin lesion	4.06	010
11444		A	Removal of skin lesion	5.02	010
11446		A	Removal of skin lesion	6.45	010
11450		A	Removal, sweat gland lesion	5.64	090
11451		A	Removal, sweat gland lesion	7.13	090
11462		A	Removal, sweat gland lesion	5.09	090
11463		A	Removal, sweat gland lesion	6.13	090
11470		A	Removal, sweat gland lesion	6.28	090
11471		A	Removal, sweat gland lesion	7.19	090
11600		A	Removal of skin lesion	2.60	010
11601		A	Removal of skin lesion	3.40	010
11602		A	Removal of skin lesion	4.01	010
11603		A	Removal of skin lesion	4.76	010
11604		A	Removal of skin lesion	5.36	010
11606		A	Removal of skin lesion	6.94	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
11620		A	Removal of skin lesion	2.74	010
11621		A	Removal of skin lesion	3.83	010
11622		A	Removal of skin lesion	4.67	010
11623		A	Removal of skin lesion	5.70	010
11624		A	Removal of skin lesion	6.90	010
11626		A	Removal of skin lesion	8.10	010
11640		A	Removal of skin lesion	3.27	010
11641		A	Removal of skin lesion	4.66	010
11642		A	Removal of skin lesion	5.67	010
11643		A	Removal of skin lesion	6.74	010
11644		A	Removal of skin lesion	8.35	010
11646		A	Removal of skin lesion	10.76	010
11700		A	Scraping of 1 to 5 nails	.65	000
11701		A	Scraping of additional nails	.47	ZZZ
11710		A	Scraping of 1 to 5 nails	.65	000
11711		A	Scraping of additional nails	.40	ZZZ
11730		A	Removal of nail plate	1.63	000
11731		A	Removal of second nail plate	1.12	ZZZ
11732		A	Remove additional nail plate		ZZZ
11740		A	Drain blood from under nail	.79	000
11750		A	Removal of nail bed	3.93	010
11752		A	Remove nail bed/finger tip	5.50	010
11760		A	Repair of nail bed	2.56	010
11762		A	Reconstruct, nail bed w/graft	5.64	010
11765		A	Excision of nail fold, toe	1.21	010
11770		A	Removal of pilonidal lesion	5.61	010
11771		A	Removal of pilonidal lesion	10.47	090
11772		A	Removal of pilonidal lesion	12.06	090
11900		A	Injection into skin lesions	.80	000
11901		A	Added skin lesion injections	1.25	000
11960		A	Insert tissue expander(s)	15.44	090
11970		A	Replace tissue expander	16.72	090
11971		A	Remove tissue expander(s)	6.86	090
12001		A	Repair superficial wound(s)	2.30	010
12002		A	Repair superficial wound(s)	2.69	010
12004		A	Repair superficial wound(s)	3.45	010
12005		A	Repair superficial wound(s)	4.45	010
12006		A	Repair superficial wound(s)	5.62	010
12007		A	Repair superficial wound(s)	6.09	010
12011		A	Repair superficial wound(s)	2.53	010
12013		A	Repair superficial wound(s)	3.07	010
12014		A	Repair superficial wound(s)	3.73	010
12015		A	Repair superficial wound(s)	4.92	010
12016		A	Repair superficial wound(s)	6.36	010
12017		A	Repair superficial wound(s)	8.34	010
12018		A	Repair superficial wound(s)	11.11	010
12020		A	Closure of split wound	3.95	010
12021		A	Closure of split wound	2.53	010
12031		A	Layer closure of wound(s)	2.92	010
12032		A	Layer closure of wound(s)	3.59	010
12034		A	Layer closure of wound(s)	4.52	010
12035		A	Layer closure of wound(s)	5.54	010
12036		A	Layer closure of wound(s)	6.67	010
12037		A	Layer closure of wound(s)	8.17	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
12041		A	Layer closure of wound(s)	3.27	010
12042		A	Layer closure of wound(s)	4.01	010
12044		A	Layer closure of wound(s)	4.90	010
12045		A	Layer closure of wound(s)	5.97	010
12046		A	Layer closure of wound(s)	7.39	010
12047		A	Layer closure of wound(s)	9.13	010
12051		A	Layer closure of wound(s)	3.55	010
12052		A	Layer closure of wound(s)	4.36	010
12053		A	Layer closure of wound(s)	5.01	010
12054		A	Layer closure of wound(s)	6.27	010
12055		A	Layer closure of wound(s)	7.99	010
12056		A	Layer closure of wound(s)	10.43	010
12057		A	Layer closure of wound(s)	11.96	010
13100		A	Repair of wound or lesion	4.37	010
13101		A	Repair of wound or lesion	6.18	010
13120		A	Repair of wound of lesion	4.79	010
13121		A	Repair of wound or lesion	7.27	010
13131		A	Repair of wound or lesion	5.97	010
13132		A	Repair of wound or lesion	9.20	010
13150		A	Repair of wound or lesion	5.77	010
13151		A	Repair of wound or lesion	7.20	010
13152		A	Repair of wound or lesion	12.05	010
13160		A	Late closure of wound	13.52	090
13300		A	Repair of wound or lesion	11.57	010
14000		A	Skin tissue rearrangement	9.24	090
14001		A	Skin tissue rearrangement	13.26	090
14020		A	Skin tissue rearrangement	11.48	090
14021		A	Skin tissue rearrangement	16.47	090
14040		A	Skin tissue rearrangement	14.59	090
14041		A	Skin tissue rearrangement	19.60	090
14060		A	Skin tissue rearrangement	16.74	090
14061		A	Skin tissue rearrangement	23.10	090
14300		A	Skin tissue rearrangement	23.67	090
14350		A	Skin tissue rearrangement	16.10	090
15000		A	Skin grant procedure	5.56	ZZZ
15050		A	Skin pinch graft procedure	5.99	090
15100		A	Skin split graft procedure	13.44	090
15101		A	Skin split graft procedure	3.59	ZZZ
15120		A	Skin split grant procedure	16.09	090
15121		A	Skin split graft procedure	6.04	ZZZ
15200		A	Skin full graft procedure	12.28	090
15201		A	Skin full graft procedure	4.53	ZZZ
15220		A	Skin full graft procedure	13.05	090
15221		A	Skin full graft procedure	4.38	ZZZ
15240		A	Skin full graft procedure	15.35	090
15241		A	Skin full graft procedure	5.76	ZZZ
15260		A	Skin full graft procedure	17.96	090
15261		A	Skin full graft procedure	7.19	ZZZ

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
15350		A	Skin homograft procedure	6.43	090
15400		A	Skin heterograft procedure	6.20	090
15570		A	Form skin pedicle	16.15	090
15572		A	Form skin pedicle	15.35	090
15574		A	Form skin pedicle	15.21	090
15576		A	Form skin pedicle	7.94	090
15580		A	Cross finger flap	11.67	090
15600		A	Skin flap procedure	7.31	090
15610		A	Skin flap procedure	7.06	090
15620		A	Skin flap procedure	8.61	090
15625		A	Skin flap procedure	6.71	090
15630		A	Skin flap procedure	9.25	090
15650		A	Transfer skin pedicle flap	9.96	090
15732		A	Muscle-skin flap, head/neck	34.44	090
15734		A	Muscle-skin flap, trunk	38.29	090
15736		A	Muscle-skin flap, arm	34.05	090
15738		A	Muscle-skin flap, leg	29.87	090
15740		A	Island pedicle flap	21.26	090
15750		A	Neurovascular pedicle	24.31	090
15755		A	Microvascular free flap	63.01	090
15760		A	Composite skin graft	16.57	090
15770		A	Derma-fat-fascia graft	15.16	090
15780		A	Abrasion treatment of skin	8.50	090
15781		A	Abrasion treatment of skin	8.82	090
15782		A	Abrasion treatment of skin	5.58	090
15783		A	Abrasion treatment of skin	6.24	090
15786		A	Abrasion treatment of lesion	2.69	010
15787		A	Abrasion, added skin lesions	.58	ZZZ
15790		A	Chemical peel, face	8.15	090
15791		A	Chemical peel, of skin	5.88	090
15810		A	Salabrasion	8.59	090
15811		A	Salabrasion	9.54	090
15819		A	Plastic surgery, neck	17.72	090
15820		A	Revision of lower eyelid	12.14	090
15821		A	Revision of lower eyelid	14.06	090
15822		A	Revision of upper eyelid	11.95	090
15823		A	Revision of upper eyelid	14.95	090
15831		A	Excise excessive skin tissue	23.27	090
15832		A	Excise excessive skin tissue	20.49	090
15833		A	Excise excessive skin tissue	17.29	090
15834		A	Excise excessive skin tissue	18.48	090
15835		A	Excise excessive skin tissue	19.14	090
15836		A	Excise excessive skin tissue	15.65	090
15837		A	Excise excessive skin tissue	14.87	090
15838		A	Excise excessive skin tissue	13.36	090
15839		A	Excise excessive skin tissue	11.92	090
15840		A	Graft for face nerve palsy	29.76	090
15841		A	Graft for face nerve palsy	40.93	090
15842		A	Graft for face nerve palsy	67.73	090
15845		A	Skin and muscle repair, face	30.99	090
15850		B	Removal of sutures	.00	XXX
15851		A	Removal of sutures	1.19	000
15852		A	Dressing change, not for burn	1.37	000
15860		A	Test for blood flow in graft	3.53	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
15920		A	Removal of tail bone ulcer	10.96	090
15922		A	Removal of tail bone ulcer	16.25	090
15931		A	Remove sacrum pressure sore	11.66	090
15933		A	Remove sacrum pressure sore	17.85	090
15934		A	Remove sacrum pressure sore	20.24	090
15935		A	Remove sacrum pressure sore	26.28	090
15936		A	Remove sacrum pressure sore	23.36	090
15937		A	Remove sacrum pressure sore	28.73	090
15940		A	Removal of pressure sore	12.48	090
15941		A	Removal of pressure sore	18.47	090
15944		A	Removal of pressure sore	21.02	090
15945		A	Removal of pressure sore	24.27	090
15946		A	Removal of pressure sore	39.27	090
15950		A	Remove thigh pressure sore	10.39	090
15951		A	Remove thigh pressure sore	18.62	090
15952		A	Remove thigh pressure sore	18.56	090
15953		A	Remove thigh pressure sore	22.12	090
15956		A	Remove thigh pressure sore	33.94	090
15958		A	Remove thigh pressure sore	35.93	090
16000		A	Initial treatment of burn(s)	1.27	000
16010		A	Treatment of burn(s)	1.22	000
16015		A	Treatment of burn(s)	4.73	000
16020		A	Treatment of burn(s)	1.17	000
16025		A	Treatment of burn(s)	2.37	000
16030		A	Treatment of burn(s)	2.71	000
16035		A	Incision of burn scab	6.76	090
16040		A	Burn wound excision	4.49	000
16041		A	Burn wound excision	5.97	000
16042		A	Burn wound excision	5.97	000
17000		A	Destruction of facial lesion	1.10	010
17001		A	Destruction of add'l lesions	.39	ZZZ
17002		A	Destruction of add'l lesions	.29	ZZZ
17010		A	Destruction of skin lesion(s)	1.54	010
17100		A	Destruction of skin lesion	.93	010
17101		A	Destruction of 2nd lesion	.30	ZZZ
17102		A	Destruction of add'l lesions	.20	ZZZ
17104		A	Destruction of skin lesions	2.13	010
17105		A	Destruction of skin lesions	1.10	010
17106		A	Destruction of skin lesions	6.70	090
17107		A	Destruction of skin lesions	13.25	090
17108		A	Destruction of skin lesions	23.20	090
17110		A	Destruction of skin lesions	.99	010
17200		A	Electrocautery of skin tags	1.05	010
17201		A	Electrocautery added lesions	.54	ZZZ
17250		A	Chemical cautery, tissue	.88	000
17260		A	Destruction of skin lesions	2.08	010
17261		A	Destruction of skin lesions	2.62	010
17262		A	Destruction of skin lesions	3.49	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
17263		A	Destruction of skin lesions	4.18	010
17264		A	Destruction of skin lesions	4.71	010
17266		A	Destruction of skin lesions	5.82	010
17270		A	Destruction of skin lesions	2.72	010
17271		A	Destruction of skin lesions	3.34	010
17272		A	Destruction of skin lesions	4.09	010
17273		A	Destruction of skin lesions	4.80	010
17274		A	Destruction of skin lesions	6.03	010
17276		A	Destruction of skin lesions	7.02	010
17280		A	Destruction of skin lesions	2.89	010
17281		A	Destruction of skin lesions	3.92	010
17282		A	Destruction of skin lesions	4.76	010
17283		A	Destruction of skin lesions	5.85	010
17284		A	Destruction of skin lesions	6.98	010
17286		A	Destruction of skin lesions	9.26	010
17304		A	Chemosurgery of skin lesion	11.99	000
17305		A	2nd stage chemosurgery	5.30	000
17306		A	3rd stage chemosurgery	4.40	000
17307		A	Follow-up skin lesion therapy	4.47	000
17310		A	Extensive skin chemosurgery	1.10	000
17340		A	Cryotherapy of skin	1.04	010
17360		A	Skin peel therapy	1.72	010
19000		A	Drainage of breast lesion	1.28	000
19001		A	Drain added breast lesion	.70	ZZZ
19020		A	Incision of breast lesion	5.05	090
19030		A	Injection for breast X-ray	2.09	000
19100		A	Biopsy of breast	2.04	000
19101		A	Biopsy of breast	5.87	010
19110		A	Nipple exploration	7.10	090
19112		A	Excise breast duct fistula	6.20	090
19120		A	Removal of breast lesion	8.29	090
19140		A	Removal of breast tissue	9.98	090
19160		A	Removal of breast tissue	11.58	090
19162		A	Remove breast tissue, nodes	23.93	090
19180		A	Removal of breast	14.81	090
19182		A	Removal of breast	14.46	090
19200		A	Removal of breast	26.38	090
19220		A	Removal of breast	27.06	090
19240		A	Removal of breast	25.97	090
19260		A	Removal of chest wall lesion	20.06	090
19271		A	Revision of chest wall	33.48	090
19272		A	Extensive chest wall surgery	34.43	090
19290		A	Place needle wire, breast	1.79	000
19291		A	Place needle wire, breast	.92	ZZZ
19316		A	Suspension of breast	24.93	090
19318		A	Reduction of large breast	30.60	090
19324		A	Enlarge breast	9.46	090
19325		A	Enlarge breast with implant	14.95	090
19328		A	Removal of breast implant	9.74	090
19330		A	Removal of implant material	11.78	090
19340		A	Immediate breast prosthesis	18.89	ZZZ
19342		A	Delayed breast prosthesis	23.19	090
19350		A	Breast reconstruction	16.50	090
19355		A	Correct inverted nipple(s)	13.11	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
19357		A	Breast reconstruction	31.02	090
19361		A	Breast reconstruction	41.23	090
19362		A	Breast reconstruction	50.20	090
19364		A	Breast reconstruction	47.59	090
19366		A	Breast reconstruction	39.05	090
19370		A	Surgery of breast capsule	14.81	090
19371		A	Removal of breast capsule	18.11	090
19380		A	Revise breast reconstruction	18.11	090

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

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
20000		A	Incision of abscess	2.79	010
20005		A	Incision of deep abscess	5.11	010
20200		A	Muscle biopsy	2.74	000
20205		A	Deep muscle biopsy	4.53	000
20206		A	Needle biopsy, muscle	2.07	000
20220		A	Bone biopsy, trocar/needle	2.67	000
20225		A	Bone biopsy, trocar/needle	4.60	000
20240		A	Bone biopsy, excisional	5.15	010
20245		A	Bone biopsy, excisional	7.67	010
20250		A	Open bone biopsy	10.37	010
20251		A	Open bone biopsy	11.79	010
20500		A	Injection of sinus tract	1.59	010
20501		A	Inject sinus tract for X-ray	1.09	000
20520		A	Removal of foreign body	2.61	010
20525		A	Removal of foreign body	5.77	010
20550		A	Inject tendon/ligament/cyst	1.29	000
20600		A	Drain/inject joint/bursa	1.19	000
20605		A	Drain/inject joint/bursa	1.19	000
20610		A	Drain/inject joint/bursa	1.30	000
20615		A	Treatment of bone cyst	2.82	010
20650		A	Insert and remove bone pin	3.29	010
20660		A	Apply, remove fixation device	4.28	000
20661		A	Application of head brace	8.67	090
20662		A	Application of pelvis brace	12.94	090
20663		A	Application of thigh brace	10.18	090
20665		A	Removal of fixation device	1.85	010
20670		A	Removal of support implant	2.55	010
20680		A	Removal of support implant	7.03	090
20690		A	Apply bone fixation device	7.70	ZZZ
20692		A	Apply bone fixation device	12.72	ZZZ
20693		A	Adjust bone fixation device	8.34	090
20694		A	Remove bone fixation device	6.79	090
20900		A	Removal of bone for graft	8.29	090
20902		A	Removal of bone for graft	12.45	090
20910		A	Remove cartilage for graft	6.01	090
20912		A	Remove cartilage for graft	11.27	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
20920		A	Removal of fascia for graft	9.27	090
20922		A	Removal of fascia for graft	11.10	090
20924		A	Removal of tendon for graft	12.25	090
20926		A	Removal of tissue for graft	8.03	090
20950		A	Record fluid pressure, muscle	2.49	000
20974		A	Electrical bone stimulation	4.46	ZZZ
20975		A	Electrical bone stimulation	6.60	ZZZ
21010		A	Incision of jaw joint	20.17	090
21015		A	Resection of facial tumor	12.26	090
21025		A	Excision of bone, lower jaw	9.57	090
21026		A	Excision of facial bone(s)	7.96	090
21029		A	Contour of face bone lesion	17.59	090
21030		A	Removal of face bone lesion	10.76	090
21031		A	Remove exostosis, mandible	5.96	090
21032		A	Remove exostosis, maxilla	8.49	090
21034		A	Removal of face bone lesion	23.09	090
21040		A	Removal of jaw bone lesion	4.99	090
21041		A	Removal of jaw bone lesion	11.27	090
21044		A	Removal of jaw bone lesion	21.69	090
21045		A	Extensive jaw surgery	30.43	090
21050		A	Removal of jaw joint	23.39	090
21060		A	Remove jaw joint cartilage	22.11	090
21070		A	Remove coronoid process	15.25	090
21100		A	Maxillofacial fixation	5.26	090
21110		A	Interdental fixation	11.01	090
21116		A	Injection, jaw joint X-ray	1.60	000
21120		A	Reconstruction of chin	8.75	090
21121		A	Reconstruction of chin	13.76	090
21122		A	Reconstruction of chin	15.16	090
21123		A	Reconstruction of chin	19.81	090
21125		A	Augmentation lower jaw bone	11.47	090
21127		A	Augmentation lower jaw bone	19.26	090
21144		A	Reconstruct midface, lefort 1	31.24	090
21145		A	Reconstruct midface, lefort 1	34.91	090
21146		A	Reconstruct midface, lefort 1	36.13	090
21147		A	Reconstruct midface, lefort 1	37.49	090
21193		A	Reconstruct lower jaw bone	29.96	090
21194		A	Reconstruct lower jaw bone	34.72	090
21195		A	Reconstruct lower jaw bone	30.03	090
21196		A	Reconstruct lower jaw bone	33.11	090
21198		A	Reconstruct lower jaw bone	29.75	090
21206		A	Reconstruct upper jaw bone	24.67	090
21208		A	Augmentation of facial bones	21.81	090
21209		A	Reduction of facial bones	11.57	090
21210		A	Face bone graft	23.25	090
21215		A	Lower jaw bone graft	26.70	090
21230		A	Rib cartilage graft	21.92	090
21235		A	Ear cartilage graft	15.60	090
21240		A	Reconstruction of jaw joint	38.47	090
21242		A	Reconstruction of jaw joint	39.90	090
21243		A	Reconstruction of jaw joint	35.03	090
21244		A	Reconstruction of lower jaw	31.83	090
21245		A	Reconstruction of jaw	23.75	090
21246		A	Reconstruction of jaw	21.51	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
21247		A	Reconstruct lower jaw bone	51.58	090
21248		A	Reconstruction of jaw	34.08	090
21249		A	Reconstruction of jaw	60.85	090
21255		A	Reconstruct lower jaw bone	38.12	090
21256		A	Reconstruction of orbit	36.90	090
21260		A	Revise eye sockets	37.65	090
21261		A	Revise eye sockets	49.08	090
21263		A	Revise eye sockets	64.78	090
21267		A	Revise eye sockets	34.24	090
21268		A	Revise eye sockets	41.06	090
21270		A	Augmentation cheek bones	23.02	090
21275		A	Revision orbitofacial bones	20.62	090
21280		A	Revision of eyelid	13.40	090
21282		A	Revision of eyelid	12.24	090
21295		A	Revision of jaw muscle/bone	2.52	090
21296		A	Revision of jaw muscle/bone	7.82	090
21300		A	Treatment of skull fracture	2.18	000
21310		A	Treatment of nose fracture	1.62	000
21315		A	Treatment of nose fracture	3.40	010
21320		A	Treatment of nose fracture	4.84	010
21325		A	Repair of nose fracture	8.08	090
21330		A	Repair of nose fracture	12.68	090
21335		A	Repair of nose fracture	22.32	090
21336		A	Repair nasal septal fracture	9.33	090
21337		A	Repair nasal septal fracture	5.67	090
21338		A	Repair nasoethmoid fracture	11.68	090
21339		A	Repair nasoethmoid fracture	15.32	090
21340		A	Repair of nose fracture	19.96	090
21343		A	Repair of sinus fracture	22.32	090
21344		A	Open treatment of complicated (EG)	28.80	090
21345		A	Repair of nose/jaw fracture	16.29	090
21346		A	Repair of nose/jaw fracture	20.29	090
21347		A	Repair of nose/jaw fracture	23.50	090
21348		A	Repair of nose/jaw fracture	14.47	090
21355		A	Repair cheek bone fracture	5.29	010
21356		A	Repair cheek bone fracture	11.89	010
21360		A	Repair cheek bone fracture	14.11	090
21365		A	Repair cheek bone fracture	27.84	090
21366		A	Repair cheek bone fracture	22.75	090
21385		A	Repair eye socket fracture	19.17	090
21386		A	Repair eye socket fracture	18.74	090
21387		A	Repair eye socket fracture	17.42	090
21390		A	Repair eye socket fracture	22.58	090
21395		A	Repair eye socket fracture	22.77	090
21400		A	Treat eye socket fracture	3.35	090
21401		A	Repair eye socket fracture	5.92	090
21406		A	Repair eye socket fracture	12.46	090
21407		A	Repair eye socket fracture	15.89	090

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21408		A	Repair eye socket fracture	18.47	090
21421		A	Treat mouth roof fracture	11.88	090
21422		A	Repair mouth roof fracture	18.62	090
21423		A	Repair mouth roof fracture	20.61	090
21431		A	Treat craniofacial fracture	13.28	090
21432		A	Repair craniofacial fracture	15.61	090
21433		A	Repair craniofacial fracture	43.72	090
21435		A	Repair craniofacial fracture	31.12	090
21436		A	Repair craniofacial fracture	42.99	090
21440		A	Repair dental ridge fracture	5.84	090
21445		A	Repair dental ridge fracture	11.67	090
21450		A	Treat lower jaw fracture	5.87	090
21451		A	Treat lower jaw fracture	12.76	090
21452		A	Treat lower jaw fracture	3.40	090
21453		A	Treat lower jaw fracture	7.21	090
21454		A	Treat lower jaw fracture	21.86	090
21461		A	Repair lower jaw fracture	21.35	090
21462		A	Repair lower jaw fracture	23.75	090
21465		A	Repair lower jaw fracture	20.53	090
21470		A	Repair lower jaw fracture	32.90	090
21480		A	Reset dislocated jaw	1.74	000
21485		A	Reset dislocated jaw	6.14	090
21490		A	Repair dislocated jaw	18.02	090
21493		A	Treat hyoid bone fracture	2.90	090
21494		A	Repair hyoid bone fracture	14.33	090
21495		A	Repair hyoid bone fracture	10.63	090
21497		A	Interdental wiring	7.93	090
21501		A	Drain neck/chest lesion	5.61	090
21502		A	Drain chest lesion	11.37	090
21510		A	Drainage of bone lesion	9.34	090
21550		A	Biopsy of neck/chest	2.99	010
21555		A	Remove lesion neck/chest	5.97	090
21556		A	Remove lesion neck/chest	9.68	090
21557		A	Remove tumor, neck or chest	18.29	090
21600		A	Partial removal of rib	11.56	090
21610		A	Partial removal of rib	14.47	090
21615		A	Removal of rib	20.81	090
21616		A	Removal of rib and nerves	19.74	090
21620		A	Partial removal of sternum	13.94	090
21627		A	Sternal debridement	11.90	090
21630		A	Extensive sternum surgery	28.64	090
21632		A	Extensive sternum surgery	30.18	090
21633		A	Extensive sternum surgery	31.09	090
21700		A	Revision of neck muscle	10.52	090
21705		A	Revision of neck muscle/rib	14.79	090
21720		A	Revision of neck muscle	9.78	090
21725		A	Revision of neck muscle	12.08	090
21740		A	Reconstruction of sternum	25.98	090
21750		A	Repair of sternum separation	18.69	090
21800		A	Treatment of rib fracture	1.75	090
21805		A	Treatment of rib fracture	4.14	090
21810		A	Treatment of rib fracture(s)	14.60	090
21820		A	Treat sternum fracture	2.72	090
21825		A	Repair sternum fracture	14.70	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
21920		A	Biopsy soft tissue of back	2.93	010
21925		A	Biopsy soft tissue of back	6.52	090
21930		A	Remove lesion, back or flank	9.79	090
21935		A	Remove tumor of back	25.07	090
22100		A	Remove part of neck vertebra	15.35	090
22101		A	Remove part, thorax vertebra	15.83	090
22102		A	Remove part, lumbar vertebra	13.83	090
22105		A	Remove part of neck vertebra	25.34	090
22106		A	Remove part, thorax vertebra	22.22	090
22107		A	Remove part, lumbar vertebra	17.38	090
22110		A	Remove part of neck vertebra	22.79	090
22112		A	Remove part, thorax vertebra	22.95	090
22114		A	Remove part, lumbar vertebra	19.97	090
22140		A	Reconstruct neck spine	41.65	090
22141		A	Reconstruct thorax spine	45.29	090
22142		A	Reconstruct lumbar spine	49.95	090
22145		A	Reconstruct vertebra(e)	14.51	ZZZ
22148		A	Harvesting bone graft	8.45	ZZZ
22150		A	Reconstruct neck spine	42.25	090
22151		A	Reconstruct thorax spine	42.72	090
22152		A	Reconstruct lumbar spine	43.40	090
22210		A	Revision of neck spine	38.65	090
22212		A	Revision of thorax spine	37.93	090
22214		A	Revision of lumbar spine	35.65	090
22220		A	Revision of neck spine	39.19	090
22222		A	Revision of thorax spine	35.37	090
22224		A	Revision of lumbar spine	37.27	090
22230		A	Additional revision of spine	11.91	ZZZ
22305		A	Treat spine process fracture	4.77	090
22310		A	Treat spine fracture	6.94	090
22315		A	Treat spine fracture	14.69	090
22325		A	Repair of spine fracture	26.89	090
22326		A	Repair neck spine fracture	36.81	090
22327		A	Repair thorax spine fracture	35.64	090
22505		A	Manipulation of spine	3.24	010
22548		A	Neck spine fusion	50.18	090
22554		A	Neck spine fusion	40.96	090
22556		A	Thorax spine fusion	48.03	090
22558		A	Lumbar spine fusion	45.29	090
22585		A	Additional spinal fusion	11.73	ZZZ
22590		A	Spine and skull spinal fusion	43.50	090
22595		A	Neck spinal fusion	45.00	090
22600		A	Neck spine fusion	40.28	090
22610		A	Thorax spine fusion	35.35	090
22612		A	Lumbar spine fusion	44.26	090
22625		A	Lumbar spine fusion	44.92	090
22630		A	Lumbar spine fusion	42.18	090
22650		A	Additional spinal fusion	12.92	ZZZ

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
22800		A	Fusion of spine	42.36	090
22802		A	Fusion of spine	63.76	090
22810		A	Fusion of spine	50.41	090
22812		A	Fusion of spine	56.89	090
22820		A	Harvesting of bone	7.91	ZZZ
22830		A	Exploration of spinal fusion	25.29	090
22840		A	Insert spine fixation device	38.20	000
22842		A	Insert spine fixation device	42.54	000
22845		A	Insert spine fixation device	34.26	000
22849		A	Reinsert spinal fixation	26.37	090
22850		A	Remove spine fixation device	19.46	090
22852		A	Remove spine fixation device	19.54	090
22855		A	Remove spine fixation device	17.69	090
22900		A	Remove abdominal wall lesion	10.19	090
23000		A	Removal of calcium deposits	7.81	090
23020		A	Release shoulder joint	16.51	090
23030		A	Drain shoulder lesion	5.64	010
23031		A	Drain shoulder bursa	3.30	010
23035		A	Drain shoulder bone lesion	14.96	090
23040		A	Exploratory shoulder surgery	18.93	090
23044		A	Exploratory shoulder surgery	14.33	090
23065		A	Biopsy shoulder tissues	3.02	010
23066		A	Biopsy shoulder tissues	5.35	090
23075		A	Removal of shoulder lesion	4.28	010
23076		A	Removal of shoulder lesion	11.31	090
23077		A	Remove tumor of shoulder	23.39	090
23100		A	Biopsy of shoulder joint	14.43	090
23101		A	Shoulder joint surgery	13.56	090
23105		A	Remove shoulder joint lining	19.65	090
23106		A	Incision of collarbone joint	11.02	090
23107		A	Explore, treat shoulder joint	19.09	090
23120		A	Partial removal, collarbone	11.95	090
23125		A	Removal of collarbone	18.52	090
23130		A	Partial removal, shoulder bone	15.15	090
23140		A	Removal of bone lesion	11.29	090
23145		A	Removal of bone lesion	17.84	090
23146		A	Removal of bone lesion	13.49	090
23150		A	Removal of humerus lesion	15.36	090
23155		A	Removal of humerus lesion	19.62	090
23156		A	Removal of humerus lesion	16.74	090
23170		A	Remove collarbone lesion	11.79	090
23172		A	Remove shoulder blade lesion	12.08	090
23174		A	Remove humerus lesion	18.35	090
23180		A	Remove collarbone lesion	12.80	090
23182		A	Remove shoulder blade lesion	15.01	090
23184		A	Remove humerus lesion	18.74	090
23190		A	Partial removal of scapula	13.73	090
23195		A	Removal of head of humerus	19.19	090
23200		A	Removal of collarbone	21.39	090
23210		A	Removal of shoulder blade	21.71	090
23220		A	Partial removal of humerus	27.16	090
23221		A	Partial removal of humerus	35.95	090
23222		A	Partial removal of humerus	33.74	090
23330		A	Remove shoulder foreign body	2.44	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
23331		A	Remove shoulder foreign body	9.60	090
23332		A	Remove shoulder foreign body	21.71	090
23350		A	Injection for shoulder X-ray	1.58	000
23395		A	Muscle transfer, shoulder/arm	25.19	090
23397		A	Muscle transfers	31.28	090
23400		A	Fixation of shoulder blade	24.33	090
23405		A	Incision of tendon and muscle	16.36	090
23406		A	Incise tendon(s) and muscles	21.14	090
23410		A	Repair of tendon(s)	24.40	090
23412		A	Repair of tendon(s)	27.94	090
23415		A	Release of shoulder ligament	15.53	090
23420		A	Repair of shoulder	29.30	090
23430		A	Repair biceps tendon rupture	18.00	090
23440		A	Removal/transplant tendon	18.34	090
23450		A	Repair shoulder capsule	27.39	090
23455		A	Repair shoulder capsule	31.53	090
23460		A	Repair shoulder capsule	30.72	090
23462		A	Repair shoulder capsule	31.91	090
23465		A	Repair shoulder capsule	31.32	090
23466		A	Repair shoulder capsule	32.45	090
23470		A	Reconstruct shoulder joint	35.20	090
23472		A	Reconstruct shoulder joint	50.64	090
23480		A	Revision of collarbone	18.14	090
23485		A	Revision of collarbone	25.70	090
23490		A	Reinforce clavicle	22.12	090
23491		A	Reinforce shoulder bones	28.19	090
23500		A	Treat clavicle fracture	3.80	090
23505		A	Treat clavicle fracture	6.47	090
23515		A	Repair clavicle fracture	14.92	090
23520		A	Treat clavicle dislocation	3.60	090
23525		A	Treat clavicle dislocation	5.66	090
23530		A	Repair clavicle dislocation	14.42	090
23532		A	Repair clavicle dislocation	15.87	090
23540		A	Treat clavicle dislocation	3.83	090
23545		A	Treat clavicle dislocation	5.32	090
23550		A	Repair clavicle dislocation	16.71	090
23552		A	Repair clavicle dislocation	16.16	090
23570		A	Treat shoulder blade fracture	4.02	090
23575		A	Treat shoulder blade fracture	7.03	090
23585		A	Repair scapula fracture	17.25	090
23600		A	Treat humerus fracture	6.03	090
23605		A	Treat humerus fracture	9.98	090
23615		A	Repair humerus fracture	20.91	090
23616		A	Repair humerus fracture	45.26	090
23620		A	Treat humerus fracture	5.76	090
23625		A	Treat humerus fracture	7.99	090
23630		A	Repair humerus fracture	16.91	090
23650		A	Treat shoulder dislocation	5.58	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
23655		A	Treat shoulder dislocation	7.62	090
23660		A	Repair shoulder dislocation	17.35	090
23665		A	Treat dislocation/fracture	7.99	090
23670		A	Repair dislocation/fracture	20.28	090
23675		A	Treat dislocation/fracture	10.10	090
23680		A	Repair dislocation/fracture	24.41	090
23700		A	Fixation of shoulder	4.86	010
23800		A	Fusion of shoulder joint	31.92	090
23802		A	Fusion of shoulder joint	30.73	090
23900		A	Amputation of arm and girdle	33.18	090
23920		A	Amputation at shoulder joint	29.63	090
23921		A	Amputation follow-up surgery	9.98	090
23930		A	Drainage of arm lesion	4.63	010
23931		A	Drainage of arm bursa	2.50	010
23935		A	Drain arm/elbow bone lesion	10.94	090
24000		A	Exploratory elbow surgery	15.39	090
24006		A	Release elbow joint	15.68	090
24065		A	Biopsy arm/elbow soft tissue	2.94	010
24066		A	Biopsy arm/elbow soft tissue	8.09	090
24075		A	Remove arm/elbow lesion	6.11	090
24076		A	Remove arm/elbow lesion	10.33	090
24077		A	Remove tumor of arm/elbow	22.61	090
24100		A	Biopsy elbow joint lining	9.52	090
24101		A	Explore/treat elbow joint	15.57	090
24102		A	Remove elbow joint lining	20.19	090
24105		A	Removal of elbow bursa	7.75	090
24110		A	Remove humerus lesion	15.83	090
24115		A	Remove/graft bone lesion	17.75	090
24116		A	Remove/graft bone lesion	22.19	090
24120		A	Remove elbow lesion	13.24	090
24125		A	Remove/graft bone lesion	13.80	090
24126		A	Remove/graft bone lesion	16.23	090
24130		A	Removal of head of radius	13.61	090
24134		A	Removal of arm bone lesion	18.79	090
24136		A	Remove radius bone lesion	16.94	090
24138		A	Remove elbow bone lesion	14.70	090
24140		A	Partial removal of arm bone	18.61	090
24145		A	Partial removal of radius	14.41	090
24147		A	Partial removal of elbow	14.56	090
24150		A	Extensive humerus surgery	28.45	090
24151		A	Extensive humerus surgery	30.36	090
24152		A	Extensive radius surgery	17.40	090
24153		A	Extensive radius surgery	22.92	090
24155		A	Removal of elbow joint	23.38	090
24160		A	Remove elbow joint implant	13.02	090
24164		A	Remove radius head implant	12.11	090
24200		A	Removal of arm foreign body	2.36	010
24201		A	Removal of arm foreign body	7.83	090
24220		A	Injection for elbow X-ray	1.89	000
24301		A	Muscle/tendon transfer	18.82	090
24305		A	Arm tendon lengthening	10.61	090
24310		A	Revision of arm tendon	9.16	090
24320		A	Repair of arm tendon	20.37	090
24330		A	Revision of arm muscles	19.19	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
24331		A	Revision of arm muscles	21.11	090
24340		A	Repair of ruptured tendon	15.57	090
24342		A	Repair of ruptured tendon	22.04	090
24350		A	Repair of tennis elbow	9.92	090
24351		A	Repair of tennis elbow	10.97	090
24352		A	Repair of tennis elbow	12.66	090
24354		A	Repair of tennis elbow	12.63	090
24356		A	Revision of tennis elbow	14.69	090
24360		A	Reconstruct elbow joint	29.16	090
24361		A	Reconstruct elbow joint	28.41	090
24362		A	Reconstruct elbow joint	28.44	090
24363		A	Replace elbow joint	46.89	090
24365		A	Reconstruct head of radius	16.51	090
24366		A	Reconstruct head of radius	21.25	090
24400		A	Revision of humerus	20.23	090
24410		A	Revision of humerus	30.17	090
24420		A	Revision of humerus	26.97	090
24430		A	Repair of humerus	28.93	090
24435		A	Repair humerus with graft	32.28	090
24470		A	Revision of elbow joint	17.39	090
24495		A	Decompression of forearm	14.32	090
24498		A	Reinforce humerus	23.13	090
24500		A	Treat humerus fracture	5.87	090
24505		A	Treat humerus fracture	9.96	090
24515		A	Repair humerus fracture	21.96	090
24516		A	Repair humerus fracture	21.96	090
24530		A	Treat humerus fracture	6.42	090
24535		A	Treat humerus fracture	12.08	090
24538		A	Treat humerus fracture	17.97	090
24545		A	Repair humerus fracture	21.01	090
24546		A	Repair humerus fracture	26.14	090
24560		A	Treat humerus fracture	5.05	090
24565		A	Treat humerus fracture	9.20	090
24575		A	Repair humerus fracture	18.84	090
24576		A	Treat humerus fracture	5.12	090
24577		A	Treat humerus fracture	10.02	090
24579		A	Repair humerus fracture	20.45	090
24586		A	Repair elbow fracture	31.16	090
24587		A	Repair elbow fracture	29.90	090
24600		A	Treat elbow dislocation	6.31	090
24605		A	Treat elbow dislocation	7.76	090
24615		A	Repair elbow dislocation	19.34	090
24620		A	Treat elbow fracture	10.97	090
24635		A	Repair elbow fracture	25.08	090
24640		A	Treat elbow dislocation	2.24	010
24650		A	Treat radius fracture	4.55	090
24655		A	Treat radius fracture	7.62	090
24665		A	Repair radius fracture	15.85	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
24666		A	Repair radius fracture	20.52	090
24670		A	Treatment of ulna fracture	4.59	090
24675		A	Treatment of ulna fracture	8.54	090
24685		A	Repair ulna fracture	17.91	090
24800		A	Fusion of elbow joint	22.72	090
24802		A	Fusion/graft of elbow joint	26.73	090
24900		A	Amputation of upper arm	17.68	090
24920		A	Amputation of upper arm	16.56	090
24925		A	Amputation follow-up surgery	13.57	090
24930		A	Amputation follow-up surgery	18.64	090
24931		A	Amputate upper arm and implant	24.50	090
24935		A	Revision of amputation	30.04	090
25000		A	Incision of tendon sheath	7.62	090
25005		A	Incision of tendon sheath	8.05	090
25020		A	Decompression of forearm	10.60	090
25023		A	Decompression of forearm	18.20	090
25028		A	Drainage of forearm lesion	7.30	090
25031		A	Drainage of forearm bursa	4.71	090
25035		A	Treat forearm bone lesion	14.03	090
25040		A	Explore/treat wrist joint	13.11	090
25065		A	Biopsy forearm soft tissues	3.26	010
25066		A	Biopsy forearm soft tissues	5.65	090
25075		A	Removal of forearm lesion	6.15	090
25076		A	Removal of forearm lesion	9.14	090
25077		A	Remove tumor, forearm/wrist	19.17	090
25085		A	Incision of wrist capsule	10.39	090
25100		A	Biopsy of wrist joint	9.20	090
25101		A	Explore/treat wrist joint	10.86	090
25105		A	Remove wrist joint lining	13.73	090
25107		A	Remove wrist joint cartilage	11.97	090
25110		A	Remove wrist tendon lesion	7.02	090
25111		A	Remove wrist tendon lesion	6.95	090
25112		A	Reremove wrist tendon lesion	8.69	090
25115		A	Remove wrist/forearm lesion	14.45	090
25116		A	Remove wrist/forearm lesion	15.78	090
25118		A	Excise wrist tendon sheath	11.08	090
25119		A	Partial removal of ulna	14.72	090
25120		A	Removal of forearm lesion	13.21	090
25125		A	Remove/graft forearm lesion	14.82	090
25126		A	Remove/graft forearm lesion	14.91	090
25130		A	Removal of wrist lesion	9.92	090
25135		A	Remove and graft wrist lesion	12.90	090
25136		A	Remove and graft wrist lesion	11.17	090
25145		A	Remove forearm bone lesion	12.61	090
25150		A	Partial removal of ulna	14.20	090
25151		A	Partial removal of radius	13.52	090
25170		A	Extensive forearm surgery	21.60	090
25210		A	Removal of wrist bone	11.13	090
25215		A	Removal of wrist bones	17.31	090
25230		A	Partial removal of radius	11.15	090
25240		A	Partial removal of ulna	10.96	090
25246		A	Injection for wrist X-ray	2.03	000
25248		A	Remove forearm foreign body	7.53	090
25250		A	Removal of wrist prosthesis	12.74	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
25251		A	Removal of wrist prosthesis	18.57	090
25260		A	Repair forearm tendon/muscle	12.68	090
25263		A	Repair forearm tendon/muscle	14.07	090
25265		A	Repair forearm tendon/muscle	18.75	090
25270		A	Repair forearm tendon/muscle	9.61	090
25272		A	Repair forearm tendon/muscle	10.76	090
25274		A	Repair forearm tendon/muscle	16.07	090
25280		A	Revise wrist/forearm tendon	11.72	090
25290		A	Incise wrist/forearm tendon	7.93	090
25295		A	Release wrist/forearm tendon	9.84	090
25300		A	Fusion of tendons at wrist	16.89	090
25301		A	Fusion of tendons at wrist	15.93	090
25310		A	Transplant forearm tendon	15.87	090
25312		A	Transplant forearm tendon	17.88	090
25315		A	Revise palsy hand tendon(s)	18.62	090
25316		A	Revise palsy hand tendon(s)	23.26	090
25317		A	Revise hand contracture	19.55	090
25318		A	Revise hand contracture	26.00	090
25320		A	Repair/revise wrist joint	19.03	090
25330		A	Revise wrist joint	21.43	090
25331		A	Revise wrist joint	29.32	090
25332		A	Revise wrist joint	22.24	090
25335		A	Realignment of hand	24.94	090
25350		A	Revision of radius	16.95	090
25355		A	Revision of radius	19.99	090
25360		A	Revision of ulna	15.20	090
25365		A	Revise radium and ulna	23.36	090
25370		A	Revise radius or ulna	25.80	090
25375		A	Revise radius and ulna	26.54	090
25390		A	Shorten radius/ulna	20.01	090
25391		A	Lengthen radius/ulna	25.72	090
25392		A	Shorten radius and ulna	27.30	090
25393		A	Lengthen radius and ulna	31.17	090
25400		A	Repair radius or ulna	22.60	090
25405		A	Repair/graft radium or ulna	27.71	090
25415		A	Repair radius and ulna	25.77	090
25420		A	Repair/graft radius and ulna	32.07	090
25425		A	Repair/graft radius or ulna	26.12	090
25426		A	Repair/graft radius and ulna	28.57	090
25440		A	Repair/graft wrist bone	20.33	090
25441		A	Reconstruct wrist joint	25.30	090
25442		A	Reconstruct wrist joint	18.53	090
25443		A	Reconstruct wrist joint	20.60	090
25444		A	Reconstruct wrist joint	22.25	090
25445		A	Reconstruct wrist joint	21.11	090
25446		A	Wrist replacement	39.18	090
25447		A	Repair wrist joint(s)	22.31	090
25449		A	Remove wrist joint implant	22.78	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
25450		A	Revision of wrist joint	16.04	090
25455		A	Revision of wrist joint	19.12	090
25490		A	Reinforce radius	19.07	090
25491		A	Reinforce ulna	19.96	090
25492		A	Reinforce radius and ulna	24.57	090
25500		A	Treat fracture of radius	4.90	090
25505		A	Treat fracture of radius	9.04	090
25515		A	Repair fracture of radius	17.36	090
25520		A	Repair fracture of radius	12.58	090
25525		A	Repair fracture of radius	24.46	090
25526		A	Repair fracture of radius	26.00	090
25530		A	Treat fracture of ulna	4.68	090
25535		A	Treat fracture of ulna	9.00	090
25545		A	Repair fracture of ulna	17.00	090
25560		A	Treat fracture radius and ulna	4.81	090
25565		A	Treat fracture radius and ulna	10.58	090
25574		A	Repair fracture radius/ulna	18.14	090
25575		A	Repair fracture radius/ulna	21.67	090
25600		A	Treat fracture radius/ulna	5.68	090
25605		A	Treat fracture radius/ulna	9.94	090
25611		A	Repair fracture radius/ulna	13.99	090
25620		A	Repair fracture radius/ulna	16.31	090
25622		A	Treat wrist bone fracture	5.01	090
25624		A	Treat wrist bone fracture	8.48	090
25628		A	Repair wrist bone fracture	15.98	090
25630		A	Treat wrist bone fracture	5.20	090
25635		A	Treat wrist bone fracture	7.99	090
25645		A	Repair wrist bone fracture	14.38	090
25650		A	Repair wrist bone fracture	5.86	090
25660		A	Treat wrist dislocation	6.64	090
25670		A	Repair wrist dislocation	15.58	090
25675		A	Treat wrist dislocation	7.07	090
25676		A	Repair wrist dislocation	15.85	090
25680		A	Treat wrist fracture	8.46	090
25685		A	Repair wrist fracture	19.30	090
25690		A	Treat wrist dislocation	10.70	090
25695		A	Repair wrist dislocation	16.03	090
25800		A	Fusion of wrist joint	21.68	090
25805		A	Fusion/graft of wrist joint	25.20	090
25810		A	Fusion/graft of wrist joint	24.19	090
25820		A	Fusion of hand bones	17.31	090
25825		A	Fusion hand bones with graft	22.36	090
25900		A	Amputation of forearm	16.38	090
25905		A	Amputation of forearm	16.54	090
25907		A	Amputation follow-up surgery	13.91	090
25909		A	Amputation follow-up surgery	14.88	090
25920		A	Amputate hand at wrist	16.16	090
25922		A	Amputate hand at wrist	13.42	090
25924		A	Amputation follow-up surgery	16.44	090
25927		A	Amputation of hand	15.65	090
25929		A	Amputation follow-up surgery	12.74	090
25931		A	Amputation follow-up surgery	12.73	090
26010		A	Drainage of finger abscess	2.05	010
26011		A	Drainage of finger abscess	3.90	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
26020		A	Drain hand tendon sheath	8.28	090
26025		A	Drainage of palm bursa	9.50	090
26030		A	Drainage of palm bursa(s)	11.93	090
26034		A	Treat hand bone lesion	10.47	090
26035		A	Decompress fingers/hand	14.38	090
26037		A	Decompress fingers/hand	13.96	090
26040		A	Release palm contracture	6.38	090
26045		A	Release palm contracture	10.81	090
26055		A	Incise finger tendon sheath	6.47	090
26060		A	Incision of finger tendon	4.02	090
26070		A	Explore/treat hand joint	6.49	090
26075		A	Explore/treat finger joint	7.76	090
26080		A	Explore/treat finger joint	7.38	090
26100		A	Biopsy hand joint lining	6.95	090
26105		A	Biopsy finger joint lining	8.34	090
26110		A	Biopsy finger joint lining	6.79	090
26115		A	Removal of hand lesion	6.02	090
26116		A	Removal of hand lesion	9.48	090
26117		A	Remove tumor, hand/finger	14.18	090
26121		A	Release palm contracture	18.14	090
26123		A	Release palm contracture	19.08	090
26125		A	Release palm contracture	15.31	090
26130		A	Remove wrist joint lining	10.90	090
26135		A	Revise finger joint, each	12.28	090
26140		A	Revise finger joint, each	10.98	090
26145		A	Tendon excision, palm/finger	11.47	090
26160		A	Remove tendon sheath lesion	5.68	090
26170		A	Removal of palm tendon, each	7.89	090
26180		A	Removal of finger tendon	9.65	090
26200		A	Remove hand bone lesion	10.39	090
26205		A	Remove/graft bone lesion	14.57	090
26210		A	Removal of finger lesion	9.46	090
26215		A	Remove/graft finger lesion	13.21	090
26230		A	Partial removal of hand bone	10.88	090
26235		A	Partial removal, finger bone	10.66	090
26236		A	Partial removal, finger bone	9.42	090
26250		A	Extensive hand surgery	14.22	090
26255		A	Extensive hand surgery	22.01	090
26260		A	Extensive finger surgery	13.34	090
26261		A	Extensive finger surgery	17.39	090
26262		A	Partial removal of finger	10.84	090
26320		A	Removal of implant from hand	7.79	090
26350		A	Repair finger/hand tendon	12.36	090
26352		A	Repair/graft hand tendon	14.83	090
26356		A	Repair finger/hand tendon	15.34	090
26357		A	Repair finger/hand tendon	15.81	090
26358		A	Repair/graft hand tendon	17.23	090
26370		A	Repair finger/hand tendon	14.39	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
26372		A	Repair/graft hand tendon	15.70	090
26373		A	Repair finger/hand tendon	15.51	090
26390		A	Revise hand/finger tendon	17.80	090
26392		A	Repair/graft hand tendon	19.53	090
26410		A	Repair hand tendon	8.14	090
26412		A	Repair/graft hand tendon	12.78	090
26415		A	Excision, hand/finger tendon	15.65	090
26416		A	Graft hand or finger tendon	18.96	090
26418		A	Repair finger tendon	8.13	090
26420		A	Repair/graft finger tendon	12.90	090
26426		A	Repair finger/hand tendon	13.09	090
26428		A	Repair/graft finger tendon	13.29	090
26432		A	Repair finger tendon	7.48	090
26433		A	Repair finger tendon	8.94	090
26434		A	Repair/graft finger tendon	11.51	090
26437		A	Realignment of tendons	10.21	090
26440		A	Release palm/finger tendon	8.88	090
26442		A	Release palm and finger tendon	10.05	090
26445		A	Release hand/finger tendon	7.92	090
26449		A	Release forearm/hand tendon	12.81	090
26450		A	Incision of palm tendon	6.17	090
26455		A	Incision of finger tendon	5.73	090
26460		A	Incise hand/finger tendon	5.34	090
26471		A	Fusion of finger tendons	10.33	090
26474		A	Fusion of finger tendons	10.42	090
26476		A	Tendon lengthening	8.20	090
26477		A	Tendon shortening	9.62	090
26478		A	Lengthening of hand tendon	10.58	090
26479		A	Shortening of hand tendon	11.61	090
26480		A	Transplant hand tendon	13.98	090
26483		A	Transplant/graft hand tendon	17.58	090
26485		A	Transplant palm tendon	14.74	090
26489		A	Transplant/graft palm tendon	13.00	090
26490		A	Revise thumb tendon	16.92	090
26492		A	Tendon transfer with graft	19.02	090
26494		A	Hand tendon/muscle transfer	16.43	090
26496		A	Revise thumb tendon	19.25	090
26497		A	Finger tendon transfer	18.40	090
26498		A	Finger tendon transfer	27.15	090
26499		A	Revision of finger	17.43	090
26500		A	Hand tendon reconstruction	9.74	090
26502		A	Hand tendon reconstruction	12.86	090
26504		A	Hand tendon reconstruction	14.74	090
26508		A	Release thumb contracture	10.42	090
26510		A	Thumb tendon transfer	9.81	090
26516		A	Fusion of knuckle joint	11.58	090
26517		A	Fusion of knuckle joints	16.50	090
26518		A	Fusion of knuckle joints	16.13	090
26520		A	Release knuckle contracture	10.14	090
26525		A	Release finger contracture	9.27	090
26527		A	Revise wrist joint	19.51	090
26530		A	Revise knuckle joint	12.31	090
26531		A	Revise knuckle with implant	15.20	090
26535		A	Revise finger joint	10.32	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
26536		A	Revise/implant finger joint	14.29	090
26540		A	Repair hand joint	13.63	090
26541		A	Repair hand joint with graft	18.42	090
26542		A	Repair hand joint with graft	12.92	090
26545		A	Reconstruct finger joint	12.61	090
26548		A	Reconstruct finger joint	14.30	090
26560		A	Repair of web finger	10.49	090
26561		A	Repair of web finger	20.79	090
26562		A	Repair of web finger	20.98	090
26565		A	Correct metacarpal flaw	13.04	090
26567		A	Correct finger deformity	11.46	090
26568		A	Lengthen metacarpal/finger	18.08	090
26591		A	Repair muscles of hand	5.55	090
26593		A	Release muscles of hand	9.64	090
26596		A	Excision constricting tissue	18.08	090
26597		A	Release of scar contracture	18.62	090
26600		A	Treat metacarpal fracture	3.55	090
26605		A	Treat metacarpal fracture	5.29	090
26607		A	Treat metacarpal fracture	9.22	090
26608		A	Treat metacarpal fracture	9.22	090
26615		A	Repair metacarpal fracture	10.75	090
26641		A	Treat thumb dislocation	5.03	090
26645		A	Treat thumb fracture	6.77	090
26650		A	Repair thumb fracture	10.09	090
26665		A	Repair thumb fracture	14.50	090
26670		A	Treat hand dislocation	4.65	090
26675		A	Treat hand dislocation	9.33	090
26676		A	Pin hand dislocation	10.76	090
26685		A	Repair hand dislocation	13.12	090
26686		A	Repair hand dislocation	14.72	090
26700		A	Treat knuckle dislocation	4.58	090
26705		A	Treat knuckle dislocation	6.05	090
26706		A	Pin knuckle dislocation	10.26	090
26715		A	Repair knuckle dislocation	10.22	090
26720		A	Treat finger fracture, each	2.80	090
26725		A	Treat finger fracture, each	4.96	090
26727		A	Treat finger fracture, each	7.76	090
26735		A	Repair finger fracture, each	10.03	090
26740		A	Treat finger fracture, each	3.12	090
26742		A	Treat finger fracture, each	6.00	090
26746		A	Repair finger fracture, each	11.01	090
26750		A	Treat finger fracture, each	2.54	090
26755		A	Treat finger fracture, each	4.22	090
26756		A	Pin finger fracture, each	6.44	090
26765		A	Repair finger fracture, each	7.12	090
26770		A	Treat finger dislocation	3.77	090
26775		A	Treat finger dislocation	4.85	090
26776		A	Pin finger dislocation	7.04	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
26785		A	Repair finger dislocation	7.50	090
26820		A	Thumb fusion with graft	15.43	090
26841		A	Fusion of thumb	13.85	090
26842		A	Thumb fusion with graft	17.52	090
26843		A	Fusion of hand joint	14.55	090
26844		A	Fusion/graft of hand joint	16.66	090
26850		A	Fusion of knuckle	11.91	090
26852		A	Fusion of knuckle with graft	14.61	090
26860		A	Fusion of finger joint	9.40	090
26861		A	Fusion of finger joint, added	4.76	ZZZ
26862		A	Fusion/graft of finger joint	13.01	090
26863		A	Fuse/graft added joint	7.78	ZZZ
26910		A	Amputate metacarpal bone	13.20	090
26951		A	Amputation of finger/thumb	7.75	090
26952		A	Amputation of finger/thumb	10.67	090
26990		A	Drainage of pelvis lesion	10.40	090
26991		A	Drainage of pelvis bursa	8.21	090
26992		A	Drainage of bone lesion	21.45	090
27000		A	Incision of hip tendon	7.41	090
27001		A	Incision of hip tendon	10.50	090
27003		A	Incision of hip tendon	14.24	090
27005		A	Incision of hip tendon	12.98	090
27006		A	Incision of hip tendons	14.93	090
27025		A	Incision of hip/thigh fascia	17.27	090
27030		A	Drainage of hip joint	25.15	090
27033		A	Exploration of hip joint	25.54	090
27035		A	Denervation of hip joint	29.57	090
27040		A	Biopsy of soft tissues	4.14	010
27041		A	Biopsy of soft tissues	12.57	090
27047		A	Remove hip/pelvis lesion	9.46	090
27048		A	Remove hip/pelvis lesion	10.77	090
27049		A	Remove tumor, hip/pelvis	24.33	090
27050		A	Biopsy of sacroiliac joint	10.19	090
27052		A	Biopsy of hip joint	16.85	090
27054		A	Removal of hip joint lining	23.34	090
27060		A	Removal of ischial bursa	9.26	090
27062		A	Remove femur lesion/bursa	9.60	090
27065		A	Removal of hip bone lesion	11.35	090
27066		A	Removal of hip bone lesion	18.24	090
27067		A	Remove/graft hip bone lesion	25.98	090
27070		A	Partial removal of hip bone	18.11	090
27071		A	Partial removal of hip bone	20.03	090
27075		A	Extensive hip surgery	31.47	090
27076		A	Extensive hip surgery	36.63	090
27077		A	Extensive hip surgery	43.15	090
27078		A	Extensive hip surgery	22.56	090
27079		A	Extensive hip surgery	22.26	090
27080		A	Removal of tail bone	11.18	090
27086		A	Remove hip foreign body	2.49	010
27087		A	Remove hip foreign body	12.27	090
27090		A	Removal of hip prosthesis	22.44	090
27091		A	Removal of hip prosthesis	43.08	090
27093		A	Injection for hip X-ray	2.23	000
27095		A	Injection for hip X-ray	2.56	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27097		A	Revision of hip tendon	16.91	090
27098		A	Transfer tendon to pelvis	16.91	090
27100		A	Transfer of abdominal muscle	19.55	090
27105		A	Transfer of spinal muscle	18.44	090
27110		A	Transfer of iliopsoas muscle	24.76	090
27111		A	Transfer of iliopsoas muscle	24.54	090
27120		A	Reconstruction of hip socket	37.07	090
27122		A	Reconstruction of hip socket	34.21	090
27125		A	Partial hip replacement	34.42	090
27130		A	Total hip replacement	51.16	090
27132		A	Total hip replacement	57.29	090
27134		A	Revise hip joint replacement	66.79	090
27137		A	Revise hip joint replacement	52.59	090
27138		A	Revise hip joint replacement	51.45	090
27140		A	Transplant of femur ridge	24.00	090
27146		A	Incision of hip bone	25.89	090
27147		A	Revision of hip bone	36.99	090
27151		A	Incision of hip bones	38.87	090
27156		A	Revision of hip bones	41.20	090
27158		A	Revision of pelvis	34.89	090
27161		A	Incision of neck of femur	31.56	090
27165		A	Incision/fixation of femur	35.28	090
27170		A	Repair/graft femur head/neck	33.61	090
27175		A	Treat slipped epiphysis	8.72	090
27176		A	Treat slipped epiphysis	22.79	090
27177		A	Repair slipped epiphysis	27.97	090
27178		A	Repair slipped epiphysis	22.61	090
27179		A	Revise head/neck of femur	24.46	090
27181		A	Repair slipped epiphysis	28.85	090
27185		A	Revision of femur epiphysis	11.91	090
27187		A	Reinforce hip bones	32.25	090
27193		A	Treat pelvic ring fracture	7.44	090
27194		A	Treat pelvic ring fracture	13.20	090
27200		A	Treat tail bone fracture	3.41	090
27202		A	Repair tail bone fracture	13.47	090
27215		A	Pelvic fracture(s) treatment	25.97	090
27216		A	Treat pelvic ring fracture	18.39	090
27217		A	Treat pelvic ring fracture	27.91	090
27218		A	Treat pelvic ring fracture	31.79	090
27220		A	Treat hip socket fracture	10.12	090
27222		A	Treat hip socket fracture	18.33	090
27226		A	Treat hip wall fracture	31.23	090
27227		A	Treat hip fracture(s)	37.34	090
27228		A	Treat hip fracture(s)	39.78	090
27230		A	Treat fracture of thigh	8.66	090
27232		A	Treat fracture of thigh	19.59	090
27235		A	Repair of thigh fracture	29.48	090
27236		A	Repair of thigh fracture	33.38	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27238		A	Treatment of thigh fracture	10.61	090
27240		A	Treatment of thigh fracture	21.93	090
27244		A	Repair of thigh fracture	32.13	090
27245		A	Repair of thigh fracture	36.36	090
27246		A	Treatment of thigh fracture	8.77	090
27248		A	Repair of thigh fracture	24.52	090
27250		A	Treat hip dislocation	9.97	090
27252		A	Treat hip dislocation	14.54	090
27253		A	Repair of hip dislocation	26.95	090
27254		A	Repair of hip dislocation	32.83	090
27256		A	Treatment of hip dislocation	5.90	010
27257		A	Treatment of hip dislocation	10.08	010
27258		A	Repair of hip dislocation	30.11	090
27259		A	Repair of hip dislocation	37.72	090
27265		A	Treatment of hip dislocation	9.57	090
27266		A	Treatment of hip dislocation	12.89	090
27275		A	Manipulation of hip joint	4.14	010
27280		A	Fusion of sacroiliac joint	23.44	090
27282		A	Fusion of pubic bones	21.08	090
27284		A	Fusion of hip joint	32.24	090
27286		A	Fusion of hip joint	32.87	090
27290		A	Amputation of leg at hip	51.05	090
27295		A	Amputation of leg at hip	36.43	090
27301		A	Drain thigh/knee lesion	8.86	090
27303		A	Drainage of bone lesion	14.44	090
27305		A	Incise thigh tendon and fascia	9.85	090
27306		A	Incision of thigh tendon	6.60	090
27307		A	Incision of thigh tendons	8.79	090
27310		A	Exploration of knee joint	19.17	090
27315		A	Partial removal, thigh nerve	12.75	090
27320		A	Partial removal, thigh nerve	11.76	090
27323		A	Biopsy thigh soft tissues	3.74	010
27324		A	Biopsy thigh soft tissues	7.61	090
27327		A	Removal of thigh lesion	7.01	090
27328		A	Removal of thigh lesion	10.04	090
27329		A	Remove tumor, thigh/knee	25.29	090
27330		A	Biopsy knee joint lining	13.55	090
27331		A	Explore/treat knee joint	16.11	090
27332		A	Removal of knee cartilage	20.29	090
27333		A	Removal of knee cartilage	24.48	090
27334		A	Remove knee joint lining	20.64	090
27335		A	Remove knee joint lining	23.64	090
27340		A	Removal of kneecap bursa	8.31	090
27345		A	Removal of knee cyst	12.09	090
27350		A	Removal of kneecap	18.41	090
27355		A	Remove femur lesion	15.70	090
27356		A	Remove femur lesion/graft	17.98	090
27357		A	Remove femur lesion/graft	19.72	090
27358		A	Remove femur lesion/fixation	9.92	ZZZ
27360		A	Partial removal leg bone(s)	19.03	090
27365		A	Extensive leg surgery	29.88	090
27370		A	Injection for knee X-ray	1.62	000
27372		A	Removal of foreign body	8.74	090
27380		A	Repair of kneecap tendon	15.67	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27381		A	Repair/graft kneecap tendon	22.50	090
27385		A	Repair of thigh muscle	17.23	090
27386		A	Repair/graft of thigh muscle	24.06	090
27390		A	Incision of thigh tendon	9.89	090
27391		A	Incision of thigh tendons	12.90	090
27392		A	Incision of thigh tendons	17.32	090
27393		A	Lengthening of thigh tendon	12.45	090
27394		A	Lengthening of thigh tendons	14.58	090
27395		A	Lengthening of thigh tendons	22.91	090
27396		A	Transplant of thigh tendon	15.37	090
27397		A	Transplants of thigh tendons	19.49	090
27400		A	Revise thigh muscles/tendons	17.47	090
27403		A	Repair of knee cartilage	17.84	090
27405		A	Repair of knee ligament	19.56	090
27407		A	Repair of knee ligament	19.59	090
27409		A	Repair of knee ligaments	29.09	090
27418		A	Repair degenerated kneecap	23.63	090
27420		A	Revision of unstable kneecap	21.63	090
27422		A	Revision of unstable kneecap	22.10	090
27424		A	Revision/removal of kneecap	22.84	090
27425		A	Lateral retinacular release	12.73	090
27427		A	Reconstruction, knee	24.64	090
27428		A	Reconstruction, knee	29.44	090
27429		A	Reconstruction, knee	24.75	090
27430		A	Revision of thigh muscles	19.58	090
27435		A	Incision of knee joint	16.81	090
27437		A	Revise kneecap	19.50	090
27438		A	Revise kneecap with implant	25.23	090
27440		A	Revision of knee joint	23.10	090
27441		A	Revision of knee joint	20.29	090
27442		A	Revision of knee joint	32.45	090
27443		A	Revision of knee joint	33.24	090
27445		A	Revision of knee joint	48.15	090
27446		A	Revision of knee joint	42.76	090
27447		A	Total knee replacement	54.72	090
27448		A	Incision of thigh	24.89	090
27450		A	Incision of thigh	29.96	090
27454		A	Realignment of thigh bone	32.04	090
27455		A	Realignment of knee	25.73	090
27457		A	Realignment of knee	27.77	090
27465		A	Shortening of thigh bone	26.85	090
27466		A	Lengthening of thigh bone	30.54	090
27468		A	Shorten/lengthen thighs	36.93	090
27470		A	Repair of thigh	33.74	090
27472		A	Repair/graft of thigh	38.97	090
27475		A	Surgery to stop leg growth	16.97	090
27477		A	Surgery to stop leg growth	27.84	090
27479		A	Surgery to stop leg growth	25.48	090

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27485		A	Surgery to stop leg growth	17.37	090
27486		A	Revise knee joint replace	46.98	090
27487		A	Revise knee joint replace	63.90	090
27488		A	Removal of knee prosthesis	32.87	090
27495		A	Reinforce thigh	34.29	090
27496		A	Decompression of thigh/knee	9.93	090
27497		A	Decompression of thigh/knee	12.15	090
27498		A	Decompression of thigh/knee	13.86	090
27499		A	Decompression of thigh/knee	15.97	090
27500		A	Treatment of thigh fracture	11.42	090
27501		A	Treatment of thigh fracture	11.42	090
27502		A	Treatment of thigh fracture	18.30	090
27503		A	Treatment of thigh fracture	18.30	090
27506		A	Repair of thigh fracture	34.20	090
27507		A	Treatment of thigh fracture	31.04	090
27508		A	Treatment of thigh fracture	10.04	090
27509		A	Treatment of thigh fracture	11.64	090
27510		A	Treatment of thigh fracture	16.00	090
27511		A	Treatment of thigh fracture	30.69	090
27513		A	Treatment of thigh fracture	35.07	090
27514		A	Repair of thigh fracture	33.97	090
27516		A	Repair of thigh growth plate	10.37	090
27517		A	Repair of thigh growth plate	17.15	090
27519		A	Repair of thigh growth plate	28.32	090
27520		A	Treat kneecap fracture	6.12	090
27524		A	Repair of kneecap fracture	21.15	090
27530		A	Treatment of knee fracture	7.09	090
27532		A	Treatment of knee fracture	13.32	090
27535		A	Treatment of knee fracture	22.78	090
27536		A	Repair of knee fracture	26.67	090
27538		A	Treat knee fracture(s)	8.49	090
27540		A	Repair of knee fracture	24.89	090
27550		A	Treat knee dislocation	8.48	090
27552		A	Treat knee dislocation	11.39	090
27556		A	Repair of knee dislocation	27.70	090
27557		A	Repair of knee dislocation	32.55	090
27558		A	Repair of knee dislocation	33.52	090
27560		A	Treat kneecap dislocation	5.27	090
27562		A	Treat kneecap dislocation	11.34	090
27566		A	Repair kneecap dislocation	23.55	090
27570		A	Fixation of knee joint	3.65	010
27580		A	Fusion of knee	30.38	090
27590		A	Amputate leg at thigh	20.92	090
27591		A	Amputate leg at thigh	24.67	090
27592		A	Amputate leg at thigh	18.26	090
27594		A	Amputation follow-up surgery	10.60	090
27596		A	Amputation follow-up surgery	18.28	090
27598		A	Amputate lower leg at knee	21.13	090
27600		A	Decompression of lower leg	9.02	090
27601		A	Decompression of lower leg	8.99	090
27602		A	Decompression of lower leg	11.39	090
27603		A	Drain lower leg lesion	7.20	090
27604		A	Drain lower leg bursa	5.45	090
27605		A	Incision of achilles tendon	4.17	010

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27606		A	Incision of achilles tendon	6.32	010
27607		A	Treat lower leg bone lesion	13.94	090
27610		A	Explore/treat ankle joint	15.70	090
27612		A	Exploration of ankle joint	16.09	090
27613		A	Biopsy lower leg soft tissue	2.91	010
27614		A	Biopsy lower leg soft tissue	7.95	090
27615		A	Remove tumor, lower leg	21.35	090
27618		A	Remove lower leg lesion	7.38	090
27619		A	Remove lower leg lesion	12.80	090
27620		A	Explore, treat ankle joint	12.56	090
27625		A	Remove ankle joint lining	17.72	090
27626		A	Remove ankle joint lining	21.03	090
27630		A	Removal of tendon lesion	8.19	090
27635		A	Remove lower leg bone lesion	16.44	090
27637		A	Remove/graft leg bone lesion	18.85	090
27638		A	Remove/graft leg bone lesion	20.39	090
27640		A	Partial removal of tibia	21.41	090
27641		A	Partial removal of fibula	16.54	090
27645		A	Extensive lower leg surgery	26.54	090
27646		A	Extensive lower leg surgery	23.97	090
27647		A	Extensive ankle/heel surgery	22.40	090
27648		A	Injection for ankle X-ray	1.54	000
27650		A	Repair achilles tendon	19.30	090
27652		A	Repair/graft achilles tendon	21.41	090
27654		A	Repair of achilles tendon	21.69	090
27656		A	Repair leg fascia defect	8.00	090
27658		A	Repair of leg tendon, each	9.17	090
27659		A	Repair of leg tendon, each	12.93	090
27664		A	Repair of leg tendon, each	8.24	090
27665		A	Repair of leg tendon, each	10.74	090
27675		A	Repair lower leg tendons	14.03	090
27676		A	Repair lower leg tendons	16.44	090
27680		A	Release of lower leg tendon	10.06	090
27681		A	Release of lower leg tendons	13.10	090
27685		A	Revision of lower leg tendon	10.34	090
27686		A	Revise lower leg tendons	14.31	090
27687		A	Revision of calf tendon	11.98	090
27690		A	Revise lower leg tendon	15.66	090
27691		A	Revise lower leg tendon	18.26	090
27692		A	Revise additional leg tendon	4.14	ZZZ
27695		A	Repair of ankle ligament	15.70	090
27696		A	Repair of ankle ligaments	15.81	090
27698		A	Repair of ankle ligament	22.76	090
27700		A	Revision of ankle joint	22.06	090
27702		A	Reconstruct ankle joint	40.39	090
27703		A	Reconstruction, ankle joint	30.29	090
27704		A	Removal of ankle implant	13.94	090
27705		A	Incision of tibia	21.89	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27707		A	Incision of fibula	9.25	090
27709		A	Incision of tibia and fibula	24.09	090
27712		A	Realignment of lower leg	24.27	090
27715		A	Revision of lower leg	27.25	090
27720		A	Repair of tibia	26.84	090
27722		A	Repair/graft of tibia	22.88	090
27724		A	Repair/graft of tibia	32.15	090
27725		A	Repair of lower leg	22.85	090
27727		A	Repair of lower leg	23.91	090
27730		A	Repair of tibia epiphysis	11.26	090
27732		A	Repair of fibula epiphysis	10.60	090
27734		A	Repair lower leg epiphyses	16.52	090
27740		A	Repair of leg epiphyses	18.32	090
27742		A	Repair of leg epiphyses	20.35	090
27745		A	Reinforce tibia	19.59	090
27750		A	Treatment of tibia fracture	6.79	090
27752		A	Treatment of tibia fracture	10.97	090
27756		A	Repair of tibia fracture	17.79	090
27758		A	Repair of tibia fracture	25.78	090
27759		A	Repair of tibia fracture	27.85	090
27760		A	Treatment of ankle fracture	5.72	090
27762		A	Treatment of ankle fracture	8.63	090
27766		A	Repair of ankle fracture	16.57	090
27780		A	Treatment of fibula fracture	4.68	090
27781		A	Treatment of fibula fracture	7.96	090
27784		A	Repair of fibula fracture	12.82	090
27786		A	Treatment of ankle fracture	5.52	090
27788		A	Treatment of ankle fracture	8.00	090
27792		A	Repair of ankle fracture	15.44	090
27808		A	Treatment of ankle fracture	5.77	090
27810		A	Treatment of ankle fracture	10.57	090
27814		A	Repair of ankle fracture	21.27	090
27816		A	Treatment of ankle fracture	7.01	090
27818		A	Treatment of ankle fracture	12.64	090
27822		A	Repair of ankle fracture	21.67	090
27823		A	Repair of ankle fracture	25.45	090
27824		A	Treat lower leg fracture	7.01	090
27825		A	Treat lower leg fracture	12.64	090
27826		A	Treat lower leg fracture	20.29	090
27827		A	Treat lower leg fracture	20.87	090
27828		A	Treat lower leg fracture	24.39	090
27829		A	Treat lower leg joint	14.57	090
27830		A	Treat lower leg dislocation	7.18	090
27831		A	Treat lower leg dislocation	8.78	090
27832		A	Repair lower leg dislocation	12.46	090
27840		A	Treat ankle dislocation	6.39	090
27842		A	Treat ankle dislocation	8.31	090
27846		A	Repair ankle dislocation	18.85	090
27848		A	Repair ankle dislocation	20.02	090
27860		A	Fixation of ankle joint	3.91	010
27870		A	Fusion of ankle joint	26.21	090
27871		A	Fusion of tibiofibular joint	17.43	090
27880		A	Amputation of lower leg	20.48	090
27881		A	Amputation of lower leg	23.34	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
27882		A	Amputation of lower leg	16.40	090
27884		A	Amputation follow-up surgery	11.39	090
27886		A	Amputation follow-up surgery	16.70	090
27888		A	Amputation of foot at ankle	19.62	090
27889		A	Amputation of foot at ankle	18.60	090
27892		A	Decompression fasciotomy, leg	10.05	090
27893		A	Decompression fasciotomy, leg	10.02	090
27894		A	Decompression fasciotomy, leg	12.42	090
28001		A	Drainage of bursa of foot	3.31	010
28002		A	Treatment of foot infection	6.34	010
28003		A	Treatment of foot infection	11.60	090
28005		A	Treat foot bone lesion	12.36	090
28008		A	Incision of foot fascia	7.18	090
28010		A	Incision of toe tendon	6.89	090
28011		A	Incision of toe tendons	5.98	090
28020		A	Exploration of a foot joint	9.67	090
28022		A	Exploration of a foot joint	7.48	090
28024		A	Exploration of a toe joint	6.77	090
28030		A	Removal of foot nerve	10.14	090
28035		A	Decompression of tibia nerve	12.33	090
28043		A	Excision of foot lesion	5.36	090
28045		A	Excision of foot lesion	8.89	090
28046		A	Resection of tumor, foot	15.56	090
28050		A	Biopsy of foot joint lining	8.30	090
28052		A	Biopsy of foot joint lining	7.91	090
28054		A	Biopsy of toe joint lining	5.72	090
28060		A	Partial removal foot fascia	9.79	090
28062		A	Removal of foot fascia	14.05	090
28070		A	Removal of foot joint lining	9.67	090
28072		A	Removal of foot joint lining	7.94	090
28080		A	Removal of foot lesion	7.80	090
28086		A	Excise foot tendon sheath	8.08	090
28088		A	Excise foot tendon sheath	7.62	090
28090		A	Removal of foot lesion	7.58	090
28092		A	Removal of toe lesions	5.78	090
28100		A	Removal of ankle/heel lesion	10.48	090
28102		A	Remove/graft foot lesion	14.94	090
28103		A	Remove/graft foot lesion	12.35	090
28104		A	Removal of foot lesion	9.66	090
28106		A	Remove/graft foot lesion	13.90	090
28107		A	Remove/graft foot lesion	10.48	090
28108		A	Removal of toe lesions	8.57	090
28110		A	Part removal of metatarsal	7.67	090
28111		A	Part removal of metatarsal	10.27	090
28112		A	Part removal of metatarsal	8.61	090
28113		A	Part removal of metatarsal	8.98	090
28114		A	Removal of metatarsal heads	18.61	090
28116		A	Revision of foot	12.20	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
28118		A	Removal of heel bone	11.87	090
28119		A	Removal of heel spur	11.07	090
28120		A	Part removal of ankle/heel	10.45	090
28122		A	Partial removal of foot bone	11.65	090
28124		A	Partial removal of toe	8.86	090
28126		A	Partial removal of toe	7.70	090
28130		A	Removal of ankle bone	15.17	090
28140		A	Removal of metatarsal	11.99	090
28150		A	Removal of toe	7.48	090
28153		A	Partial removal of toe	7.72	090
28160		A	Partial removal of toe	8.06	090
28171		A	Extensive foot surgery	17.82	090
28173		A	Extensive foot surgery	14.65	090
28175		A	Extensive foot surgery	11.51	090
28190		A	Removal of foot foreign body	2.52	010
28192		A	Removal of foot foreign body	6.72	090
28193		A	Removal of foot foreign body	8.16	090
28200		A	Repair of foot tendon	9.98	090
28202		A	Repair/graft of foot tendon	12.90	090
28208		A	Repair of foot tendon	7.21	090
28210		A	Repair/graft of foot tendon	12.12	090
28220		A	Release of foot tendon	8.55	090
28222		A	Release of foot tendons	12.34	090
28225		A	Release of foot tendon	6.05	090
28226		A	Release of foot tendons	8.05	090
28230		A	Incision of foot tendon(s)	6.67	090
28232		A	Incision of toe tendon	5.04	090
28234		A	Incision of foot tendon	4.90	090
28236		A	Transfer of foot tendon	16.51	090
28238		A	Revision of foot tendon	15.29	090
28240		A	Release of big toe	6.50	090
28250		A	Revision of foot fascia	10.62	090
28260		A	Release of midfoot joint	12.45	090
28261		A	Revision of foot tendon	15.46	090
28262		A	Revision of foot and ankle	25.43	090
28264		A	Release of midfoot joint	20.44	090
28270		A	Release of foot contracture	7.47	090
28272		A	Release of toe joint, each	5.92	090
28280		A	Fusion of toes	7.47	090
28285		A	Repair of hammertoe	9.16	090
28286		A	Repair of hammertoe	8.36	090
28288		A	Partial removal of foot bone	7.87	090
28290		A	Correction of bunion	11.31	090
28292		A	Correction of bunion	13.96	090
28293		A	Correction of bunion	18.70	090
28294		A	Correction of bunion	18.10	090
28296		A	Correction of bunion	18.42	090
28297		A	Correction of bunion	18.67	090
28298		A	Correction of bunion	17.14	090
28299		A	Correction of bunion	19.56	090
28300		A	Incision of heel bone	16.42	090
28302		A	Incision of ankle bone	19.04	090
28304		A	Incision of midfoot bones	15.83	090
28305		A	Incise/graft midfoot bones	20.80	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
28306		A	Incision of metatarsal	10.75	090
28307		A	Incision of metatarsal	12.61	090
28308		A	Incision of metatarsal	11.28	090
28309		A	Incision of metatarsals	16.64	090
28310		A	Revision of big toe	9.66	090
28312		A	Revision of toe	9.28	090
28313		A	Repair deformity of toe	7.64	090
28315		A	Removal of sesamoid bone	9.24	090
28320		A	Repair of foot bones	18.41	090
28322		A	Repair of metatarsals	13.27	090
28340		A	Resect enlarged toe tissue	13.73	090
28341		A	Resect enlarged toe	16.40	090
28344		A	Repair extra toe(s)	8.12	090
28345		A	Repair webbed toe(s)	11.52	090
28400		A	Treatment of heel fracture	5.10	090
28405		A	Treatment of heel fracture	8.71	090
28406		A	Treatment of heel fracture	12.72	090
28415		A	Repair of heel fracture	23.64	090
28420		A	Repair/graft heel fracture	28.26	090
28430		A	Treatment of ankle fracture	4.71	090
28435		A	Treatment of ankle fracture	7.06	090
28436		A	Treatment of ankle fracture	9.20	090
28445		A	Repair of ankle fracture	18.83	090
28450		A	Treat midfoot fracture, each	3.85	090
28455		A	Treat midfoot fracture, each	5.79	090
28456		A	Repair midfoot fracture	4.99	090
28465		A	Repair midfoot fracture, each	12.83	090
28470		A	Treat metatarsal fracture	3.76	090
28475		A	Treat metatarsal fracture	5.36	090
28476		A	Repair metatarsal fracture	6.92	090
28485		A	Repair metatarsal fracture	10.55	090
28490		A	Treat big toe fracture	2.00	090
28495		A	Treat big toe fracture	2.72	090
28496		A	Repair big toe fracture	4.52	090
28505		A	Repair big toe fracture	6.94	090
28510		A	Treatment of toe fracture	1.98	090
28515		A	Treatment of toe fracture	2.59	090
28525		A	Repair of toe fracture	5.41	090
28530		A	Treat sesamoid bone fracture	2.09	090
28531		A	Treat sesamoid bone fracture	4.20	090
28540		A	Treat foot dislocation	2.58	090
28545		A	Treat foot dislocation	3.64	090
28546		A	Treat foot dislocation	6.03	090
28555		A	Repair foot dislocation	12.08	090
28570		A	Treat foot dislocation	3.31	090
28575		A	Treat foot dislocation	6.06	090
28576		A	Treat foot dislocation	6.92	090
28585		A	Repair foot dislocation	13.00	090

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28600		A	Treat foot dislocation	2.54	090
28605		A	Treat foot dislocation	4.98	090
28606		A	Treat foot dislocation	8.49	090
28615		A	Repair foot dislocation	10.79	090
28630		A	Treat toe dislocation	2.79	010
28635		A	Treat toe dislocation	3.48	010
28636		A	Treat toe dislocation	5.60	010
28645		A	Repair toe dislocation	7.55	090
28660		A	Treat toe dislocation	1.88	010
28665		A	Treat toe dislocation	2.96	010
28666		A	Treat toe dislocation	5.35	010
28675		A	Repair of toe dislocation	6.04	090
28705		A	Fusion of foot bones	31.40	090
28715		A	Fusion of foot bones	26.18	090
28725		A	Fusion of foot bones	21.61	090
28730		A	Fusion of foot bones	20.11	090
28735		A	Fusion of foot bones	21.06	090
28737		A	Revision of foot bones	18.79	090
28740		A	Fusion of foot bones	12.01	090
28750		A	Fusion of big toe joint	10.80	090
28755		A	Fusion of big toe joint	8.61	090
28760		A	Fusion of big toe joint	11.47	090
28800		A	Amputation of midfoot	15.07	090
28805		A	Amputation through metatarsal	14.93	090
28810		A	Amputation toe and metatarsal	10.11	090
28820		A	Amputation of toe	6.57	090
28825		A	Partial amputation of toe	5.90	090
29000		A	Application of body cast	4.29	000
29010		A	Application of body cast	4.68	000
29015		A	Application of body cast	5.04	000
29020		A	Application of body cast	4.14	000
29025		A	Application of body cast	3.31	000
29035		A	Application of body cast	3.99	000
29040		A	Application of body cast	4.50	000
29044		A	Application of body cast	4.50	000
29046		A	Application of body cast	4.95	000
29049		A	Application of shoulder cast	1.37	000
29055		A	Application of shoulder cast	3.14	000
29058		A	Application of shoulder cast	2.06	000
29065		A	Application of long arm cast	1.78	000
29075		A	Application of forearm cast	1.48	000
29085		A	Apply hand/wrist cast	1.45	000
29105		A	Apply long arm splint	1.45	000
29125		A	Apply forearm splint	1.01	000
29126		A	Apply forearm splint	1.23	000
29130		A	Application of finger splint	.70	000
29131		A	Application of finger splint	1.00	000
29200		A	Strapping of chest	.95	000
29220		A	Strapping of low back	1.08	000
29240		A	Strapping of shoulder	1.01	000
29260		A	Strapping of elbow or wrist	.82	000
29280		A	Strapping of hand or finger	.75	000
29305		A	Application of hip cast	4.17	000
29325		A	Application of hip casts	4.52	000

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29345		A	Application of long leg cast	2.57	000
29355		A	Application of long leg cast	2.78	000
29358		A	Apply long leg cast brace	3.76	000
29365		A	Application of long leg cast	2.17	000
29405		A	Apply short leg cast	1.76	000
29425		A	Apply short leg cast	2.09	000
29435		A	Apply short leg cast	2.52	000
29440		A	Addition of walker to cast	.84	000
29450		A	Application of leg cast	1.46	000
29505		A	Application of long leg splint	1.33	000
29515		A	Application of lower leg splint	1.27	000
29520		A	Strapping of hip	.93	000
29530		A	Strapping of knee	.97	000
29540		A	Strapping of ankle	.84	000
29550		A	Strapping of toes	.78	000
29580		A	Application of paste boot	.92	000
29590		A	Application of foot splint	1.07	000
29700		A	Removal/revision of cast	1.25	000
29705		A	Removal/revision of cast	1.52	000
29710		A	Removal/revision of cast	1.88	000
29715		A	Removal/revision of cast	1.90	000
29720		A	Repair of body cast	.95	000
29730		A	Windowing of cast	1.05	000
29740		A	Wedging of cast	1.55	000
29750		A	Wedging of clubfoot cast	1.85	000
29800		A	Jaw arthroscopy/surgery	9.74	090
29804		A	Jaw arthroscopy/surgery	24.75	090
29815		A	Shoulder arthroscopy	11.26	090
29819		A	Shoulder arthroscopy/surgery	19.28	090
29820		A	Shoulder arthroscopy/surgery	18.73	090
29821		A	Shoulder arthroscopy/surgery	22.48	090
29822		A	Shoulder arthroscopy/surgery	19.36	090
29823		A	Shoulder arthroscopy/surgery	24.09	090
29825		A	Shoulder arthroscopy/surgery	21.68	090
29826		A	Shoulder arthroscopy/surgery	24.80	090
29830		A	Elbow arthroscopy	11.68	090
29834		A	Elbow arthroscopy/surgery	12.82	090
29835		A	Elbow arthroscopy/surgery	13.23	090
29836		A	Elbow arthroscopy/surgery	15.42	090
29837		A	Elbow arthroscopy/surgery	14.05	090
29838		A	Elbow arthroscopy/surgery	15.48	090
29840		A	Wrist arthroscopy	9.21	090
29843		A	Wrist arthroscopy/surgery	12.26	090
29844		A	Wrist arthroscopy/surgery	12.64	090
29845		A	Wrist arthroscopy/surgery	15.36	090
29846		A	Wrist arthroscopy/surgery	20.65	090
29847		A	Wrist arthroscopy/surgery	14.58	090
29848		A	Wrist arthroscopy/surgery	8.43	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
29850		A	Knee arthroscopy/surgery	20.38	090
29851		A	Knee arthroscopy/surgery	24.89	090
29855		A	Tibial arthroscopy/surgery	22.78	090
29856		A	Tibial arthroscopy/surgery	26.67	090
29870		A	Knee arthroscopy, diagnostic	9.54	090
29871		A	Knee arthroscopy/drainage	13.91	090
29874		A	Knee arthroscopy/surgery	17.86	090
29875		A	Knee arthroscopy/surgery	17.54	090
29876		A	Knee arthroscopy/surgery	21.19	090
29877		A	Knee arthroscopy/surgery	19.76	090
29879		A	Knee arthroscopy/surgery	22.89	090
29880		A	Knee arthroscopy/surgery	23.70	090
29881		A	Knee arthroscopy/surgery	20.24	090
29882		A	Knee arthroscopy/surgery	21.59	090
29883		A	Knee arthroscopy/surgery	28.42	090
29884		A	Knee arthroscopy/surgery	17.87	090
29885		A	Knee arthroscopy/surgery	18.06	090
29886		A	Knee arthroscopy/surgery	14.91	090
29887		A	Knee arthroscopy/surgery	20.56	090
29888		A	Knee arthroscopy/surgery	35.94	090
29889		A	Knee arthroscopy/surgery	22.50	090
29894		A	Ankle arthroscopy/surgery	18.83	090
29895		A	Ankle arthroscopy/surgery	17.75	090
29897		A	Ankle arthroscopy/surgery	19.25	090
29898		A	Ankle arthroscopy/surgery	22.13	090

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

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
30000		A	Drainage of nose lesion	2.04	010
30020		A	Drainage of nose lesion	2.07	010
30100		A	Intranasal biopsy	1.71	000
30110		A	Removal of nose polyp(s)	3.00	010
30115		A	Removal of nose polyp(s)	7.38	090
30117		A	Removal of intranasal lesion	6.18	090
30118		A	Removal of intranasal lesion	18.12	090
30120		A	Revision of nose	12.91	090
30124		A	Removal of nose lesion	4.52	090
30125		A	Removal of nose lesion	13.03	090
30130		A	Removal of turbinate bones	5.03	090
30140		A	Removal of turbinate bones	6.63	090
30150		A	Partial removal of nose	17.37	090
30160		A	Removal of nose	22.84	090
30200		A	Injection treatment of nose	1.19	000
30210		A	Nasal sinus therapy	1.32	010
30220		A	Insert nasal septal button	3.15	010
30300		A	Remove nasal foreign body	1.51	010
30310		A	Remove nasal foreign body	3.70	010
30320		A	Remove nasal foreign body	9.10	090
30460		A	Revision of nose	18.96	090
30462		A	Revision of nose	37.92	090
30520		A	Repair of nasal septum	15.08	090
30540		A	Repair nasal defect	14.76	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
30545		A	Repair nasal defect	22.63	090
30560		A	Release of nasal adhesions	1.84	010
30580		A	Repair upper jaw fistula	13.29	090
30600		A	Repair mouth/nose fistula	10.03	090
30620		A	Reconstruction inner nose	16.12	090
30630		A	Repair nasal septum defect	13.74	090
30801		A	Cauterization inner nose	1.55	010
30802		A	Cauterization inner nose	3.04	010
30901		A	Control of nosebleed	1.85	000
30903		A	Control of nosebleed	2.48	000
30905		A	Control of nosebleed	3.92	000
30906		A	Repeat control of nosebleed	3.66	000
30915		A	Ligation nasal sinus artery	12.20	090
30920		A	Ligation upper jaw artery	20.84	090
30930		A	Therapy fracture of nose	2.01	010
31000		A	Irrigation maxillary sinus	1.58	010
31002		A	Irrigation sphenoid sinus	2.40	010
31020		A	Exploration maxillary sinus	5.74	090
31030		A	Exploration maxillary sinus	14.48	090
31032		A	Explore sinus, remove polyps	16.42	090
31040		A	Exploration behind upper jaw	17.64	090
31050		A	Exploration sphenoid sinus	11.62	090
31051		A	Sphenoid sinus surgery	15.74	090
31070		A	Exploration of frontal sinus	9.18	090
31071		A	Exploration of frontal sinus	9.01	090
31075		A	Exploration of frontal sinus	20.07	090
31080		A	Removal of frontal sinus	20.99	090
31081		A	Removal of frontal sinus	23.47	090
31084		A	Removal of frontal sinus	28.94	090
31085		A	Removal of frontal sinus	30.61	090
31086		A	Removal of frontal sinus	23.95	090
31087		A	Removal of frontal sinus	23.78	090
31090		A	Exploration of sinuses	29.69	090
31200		A	Removal of ethmoid sinus	9.75	090
31201		A	Removal of ethmoid sinus	15.65	090
31205		A	Removal of ethmoid sinus	18.49	090
31225		A	Removal of upper jaw	36.76	090
31230		A	Removal of upper jaw	45.07	090
31250		A	Nasal endoscopy, diagnostic	2.60	000
31252		A	Nasal endoscopy, polypectomy	6.67	000
31254		A	Revision of ethmoid sinus	11.54	000
31255		A	Removal of ethmoid sinus	18.51	000
31256		A	Exploration maxillary sinus	7.43	000
31258		A	Nasal endoscopy, surgical	5.22	000
31260		A	Endoscopy, maxillary sinus	5.25	000
31263		A	Endoscopy, maxillary sinus	8.15	000
31265		A	Endoscopy, maxillary sinus	9.86	000
31267		A	Endoscopy, maxillary sinus	11.12	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
31268		A	Endoscopy, maxillary sinus	6.16	000
31270		A	Endoscopy, sphenoid sinus	3.73	000
31275		A	Sphenoid endoscopy, surgical	10.32	000
31277		A	Sphenoid endoscopy, surgical	11.91	000
31285		A	Endoscopy, combined sinuses	7.13	000
31300		A	Removal of larynx lesion	26.09	090
31320		A	Diagnostic incision larynx	8.86	090
31360		A	Removal of larynx	36.48	090
31365		A	Removal of larynx	51.70	090
31367		A	Partial removal of larynx	37.99	090
31368		A	Partial removal of larynx	53.24	090
31370		A	Partial removal of larynx	37.47	090
31375		A	Partial removal of larynx	34.90	090
31380		A	Partial removal of larynx	37.55	090
31382		A	Partial removal of larynx	36.28	090
31390		A	Removal of larynx and pharynx	59.42	090
31395		A	Reconstruct larynx and pharynx	67.52	090
31400		A	Revision of larynx	17.73	090
31420		A	Removal of epiglottis	17.95	090
31500		A	Insert of emergency airway	3.63	000
31502		A	Change of windpipe airway	1.30	000
31505		A	Diagnostic laryngoscopy	1.09	000
31510		A	Laryngoscopy with biopsy	2.57	000
31511		A	Remove foreign body, larynx	3.23	000
31512		A	Removal of larynx lesion	4.04	000
31513		A	Injection into vocal cord	5.87	000
31515		A	Laryngoscopy for aspiration	3.07	000
31520		A	Diagnostic laryngoscopy	4.38	000
31525		A	Diagnostic laryngoscopy	5.04	000
31526		A	Diagnostic laryngoscopy	6.38	000
31527		A	Laryngoscopy for treatment	6.54	000
31528		A	Laryngoscopy and dilatation	5.30	000
31529		A	Laryngoscopy and dilatation	5.38	000
31530		A	Operative laryngoscopy	7.39	000
31531		A	Operative laryngoscopy	9.86	000
31535		A	Operative laryngoscopy	7.56	000
31536		A	Operative laryngoscopy	9.25	000
31540		A	Operative laryngoscopy	10.26	000
31541		A	Operative laryngoscopy	11.13	000
31560		A	Operative laryngoscopy	10.95	000
31561		A	Operative laryngoscopy	15.85	000
31570		A	Laryngoscopy with injection	10.14	000
31571		A	Laryngoscopy with injection	10.54	000
31575		A	Diagnostic laryngoscopy	2.80	000
31576		A	Laryngoscopy with biopsy	5.27	000
31577		A	Remove foreign body, larynx	6.46	000
31578		A	Removal of larynx lesion	7.87	000
31579		A	Diagnostic laryngoscopy	4.83	000
31580		A	Revision of larynx	27.92	090
31584		A	Repair of larynx fracture	32.62	090
31585		A	Repair of larynx fracture	8.56	090
31586		A	Repair of larynx fracture	14.47	090
31587		A	Revision of larynx	15.95	090
31595		A	Larynx nerve surgery	15.13	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
31600		A	Incision of windpipe	8.22	000
31601		A	Incision of windpipe	10.07	000
31603		A	Incision of windpipe	8.98	000
31605		A	Incision of windpipe	8.23	000
31610		A	Incision of windpipe	15.39	090
31611		A	Surgery/speech prosthesis	15.35	090
31612		A	Puncture/clear windpipe	2.18	000
31613		A	Repair windpipe opening	6.75	090
31614		A	Repair windpipe opening	13.51	090
31615		A	Visualization of windpipe	4.24	000
31622		A	Diagnostic bronchoscopy	6.68	000
31625		A	Bronchoscopy with biopsy	7.51	000
31628		A	Bronchoscopy with biopsy	9.32	000
31629		A	Bronchoscopy with biopsy	8.19	000
31630		A	Bronchoscopy with repair	7.99	000
31631		A	Bronchoscopy with dilation	8.76	000
31635		A	Remove foreign body, airway	8.68	000
31640		A	Bronchoscopy and remove lesion	10.57	000
31641		A	Bronchoscopy, treat blockage	13.72	000
31645		A	Bronchoscopy, clear airways	7.06	000
31646		A	Bronchoscopy, reclear airways	6.03	000
31656		A	Bronchoscopy, inject for X-ray	5.82	000
31659		A	Bronchoscopic procedures	7.56	000
31700		A	Insertion of airway catheter	2.87	000
31708		A	Instill airway contrast dye	2.28	000
31710		A	Insertion of airway catheter	2.31	000
31715		A	Injection for bronchus X-ray	1.64	000
31717		A	Bronchial brush biopsy	2.94	000
31720		A	Clearance of airways	1.88	000
31725		A	Clearance of airways	3.53	000
31730		A	Intro windpipe wire/tube	5.55	000
31750		A	Repair of windpipe	18.93	090
31760		A	Repair of windpipe	34.20	090
31766		A	Reconstruction of windpipe	48.65	090
31770		A	Repair/graft of bronchus	38.23	090
31775		A	Reconstruct bronchus	40.43	090
31780		A	Reconstruct windpipe	35.34	090
31781		A	Reconstruct windpipe	41.02	090
31785		A	Remove windpipe lesion	26.29	090
31786		A	Remove windpipe lesion	38.01	090
31800		A	Repair of windpipe injury	12.39	090
31805		A	Repair of windpipe injury	23.74	090
31820		A	Closure of windpipe lesion	8.12	090
31825		A	Repair of windpipe defect	11.88	090
31830		A	Revise windpipe scar	8.33	090
32000		A	Drainage of chest	2.53	000
32002		A	Treatment of collapsed lung	3.73	000
32005		A	Treat lung lining chemically	3.43	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
32020		A	Insertion of chest tube	7.01	000
32035		A	Exploration of chest	14.39	090
32036		A	Exploration of chest	15.84	090
32095		A	Biopsy through chest wall	16.61	090
32100		A	Exploration/biopsy of chest	23.08	090
32110		A	Explore/repair chest	25.03	090
32120		A	Re-exploration of chest	20.58	090
32124		A	Explore chest, free adhesions	23.76	090
32140		A	Removal of lung lesion(s)	26.59	090
32141		A	Remove/treat lung lesions	27.72	090
32150		A	Removal of lung lesion(s)	24.55	090
32151		A	Remove lung foreign body	22.87	090
32160		A	Open chest heart massage	18.46	090
32200		A	Drainage of lung lesion	20.97	090
32215		A	Treat chest lining	18.85	090
32220		A	Release of lung	36.07	090
32225		A	Partial release of lung	25.91	090
32310		A	Removal of chest lining	27.48	090
32315		A	Partial temoval chest lining	22.75	090
32320		A	Free/remove chest lining	40.20	090
32400		A	Needle biopsy chest lining	3.36	000
32402		A	Open biopsy chest lining	15.26	090
32405		A	Biopsy, lung or mediastinum	4.22	000
32420		A	Puncture/clear lung	3.82	000
32440		A	Removal of lung	40.78	090
32445		A	Removal of lung	47.24	090
32450		A	Removal of lung	45.74	090
32480		A	Partial removal of lung	37.37	090
32485		A	Partial removal of lung	46.40	090
32490		A	Partial removal of lung	48.34	090
32500		A	Partial removal of lung	28.77	090
32520		A	Remove lung and revise chest	43.45	090
32522		A	Remove lung and revise chest	47.44	090
32525		A	Remove lung and revise chest	51.80	090
32540		A	Removal of lung lesion	29.72	090
32545		A	Removal of lung lobe/lesion	35.60	090
32700		A	Visualize chest cavity	9.48	000
32705		A	Inspect/biopsy chest cavity	10.44	000
32800		A	Repair lung hernia	21.82	090
32810		A	Close chest after drainage	19.24	090
32815		A	Close bronchial fistula	39.00	090
32900		A	Removal of rib(s)	28.23	090
32905		A	Revise and repair chest wall	34.25	090
32906		A	Revise and repair chest wall	43.34	090
32940		A	Revision of lung	31.21	090
32960		A	Therapeutic pneumothorax	2.90	000
33010		A	Drainage of heart sac	3.93	000
33011		A	Repeat drainage of heart sac	3.47	000
33015		A	Incision of heart sac	10.50	090
33020		A	Incision of heart sac	26.46	090
33025		A	Incision of heart sac	27.08	090
33030		A	Partial removal of heart sac	42.28	090
33031		A	Partial removal of heart sac	35.20	090
33050		A	Removal of heart sac lesion	23.32	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
33100		A	Removal of heart sac	39.56	090
33120		A	Removal of heart lesion	56.41	090
33130		A	Removal of heart lesion	35.12	090
33200		A	Insertion of heart pacemaker	25.00	090
33201		A	Insertion of heart pacemaker	21.55	090
33206		A	Insertion of heart pacemaker	16.04	090
33207		A	Insertion of heart pacemaker	17.43	090
33208		A	Insertion of heart pacemaker	20.22	090
33210		A	Insertion of heart electrode	6.87	000
33212		A	Insertion of pulse generator	12.17	090
33216		A	Revision implanted electrode	10.84	090
33218		A	Repair pacemaker electrodes	10.24	090
33219		A	Repair of pacemaker	11.24	090
33222		A	Pacemaker AICD pocket	11.30	090
33232		A	Removal of pacemaker	9.45	090
33245		A	Implant heart defibrillator	31.31	090
33246		A	Implant heart defibrillator	42.86	090
33248		A	Revise/remove defibrillator	26.98	090
33250		A	Ablate heart dysrhythm focus	32.15	090
33251		A	Ablate heart dysrhythm focus	41.88	090
33260		A	Ablate heart dysrhythm focus	30.04	090
33261		A	Ablate heart dysrhythm focus	39.09	090
33300		A	Repair of heart wound	32.85	090
33305		A	Repair of heart wound	39.32	090
33310		A	Exploratory heart surgery	30.23	090
33315		A	Exploratory heart surgery	36.99	090
33320		A	Repair major blood vessel(s)	31.74	090
33322		A	Repair major blood vessel(s)	43.23	090
33330		A	Insert major vessel graft	33.68	090
33335		A	Insert major vessel graft	45.14	090
33400		A	Repair of aortic valve	51.95	090
33404		A	Prepare heart-aorta conduit	49.39	090
33405		A	Replacement of aortic valve	63.55	090
33411		A	Replacement of aortic valve	75.23	090
33412		A	Replacement of aortic valve	59.54	090
33415		A	Revision, subvalvular tissue	46.05	090
33416		A	Revise ventricle muscle	60.68	090
33420		A	Revision of mitral valve	42.77	090
33422		A	Revision of mitral valve	63.55	090
33425		A	Repair of mitral valve	61.43	090
33426		A	Repair of mitral valve	62.93	090
33427		A	Repair of mitral valve	72.18	090
33430		A	Replacement of mitral valve	69.46	090
33452		A	Revision of tricuspid valve	37.52	090
33460		A	Revision of tricuspid valve	53.66	090
33465		A	Replace tricuspid valve	64.25	090
33468		A	Revision of tricuspid valve	51.49	090
33474		A	Revision of pulmonary valve	35.91	090

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33500		A	Repair heart vessel fistula	42.06	090
33501		A	Repair heart vessel fistula	34.09	090
33502		A	Coronary artery correction	34.91	090
33503		A	Coronary artery graft	34.92	090
33504		A	Coronary artery graft	39.09	090
33510		A	Coronary artery bypass	49.50	090
33511		A	Coronary arteries bypass	61.27	090
33512		A	Coronary arteries bypass	65.11	090
33513		A	Coronary arteries bypass	67.95	090
33514		A	Coronary arteries bypass	70.36	090
33516		A	Coronary arteries bypass	72.51	090
33517		A	CABG, artery-vein, single	5.24	090
33518		A	CABG, artery-vein, two	10.14	090
33519		A	CABG, artery-vein, three	12.65	090
33521		A	CABG, artery-vein, four	14.51	090
33522		A	CABG, artery-vein, five	16.36	090
33523		A	CABG, artery-vein, six+	18.22	090
33530		A	Coronary artery, bypass/reop	19.51	ZZZ
33533		A	CABG, arterial, single	58.21	090
33534		A	CABG, arterial, two	68.71	090
33535		A	CABG, arterial, three	74.52	090
33536		A	CABG, arterial, four+	80.32	090
33542		A	Removal of heart lesion	61.99	090
33545		A	Repair of heart damage	74.31	090
33570		A	Revise coronary circulation	33.58	090
33641		A	Repair heart septum defect	51.59	090
33645		A	Revision of heart veins	42.03	090
33800		A	Aortic suspension	28.17	090
33860		A	Ascending aorta graft	74.32	090
33865		A	Ascending aorta graft	95.88	090
33870		A	Transverse aortic arch graft	88.85	090
33875		A	Thoracic aorta graft	62.94	090
33877		A	Thoracoabdominal graft	91.54	090
33910		A	Remove lung artery emboli	39.06	090
33915		A	Remove lung artery emboli	32.93	090
33916		A	Surgery of great vessel	44.85	090
33970		A	Aortic circulation assist	16.50	000
33971		A	Aortic circulation assist	10.35	090
33972		A	Aortic circulation assist	2.76	XXX
34001		A	Removal of artery clot	22.93	090
34051		A	Removal of artery clot	23.92	090
34101		A	Removal of artery clot	18.54	090
34111		A	Removal of arm artery clot	16.12	090
34151		A	Removal of artery clot	29.31	090
34201		A	Removal of artery clot	18.45	090
34203		A	Removal of leg artery clot	21.23	090
34401		A	Removal of vein clot	21.01	090
34421		A	Removal of vein clot	17.67	090
34451		A	Removal of vein clot	25.71	090
34471		A	Removal of vein clot	13.25	090
34490		A	Removal of vein clot	15.08	090
35001		A	Repair defect of artery	36.82	090
35002		A	Repair artery rupture, neck	34.31	090
35005		A	Repair defect of artery	28.90	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
35011		A	Repair defect of artery	26.22	090
35013		A	Repair artery rupture, arm	33.28	090
35021		A	Repair defect of artery	38.40	090
35022		A	Repair artery rupture, chest	38.50	090
35045		A	Repair defect of arm artery	24.41	090
35081		A	Repair defect of artery	47.23	090
35082		A	Repair artery rupture, aorta	55.79	090
35091		A	Repair defect of artery	54.56	090
35092		A	Repair artery rupture, aorta	67.03	090
35102		A	Repair defect of artery	49.33	090
35103		A	Repair artery rupture, groin	62.07	090
35111		A	Repair defect of artery	35.82	090
35112		A	Repair artery rupture, spleen	29.88	090
35121		A	Repair defect of artery	47.07	090
35122		A	Repair artery rupture, belly	53.69	090
35131		A	Repair defect of artery	35.61	090
35132		A	Repair artery rupture, groin	42.21	090
35141		A	Repair defect of artery	30.43	090
35142		A	Repair artery rupture, thigh	33.45	090
35151		A	Repair defect of artery	33.66	090
35152		A	Repair artery rupture, knee	26.53	090
35180		A	Repair blood vessel lesion	20.92	090
35182		A	Repair blood vessel lesion	28.32	090
35184		A	Repair blood vessel lesion	22.22	090
35188		A	Repair blood vessel lesion	22.69	090
35189		A	Repair blood vessel lesion	30.49	090
35190		A	Repair blood vessel lesion	24.00	090
35201		A	Repair blood vessel lesion	20.61	090
35206		A	Repair blood vessel lesion	20.34	090
35207		A	Repair blood vessel lesion	21.49	090
35211		A	Repair blood vessel lesion	35.91	090
35216		A	Repair blood vessel lesion	29.74	090
35221		A	Repair blood vessel lesion	28.18	090
35226		A	Repair blood vessel lesion	20.08	090
35231		A	Repair blood vessel lesion	29.18	090
35236		A	Repair blood vessel lesion	24.36	090
35241		A	Repair blood vessel lesion	37.06	090
35246		A	Repair blood vessel lesion	37.07	090
35251		A	Repair blood vessel lesion	27.47	090
35256		A	Repair blood vessel lesion	24.55	090
35261		A	Repair blood vessel lesion	25.78	090
35266		A	Repair blood vessel lesion	22.76	090
35271		A	Repair blood vessel lesion	35.05	090
35276		A	Repair blood vessel lesion	30.05	090
35281		A	Repair blood vessel lesion	35.23	090
35286		A	Repair blood vessel lesion	24.47	090
35301		A	Rechanneling of artery	33.11	090
35311		A	Rechanneling of artery	48.61	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
35321		A	Rechanneling of artery	26.29	090
35331		A	Rechanneling of artery	37.99	090
35341		A	Rechanneling of artery	44.21	090
35351		A	Rechanneling of artery	36.74	090
35355		A	Rechanneling of artery	33.10	090
35361		A	Rechanneling of artery	44.92	090
35363		A	Rechanneling of artery	49.72	090
35371		A	Rechanneling of artery	25.10	090
35372		A	Rechanneling of artery	25.46	090
35381		A	Rechanneling of artery	30.51	090
35450		A	Repair arterial blockage	24.72	000
35452		A	Repair arterial blockage	11.87	000
35454		A	Repair arterial blockage	16.60	000
35456		A	Repair arterial blockage	19.16	000
35458		A	Repair arterial blockage	21.19	000
35459		A	Repair arterial blockage	14.14	000
35460		A	Repair venous blockage	9.90	000
35470		A	Repair arterial blockage	23.26	000
35471		A	Repair arterial blockage	24.72	000
35473		A	Repair arterial blockage	16.60	000
35474		A	Repair arterial blockage	19.17	000
35475		A	Repair arterial blockage	21.19	000
35476		A	Repair venous blockage	9.90	000
35480		A	Atherectomy, open	25.76	000
35481		A	Atherectomy, open	12.58	000
35482		A	Atherectomy, open	17.22	000
35483		A	Atherectomy, open	19.93	000
35484		A	Atherectomy, open	22.16	000
35485		A	Atherectomy, open	15.02	000
35490		A	Atherectomy, percutaneous	25.76	000
35491		A	Atherectomy, percutaneous	12.58	000
35492		A	Atherectomy, percutaneous	17.22	000
35493		A	Atherectomy, percutaneous	19.93	000
35494		A	Atherectomy, percutaneous	22.16	000
35495		A	Atherectomy, percutaneous	15.02	000
35501		A	Artery bypass graft	40.58	090
35506		A	Artery bypass graft	40.51	090
35507		A	Artery bypass graft	39.25	090
35508		A	Artery bypass graft	38.26	090
35509		A	Artery bypass graft	38.89	090
35511		A	Artery bypass graft	27.58	090
35515		A	Artery bypass graft	30.35	090
35516		A	Artery bypass graft	35.22	090
35518		A	Artery bypass graft	34.34	090
35521		A	Artery bypass graft	35.14	090
35526		A	Artery bypass graft	33.82	090
35531		A	Artery bypass graft	47.87	090
35533		A	Artery bypass graft	43.91	090
35536		A	Artery bypass graft	46.61	090
35541		A	Artery bypass graft	46.98	090
35546		A	Artery bypass graft	49.28	090
35551		A	Artery bypass graft	47.87	090
35556		A	Artery bypass graft	37.87	090
35558		A	Artery bypass graft	32.27	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
35560		A	Artery bypass graft	45.75	090
35563		A	Artery bypass graft	23.72	090
35565		A	Artery bypass graft	34.65	090
35566		A	Artery bypass graft	45.00	090
35571		A	Artery bypass graft	39.87	090
35582		A	Vein bypass graft	53.65	090
35583		A	Vein bypass graft	40.79	090
35585		A	Vein bypass graft	46.56	090
35587		A	Vein bypass graft	42.63	090
35601		A	Artery bypass graft	37.85	090
35606		A	Artery bypass graft	37.95	090
35612		A	Artery bypass graft	33.92	090
35616		A	Artery bypass graft	34.05	090
35621		A	Artery bypass graft	35.45	090
35626		A	Artery bypass graft	46.31	090
35631		A	Artery bypass graft	44.22	090
35636		A	Artery bypass graft	36.95	090
35637		A	Artery bypass graft	39.53	090
35638		A	Artery bypass graft	25.16	090
35641		A	Artery bypass graft	46.77	090
35642		A	Artery bypass graft	29.05	090
35645		A	Artery bypass graft	29.23	090
35646		A	Artery bypass graft	51.84	090
35650		A	Artery bypass graft	33.22	090
35651		A	Artery bypass graft	51.78	090
35654		A	Artery bypass graft	43.40	090
35656		A	Artery bypass graft	35.57	090
35661		A	Artery bypass graft	31.21	090
35663		A	Artery bypass graft	34.19	090
35665		A	Artery bypass graft	34.82	090
35666		A	Artery bypass graft	41.14	090
35671		A	Artery bypass graft	37.84	090
35681		A	Artery bypass graft	28.36	ZZZ
35701		A	Exploration, carotid artery	12.36	090
35721		A	Exploration, femoral artery	11.02	090
35741		A	Exploration, popliteal artery	11.23	090
35761		A	Exploration of artery/vein	11.30	090
35800		A	Explore neck vessels	12.18	090
35820		A	Explore chest vessels	20.89	090
35840		A	Explore abdominal vessels	17.13	090
35860		A	Explore limb vessels	11.31	090
35875		A	Removal of clot in graft	20.28	090
35900		A	Remove vessel graft	18.34	090
35910		A	Revise circulation	45.00	090
36000		A	Place needle in vein	.69	XXX
36005		A	Injection, venography	1.47	000
36010		A	Place catheter in vein	4.82	000
36011		A	Place catheter in vein	5.26	XXX

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36012		A	Place catheter in vein	6.51	XXX
36013		A	Place catheter in artery	4.91	XXX
36014		A	Place catheter in artery	5.56	XXX
36015		A	Place catheter in artery	6.51	XXX
36100		A	Place catheter in artery	5.90	XXX
36120		A	Place catheter in artery	4.59	XXX
36140		A	Place catheter in artery	3.65	XXX
36145		A	Place catheter in vein shunt	5.70	XXX
36160		A	Place catheter in aorta	5.15	XXX
36200		A	Place catheter in aorta	6.02	XXX
36215		A	Place catheter in arteries	7.50	XXX
36216		A	Place catheter in arteries	8.33	XXX
36217		A	Place catheter in arteries	9.37	XXX
36218		A	Place catheter in arteries	3.96	XXX
36230		A	Place catheter in artery	8.16	XXX
36245		A	Place catheter in arteries	8.12	XXX
36246		A	Place catheter in arteries	8.33	XXX
36247		A	Place catheter in arteries	9.37	XXX
36248		A	Place catheter in arteries	3.96	XXX
36260		A	Insertion of infusion pump	17.27	090
36261		A	Revision of infusion pump	7.70	090
36262		A	Removal of infusion pump	6.02	090
36400		A	Drawing blood	.27	XXX
36405		A	Drawing blood	.65	XXX
36406		A	Drawing blood	.34	XXX
36410		A	Drawing blood	.41	XXX
36420		A	Drawing blood	1.58	XXX
36425		A	Drawing blood	.86	XXX
36430		A	Blood transfusion service	1.00	XXX
36440		A	Blood transfusion service	2.03	XXX
36450		A	Exchange transfusion service	4.28	XXX
36455		A	Exchange transfusion service	4.91	XXX
36470		A	Injection therapy of vein	1.33	010
36471		A	Injection therapy of veins	1.95	010
36481		A	Insertion of catheter, vein	12.90	000
36488		A	Insertion of catheter, vein	2.44	000
36489		A	Insertion of catheter, vein	2.48	000
36490		A	Insertion of catheter, vein	3.24	000
36491		A	Insertion of catheter, vein	3.41	000
36493		A	Repositioning of CVC	1.99	000
36500		A	Insertion of catheter, vein	3.69	000
36510		A	Insertion of catheter, vein	1.45	000
36520		A	Plasma and/or cell exchange	3.63	000
36522		A	Photopheresis	6.94	ZZZ
36530		A	Insertion of infusion pump	10.50	010
36531		A	Revision of infusion pump	9.46	010
36532		A	Removal of infusion pump	5.34	010
36533		A	Insertion of access port	8.83	010
36534		A	Revision of access port	7.48	010
36535		A	Removal of access port	4.35	010
36600		A	Withdrawal of arterial blood	.61	XXX
36620		A	Insertion catheter, artery	1.94	000
36625		A	Insertion catheter, artery	3.15	000
36640		A	Insertion catheter, artery	4.77	000

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36660		A	Insertion catheter, artery	1.96	000
36680		A	Insert needle, bone cavity	2.54	000
36800		A	Insertion of cannula	4.90	000
36810		A	Insertion of cannula	9.44	000
36815		A	Insertion of cannula	6.82	000
36820		A	Insertion of cannula	12.37	000
36821		A	Artery-vein fusion	16.91	090
36822		A	Insertion of cannula(s)	11.31	090
36825		A	Artery-vein graft	22.40	090
36830		A	Artery-vein graft	21.17	090
36832		A	Revise artery-vein fistula	18.83	090
36860		A	Cannula declotting	4.94	000
36861		A	Cannula declotting	8.22	000
37140		A	Revision of circulation	41.44	090
37145		A	Revision of circulation	42.06	090
37160		A	Revision of circulation	41.17	090
37180		A	Revision of circulation	39.94	090
37181		A	Splice spleen/kidney veins	44.79	090
37190		A	Repair of circulation defect	18.56	090
37200		A	Transcatheter biopsy	6.35	000
37201		A	Transcatheter therapy infuse	13.38	000
37202		A	Transcatheter therapy infuse	10.49	000
37203		A	Transcatheter retrieval	9.30	000
37204		A	Transcatheter occlusion	33.47	000
37205		A	Transcatheter stent	13.93	000
37206		A	Transcatheter stent	6.96	ZZZ
37207		A	Transcatheter stent	13.93	000
37208		A	Transcatheter stent	6.96	ZZZ
37565		A	Ligation of neck vein	8.32	090
37600		A	Ligation of neck artery	10.87	090
37605		A	Ligation of neck artery	11.05	090
37606		A	Ligation of neck artery	11.94	090
37609		A	Temporal artery procedure	4.82	010
37615		A	Ligation of neck artery	12.21	090
37616		A	Ligation of chest artery	19.87	090
37617		A	Ligation of abdomen artery	23.67	090
37618		A	Ligation of extremity artery	10.05	090
37620		A	Revision of major vein	19.36	090
37650		A	Revision of major vein	8.89	090
37660		A	Revision of major vein	16.41	090
37700		A	Revise leg vein	7.79	090
37720		A	Removal of leg vein	11.23	090
37730		A	Removal of leg veins	14.77	090
37735		A	Removal of leg veins/lesion	19.71	090
37760		A	Revision of leg veins	18.73	090
37780		A	Revision of leg vein	5.75	090
37785		A	Revise secondary varicosity	4.75	090
38100		A	Removal of spleen, total	22.16	090

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38101		A	Removal of spleen, partial	21.00	090
38115		A	Repair of ruptured spleen	21.63	090
38200		A	Injection for spleen X-ray	4.52	000
38230		A	Bone marrow collection	6.16	010
38240		A	Bone marrow transplantation	4.46	XXX
38241		A	Bone marrow transplantation	4.41	XXX
38300		A	Drainage lymph node lesion	2.18	010
38305		A	Drainage lymph node lesion	6.57	090
38308		A	Incision of lymph channels	8.35	090
38380		A	Thoracic duct procedure	11.68	090
38381		A	Thoracic duct procedure	21.05	090
38382		A	Thoracic duct procedure	15.12	090
38500		A	Biopsy/removal, lymph node(s)	4.71	010
38505		A	Needle biopsy, lymph node(s)	2.40	000
38510		A	Biopsy/removal, lymph node(s)	6.85	090
38520		A	Biopsy/removal, lymph node(s)	8.37	090
38525		A	Biopsy/removal, lymph node(s)	7.46	090
38530		A	Biopsy/removal, lymph node(s)	9.61	090
38542		A	Explore deep node(s), neck	10.23	090
38550		A	Removal neck/armpit lesion	10.27	090
38555		A	Removal neck/armpit lesion	21.65	090
38562		A	Removal, pelvic lymph nodes	17.65	090
38564		A	Removal, abdomen lymph nodes	18.74	090
38700		A	Removal of lymph nodes, neck	18.33	090
38720		A	Removal of lymph nodes, neck	29.96	090
38724		A	Removal of lymph nodes, neck	29.35	090
38740		A	Remove armpit lymph nodes	11.88	090
38745		A	Remove armpits lymph nodes	17.85	090
38760		A	Remove groin lymph nodes	16.01	090
38765		A	Remove groin lymph nodes	29.79	090
38770		A	Remove pelvis lymph nodes	29.02	090
38780		A	Remove abdomen lymph nodes	33.89	090
38790		A	Injection for lymphatic X-ray	3.80	000
38794		A	Access thoracic lymph duct	7.26	090
39000		A	Exploration of chest	12.00	090
39010		A	Exploration of chest	23.57	090
39020		A	Exploration of chest	23.48	090
39200		A	Removal chest lesion	25.85	090
39220		A	Removal chest lesion	33.58	090
39400		A	Visualization of chest	11.06	010
39501		A	Repair diaphragm laceration	24.59	090
39502		A	Repair paraesophageal hernia	29.28	090
39503		A	Repair of diaphragm hernia	61.30	090
39520		A	Repair of diaphragm hernia	29.89	090
39530		A	Repair of diaphragm hernia	30.63	090
39531		A	Repair of diaphragm hernia	26.90	090
39540		A	Repair of diaphragm hernia	26.21	090
39541		A	Repair of diaphragm hernia	27.32	090
39545		A	Revision of diaphragm	21.58	090
39547		A	Revision of diaphragm	20.68	090
40490		A	Biopsy of lip	2.04	000
40500		A	Partial excision of lip	11.81	090
40510		A	Partial excision of lip	11.21	090
40520		A	Partial excision of lip	9.65	090

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40525		A	Reconstruct lip with flap	17.93	090
40527		A	Reconstruct lip with flap	21.45	090
40530		A	Partial removal of lip	10.91	090
40650		A	Repair lip	8.70	090
40652		A	Repair lip	10.06	090
40654		A	Repair lip	12.93	090
40700		A	Repair cleft lip/nasal	21.71	090
40701		A	Repair cleft lip/nasal	36.83	090
40702		A	Repair cleft lip/nasal	22.78	090
40720		A	Repair cleft lip/nasal	24.12	090
40761		A	Repair cleft lip/nasal	26.45	090
40800		A	Drainage of mouth lesion	1.93	010
40801		A	Drainage of mouth lesion	4.35	010
40804		A	Removal foreign body, mouth	1.85	010
40805		A	Removal foreign body, mouth	5.42	010
40806		A	Incision of lip fold	.68	000
40808		A	Biopsy of mouth lesion	1.75	010
40810		A	Excision of mouth lesion	2.55	010
40812		A	Excise/repair mouth lesion	3.92	010
40814		A	Excise/repair mouth lesion	6.80	090
40816		A	Excision of mouth lesion	7.06	090
40818		A	Excise oral mucosa for graft	4.71	090
40819		A	Excise lip or cheek fold	3.65	090
40820		A	Treatment of mouth lesion	1.84	010
40830		A	Repair mouth laceration	2.47	010
40831		A	Repair mouth laceration	4.56	010
41000		A	Drainage of mouth lesion	2.10	010
41005		A	Drainage of mouth lesion	1.91	010
41006		A	Drainage of mouth lesion	4.18	090
41007		A	Drainage of mouth lesion	6.07	090
41008		A	Drainage of mouth lesion	4.37	090
41009		A	Drainage of mouth lesion	6.97	090
41010		A	Incision of tongue fold	1.61	010
41015		A	Drainage of mouth lesion	4.75	090
41016		A	Drainage of mouth lesion	7.76	090
41017		A	Drainage of mouth lesion	5.31	090
41018		A	Drainage of mouth lesion	9.05	090
41100		A	Biopsy of tongue	2.47	010
41105		A	Biopsy of tongue	2.52	010
41108		A	Biopsy of floor of mouth	1.93	010
41110		A	Excision of tongue lesion	2.90	010
41112		A	Excision of tongue lesion	5.25	090
41113		A	Excision of tongue lesion	6.83	090
41114		A	Excision of tongue lesion	14.98	090
41115		A	Excision of tongue fold	3.62	010
41116		A	Excision of mouth lesion	5.10	090
41120		A	Partial removal of tongue	16.96	090
41130		A	Partial removal of tongue	20.40	090

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41135		A	Tongue and neck surgery	37.75	090
41140		A	Removal of tongue	44.67	090
41145		A	Tongue removal; neck surgery	53.15	090
41150		A	Tongue, mouth, jaw surgery	40.56	090
41153		A	Tongue, mouth, neck surgery	48.86	090
41155		A	Tongue, jaw, and neck surgery	56.81	090
41250		A	Repair tongue laceration	3.04	010
41251		A	Repair tongue laceration	4.48	010
41252		A	Repair tongue laceration	5.52	010
41500		A	Fixation of tongue	7.05	090
41510		A	Tongue to lip surgery	6.26	090
41520		A	Reconstruction, tongue fold	5.76	090
41800		A	Drainage of gum lesion	1.88	010
41805		A	Removal foreign body, gum	2.11	010
41806		A	Removal foreign body, jawbone	4.45	010
41825		A	Excision of gum lesion	2.88	010
41826		A	Excision of gum lesion	4.51	010
41827		A	Excision of gum lesion	7.39	090
42000		A	Drainage mouth roof lesion	1.88	010
42100		A	Biopsy roof of mouth	2.14	010
42104		A	Excision lesion, mouth roof	3.37	010
42106		A	Excision lesion, mouth roof	5.06	010
42107		A	Excision lesion, mouth roof	9.58	090
42120		A	Remove palate/lesion	14.71	090
42140		A	Excision of uvula	3.03	090
42145		A	Repair, palate, pharynx/uvula	21.87	090
42160		A	Treatment mouth roof lesion	3.43	010
42180		A	Repair palate	4.93	010
42182		A	Repair palate	7.61	010
42200		A	Reconstruct cleft palate	17.52	090
42205		A	Reconstruct cleft palate	20.54	090
42210		A	Reconstruct cleft palate	23.42	090
42215		A	Reconstruct cleft palate	16.91	090
42220		A	Reconstruct cleft palate	12.79	090
42225		A	Reconstruct cleft palate	16.98	090
42226		A	Lengthening of palate	18.15	090
42227		A	Lengthening of palate	16.76	090
42235		A	Repair palate	13.57	090
42260		A	Repair nose to lip fistula	8.56	090
42280		A	Preparation, palate mold	3.64	010
42281		A	Insertion, palate prosthesis	3.39	010
42300		A	Drainage of salivary gland	2.96	010
42305		A	Drainage of salivary gland	8.08	090
42310		A	Drainage of salivary gland	2.66	010
42320		A	Drainage of salivary gland	4.34	010
42325		A	Create salivary cyst drain	4.97	090
42326		A	Create salivary cyst drain	8.30	090
42330		A	Removal of salivary stone	3.39	010
42335		A	Removal of salivary stone	5.95	090
42340		A	Removal of salivary stone	9.16	090
42400		A	Biopsy of salivary gland	1.66	000
42405		A	Biopsy of salivary gland	4.99	010
42408		A	Excision of salivary cyst	8.03	090
42409		A	Drainage of salivary cyst	5.80	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
42410		A	Excise parotid gland/lesion	15.71	090
42415		A	Excise parotid gland/lesion	30.39	090
42420		A	Excise parotid gland/lesion	35.24	090
42425		A	Excise parotid gland/lesion	24.79	090
42426		A	Excise parotid gland/lesion	46.79	090
42440		A	Excision submaxillary gland	15.46	090
42450		A	Excision sublingual gland	8.16	090
42500		A	Repair salivary duct	9.13	090
42505		A	Repair salivary duct	14.02	090
42507		A	Parotid duct diversion	11.24	090
42508		A	Parotid duct diversion	17.13	090
42509		A	Parotid duct diversion	19.55	090
42510		A	Parotid duct diversion	16.15	090
42550		A	Injection for salivary X-ray	1.75	000
42600		A	Closure of salivary fistula	8.91	090
42650		A	Dilation of salivary duct	1.46	010
42660		A	Dilation of salivary duct	1.71	000
42665		A	Ligation of salivary duct	4.70	090
42700		A	Drainage of tonsil abscess	2.53	010
42720		A	Drainage of throat abscess	4.72	010
42725		A	Drainage of throat abscess	12.61	090
42800		A	Biopsy of throat	2.17	010
42802		A	Biopsy of throat	2.63	010
42804		A	Biopsy of upper nose/throat	2.39	010
42806		A	Biopsy of upper nose/throat	3.09	010
42808		A	Excise pharynx lesion	5.02	010
42809		A	Remove pharynx foreign body	2.67	010
42810		A	Excision of neck cyst	6.76	090
42815		A	Excision of neck cyst	16.18	090
42820		A	Remove tonsils and adenoids	7.04	090
42821		A	Remove tonsils and adenoids	8.46	090
42825		A	Removal of tonsils	6.16	090
42826		A	Removal of tonsils	7.43	090
42830		A	Removal of adenoids	4.59	090
42831		A	Removal of adenoids	5.20	090
42835		A	Removal of adenoids	4.19	090
42836		A	Removal of adenoids	6.18	090
42842		A	Extensive surgery of throat	15.53	090
42844		A	Extensive surgery of throat	24.79	090
42845		A	Extensive surgery of throat	42.61	090
42860		A	Excision of tonsil tags	4.23	090
42870		A	Excision of lingual tonsil	7.79	090
42880		A	Excise nose/throat lesion	11.15	090
42890		A	Partial removal of pharynx	21.68	090
42892		A	Revision of pharyngeal walls	26.11	090
42894		A	Revision of pharyngeal walls	38.54	090
42900		A	Repair throat wound	9.72	010
42950		A	Reconstruction of throat	18.53	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
42953		A	Repair throat, esophagus	15.41	090
42955		A	Surgical opening of throat	10.28	090
42960		A	Control throat bleeding	3.50	010
42961		A	Control throat bleeding	7.18	090
42962		A	Control throat bleeding	13.27	090
42970		A	Control nose/throat bleeding	5.98	090
42971		A	Control nose/throat bleeding	8.82	090
42972		A	Control nose/throat bleeding	11.79	090
43000		A	Incision of esophagus	13.18	090
43020		A	Incision of esophagus	14.99	090
43030		A	Throat muscle surgery	18.03	090
43040		A	Incision of esophagus	18.05	090
43045		A	Incision of esophagus	33.47	090
43100		A	Excision of esophagus lesion	15.54	090
43101		A	Excision of esophagus lesion	26.34	090
43105		A	Removal of upper esophagus	35.14	090
43106		A	Removal of upper esophagus	42.05	090
43110		A	Partial removal of esophagus	53.92	090
43111		A	Partial removal of esophagus	44.57	090
43115		A	Partial removal of esophagus	59.71	090
43119		A	Removal of esophagus	53.60	090
43120		A	Remove esophagus and stomach	51.14	090
43130		A	Removal of esophagus pouch	22.61	090
43135		A	Removal of esophagus pouch	28.79	090
43136		A	Fixation of esophagus pouch	23.72	090
43200		A	Esophagus endoscopy	4.47	000
43202		A	Esophagus endoscopy, biopsy	5.39	000
43204		A	Esophagus endoscopy and inject	9.37	000
43215		A	Esophagus endoscopy	7.34	000
43217		A	Esophagus endoscopy	7.61	000
43219		A	Esophagus endoscopy	7.10	000
43220		A	Esophagus endoscopy, dilation	5.63	000
43226		A	Esophagus endoscopy, dilation	5.92	000
43227		A	Esophagus endoscopy, repair	8.82	000
43228		A	Esophagus endoscopy, repair	8.91	000
43234		A	Upper GI endoscopy, exam	5.30	000
43235		A	Upper GI endoscopy, diagnosis	6.31	000
43239		A	Upper GI endoscopy, biopsy	7.21	000
43241		A	Upper GI endoscopy with tube	7.54	000
43243		A	Upper GI endoscopy and inject	10.57	000
43245		A	Operative upper GI endoscopy	8.49	000
43246		A	Place gastrostomy tube	10.78	000
43247		A	Operative upper GI endoscopy	8.55	000
43251		A	Operative upper GI endoscopy	9.37	000
43255		A	Operative upper GI endoscopy	10.39	000
43258		A	Operative upper GI endoscopy	10.33	000
43260		A	Endoscopy, bile duct/pancreas	12.36	000
43262		A	Endoscopy, bile duct/pancreas	16.96	000
43263		A	Endoscopy, bile duct/pancreas	12.42	000
43264		A	Endoscopy, bile duct/pancreas	18.46	000
43265		A	Endoscopy, bile duct/pancreas	16.28	000
43267		A	Endoscopy, bile duct/pancreas	15.31	000
43268		A	Endoscopy, bile duct/pancreas	16.68	000
43269		A	Endoscopy, bile duct/pancreas	13.89	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
43271		A	Endoscopy, bile duct/pancreas	15.53	000
43272		A	Endoscopy, bile duct/pancreas	13.45	000
43300		A	Repair of esophagus	22.24	090
43305		A	Repair esophagus and fistula	31.51	090
43310		A	Repair of esophagus	44.15	090
43312		A	Repair esophagus and fistula	43.30	090
43320		A	Fuse esophagus and stomach	27.08	090
43321		A	Fuse esophagus and stomach	30.03	090
43324		A	Revise esophagus and stomach	29.29	090
43325		A	Revise esophagus and stomach	28.27	090
43326		A	Revise esophagus and stomach	23.52	090
43330		A	Repair of esophagus	27.74	090
43331		A	Repair of esophagus	31.36	090
43340		A	Fuse esophagus and intestine	28.81	090
43341		A	Fuse esophagus and intestine	26.66	090
43350		A	Surgical opening, esophagus	20.25	090
43351		A	Surgical opening, esophagus	23.64	090
43352		A	Surgical opening, esophagus	21.12	090
43400		A	Ligate esophagus veins	27.92	090
43401		A	Esophagus surgery for veins	27.67	090
43410		A	Repair esophagus wound	19.88	090
43415		A	Repair esophagus wound	30.84	090
43420		A	Repair esophagus opening	16.88	090
43425		A	Repair esophagus opening	27.14	090
43450		A	Dilate esophagus	2.19	000
43451		A	Redilate esophagus	1.93	000
43453		A	Dilate esophagus	3.14	000
43455		A	Dilate esophagus	5.35	000
43456		A	Dilate esophagus	6.24	000
43460		A	Pressure treatment esophagus	5.66	000
43500		A	Surgical opening of stomach	14.79	090
43501		A	Surgical repair of stomach	22.55	090
43510		A	Surgical opening of stomach	18.44	090
43520		A	Incision of pyloric muscle	12.29	090
43600		A	Biopsy of stomach	2.50	000
43605		A	Biopsy of stomach	15.29	090
43610		A	Excision of stomach lesion	19.78	090
43620		A	Removal of stomach	39.26	090
43625		A	Removal of stomach	47.14	090
43630		A	Partial removal of stomach	31.89	090
43635		A	Partial removal of stomach	34.52	090
43638		A	Partial removal of stomach	35.40	090
43640		A	Vagotomy and pylorus repair	25.56	090
43641		A	Vagotomy and pylorus repair	25.55	090
43750		A	Place gastrostomy tube	10.61	010
43760		A	Change gastrostomy tube	1.88	000
43761		A	Reposition gastrostomy tube	3.29	000
43800		A	Reconstruction of pylorus	17.58	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
43810		A	Fusion of stomach and bowel	19.08	090
43820		A	Fusion of stomach and bowel	20.26	090
43825		A	Fusion of stomach and bowel	26.38	090
43830		A	Place gastrostomy tube	12.37	090
43831		A	Place gastrostomy tube	12.45	090
43832		A	Place gastrostomy tube	19.89	090
43840		A	Repair of stomach lesion	19.77	090
43842		A	Gastroplasty, for obesity	28.02	090
43843		A	Gastroplasty, for obesity	28.02	090
43844		A	Gastric bypass for obesity	23.55	090
43846		A	Gastric bypass for obesity	30.31	090
43850		A	Revise stomach-bowel fusion	31.87	090
43855		A	Revise stomach-bowel fusion	31.73	090
43860		A	Revise stomach-bowel fusion	31.88	090
43865		A	Revise stomach-bowel fusion	35.19	090
43870		A	Repair stomach opening	13.33	090
43880		A	Repair stomach-bowel fistula	28.11	090
43885		A	Revise stomach placement	18.99	090
44005		A	Freeing of bowel adhesion	22.39	090
44010		A	Incision of small bowel	17.42	090
44015		A	Tube jejunostomy	6.23	ZZZ
44020		A	Exploration of small bowel	19.97	090
44021		A	Decompress small bowel	19.18	090
44025		A	Incision of large bowel	20.26	090
44040		A	Exteriorization of bowel	23.73	090
44050		A	Reduce bowel obstruction	19.27	090
44055		A	Correct malrotation of bowel	21.05	090
44100		A	Biopsy of bowel	3.53	000
44110		A	Excision of bowel lesion(s)	18.06	090
44111		A	Excision of bowel lesion(s)	22.57	090
44120		A	Removal of small intestine	24.43	090
44125		A	Removal of small intestine	25.91	090
44130		A	Bowel to bowel fusion	21.40	090
44140		A	Partial removal of colon	30.70	090
44141		A	Partial removal of colon	31.69	090
44143		A	Partial removal of colon	29.73	090
44144		A	Partial removal of colon	29.46	090
44145		A	Partial removal of colon	38.02	090
44146		A	Partial removal of colon	40.96	090
44147		A	Partial removal of colon	35.31	090
44150		A	Removal of colon	36.67	090
44151		A	Removal of colon/ileostomy	30.23	090
44152		A	Removal of colon/ileostomy	41.46	090
44153		A	Removal of colon/ileostomy	47.30	090
44155		A	Removal of colon	41.86	090
44156		A	Removal of colon/ileostomy	34.23	090
44160		A	Removal of colon	28.86	090
44300		A	Open bowel to skin	14.94	090
44310		A	Ileostomy/jejunostomy	19.42	090
44312		A	Revision of ileostomy	8.87	090
44314		A	Revision of ileostomy	17.57	090
44316		A	Revise bowel pouch	24.60	090
44320		A	Colostomy	20.28	090
44322		A	Colostomy with biopsies	21.01	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
44340		A	Revision of colostomy	6.97	090
44345		A	Revision of colostomy	15.87	090
44346		A	Revision of colostomy	19.06	090
44360		A	Small bowel endoscopy	7.08	000
44361		A	Small bowel endoscopy, biopsy	8.37	000
44363		A	Small bowel endoscopy	7.27	000
44364		A	Small bowel endoscopy	9.48	000
44366		A	Small bowel endoscopy	11.27	000
44369		A	Small bowel endoscopy	12.72	000
44372		A	Small bowel endoscopy	11.41	000
44373		A	Small bowel endoscopy	9.98	000
44380		A	Small bowel endoscopy	4.12	000
44382		A	Small bowel endoscopy	5.31	000
44385		A	Endoscopy of bowel pouch	5.15	000
44386		A	Endoscopy, bowel pouch, biopsy	3.81	000
44388		A	Colon endoscopy	6.91	000
44389		A	Colonoscopy with biopsy	7.82	000
44390		A	Colonoscopy for foreign body	6.74	000
44391		A	Colonoscopy for bleeding	10.07	000
44392		A	Colonoscopy and polypectomy	10.29	000
44393		A	Colonoscopy, lesion removal	10.86	000
44600		A	Repair of bowel lesion	18.80	090
44605		A	Repair of bowel lesion	23.45	090
44610		A	Repair of bowel lesions	23.78	090
44620		A	Repair bowel opening	16.79	090
44625		A	Repair bowel opening	23.47	090
44640		A	Repair bowel-skin fistula	21.20	090
44650		A	Repair bowel fistula	22.49	090
44660		A	Repair bowel-bladder fistula	22.68	090
44661		A	Repair bowel-bladder fistula	31.61	090
44680		A	Surgical revision, intestine	24.01	090
44800		A	Excision of bowel pouch	16.39	090
44820		A	Excision of mesentery lesion	16.22	090
44850		A	Repair of mesentery	15.32	090
44900		A	Drainage of appendix abscess	12.98	090
44950		A	Appendectomy	11.84	090
44955		A	Appendectomy	4.97	ZZZ
44960		A	Appendectomy	16.82	090
45000		A	Drainage of pelvic abscess	6.15	090
45005		A	Drainage of rectal abscess	3.45	010
45020		A	Drainage of rectal abscess	7.49	090
45100		A	Biopsy of rectum	5.59	090
45108		A	Removal of anorectal lesion	7.45	090
45110		A	Removal of rectum	41.06	090
45111		A	Partial removal of rectum	28.94	090
45112		A	Removal of rectum	43.13	090
45114		A	Partial removal of rectum	39.48	090
45116		A	Partial removal of rectum	32.04	090

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45120		A	Removal of rectum	42.33	090
45121		A	Removal of rectum and colon	37.81	090
45130		A	Excision of rectal prolapse	23.57	090
45135		A	Excision of rectal prolapse	34.27	090
45150		A	Excision of rectal stricture	9.23	090
45160		A	Excision of rectal lesion	21.24	090
45170		A	Excision of rectal lesion	10.25	090
45180		A	Removal of rectal lesion	13.79	090
45300		A	Proctosigmoidoscopy	1.32	000
45302		A	Proctosigmoidoscopy	1.65	000
45303		A	Proctosigmoidoscopy	1.40	000
45305		A	Proctosigmoidoscopy; biopsy	1.97	000
45307		A	Proctosigmoidoscopy	3.15	000
45310		A	Proctosigmoidoscopy	3.23	000
45315		A	Proctosigmoidoscopy	3.38	000
45317		A	Proctosigmoidoscopy	4.19	000
45320		A	Proctosigmoidoscopy	5.06	000
45321		A	Proctosigmoidoscopy	3.84	000
45330		A	Sigmoidoscopy, diagnostic	2.38	000
45331		A	Sigmoidoscopy and biopsy	3.13	000
45332		A	Sigmoidoscopy	3.88	000
45333		A	Sigmoidoscopy and polypectomy	4.64	000
45334		A	Sigmoidoscopy for bleeding	5.93	000
45336		A	Sigmoidoscopy, lesion removal	6.66	000
45337		A	Sigmoidoscopy, decompression	6.10	000
45355		A	Surgical colonoscopy	4.85	000
45378		A	Diagnostic colonoscopy	8.20	000
45379		A	Colonoscopy	10.48	000
45380		A	Colonoscopy and biopsy	9.16	000
45382		A	Colonoscopy, control bleeding	12.02	000
45383		A	Colonoscopy, lesion removal	12.30	000
45385		A	Colonoscopy, lesion removal	12.42	000
45500		A	Repair of rectum	13.59	090
45505		A	Repair of rectum	12.86	090
45520		A	Treatment of rectal prolapse	1.26	000
45540		A	Correct rectal prolapse	23.70	090
45541		A	Correct rectal prolapse	21.70	090
45550		A	Repair rectum; remove sigmoid	26.95	090
45560		A	Repair of rectocele	13.16	090
45800		A	Repair rectum-bladder fistula	23.93	090
45805		A	Repair fistula; colostomy	29.52	090
45820		A	Repair rectourethral fistula	23.50	090
45825		A	Repair fistula; colostomy	26.90	090
45900		A	Reduction of rectal prolapse	2.38	010
45905		A	Dilation of anal sphincter	2.35	010
45910		A	Dilation of rectal narrowing	2.86	010
45915		A	Remove rectal obstruction	2.98	010
46000		A	Incision of anal fistula	3.79	010
46030		A	Removal of rectal marker	1.68	010
46040		A	Incision of rectal abscess	6.95	090
46045		A	Incision of rectal abscess	6.12	090
46050		A	Incision of anal abscess	1.85	010
46060		A	Incision of rectal abscess	11.33	090
46070		A	Incision of anal septum	4.31	090

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46080		A	Incision of anal sphincter	4.85	010
46083		A	Incise external hemorrhoid	2.07	010
46200		A	Removal of anal fissure	6.87	090
46210		A	Removal of anal crypt	3.45	090
46211		A	Removal of anal crypts	6.35	090
46220		A	Removal of anal tab	2.27	010
46221		A	Ligation of hemorrhoid(s)	2.18	010
46230		A	Removal of anal tabs	3.49	010
46250		A	Hemorrhoidectomy	7.63	090
46255		A	Hemorrhoidectomy	10.41	090
46257		A	Remove hemorrhoids and fissure	12.04	090
46258		A	Remove hemorrhoids and fistula	13.18	090
46260		A	Hemorrhoidectomy	13.85	090
46261		A	Remove hemorrhoids and fissure	14.30	090
46262		A	Remove hemorrhoids and fistula	14.68	090
46270		A	Removal of anal fistula	6.58	090
46275		A	Removal of anal fistula	10.79	090
46280		A	Removal of anal fistula	12.75	090
46285		A	Removal of anal fistula	6.57	090
46320		A	Removal of hemorrhoid clot	2.40	010
46500		A	Injection into hemorrhoids	1.92	010
46600		A	Diagnostic anoscopy	.81	000
46602		A	Diagnostic anoscopy	1.07	000
46604		A	Anoscopy and dilation	1.75	000
46606		A	Anoscopy and biopsy	1.22	000
46608		A	Anoscopy; remove foreign body	2.70	000
46610		A	Anoscopy; remove lesion	2.51	000
46612		A	Anoscopy; remove lesions	3.19	000
46614		A	Anoscopy; control bleeding	3.79	000
46700		A	Repair of anal stricture	13.61	090
46705		A	Repair of anal stricture	10.71	090
46715		A	Repair of anovaginal fistula	11.92	090
46716		A	Repair of anovaginal fistula	17.88	090
46730		A	Construction of absent anus	30.31	090
46735		A	Construction of absent anus	34.48	090
46740		A	Construction of absent anus	32.33	090
46750		A	Repair of anal sphincter	14.43	090
46751		A	Repair of anal sphincter	12.74	090
46753		A	Reconstruction of anus	11.83	090
46754		A	Removal of suture from anus	3.25	010
46760		A	Repair of anal sphincter	18.71	090
46761		A	Repair of anal sphincter	18.24	090
46762		A	Implant artificial sphincter	16.09	090
46900		A	Destruction, anal lesion(s)	2.28	010
46910		A	Destruction, anal lesion(s)	2.55	010
46916		A	Cryosurgery, anal lesion(s)	2.56	010
46917		A	Laser surgery, anal lesion(s)	4.01	010
46922		A	Excision of anal lesion(s)	3.29	010

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46924		A	Destruction, anal lesion(s)	5.68	010
46934		A	Destruction of hemorrhoids	5.24	090
46935		A	Destruction of hemorrhoids	4.23	010
46936		A	Destruction of hemorrhoids	6.74	090
46937		A	Cryotherapy of rectal lesion	5.41	010
46938		A	Cryotherapy of rectal lesion	7.42	090
46940		A	Treatment of anal fissure	2.93	010
46942		A	Treatment of anal fissure	2.58	010
46945		A	Ligation of hemorrhoids	3.85	090
46946		A	Ligation of hemorrhoids	5.19	090
47000		A	Needle biopsy of liver	3.44	000
47001		A	Needle biopsy of liver	3.44	ZZZ
47010		A	Drainage of liver lesion	16.54	090
47100		A	Wedge biopsy of liver	10.70	090
47120		A	Partial removal of liver	34.29	090
47122		A	Extensive removal of liver	53.54	090
47125		A	Partial removal of liver	49.45	090
47130		A	Partial removal of liver	54.36	090
47300		A	Surgery for liver lesion	17.81	090
47350		A	Repair liver wound	20.12	090
47355		A	Repair liver wound	20.65	090
47360		A	Repair liver wound	28.24	090
47400		A	Incision of liver duct	28.86	090
47420		A	Incision of bile duct	26.63	090
47425		A	Incision of bile duct	28.66	090
47440		A	Incision of bile duct	30.86	090
47460		A	Incise bile duct sphincter	31.59	090
47480		A	Incision of gallbladder	17.02	090
47490		A	Incision of gallbladder	10.02	090
47500		A	Injection for liver X-rays	3.62	000
47505		A	Injection for liver X-rays	2.39	000
47510		A	Insert catheter, bile duct	10.60	090
47511		A	Insert bile duct drain	13.18	090
47525		A	Change bile duct catheter	7.24	010
47530		A	Revise, reinsert bile tube	7.18	090
47550		A	Bile duct endoscopy	4.90	000
47552		A	Biliary endoscopy, through skin	7.70	000
47553		A	Biliary endoscopy, through skin	10.75	000
47554		A	Biliary endoscopy, through skin	13.69	000
47555		A	Biliary endoscopy, through skin	10.57	000
47556		A	Biliary endoscopy, through skin	11.60	000
47600		A	Removal of gallbladder	19.63	090
47605		A	Removal of gallbladder	21.24	090
47610		A	Removal of gallbladder	25.02	090
47612		A	Removal of gallbladder	31.59	090
47620		A	Removal of gallbladder	29.14	090
47630		A	Remove bile duct stone	12.54	090
47700		A	Exploration of bile ducts	22.86	090
47701		A	Bile duct revision	36.82	090
47710		A	Excision of bile duct tumor	32.75	090
47715		A	Excision of bile duct cyst	24.32	090
47716		A	Fusion of bile duct cyst	20.53	090
47720		A	Fuse gallbladder and bowel	22.77	090
47721		A	Fuse upper GI structures	28.00	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
47740		A	Fuse gallbladder and bowel	26.05	090
47760		A	Fuse bile ducts and bowel	33.88	090
47765		A	Fuse liver ducts and bowel	36.28	090
47780		A	Fuse bile ducts and bowel	35.98	090
47800		A	Reconstruction of bile ducts	33.15	090
47801		A	Placement, bile duct support	17.62	090
47802		A	Fuse liver duct and intestine	27.94	090
48000		A	Drainage of abdomen	21.49	090
48020		A	Removal of pancreatic stone	21.23	090
48100		A	Biopsy of pancreas	15.23	090
48102		A	Needle biopsy, pancreas	7.12	010
48120		A	Removal of pancreas lesion	24.34	090
48140		A	Partial removal of pancreas	34.09	090
48145		A	Partial removal of pancreas	37.58	090
48148		A	Removal of pancreatic duct	24.22	090
48150		A	Partial removal of pancreas	56.97	090
48151		A	Partial removal of pancreas	40.11	090
48155		A	Removal of pancreas	43.45	090
48180		A	Fuse pancreas and bowel	35.92	090
48500		A	Surgery of pancreas cyst	22.07	090
48510		A	Drain pancreatic pseudocyst	20.08	090
48520		A	Fuse pancreas cyst and bowel	26.37	090
48540		A	Fuse pancreas cyst and bowel	30.77	090
49000		A	Exploration of abdomen	17.04	090
49002		A	Reopening of abdomen	16.57	090
49010		A	Exploration behind abdomen	19.36	090
49020		A	Drain abdominal abscess	14.75	090
49040		A	Drain abdominal abscess	16.43	090
49060		A	Drain abdominal abscess	17.08	090
49080		A	Puncture, peritoneal cavity	2.30	000
49081		A	Removal of abdominal fluid	2.09	000
49085		A	Remove abdomen foreign body	12.07	090
49180		A	Biopsy, abdominal mass	3.48	000
49200		A	Removal of abdominal lesion	19.03	090
49201		A	Removal of abdominal lesion	27.86	090
49215		A	Excise sacral spine tumor	31.21	090
49220		A	Multiple surgery, abdomen	28.15	090
49250		A	Excision of umbilicus	12.82	090
49255		A	Removal of omentum	10.39	090
49300		A	Peritoneoscopy	8.23	000
49301		A	Peritoneoscopy with biopsy	9.71	000
49302		A	Peritoneoscopy with X-ray	7.90	000
49303		A	Peritoneoscopy, X-ray and biopsy	9.56	000
49310		A	Laparoscopic cholecystectomy	20.21	090
49311		A	Laparoscopic cholecystectomy	21.58	090
49315		A	Laparoscopy, surgical	11.84	090
49400		A	Air injection into abdomen	3.21	000
49401		A	Air injection into abdomen	2.84	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
49420		A	Insert abdominal drain	3.99	000
49421		A	Insert abdominal drain	9.74	090
49425		A	Insert abdomen-venous drain	20.25	090
49426		A	Revise abdomen-venous shunt	14.95	090
49427		A	Injection, abdominal shunt	1.43	000
49500		A	Repair inguinal hernia	10.83	090
49505		A	Repair inguinal hernia	11.52	090
49510		A	Repair hernia, remove testis	12.72	090
49515		A	Repair inguinal hernia	12.81	090
49520		A	Rerepair inguinal hernia	14.09	090
49525		A	Repair inguinal hernia	13.54	090
49530		A	Repair incarcerated hernia	13.69	090
49535		A	Repair strangulated hernia	16.24	090
49540		A	Repair lumbar hernia	14.13	090
49550		A	Repair femoral hernia	11.64	090
49552		A	Repair femoral hernia	12.86	090
49555		A	Repair femoral hernia	14.47	090
49560		A	Repair abdominal hernia	16.24	090
49565		A	Rerepair abdominal hernia	15.96	090
49570		A	Repair epigastric hernia	9.62	090
49575		A	Repair epigastric hernia	13.03	090
49580		A	Repair umbilical hernia	8.62	090
49581		A	Repair umbilical hernia	10.15	090
49590		A	Repair abdominal hernia	13.24	090
49600		A	Repair umbilical lesion	15.53	090
49605		A	Repair umbilical lesion	32.31	090
49606		A	Repair umbilical lesion	27.35	090
49610		A	Repair umbilical lesion	16.48	090
49611		A	Repair umbilical lesion	17.84	090
49900		A	Repair of abdominal wall	8.86	090
49905		A	Omental flap	10.72	ZZZ

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

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
50010		A	Exploration of kidney	20.67	090
50020		A	Drainage of kidney abscess	20.13	090
50040		A	Drainage of kidney	21.74	090
50045		A	Exploration of kidney	25.25	090
50060		A	Removal of kidney stone	31.54	090
50065		A	Incision of kidney	34.98	090
50070		A	Incision of kidney	33.43	090
50075		A	Removal of kidney stone	42.64	090
50080		A	Removal of kidney stone	27.34	090
50081		A	Removal of kidney stone	37.05	090
50100		A	Revise kidney blood vessels	26.79	090
50120		A	Exploration of kidney	27.16	090
50125		A	Explore and drain kidney	27.68	090
50130		A	Removal of kidney stone	30.19	090
50135		A	Exploration of kidney	36.77	090
50200		A	Biopsy of kidney	5.45	000
50205		A	Biopsy of kidney	19.13	090
50220		A	Removal of kidney	30.70	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
50225		A	Removal of kidney	37.10	090
50230		A	Removal of kidney	40.74	090
50234		A	Removal of kidney and ureter	39.43	090
50236		A	Removal of kidney and ureter	42.86	090
50240		A	Partial removal of kidney	37.94	090
50280		A	Removal of kidney lesion	26.65	090
50290		A	Removal of kidney lesion	23.74	090
50340		A	Removal of kidney	25.12	090
50360		A	Transplantation of kidney	55.26	090
50365		A	Transplantation of kidney	66.82	090
50370		A	Remove transplanted kidney	23.86	090
50380		A	Reimplantation of kidney	28.24	090
50390		A	Drainage of kidney lesion	5.11	000
50392		A	Insert kidney drain	8.21	000
50393		A	Insert ureteral tube	10.23	000
50394		A	Injection for kidney X-ray	1.37	000
50395		A	Create passage to kidney	8.80	000
50396		A	Measure kidney pressure	2.68	000
50398		A	Change kidney tube	2.07	000
50400		A	Revision of kidney/ureter	33.12	090
50405		A	Revision of kidney/ureter	41.50	090
50500		A	Repair of kidney wound	32.35	090
50520		A	Close kidney-skin fistula	27.75	090
50525		A	Repair renal-abdomen fistula	35.14	090
50526		A	Repair renal-abdomen fistula	31.81	090
50540		A	Revision of horseshoe kidney	34.11	090
50551		A	Kidney endoscopy	8.06	000
50553		A	Kidney endoscopy	7.91	000
50555		A	Kidney endoscopy and biopsy	11.71	000
50557		A	Kidney endoscopy and treatment	11.83	000
50559		A	Renal endoscopy; radio tracer	8.38	000
50561		A	Kidney endoscopy and treatment	13.24	000
50570		A	Kidney endoscopy	11.32	000
50572		A	Kidney endoscopy	18.39	000
50574		A	Kidney endoscopy and biopsy	18.81	000
50576		A	Kidney endoscopy and treatment	20.49	000
50578		A	Renal endoscopy; radio tracer	16.30	000
50580		A	Kidney endoscopy and treatment	15.96	000
50590		A	Fragmenting of kidney stone	20.64	090
50600		A	Exploration of ureter	25.54	090
50605		A	Insert ureteral support	21.28	090
50610		A	Removal of ureter stone	27.82	090
50620		A	Removal of ureter stone	26.82	090
50630		A	Removal of ureter stone	27.89	090
50650		A	Removal of ureter	29.68	090
50660		A	Removal of ureter	32.48	090
50684		A	Injection for ureter X-ray	1.31	000
50686		A	Measure ureter pressure	1.94	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
50688		A	Change of ureter tube	1.59	010
50690		A	Injection for ureter X-ray	1.52	000
50700		A	Revision of ureter	27.93	090
50715		A	Release of ureter	30.34	090
50722		A	Release of ureter	27.24	090
50725		A	Release/revise ureter	30.84	090
50727		A	Revise ureter	13.48	090
50728		A	Revise ureter	19.84	090
50740		A	Fusion of ureter and kidney	31.91	090
50750		A	Fusion of ureter and kidney	33.50	090
50760		A	Fusion of ureters	32.06	090
50770		A	Splicing of ureters	34.88	090
50780		A	Reimplant ureter in bladder	32.35	090
50782		A	Ureteroneocystostomy	33.47	090
50783		A	Ureteroneocystostomy	34.44	090
50785		A	Reimplant ureter in bladder	36.31	090
50800		A	Implant ureter in bowel	29.16	090
50810		A	Fusion of ureter and bowel	32.41	090
50815		A	Urine shunt to bowel	40.32	090
50820		A	Construct bowel bladder	41.40	090
50825		A	Construct bowel bladder	59.74	090
50830		A	Revise urine flow	52.54	090
50840		A	Replace ureter by bowel	32.86	090
50860		A	Transplant ureter to skin	26.08	090
50900		A	Repair of ureter	23.68	090
50920		A	Closure ureter/skin fistula	23.77	090
50930		A	Closure ureter/bowel fistula	31.40	090
50940		A	Release of ureter	24.36	090
50951		A	Endoscopy of ureter	7.76	000
50953		A	Endoscopy of ureter	8.15	000
50955		A	Ureter endoscopy and biopsy	9.63	000
50957		A	Ureter endoscopy and treatment	9.63	000
50959		A	Ureter endoscopy and tracer	8.08	000
50961		A	Ureter endoscopy and treatment	8.99	000
50970		A	Ureter endoscopy	12.86	000
50972		A	Ureter endoscopy and catheter	8.71	000
50974		A	Ureter endoscopy and biopsy	16.85	000
50976		A	Ureter endoscopy and treatment	16.11	000
50978		A	Ureter endoscopy and tracer	9.63	000
50980		A	Ureter endoscopy and treatment	10.34	000
51000		A	Drainage of bladder	1.32	000
51005		A	Drainage of bladder	1.53	000
51010		A	Drainage of bladder	3.64	010
51020		A	Incise and treat bladder	13.55	090
51030		A	Incise and treat bladder	11.02	090
51040		A	Incise and drain bladder	12.03	090
51045		A	Incise bladder, drain ureter	11.52	090
51050		A	Removal of bladder stone	13.80	090
51060		A	Removal of ureter stone	21.26	090
51065		A	Removal of ureter stone	15.83	090
51080		A	Drainage of bladder abscess	11.13	090
51500		A	Removal of bladder cyst	17.52	090
51520		A	Removal of bladder lesion	18.04	090
51525		A	Removal of bladder lesion	24.50	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
51530		A	Removal of bladder lesion	21.56	090
51535		A	Repair of ureter lesion	20.30	090
51550		A	Partial removal of bladder	26.22	090
51555		A	Partial removal of bladder	33.26	090
51565		A	Revise bladder and ureter(s)	37.52	090
51570		A	Removal of bladder	39.50	090
51575		A	Removal of bladder and nodes	53.04	090
51580		A	Remove bladder; revise tract	50.27	090
51585		A	Removal of bladder and nodes	59.82	090
51590		A	Remove bladder; revise tract	57.27	090
51595		A	Remove bladder; revise tract	71.24	090
51596		A	Remove bladder; create pouch	74.46	090
51597		A	Removal of pelvic structures	69.87	090
51600		A	Injection for bladder X-ray	1.19	000
51605		A	Preparation for bladder X-ray	1.46	000
51610		A	Injection for bladder X-ray	1.91	000
51700		A	Irrigation of bladder	1.13	000
51705		A	Change of bladder tube	1.41	010
51710		A	Change of bladder tube	2.12	010
51720		A	Treatment of bladder lesion	2.50	000
51725	26	A	Simple cystometrogram	2.23	000
51725		A	Simple cystometrogram	2.63	000
51725	TC	A	Simple cystometrogram	.40	000
51726	26	A	Complex cystometrogram	2.61	000
51726		A	Complex cystometrogram	3.14	000
51726	TC	A	Complex cystometrogram	.52	000
51736	26	A	Urine flow measurement	1.13	000
51736		A	Urine flow measurement	1.29	000
51736	TC	A	Urine flow measurement	.15	000
51739	26	A	Sound record of urine stream	1.16	000
51739		A	Sound record of urine stream	1.31	000
51739	TC	A	Sound record of urine stream	.15	000
51741	26	A	Electro-uroflowmetry, first	1.98	000
51741		A	Electro-uroflowmetry, first	2.20	000
51741	TC	A	Electro-uroflowmetry, first	.22	000
51772	26	A	Urethra pressure profile	2.22	000
51772		A	Urethra pressure profile	2.67	000
51772	TC	A	Urethra pressure profile	.45	000
51785	26	A	Anal/urinary muscle study	2.27	000
51785		A	Anal/urinary muscle study	2.69	000
51785	TC	A	Anal/urinary muscle study	.42	000
51792	26	A	Urinary reflex study	1.76	000
51792		A	Urinary reflex study	3.19	000
51792	TC	A	Urinary reflex study	1.43	000
51795	26	A	Urine voiding pressure study	2.19	000
51795		A	Urine voiding pressure study	3.13	000
51795	TC	A	Urine voiding pressure study	.94	000
51797	26	A	Intraabdominal pressure test	2.19	000

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51797		A	Intraabdominal pressure test	2.67	000
51797	TC	A	Intraabdominal pressure test	.48	000
51800		A	Revision of bladder/urethra	29.78	090
51820		A	Revision of urinary tract	25.42	090
51840		A	Attach bladder/urethra	20.14	090
51841		A	Attach bladder/urethra	24.47	090
51845		A	Repair bladder neck	20.75	090
51860		A	Repair of bladder wound	19.70	090
51865		A	Repair of bladder wound	26.20	090
51880		A	Repair of bladder opening	12.73	090
51900		A	Repair bladder/vagina lesion	24.63	090
51920		A	Close bladder-uterus fistula	18.85	090
51925		A	Hysterectomy/bladder repair	26.23	090
51940		A	Correction of bladder defect	46.13	090
51960		A	Revision of bladder and bowel	44.68	090
51980		A	Construct bladder opening	18.67	090
52000		A	Cystoscopy	3.48	000
52005		A	Cystoscopy and ureter catheter	4.78	000
52007		A	Cystoscopy and biopsy	6.10	000
52010		A	Cystoscopy and duct catheter	5.13	000
52204		A	Cystoscopy	4.98	000
52214		A	Cystoscopy and treatment	6.79	000
52224		A	Cystoscopy and treatment	6.31	000
52234		A	Cystoscopy and treatment	9.77	000
52235		A	Cystoscopy and treatment	14.45	000
52240		A	Cystoscopy and treatment	21.34	000
52250		A	Cystoscopy and radio tracer	7.67	000
52260		A	Cystoscopy and treatment	6.27	000
52265		A	Cystoscopy and treatment	4.45	000
52270		A	Cystoscopy and revise urethra	7.64	000
52275		A	Cystoscopy and revise urethra	8.47	000
52276		A	Cystoscopy and treatment	8.91	000
52277		A	Cystoscopy and treatment	11.47	000
52281		A	Cystoscopy and treatment	5.34	000
52283		A	Cystoscopy and treatment	5.44	000
52285		A	Cystoscopy and treatment	6.84	000
52290		A	Cystoscopy and treatment	7.21	000
52300		A	Cystoscopy and treatment	9.20	000
52305		A	Cystoscopy and treatment	9.18	000
52310		A	Cystoscopy and treatment	6.07	000
52315		A	Cystoscopy and treatment	9.69	000
52317		A	Remove bladder stone	13.49	000
52318		A	Remove bladder stone	17.84	000
52320		A	Cystoscopy and treatment	10.00	000
52325		A	Cystoscopy, stone removal	13.80	000
52330		A	Cystoscopy and treatment	8.88	000
52332		A	Cystoscopy and treatment	6.33	000
52334		A	Create passage to kidney	8.50	000
52335		A	Endoscopy of urinary tract	11.02	000
52336		A	Cystoscopy, stone removal	17.92	000
52337		A	Cystoscopy, stone removal	19.91	000
52338		A	Cystoscopy and treatment	13.85	000
52339		A	Cystoscopy and treatment	15.37	000
52340		A	Cystoscopy and treatment	13.46	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
52450		A	Incision of prostate	12.57	090
52500		A	Revision of bladder neck	15.95	090
52510		A	Dilation prostatic urethra	14.36	090
52601		A	Prostatectomy (TURP)	24.48	090
52606		A	Control postop bleeding	11.23	090
52612		A	Prostatectomy, first stage	17.95	090
52614		A	Prostatectomy, second stage	13.76	090
52620		A	Remove residual prostate	11.88	090
52630		A	Remove prostate regrowth	18.98	090
52640		A	Relieve bladder contracture	13.06	090
52650		A	Prostatectomy	18.59	090
52700		A	Drainage of prostate abscess	9.99	090
53000		A	Incision of urethra	3.93	010
53010		A	Incision of urethra	6.87	090
53020		A	Incision of urethra	2.69	000
53025		A	Incision of urethra	2.01	000
53040		A	Drainage of urethra abscess	8.13	090
53060		A	Drainage of urethra abscess	3.20	010
53080		A	Drainage of urinary leakage	10.31	090
53085		A	Drainage of urinary leakage	17.16	090
53200		A	Biopsy of urethra	3.82	000
53210		A	Removal of urethra	19.11	090
53215		A	Removal of urethra	25.60	090
53220		A	Treatment of urethra lesion	11.85	090
53230		A	Removal of urethra lesion	17.75	090
53235		A	Removal of urethra lesion	15.21	090
53240		A	Surgery for urethra pouch	10.83	090
53250		A	Removal of urethra gland	10.15	090
53260		A	Treatment of urethra lesion	4.22	010
53265		A	Treatment of urethra lesion	5.18	010
53270		A	Removal of urethra gland	3.97	010
53275		A	Repair of urethra defect	7.02	010
53400		A	Revise urethra, 1st stage	20.08	090
53405		A	Revise urethra, 2nd stage	25.27	090
53410		A	Reconstruction of urethra	25.11	090
53415		A	Reconstruction of urethra	31.63	090
53420		A	Reconstruct urethra, stage 1	25.21	090
53425		A	Reconstruct urethra, stage 2	25.40	090
53430		A	Reconstruction of urethra	23.61	090
53440		A	Correct bladder function	25.91	090
53442		A	Remove perineal prosthesis	14.17	090
53443		A	Reconstruction of urethra	30.21	090
53445		A	Correct urine flow control	35.40	090
53447		A	Remove artificial sphincter	22.45	090
53449		A	Correct artificial sphincter	18.36	090
53450		A	Revision of urethra	8.78	090
53460		A	Revision of urethra	9.47	090
53502		A	Repair of urethra injury	12.77	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
53505		A	Repair of urethra injury	12.94	090
53510		A	Repair of urethra injury	17.25	090
53515		A	Repair of urethra injury	22.66	090
53520		A	Repair of urethra defect	14.70	090
53600		A	Dilate urethra stricture	1.58	000
53601		A	Dilate urethra stricture	1.30	000
53605		A	Dilate urethra stricture	1.81	000
53620		A	Dilate urethra stricture	2.17	000
53621		A	Dilate urethra stricture	1.78	000
53640		A	Relieve bladder retention	2.25	000
53660		A	Dilation of urethra	1.02	000
53661		A	Dilation of urethra	1.00	000
53665		A	Dilation of urethra	1.16	000
53670		A	Insert urinary catheter	.75	000
53675		A	Insert urinary catheter	2.02	000
54000		A	Slitting of prepuce	2.21	010
54001		A	Slitting of prepuce	3.09	010
54015		A	Drain penis lesion	6.18	010
54050		A	Destruction, penis lesion(s)	1.62	010
54055		A	Destruction, penis lesion(s)	1.88	010
54056		A	Cryosurgery, penis lesion(s)	1.78	010
54057		A	Laser surgery, penis lesion(s)	3.40	010
54060		A	Excision of penis lesion(s)	3.17	010
54065		A	Destruction, penis lesion(s)	5.07	010
54100		A	Biopsy of penis	2.65	000
54105		A	Biopsy of penis	4.62	010
54110		A	Treatment of penis lesion	16.36	090
54111		A	Treat penis lesion, graft	23.19	090
54112		A	Treat penis lesion, graft	27.15	090
54115		A	Treatment of penis lesion	10.32	090
54120		A	Partial removal of penis	16.37	090
54125		A	Removal of penis	25.49	090
54130		A	Remove penis and nodes	34.95	090
54135		A	Remove penis and nodes	44.59	090
54150		A	Circumcision	2.40	010
54152		A	Circumcision	4.27	010
54160		A	Circumcision	4.30	010
54161		A	Circumcision	5.62	010
54200		A	Treatment of penis lesion	1.36	010
54205		A	Treatment of penis lesion	12.85	090
54220		A	Treatment of penis lesion	4.18	000
54230		A	Prepare penis study	2.80	000
54235		A	Penile injection	1.68	000
54240	26	A	Penis pressure study	1.90	000
54240		A	Penis pressure study	2.43	000
54240	TC	A	Penis pressure study	.53	000
54250	26	A	Test penile erection/rigid	2.81	000
54250		A	Test penile erection/rigid	3.12	000
54250	TC	A	Test penile erection/rigid	.31	000
54300		A	Revision of penis	17.79	090
54304		A	Revision of penis	21.72	090
54308		A	Reconstruction of urethra	18.23	090
54312		A	Reconstruction of urethra	23.48	090
54316		A	Reconstruction of urethra	28.48	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
54318		A	Reconstruction of urethra	19.05	090
54322		A	Reconstruction of urethra	20.76	090
54324		A	Reconstruction of urethra	27.57	090
54326		A	Reconstruction of urethra	26.40	090
54328		A	Revise penis, urethra	26.76	090
54332		A	Revise penis, urethra	29.88	090
54336		A	Revise penis, urethra	39.16	090
54340		A	Secondary urethral surgery	15.25	090
54344		A	Secondary urethral surgery	32.93	090
54348		A	Secondary urethral surgery	29.18	090
54352		A	Reconstruct urethra, penis	41.65	090
54360		A	Penis plastic surgery	19.20	090
54380		A	Repair penis	22.83	090
54385		A	Repair penis	26.18	090
54390		A	Repair penis and bladder	36.17	090
54400		A	Insert semi-rigid prosthesis	22.77	090
54401		A	Insert self-contd prosthesis	28.96	090
54402		A	Remove penis prosthesis	15.30	090
54405		A	Insert multi-comp prosthesis	35.99	090
54407		A	Remove multi-comp prosthesis	24.90	090
54409		A	Revise penis prosthesis	21.39	090
54420		A	Revision of penis	19.36	090
54430		A	Revision of penis	17.26	090
54435		A	Revision of penis	10.19	090
54450		A	Preputial stretching	1.87	000
54500		A	Biopsy of testis	1.81	000
54505		A	Biopsy of testis	5.51	010
54510		A	Removal of testis lesion	8.66	090
54520		A	Removal of testis	10.73	090
54530		A	Removal of testis	16.11	090
54535		A	Extensive testis surgery	20.96	090
54550		A	Exploration for testis	13.23	090
54560		A	Exploration for testis	18.53	090
54600		A	Reduce testis torsion	11.71	090
54620		A	Suspension of testis	8.34	010
54640		A	Suspension of testis	15.18	090
54645		A	Suspension of testis, stage 2	9.58	090
54660		A	Revision of testis	8.55	090
54680		A	Relocation of testis(es)	20.56	090
54700		A	Drainage of scrotum	4.44	010
54800		A	Biopsy of epididymis	4.49	000
54820		A	Exploration of epididymis	7.64	090
54830		A	Remove epididymis lesion	8.99	090
54840		A	Remove epididymis lesion	10.32	090
54860		A	Removal of epididymis	11.69	090
54861		A	Removal of epididymis	16.55	090
54900		A	Fusion of spermatic ducts	22.48	090
54901		A	Fusion of spermatic ducts	30.85	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
55000		A	Drainage of hydrocele	1.90	000
55040		A	Removal of hydrocele	10.55	090
55041		A	Removal of hydroceles	15.60	090
55060		A	Repair of hydrocele	9.84	090
55100		A	Drainage of scrotum abscess	2.76	010
55110		A	Explore scrotum	9.15	090
55120		A	Removal of scrotum lesion	6.82	090
55150		A	Removal of scrotum	12.63	090
55175		A	Revision of scrotum	9.89	090
55180		A	Revision of scrotum	17.73	090
55200		A	Incision of sperm duct	6.36	090
55250		A	Removal of sperm duct(s)	6.12	090
55300		A	Preparation, sperm duct X-ray	6.50	000
55400		A	Repair of sperm duct	15.45	090
55450		A	Ligation of sperm duct	6.83	010
55500		A	Removal of hydrocele	10.10	090
55520		A	Removal of sperm cord lesion	9.35	090
55530		A	Revise spermatic cord veins	11.21	090
55535		A	Revise spermatic cord veins	11.12	090
55540		A	Revise hernia and sperm veins	12.63	090
55600		A	Incise sperm duct pouch	10.93	090
55605		A	Incise sperm duct pouch	13.79	090
55650		A	Remove sperm duct pouch	19.30	090
55680		A	Remove sperm pouch lesion	9.63	090
55700		A	Biopsy of prostate	3.22	000
55705		A	Biopsy of prostate	8.12	010
55720		A	Drainage of prostate abscess	11.48	090
55725		A	Drainage of prostate abscess	13.88	090
55801		A	Removal of prostate	30.43	090
55810		A	Extensive prostate surgery	40.85	090
55812		A	Extensive prostate surgery	45.34	090
55815		A	Extensive prostate surgery	56.07	090
55821		A	Removal of prostate	27.85	090
55831		A	Removal of prostate	30.22	090
55840		A	Extensive prostate surgery	39.45	090
55842		A	Extensive prostate surgery	43.73	090
55845		A	Extensive prostate surgery	54.20	090
55860		A	Surgical exposure, prostate	21.27	090
55862		A	Extensive prostate surgery	30.05	090
55865		A	Extensive prostate surgery	48.38	090
56300		A	Pelvis laparoscopy, DX	9.18	010
56301		A	Laparoscopy, surgical	10.92	010
56302		A	Laparoscopy, surgical	7.58	010
56303		A	Laparoscopy, surgical	12.21	010
56304		A	Laparoscopy, surgical	11.04	010
56305		A	Laparoscopy, surgical	9.84	010
56306		A	Laparoscopy, surgical	10.12	010
56307		A	Laparoscopy, surgical	14.09	010
56308		A	Laparoscopy, surgical	25.11	010
56309		A	Laparoscopy, surgical	11.24	010
56350		A	Hysteroscopy, diagnostic	4.76	000
56351		A	Hysteroscopy, surgical	5.23	000
56352		A	Hysteroscopy, surgical	7.61	000
56353		A	Hysteroscopy, surgical	8.00	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
56354		A	Hysteroscopy, surgical	10.86	000
56355		A	Hysteroscopy, surgical	5.47	000
56356		A	Hysteroscopy, surgical	11.27	000
56405		A	I & D of vulva/periueum	2.30	010
56420		A	Drainage of gland abscess	2.26	010
56440		A	Surgery for vulva lesion	5.87	010
56441		A	Lysis of labial lesion(s)	3.83	010
56501		A	Destruction, vulva lesion(s)	2.14	010
56515		A	Destruction, vulva lesion(s)	5.46	010
56605		A	Biopsy of vulva/perineum	1.43	000
56606		A	Biopsy of vulva/perineum	.72	000
56620		A	Partial removal of vulva	14.97	090
56625		A	Removal of vulva	19.98	090
56630		A	Extensive vulva surgery	30.21	090
56631		A	Vulvectomy, radical, partial	40.30	090
56633		A	Vulvectomy, radical, complete	32.09	090
56634		A	Vulvectomy, radical, complete	41.76	090
56637		A	Vulvectomy, radical, complete	42.69	090
56640		A	Extensive vulva surgery	42.61	090
56700		A	Partial removal of hymen	4.55	010
56720		A	Incision of hymen	1.27	000
56740		A	Remove vagina gland lesion	6.97	010
56800		A	Repair of vagina	7.16	010
56805		A	Repair of clitoris	28.60	090
56810		A	Repair of perineum	7.05	010
57000		A	Exploration of vagina	5.27	010
57010		A	Drainage of pelvic abscess	8.57	090
57020		A	Drainage of pelvic fluid	2.29	000
57061		A	Destruction vagina lesion(s)	2.17	010
57065		A	Destruction vagina lesion(s)	6.56	010
57100		A	Biopsy of vagina	1.71	000
57105		A	Biopsy of vagina	3.49	010
57108		A	Partial removal of vagina	11.92	090
57110		A	Removal of vagina	19.86	090
57120		A	Closure of vagina	14.99	090
57130		A	Remove vagina lesion	5.49	010
57135		A	Remove vagina lesion	4.92	010
57150		A	Treat vagina infection	1.17	000
57160		A	Insertion of pessary	1.19	000
57170		A	Fitting of diaphragm/cap	1.28	000
57180		A	Treat vaginal bleeding	2.20	010
57200		A	Repair of vagina	6.93	090
57210		A	Repair vagina/perineum	8.59	090
57220		A	Revision of urethra	8.99	090
57230		A	Repair of urethral lesion	9.50	090
57240		A	Repair bladder and vagina	14.34	090
57250		A	Repair rectum and vagina	14.16	090
57260		A	Repair of vagina	17.81	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
57265		A	Extensive repair of vagina	18.81	090
57268		A	Repair of bowel bulge	14.42	090
57270		A	Repair of bowel pouch	15.44	090
57280		A	Suspension of vagina	18.43	090
57282		A	Repair of vaginal prolapse	18.38	090
57288		A	Repair bladder defect	24.34	090
57289		A	Repair bladder and vagina	16.41	090
57291		A	Construction of vagina	13.87	090
57292		A	Construct vagina with graft	20.20	090
57300		A	Repair rectum-vagina fistula	16.12	090
57305		A	Repair rectum-vagina fistula	17.60	090
57307		A	Fistula repair and colostomy	17.34	090
57310		A	Repair urethrovaginal lesion	10.92	090
57311		A	Repair urethrovaginal lesion	13.26	090
57320		A	Repair bladder-vagina lesion	18.24	090
57330		A	Repair bladder-vagina lesion	20.81	090
57335		A	Repair of vagina	16.82	090
57400		A	Dilation of vagina	1.21	000
57410		A	Pelvic examination	1.00	000
57415		A	Removal vaginal foreign body	1.32	010
57452		A	Examination of vagina	1.76	000
57454		A	Vagina examination and biopsy	2.70	000
57460		A	Colposcopy (vaginoscopy)	5.27	000
57500		A	Biopsy of cervix	1.65	000
57505		A	Endocervical curettage	1.84	010
57510		A	Cauterization of cervix	2.48	010
57511		A	Cryocautery of cervix	2.86	010
57513		A	Laser surgery of cervix	5.49	010
57520		A	Conization cervix	7.49	090
57530		A	Removal of cervix	8.72	090
57540		A	Removal of residual cervix	14.01	090
57545		A	Remove cervix, repair pelvic	12.12	090
57550		A	Removal of residual cervix	13.54	090
57555		A	Remove cervix, repair vagina	20.03	090
57556		A	Remove cervix, repair bowel	18.61	090
57700		A	Revision of cervix	6.01	090
57720		A	Revision of cervix	7.09	090
57800		A	Dilation of cervical canal	1.35	000
57820		A	D&C of residual cervix	4.47	010
58100		A	Biopsy of uterus lining	1.49	000
58120		A	Dilation and curettage (D&C)	5.63	010
58140		A	Removal of uterus lesion	17.37	090
58145		A	Removal of uterus lesion	16.91	090
58150		A	Total hysterectomy	24.42	090
58152		A	Total hysterectomy	28.34	090
58180		A	Partial hysterectomy	20.60	090
58200		A	Extensive hysterectomy	35.87	090
58210		A	Extensive hysterectomy	45.18	090
58240		A	Removal of pelvis contents	62.75	090
58260		A	Vaginal hysterectomy	22.59	090
58262		A	Vaginal hysterectomy	24.29	090
58263		A	Vaginal hysterectomy	26.57	090
58267		A	Hysterectomy and vagina repair	27.63	090
58270		A	Hysterectomy and vagina repair	24.86	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
58275		A	Hysterectomy, revise vagina	27.07	090
58280		A	Hysterectomy, revise vagina	26.90	090
58285		A	Extensive hysterectomy	31.46	090
58300		A	Insert intrauterine device	1.89	000
58301		A	Remove intrauterine device	1.27	000
58310		A	Artificial insemination	1.76	000
58311		A	Artificial insemination	2.04	000
58340		A	Inject for uterus/tube X-ray	1.53	000
58345		A	Reopen fallopian tube	8.51	010
58350		A	Reopen fallopian tube	1.79	010
58400		A	Suspension of uterus	12.30	090
58410		A	Suspension of uterus	13.08	090
58520		A	Repair of ruptured uterus	11.47	090
58540		A	Revision of uterus	15.97	090
58600		A	Division of fallopian tube	11.83	090
58605		A	Division of fallopian tube	9.12	090
58611		A	Ligate oviduct(s)	1.20	ZZZ
58615		A	Occlude fallopian tube(s)	7.09	010
58700		A	Removal of fallopian tube	13.36	090
58720		A	Removal of ovary/tube(s)	15.05	090
58740		A	Revise fallopian tube(s)	15.40	090
58750		A	Repair oviduct(s)	16.43	090
58752		A	Revise ovarian tube(s)	15.54	090
58760		A	Remove tubal obstruction	13.33	090
58770		A	Create new tubal opening	13.22	090
58800		A	Drainage of ovarian cyst(s)	6.94	090
58805		A	Drainage of ovarian cyst(s)	12.95	090
58820		A	Drainage of ovarian abscess	7.18	090
58822		A	Drainage of ovarian abscess	10.48	090
58825		A	Transposition, ovary(s)	10.47	090
58900		A	Biopsy of ovary(s)	11.60	090
58920		A	Partial removal of ovary(s)	14.26	090
58925		A	Removal of ovarian cyst(s)	14.14	090
58940		A	Removal of ovary(s)	14.17	090
58943		A	Removal of ovary(s)	31.94	090
58950		A	Resect ovarian malignancy	27.45	090
58951		A	Resect ovarian malignancy	42.06	090
58952		A	Resect ovarian malignancy	42.86	090
58960		A	Exploration of abdomen	25.88	090
59000		A	Amniocentesis	2.42	000
59012		A	Fetal cord puncture, prenatal	6.37	000
59015		A	Chorion biopsy	3.52	000
59020	26	A	Fetal contract stress test	1.74	000
59020		A	Fetal contract stress test	2.32	000
59020	TC	A	Fetal contract stress test	.58	000
59025	26	A	Fetal nonstress test	1.00	000
59025		A	Fetal nonstress test	1.24	000
59025	TC	A	Fetal nonstress test	.24	000

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59030		A	Fetal scalp blood sample	3.77	000
59050		A	Fetal monitor with report	2.50	XXX
59100		A	Remove uterus lesion	10.96	090
59120		A	Treat ectopic pregnancy	16.24	090
59121		A	Treat ectopic pregnancy	13.32	090
59130		A	Treat ectopic pregnancy	14.53	090
59135		A	Treat ectopic pregnancy	23.98	090
59136		A	Treat ectopic pregnancy	16.19	090
59140		A	Treat ectopic pregnancy	10.06	090
59150		A	Treat ectopic pregnancy	11.79	090
59151		A	Treat ectopic pregnancy	16.47	090
59160		A	D&C after delivery	6.04	010
59200		A	Insert cervical dilator	1.44	000
59300		A	Episiotomy or vaginal repair	3.52	000
59320		A	Revision of cervix	4.62	000
59325		A	Revision of cervix	7.26	000
59350		A	Repair of uterus	9.22	000
59400		A	Obstetrical care	35.78	MMM
59410		A	Obstetrical care	22.76	MMM
59412		A	Antepartum manipulation	3.18	MMM
59414		A	Deliver placenta	3.00	MMM
59430		A	Care after delivery	2.48	MMM
59510		A	Cesarean delivery	34.12	MMM
59515		A	Cesarean delivery	23.56	MMM
59525		A	Remove uterus after Cesarean	13.20	MMM
59812		A	Treatment of miscarriage	7.35	090
59820		A	Care of miscarriage	8.14	090
59821		A	Treatment of miscarriage	7.55	090
59830		A	Treat uterus infection	11.01	090
59840		A	Abortion	6.71	010
59841		A	Abortion	7.63	010
59850		A	Abortion	10.21	090
59851		A	Abortion	10.68	090
59852		A	Abortion	14.33	090
59870		A	Evacuate mole of uterus	7.59	090

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

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
60000		A	Drain thyroid/tongue cyst	2.42	010
60100		A	Biopsy of thyroid	2.12	000
60200		A	Remove thyroid lesion	15.82	090
60220		A	Partial removal of thyroid	19.81	090
60225		A	Partial removal of thyroid	23.84	090
60240		A	Removal of thyroid	28.05	090
60245		A	Partial removal of thyroid	22.63	090
60246		A	Partial removal of thyroid	28.30	090
60252		A	Removal of thyroid	31.29	090
60254		A	Extensive thyroid surgery	38.54	090
60260		A	Repeat thyroid surgery	18.20	090
60270		A	Removal of thyroid	32.67	090
60280		A	Remove thyroid duct lesion	14.37	090
60281		A	Remove thyroid duct lesion	13.94	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
60500		A	Explore parathyroid glands	28.84	090
60502		A	Re-explore parathyroids	32.82	090
60505		A	Explore parathyroid glands	35.44	090
60520		A	Removal of thymus gland	32.87	090
60540		A	Explore adrenal gland	29.66	090
60545		A	Explore adrenal gland	34.94	090
60600		A	Remove carotid body lesion	29.34	090
60605		A	Remove carotid body lesion	30.96	090
61000		A	Remove cranial cavity fluid	2.80	000
61001		A	Remove cranial cavity fluid	2.53	000
61020		A	Remove brain cavity fluid	2.95	000
61026		A	Injection into brain canal	3.91	000
61050		A	Remove brain canal fluid	2.88	000
61055		A	Injection into brain canal	4.16	000
61070		A	Brain canal shunt procedure	1.43	000
61105		A	Drill skull for examination	16.19	090
61106		A	Drill skull for exam/surgery	14.52	ZZZ
61107		A	Drill skull for implantation	12.40	000
61108		A	Drill skull for drainage	24.73	090
61120		A	Pierce skull for examination	16.27	090
61130		A	Pierce skull, exam/surgery	12.18	ZZZ
61140		A	Pierce skull for biopsy	31.20	090
61150		A	Pierce skull for drainage	33.34	090
61151		A	Pierce skull for drainage	14.06	090
61154		A	Pierce skull, remove clot	34.23	090
61156		A	Pierce skull for drainage	34.03	090
61210		A	Pierce skull; implant device	14.33	000
61215		A	Insert brain-fluid device	20.48	090
61250		A	Pierce skull and explore	20.39	090
61253		A	Pierce skull and explore	24.16	090
61304		A	Open skull for exploration	50.66	090
61305		A	Open skull for exploration	58.18	090
61312		A	Open skull for drainage	48.44	090
61313		A	Open skull for drainage	48.29	090
61314		A	Open skull for drainage	52.38	090
61315		A	Open skull for drainage	54.23	090
61320		A	Open skull for drainage	45.69	090
61321		A	Open skull for drainage	49.73	090
61330		A	Decompress eye socket	29.84	090
61332		A	Explore/biopsy eye socket	49.42	090
61333		A	Explore orbit; remove lesion	50.23	090
61334		A	Explore orbit; remove object	33.43	090
61340		A	Relieve cranial pressure	29.24	090
61343		A	Incise skull, pressure relief	62.46	090
61345		A	Relieve cranial pressure	47.68	090
61440		A	Incise skull for surgery	48.31	090
61450		A	Incise skull for surgery	47.81	090
61458		A	Incise skull for brain wound	57.44	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
61460		A	Incise skull for surgery	55.34	090
61470		A	Incise skull for surgery	36.99	090
61480		A	Incise skull for surgery	33.52	090
61490		A	Incise skull for surgery	29.31	090
61500		A	Removal of skull lesion	40.04	090
61501		A	Remove infected skull bone	35.38	090
61510		A	Removal of brain lesion	54.59	090
61512		A	Remove brain lining lesion	57.74	090
61514		A	Removal of brain abscess	53.05	090
61516		A	Removal of brain lesion	53.20	090
61518		A	Removal of brain lesion	67.07	090
61519		A	Remove brain lining lesion	70.12	090
61520		A	Removal of brain lesion	77.44	090
61521		A	Removal of brain lesion	77.70	090
61522		A	Removal of brain abscess	50.96	090
61524		A	Removal of brain lesion	57.90	090
61526		A	Removal of brain lesion	67.90	090
61531		A	Implant brain electrodes	37.22	090
61533		A	Insert brain electrodes	36.92	090
61534		A	Removal of brain lesion	27.45	090
61535		A	Remove brain electrodes	19.05	090
61536		A	Removal of brain lesion	55.01	090
61538		A	Removal of brain tissue	61.44	090
61539		A	Removal of brain tissue	56.72	090
61541		A	Incision of brain tissue	50.17	090
61542		A	Removal of brain tissue	50.81	090
61543		A	Removal of brain tissue	40.15	090
61544		A	Remove and treat brain lesion	53.92	090
61545		A	Excision of brain tumor	64.50	090
61546		A	Removal of pituitary gland	60.55	090
61548		A	Removal of pituitary gland	48.35	090
61550		A	Release of skull seams	27.17	090
61552		A	Release of skull seams	35.28	090
61570		A	Remove brain foreign body	42.16	090
61571		A	Incise skull for brain wound	45.80	090
61575		A	Skull base/brainstem surgery	69.78	090
61576		A	Skull base/brainstem surgery	65.69	090
61624		A	Occlusion/embolization cath	37.18	000
61626		A	Occlusion/embolization cath	30.67	000
61680		A	Intracranial vessel surgery	72.65	090
61682		A	Intracranial vessel surgery	83.19	090
61684		A	Intracranial vessel surgery	72.44	090
61686		A	Intracranial vessel surgery	87.58	090
61690		A	Intracranial vessel surgery	65.07	090
61692		A	Intracranial vessel surgery	70.06	090
61700		A	Inner skull vessel surgery	71.51	090
61702		A	Inner skull vessel surgery	81.30	090
61703		A	Clamp neck artery	30.51	090
61705		A	Revise circulation to head	69.57	090
61708		A	Revise circulation to head	61.23	090
61710		A	Revise circulation to head	46.68	090
61711		A	Fusion of skull arteries	73.05	090
61712		A	Skull or spine microsurgery	9.58	ZZZ
61720		A	Incise skull/brain surgery	44.06	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
61735		A	Incise skull/brain surgery	31.53	090
61750		A	Incise skull; brain biopsy	37.48	090
61751		A	Brain biopsy with CAT scan	44.14	090
61760		A	Implant brain electrodes	38.46	090
61770		A	Incise skull for treatment	37.63	090
61790		A	Treat trigeminal nerve	30.00	090
61791		A	Treat trigeminal tract	27.04	090
61793		A	Focus radiation beam	39.83	090
61795		A	Brain surgery using computer	14.13	000
61850		A	Implant neuroelectrodes	29.65	090
61855		A	Implant neuroelectrodes	24.71	090
61860		A	Implant neuroelectrodes	20.78	090
61865		A	Implant neuroelectrodes	40.27	090
61870		A	Implant neuroelectrodes	10.71	090
61875		A	Implant neuroelectrodes	17.06	090
61880		A	Revise/remove neuroelectrode	11.12	090
61885		A	Implant neuroreceiver	4.58	090
61888		A	Revise/remove neuroreceiver	5.74	010
62000		A	Repair of skull fracture	17.95	090
62005		A	Repair of skull fracture	27.72	090
62010		A	Treatment of head injury	40.56	090
62100		A	Repair brain fluid leakage	45.63	090
62121		A	Incise skull repair	40.76	090
62140		A	Repair of skull defect	28.12	090
62141		A	Repair of skull defect	34.38	090
62142		A	Remove skull plate/flap	26.15	090
62143		A	Replace skull plate/flap	22.77	090
62145		A	Repair of skull and brain	32.96	090
62146		A	Repair of skull with graft	28.04	090
62147		A	Repair of skull with graft	33.64	090
62180		A	Establish brain cavity shunt	29.23	090
62190		A	Establish brain cavity shunt	29.12	090
62192		A	Establish brain cavity shunt	28.34	090
62194		A	Replace/irrigate catheter	4.96	010
62200		A	Establish brain cavity shunt	33.34	090
62201		A	Establish brain cavity shunt	22.43	090
62220		A	Establish brain cavity shunt	31.76	090
62223		A	Establish brain cavity shunt	31.93	090
62225		A	Replace/irrigate catheter	10.03	090
62230		A	Replace/revise brain shunt	21.11	090
62256		A	Remove brain cavity shunt	13.29	090
62258		A	Replace brain cavity shunt	30.57	090
62268		A	Drain spinal cord cyst	7.19	000
62269		A	Needle biopsy spinal cord	6.11	000
62270		A	Spinal fluid tap, diagnostic	1.90	000
62272		A	Drain spinal fluid	2.48	000
62273		A	Treat lumbar spine lesion	3.50	000
62274		A	Inject spinal anesthetic	2.68	000

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62275		A	Inject spinal anesthetic	2.56	000
62276		A	Inject spinal anesthetic	3.48	000
62277		A	Inject spinal anesthetic	3.20	000
62278		A	Inject spinal anesthetic	2.71	000
62279		A	Inject spinal anesthetic	2.61	000
62280		A	Treat spinal cord lesion	3.45	010
62281		A	Treat spinal cord lesion	3.74	010
62282		A	Treat spinal canal lesion	4.33	010
62284		A	Injection for myelogram	4.06	000
62287		A	Percutaneous diskectomy	21.64	090
62288		A	Injection into spinal canal	3.06	000
62289		A	Injection into spinal canal	2.95	000
62290		A	Inject for spine disk X-ray	5.69	000
62291		A	Inject for spine disk X-ray	5.04	000
62292		A	Injection into disk lesion	21.53	090
62294		A	Injection into spinal artery	14.57	090
62298		A	Injection into spinal canal	3.37	000
63001		A	Removal of spinal lamina	36.52	090
63003		A	Removal of spinal lamina	35.28	090
63005		A	Removal of spinal lamina	34.01	090
63011		A	Removal of spinal lamina	22.73	090
63012		A	Removal of spinal lamina	34.93	090
63015		A	Removal of spinal lamina	43.24	090
63016		A	Removal of spinal lamina	43.22	090
63017		A	Removal of spinal lamina	42.02	090
63020		A	Neck spine disk surgery	33.83	090
63030		A	Low back disk surgery	30.35	090
63035		A	Added spinal disk surgery	8.04	ZZZ
63040		A	Neck spine disk surgery	44.87	090
63042		A	Low back disk surgery	45.43	090
63045		A	Removal of spinal lamina	43.07	090
63046		A	Removal of spinal lamina	43.23	090
63047		A	Removal of spinal lamina	42.21	090
63048		A	Removal of spinal lamina	9.90	ZZZ
63055		A	Decompress spinal cord	47.97	090
63056		A	Decompress spinal cord	44.15	090
63057		A	Decompress spinal cord	8.92	ZZZ
63064		A	Decompress spinal cord	50.62	090
63066		A	Decompress spinal cord	6.15	ZZZ
63075		A	Neck spine disk surgery	40.17	090
63076		A	Neck spine disk surgery	10.33	ZZZ
63077		A	Spine disk surgery, thorax	41.48	090
63078		A	Spine disk surgery, thorax	6.30	ZZZ
63081		A	Removal of vertebral body	52.17	090
63082		A	Removal of vertebral body	12.59	ZZZ
63085		A	Removal of vertebral body	56.48	090
63086		A	Removal of vertebral body	10.04	ZZZ
63087		A	Removal of vertebral body	60.02	090
63088		A	Removal of vertebral body	12.29	ZZZ
63090		A	Removal of vertebral body	59.65	090
63091		A	Removal of vertebral body	6.17	ZZZ
63170		A	Incise spinal cord tract(s)	39.89	090
63172		A	Drainage of spinal cyst	44.44	090
63173		A	Drainage of spinal cyst	37.65	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
63180		A	Revise spinal cord ligaments	30.26	090
63182		A	Revise spinal cord ligaments	37.39	090
63185		A	Incise spinal column/nerves	31.88	090
63190		A	Incise spinal column/nerves	40.68	090
63191		A	Incise spinal column/nerves	31.47	090
63194		A	Incise spinal column and cord	32.66	090
63195		A	Incise spinal column and cord	32.96	090
63196		A	Incise spinal column and cord	37.95	090
63197		A	Incise spinal column and cord	36.13	090
63198		A	Incise spinal column and cord	41.66	090
63199		A	Incise spinal column and cord	47.74	090
63200		A	Release of spinal cord	31.91	090
63250		A	Revise spinal cord vessels	71.41	090
63251		A	Revise spinal cord vessels	65.70	090
63252		A	Revise spinal cord vessels	72.09	090
63265		A	Excise intraspinal lesion	45.38	090
63266		A	Excise intraspinal lesion	49.16	090
63267		A	Excise intraspinal lesion	43.64	090
63268		A	Excise intraspinal lesion	32.05	090
63270		A	Excise intraspinal lesion	46.09	090
63271		A	Excise intraspinal lesion	55.67	090
63272		A	Excise intraspinal lesion	50.55	090
63273		A	Excise intraspinal lesion	43.04	090
63275		A	Biopsy/excise spinal tumor	54.15	090
63276		A	Biopsy/excise spinal tumor	50.98	090
63277		A	Biopsy/excise spinal tumor	46.86	090
63278		A	Biopsy/excise spinal tumor	46.22	090
63280		A	Biopsy/excise spinal tumor	59.11	090
63281		A	Biopsy/excise spinal tumor	58.37	090
63282		A	Biopsy/excise spinal tumor	52.93	090
63283		A	Biopsy/excise spinal tumor	45.43	090
63285		A	Biopsy/excise spinal tumor	62.85	090
62386		A	Biopsy/excise spinal tumor	67.11	090
63287		A	Biopsy/excise spinal tumor	64.29	090
63290		A	Biopsy/excise spinal tumor	66.44	090
63300		A	Removal of vertebral body	42.03	090
63301		A	Removal of vertebral body	46.77	090
63302		A	Removal of vertebral body	49.75	090
63303		A	Removal of vertebral body	50.15	090
63304		A	Removal of vertebral body	51.86	090
63305		A	Removal of vertebral body	55.35	090
63306		A	Removal of vertebral body	55.38	090
63307		A	Removal of vertebral body	56.69	090
63308		A	Removal of vertebral body	9.97	ZZZ
63600		A	Remove spinal cord lesion	26.05	090
63610		A	Stimulation of spinal cord	17.21	000
63615		A	Remove lesion of spinal cord	28.81	090
63650		A	Implant neuroelectrodes	17.83	090

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63655		A	Implant neuroelectrodes	32.70	090
63657		A	Implant neuroelectrodes	16.37	090
63658		A	Implant neuroelectrodes	28.73	090
63660		A	Revise/remove neuroelectrode	14.70	090
63685		A	Implant neuroreceiver	14.92	090
63688		A	Revise/remove neuroreceiver	12.58	090
63690		A	Analysis of neuroreceiver	1.42	XXX
63691		A	Analysis of neuroreceiver	1.16	XXX
63707		A	Repair spinal fluid leakage	27.11	090
63709		A	Repair spinal fluid leakage	34.23	090
63710		A	Graft repair of spine defect	24.22	090
63740		A	Install spinal shunt	29.08	090
63741		A	Install spinal shunt	21.77	090
63744		A	Revision of spinal shunt	16.39	090
63746		A	Removal of spinal shunt	12.03	090
63750		A	Insert spinal canal catheter	24.89	090
63780		A	Insert spinal canal catheter	8.71	090
64400		A	Injection for nerve block	1.88	010
64402		A	Injection for nerve block	2.16	010
64405		A	Injection for nerve block	2.17	010
64408		A	Injection for nerve block	2.90	010
64410		A	Injection for nerve block	2.63	010
64412		A	Injection for nerve block	2.07	010
64413		A	Injection for nerve block	2.48	010
64415		A	Injection for nerve block	2.03	010
64417		A	Injection for nerve block	2.45	010
64418		A	Injection for nerve block	2.47	010
64420		A	Injection for nerve block	2.19	010
64421		A	Injection for nerve block	3.07	010
64425		A	Injection for nerve block	2.44	010
64430		A	Injection for nerve block	2.63	010
64435		A	Injection for nerve block	2.38	010
64440		A	Injection for nerve block	2.57	010
64441		A	Injection for nerve block	3.28	010
64442		A	Injection for nerve block	3.13	010
64443		A	Injection for nerve block	2.39	ZZZ
64445		A	Injection for nerve block	2.41	010
64450		A	Injection for nerve block	2.21	010
64505		A	Injection for nerve block	2.36	010
64508		A	Injection for nerve block	2.54	010
64510		A	Injection for nerve block	2.50	010
64520		A	Injection for nerve block	2.53	010
64530		A	Injection for nerve block	3.39	010
64550		A	Apply neurostimulator	.65	000
64553		A	Implant neuroelectrodes	3.40	010
64555		A	Implant neuroelectrodes	2.76	010
64560		A	Implant neuroelectrodes	3.99	010
64565		A	Implant neuroelectrodes	2.57	010
64573		A	Implant neuroelectrodes	8.07	090
64575		A	Implant neuroelectrodes	7.73	090
64577		A	Implant neuroelectrodes	7.74	090
64580		A	Implant neuroelectrodes	7.17	090
64585		A	Revise/remove neuroelectrode	3.09	010
64590		A	Implant neuroreceiver	4.49	010

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64595		A	Revise/remove neuroreceiver	2.98	010
64600		A	Injection treatment of nerve	5.29	010
64605		A	Injection treatment of nerve	7.48	010
64610		A	Injection treatment of nerve	15.54	010
64612		A	Destroy nerve, face muscle	3.53	010
64613		A	Destroy nerve, spine muscle	3.53	010
64620		A	Injection treatment of nerve	4.37	090
64622		A	Injection treatment of nerve	5.60	090
64623		A	Injection treatment of nerve	1.98	ZZZ
64630		A	Injection treatment of nerve	5.36	090
64640		A	Injection treatment of nerve	4.32	090
64680		A	Injection treatment of nerve	4.94	090
64702		A	Revise finger/toe nerve	8.85	090
64704		A	Revise hand/foot nerve	10.46	090
64708		A	Revise arm/leg nerve	14.20	090
64712		A	Revision of sciatic nerve	17.94	090
64713		A	Revision of arm nerve(s)	21.25	090
64714		A	Revise low back nerve(s)	17.28	090
64716		A	Revision of cranial nerve	11.25	090
64718		A	Revise ulnar nerve at elbow	13.15	090
64719		A	Revise ulnar nerve at wrist	10.40	090
64721		A	Carpal tunnel surgery	9.59	090
64722		A	Relieve pressure on nerve(s)	12.07	090
64726		A	Release foot/toe nerve	4.83	090
64727		A	Internal nerve revision	6.82	ZZZ
64732		A	Incision of brow nerve	9.10	090
64734		A	Incision of cheek nerve	9.82	090
64736		A	Incision of chin nerve	9.26	090
64738		A	Incision of jaw nerve	11.06	090
64740		A	Incision of tongue nerve	11.04	090
64742		A	Incision of facial nerve	11.37	090
64744		A	Incise nerve, back of head	11.88	090
64746		A	Incise diaphragm nerve	10.08	090
64752		A	Incision of vagus nerve	11.35	090
64755		A	Incision of stomach nerves	25.57	090
64760		A	Incision of vagus nerve	14.46	090
64761		A	Incision of pelvis nerve	11.26	090
64763		A	Incise hip/thigh nerve	12.34	090
64766		A	Incise hip/thigh nerve	16.05	090
64771		A	Sever cranial nerve	14.10	090
64772		A	Incision of spinal nerve	14.69	090
64774		A	Remove skin nerve lesion	8.05	090
64776		A	Remove digit nerve lesion	8.05	090
64778		A	Added digit nerve surgery	6.22	ZZZ
64782		A	Remove limb nerve lesion	10.97	090
64783		A	Added limb nerve surgery	7.42	ZZZ
64784		A	Remove nerve lesion	16.04	090
64786		A	Remove sciatic nerve lesion	29.69	090

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64787		A	Implant nerve end	8.33	ZZZ
64788		A	Remove skin nerve lesion	8.41	090
64790		A	Removal of nerve lesion	19.21	090
64792		A	Removal of nerve lesion	24.95	090
64795		A	Biopsy of nerve	5.75	000
64802		A	Remove sympathetic nerves	14.62	090
64804		A	Remove sympathetic nerves	28.54	090
64809		A	Remove sympathetic nerves	25.15	090
64818		A	Remove sympathetic nerves	19.48	090
64830		A	Microrepair of nerve	5.45	ZZZ
64831		A	Repair of digit nerve	12.84	090
64832		A	Repair additional nerve	7.37	ZZZ
64834		A	Repair of hand or foot nerve	13.92	090
64835		A	Repair of hand or foot nerve	17.44	090
64836		A	Repair of hand or foot nerve	18.32	090
64837		A	Repair additional nerve	11.48	ZZZ
64840		A	Repair of leg nerve	23.44	090
64856		A	Repair/transpose nerve	22.39	090
64857		A	Repair arm/leg nerve	24.41	090
64858		A	Repair sciatic nerve	28.33	090
64859		A	Additional nerve surgery	8.30	ZZZ
64861		A	Repair of arm nerves	32.78	090
64862		A	Repair of low back nerves	41.25	090
64864		A	Repair of facial nerve	20.85	090
64865		A	Repair of facial nerve	28.47	090
64866		A	Fusion of facial/other nerve	27.83	090
64868		A	Fusion of facial/other nerve	25.93	090
64870		A	Fusion of facial/other nerve	30.68	090
64885		A	Nerve graft, head or neck	30.88	090
64886		A	Nerve graft, head or neck	36.82	090
64890		A	Nerve graft, hand or foot	28.50	090
64891		A	Nerve graft, hand or foot	27.26	090
64892		A	Nerve graft, arm or leg	26.44	090
64893		A	Nerve graft, arm or leg	30.54	090
64895		A	Nerve graft, hand or foot	33.86	090
64896		A	Nerve graft, hand or foot	38.74	090
64897		A	Nerve graft, arm or leg	32.24	090
64898		A	Nerve graft, arm or leg	34.94	090
64901		A	Additional nerve graft	21.23	ZZZ
64902		A	Additional nerve graft	24.72	ZZZ
64905		A	Nerve pedicle transfer	23.43	090
64907		A	Nerve pedicle transfer	33.22	090
65091		A	Revise eye	15.18	090
65093		A	Revise eye with implant	16.98	090
65101		A	Removal of eye	15.70	090
65103		A	Remove eye/insert implant	17.27	090
65105		A	Remove eye/attach implant	18.77	090
65110		A	Removal of eye	30.28	090
65112		A	Remove eye, revise socket	28.73	090
65114		A	Remove eye, revise socket	31.24	090
65130		A	Insert ocular implant	16.04	090
65135		A	Insert ocular implant	12.74	090
65140		A	Attach ocular implant	14.06	090
65150		A	Revise ocular implant	17.37	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
65155		A	Reinsert ocular implant	23.03	090
65175		A	Removal of ocular implant	13.83	090
65205		A	Remove foreign body from eye	1.17	000
65210		A	Remove foreign body from eye	1.35	000
65220		A	Remove foreign body from eye	1.28	000
65222		A	Remove foreign body from eye	1.54	000
65235		A	Remove foreign body from eye	13.08	090
65260		A	Remove foreign body from eye	19.53	090
65265		A	Remove foreign body from eye	22.70	090
65270		A	Repair of eye wound	3.11	010
65272		A	Repair of eye wound	5.36	090
65273		A	Repair of eye wound	7.34	090
65275		A	Repair of eye wound	5.86	090
65280		A	Repair of eye wound	16.81	090
65285		A	Repair of eye wound	25.03	090
65286		A	Repair of eye wound	10.23	090
65290		A	Repair of eye socket wound	11.63	090
65400		A	Removal of eye lesion	12.42	090
65410		A	Biopsy of cornea	3.17	000
65420		A	Removal of eye lesion	8.49	090
65426		A	Removal of eye lesion	12.60	090
65430		A	Corneal smear	1.46	000
65435		A	Curette/treat cornea	1.74	000
65436		A	Curette/treat cornea	5.66	090
65450		A	Treatment of corneal lesion	6.53	090
65600		A	Revision of cornea	5.92	090
65710		A	Corneal transplant	31.75	090
65730		A	Corneal transplant	37.68	090
65750		A	Corneal transplant	39.19	090
65755		A	Corneal transplant	40.29	090
65770		A	Revise cornea with implant	31.22	090
65772		A	Correction of astigmatism	10.19	090
65775		A	Correction of astigmatism	15.69	090
65800		A	Drainage of eye	3.74	000
65805		A	Drainage of eye	3.83	000
65810		A	Drainage of eye	10.32	090
65815		A	Drainage of eye	9.50	090
65820		A	Relieve inner eye pressure	17.67	090
65850		A	Incision of eye	24.15	090
65855		A	Laser surgery of eye	15.21	090
65860		A	Incise inner eye adhesions	10.55	090
65865		A	Incise inner eye adhesions	13.33	090
65870		A	Incise inner eye adhesions	12.13	090
65875		A	Incise inner eye adhesions	12.78	090
65880		A	Incise inner eye adhesions	13.94	090
65900		A	Remove eye lesion	19.26	090
65920		A	Remove implant from eye	16.74	090
65930		A	Remove blood clot from eye	15.15	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
66020		A	Injection treatment of eye	4.18	010
66030		A	Injection treatment of eye	1.79	010
66130		A	Remove eye lesion	13.17	090
66150		A	Incision of eye	19.22	090
66155		A	Incision of eye	17.76	090
66160		A	Incision of eye	20.84	090
66165		A	Incision of eye	18.79	090
66170		A	Incision of eye	24.15	090
66180		A	Implant eye shunt	31.99	090
66185		A	Revise eye shunt	18.95	090
66220		A	Repair eye lesion	13.67	090
66225		A	Repair/graft eye lesion	28.11	090
66250		A	Follow-up surgery of eye	13.29	090
66500		A	Incision of iris	8.83	090
66505		A	Incision of iris	7.40	090
66600		A	Remove iris and lesion	18.12	090
66605		A	Removal of iris	24.95	090
66625		A	Removal of iris	14.66	090
66630		A	Removal of iris	14.92	090
66635		A	Removal of iris	15.92	090
66680		A	Repair iris and ciliary body	11.92	090
66682		A	Repair iris and ciliary body	13.59	090
66700		A	Destruction, ciliary body	11.36	090
66710		A	Destruction, ciliary body	12.53	090
66720		A	Destruction, ciliary body	12.00	090
66740		A	Destruction, ciliary body	12.41	090
66761		A	Revision of iris	13.34	090
66762		A	Revision of iris	15.53	090
66770		A	Removal of inner eye lesion	14.01	090
66820		A	Incision, secondary cataract	9.48	090
66821		A	Lasering, secondary cataract	9.95	090
66825		A	Reposition intraocular lens	15.50	090
66830		A	Removal of lens lesion	15.92	090
66840		A	Removal of lens material	18.37	090
66850		A	Removal of lens material	22.23	090
66852		A	Removal of lens material	27.30	090
66920		A	Extraction of lens	20.19	090
66930		A	Extraction of lens	20.84	090
66940		A	Extraction of lens	20.89	090
66983		A	Remove cataract, insert lens	27.23	090
66984		A	Remove cataract, insert lens	28.70	090
66985		A	Insert lens prosthesis	20.71	090
66986		A	Exchange lens prosthesis	24.68	090
67005		A	Partial removal of eye fluid	28.75	090
67010		A	Partial removal of eye fluid	27.40	090
67015		A	Release of eye fluid	13.52	090
67025		A	Replace eye fluid	13.58	090
67028		A	Injection eye drug	6.14	000
67030		A	Incise inner eye strands	14.58	090
67031		A	Laser surgery, eye strands	18.35	090
67036		A	Removal of inner eye fluid	41.22	090
67038		A	Strip retinal membrane	56.18	090
67039		A	Laser treatment of retina	47.11	090
67040		A	Laser treatment of retina	51.28	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
67101		A	Repair, detached retina	20.29	090
67105		A	Repair, detached retina	23.12	090
67107		A	Repair detached retina	35.93	090
67108		A	Repair detached retina	55.08	090
67109		A	Repair detached retina	33.80	090
67110		A	Repair detached retina	26.97	090
67112		A	Re-repair detached retina	33.61	090
67115		A	Release, encircling material	13.12	090
67120		A	Remove eye implant material	13.16	090
67121		A	Remove eye implant material	20.16	090
67141		A	Treatment of retina	14.62	090
67145		A	Treatment of retina	14.94	090
67208		A	Treatment of retinal lesion	17.08	090
67210		A	Treatment of retinal lesion	19.05	090
67218		A	Treatment of retinal lesion	26.81	090
67227		A	Treatment of retinal lesion	16.71	090
67228		A	Treatment of retinal lesion	22.38	090
67250		A	Reinforce eye wall	15.81	090
67255		A	Reinforce/graft eye wall	25.99	090
67311		A	Revise eye muscle	15.78	090
67312		A	Revise two eye muscles	18.41	090
67314		A	Revise eye muscle	18.91	090
67316		A	Revise two eye muscles	21.32	090
67318		A	Revise eye muscle(s)	14.04	090
67320		A	Revise eye muscle(s)	21.42	090
67331		A	Eye surgery follow-up	18.42	090
67332		A	Re-revise eye muscles	20.34	090
67334		A	Revise eye muscle w/suture	14.24	090
67335		A	Eye suture during surgery	10.91	ZZZ
67340		A	Revise eye muscle	17.83	090
67343		A	Release eye tissue	13.19	090
67345		A	Destroy nerve of eye muscle	5.38	010
67350		A	Biopsy eye muscle	5.41	000
67400		A	Explore/biopsy eye socket	20.75	090
67405		A	Explore/drain eye socket	18.07	090
67412		A	Explore/treat eye socket	21.73	090
67413		A	Explore/treat eye socket	18.47	090
67414		A	Explore/decompress eye socket	18.98	090
67415		A	Biopsy of eye	3.90	000
67420		A	Explore/treat eye socket	31.21	090
67430		A	Explore/treat eye socket	24.10	090
67440		A	Explore/drain eye socket	29.52	090
67445		A	Explore/decompress eye socket	25.19	090
67450		A	Explore/biopsy eye socket	28.97	090
67500		A	Inject/treat eye socket	1.58	000
67505		A	Inject/treat eye socket	1.91	000
67515		A	Inject/treat eye socket	1.21	000
67550		A	Insert eye socket implant	20.03	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
67560		A	Revise eye socket implant	18.96	090
67570		A	Decompress optic nerve	20.63	090
67700		A	Drainage of eyelid abscess	1.85	010
67710		A	Incision of eyelid	2.03	010
67715		A	Incision of eyelid fold	2.77	010
67800		A	Remove eyelid lesion	2.36	010
67801		A	Remove eyelid lesions	3.34	010
67805		A	Remove eyelid lesions	3.66	010
67808		A	Remove eyelid lesion(s)	5.85	090
67810		A	Biopsy of eyelid	2.36	000
67820		A	Revise eyelashes	1.29	000
67825		A	Revise eyelashes	2.29	010
67830		A	Revise eyelashes	4.89	010
67835		A	Revise eyelashes	14.33	090
67840		A	Remove eyelid lesion	3.30	010
67850		A	Treat eyelid lesion	2.53	010
67875		A	Closure of eyelid by suture	3.48	000
67880		A	Revision of eyelid	7.72	090
67882		A	Revision of eyelid	11.43	090
67900		A	Repair brow defect	8.55	090
67901		A	Repair eyelid defect	17.37	090
67902		A	Repair eyelid defect	18.24	090
67903		A	Repair eyelid defect	19.13	090
67904		A	Repair eyelid defect	18.57	090
67906		A	Repair eyelid defect	12.49	090
67908		A	Repair eyelid defect	15.52	090
67909		A	Revise eyelid defect	13.33	090
67911		A	Revise eyelid defect	16.79	090
67914		A	Repair eyelid defect	10.69	090
67915		A	Repair eyelid defect	4.46	090
67916		A	Repair eyelid defect	12.01	090
67917		A	Repair eyelid defect	14.31	090
67921		A	Repair eyelid defect	7.34	090
67922		A	Repair eyelid defect	4.28	090
67923		A	Repair eyelid defect	12.96	090
67924		A	Repair eyelid defect	14.01	090
67930		A	Repair eyelid wound	4.97	010
67935		A	Repair eyelid wound	10.16	090
67938		A	Remove eyelid foreign body	1.86	010
67950		A	Revision of eyelid	13.85	090
67961		A	Revision of eyelid	13.78	090
67966		A	Revision of eyelid	17.34	090
67971		A	Reconstruction of eyelid	20.91	090
67973		A	Reconstruction of eyelid	27.05	090
67974		A	Reconstruction of eyelid	27.52	090
67975		A	Reconstruction of eyelid	13.43	090
68020		A	Incise/drain eyelid lining	1.89	010
68040		A	Treatment of eyelid lesions	1.33	000
68100		A	Biopsy of eyelid lining	2.41	000
68110		A	Remove eyelid lining lesion	3.04	010
68115		A	Remove eyelid lining lesion	4.37	010
68130		A	Remove eyelid lining lesion	9.09	090
68135		A	Remove eyelid lining lesion	2.60	010
68200		A	Treat eyelid by injection	1.06	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
68320		A	Revise/graft eyelid lining	13.15	090
68325		A	Revise/graft eyelid lining	17.67	090
68326		A	Revise/graft eyelid lining	15.87	090
68328		A	Revise/graft eyelid lining	20.39	090
68330		A	Revise eyelid lining	11.30	090
68335		A	Revise/graft eyelid lining	18.89	090
68340		A	Separate eyelid adhesions	7.25	090
68360		A	Revise eyelid lining	10.35	090
68362		A	Revise eyelid lining	15.40	090
68400		A	Incise/drain tear gland	2.71	010
68420		A	Incise/drain tear sac	3.35	010
68440		A	Incise tear duct opening	1.70	010
68500		A	Removal of tear gland	18.86	090
68505		A	Partial removal tear gland	19.67	090
68510		A	Biopsy of tear gland	8.60	000
68520		A	Removal of tear sac	16.85	090
68525		A	Biopsy of tear sac	8.37	000
68530		A	Clearance of tear duct	6.66	010
68540		A	Remove tear gland lesion	18.98	090
68550		A	Remove tear gland lesion	24.81	090
68700		A	Repair tear ducts	9.14	090
68705		A	Revise tear duct opening	3.11	010
68720		A	Create tear sac drain	21.07	090
68745		A	Create tear duct drain	15.30	090
68750		A	Create tear duct drain	23.74	090
68760		A	Close tear duct opening	2.66	010
68761		A	Closure of the lacrimal punctum	2.28	010
68770		A	Close tear system fistula	11.17	090
68800		A	Dilate tear duct opening(s)	1.56	010
68820		A	Explore tear duct system	2.08	010
68825		A	Explore tear duct system	3.12	010
68830		A	Reopen tear duct channel	4.17	010
68840		A	Explore/irrigate tear ducts	1.77	010
68850		A	Injection for tear sac X-ray	1.36	000
69000		A	Drain external ear lesion	1.80	010
69005		A	Drain external ear lesion	3.36	010
69020		A	Drain outer ear canal lesion	1.95	010
69100		A	Biopsy of external ear	1.49	000
69105		A	Biopsy of external ear canal	1.73	000
69110		A	Partial removal external ear	6.31	090
69120		A	Removal of external ear	4.87	090
69140		A	Remove ear canal lesion(s)	16.50	090
69145		A	Remove ear canal lesion(s)	5.30	090
69150		A	Extensive ear canal surgery	24.67	090
69155		A	Extensive ear/neck surgery	34.50	090
69200		A	Clear outer ear canal	1.24	000
69205		A	Clear outer ear canal	2.32	010
69210		A	Remove impacted ear wax	.87	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
69220		A	Clean out mastoid cavity	1.39	000
69222		A	Clean out mastoid cavity	2.19	010
69310		A	Rebuild outer ear canal	21.45	090
69320		A	Rebuild outer ear canal	32.82	090
69400		A	Inflate middle ear canal	1.33	000
69401		A	Inflate middle ear canal	.91	000
69405		A	Catheterize middle ear canal	3.15	010
69410		A	Inset middle ear baffle	.98	000
69420		A	Incision of eardrum	2.06	010
69421		A	Incision of eardrum	2.95	010
69424		A	Remove ventilating tube	1.52	000
69433		A	Create eardrum opening	2.94	010
69436		A	Create eardrum opening	4.25	010
69440		A	Exploration of middle ear	16.84	090
69450		A	Eardrum revision	17.12	090
69501		A	Mastoidectomy	20.76	090
69502		A	Mastoidectomy	26.65	090
69505		A	Remove mastoid structures	30.47	090
69511		A	Extensive mastoid surgery	31.76	090
69530		A	Extensive mastoid surgery	36.40	090
69535		A	Remove part of temporal bone	62.63	090
69540		A	Remove ear lesion	2.55	010
69550		A	Remove ear lesion	30.69	090
69552		A	Remove ear lesion	37.34	090
69554		A	Remove ear lesion	51.14	090
69601		A	Mastoid surgery revision	28.23	090
69602		A	Mastoid surgery revision	31.00	090
69603		A	Mastoid surgery revision	32.60	090
69604		A	Mastoid surgery revision	41.66	090
69605		A	Mastoid surgery revision	34.76	090
69610		A	Repair of eardrum	5.48	010
69620		A	Repair of eardrum	17.65	090
69631		A	Repair eardrum structures	26.03	090
69632		A	Rebuild eardrum structures	30.02	090
69633		A	Rebuild eardrum structures	30.06	090
69635		A	Repair eardrum structures	32.59	090
69636		A	Rebuild eardrum structures	36.20	090
69637		A	Rebuild eardrum structures	37.46	090
69641		A	Revise middle ear and mastoid	31.55	090
69642		A	Revise middle ear and mastoid	38.95	090
69643		A	Revise middle ear and mastoid	39.27	090
69644		A	Revise middle ear and mastoid	43.67	090
69645		A	Revise middle ear and mastoid	41.51	090
69646		A	Revise middle ear and mastoid	41.44	090
69650		A	Release middle ear bone	23.32	090
69660		A	Revise middle ear bone	30.09	090
69661		A	Revise middle ear bone	35.51	090
69662		A	Revise middle ear bone	34.81	090
69666		A	Repair middle ear structures	26.91	090
69667		A	Repair middle ear structures	26.52	090
69670		A	Remove mastoid air cells	22.26	090
69676		A	Remove middle ear nerve	18.58	090
69700		A	Close mastoid fistula	16.62	090
69711		A	Remove/repair hearing aid	19.09	090

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
69720		A	Release facial nerve	35.86	090
69725		A	Release facial nerve	35.14	090
69740		A	Repair facial nerve	28.82	090
69745		A	Repair facial nerve	33.51	090
69801		A	Incise inner ear	26.29	090
69802		A	Incise inner ear	24.86	090
69805		A	Explore inner ear	30.72	090
69806		A	Explore inner ear	36.99	090
69820		A	Establish inner ear window	19.95	090
69840		A	Revise inner ear window	19.12	090
69905		A	Remove inner ear	30.82	090
69910		A	Remove inner ear and mastoid	37.96	090
69915		A	Incise inner ear nerve	39.52	090
69930		A	Implant cochlear device	48.97	090
69950		A	Incise inner ear nerve	41.32	090
69955		A	Release facial nerve	44.54	090
69960		A	Release inner ear canal	39.45	090
69970		A	Remove inner ear lesion	44.15	090

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

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
70010	26	A	Contrast X-ray of brain	1.80	XXX
70010		A	Contrast X-ray of brain	6.10	XXX
70010	TC	A	Contrast X-ray of brain	4.30	XXX
70015	26	A	Contrast X-ray of brain	1.80	XXX
70015		A	Contrast X-ray of brain	3.15	XXX
70015	TC	A	Contrast X-ray of brain	1.35	XXX
70030	26	A	X-ray eye for foreign body	.25	XXX
70030		A	X-ray eye for foreign body	.68	XXX
70030	TC	A	X-ray eye for foreign body	.42	XXX
70100	26	A	X-ray exam of jaw	.27	XXX
70100		A	X-ray exam of jaw	.80	XXX
70100	TC	A	X-ray exam of jaw	.53	XXX
70110	26	A	X-ray exam of jaw	.38	XXX
70110		A	X-ray exam of jaw	1.00	XXX
70110	TC	A	X-ray exam of jaw	.62	XXX
70120	26	A	X-ray exam of mastoids	.27	XXX
70120		A	X-ray exam of mastoids	.90	XXX
70120	TC	A	X-ray exam of mastoids	.62	XXX
70130	26	A	X-ray exam of mastoids	.51	XXX
70130		A	X-ray exam of mastoids	1.30	XXX
70130	TC	A	X-ray exam of mastoids	.79	XXX
70134	26	A	X-ray exam of middle ear	.51	XXX
70134		A	X-ray exam of middle ear	1.25	XXX
70134	TC	A	X-ray exam of middle ear	.74	XXX
70140	26	A	X-ray exam of facial bones	.28	XXX
70140		A	X-ray exam of facial bones	.91	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
70140	TC	A	X-ray exam of facial bones	.62	XXX
70150	26	A	X-ray exam of facial bones	.39	XXX
70150		A	X-ray exam of facial bones	1.18	XXX
70150	TC	A	X-ray exam of facial bones	.79	XXX
70160	26	A	X-ray exam of nasal bones	.25	XXX
70160		A	X-ray exam of nasal bones	.78	XXX
70160	TC	A	X-ray exam of nasal bones	.53	XXX
70170	26	A	X-ray exam of tear duct	.45	XXX
70170		A	X-ray exam of tear duct	1.39	XXX
70170	TC	A	X-ray exam of tear duct	.94	XXX
70190	26	A	X-ray exam of eye sockets	.31	XXX
70190		A	X-ray exam of eye sockets	.94	XXX
70190	TC	A	X-ray exam of eye sockets	.62	XXX
70200	26	A	X-ray exam of eye sockets	.42	XXX
70200		A	X-ray exam of eye sockets	1.21	XXX
70200	TC	A	X-ray exam of eye sockets	.79	XXX
70210	26	A	X-ray exam of sinuses	.25	XXX
70210		A	X-ray exam of sinuses	.88	XXX
70210	TC	A	X-ray exam of sinuses	.62	XXX
70220	26	A	X-ray exam of sinuses	.38	XXX
70220		A	X-ray exam of sinuses	1.17	XXX
70220	TC	A	X-ray exam of sinuses	.79	XXX
70240	26	A	X-ray exam pituitary saddle	.28	XXX
70240		A	X-ray exam pituitary saddle	.71	XXX
70240	TC	A	X-ray exam pituitary saddle	.42	XXX
70250	26	A	X-ray exam of skull	.36	XXX
70250		A	X-ray exam of skull	.98	XXX
70250	TC	A	X-ray exam of skull	.62	XXX
70260	26	A	X-ray exam of skull	.51	XXX
70260		A	X-ray exam of skull	1.40	XXX
70260	TC	A	X-ray exam of skull	.89	XXX
70300	26	A	X-ray exam of teeth	.16	XXX
70300		A	X-ray exam of teeth	.41	XXX
70300	TC	A	X-ray exam of teeth	.26	XXX
70310	26	A	X-ray exam of teeth	.24	XXX
70310		A	X-ray exam of teeth	.66	XXX
70310	TC	A	X-ray exam of teeth	.42	XXX
70320	26	A	Full mouth X-ray of teeth	.33	XXX
70320		A	Full mouth X-ray of teeth	1.12	XXX
70320	TC	A	Full mouth X-ray of teeth	.79	XXX
70328	26	A	X-ray exam of jaw joint	.27	XXX
70328		A	X-ray exam of jaw joint	.77	XXX
70328	TC	A	X-ray exam of jaw joint	.50	XXX
70330	26	A	X-ray exam of jaw joints	.36	XXX
70330		A	X-ray exam of jaw joints	1.20	XXX
70330	TC	A	X-ray exam of jaw joints	.83	XXX
70332	26	A	X-ray exam of jaw joint	.83	XXX
70332		A	X-ray exam of jaw joint	2.92	XXX
70332	TC	A	X-ray exam of jaw joint	2.09	XXX
70336	26	A	Magnetic image jaw joint	1.44	XXX
70336		A	Magnetic image jaw joint	12.58	XXX
70336	TC	A	Magnetic image jaw joint	11.14	XXX
70350	26	A	X-ray head for orthodontia	.25	XXX
70350		A	X-ray head for orthodontia	.62	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
70350	TC	A	X-ray head for orthodontia	.36	XXX
70355	26	A	Panoramic X-ray of jaws	.29	XXX
70355		A	Panoramic X-ray of jaws	.87	XXX
70355	TC	A	Panoramic X-ray of jaws	.57	XXX
70360	26	A	X-ray exam of neck	.25	XXX
70360		A	X-ray exam of neck	.68	XXX
70360	TC	A	X-ray exam of neck	.42	XXX
70370	26	A	Throat X-ray and fluoroscopy	.48	XXX
70370		A	Throat X-ray and fluoroscopy	1.77	XXX
70370	TC	A	Throat X-ray and fluoroscopy	1.29	XXX
70371	26	A	Speech evaluation, complex	1.28	XXX
70371		A	Speech evaluation, complex	3.37	XXX
70371	TC	A	Speech evaluation, complex	2.09	XXX
70373	26	A	Contrast X-ray of larynx	.67	XXX
70373		A	Contrast X-ray of larynx	2.44	XXX
70373	TC	A	Contrast X-ray of larynx	1.77	XXX
70380	26	A	X-ray exam of salivary gland	.25	XXX
70380		A	X-ray exam of salivary gland	.93	XXX
70380	TC	A	X-ray exam of salivary gland	.67	XXX
70390	26	A	X-ray exam of salivary duct	.57	XXX
70390		A	X-ray exam of salivary duct	2.34	XXX
70390	TC	A	X-ray exam of salivary duct	1.77	XXX
70450	26	A	CAT scan of head or brain	1.29	XXX
70450		A	CAT scan of head or brain	5.99	XXX
70450	TC	A	CAT scan of head or brain	4.69	XXX
70460	26	A	Contrast CAT scan of head	1.72	XXX
70460		A	Contrast CAT scan of head	7.35	XXX
70460	TC	A	Contrast CAT scan of head	5.62	XXX
70470	26	A	Contrast CAT scans of head	1.93	XXX
70470		A	Contrast CAT scans of head	8.96	XXX
70470	TC	A	Contrast CAT scans of head	7.03	XXX
70480	26	A	CAT scan of skull	1.95	XXX
70480		A	CAT scan of skull	6.64	XXX
70480	TC	A	CAT scan of skull	4.69	XXX
70481	26	A	Contrast CAT scan of skull	2.10	XXX
70481		A	Contrast CAT scan of skull	7.72	XXX
70481	TC	A	Contrast CAT scan of skull	5.62	XXX
70482	26	A	Contrast CAT scans of skull	2.20	XXX
70482		A	Contrast CAT scans of skull	9.23	XXX
70482	TC	A	Contrast CAT scans of skull	7.03	XXX
70486	26	A	CAT scan of face, jaw	1.73	XXX
70486		A	CAT scan of face, jaw	6.43	XXX
70486	TC	A	CAT scan of face, jaw	4.69	XXX
70487	26	A	Contrast CAT scan, face/jaw	1.97	XXX
70487		A	Contrast CAT scan, face/jaw	7.59	XXX
70487	TC	A	Contrast CAT scan, face/jaw	5.62	XXX
70488	26	A	Contrast CAT scans face/jaw	2.16	XXX
70488		A	Contrast CAT scans face/jaw	9.19	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
70488	TC	A	Contrast CAT scans face/jaw	7.03	XXX
70490	26	A	CAT scan of neck tissue	1.95	XXX
70490		A	CAT scan of neck tissue	6.64	XXX
70490	TC	A	CAT scan of neck tissue	4.69	XXX
70491	26	A	Contrast CAT of neck tissue	2.10	XXX
70491		A	Contrast CAT of neck tissue	7.72	XXX
70491	TC	A	Contrast CAT of neck tissue	5.62	XXX
70492	26	A	Contrast CAT of neck tissue	2.20	XXX
70492		A	Contrast CAT of neck tissue	9.23	XXX
70492	TC	A	Contrast CAT of neck tissue	7.03	XXX
70540	26	A	Magnetic image, face, neck (MRI)	2.25	XXX
70540		A	Magnetic image, face, neck (MRI)	13.39	XXX
70540	TC	A	Magnetic image, face, neck (MRI)	11.14	XXX
70551	26	A	Magnetic image, brain (MRI)	2.25	XXX
70551		A	Magnetic image, brain (MRI)	13.39	XXX
70551	TC	A	Magnetic image, brain (MRI)	11.14	XXX
70552	26	A	Magnetic image, brain (MRI)	2.70	XXX
70552		A	Magnetic image, brain (MRI)	16.06	XXX
70552	TC	A	Magnetic image, brain (MRI)	13.36	XXX
70553	26	A	Magnetic image, brain (MRI)	3.60	XXX
70553		A	Magnetic image, brain (MRI)	28.34	XXX
70553	TC	A	Magnetic image, brain (MRI)	24.74	XXX
71010	26	A	Chest X-ray	.26	XXX
71010		A	Chest X-ray	.74	XXX
71010	TC	A	Chest X-ray	.48	XXX
71015	26	A	Chest X-ray	.31	XXX
71015		A	Chest X-ray	.84	XXX
71015	TC	A	Chest X-ray	.53	XXX
71020	26	A	Chest X-ray	.32	XXX
71020		A	Chest X-ray	.95	XXX
71020	TC	A	Chest X-ray	.62	XXX
71021	26	A	Chest X-ray	.40	XXX
71021		A	Chest X-ray	1.14	XXX
71021	TC	A	Chest X-ray	.74	XXX
71022	26	A	Chest X-ray	.46	XXX
71022		A	Chest X-ray	1.20	XXX
71022	TC	A	Chest X-ray	.74	XXX
71023	26	A	Chest X-ray and fluoroscopy	.58	XXX
71023		A	Chest X-ray and fluoroscopy	1.36	XXX
71023	TC	A	Chest X-ray and fluoroscopy	.79	XXX
71030	26	A	Chest X-ray	.46	XXX
71030		A	Chest X-ray	1.25	XXX
71030	TC	A	Chest X-ray	.79	XXX
71034	26	A	Chest X-ray and fluoroscopy	.71	XXX
71034		A	Chest X-ray and fluoroscopy	2.14	XXX
71034	TC	A	Chest X-ray and fluoroscopy	1.44	XXX
71035	26	A	Chest X-ray	.26	XXX
71035		A	Chest X-ray	.79	XXX
71035	TC	A	Chest X-ray	.53	XXX
71036	26	A	X-ray guidance for biopsy	.83	XXX
71036		A	X-ray guidance for biopsy	2.40	XXX
71036	TC	A	X-ray guidance for biopsy	1.57	XXX
71038	26	A	X-ray guidance for biopsy	.83	XXX
71038		A	X-ray guidance for biopsy	2.51	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
71038	TC	A	X-ray guidance for biopsy	1.67	XXX
71040	26	A	Contrast X-ray of bronchi	.89	XXX
71040		A	Contrast X-ray of bronchi	2.35	XXX
71040	TC	A	Contrast X-ray of bronchi	1.46	XXX
71060	26	A	Contrast X-ray of bronchi	1.13	XXX
71060		A	Contrast X-ray of bronchi	3.32	XXX
71060	TC	A	Contrast X-ray of bronchi	2.19	XXX
71090	26	A	X-ray and pacemaker insertion	.83	XXX
71090		A	X-ray and pacemaker insertion	2.51	XXX
71090	TC	A	X-ray and pacemaker insertion	1.67	XXX
71100	26	A	X-ray exam of ribs	.33	XXX
71100		A	X-ray exam of ribs	91	XXX
71100	TC	A	X-ray exam of ribs	.57	XXX
71101	26	A	X-ray exam of ribs, chest	.41	XXX
71101		A	X-ray exam of ribs, chest	1.08	XXX
71101	TC	A	X-ray exam of ribs, chest	.67	XXX
71110	26	A	X-ray exam of ribs	.41	XXX
71110		A	X-ray exam of ribs	1.20	XXX
71110	TC	A	X-ray exam of ribs	.79	XXX
71111	26	A	X-ray exam of ribs, chest	.48	XXX
71111		A	X-ray exam of ribs, chest	1.37	XXX
71111	TC	A	X-ray exam of ribs, chest	.89	XXX
71120	26	A	X-ray exam of breastbone	.29	XXX
71120		A	X-ray exam of breastbone	.95	XXX
71120	TC	A	X-ray exam of breastbone	.65	XXX
71130	26	A	X-ray exam of breastbone	.32	XXX
71130		A	X-ray exam of breastbone	1.02	XXX
71130	TC	A	X-ray exam of breastbone	.70	XXX
71250	26	A	CAT scan of chest	1.76	XXX
71250		A	CAT scan of chest	7.63	XXX
71250	TC	A	CAT scan of chest	5.86	XXX
71260	26	A	Contrast CAT scan of chest	1.88	XXX
71260		A	Contrast CAT scan of chest	8.91	XXX
71260	TC	A	Contrast CAT scan of chest	7.03	XXX
71270	26	A	Contrast CAT scans of chest	2.10	XXX
71270		A	Contrast CAT scans of chest	10.88	XXX
71270	TC	A	Contrast CAT scans of chest	8.78	XXX
71550	26	A	Magnetic image, chest	2.44	XXX
71550		A	Magnetic image, chest	13.58	XXX
71550	TC	A	Magnetic image, chest	11.14	XXX
72010	26	A	X-ray exam of spine	.68	XXX
72010		A	X-ray exam of spine	1.69	XXX
72010	TC	A	X-ray exam of spine	1.02	XXX
72020	26	A	X-ray exam of spine	.23	XXX
72020		A	X-ray exam of spine	.65	XXX
72020	TC	A	X-ray exam of spine	.42	XXX
72040	26	A	X-ray exam of neck spine	.32	XXX
72040		A	X-ray exam of neck spine	.93	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
72040	TC	A	X-ray exam of neck spine	.60	XXX
72050	26	A	X-ray exam of neck spine	.46	XXX
72050		A	X-ray exam of neck spine	1.35	XXX
72050	TC	A	X-ray exam of neck spine	.89	XXX
72052	26	A	X-ray exam of neck spine	.54	XXX
72052		A	X-ray exam of neck spine	1.66	XXX
72052	TC	A	X-ray exam of neck spine	1.12	XXX
72069	26	A	X-ray exam of trunk spine	.32	XXX
72069		A	X-ray exam of trunk spine	.82	XXX
72069	TC	A	X-ray exam of trunk spine	.50	XXX
72070	26	A	X-ray exam of thorax spine	.32	XXX
72070		A	X-ray exam of thorax spine	.98	XXX
72070	TC	A	X-ray exam of thorax spine	.65	XXX
72072	26	A	X-ray exam of thoracic spine	.32	XXX
72072		A	X-ray exam of thoracic spine	1.06	XXX
72072	TC	A	X-ray exam of thoracic spine	.74	XXX
72074	26	A	X-ray exam of thoracic spine	.32	XXX
72074		A	X-ray exam of thoracic spine	1.23	XXX
72074	TC	A	X-ray exam of thoracic spine	.91	XXX
72080	26	A	X-ray exam of trunk spine	.32	XXX
72080		A	X-ray exam of trunk spine	1.00	XXX
72080	TC	A	X-ray exam of trunk spine	.67	XXX
72090	26	A	X-ray exam of trunk spine	.42	XXX
72090		A	X-ray exam of trunk spine	1.09	XXX
72090	TC	A	X-ray exam of trunk spine	.67	XXX
72100	26	A	X-ray exam of lower spine	.32	XXX
72100		A	X-ray exam of lower spine	1.00	XXX
72100	TC	A	X-ray exam of lower spine	.67	XXX
72110	26	A	X-ray exam of lower spine	.46	XXX
72110		A	X-ray exam of lower spine	1.37	XXX
72110	TC	A	X-ray exam of lower spine	.91	XXX
72114	26	A	X-ray exam of lower spine	.54	XXX
72114		A	X-ray exam of lower spine	1.71	XXX
72114	TC	A	X-ray exam of lower spine	1.17	XXX
72120	26	A	X-ray exam of lower spine	.32	XXX
72120		A	X-ray exam of lower spine	1.21	XXX
72120	TC	A	X-ray exam of lower spine	.89	XXX
72125	26	A	CAT scan of neck spine	1.76	XXX
72125		A	CAT scan of neck spine	7.63	XXX
72125	TC	A	CAT scan of neck spine	5.86	XXX
72126	26	A	Contrast CAT scan of neck	1.84	XXX
72126		A	Contrast CAT scan of neck	8.87	XXX
72126	TC	A	Contrast CAT scan of neck	7.03	XXX
72127	26	A	Contrast CAT scans of neck	1.93	XXX
72127		A	Contrast CAT scans of neck	10.71	XXX
72127	TC	A	Contrast CAT scans of neck	8.78	XXX
72128	26	A	CAT scan of thorax spine	1.76	XXX
72128		A	CAT scan of thorax spine	7.63	XXX
72128	TC	A	CAT scan of thorax spine	5.86	XXX
72129	26	A	Contrast CAT scan of thorax	1.84	XXX
72129		A	Contrast CAT scan of thorax	8.87	XXX
72129	TC	A	Contrast CAT scan of thorax	7.03	XXX
72130	26	A	Contrast CAT scans of thorax	1.93	XXX
72130		A	Contrast CAT scans of thorax	10.71	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
72130	TC	A	Contrast CAT scans of thorax	8.78	XXX
72131	26	A	CAT scan of lower spine	1.76	XXX
72131		A	CAT scan of lower spine	7.63	XXX
72131	TC	A	CAT scan of lower spine	5.86	XXX
72132	26	A	Contrast CAT of lower spine	1.84	XXX
72132		A	Contrast CAT of lower spine	8.87	XXX
72132	TC	A	Contrast CAT of lower spine	7.03	XXX
72133	26	A	Contrast CAT scans, low spine	1.93	XXX
72133		A	Contrast CAT scans, low spine	10.71	XXX
72133	TC	A	Contrast CAT scans, low spine	8.78	XXX
72141	26	A	Magnetic image, neck spine	2.44	XXX
72141		A	Magnetic image, neck spine	13.58	XXX
72141	TC	A	Magnetic image, neck spine	11.14	XXX
72142	26	A	Magnetic image, neck spine	2.92	XXX
72142		A	Magnetic image, neck spine	16.28	XXX
72142	TC	A	Magnetic image, neck spine	13.36	XXX
72146	26	A	Magnetic image, chest spine	2.44	XXX
72146		A	Magnetic image, chest spine	14.81	XXX
72146	TC	A	Magnetic image, chest spine	12.37	XXX
72147	26	A	Magnetic image, chest spine	2.92	XXX
72147		A	Magnetic image, chest spine	16.28	XXX
72147	TC	A	Magnetic image, chest spine	13.36	XXX
72148	26	A	Magnetic image, lumbar spine	2.25	XXX
72148		A	Magnetic image, lumbar spine	14.62	XXX
72148	TC	A	Magnetic image, lumbar spine	12.37	XXX
72149	26	A	Magnetic image, lumbar spine	2.70	XXX
72149		A	Magnetic image, lumbar spine	16.06	XXX
72149	TC	A	Magnetic image, lumbar spine	13.36	XXX
72156	26	A	Magnetic image, spine (MRI)	3.90	XXX
72156		A	Magnetic image, spine (MRI)	28.64	XXX
72156	TC	A	Magnetic image, spine (MRI)	24.74	XXX
72157	26	A	Magnetic image, spine (MRI)	3.90	XXX
72157		A	Magnetic image, spine (MRI)	28.64	XXX
72157	TC	A	Magnetic image, spine (MRI)	24.74	XXX
72158	26	A	Magnetic image, spine (MRI)	3.60	XXX
72158		A	Magnetic image, spine (MRI)	28.34	XXX
72158	TC	A	Magnetic image, spine (MRI)	24.74	XXX
72170	26	A	X-ray exam of pelvis	.25	XXX
72170		A	X-ray exam of pelvis	.77	XXX
72170	TC	A	X-ray exam of pelvis	.53	XXX
72190	26	A	X-ray exam of pelvis	.31	XXX
72190		A	X-ray exam of pelvis	.99	XXX
72190	TC	A	X-ray exam of pelvis	.67	XXX
72192	26	A	CAT scan of pelvis	1.65	XXX
72192		A	CAT scan of pelvis	7.51	XXX
72192	TC	A	CAT scan of pelvis	5.86	XXX
72193	26	A	Contrast CAT scan of pelvis	1.76	XXX
72193		A	Contrast CAT scan of pelvis	8.56	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
72193	TC	A	Contrast CAT scan of pelvis	6.80	XXX
72194	26	A	Contrast CAT scans of pelvis	1.84	XXX
72194		A	Contrast CAT scans of pelvis	10.28	XXX
72194	TC	A	Contrast CAT scans of pelvis	8.44	XXX
72196	26	A	Magnetic image, pelvis	2.44	XXX
72196		A	Magnetic image, pelvis	13.58	XXX
72196	TC	A	Magnetic image, pelvis	11.14	XXX
72200	26	A	X-ray exam sacroiliac joints	.25	XXX
72200		A	X-ray exam sacroiliac joints	.78	XXX
72200	TC	A	X-ray exam sacroiliac joints	.53	XXX
72202	26	A	X-ray exam sacroiliac joints	.28	XXX
72202		A	X-ray exam sacroiliac joints	.91	XXX
72202	TC	A	X-ray exam sacroiliac joints	.62	XXX
72220	26	A	X-ray exam of tailbone	.25	XXX
72220		A	X-ray exam of tailbone	.83	XXX
72220	TC	A	X-ray exam of tailbone	.57	XXX
72240	26	A	Contrast X-ray of neck spine	1.38	XXX
72240		A	Contrast X-ray of neck spine	6.09	XXX
72240	TC	A	Contrast X-ray of neck spine	4.71	XXX
72255	26	A	Contrast X-ray thorax spine	1.38	XXX
72255		A	Contrast X-ray thorax spine	5.68	XXX
72255	TC	A	Contrast X-ray thorax spine	4.30	XXX
72265	26	A	Contrast X-ray lower spine	1.26	XXX
72265		A	Contrast X-ray lower spine	5.30	XXX
72265	TC	A	Contrast X-ray lower spine	4.04	XXX
72270	26	A	Contrast X-ray of spine	2.02	XXX
72270		A	Contrast X-ray of spine	8.07	XXX
72270	TC	A	Contrast X-ray of spine	6.05	XXX
72285	26	A	X-ray of neck spine disk	1.26	XXX
72285		A	X-ray of neck spine disk	9.60	XXX
72285	TC	A	X-ray of neck spine disk	8.34	XXX
72295	26	A	X-ray of lower spine disk	1.26	XXX
72295		A	X-ray of lower spine disk	9.07	XXX
72295	TC	A	X-ray of lower spine disk	7.81	XXX
73000	26	A	X-ray exam of collarbone	.24	XXX
73000		A	X-ray exam of collarbone	.76	XXX
73000	TC	A	X-ray exam of collarbone	.53	XXX
73010	26	A	X-ray exam of shoulder blade	.25	XXX
73010		A	X-ray exam of shoulder blade	.78	XXX
73010	TC	A	X-ray exam of shoulder blade	.53	XXX
73020	26	A	X-ray exam of shoulder	.23	XXX
73020		A	X-ray exam of shoulder	.70	XXX
73020	TC	A	X-ray exam of shoulder	.48	XXX
73030	26	A	X-ray exam of shoulder	.26	XXX
73030		A	X-ray exam of shoulder	.84	XXX
73030	TC	A	X-ray exam of shoulder	.57	XXX
73040	26	A	Contrast X-ray of shoulder	.83	XXX
73040		A	Contrast X-ray of shoulder	2.92	XXX
73040	TC	A	Contrast X-ray of shoulder	2.09	XXX
73050	26	A	X-ray exam of shoulders	.29	XXX
73050		A	X-ray exam of shoulders	.97	XXX
73050	TC	A	X-ray exam of shoulders	.67	XXX
73060	26	A	X-ray exam of humerus	.25	XXX
73060		A	X-ray exam of humerus	.83	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
73060	TC	A	X-ray exam of humerus	.57	XXX
73070	26	A	X-ray exam of elbow	.23	XXX
73070		A	X-ray exam of elbow	.75	XXX
73070	TC	A	X-ray exam of elbow	.53	XXX
73080	26	A	X-ray exam of elbow	.25	XXX
73080		A	X-ray exam of elbow	.83	XXX
73080	TC	A	X-ray exam of elbow	.57	XXX
73085	26	A	Contrast X-ray of elbow	.83	XXX
73085		A	Contrast X-ray of elbow	2.92	XXX
73085	TC	A	Contrast X-ray of elbow	2.09	XXX
73090	26	A	X-ray exam of forearm	.24	XXX
73090		A	X-ray exam of forearm	.76	XXX
73090	TC	A	X-ray exam of forearm	.53	XXX
73092	26	A	X-ray exam of arm, infant	.24	XXX
73092		A	X-ray exam of arm, infant	.73	XXX
73092	TC	A	X-ray exam of arm, infant	.50	XXX
73100	26	A	X-ray exam of wrist	.24	XXX
73100		A	X-ray exam of wrist	.73	XXX
73100	TC	A	X-ray exam of wrist	.50	XXX
73110	26	A	X-ray exam of wrist	.25	XXX
73110		A	X-ray exam of wrist	.79	XXX
73110	TC	A	X-ray exam of wrist	.54	XXX
73115	26	A	Contrast X-ray of wrist	.83	XXX
73115		A	Contrast X-ray of wrist	2.40	XXX
73115	TC	A	Contrast X-ray of wrist	1.57	XXX
73120	26	A	X-ray exam of hand	.24	XXX
73120		A	X-ray exam of hand	.73	XXX
73120	TC	A	X-ray exam of hand	.50	XXX
73130	26	A	X-ray exam of hand	.25	XXX
73130		A	X-ray exam of hand	.79	XXX
73130	TC	A	X-ray exam of hand	.54	XXX
73140	26	A	X-ray exam of finger(s)	.20	XXX
73140		A	X-ray exam of finger(s)	.62	XXX
73140	TC	A	X-ray exam of finger(s)	.42	XXX
73200	26	A	CAT scan of arm	1.65	XXX
73200		A	CAT scan of arm	6.57	XXX
73200	TC	A	CAT scan of arm	4.92	XXX
73201	26	A	Contrast CAT scan of arm	1.76	XXX
73201		A	Contrast CAT scan of arm	7.63	XXX
73201	TC	A	Contrast CAT scan of arm	5.86	XXX
73202	26	A	Contrast CAT scans of arm	1.84	XXX
73202		A	Contrast CAT scans of arm	9.23	XXX
73202	TC	A	Contrast CAT scans of arm	7.38	XXX
73220	26	A	Magnetic image, arm, hand	2.25	XXX
73220		A	Magnetic image, arm, hand	13.39	XXX
73220	TC	A	Magnetic image, arm, hand	11.14	XXX
73221	26	A	Magnetic image, joint of arm	1.44	XXX
73221		A	Magnetic image, joint of arm	12.58	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
73221	TC	A	Magnetic image, joint of arm	11.14	XXX
73500	26	A	X-ray exam of hip	.25	XXX
73500		A	X-ray exam of hip	.73	XXX
73500	TC	A	X-ray exam of hip	.48	XXX
73510	26	A	X-ray exam of hip	.31	XXX
73510		A	X-ray exam of hip	.89	XXX
73510	TC	A	X-ray exam of hip	.57	XXX
73520	26	A	X-ray exam of hips	.39	XXX
73520		A	X-ray exam of hips	1.06	XXX
73520	TC	A	X-ray exam of hips	.67	XXX
73525	26	A	Contrast X-ray of hip	.83	XXX
73525		A	Contrast X-ray of hip	2.92	XXX
73525	TC	A	Contrast X-ray of hip	2.09	XXX
73530	26	A	X-ray exam of hip	.43	XXX
73530		A	X-ray exam of hip	.96	XXX
73530	TC	A	X-ray exam of hip	.53	XXX
73540	26	A	X-ray exam of pelvis and hips	.30	XXX
73540		A	X-ray exam of pelvis and hips	.88	XXX
73540	TC	A	X-ray exam of pelvis and hips	.57	XXX
73550	26	A	X-ray exam of thigh	.25	XXX
73550		A	X-ray exam of thigh	.83	XXX
73550	TC	A	X-ray exam of thigh	.57	XXX
73560	26	A	X-ray exam of knee	.25	XXX
73560		A	X-ray exam of knee	.77	XXX
73560	TC	A	X-ray exam of knee	.53	XXX
73562	26	A	X-ray exam of knee	.27	XXX
73562		A	X-ray exam of knee	.85	XXX
73562	TC	A	X-ray exam of knee	.57	XXX
73564	26	A	X-ray exam of knee	.33	XXX
73564		A	X-ray exam of knee	.95	XXX
73564	TC	A	X-ray exam of knee	.62	XXX
73565	26	A	X-ray exam of knee	.25	XXX
73565		A	X-ray exam of knee	.74	XXX
73565	TC	A	X-ray exam of knee	.50	XXX
73580	26	A	Contrast X-ray of knee joint	.83	XXX
73580		A	Contrast X-ray of knee joint	3.45	XXX
73580	TC	A	Contrast X-ray of knee joint	2.61	XXX
73590	26	A	X-ray exam of lower leg	.25	XXX
73590		A	X-ray exam of lower leg	.77	XXX
73590	TC	A	X-ray exam of lower leg	.53	XXX
73592	26	A	X-ray exam of leg, infant	.24	XXX
73592		A	X-ray exam of leg, infant	.73	XXX
73592	TC	A	X-ray exam of leg, infant	.50	XXX
73600	26	A	X-ray exam of ankle	.24	XXX
73600		A	X-ray exam of ankle	.73	XXX
73600	TC	A	X-ray exam of ankle	.50	XXX
73610	26	A	X-ray exam of ankle	.25	XXX
73610		A	X-ray exam of ankle	.79	XXX
73610	TC	A	X-ray exam of ankle	.54	XXX
73615	26	A	Contrast X-ray of ankle	.83	XXX
73615		A	Contrast X-ray of ankle	2.92	XXX
73615	TC	A	Contrast X-ray of ankle	2.09	XXX
73620	26	A	X-ray exam of foot	.24	XXX
73620		A	X-ray exam of foot	.73	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
73620	TC	A	X-ray exam of foot	.50	XXX
73630	26	A	X-ray exam of foot	.25	XXX
73630		A	X-ray exam of foot	.79	XXX
73630	TC	A	X-ray exam of foot	.54	XXX
73650	26	A	X-ray exam of heel	.24	XXX
73650		A	X-ray exam of heel	.71	XXX
73650	TC	A	X-ray exam of heel	.48	XXX
73660	26	A	X-ray exam of toe(s)	.20	XXX
73660		A	X-ray exam of toe(s)	.62	XXX
73660	TC	A	X-ray exam of toe(s)	.42	XXX
73700	26	A	CAT scan of leg	1.65	XXX
73700		A	CAT scan of leg	6.57	XXX
73700	TC	A	CAT scan of leg	4.92	XXX
73701	26	A	Contrast CAT scan of leg	1.76	XXX
73701		A	Contrast CAT scan of leg	7.63	XXX
73701	TC	A	Contrast CAT scan of leg	5.86	XXX
73702	26	A	Contrast CAT scans of leg	1.84	XXX
73702		A	Contrast CAT scans of leg	9.23	XXX
73702	TC	A	Contrast CAT scans of leg	7.38	XXX
73720	26	A	Magnetic image, leg, foot	2.25	XXX
73720		A	Magnetic image, leg, foot	13.39	XXX
73720	TC	A	Magnetic image, leg, foot	11.14	XXX
73721	26	A	Magnetic image, joint of leg	1.44	XXX
73721		A	Magnetic image, joint of leg	12.58	XXX
73721	TC	A	Magnetic image, joint of leg	11.14	XXX
74000	26	A	X-ray exam of abdomen	.26	XXX
74000		A	X-ray exam of abdomen	.79	XXX
74000	TC	A	X-ray exam of abdomen	.53	XXX
74010	26	A	X-ray exam of abdomen	.35	XXX
74010		A	X-ray exam of abdomen	.93	XXX
74010	TC	A	X-ray exam of abdomen	.57	XXX
74020	26	A	X-ray exam of abdomen	.41	XXX
74020		A	X-ray exam of abdomen	1.03	XXX
74020	TC	A	X-ray exam of abdomen	.62	XXX
74022	26	A	X-ray exam series, abdomen	.48	XXX
74022		A	X-ray exam series, abdomen	1.22	XXX
74022	TC	A	X-ray exam series, abdomen	.74	XXX
74150	26	A	CAT scan of abdomen	1.80	XXX
74150		A	CAT scan of abdomen	7.42	XXX
74150	TC	A	CAT scan of abdomen	5.62	XXX
74160	26	A	Contrast CAT scan of abdomen	1.93	XXX
74160		A	Contrast CAT scan of abdomen	8.73	XXX
74160	TC	A	Contrast CAT scan of abdomen	6.80	XXX
74170	26	A	Contrast CAT scans, abdomen	2.13	XXX
74170		A	Contrast CAT scans, abdomen	10.57	XXX
74170	TC	A	Contrast CAT scans, abdomen	8.44	XXX
74181	26	A	Magnetic image, abdomen (MRI)	2.44	XXX
74181		A	Magnetic image, abdomen (MRI)	13.58	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
74181	TC	A	Magnetic image, abdomen (MRI)	11.14	XXX
74210	26	A	Contrast X-ray exam of throat	.53	XXX
74210		A	Contrast X-ray exam of throat	1.70	XXX
74210	TC	A	Contrast X-ray exam of throat	1.17	XXX
74220	26	A	Contrast X-ray exam, esophagus	.71	XXX
74220		A	Contrast X-ray exam, esophagus	1.87	XXX
74220	TC	A	Contrast X-ray exam, esophagus	1.17	XXX
74230	26	A	Cinema X-ray throat/esophagus	.82	XXX
74230		A	Cinema X-ray throat/esophagus	2.12	XXX
74230	TC	A	Cinema X-ray throat/esophagus	1.29	XXX
74235	26	A	Remove esophagus obstruction	1.80	XXX
74235		A	Remove esophagus obstruction	4.42	XXX
74235	TC	A	Remove esophagus obstruction	2.61	XXX
74240	26	A	X-ray exam upper GI tract	1.06	XXX
74240		A	X-ray exam upper GI tract	2.51	XXX
74240	TC	A	X-ray exam upper GI tract	1.46	XXX
74241	26	A	X-ray exam upper GI tract	1.06	XXX
74241		A	X-ray exam upper GI tract	2.54	XXX
74241	TC	A	X-ray exam upper GI tract	1.48	XXX
74245	26	A	X-ray exam upper GI tract	1.38	XXX
74245		A	X-ray exam upper GI tract	3.76	XXX
74245	TC	A	X-ray exam upper GI tract	2.37	XXX
74246	26	A	Contrast X-ray upper GI tract	1.06	XXX
74246		A	Contrast X-ray upper GI tract	2.70	XXX
74246	TC	A	Contrast X-ray upper GI tract	1.64	XXX
74247	26	A	Contrast X-ray upper GI tract	1.06	XXX
74247		A	Contrast X-ray upper GI tract	2.73	XXX
74247	TC	A	Contrast X-ray upper GI tract	1.67	XXX
74249	26	A	Contrast X-ray upper GI tract	1.38	XXX
74249		A	Contrast X-ray upper GI tract	3.94	XXX
74249	TC	A	Contrast X-ray upper GI tract	2.56	XXX
74250	26	A	X-ray exam of small bowel	.72	XXX
74250		A	X-ray exam of small bowel	2.01	XXX
74250	TC	A	X-ray exam of small bowel	1.29	XXX
74260	26	A	X-ray exam of small bowel	.77	XXX
74260		A	X-ray exam of small bowel	2.25	XXX
74260	TC	A	X-ray exam of small bowel	1.48	XXX
74270	26	A	Contrast X-ray exam of colon	1.06	XXX
74270		A	Contrast X-ray exam of colon	2.75	XXX
74270	TC	A	Contrast X-ray exam of colon	1.69	XXX
74280	26	A	Contrast X-ray exam of colon	1.51	XXX
74280		A	Contrast X-ray exam of colon	3.73	XXX
74280	TC	A	Contrast X-ray exam of colon	2.22	XXX
74283	26	A	Contrast X-ray exam of colon	3.07	XXX
74283		A	Contrast X-ray exam of colon	5.61	XXX
74283	TC	A	Contrast X-ray exam of colon	2.55	XXX
74290	26	A	Contrast X-ray, gallbladder	.48	XXX
74290		A	Contrast X-ray, gallbladder	1.22	XXX
74290	TC	A	Contrast X-ray, gallbladder	.74	XXX
74291	26	A	Contrast X-rays, gallbladder	.29	XXX
74291		A	Contrast X-rays, gallbladder	.72	XXX
74291	TC	A	Contrast X-rays, gallbladder	.42	XXX
74300	26	A	X-ray bile ducts, pancreas	.54	XXX
74301	26	A	Additional X-rays at surgery	.31	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
74305	26	A	X-ray bile ducts, pancreas	.64	XXX
74305		A	X-ray bile ducts, pancreas	1.42	XXX
74305	TC	A	X-ray bile ducts, pancreas	.79	XXX
74320	26	A	Contrast X-ray of bile ducts	.83	XXX
74320		A	Contrast X-ray of bile ducts	3.96	XXX
74320	TC	A	Contrast X-ray of bile ducts	3.12	XXX
74327	26	A	X-ray for bile stone removal	1.07	XXX
74327		A	X-ray for bile stone removal	2.82	XXX
74327	TC	A	X-ray for bile stone removal	1.75	XXX
74328	26	A	X-ray for bile duct endoscopy	1.07	XXX
74328		A	X-ray for bile duct endoscopy	4.19	XXX
74328	TC	A	X-ray for bile duct endoscopy	3.12	XXX
74329	26	A	X-ray for pancreas endoscopy	1.07	XXX
74329		A	X-ray for pancreas endoscopy	4.19	XXX
74329	TC	A	X-ray for pancreas endoscopy	3.12	XXX
74330	26	A	X-ray, bile/pancreas endoscopy	1.07	XXX
74330		A	X-ray, bile/pancreas endoscopy	4.19	XXX
74330	TC	A	X-ray, bile/pancreas endoscopy	3.12	XXX
74340	26	A	X-ray guide for GI tube	.83	XXX
74340		A	X-ray guide for GI tube	3.45	XXX
74340	TC	A	X-ray guide for GI tube	2.61	XXX
74350	26	A	X-ray guide, stomach tube	1.16	XXX
74350		A	X-ray guide, stomach tube	4.28	XXX
74350	TC	A	X-ray guide, stomach tube	3.12	XXX
74355	26	A	X-ray guide, intestinal tube	1.16	XXX
74355		A	X-ray guide, intestinal tube	3.77	XXX
74355	TC	A	X-ray guide, intestinal tube	2.61	XXX
74360	26	A	X-ray guide, GI dilation	.83	XXX
74360		A	X-ray guide, GI dilation	3.96	XXX
74360	TC	A	X-ray guide, GI dilation	3.12	XXX
74363	26	A	X-ray, bile duct dilatation	1.34	XXX
74400	26	A	Contrast X-ray urinary tract	.75	XXX
74400		A	Contrast X-ray urinary tract	2.42	XXX
74400	TC	A	Contrast X-ray urinary tract	1.67	XXX
74405	26	A	Contrast X-ray urinary tract	.75	XXX
74405		A	Contrast X-ray urinary tract	2.73	XXX
74405	TC	A	Contrast X-ray urinary tract	1.98	XXX
74410	26	A	Contrast X-ray urinary tract	.75	XXX
74410		A	Contrast X-ray urinary tract	2.68	XXX
74410	TC	A	Contrast X-ray urinary tract	1.93	XXX
74415	26	A	Contrast X-ray urinary tract	.75	XXX
74415		A	Contrast X-ray urinary tract	2.85	XXX
74415	TC	A	Contrast X-ray urinary tract	2.11	XXX
74420	26	A	Contrast X-ray urinary tract	.53	XXX
74420		A	Contrast X-ray urinary tract	3.14	XXX
74420	TC	A	Contrast X-ray urinary tract	2.61	XXX
74425	26	A	Contrast X-ray urinary tract	.53	XXX
74425		A	Contrast X-ray urinary tract	1.82	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
74425	TC	A	Contrast X-ray urinary tract	1.29	XXX
74430	26	A	Contrast X-ray of bladder	.48	XXX
74430		A	Contrast X-ray of bladder	1.52	XXX
74430	TC	A	Contrast X-ray of bladder	1.04	XXX
74440	26	A	X-ray exam male genital tract	.57	XXX
74440		A	X-ray exam male genital tract	1.69	XXX
74440	TC	A	X-ray exam male genital tract	1.12	XXX
74445	26	A	X-ray exam of penis	1.73	XXX
74445		A	X-ray exam of penis	2.85	XXX
74445	TC	A	X-ray exam of penis	1.12	XXX
74450	26	A	X-ray exam urethra/bladder	.49	XXX
74450		A	X-ray exam urethra/bladder	1.95	XXX
74450	TC	A	X-ray exam urethra/bladder	1.46	XXX
74455	26	A	X-ray exam urethra/bladder	.49	XXX
74455		A	X-ray exam urethra/bladder	2.06	XXX
74455	TC	A	X-ray exam urethra/bladder	1.57	XXX
74470	26	A	X-ray exam of kidney lesion	.83	XXX
74470		A	X-ray exam of kidney lesion	2.08	XXX
74470	TC	A	X-ray exam of kidney lesion	1.24	XXX
74475	26	A	X-ray control catheter insert	.83	XXX
74475		A	X-ray control catheter insert	4.87	XXX
74475	TC	A	X-ray control catheter insert	4.04	XXX
74480	26	A	X-ray control catheter insert	.83	XXX
74480		A	X-ray control catheter insert	4.87	XXX
74480	TC	A	X-ray control catheter insert	4.04	XXX
74485	26	A	X-ray guide, GU dilation	.83	XXX
74485		A	X-ray guide, GU dilation	3.96	XXX
74485	TC	A	X-ray guide, GU dilation	3.12	XXX
74710	26	A	X-ray measurement of pelvis	.51	XXX
74710		A	X-ray measurement of pelvis	1.55	XXX
74710	TC	A	X-ray measurement of pelvis	1.04	XXX
74740	26	A	X-ray female genital tract	.57	XXX
74740		A	X-ray female genital tract	1.86	XXX
74740	TC	A	X-ray female genital tract	1.29	XXX
74742	26	A	X-ray fallopian tube	.90	XXX
74742		A	X-ray fallopian tube	4.03	XXX
74742	TC	A	X-ray fallopian tube	3.12	XXX
74775	26	A	X-ray exam of perineum	.95	XXX
74775		A	X-ray exam of perineum	2.41	XXX
74775	TC	A	X-ray exam of perineum	1.46	XXX
75500	26	A	Cinema X-ray heart vessels	1.73	XXX
75500		A	Cinema X-ray heart vessels	13.21	XXX
75500	TC	A	Cinema X-ray heart vessels	11.47	XXX
75505	26	A	X-ray exam of heart vessels	1.73	XXX
75505		A	X-ray exam of heart vessels	13.21	XXX
75505	TC	A	X-ray exam of heart vessels	11.47	XXX
75507	26	A	X-ray exam of heart vessels	1.99	XXX
75507		A	X-ray exam of heart vessels	13.46	XXX
75507	TC	A	X-ray exam of heart vessels	11.47	XXX
75519	26	A	Heart X-ray/catheterization	1.28	XXX
75519		A	Heart X-ray/catheterization	12.76	XXX
75519	TC	A	Heart X-ray/catheterization	11.47	XXX
75523	26	A	Heart X-ray/catheterization	1.28	XXX
75523		A	Heart X-ray/catheterization	12.76	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
75523	TC	A	Heart X-ray/catheterization	11.47	XXX
75527	26	A	Heart X-ray/catheterization	2.28	XXX
75527		A	Heart X-ray/catheterization	13.76	XXX
75527	TC	A	Heart X-ray/catheterization	11.47	XXX
75552	26	A	Magnetic image, myocardium	2.44	XXX
75552		A	Magnetic image, myocardium	13.58	XXX
75552	TC	A	Magnetic image, myocardium	11.14	XXX
75600	26	A	Contrast X-ray exam of aorta	.75	XXX
75600		A	Contrast X-ray exam of aorta	13.26	XXX
75600	TC	A	Contrast X-ray exam of aorta	12.52	XXX
75605	26	A	Contrast X-ray exam of aorta	1.73	XXX
75605		A	Contrast X-ray exam of aorta	14.25	XXX
75605	TC	A	Contrast X-ray exam of aorta	12.52	XXX
75625	26	A	Contrast X-ray exam of aorta	1.73	XXX
75625		A	Contrast X-ray exam of aorta	14.25	XXX
75625	TC	A	Contrast X-ray exam of aorta	12.52	XXX
75630	26	A	X-ray aorta, leg arteries	1.99	XXX
75630		A	X-ray aorta, leg arteries	15.04	XXX
75630	TC	A	X-ray aorta, leg arteries	13.05	XXX
75650	26	A	Artery X-rays, head and neck	2.26	XXX
75650		A	Artery X-rays, head and neck	14.78	XXX
75650	TC	A	Artery X-rays, head and neck	12.52	XXX
75658	26	A	X-ray exam of arm arteries	1.99	XXX
75658		A	X-ray exam of arm arteries	14.51	XXX
75658	TC	A	X-ray exam of arm arteries	12.52	XXX
75660	26	A	Artery X-rays, head and neck	1.99	XXX
75660		A	Artery X-rays, head and neck	14.51	XXX
75660	TC	A	Artery X-rays, head and neck	12.52	XXX
75662	26	A	Artery X-rays, head and neck	2.52	XXX
75662		A	Artery X-rays, head and neck	15.04	XXX
75662	TC	A	Artery X-rays, head and neck	12.52	XXX
75665	26	A	Artery X-rays, head and neck	1.99	XXX
75665		A	Artery X-rays, head and neck	14.51	XXX
75665	TC	A	Artery X-rays, head and neck	12.52	XXX
75671	26	A	Artery X-rays, head and neck	2.52	XXX
75671		A	Artery X-rays, head and neck	15.04	XXX
75671	TC	A	Artery X-rays, head and neck	12.52	XXX
75676	26	A	Artery X-rays, neck	1.99	XXX
75676		A	Artery X-rays, neck	14.51	XXX
75676	TC	A	Artery X-rays, neck	12.52	XXX
75680	26	A	Artery X-rays, neck	2.52	XXX
75680		A	Artery X-rays, neck	15.04	XXX
75680	TC	A	Artery X-rays, neck	12.52	XXX
75685	26	A	Artery X-rays, spine	1.99	XXX
75685		A	Artery X-rays, spine	14.51	XXX
75685	TC	A	Artery X-rays, spine	12.52	XXX
75705	26	A	Artery X-rays, spine	3.31	XXX
75705		A	Artery X-rays, spine	15.83	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
75705	TC	A	Artery X-rays, spine	12.52	XXX
75710	26	A	Artery X-rays, arm/leg	1.73	XXX
75710		A	Artery X-rays, arm/leg	14.25	XXX
75710	TC	A	Artery X-rays, arm/leg	12.52	XXX
75716	26	A	Artery X-rays, arms/legs	1.99	XXX
75716		A	Artery X-rays, arms/legs	14.51	XXX
75716	TC	A	Artery X-rays, arms/legs	12.52	XXX
75722	26	A	Artery X-rays, kidney	1.73	XXX
75722		A	Artery X-rays, kidney	14.25	XXX
75722	TC	A	Artery X-rays, kidney	12.52	XXX
75724	26	A	Artery X-rays, kidneys	2.26	XXX
75724		A	Artery X-rays, kidneys	14.78	XXX
75724	TC	A	Artery X-rays, kidneys	12.52	XXX
75726	26	A	Artery X-rays, abdomen	1.73	XXX
75726		A	Artery X-rays, abdomen	14.25	XXX
75726	TC	A	Artery X-rays, abdomen	12.52	XXX
75731	26	A	Artery X-rays, adrenal gland	1.73	XXX
75731		A	Artery X-rays, adrenal gland	14.25	XXX
75731	TC	A	Artery X-rays, adrenal gland	12.52	XXX
75733	26	A	Artery X-rays, adrenal glands	1.99	XXX
75733		A	Artery X-rays, adrenal glands	14.51	XXX
75733	TC	A	Artery X-rays, adrenal glands	12.52	XXX
75736	26	A	Artery X-rays, pelvis	1.73	XXX
75736		A	Artery X-rays, pelvis	14.25	XXX
75736	TC	A	Artery X-rays, pelvis	12.52	XXX
75741	26	A	Artery X-rays, lung	1.99	XXX
75741		A	Artery X-rays, lung	14.51	XXX
75741	TC	A	Artery X-rays, lung	12.52	XXX
75743	26	A	Artery X-rays, lungs	2.52	XXX
75743		A	Artery X-rays, lungs	15.04	XXX
75743	TC	A	Artery X-rays, lungs	12.52	XXX
75746	26	A	Artery X-rays, lung	1.73	XXX
75746		A	Artery X-rays, lung	14.25	XXX
75746	TC	A	Artery X-rays, lung	12.52	XXX
75750	26	A	Artery X-rays, heart	1.73	XXX
75750		A	Artery X-rays, heart	14.25	XXX
75750	TC	A	Artery X-rays, heart	12.52	XXX
75752	26	A	Artery X-rays, heart	1.73	XXX
75752		A	Artery X-rays, heart	14.25	XXX
75752	TC	A	Artery X-rays, heart	12.52	XXX
75754	26	A	Artery X-rays, heart	2.00	XXX
75754		A	Artery X-rays, heart	14.52	XXX
75754	TC	A	Artery X-rays, heart	12.52	XXX
75756	26	A	Artery X-rays, chest	1.73	XXX
75756		A	Artery X-rays, chest	14.25	XXX
75756	TC	A	Artery X-rays, chest	12.52	XXX
75762	26	A	Coronary bypass X-ray	1.73	XXX
75762		A	Coronary bypass X-ray	14.25	XXX
75762	TC	A	Coronary bypass X-ray	12.52	XXX
75766	26	A	Coronary bypass X-ray	1.99	XXX
75766		A	Coronary bypass X-ray	14.51	XXX
75766	TC	A	Coronary bypass X-ray	12.52	XXX
75774	26	A	Artery X-ray, each vessel	.53	XXX
75774		A	Artery X-ray, each vessel	13.05	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
75774	TC	A	Artery X-ray, each vessel	12.52	XXX
75790	26	A	Visualize A-V shunt	2.79	XXX
75790		A	Visualize A-V shunt	4.14	XXX
75790	TC	A	Visualize A-V shunt	1.35	XXX
75801	26	A	Lymph vessel X-ray, arm/leg	1.23	XXX
75801		A	Lymph vessel X-ray, arm/leg	6.61	XXX
75801	TC	A	Lymph vessel X-ray, arm/leg	5.38	XXX
75803	26	A	Lymph vessel X-ray, arms/legs	1.77	XXX
75803		A	Lymph vessel X-ray, arms/legs	7.16	XXX
75803	TC	A	Lymph vessel X-ray, arms/legs	5.38	XXX
75805	26	A	Lymph vessel X-ray, trunk	1.23	XXX
75805		A	Lymph vessel X-ray, trunk	7.28	XXX
75805	TC	A	Lymph vessel X-ray, trunk	6.05	XXX
75807	26	A	Lymph vessel X-ray, trunk	1.77	XXX
75807		A	Lymph vessel X-ray, trunk	7.83	XXX
75807	TC	A	Lymph vessel X-ray, trunk	6.05	XXX
75809	26	A	Nonvascular shunt, X-ray	.70	XXX
75809		A	Nonvascular shunt, X-ray	1.48	XXX
75809	TC	A	Nonvascular shunt, X-ray	.79	XXX
75810	26	A	Vein X-ray, spleen/liver	1.73	XXX
75810		A	Vein X-ray, spleen/liver	14.25	XXX
75810	TC	A	Vein X-ray, spleen/liver	12.52	XXX
75820	26	A	Vein X-ray, arm/leg	1.07	XXX
75820		A	Vein X-ray, arm/leg	2.01	XXX
75820	TC	A	Vein X-ray, arm/leg	.94	XXX
75822	26	A	Vein X-ray, arms/legs	1.61	XXX
75822		A	Vein X-ray, arms/legs	3.08	XXX
75822	TC	A	Vein X-ray, arms/legs	1.48	XXX
75825	26	A	Vein X-ray, trunk	1.73	XXX
75825		A	Vein X-ray, trunk	14.25	XXX
75825	TC	A	Vein X-ray, trunk	12.52	XXX
75827	26	A	Vein X-ray, chest	1.73	XXX
75827		A	Vein X-ray, chest	14.25	XXX
75827	TC	A	Vein X-ray, chest	12.52	XXX
75831	26	A	Vein X-ray, kidney	1.73	XXX
75831		A	Vein X-ray, kidney	14.25	XXX
75831	TC	A	Vein X-ray, kidney	12.52	XXX
75833	26	A	Vein X-ray, kidneys	2.26	XXX
75833		A	Vein X-ray, kidneys	14.78	XXX
75833	TC	A	Vein X-ray, kidneys	12.52	XXX
75840	26	A	Vein X-ray, adrenal gland	1.73	XXX
75840		A	Vein X-ray, adrenal gland	14.25	XXX
75840	TC	A	Vein X-ray, adrenal gland	12.52	XXX
75842	26	A	Vein X-ray, adrenal glands	2.26	XXX
75842		A	Vein X-ray, adrenal glands	14.78	XXX
75842	TC	A	Vein X-ray, adrenal glands	12.52	XXX
75860	26	A	Vein X-ray, neck	1.73	XXX
75860		A	Vein X-ray, neck	14.25	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
75860	TC	A	Vein X-ray, neck	12.52	XXX
75870	26	A	Vein X-ray, skull	1.73	XXX
75870		A	Vein X-ray, skull	14.25	XXX
75870	TC	A	Vein X-ray, skull	12.52	XXX
75872	26	A	Vein X-ray, skull	1.73	XXX
75872		A	Vein X-ray, skull	14.25	XXX
75872	TC	A	Vein X-ray, skull	12.52	XXX
75880	26	A	Vein X-ray, eye socket	1.07	XXX
75880		A	Vein X-ray, eye socket	2.01	XXX
75880	TC	A	Vein X-ray, eye socket	.94	XXX
75885	26	A	Vein X-ray, liver	2.19	XXX
75885		A	Vein X-ray, liver	14.71	XXX
75885	TC	A	Vein X-ray, liver	12.52	XXX
75887	26	A	Vein X-ray, liver	2.19	XXX
75887		A	Vein X-ray, liver	14.71	XXX
75887	TC	A	Vein X-ray, liver	12.52	XXX
75889	26	A	Vein X-ray, liver	1.73	XXX
75889		A	Vein X-ray, liver	14.25	XXX
75889	TC	A	Vein X-ray, liver	12.52	XXX
75891	26	A	Vein X-ray, liver	1.73	XXX
75891		A	Vein X-ray, liver	14.25	XXX
75891	TC	A	Vein X-ray, liver	12.52	XXX
75893	26	A	Venous sampling by catheter	.83	XXX
75893		A	Venous sampling by catheter	13.35	XXX
75893	TC	A	Venous sampling by catheter	12.52	XXX
75894	26	A	X-rays, transcatheter therapy	1.99	XXX
75894		A	X-rays, transcatheter therapy	25.98	XXX
75894	TC	A	X-rays, transcatheter therapy	23.99	XXX
75896	26	A	X-rays, transcatheter therapy	1.99	XXX
75896		A	X-rays, transcatheter therapy	22.84	XXX
75896	TC	A	X-rays, transcatheter therapy	20.85	XXX
75898	26	A	Follow-up angiogram	2.51	XXX
75898		A	Follow-up angiogram	3.55	XXX
75898	TC	A	Follow-up angiogram	1.04	XXX
75940	26	A	X-ray placement, vein filter	.83	XXX
75940		A	X-ray placement, vein filter	13.35	XXX
75940	TC	A	X-ray placement, vein filter	12.52	XXX
75960	26	A	Transcatheter intro, stent	1.24	XXX
75960		A	Transcatheter intro, stent	16.04	XXX
75960	TC	A	Transcatheter intro, stent	14.80	XXX
75961	26	A	Transcatheter retrieval	6.46	XXX
75961		A	Transcatheter retrieval	16.89	XXX
75961	TC	A	Transcatheter retrieval	10.43	XXX
75962	26	A	Repair arterial blockage	.83	XXX
75962		A	Repair arterial blockage	16.47	XXX
75962	TC	A	Repair arterial blockage	15.64	XXX
75964	26	A	Repair artery blockage, each	.53	XXX
75964		A	Repair artery blockage, each	8.88	XXX
75964	TC	A	Repair artery blockage, each	8.35	XXX
75966	26	A	Repair arterial blockage	1.99	XXX
75966		A	Repair arterial blockage	17.63	XXX
75966	TC	A	Repair arterial blockage	15.64	XXX
75968	26	A	Repair artery blockage, each	.53	XXX
75968		A	Repair artery blockage, each	8.88	XXX

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75968	TC	A	Repair artery blockage, each	8.35	XXX
75970	26	A	Transcatheter biopsy	1.26	XXX
75970		A	Transcatheter biopsy	12.74	XXX
75970	TC	A	Transcatheter biopsy	11.47	XXX
75978	26	A	Repair venous blockage	1.07	XXX
75980	26	A	Contrast X-ray exam bile duct	2.19	XXX
75980		A	Contrast X-ray exam bile duct	7.58	XXX
75980	TC	A	Contrast X-ray exam bile duct	5.38	XXX
75982	26	A	Contrast X-ray exam bile duct	2.19	XXX
75982		A	Contrast X-ray exam bile duct	8.25	XXX
75982	TC	A	Contrast X-ray exam bile duct	6.05	XXX
75984	26	A	X-ray control catheter change	1.10	XXX
75984		A	X-ray control catheter change	3.03	XXX
75984	TC	A	X-ray control catheter change	1.93	XXX
75989	26	A	Abscess drainage under X-ray	1.80	XXX
75989		A	Abscess drainage under X-ray	4.93	XXX
75989	TC	A	Abscess drainage under X-ray	3.12	XXX
75992	26	A	Atherectomy, X-ray exam	.83	XXX
75992		A	Atherectomy, X-ray exam	16.47	XXX
75992	TC	A	Atherectomy, X-ray exam	15.64	XXX
75993	26	A	Atherectomy, X-ray exam	.53	XXX
75993		A	Atherectomy, X-ray exam	8.88	XXX
75993	TC	A	Atherectomy, X-ray exam	8.35	XXX
75994	26	A	Atherectomy, X-ray exam	1.99	XXX
75994		A	Atherectomy, X-ray exam	17.63	XXX
75994	TC	A	Atherectomy, X-ray exam	15.64	XXX
75995	26	A	Atherectomy, X-ray exam	1.99	XXX
75995		A	Atherectomy, X-ray exam	17.63	XXX
75995	TC	A	Atherectomy, X-ray exam	15.64	XXX
75996	26	A	Atherectomy, X-ray exam	.53	XXX
75996		A	Atherectomy, X-ray exam	8.88	XXX
75996	TC	A	Atherectomy, X-ray exam	8.35	XXX
76000	26	A	Fluoroscope examination	.25	XXX
76000		A	Fluoroscope examination	1.54	XXX
76000	TC	A	Fluoroscope examination	1.29	XXX
76001	26	A	Fluoroscope exam, extensive	1.03	XXX
76001		A	Fluoroscope exam, extensive	3.64	XXX
76001	TC	A	Fluoroscope exam, extensive	2.61	XXX
76003	26	A	Needle localization by X-ray	.83	XXX
76003		A	Needle localization by X-ray	2.13	XXX
76003	TC	A	Needle localization by X-ray	1.29	XXX
76010	26	A	X-ray, nose to rectum	.26	XXX
76010		A	X-ray, nose to rectum	.79	XXX
76010	TC	A	X-ray, nose to rectum	.53	XXX
76020	26	A	X-rays for bone age	.28	XXX
76020		A	X-rays for bone age	.81	XXX
76020	TC	A	X-rays for bone age	.53	XXX
76040	26	A	X-rays, bone evaluation	.41	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
76040		A	X-rays, bone evaluation	1.20	XXX
76040	TC	A	X-rays, bone evaluation	.79	XXX
76061	26	A	X-rays, bone survey	.68	XXX
76061		A	X-rays, bone survey	1.66	XXX
76061	TC	A	X-rays, bone survey	.99	XXX
76062	26	A	X-rays, bone survey	.83	XXX
76062		A	X-rays, bone survey	2.27	XXX
76062	TC	A	X-rays, bone survey	1.44	XXX
76065	26	A	X-rays, bone evaluation	.42	XXX
76065		A	X-rays, bone evaluation	1.16	XXX
76065	TC	A	X-rays, bone evaluation	.74	XXX
76066	26	A	Joint(s) survey, single film	.46	XXX
76066		A	Joint(s) survey, single film	1.56	XXX
76066	TC	A	Joint(s) survey, single film	1.10	XXX
76070	26	A	CT scan, bone density study	.38	XXX
76070		A	CT scan, bone density study	3.31	XXX
76070	TC	A	CT scan, bone density study	2.93	XXX
76080	26	A	X-ray exam of fistula	.83	XXX
76080		A	X-ray exam of fistula	1.87	XXX
76080	TC	A	X-ray exam of fistula	1.04	XXX
76086	26	A	X-ray of mammary duct	.54	XXX
76086		A	X-ray of mammary duct	3.15	XXX
76086	TC	A	X-ray of mammary duct	2.61	XXX
76088	26	A	X-ray of mammary ducts	.68	XXX
76088		A	X-ray of mammary ducts	4.32	XXX
76088	TC	A	X-ray of mammary ducts	3.64	XXX
76090	26	A	Mammogram, one breast	.38	XXX
76090		A	Mammogram, one breast	1.42	XXX
76090	TC	A	Mammogram, one breast	1.04	XXX
76091	26	A	Mammogram, both breasts	.62	XXX
76091		A	Mammogram, both breasts	1.91	XXX
76091	TC	A	Mammogram, both breasts	1.29	XXX
76096	26	A	X-ray exam, breast nodule	.86	XXX
76096		A	X-ray exam, breast nodule	2.15	XXX
76096	TC	A	X-ray exam, breast nodule	1.29	XXX
76098	26	A	X-ray exam, breast specimen	.24	XXX
76098		A	X-ray exam, breast specimen	.66	XXX
76098	TC	A	X-ray exam, breast specimen	.42	XXX
76100	26	A	X-ray exam of body section	.89	XXX
76100		A	X-ray exam of body section	2.14	XXX
76100	TC	A	X-ray exam of body section	1.24	XXX
76101	26	A	Complex body section X-ray	.89	XXX
76101		A	Complex body section X-ray	2.30	XXX
76101	TC	A	Complex body section X-ray	1.41	XXX
76102	26	A	Complex body section X-rays	.89	XXX
76102		A	Complex body section X-rays	2.61	XXX
76102	TC	A	Complex body section X-rays	1.72	XXX
76120	26	A	Cinematic X-rays	.58	XXX
76120		A	Cinematic X-rays	1.62	XXX
76120	TC	A	Cinematic X-rays	1.04	XXX
76125	26	A	Cinematic X-rays	.40	XXX
76125		A	Cinematic X-rays	1.19	XXX
76125	TC	A	Cinematic X-rays	.79	XXX
76150		A	X-ray exam, dry process	.42	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
76355	26	A	CAT scan for localization	1.83	XXX
76355		A	CAT scan for localization	10.04	XXX
76355	TC	A	CAT scan for localization	8.21	XXX
76360	26	A	CAT scan for needle biopsy	1.75	XXX
76360		A	CAT scan for needle biopsy	9.96	XXX
76360	TC	A	CAT scan for needle biopsy	8.21	XXX
76365	26	A	CAT scan for cyst aspiration	1.75	XXX
76365		A	CAT scan for cyst aspiration	9.96	XXX
76365	TC	A	CAT scan for cyst aspiration	8.21	XXX
76370	26	A	CAT scan for therapy guide	1.29	XXX
76370		A	CAT scan for therapy guide	4.22	XXX
76370	TC	A	CAT scan for therapy guide	2.93	XXX
76375	26	A	CAT scans, other planes	.24	XXX
76375		A	CAT scans, other planes	3.74	XXX
76375	TC	A	CAT scans, other planes	3.51	XXX
76380	26	A	CAT scan follow-up study	1.49	XXX
76380		A	CAT scan follow-up study	4.97	XXX
76380	TC	A	CAT scan follow-up study	3.48	XXX
76400	26	A	Magnetic image, bone marrow	2.44	XXX
76400		A	Magnetic image, bone marrow	13.58	XXX
76400	TC	A	Magnetic image, bone marrow	11.14	XXX
76506	26	A	Echo exam of head	.96	XXX
76506		A	Echo exam of head	2.37	XXX
76506	TC	A	Echo exam of head	1.41	XXX
76511	26	A	Echo exam of eye	1.23	XXX
76511		A	Echo exam of eye	2.48	XXX
76511	TC	A	Echo exam of eye	1.24	XXX
76512	26	A	Echo exam of eye	1.01	XXX
76512		A	Echo exam of eye	2.53	XXX
76512	TC	A	Echo exam of eye	1.52	XXX
76513	26	A	Echo exam of eye, water bath	1.01	XXX
76513		A	Echo exam of eye, water bath	2.53	XXX
76513	TC	A	Echo exam of eye, water bath	1.52	XXX
76516	26	A	Echo exam of eye	.83	XXX
76516		A	Echo exam of eye	2.08	XXX
76516	TC	A	Echo exam of eye	1.24	XXX
76519	26	A	Echo exam of eye	.83	XXX
76519		A	Echo exam of eye	2.08	XXX
76519	TC	A	Echo exam of eye	1.24	XXX
76529	26	A	Echo exam of eye	.87	XXX
76529		A	Echo exam of eye	2.23	XXX
76529	TC	A	Echo exam of eye	1.36	XXX
76536	26	A	Echo exam of head and neck	.86	XXX
76536		A	Echo exam of head and neck	2.27	XXX
76536	TC	A	Echo exam of head and neck	1.41	XXX
76604	26	A	Echo exam of chest	.85	XXX
76604		A	Echo exam of chest	2.14	XXX
76604	TC	A	Echo exam of chest	1.29	XXX

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76645	26	A	Echo exam of breast	.83	XXX
76645		A	Echo exam of breast	1.87	XXX
76645	TC	A	Echo exam of breast	1.04	XXX
76700	26	A	Echo exam of abdomen	1.23	XXX
76700		A	Echo exam of abdomen	3.18	XXX
76700	TC	A	Echo exam of abdomen	1.95	XXX
76705	26	A	Echo exam of abdomen	.90	XXX
76705		A	Echo exam of abdomen	2.31	XXX
76705	TC	A	Echo exam of abdomen	1.41	XXX
76770	26	A	Echo exam abdomen back wall	1.13	XXX
76770		A	Echo exam abdomen back wall	3.08	XXX
76770	TC	A	Echo exam abdomen back wall	1.95	XXX
76775	26	A	Echo exam abdomen back wall	.89	XXX
76775		A	Echo exam abdomen back wall	2.30	XXX
76775	TC	A	Echo exam abdomen back wall	1.41	XXX
76778	26	A	Echo exam kidney transplant	1.13	XXX
76778		A	Echo exam kidney transplant	3.08	XXX
76778	TC	A	Echo exam kidney transplant	1.95	XXX
76800	26	A	Echo exam spinal canal	1.72	XXX
76800		A	Echo exam spinal canal	3.13	XXX
76800	TC	A	Echo exam spinal canal	1.41	XXX
76805	26	A	Echo exam of pregnant uterus	1.51	XXX
76805		A	Echo exam of pregnant uterus	3.60	XXX
76805	TC	A	Echo exam of pregnant uterus	2.09	XXX
76810	26	A	Echo exam of pregnant uterus	2.99	XXX
76810		A	Echo exam of pregnant uterus	7.15	XXX
76810	TC	A	Echo exam of pregnant uterus	4.16	XXX
76815	26	A	Echo exam of pregnant uterus	.99	XXX
76815		A	Echo exam of pregnant uterus	2.40	XXX
76815	TC	A	Echo exam of pregnant uterus	1.41	XXX
76816	26	A	Echo exam follow-up or repeat	.87	XXX
76816		A	Echo exam follow-up or repeat	1.97	XXX
76816	TC	A	Echo exam follow-up or repeat	1.10	XXX
76818	26	A	Fetal biophysical profile	1.17	XXX
76818		A	Fetal biophysical profile	2.78	XXX
76818	TC	A	Fetal biophysical profile	1.61	XXX
76825	26	A	Echo exam of fetal heart	1.16	XXX
76825		A	Echo exam of fetal heart	3.11	XXX
76825	TC	A	Echo exam of fetal heart	1.95	XXX
76826	26	A	Echo exam of fetal heart	1.50	XXX
76826		A	Echo exam of fetal heart	2.20	XXX
76826	TC	A	Echo exam of fetal heart	.71	XXX
76827	26	A	Echo exam of fetal heart	1.22	XXX
76827		A	Echo exam of fetal heart	2.94	XXX
76827	TC	A	Echo exam of fetal heart	1.73	XXX
76828	26	A	Echo exam of fetal heart	.78	XXX
76828		A	Echo exam of fetal heart	.94	XXX
76828	TC	A	Echo exam of fetal heart	.16	XXX
76830	26	A	Echo exam, transvaginal	1.06	XXX
76830		A	Echo exam, transvaginal	2.58	XXX
76830	TC	A	Echo exam, transvaginal	1.52	XXX
76856	26	A	Echo exam of pelvis	1.06	XXX
76856		A	Echo exam of pelvis	2.58	XXX
76856	TC	A	Echo exam of pelvis	1.52	XXX

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76857	26	A	Echo exam of pelvis	.57	XXX
76857		A	Echo exam of pelvis	1.61	XXX
76857	TC	A	Echo exam of pelvis	1.04	XXX
76870	26	A	Echo exam of scrotum	.97	XXX
76870		A	Echo exam of scrotum	2.49	XXX
76870	TC	A	Echo exam of scrotum	1.52	XXX
76872	26	A	Echo exam of prostate	1.06	XXX
76872		A	Echo exam of prostate	2.58	XXX
76872	TC	A	Echo exam of prostate	1.52	XXX
76880	26	A	Echo exam of extremity	.90	XXX
76880		A	Echo exam of extremity	2.31	XXX
76880	TC	A	Echo exam of extremity	1.41	XXX
76930	26	A	Echo guide for heart sac tap	1.03	XXX
76930		A	Echo guide for heart sac tap	2.55	XXX
76930	TC	A	Echo guide for heart sac tap	1.52	XXX
76932	26	A	Echo guide for heart biopsy	1.03	XXX
76932		A	Echo guide for heart biopsy	2.55	XXX
76932	TC	A	Echo guide for heart biopsy	1.52	XXX
76934	26	A	Echo guide for chest tap	1.03	XXX
76934		A	Echo guide for chest tap	2.55	XXX
76934	TC	A	Echo guide for chest tap	1.52	XXX
76938	26	A	Echo exam for drainage	1.03	XXX
76938		A	Echo exam for drainage	2.55	XXX
76938	TC	A	Echo exam for drainage	1.52	XXX
76942	26	A	Echo guide for biopsy	1.03	XXX
76942		A	Echo guide for biopsy	2.55	XXX
76942	TC	A	Echo guide for biopsy	1.52	XXX
76946	26	A	Echo guide for amniocentesis	.57	XXX
76946		A	Echo guide for amniocentesis	2.09	XXX
76946	TC	A	Echo guide for amniocentesis	1.52	XXX
76948	26	A	Echo guide, ova aspiration	.57	XXX
76948		A	Echo guide, ova aspiration	2.09	XXX
76948	TC	A	Echo guide, ova aspiration	1.52	XXX
76950	26	A	Echo guidance radiotherapy	.89	XXX
76950		A	Echo guidance radiotherapy	2.18	XXX
76950	TC	A	Echo guidance radiotherapy	1.29	XXX
76960	26	A	Echo guidance radiotherapy	.89	XXX
76960		A	Echo guidance radiotherapy	2.18	XXX
76960	TC	A	Echo guidance radiotherapy	1.29	XXX
76970	26	A	Ultrasound exam follow-up	.61	XXX
76970		A	Ultrasound exam follow-up	1.65	XXX
76970	TC	A	Ultrasound exam follow-up	1.04	XXX
76986	26	A	Echo exam at surgery	1.82	XXX
76986		A	Echo exam at surgery	4.44	XXX
76986	TC	A	Echo exam at surgery	2.61	XXX
77261		A	Radiation therapy planning	2.12	XXX
77262		A	Radiation therapy planning	3.19	XXX
77263		A	Radiation therapy planning	4.75	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
77280	26	A	Set radiation therapy field	1.07	XXX
77280		A	Set radiation therapy field	4.52	XXX
77280	TC	A	Set radiation therapy field	3.45	XXX
77285	26	A	Set radiation therapy field	1.59	XXX
77285		A	Set radiation therapy field	7.12	XXX
77285	TC	A	Set radiation therapy field	5.54	XXX
77290	26	A	Set radiation therapy field	2.38	XXX
77290		A	Set radiation therapy field	8.84	XXX
77290	TC	A	Set radiation therapy field	6.47	XXX
77300	26	A	Radiation therapy dose plan	.94	XXX
77300		A	Radiation therapy dose plan	2.27	XXX
77300	TC	A	Radiation therapy dose plan	1.33	XXX
77305	26	A	Radiation therapy dose plan	1.07	XXX
77305		A	Radiation therapy dose plan	2.91	XXX
77305	TC	A	Radiation therapy dose plan	1.85	XXX
77310	26	A	Radiation therapy dose plan	1.59	XXX
77310		A	Radiation therapy dose plan	3.90	XXX
77310	TC	A	Radiation therapy dose plan	2.32	XXX
77315	26	A	Radiation therapy dose plan	2.38	XXX
77315		A	Radiation therapy dose plan	5.02	XXX
77315	TC	A	Radiation therapy dose plan	2.64	XXX
77321	26	A	Radiation therapy port plan	1.44	XXX
77321		A	Radiation therapy port plan	5.45	XXX
77321	TC	A	Radiation therapy port plan	4.01	XXX
77326	26	A	Radiation therapy dose plan	1.41	XXX
77326		A	Radiation therapy dose plan	3.77	XXX
77326	TC	A	Radiation therapy dose plan	2.36	XXX
77327	26	A	Radiation therapy dose plan	2.12	XXX
77327		A	Radiation therapy dose plan	5.57	XXX
77327	TC	A	Radiation therapy dose plan	3.45	XXX
77328	26	A	Radiation therapy dose plan	3.17	XXX
77328		A	Radiation therapy dose plan	8.09	XXX
77328	TC	A	Radiation therapy dose plan	4.92	XXX
77331	26	A	Special radiation dosimetry	1.32	XXX
77331		A	Special radiation dosimetry	1.83	XXX
77331	TC	A	Special radiation dosimetry	.51	XXX
77332	26	A	Radiation treatment aid(s)	.83	XXX
77332		A	Radiation treatment aid(s)	2.16	XXX
77332	TC	A	Radiation treatment aid(s)	1.33	XXX
77333	26	A	Radiation treatment aid(s)	1.27	XXX
77333		A	Radiation treatment aid(s)	3.16	XXX
77333	TC	A	Radiation treatment aid(s)	1.89	XXX
77334	26	A	Radiation treatment aid(s)	1.87	XXX
77334		A	Radiation treatment aid(s)	5.09	XXX
77334	TC	A	Radiation treatment aid(s)	3.22	XXX
77336		A	Radiation physics consult	2.96	XXX
77370		A	Radiation physics consult	3.47	XXX
77401		A	Radiation treatment delivery	1.76	XXX
77402		A	Radiation treatment delivery	1.76	XXX
77403		A	Radiation treatment delivery	1.76	XXX
77404		A	Radiation treatment delivery	1.76	XXX
77406		A	Radiation treatment delivery	1.76	XXX
77407		A	Radiation treatment delivery	2.08	XXX
77408		A	Radiation treatment delivery	2.08	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
77409		A	Radiation treatment delivery	2.08	XXX
77411		A	Radiation treatment delivery	2.08	XXX
77412		A	Radiation treatment delivery	2.32	XXX
77413		A	Radiation treatment delivery	2.32	XXX
77414		A	Radiation treatment delivery	2.32	XXX
77416		A	Radiation treatment delivery	2.32	XXX
77417		A	Radiology port film(s)	.59	XXX
77420		A	Weekly radiation therapy	2.45	XXX
77425		A	Weekly radiation therapy	3.71	XXX
77430		A	Weekly radiation therapy	5.46	XXX
77431		A	Radiation therapy management	2.74	XXX
77470	26	A	Special radiation treatment	3.17	XXX
77470		A	Special radiation treatment	14.24	XXX
77470	TC	A	Special radiation treatment	11.07	XXX
77600	26	A	Hyperthermia treatment	2.38	XXX
77600		A	Hyperthermia treatment	5.40	XXX
77600	TC	A	Hyperthermia treatment	3.02	XXX
77605	26	A	Hyperthermia treatment	3.17	XXX
77605		A	Hyperthermia treatment	7.20	XXX
77605	TC	A	Hyperthermia treatment	4.03	XXX
77610	26	A	Hyperthermia treatment	2.38	XXX
77610		A	Hyperthermia treatment	5.40	XXX
77610	TC	A	Hyperthermia treatment	3.02	XXX
77615	26	A	Hyperthermia treatment	3.17	XXX
77615		A	Hyperthermia treatment	7.20	XXX
77615	TC	A	Hyperthermia treatment	4.03	XXX
77620	26	A	Hyperthermia treatment	2.38	XXX
77620		A	Hyperthermia treatment	5.40	XXX
77620	TC	A	Hyperthermia treatment	3.02	XXX
77750	26	A	Infuse radioactive materials	6.96	XXX
77750		A	Infuse radioactive materials	8.28	XXX
77750	TC	A	Infuse radioactive materials	1.32	XXX
77761	26	A	Radioelement application	5.40	XXX
77761		A	Radioelement application	7.90	XXX
77761	TC	A	Radioelement application	2.50	XXX
77762	26	A	Radioelement application	8.12	XXX
77762		A	Radioelement application	11.71	XXX
77762	TC	A	Radioelement application	3.59	XXX
77763	26	A	Radioelement application	12.15	XXX
77763		A	Radioelement application	16.62	XXX
77763	TC	A	Radioelement application	4.46	XXX
77776	26	A	Radioelement application	7.08	XXX
77776		A	Radioelement application	9.24	XXX
77776	TC	A	Radioelement application	2.16	XXX
77777	26	A	Radioelement application	10.60	XXX
77777		A	Radioelement application	14.81	XXX
77777	TC	A	Radioelement application	4.20	XXX
77778	26	A	Radioelement application	15.89	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
77778		A	Radioelement application	20.97	XXX
77778	TC	A	Radioelement application	5.09	XXX
77781	26	A	High intensity brachytherapy	2.36	XXX
77781		A	High intensity brachytherapy	22.54	XXX
77781	TC	A	High intensity brachytherapy	20.18	XXX
77782	26	A	High intensity brachytherapy	3.55	XXX
77782		A	High intensity brachytherapy	23.73	XXX
77782	TC	A	High intensity brachytherapy	20.18	XXX
77783	26	A	High intensity brachytherapy	5.29	XXX
77783		A	High intensity brachytherapy	25.47	XXX
77783	TC	A	High intensity brachytherapy	20.18	XXX
77784	26	A	High intensity brachytherapy	7.96	XXX
77784		A	High intensity brachytherapy	28.14	XXX
77784	TC	A	High intensity brachytherapy	20.18	XXX
77789	26	A	Radioelement application	1.59	XXX
77789		A	Radioelement application	2.04	XXX
77789	TC	A	Radioelement application	.45	XXX
77790	26	A	Radioelement handling	1.59	XXX
77790		A	Radioelement handling	2.10	XXX
77790	TC	A	Radioelement handling	.51	XXX
78000	26	A	Nuclear exam of thyroid	.28	XXX
78000		A	Nuclear exam of thyroid	1.24	XXX
78000	TC	A	Nuclear exam of thyroid	.96	XXX
78001	26	A	Nuclear exams of thyroid	.39	XXX
78001		A	Nuclear exams of thyroid	1.68	XXX
78001	TC	A	Nuclear exams of thyroid	1.29	XXX
78003	26	A	Special thyroid nuclear exam	.49	XXX
78003		A	Special thyroid nuclear exam	1.45	XXX
78003	TC	A	Special thyroid nuclear exam	.96	XXX
78006	26	A	Thyroid imaging, with uptake	.75	XXX
78006		A	Thyroid imaging, with uptake	3.12	XXX
78006	TC	A	Thyroid imaging, with uptake	2.37	XXX
78007	26	A	Thyroid imaging, with uptake	.77	XXX
78007		A	Thyroid imaging, with uptake	3.32	XXX
78007	TC	A	Thyroid imaging, with uptake	2.56	XXX
78010	26	A	Nuclear scan of thyroid	.59	XXX
78010		A	Nuclear scan of thyroid	2.39	XXX
78010	TC	A	Nuclear scan of thyroid	1.80	XXX
78011	26	A	Nuclear scan, thyroid flow	.70	XXX
78011		A	Nuclear scan, thyroid flow	3.09	XXX
78011	TC	A	Nuclear scan, thyroid flow	2.39	XXX
78015	26	A	Nuclear scan of thyroid	1.03	XXX
78015		A	Nuclear scan of thyroid	3.58	XXX
78015	TC	A	Nuclear scan of thyroid	2.56	XXX
78016	26	A	Extensive thyroid scan	1.25	XXX
78016		A	Extensive thyroid scan	4.71	XXX
78016	TC	A	Extensive thyroid scan	3.46	XXX
78017	26	A	Multiple nuclear scans	1.32	XXX
78017		A	Multiple nuclear scans	5.02	XXX
78017	TC	A	Multiple nuclear scans	3.70	XXX
78018	26	A	Whole body nuclear scans	1.44	XXX
78018		A	Whole body nuclear scans	6.83	XXX
78018	TC	A	Whole body nuclear scans	5.39	XXX
78070	26	A	Nuclear scan of parathyroid	.78	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78070		A	Nuclear scan of parathyroid	2.58	XXX
78070	TC	A	Nuclear scan of parathyroid	1.80	XXX
78075	26	A	Nuclear scan of adrenals	1.13	XXX
78075		A	Nuclear scan of adrenals	6.52	XXX
78075	TC	A	Nuclear scan of adrenals	5.39	XXX
78102	26	A	Nuclear scan of bone marrow	.84	XXX
78102		A	Nuclear scan of bone marrow	2.87	XXX
78102	TC	A	Nuclear scan of bone marrow	2.03	XXX
78103	26	A	Nuclear scan of bone marrow	1.14	XXX
78103		A	Nuclear scan of bone marrow	4.28	XXX
78103	TC	A	Nuclear scan of bone marrow	3.14	XXX
78104	26	A	Nuclear scan of bone marrow	1.22	XXX
78104		A	Nuclear scan of bone marrow	5.26	XXX
78104	TC	A	Nuclear scan of bone marrow	4.04	XXX
78110	26	A	Nuclear exam, plasma volume	.28	XXX
78110		A	Nuclear exam, plasma volume	1.22	XXX
78110	TC	A	Nuclear exam, plasma volume	.94	XXX
78111	26	A	Nuclear exam, plasma volume	.33	XXX
78111		A	Nuclear exam, plasma volume	2.89	XXX
78111	TC	A	Nuclear exam, plasma volume	2.56	XXX
78120	26	A	Nuclear exam of RBC mass	.35	XXX
78120		A	Nuclear exam of RBC mass	2.07	XXX
78120	TC	A	Nuclear exam of RBC mass	1.72	XXX
78121	26	A	Nuclear exam of RBC mass	.48	XXX
78121		A	Nuclear exam of RBC mass	3.37	XXX
78121	TC	A	Nuclear exam of RBC mass	2.88	XXX
78122	26	A	Nuclear exam, blood volume	.68	XXX
78122		A	Nuclear exam, blood volume	5.26	XXX
78122	TC	A	Nuclear exam, blood volume	4.58	XXX
78130	26	A	Red cell survival exam	.93	XXX
78130		A	Red cell survival exam	3.77	XXX
78130	TC	A	Red cell survival exam	2.84	XXX
78135	26	A	Red cell survival exam	.97	XXX
78135		A	Red cell survival exam	5.81	XXX
78135	TC	A	Red cell survival exam	4.84	XXX
78140	26	A	Nuclear exam, red blood cells	.93	XXX
78140		A	Nuclear exam, red blood cells	4.84	XXX
78140	TC	A	Nuclear exam, red blood cells	3.91	XXX
78160	26	A	Nuclear exam of plasma iron	.49	XXX
78160		A	Nuclear exam of plasma iron	4.13	XXX
78160	TC	A	Nuclear exam of plasma iron	3.64	XXX
78162	26	A	Nuclear exam, iron absorption	.68	XXX
78162		A	Nuclear exam, iron absorption	3.85	XXX
78162	TC	A	Nuclear exam, iron absorption	3.17	XXX
78170	26	A	Nuclear exam, red cell iron	.62	XXX
78170		A	Nuclear exam, red cell iron	5.90	XXX
78170	TC	A	Nuclear exam, red cell iron	5.28	XXX
78172	26	A	Nuclear exam, total body iron	.82	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78185	26	A	Nuclear scan of spleen	.61	XXX
78185		A	Nuclear scan of spleen	2.95	XXX
78185	TC	A	Nuclear scan of spleen	2.35	XXX
78190	26	A	Nuclear exam of platelets	1.65	XXX
78190		A	Nuclear exam of platelets	7.33	XXX
78190	TC	A	Nuclear exam of platelets	5.68	XXX
78191	26	A	Nuclear exam of platelets	.93	XXX
78191		A	Nuclear exam of platelets	8.22	XXX
78191	TC	A	Nuclear exam of platelets	7.29	XXX
78192	26	A	Nuclear exam, WBC scan	1.21	XXX
78192		A	Nuclear exam, WBC scan	4.58	XXX
78192	TC	A	Nuclear exam, WBC scan	3.37	XXX
78193	26	A	Nuclear exam, WBC scan	1.33	XXX
78193		A	Nuclear exam, WBC scan	11.02	XXX
78193	TC	A	Nuclear exam, WBC scan	9.69	XXX
78195	26	A	Nuclear scan of lymph system	1.07	XXX
78195		A	Nuclear scan of lymph system	5.11	XXX
78195	TC	A	Nuclear scan of lymph system	4.04	XXX
78201	26	A	Nuclear scan of liver	.66	XXX
78201		A	Nuclear scan of liver	3.00	XXX
78201	TC	A	Nuclear scan of liver	2.35	XXX
78202	26	A	Nuclear scan of liver	.78	XXX
78202		A	Nuclear scan of liver	3.65	XXX
78202	TC	A	Nuclear scan of liver	2.87	XXX
78205	26	A	Nuclear scan of liver (3D)	1.09	XXX
78205		A	Nuclear scan of liver (3D)	6.95	XXX
78205	TC	A	Nuclear scan of liver (3D)	5.86	XXX
78215	26	A	Nuclear scan, liver and spleen	.75	XXX
78215		A	Nuclear scan, liver and spleen	3.66	XXX
78215	TC	A	Nuclear scan, liver and spleen	2.91	XXX
78216	26	A	Nuclear scan, liver/spleen	.87	XXX
78216		A	Nuclear scan, liver/spleen	4.33	XXX
78216	TC	A	Nuclear scan, liver/spleen	3.46	XXX
78220	26	A	Nuclear scan, liver function	.75	XXX
78220		A	Nuclear scan, liver function	4.44	XXX
78220	TC	A	Nuclear scan, liver function	3.70	XXX
78223	26	A	Nuclear scan, biliary tract	1.27	XXX
78223		A	Nuclear scan, biliary tract	4.91	XXX
78223	TC	A	Nuclear scan, biliary tract	3.64	XXX
78230	26	A	Nuclear scan, salivary gland	.70	XXX
78230		A	Nuclear scan, salivary gland	2.86	XXX
78230	TC	A	Nuclear scan, salivary gland	2.16	XXX
78231	26	A	Nuclear scans,salivary gland	.80	XXX
78231		A	Nuclear scans,salivary gland	3.94	XXX
78231	TC	A	Nuclear scans,salivary gland	3.14	XXX
78232	26	A	Nuclear exam, salivary gland	.73	XXX
78232		A	Nuclear exam, salivary gland	4.23	XXX
78232	TC	A	Nuclear exam, salivary gland	3.51	XXX
78258	26	A	Nuclear imaging of esophagus	1.13	XXX
78258		A	Nuclear imaging of esophagus	3.99	XXX
78258	TC	A	Nuclear imaging of esophagus	2.87	XXX
78261	26	A	Nuclear scan, gastric mucosa	1.06	XXX
78261		A	Nuclear scan, gastric mucosa	5.13	XXX
78261	TC	A	Nuclear scan, gastric mucosa	4.07	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78262	26	A	Gullet reflux nuclear exam	1.04	XXX
78262		A	Gullet reflux nuclear exam	5.25	XXX
78262	TC	A	Gullet reflux nuclear exam	4.21	XXX
78264	26	A	Nuclear exam, stomach	1.19	XXX
78264		A	Nuclear exam, stomach	5.28	XXX
78264	TC	A	Nuclear exam, stomach	4.09	XXX
78270	26	A	Vit B-12 absorption exams	.30	XXX
78270		A	Vit B-12 absorption exams	1.85	XXX
78270	TC	A	Vit B-12 absorption exams	1.54	XXX
78271	26	A	Vit B-12 absorption exams	.30	XXX
78271		A	Vit B-12 absorption exams	1.94	XXX
78271	TC	A	Vit B-12 absorption exams	1.64	XXX
78272	26	A	Vit B-12 absorption exams	.41	XXX
78272		A	Vit B-12 absorption exams	2.72	XXX
78272	TC	A	Vit B-12 absorption exams	2.31	XXX
78276	26	A	Nuclear exam, GI blood loss	1.09	XXX
78276		A	Nuclear exam, GI blood loss	4.26	XXX
78276	TC	A	Nuclear exam, GI blood loss	3.17	XXX
78278	26	A	Nuclear scan, GI blood loss	1.51	XXX
78278		A	Nuclear scan, GI blood loss	6.34	XXX
78278	TC	A	Nuclear scan, GI blood loss	4.84	XXX
78280	26	A	GI Blood loss exam	.58	XXX
78280		A	GI Blood loss exam	3.80	XXX
78280	TC	A	GI Blood loss exam	3.22	XXX
78282	26	A	GI Protein loss exam	.58	XXX
78290	26	A	Nuclear scan of bowel	1.04	XXX
78290		A	Nuclear scan of bowel	4.06	XXX
78290	TC	A	Nuclear scan of bowel	3.02	XXX
78291	26	A	Test venous drain, abdomen	1.33	XXX
78291		A	Test venous drain, abdomen	4.37	XXX
78291	TC	A	Test venous drain, abdomen	3.04	XXX
78300	26	A	Nuclear scan of bone	.95	XXX
78300		A	Nuclear scan of bone	3.43	XXX
78300	TC	A	Nuclear scan of bone	2.48	XXX
78305	26	A	Nuclear scan of bones	1.26	XXX
78305		A	Nuclear scan of bones	4.90	XXX
78305	TC	A	Nuclear scan of bones	3.64	XXX
78306	26	A	Nuclear scan of skeleton	1.31	XXX
78306		A	Nuclear scan of skeleton	5.56	XXX
78306	TC	A	Nuclear scan of skeleton	4.24	XXX
78310	26	A	Bone blood flow scan	.83	XXX
78310		A	Bone blood flow scan	2.00	XXX
78310	TC	A	Bone blood flow scan	1.17	XXX
78315	26	A	Nuclear scan of bone	1.55	XXX
78315		A	Nuclear scan of bone	6.29	XXX
78315	TC	A	Nuclear scan of bone	4.74	XXX
78320	26	A	Nuclear scan of bone (3D)	1.58	XXX
78320		A	Nuclear scan of bone (3D)	7.44	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78320	TC	A	Nuclear scan of bone (3D)	5.86	XXX
78350	26	A	Bone mineral content study	.33	XXX
78350		A	Bone mineral content study	1.09	XXX
78350	TC	A	Bone mineral content study	.76	XXX
78414	26	A	Nuclear exam of heart flow	.68	XXX
78428	26	A	Nuclear exam, heart shunt	1.19	XXX
78428		A	Nuclear exam, heart shunt	3.43	XXX
78428	TC	A	Nuclear exam, heart shunt	2.24	XXX
78445	26	A	Nuclear scan of blood flow	.75	XXX
78445		A	Nuclear scan of blood flow	2.62	XXX
78445	TC	A	Nuclear scan of blood flow	1.88	XXX
78455	26	A	Nuclear scan of vein clot	1.11	XXX
78455		A	Nuclear scan of vein clot	5.06	XXX
78455	TC	A	Nuclear scan of vein clot	3.96	XXX
78457	26	A	Nuclear scan vein thrombosis	1.17	XXX
78457		A	Nuclear scan vein thrombosis	3.81	XXX
78457	TC	A	Nuclear scan vein thrombosis	2.64	XXX
78458	26	A	Nuclear scan vein thrombosis	1.36	XXX
78458		A	Nuclear scan vein thrombosis	5.35	XXX
78458	TC	A	Nuclear scan vein thrombosis	3.99	XXX
78460	26	A	Nuclear scan, heart muscle	1.31	XXX
78460		A	Nuclear scan, heart muscle	3.66	XXX
78460	TC	A	Nuclear scan, heart muscle	2.35	XXX
78461	26	A	Nuclear scan, heart muscle	1.86	XXX
78461		A	Nuclear scan, heart muscle	6.56	XXX
78461	TC	A	Nuclear scan, heart muscle	4.69	XXX
78464	26	A	Nuclear scan, heart muscle	1.65	XXX
78464		A	Nuclear scan, heart muscle	8.69	XXX
78464	TC	A	Nuclear scan, heart muscle	7.04	XXX
78465	26	A	Nuclear scan, heart muscle	2.22	XXX
78465		A	Nuclear scan, heart muscle	13.94	XXX
78465	TC	A	Nuclear scan, heart muscle	11.71	XXX
78466	26	A	Nuclear scan, heart muscle	1.06	XXX
78466		A	Nuclear scan, heart muscle	3.67	XXX
78466	TC	A	Nuclear scan, heart muscle	2.61	XXX
78468	26	A	Nuclear scan, heart muscle	1.21	XXX
78468		A	Nuclear scan, heart muscle	4.85	XXX
78468	TC	A	Nuclear scan, heart muscle	3.64	XXX
78469	26	A	Nuclear scan, heart muscle	1.39	XXX
78469		A	Nuclear scan, heart muscle	6.59	XXX
78469	TC	A	Nuclear scan, heart muscle	5.20	XXX
78472	26	A	Nuclear scan, heart muscle	1.49	XXX
78472		A	Nuclear scan, heart muscle	6.97	XXX
78472	TC	A	Nuclear scan, heart muscle	5.48	XXX
78473	26	A	Nuclear scan, cardiac muga	2.23	XXX
78473		A	Nuclear scan, cardiac muga	10.44	XXX
78473	TC	A	Nuclear scan, cardiac muga	8.21	XXX
78478	26	A	Nuclear scan, heart muscle	.94	XXX
78478		A	Nuclear scan, heart muscle	2.49	XXX
78478	TC	A	Nuclear scan, heart muscle	1.55	XXX
78480	26	A	Nuclear scan, heart muscle	.94	XXX
78480		A	Nuclear scan, heart muscle	2.49	XXX
78480	TC	A	Nuclear scan, heart muscle	1.55	XXX
78481	26	A	Nuclear scan, heart muscle	1.49	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78481		A	Nuclear scan, heart muscle	6.69	XXX
78481	TC	A	Nuclear scan, heart muscle	5.20	XXX
78483	26	A	Nuclear scan, heart muscle	2.23	XXX
78483		A	Nuclear scan, heart muscle	10.06	XXX
78483	TC	A	Nuclear scan, heart muscle	7.82	XXX
78580	26	A	Nuclear scan of lung	1.13	XXX
78580		A	Nuclear scan of lung	4.54	XXX
78580	TC	A	Nuclear scan of lung	3.41	XXX
78581	26	A	Nuclear scan of lung	1.06	XXX
78581		A	Nuclear scan of lung	3.43	XXX
78581	TC	A	Nuclear scan of lung	2.37	XXX
78582	26	A	Nuclear scan of lung	1.38	XXX
78582		A	Nuclear scan of lung	5.13	XXX
78582	TC	A	Nuclear scan of lung	3.75	XXX
78584	26	A	Nuclear scan of lung	1.51	XXX
78584		A	Nuclear scan of lung	4.68	XXX
78584	TC	A	Nuclear scan of lung	3.17	XXX
78585	26	A	Nuclear scan of lung	1.65	XXX
78585		A	Nuclear scan of lung	7.24	XXX
78585	TC	A	Nuclear scan of lung	5.59	XXX
78586	26	A	Nuclear scan of lung	.61	XXX
78586		A	Nuclear scan of lung	3.18	XXX
78586	TC	A	Nuclear scan of lung	2.58	XXX
78587	26	A	Nuclear scan of lung	.75	XXX
78587		A	Nuclear scan of lung	3.53	XXX
78587	TC	A	Nuclear scan of lung	2.79	XXX
78591	26	A	Nuclear scan of lung	.61	XXX
78591		A	Nuclear scan of lung	3.44	XXX
78591	TC	A	Nuclear scan of lung	2.84	XXX
78593	26	A	Nuclear scan of lung	.75	XXX
78593		A	Nuclear scan of lung	4.17	XXX
78593	TC	A	Nuclear scan of lung	3.43	XXX
78594	26	A	Nuclear scan of lung	.82	XXX
78594		A	Nuclear scan of lung	5.77	XXX
78594	TC	A	Nuclear scan of lung	4.94	XXX
78596	26	A	Nuclear study of lung	1.93	XXX
78596		A	Nuclear study of lung	8.97	XXX
78596	TC	A	Nuclear study of lung	7.04	XXX
78600	26	A	Nuclear scan of brain	.67	XXX
78600		A	Nuclear scan of brain	3.53	XXX
78600	TC	A	Nuclear scan of brain	2.87	XXX
78601	26	A	Nuclear scan of brain	.79	XXX
78601		A	Nuclear scan of brain	4.17	XXX
78601	TC	A	Nuclear scan of brain	3.37	XXX
78605	26	A	Nuclear scan of brain	.82	XXX
78605		A	Nuclear scan of brain	4.20	XXX
78605	TC	A	Nuclear scan of brain	3.37	XXX
78606	26	A	Nuclear scan of brain	.97	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78606		A	Nuclear scan of brain	4.81	XXX
78606	TC	A	Nuclear scan of brain	3.84	XXX
78607	26	A	Nuclear scan of brain (3D)	1.86	XXX
78607		A	Nuclear scan of brain (3D)	8.38	XXX
78607	TC	A	Nuclear scan of brain (3D)	6.51	XXX
78610	26	A	Nuclear scan of brain	.45	XXX
78610		A	Nuclear scan of brain	2.02	XXX
78610	TC	A	Nuclear scan of brain	1.57	XXX
78615	26	A	Cerebral blood flow scan	.64	XXX
78615		A	Cerebral blood flow scan	4.46	XXX
78615	TC	A	Cerebral blood flow scan	3.82	XXX
78630	26	A	Cerebrospinal fluid scan	1.04	XXX
78630		A	Cerebrospinal fluid scan	6.04	XXX
78630	TC	A	Cerebrospinal fluid scan	5.00	XXX
78635	26	A	Cerebrospinal fluid scan	.93	XXX
78635		A	Cerebrospinal fluid scan	3.46	XXX
78635	TC	A	Cerebrospinal fluid scan	2.53	XXX
78645	26	A	Cerebrospinal fluid scan	.87	XXX
78645		A	Cerebrospinal fluid scan	4.28	XXX
78645	TC	A	Cerebrospinal fluid scan	3.41	XXX
78650	26	A	Cerebrospinal fluid scan	.93	XXX
78650		A	Cerebrospinal fluid scan	5.54	XXX
78650	TC	A	Cerebrospinal fluid scan	4.61	XXX
78652	26	A	Cerebrospinal fluid scan (3D)	1.37	XXX
78652		A	Cerebrospinal fluid scan (3D)	7.23	XXX
78652	TC	A	Cerebrospinal fluid scan (3D)	5.86	XXX
78655	26	A	Nuclear exam of eye lesion	.86	XXX
78655		A	Nuclear exam of eye lesion	5.81	XXX
78655	TC	A	Nuclear exam of eye lesion	4.94	XXX
78660	26	A	Nuclear exam of tear flow	.82	XXX
78660		A	Nuclear exam of tear flow	2.93	XXX
78660	TC	A	Nuclear exam of tear flow	2.11	XXX
78700	26	A	Nuclear scan of kidney	.68	XXX
78700		A	Nuclear scan of kidney	3.69	XXX
78700	TC	A	Nuclear scan of kidney	3.02	XXX
78701	26	A	Nuclear scan of kidney	.75	XXX
78701		A	Nuclear scan of kidney	4.28	XXX
78701	TC	A	Nuclear scan of kidney	3.54	XXX
78704	26	A	Nuclear scan of kidney	1.13	XXX
78704		A	Nuclear scan of kidney	5.05	XXX
78704	TC	A	Nuclear scan of kidney	3.93	XXX
78707	26	A	Nuclear scan of kidney	1.42	XXX
78707		A	Nuclear scan of kidney	5.87	XXX
78707	TC	A	Nuclear scan of kidney	4.45	XXX
78710	26	A	Nuclear scan of kidney (3D)	1.01	XXX
78710		A	Nuclear scan of kidney (3D)	6.87	XXX
78710	TC	A	Nuclear scan of kidney (3D)	5.86	XXX
78715	26	A	Nuclear exam of kidney	.45	XXX
78715		A	Nuclear exam of kidney	2.02	XXX
78715	TC	A	Nuclear exam of kidney	1.57	XXX
78725	26	A	Nuclear exam of kidney	.57	XXX
78725		A	Nuclear exam of kidney	2.34	XXX
78725	TC	A	Nuclear exam of kidney	1.77	XXX
78726	26	A	Nuclear exam of kidney	1.32	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
78726		A	Nuclear exam of kidney	4.26	XXX
78726	TC	A	Nuclear exam of kidney	2.94	XXX
78727	26	A	Nuclear exam renal surgery	1.51	XXX
78727		A	Nuclear exam renal surgery	5.46	XXX
78727	TC	A	Nuclear exam renal surgery	3.96	XXX
78730	26	A	Nuclear exam of bladder	.53	XXX
78730		A	Nuclear exam of bladder	1.99	XXX
78730	TC	A	Nuclear exam of bladder	1.46	XXX
78740	26	A	Nuclear exam of ureter	.87	XXX
78740		A	Nuclear exam of ureter	2.98	XXX
78740	TC	A	Nuclear exam of ureter	2.11	XXX
78760	26	A	Nuclear scan of testes	1.00	XXX
78760		A	Nuclear scan of testes	3.66	XXX
78760	TC	A	Nuclear scan of testes	2.66	XXX
78761	26	A	Scan of testes/blood flow	1.09	XXX
78761		A	Scan of testes/blood flow	4.26	XXX
78761	TC	A	Scan of testes/blood flow	3.17	XXX
78800	26	A	Nuclear exam of lesion	.99	XXX
78800		A	Nuclear exam of lesion	4.36	XXX
78800	TC	A	Nuclear exam of lesion	3.37	XXX
78801	26	A	Nuclear exam of lesions	1.20	XXX
78801		A	Nuclear exam of lesions	5.39	XXX
78801	TC	A	Nuclear exam of lesions	4.20	XXX
78802	26	A	Nuclear exam of lesions	1.31	XXX
78802		A	Nuclear exam of lesions	6.81	XXX
78802	TC	A	Nuclear exam of lesions	5.50	XXX
78803	26	A	Nuclear scan of tumor (3D)	1.65	XXX
78803		A	Nuclear scan of tumor (3D)	8.16	XXX
78803	TC	A	Nuclear scan of tumor (3D)	6.51	XXX
78805	26	A	Nuclear exam of abscess	1.04	XXX
78805		A	Nuclear exam of abscess	4.41	XXX
78805	TC	A	Nuclear exam of abscess	3.37	XXX
78806	26	A	Nuclear exam of abscess	1.29	XXX
78806		A	Nuclear exam of abscess	6.79	XXX
78806	TC	A	Nuclear exam of abscess	5.50	XXX
78890	26	A	Automated data, nuclear med	.07	XXX
78890		A	Automated data, nuclear med	1.36	XXX
78890	TC	A	Automated data, nuclear med	1.29	XXX
78891	26	A	Automated data, nuclear med	.16	XXX
78891		A	Automated data, nuclear med	2.77	XXX
78891	TC	A	Automated data, nuclear med	2.61	XXX
79000	26	A	Nuclear therapy, thyroid	2.73	XXX
79000		A	Nuclear therapy, thyroid	5.35	XXX
79000	TC	A	Nuclear therapy, thyroid	2.61	XXX
79001	26	A	Nuclear therapy, thyroid	1.59	XXX
79001		A	Nuclear therapy, thyroid	2.88	XXX
79001	TC	A	Nuclear therapy, thyroid	1.29	XXX
79020	26	A	Nuclear therapy, thyroid	2.74	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
79020		A	Nuclear therapy, thyroid	5.36	XXX
79020	TC	A	Nuclear therapy, thyroid	2.61	XXX
79030	26	A	Nuclear therapy, thyroid	3.18	XXX
79030		A	Nuclear therapy, thyroid	5.80	XXX
79030	TC	A	Nuclear therapy, thyroid	2.61	XXX
79035	26	A	Nuclear therapy, thyroid	3.82	XXX
79035		A	Nuclear therapy, thyroid	6.43	XXX
79035	TC	A	Nuclear therapy, thyroid	2.61	XXX
79100	26	A	Nuclear therapy, blood	2.00	XXX
79100		A	Nuclear therapy, blood	4.61	XXX
79100	TC	A	Nuclear therapy, blood	2.61	XXX
79200	26	A	Radionuclide therapy	3.03	XXX
79200		A	Radionuclide therapy	5.64	XXX
79200	TC	A	Radionuclide therapy	2.61	XXX
79300	26	A	Radionuclide therapy	2.43	XXX
79400	26	A	Radionuclide therapy	2.97	XXX
79400		A	Radionuclide therapy	5.58	XXX
79400	TC	A	Radionuclide therapy	2.61	XXX
79420	26	A	Radionuclide therapy	2.29	XXX
79440	26	A	Radionuclide therapy	3.03	XXX
79440		A	Radionuclide therapy	5.64	XXX
79440	TC	A	Radionuclide therapy	2.61	XXX

G. Procedure code numbers 90780 to 99373 relate to medical services and evaluation and management services.

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
90780		A	IV infusion therapy, one hour	1.18	XXX
90781		A	IV infusion, additional hour	.59	XXX
90782		T	Injection (SC)/(IM)	.10	XXX
90783		T	Injection (IA)	.41	XXX
90784		T	Injection (IV)	.52	XXX
90788		T	Injection of antibiotic	.11	XXX
90798		A	Injection for severe allergy	.41	XXX
90801		A	Psychiatric interview	2.98	XXX
90820		A	Diagnostic interview	2.71	XXX
90825		A	Evaluation of tests/records	1.32	XXX
90830		A	Psychologival testing	1.82	XXX
90835		A	Special interview	3.44	XXX
90841		B	Psychotherapy	.00	XXX
90843		A	Psychotherapy, 20 to 30 minutes	1.50	XXX
90844		A	Psychotherapy, 45 to 50 minutes	2.36	XXX
90845		A	Medical psychoanalysis	2.26	XXX
90846		A	Special family therapy	2.54	XXX
90847		A	Special family therapy	2.88	XXX
90853		A	Special group therapy	.71	XXX
90855		A	Individual psychotherapy	2.51	XXX
90857		A	Special group therapy	.60	XXX
90862		A	Medication management	1.37	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
90870		A	Electroconvulsive therapy	2.45	000
90871		A	Electroconvulsive therapy	3.71	000
90880		A	Medical hypnotherapy	2.93	XXX
90887		A	Consultation with family	1.87	XXX
90889		B	Preparation of report	.00	XXX
90900		A	Biofeedback, electromyogram	1.86	000
90902		A	Biofeedback, nerve impulse	1.58	000
90904		A	Biofeedback, blood pressure	1.27	000
90906		A	Biofeedback, blood flow	2.58	000
90908		A	Biofeedback, brain waves	1.81	000
90910		A	Biofeedback, oculogram	1.65	000
90915		A	Biofeedback, unspecified	1.71	000
90935		A	Hemodialysis, one evaluation	2.72	000
90937		A	Hemodialysis, repeated evaluations	5.10	000
90945		A	Dialysis, one evaluation	2.53	000
90947		A	Dialysis, repeated evaluations	4.27	000
90997		A	Hemoperfusion	4.44	000
91000	26	A	Esophageal intubation	1.64	000
91000		A	Esophageal intubation	1.71	000
91000	TC	A	Esophageal intubation	.08	000
91010	26	A	Esophagus motility study	3.27	000
91010		A	Esophagus motility study	4.09	000
91010	TC	A	Esophagus motility study	.82	000
91011	26	A	Esophagus motility study	3.78	000
91011		A	Esophagus motility study	4.80	000
91011	TC	A	Esophagus motility study	1.02	000
91012	26	A	Esophagus motility study	4.09	000
91012		A	Esophagus motility study	5.24	000
91012	TC	A	Esophagus motility study	1.15	000
91020	26	A	Esophagogastric study	3.79	000
91020		A	Esophagogastric study	4.56	000
91020	TC	A	Esophagogastric study	.77	000
91030	26	A	Acid perfusion of esophagus	1.59	000
91030		A	Acid perfusion of esophagus	1.81	000
91030	TC	A	Acid perfusion of esophagus	.22	000
91032	26	A	Esophagus, acid reflux test	2.95	000
91032		A	Esophagus, acid reflux test	3.70	000
91032	TC	A	Esophagus, acid reflux test	.75	000
91033	26	A	Prolonged acid reflux test	3.53	000
91033		A	Prolonged acid reflux test	4.89	000
91033	TC	A	Prolonged acid reflux test	1.35	000
91052	26	A	Gastric analysis test	2.28	000
91052		A	Gastric analysis test	2.62	000
91052	TC	A	Gastric analysis test	.33	000
91055	26	A	Gastric intubation for smear	1.85	000
91055		A	Gastric intubation for smear	2.15	000
91055	TC	A	Gastric intubation for smear	.30	000
91060	26	A	Gastric saline load test	1.00	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
91060		A	Gastric saline load test	1.22	000
91060	TC	A	Gastric saline load test	.22	000
91065	26	A	Breath hydrogen test	.98	000
91065		A	Breath hydrogen test	1.32	000
91065	TC	A	Breath hydrogen test	.35	000
91100		A	Pass intestine bleeding tube	1.70	000
91105		A	Gastric intubation treatment	.95	000
91122	26	A	Anal pressure record	2.95	000
91122		A	Anal pressure record	3.69	000
91122	TC	A	Anal pressure record	.74	000
92002		A	Eye exam, new patient	1.54	XXX
92004		A	Eye exam, new patient	2.24	XXX
92012		A	Eye exam, established patient	1.29	XXX
92014		A	Eye exam, established patient	1.64	XXX
92018		A	New eye exam and treatment	2.05	XXX
92019		A	Eye exam and treatment	1.84	XXX
92020		A	Special eye evaluation	.66	XXX
92060	26	A	Special eye evaluation	.73	XXX
92060		A	Special eye evaluation	.91	XXX
92060	TC	A	Special eye evaluation	.18	XXX
92065	26	A	Orthoptic/pleoptic training	.57	XXX
92065		A	Orthoptic/pleoptic training	.73	XXX
92065	TC	A	Orthoptic/pleoptic training	.16	XXX
92070		A	Fitting of contact lens	1.96	XXX
92081	26	A	Visual field examination(s)	.53	XXX
92081		A	Visual field examination(s)	.68	XXX
92081	TC	A	Visual field examination(s)	.15	XXX
92082	26	A	Visual field examination(s)	.75	XXX
92082		A	Visual field examination(s)	.94	XXX
92082	TC	A	Visual field examination(s)	.19	XXX
92083	26	A	Visual field examination(s)	1.10	XXX
92083		A	Visual field examination(s)	1.37	XXX
92083	TC	A	Visual field examination(s)	.28	XXX
92100		A	Serial tonometry exam(s)	1.19	XXX
92120		A	Tonography and eye evaluation	1.15	XXX
92130		A	Water provocation tonography	1.34	XXX
92140		A	Glaucoma provocative tests	.82	XXX
92225		A	Special eye exam, initial	1.07	XXX
92226		A	Special eye exam, subsequent	.93	XXX
92230		A	Eye exam with photos	1.34	XXX
92235	26	A	Eye exam with photos	1.44	XXX
92235		A	Eye exam with photos	2.47	XXX
92235	TC	A	Eye exam with photos	1.03	XXX
92250	26	A	Eye exam with photos	.70	XXX
92250		A	Eye exam with photos	.87	XXX
92250	TC	A	Eye exam with photos	.17	XXX
92260		A	Ophthalmoscopy/dynamometry	1.09	XXX
92265	26	A	Eye muscle evaluation	.90	XXX
92265		A	Eye muscle evaluation	1.13	XXX
92265	TC	A	Eye muscle evaluation	.23	XXX
92270	26	A	Electro-oculography	1.21	XXX
92270		A	Electro-oculography	1.52	XXX
92270	TC	A	Electro-oculography	.31	XXX
92275	26	A	Electroretinography	1.57	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
92275		A	Electroretinography	1.97	XXX
92275	TC	A	Electroretinography	.40	XXX
92280	26	A	Special eye evaluation	.96	XXX
92280		A	Special eye evaluation	1.21	XXX
92280	TC	A	Special eye evaluation	.25	XXX
92283	26	A	Color vision examination	.43	XXX
92283		A	Color vision examination	.55	XXX
92283	TC	A	Color vision examination	.12	XXX
92284	26	A	Dark adaptation eye exam	.65	XXX
92284		A	Dark adaptation eye exam	.82	XXX
92284	TC	A	Dark adaptation eye exam	.17	XXX
92285	26	A	Eye photography	.38	XXX
92285		A	Eye photography	.49	XXX
92285	TC	A	Eye photography	.11	XXX
92286	26	A	Internal eye photography	1.54	XXX
92286		A	Internal eye photography	1.95	XXX
92286	TC	A	Internal eye photography	.40	XXX
92287		A	Internal eye photography	2.40	XXX
92311		A	Contact lens fitting	2.01	XXX
92312		A	Contact lens fitting	2.47	XXX
92313		A	Contact lens fitting	1.84	XXX
92315		A	Prescription of contact lens	1.15	XXX
92316		A	Prescription of contact lens	1.67	XXX
92317		A	Prescription of contact lens	.87	XXX
92325		A	Modification of contact lens	.38	XXX
92326		A	Replacement of contact lens	1.60	XXX
92330		A	Fitting of artificial eye	2.29	XXX
92335		A	Fitting of artificial eye	2.51	XXX
92352		A	Special spectacles fitting	.67	XXX
92353		A	Special spectacles fitting	.93	XXX
92354		A	Special spectacles fitting	8.46	XXX
92355		A	Special spectacles fitting	4.11	XXX
92358		A	Eye prosthesis service	.95	XXX
92371		A	Repair and adjust spectacles	.61	XXX
92392		A	Supply of low vision aids	3.84	XXX
92393		A	Supply of artificial eye	12.41	XXX
92395		A	Supply of spectacles	1.38	XXX
92396		A	Supply of contact lenses	2.23	XXX
92502		A	Ear and throat examination	2.75	000
92504		A	Ear microscopy examination	.45	XXX
92506		A	Speech and hearing evaluation	1.44	XXX
92507		A	Speech/hearing therapy	.88	XXX
92508		A	Speech/hearing therapy	.45	XXX
92511		A	Nasopharyngoscopy	1.77	000
92512		A	Nasal function studies	1.08	XXX
92516		A	Facial nerve function test	.86	XXX
92520		A	Laryngeal function studies	1.35	XXX
92531		B	Spontaneous nystagmus study	.00	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
92532		B	Positional nystagmus study	.00	XXX
92533		B	Caloric vestibular test	.00	XXX
92534		B	Optokinetic nystagmus	.00	XXX
92541	26	A	Spontaneous nystagmus test	.90	XXX
92541		A	Spontaneous nystagmus test	1.13	XXX
92541	TC	A	Spontaneous nystagmus test	.23	XXX
92542	26	A	Positional nystagmus test	.71	XXX
92542		A	Positional nystagmus test	.97	XXX
92542	TC	A	Positional nystagmus test	.27	XXX
92543	26	A	Caloric vestibular test	.83	XXX
92543		A	Caloric vestibular test	1.26	XXX
92543	TC	A	Caloric vestibular test	.43	XXX
92544	26	A	Optokinetic nystagmus test	.54	XXX
92544		A	Optokinetic nystagmus test	.75	XXX
92544	TC	A	OptokineTic nystagmus test	.21	XXX
92545	26	A	Oscillating tracking test	.44	XXX
92545		A	Oscillating tracking test	.65	XXX
92545	TC	A	Oscillating tracking test	.21	XXX
92546	26	A	Torsion swing recording	.60	XXX
92546		A	Torsion swing recording	.84	XXX
92546	TC	A	Torsion swing recording	.24	XXX
92547		A	Supplemental electrical test	.58	XXX
92552		A	Pure tone audiometry, air	.45	XXX
92553		A	Audiometry, air and bone	.68	XXX
92555		A	Speech threshold audiometry	.38	XXX
92556		A	Speech audiometry, complete	.59	XXX
92557		A	Comprehensive hearing test	1.21	XXX
92561		A	Bekesy audiometry, diagnosis	.73	XXX
92562		A	Loudness balance test	.42	XXX
92563		A	Tone decay hearing test	.38	XXX
92564		A	SISI hearing test	.48	XXX
92565		A	Stenger test, pure tone	.40	XXX
92567		A	Tympanometry	.55	XXX
92568		A	Acoustic reflex testing	.38	XXX
92569		A	Acoustic reflex decay test	.42	XXX
92571		A	Filtered speech hearing test	.39	XXX
92572		A	Staggered spondaic word test	.09	XXX
92573		A	Lombard test	.35	XXX
92574		A	Swinging story test	1.22	XXX
92575		A	Sensorineural acuity test	.30	XXX
92576		A	Synthetic sentence test	.45	XXX
92577		A	Stenger test, speech	.74	XXX
92578		A	Delayed auditory feedback	.56	XXX
92580		A	Electrodermal audiometry	.69	XXX
92582		A	Conditioning play audiometry	.74	XXX
92583		A	Select picture audiometry	.91	XXX
92584		A	Electrocochleography	2.54	XXX
92585	26	A	Brainstem evoked audiometry	2.11	XXX
92585		A	Brainstem evoked audiometry	3.98	XXX
92585	TC	A	Brainstem evoked audiometry	1.87	XXX
92589		A	Auditory function test(s)	.56	XXX
92596		A	Ear protector evaluation	.61	XXX
92950		A	Heart/lung resuscitation/CPR	6.28	000
92953		A	Temporary external pacing	2.33	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
92960		A	Heart electroconversion	4.29	000
92970		A	Cardioassist, internal	7.38	000
92971		A	Cardioassist, external	2.97	000
92975		A	Dissolve clot, heart vessel	13.42	000
92977		A	Dissolve clot, heart vessel	8.06	XXX
92982		A	Coronary artery dilation	27.18	000
92984		A	Coronary artery dilation	7.86	000
92986		A	Revision of aortic valve	33.48	090
92990		A	Revision of pulmonary valve	26.69	090
92995		A	Coronary atherectomy	28.17	XXX
92996		A	Coronary atherectomy	8.04	XXX
93000		Z	Electrocardiogram, complete	.77	XXX
93005		A	Electrocardiogram, tracing	.45	XXX
93010		Z	Electrocardiogram report	.33	XXX
93012		A	Transmission of ECG	.26	XXX
93014		A	Report on transmitted ECG	.38	XXX
93015		A	Cardiovascular stress test	3.25	XXX
93017		A	Cardiovascular stress test	1.68	XXX
93018		A	Cardiovascular stress test	1.27	XXX
93024	26	A	Cardiac drug stress test	2.98	XXX
93024		A	Cardiac drug stress test	4.11	XXX
93024	TC	A	Cardiac drug stress test	1.13	XXX
93040		Z	Rhythm ECG with report	.42	XXX
93041		A	Rhythm ECG, tracing	.14	XXX
93042		Z	Rhythm ECG, report	.28	XXX
93201		A	Phonocardiogram and ECG lead	1.52	XXX
93202		A	Phonocardiogram and ECG lead	.80	XXX
93204		A	Phonocardiogram and ECG lead	.72	XXX
93205		A	Special phonocardiogram	1.41	XXX
93208		A	Special phonocardiogram	.34	XXX
93209		A	Special phonocardiogram	1.06	XXX
93210	26	A	Intracardiac phonocardiogram	1.80	XXX
93210		A	Intracardiac phonocardiogram	2.75	XXX
93210	TC	A	Intracardiac phonocardiogram	.96	XXX
93220		A	Vectorcardiogram	1.34	XXX
93221		A	Vectorcardiogram tracing	.61	XXX
93222		A	Vectorcardiogram report	.73	XXX
93224		A	ECG monitor/report, 24 hours	4.87	XXX
93225		A	ECG monitor/record, 24 hours	1.24	XXX
93226		A	ECG monitor/report, 24 hours	2.19	XXX
93227		A	ECG monitor/review, 24 hours	1.45	XXX
93230		A	ECG monitor/report, 24 hours	5.36	XXX
93231		A	ECG monitor/record, 24 hours	1.53	XXX
93232		A	ECG monitor/report, 24 hours	2.17	XXX
93233		A	ECG monitor/review, 24 hours	1.67	XXX
93235		A	ECG monitor/report, 24 hours	4.02	XXX
93236		A	ECG monitor/report, 24 hours	2.61	XXX
93237		A	ECG monitor/review, 24 hours	1.41	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
93255	26	A	Apexcardiography	.33	XXX
93255		A	Apexcardiography	.49	XXX
93255	TC	A	Apexcardiography	.15	XXX
93268	26	A	ECG record/review	.73	XXX
93268		A	ECG record/review	1.20	XXX
93268	TC	A	ECG record/review	.47	XXX
93278	26	A	ECG/signal-averaged	1.14	XXX
93278		A	ECG/signal-averaged	2.32	XXX
93278	TC	A	ECG/signal-averaged	1.18	XXX
93280	26	A	Cardiac fluoroscopy	.95	XXX
93280		A	Cardiac fluoroscopy	1.36	XXX
93280	TC	A	Cardiac fluoroscopy	.40	XXX
93307	26	A	Echo exam of heart	2.05	XXX
93307		A	Echo exam of heart	5.91	XXX
93307	TC	A	Echo exam of heart	3.86	XXX
93308	26	A	Echo exam of heart	1.27	XXX
93308		A	Echo exam of heart	3.21	XXX
93308	TC	A	Echo exam of heart	1.94	XXX
93312	26	A	Echo exam of heart	3.05	XXX
93312		A	Echo exam of heart	6.88	XXX
93312	TC	A	Echo exam of heart	3.83	XXX
93313		A	Echo exam of heart	1.68	XXX
93314	26	A	Echo exam of heart	1.68	XXX
93314		A	Echo exam of heart	5.51	XXX
93314	TC	A	Echo exam of heart	3.83	XXX
93320	26	A	Doppler echo exam, heart	1.11	XXX
93320		A	Doppler echo exam, heart	2.83	XXX
93320	TC	A	Doppler echo exam, heart	1.72	XXX
93321	26	A	Doppler echo exam, heart	.44	XXX
93321		A	Doppler echo exam, heart	1.55	XXX
93321	TC	A	Doppler echo exam, heart	1.12	XXX
93325	26	A	Doppler color flow	1.58	XXX
93325		A	Doppler color flow	3.04	XXX
93325	TC	A	Doppler color flow	1.46	XXX
93350	26	A	Echo exam of heart	3.78	XXX
93350		A	Echo exam of heart	7.23	XXX
93350	TC	A	Echo exam of heart	3.46	XXX
93501	26	A	Right heart catheterization	6.93	000
93501		A	Right heart catheterization	23.88	000
93501	TC	A	Right heart catheterization	16.94	000
93503		A	Insert/place heart catheter	5.12	000
93505	26	A	Biopsy of heart lining	7.88	000
93505		A	Biopsy of heart lining	9.90	000
93505	TC	A	Biopsy of heart lining	2.02	000
93510	26	A	Left heart catheterization	8.62	000
93510		A	Left heart catheterization	44.69	000
93510	TC	A	Left heart catheterization	36.07	000
93511	26	A	Left heart catheterization	7.91	000
93511		A	Left heart catheterization	43.98	000
93511	TC	A	Left heart catheterization	36.07	000
93514	26	A	Left heart catheterization	12.02	000
93514		A	Left heart catheterization	48.09	000
93514	TC	A	Left heart catheterization	36.07	000
93524	26	A	Left heart catheterization	11.99	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
93524		A	Left heart catheterization	59.12	000
93524	TC	A	Left heart catheterization	47.13	000
93526	26	A	Right and left heart catheters	13.12	000
93526		A	Right and left heart catheters	60.25	000
93526	TC	A	Right and left heart catheters	47.13	000
93527	26	A	Right and left heart catheters	14.95	000
93527		A	Right and left heart catheters	62.08	000
93527	TC	A	Right and left heart catheters	47.13	000
93528	26	A	Right and left heart catheters	13.87	000
93528		A	Right and left heart catheters	61.00	000
93528	TC	A	Right and left heart catheters	47.13	000
93529	26	A	Right, left heart catheterization	7.98	000
93529		A	Right, left heart catheterization	55.12	000
93529	TC	A	Right, left heart catheterization	47.13	000
93536		A	Insert circulation assist	13.39	000
93541		A	Injection for lung angiogram	2.47	000
93542		A	Injection for heart X-rays	2.49	000
93543		A	Injection for heart X-rays	1.86	000
93544		A	Injection for aortography	1.83	000
93545		A	Injection for coronary X-rays	3.70	000
93546	26	A	Heart catheter and angiogram	11.48	000
93546		A	Heart catheter and angiogram	51.28	000
93546	TC	A	Heart catheter and angiogram	39.80	000
93547	26	A	Heart catheter and angiogram	13.38	000
93547		A	Heart catheter and angiogram	53.17	000
93547	TC	A	Heart catheter and angiogram	39.80	000
93548	26	A	Heart catheter and angiogram	14.49	000
93548		A	Heart catheter and angiogram	54.29	000
93548	TC	A	Heart catheter and angiogram	39.80	000
93549	26	A	Heart catheter and angiogram	17.40	000
93549		A	Heart catheter and angiogram	57.19	000
93549	TC	A	Heart catheter and angiogram	39.80	000
93550	26	A	Heart catheter and angiogram	19.26	000
93550		A	Heart catheter and angiogram	59.06	000
93550	TC	A	Heart catheter and angiogram	39.80	000
93551		A	X-ray aortocoronary bypass	1.78	000
93552	26	A	Heart catheter and angiogram	16.13	000
93552		A	Heart catheter and angiogram	60.16	000
93552	TC	A	Heart catheter and angiogram	44.04	000
93553	26	A	Heart catheter and angiogram	18.74	000
93553		A	Heart catheter and angiogram	62.78	000
93553	TC	A	Heart catheter and angiogram	44.04	000
93561	26	A	Cardiac output measurement	1.99	000
93561		A	Cardiac output measurement	2.55	000
93561	TC	A	Cardiac output measurement	.56	000
93562	26	A	Cardiac output measurement	.91	000
93562		A	Cardiac output measurement	1.23	000
93562	TC	A	Cardiac output measurement	.32	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
93600	26	A	Bundle of HIS recording	5.58	000
93600		A	Bundle of HIS recording	7.53	000
93600	TC	A	Bundle of HIS recording	1.95	000
93602	26	A	Intra-atrial recording	4.03	000
93602		A	Intra-atrial recording	5.14	000
93602	TC	A	Intra-atrial recording	1.11	000
93603	26	A	Right ventricular recording	4.46	000
93603		A	Right ventricular recording	6.14	000
93603	TC	A	Right ventricular recording	1.68	000
93607	26	A	Right ventricular recording	5.66	000
93607		A	Right ventricular recording	7.16	000
93607	TC	A	Right ventricular recording	1.50	000
93609	26	A	Mapping of tachycardia	14.33	000
93609		A	Mapping of tachycardia	17.04	000
93609	TC	A	Mapping of tachycardia	2.72	000
93610	26	A	Intra-atrial pacing	5.52	000
93610		A	Intra-atrial pacing	6.87	000
93610	TC	A	Intra-atrial pacing	1.36	000
93612	26	A	Intraventricular pacing	5.54	000
93612		A	Intraventricular pacing	7.17	000
93612	TC	A	Intraventricular pacing	1.62	000
93615	26	A	Esophageal recording	1.36	000
93615		A	Esophageal recording	1.67	000
93615	TC	A	Esophageal recording	.31	000
93616	26	A	Esophageal recording	2.95	000
93616		A	Esophageal recording	3.25	000
93616	TC	A	Esophageal recording	.31	000
93618	26	A	Heart rhythm pacing	10.75	000
93618		A	Heart rhythm pacing	14.72	000
93618	TC	A	Heart rhythm pacing	3.97	000
93620	26	A	Electrophysiology evaluation	26.04	000
93620		A	Electrophysiology evaluation	34.99	000
93620	TC	A	Electrophysiology evaluation	8.95	000
93621	26	A	Electrophysiology evaluation	28.67	000
93622	26	A	Electrophysiology evaluation	28.51	000
93623	26	A	Stimulation, pacing heart	5.83	000
93624	26	A	Electrophysiologic study	7.28	000
93624		A	Electrophysiologic study	9.27	000
93624	TC	A	Electrophysiologic study	1.99	000
93631	26	A	Heart pacing, mapping	14.02	000
93631		A	Heart pacing, mapping	20.39	000
93631	TC	A	Heart pacing, mapping	6.37	000
93640	26	A	Evaluation heart device	12.15	000
93640		A	Evaluation heart device	19.33	000
93640	TC	A	Evaluation heart device	7.18	000
93650	26	A	Ablate heart dysrhythm focus	34.30	000
93660	26	A	Tilt table evaluation	3.50	000
93720		A	Total body plethysmography	1.23	XXX
93721		A	Plethysmography tracing	.72	XXX
93722		A	Plethysmography report	.50	XXX
93731	26	A	Analyze pacemaker system	.80	XXX
93731		A	Analyze pacemaker system	1.31	XXX
93731	TC	A	Analyze pacemaker system	.51	XXX
93732	26	A	Analyze pacemaker system	1.32	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
93732		A	Analyze pacemaker system	1.84	XXX
93732	TC	A	Analyze pacemaker system	.53	XXX
93733	26	A	Telephone analysis, pacemaker	.45	XXX
93733		A	Telephone analysis, pacemaker	1.18	XXX
93733	TC	A	Telephone analysis, pacemaker	.73	XXX
93734	26	A	Analyze pacemaker system	.70	XXX
93734		A	Analyze pacemaker system	1.05	XXX
93734	TC	A	Analyze pacemaker system	.34	XXX
93735	26	A	Analyze pacemaker system	.98	XXX
93735		A	Analyze pacemaker system	1.42	XXX
93735	TC	A	Analyze pacemaker system	.45	XXX
93736	26	A	Telephone analysis, pacemaker	.44	XXX
93736		A	Telephone analysis, pacemaker	1.09	XXX
93736	TC	A	Telephone analysis, pacemaker	.65	XXX
93737	26	A	Analyze cardio/defibrillator	.74	XXX
93737		A	Analyze cardio/defibrillator	1.24	XXX
93737	TC	A	Analyze cardio/defibrillator	.51	XXX
93738	26	A	Analyze cardio/defibrillator	1.35	XXX
93738		A	Analyze cardio/defibrillator	1.88	XXX
93738	TC	A	Analyze cardio/defibrillator	.53	XXX
93740	26	A	Temperature gradient studies	.47	XXX
93740		A	Temperature gradient studies	.63	XXX
93740	TC	A	Temperature gradient studies	.15	XXX
93760	26	A	Cephalic thermogram	.72	XXX
93760		A	Cephalic thermogram	1.88	XXX
93760	TC	A	Cephalic thermogram	1.16	XXX
93762	26	A	Peripheral thermogram	.75	XXX
93762		A	Peripheral thermogram	2.25	XXX
93762	TC	A	Peripheral thermogram	1.50	XXX
93770	26	A	Measure venous pressure	.34	XXX
93770		A	Measure venous pressure	.37	XXX
93770	TC	A	Measure venous pressure	.03	XXX
93797		A	Cardiac rehab	.49	000
93798		A	Cardiac rehab/monitor	.79	000
93875	26	A	Extracranial study	.81	XXX
93875		A	Extracranial study	1.94	XXX
93875	TC	A	Extracranial study	1.13	XXX
93880	26	A	Extracranial study	1.11	XXX
93880		A	Extracranial study	4.71	XXX
93880	TC	A	Extracranial study	3.60	XXX
93882	26	A	Extracranial study	.55	XXX
93882		A	Extracranial study	4.14	XXX
93882	TC	A	Extracranial study	3.60	XXX
93886	26	A	Intracranial study	1.67	XXX
93886		A	Intracranial study	5.26	XXX
93886	TC	A	Intracranial study	3.60	XXX
93888	26	A	Intracranial study	1.13	XXX
93888		A	Intracranial study	4.72	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
93888	TC	A	Intracranial study	3.60	XXX
93920	26	A	Upper extremity study	1.00	XXX
93920		A	Upper extremity study	3.70	XXX
93920	TC	A	Upper extremity study	2.70	XXX
93921	26	A	Lower extremity study	1.12	XXX
93921		A	Lower extremity study	3.13	XXX
93921	TC	A	Lower extremity study	2.01	XXX
93925	26	A	Lower extremity study	1.11	XXX
93925		A	Lower extremity study	4.71	XXX
93925	TC	A	Lower extremity study	3.60	XXX
93926	26	A	Lower extremity study	.55	XXX
93926		A	Lower extremity study	4.14	XXX
93926	TC	A	Lower extremity study	3.60	XXX
93930	26	A	Upper extremity study	.93	XXX
93930		A	Upper extremity study	4.52	XXX
93930	TC	A	Upper extremity study	3.60	XXX
93931	26	A	Upper extremity study	.45	XXX
93931		A	Upper extremity study	4.04	XXX
93931	TC	A	Upper extremity study	3.60	XXX
93965	26	A	Extremity study	.87	XXX
93965		A	Extremity study	2.00	XXX
93965	TC	A	Extremity study	1.13	XXX
93970	26	A	Extremity study	1.31	XXX
93970		A	Extremity study	4.90	XXX
93970	TC	A	Extremity study	3.60	XXX
93971	26	A	Extremity study	.64	XXX
93971		A	Extremity study	4.24	XXX
93971	TC	A	Extremity study	3.60	XXX
93975	26	A	Visceral vascular study	2.73	XXX
93975		A	Visceral vascular study	6.33	XXX
93975	TC	A	Visceral vascular study	3.60	XXX
93976	26	A	Visceral vascular study	1.38	XXX
93976		A	Visceral vascular study	4.97	XXX
93976	TC	A	Visceral vascular study	3.60	XXX
93978	26	A	Visceral vascular study	1.24	XXX
93978		A	Visceral vascular study	4.83	XXX
93978	TC	A	Visceral vascular study	3.60	XXX
93979	26	A	Visceral vascular study	.62	XXX
93979		A	Visceral vascular study	4.22	XXX
93979	TC	A	Visceral vascular study	3.60	XXX
93980	26	A	Penile vascular study	3.29	XXX
93980		A	Penile vascular study	6.88	XXX
93980	TC	A	Penile vascular study	3.60	XXX
93981	26	A	Penile vascular study	1.62	XXX
93981		A	Penile vascular study	4.94	XXX
93981	TC	A	Penile vascular study	3.32	XXX
94010	26	A	Breathing capacity test	.46	XXX
94010		A	Breathing capacity test	.88	XXX
94010	TC	A	Breathing capacity test	.42	XXX
94060	26	A	Evaluation of wheezing	.70	XXX
94060		A	Evaluation of wheezing	1.63	XXX
94060	TC	A	Evaluation of wheezing	.93	XXX
94070	26	A	Evaluation of wheezing	1.01	XXX
94070		A	Evaluation of wheezing	2.47	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
94070	TC	A	Evaluation of wheezing	1.46	XXX
94150	26	A	Vital capacity test	.23	XXX
94150		A	Vital capacity test	.32	XXX
94150	TC	A	Vital capacity test	.09	XXX
94160	26	A	Vital capacity screening	.37	XXX
94160		A	Vital capacity screening	.55	XXX
94160	TC	A	Vital capacity screening	.18	XXX
94200	26	A	Lung function test (MBC/MVV)	.29	XXX
94200		A	Lung function test (MBC/MVV)	.54	XXX
94200	TC	A	Lung function test (MBC/MVV)	.25	XXX
94240	26	A	Residual lung capacity	.50	XXX
94240		A	Residual lung capacity	1.19	XXX
94240	TC	A	Residual lung capacity	.69	XXX
94250	26	A	Expired gas collection	.26	XXX
94250		A	Expired gas collection	.40	XXX
94250	TC	A	Expired gas collection	.13	XXX
94260	26	A	Thoracic gas volume	.40	XXX
94260		A	Thoracic gas volume	.95	XXX
94260	TC	A	Thoracic gas volume	.55	XXX
94350	26	A	Lung nitrogen washout curve	.47	XXX
94350		A	Lung nitrogen washout curve	1.03	XXX
94350	TC	A	Lung nitrogen washout curve	.55	XXX
94360	26	A	Measure airflow resistance	.45	XXX
94360		A	Measure airflow resistance	1.41	XXX
94360	TC	A	Measure airflow resistance	.96	XXX
94370	26	A	Breath airway closing volume	.40	XXX
94370		A	Breath airway closing volume	.67	XXX
94370	TC	A	Breath airway closing volume	.27	XXX
94375	26	A	Respiratory flow volume loop	.52	XXX
94375		A	Respiratory flow volume loop	1.01	XXX
94375	TC	A	Respiratory flow volume loop	.49	XXX
94400	26	A	CO_2 breathing response curve	.98	XXX
94400		A	CO_2 breathing response curve	1.32	XXX
94400	TC	A	CO_2 breathing response curve	.34	XXX
94450	26	A	Hypoxia response curve	.66	XXX
94450		A	Hypoxia response curve	1.04	XXX
94450	TC	A	Hypoxia response curve	.38	XXX
94620	26	A	Pulmonary stress testing	1.64	XXX
94620		A	Pulmonary stress testing	3.06	XXX
94620	TC	A	Pulmonary stress testing	1.42	XXX
94640		A	Airway inhalation treatment	.41	XXX
94650		A	Pressure breathing (IPPB)	.38	XXX
94651		A	Pressure breathing (IPPB)	.37	XXX
94652		A	Pressure breathing (IPPB)	.47	XXX
94656		A	Initial, ventilator management	2.46	000
94657		A	Cont. ventilator management	1.51	000
94660		A	Pos. airway pressure, CPAP	1.53	000
94662		A	Neg. pressure ventilation, CNP	1.09	000

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
94664		A	Aerosol or vapor inhalations	.53	XXX
94665		A	Aerosol or vapor inhalations	.50	XXX
94667		A	Chest wall manipulation	.59	XXX
94668		A	Chest wall manipulation	.35	XXX
94680	26	A	Exhaled air analysis: O_2	.60	XXX
94680		A	Exhaled air analysis: O_2	1.15	XXX
94680	TC	A	Exhaled air analysis: O_2	.55	XXX
94681	26	A	Exhaled air analysis: O_2, CO_2	.69	XXX
94681		A	Exhaled air analysis: O_2, CO_2	2.09	XXX
94681	TC	A	Exhaled air analysis: O_2, CO_2	1.41	XXX
94690	26	A	Exhaled air analysis	.12	XXX
94690		A	Exhaled air analysis	.66	XXX
94690	TC	A	Exhaled air analysis	.54	XXX
94720	26	A	Monoxide diffusing capacity	.50	XXX
94720		A	Monoxide diffusing capacity	1.34	XXX
94720	TC	A	Monoxide diffusing capacity	.84	XXX
94725	26	A	Membrane diffusion capacity	.44	XXX
94725		A	Membrane diffusion capacity	2.19	XXX
94725	TC	A	Membrane diffusion capacity	1.75	XXX
94750	26	A	Pulmonary compliance study	.52	XXX
94750		A	Pulmonary compliance study	1.10	XXX
94750	TC	A	Pulmonary compliance study	.58	XXX
94760		A	Measure blood oxygen level	.26	XXX
94761		A	Measure blood oxygen level	.69	XXX
94762		A	Measure blood oxygen level	1.14	XXX
94770	26	A	Exhaled carbon dioxide test	.33	XXX
94770		A	Exhaled carbon dioxide test	.67	XXX
94770	TC	A	Exhaled carbon dioxide test	.34	XXX
95004		A	Allergy skin tests	.09	XXX
95010		A	Sensitivity skin tests	.36	XXX
95015		A	Sensitivity skin tests	.26	XXX
95024		A	Allergy skin tests	.14	XXX
95027		A	Skin end point titration	.14	XXX
95028		A	Allergy skin tests	.22	XXX
95040		A	Allergy patch tests, 1 to 10	.19	XXX
95041		A	Allergy patch tests, 11 to 20	.19	XXX
95042		A	Allergy patch tests, 21 to 30	.19	XXX
95043		A	Allergy patch tests, over 30	.19	XXX
95050		A	Photo patch tests, 1 to 10	.47	XXX
95051		A	Photo patch tests, over 10	.13	XXX
95056		A	Photosensitivity tests	.17	XXX
95060		A	Eye allergy tests	.34	XXX
95065		A	Nose allergy test	.19	XXX
95070		A	Bronchial allergy tests	2.17	XXX
95071		A	Bronchial allergy tests	2.78	XXX
95075		A	Ingestion challenge test	2.95	XXX
95078		A	Provocative testing	.25	XXX
95105		A	Allergy patient counseling	.75	XXX
95115		A	Immunotherapy, one injection	.44	XXX
95117		A	Immunotherapy injections	.68	XXX
95180		A	Rapid desensitization	2.20	XXX
95805	26	A	Multiple sleep latency Test	2.54	XXX
95805		A	Multiple sleep latency Test	7.75	XXX
95805	TC	A	Multiple sleep latency Test	5.21	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
95816	26	A	Electroencephalogram (EEG)	1.39	XXX
95816		A	Electroencephalogram (EEG)	2.72	XXX
95816	TC	A	Electroencephalogram (EEG)	1.33	XXX
95817	26	A	Electroencephalogram (EEG)	1.39	XXX
95817		A	Electroencephalogram (EEG)	3.35	XXX
95817	TC	A	Electroencephalogram (EEG)	1.96	XXX
95819	26	A	Electroencephalogram (EEG)	1.63	XXX
95819		A	Electroencephalogram (EEG)	2.96	XXX
95819	TC	A	Electroencephalogram (EEG)	1.33	XXX
95821	26	A	Portable EEG	1.70	XXX
95821		A	Portable EEG	3.66	XXX
95821	TC	A	Portable EEG	1.96	XXX
95822	26	A	Sleep electroencephalogram	1.69	XXX
95822		A	Sleep electroencephalogram	3.51	XXX
95822	TC	A	Sleep electroencephalogram	1.81	XXX
95823	26	A	Activation EEG	3.63	XXX
95823		A	Activation EEG	5.33	XXX
95823	TC	A	Activation EEG	1.71	XXX
95824	26	A	Electroencephalography	1.37	XXX
95824		A	Electroencephalography	1.79	XXX
95824	TC	A	Electroencephalography	.42	XXX
95826	26	A	Depth electroencephalogram	1.94	XXX
95826		A	Depth electroencephalogram	2.66	XXX
95826	TC	A	Depth electroencephalogram	.73	XXX
95827	26	A	Night electroencephalogram	2.03	XXX
95827		A	Night electroencephalogram	4.32	XXX
95827	TC	A	Night electroencephalogram	2.29	XXX
95828	26	A	Polysomnography	4.70	XXX
95828		A	Polysomnography	9.91	XXX
95828	TC	A	Polysomnography	5.21	XXX
95829	26	A	Surgery electrocorticogram	6.82	XXX
95829		A	Surgery electrocorticogram	6.97	XXX
95829	TC	A	Surgery electrocorticogram	.15	XXX
95830		A	Insert electrodes for EEG	2.57	XXX
95831		A	Limb muscle testing, manual	.58	XXX
95832		A	Hand muscle testing, manual	.55	XXX
95833		A	Body muscle testing, manual	.91	XXX
95834		A	Body muscle testing, manual	1.28	XXX
95842	26	A	Muscle testing, electrical	1.01	XXX
95842		A	Muscle testing, electrical	1.21	XXX
95842	TC	A	Muscle testing, electrical	.20	XXX
95851		A	Range of motion measurements	.53	XXX
95852		A	Range of motion measurements	.35	XXX
95857		A	Tensilon test	1.08	XXX
95858	26	A	Tensilon test and myogram	2.28	XXX
95858		A	Tensilon test and myogram	2.69	XXX
95858	TC	A	Tensilon test and myogram	.41	XXX
95860	26	A	Muscle test, one limb	1.75	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
95860		A	Muscle test, one limb	2.12	XXX
95860	TC	A	Muscle test, one limb	.37	XXX
95861	26	A	Muscle test, two limbs	2.92	XXX
95861		A	Muscle test, two limbs	3.66	XXX
95861	TC	A	Muscle test, two limbs	.74	XXX
95863	26	A	Muscle test, three limbs	3.40	XXX
95863		A	Muscle test, three limbs	4.33	XXX
95863	TC	A	Muscle test, three limbs	.94	XXX
95864	26	A	Muscle test, four limbs	3.88	XXX
95864		A	Muscle test, four limbs	5.67	XXX
95864	TC	A	Muscle test, four limbs	1.79	XXX
95867	26	A	Muscle test, head or neck	1.26	XXX
95867		A	Muscle test, head or neck	1.84	XXX
95867	TC	A	Muscle test, head or neck	.58	XXX
95868	26	A	Muscle test, head or neck	2.87	XXX
95868		A	Muscle test, head or neck	3.56	XXX
95868	TC	A	Muscle test, head or neck	.70	XXX
95869	26	A	Muscle test, limited	.71	XXX
95869		A	Muscle test, limited	.92	XXX
95869	TC	A	Muscle test, limited	.21	XXX
95872	26	A	Muscle test, one fiber	2.26	XXX
95872		A	Muscle test, one fiber	2.87	XXX
95872	TC	A	Muscle test, one fiber	.61	XXX
95875	26	A	Limb exercise test	1.61	XXX
95875		A	Limb exercise test	2.04	XXX
95875	TC	A	Limb exercise test	.42	XXX
95880		A	Cerebral aphasia testing	1.82	XXX
95881		A	Cerebral developmental test	1.82	XXX
95882		A	Cognitive function testing	1.82	XXX
95883		A	Neuropsychological testing	1.82	XXX
95900	26	A	Motor nerve conduction test	.79	XXX
95900		A	Motor nerve conduction test	1.07	XXX
95900	TC	A	Motor nerve conduction test	.28	XXX
95904	26	A	Sense nerve conduction test	.69	XXX
95904		A	Sense nerve conduction test	.91	XXX
95904	TC	A	Sense nerve conduction test	.22	XXX
95920	26	A	Intraoperative nerve testing	3.67	XXX
95920		A	Intraoperative nerve testing	4.97	XXX
95920	TC	A	Intraoperative nerve testing	1.29	XXX
95925	26	A	Somatosensory testing	1.84	XXX
95925		A	Somatosensory testing	3.23	XXX
95925	TC	A	Somatosensory testing	1.39	XXX
95933	26	A	Blink reflex test	1.14	XXX
95933		A	Blink reflex test	1.94	XXX
95933	TC	A	Blink reflex test	.79	XXX
95935	26	A	"H" or "F" reflex study	.96	XXX
95935		A	"H" or "F" reflex study	1.17	XXX
95935	TC	A	"H" or "F" reflex study	.21	XXX
95937	26	A	Neuromuscular junction test	1.10	XXX
95937		A	Neuromuscular junction test	1.43	XXX
95937	TC	A	Neuromuscular junction test	.33	XXX
95950	26	A	Ambulatory EEG monitoring	2.83	XXX
95950		A	Ambulatory EEG monitoring	9.23	XXX
95950	TC	A	Ambulatory EEG monitoring	6.40	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
95951	26	A	EEG monitoring/videorecord	5.46	XXX
95951		A	EEG monitoring/videorecord	13.17	XXX
95951	TC	A	EEG monitoring/videorecord	7.70	XXX
95953	26	A	EEG monitoring/computer	4.43	XXX
95953		A	EEG monitoring/computer	10.83	XXX
95953	TC	A	EEG monitoring/computer	6.40	XXX
95954	26	A	EEG monitoring/giving drugs	4.53	XXX
95954		A	EEG monitoring/giving drugs	5.03	XXX
95954	TC	A	EEG monitoring/giving drugs	.50	XXX
95955	26	A	EEG during surgery	2.13	XXX
95955		A	EEG during surgery	4.13	XXX
95955	TC	A	EEG during surgery	2.00	XXX
95956	26	A	EEG monitoring/cable/radio	4.72	XXX
95956		A	EEG monitoring/cable/radio	12.43	XXX
95956	TC	A	EEG monitoring/cable/radio	7.70	XXX
95958	26	A	EEG monitoring/function test	7.86	XXX
95958		A	EEG monitoring/function test	9.62	XXX
95958	TC	A	EEG monitoring/function test	1.76	XXX
95961	26	A	Electrode stimulation, brain	4.55	XXX
95961		A	Electrode stimulation, brain	5.85	XXX
95961	TC	A	Electrode stimulation, brain	1.29	XXX
95962	26	A	Electrode stimulation, brain	4.80	XXX
95962		A	Electrode stimulation, brain	6.10	XXX
95962	TC	A	Electrode stimulation, brain	1.29	XXX
96400		A	Chemotherapy, (SC)/(IM)	.13	XXX
96408		A	Chemotherapy, push technique	.96	XXX
96410		A	Chemotherapy, infusion method	1.53	XXX
96412		A	Chemotherapy, infusion method	1.15	XXX
96414		A	Chemotherapy, infusion method	1.33	XXX
96420		A	Chemotherapy, push technique	1.25	XXX
96422		A	Chemotherapy, infusion method	1.23	XXX
96423		A	Chemotherapy, infusion method	.49	XXX
96425		A	Chemotherapy, infusion method	1.43	XXX
96440		A	Chemotherapy, intracavitary	3.28	000
96445		A	Chemotherapy, intracavitary	3.29	000
96450		A	Chemotherapy, into CNS	2.85	000
96520		A	Pump refilling, maintenance	.89	XXX
96530		A	Pump refilling, maintenance	1.05	XXX
96542		A	Chemotherapy injection	2.63	XXX
96545		B	Provide chemotherapy agent	.00	XXX
96900		A	Ultraviolet light therapy	.40	XXX
96910		A	Photochemotherapy with UV-B	.58	XXX
96912		A	Photochemotherapy with UV-A	.67	XXX
99000		B	Specimen handling	.00	XXX
99001		B	Specimen handling	.00	XXX
99002		B	Device handling	.00	XXX
99024		B	Postop follow-up visit	.00	XXX
99025		B	Initial surgical evaluation	.00	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
99050		B	Postop follow-up visit	.00	XXX
99052		B	Medical services at night	.00	XXX
99054		B	Medical services, unusual hours	.00	XXX
99056		B	Nonoffice medical services	.00	XXX
99058		B	Office emergency care	.00	XXX
99070		B	Special supplies	.00	XXX
99071		B	Patient education materials	.00	XXX
99078		B	Group health education	.00	XXX
99080		B	Special reports or forms	.00	XXX
99090		B	Computer data analysis	.00	XXX
99150		B	Prolonged MD attendance	.00	XXX
99151		B	Prolonged MD attendance	.00	XXX
99175		A	Induction of vomiting	1.40	XXX
99180		A	Hyperbaric oxygen, initial	2.00	XXX
99182		A	Hyperbaric oxygen, subsequent	1.57	XXX
99185		A	Regional hypothermia	.64	XXX
99186		A	Total body hypothermia	2.09	XXX
99190		A	Special pump services	3.17	000
99191		A	Special pump services	1.95	000
99192		A	Special pump services	1.45	000
99195		A	Phlebotomy	.44	XXX
99201		A	Office/outpatient visit, new	.80	XXX
99202		A	Office/outpatient visit, new	1.29	XXX
99203		A	Office/outpatient visit, new	1.77	XXX
99204		A	Office/outpatient visit, new	2.61	XXX
99205		A	Office/outpatient visit, new	3.28	XXX
99211		A	Office/outpatient visit, est	.39	XXX
99212		A	Office/outpatient visit, est	.70	XXX
99213		A	Office/outpatient visit, est	.98	XXX
99214		A	Office/outpatient visit, est	1.52	XXX
99215		A	Office/outpatient visit, est	2.39	XXX
99218		A	Observation care	1.82	XXX
99219		A	Observation care	2.89	XXX
99220		A	Observation care	3.67	XXX
99221		A	Initial hospital care	1.82	XXX
99222		A	Initial hospital care	3.00	XXX
99223		A	Initial hospital care	3.85	XXX
99231		A	Subsequent hospital care	.96	XXX
99232		A	Subsequent hospital care	1.42	XXX
99233		A	Subsequent hospital care	1.94	XXX
99238		A	Hospital discharge day	1.66	XXX
99241		A	Office consultation	1.21	XXX
99242		A	Office consultation	1.94	XXX
99243		A	Office consultation	2.50	XXX
99244		A	Office consultation	3.56	XXX
99245		A	Office consultation	4.75	XXX
99251		A	Initial inpatient consult	1.32	XXX
99252		A	Initial inpatient consult	2.00	XXX
99253		A	Initial inpatient consult	2.64	XXX
99254		A	Initial inpatient consult	3.63	XXX
99255		A	Initial inpatient consult	4.91	XXX
99261		A	Follow-up inpatient consult	.72	XXX
99262		A	Follow-up inpatient consult	1.28	XXX
99263		A	Follow-up inpatient consult	1.92	XXX

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99271		A	Confirmatory consultation	1.14	XXX
99272		A	Confirmatory consultation	1.66	XXX
99273		A	Confirmatory consultation	2.19	XXX
99274		A	Confirmatory consultation	2.98	XXX
99275		A	Confirmatory consultation	3.93	XXX
99281		A	Emergency department visit	.59	XXX
99282		A	Emergency department visit	.91	XXX
99283		A	Emergency department visit	1.64	XXX
99284		A	Emergency department visit	2.49	XXX
99285		A	Emergency department visit	3.90	XXX
99288		B	Direct advanced life support	.00	XXX
99291		A	Critical care, first hour	5.27	XXX
99292		A	Critical care, additional 30 minutes	2.58	XXX
99301		A	Nursing facility care	1.58	XXX
99302		A	Nursing facility care	2.25	XXX
99303		A	Nursing facility care	3.35	XXX
99311		A	Nursing facility care, subsequent	.91	XXX
99312		A	Nursing facility care, subsequent	1.34	XXX
99313		A	Nursing facility care, subsequent	1.73	XXX
99321		A	Rest home visit, new patient	1.11	XXX
99322		A	Rest home visit, new patient	1.59	XXX
99323		A	Rest home visit, new patient	2.10	XXX
99331		A	Rest home visit, established patient	.91	XXX
99332		A	Rest home visit, established patient	1.21	XXX
99333		A	Rest home visit, established patient	1.50	XXX
99341		A	Home visit, new patient	1.71	XXX
99342		A	Home visit, new patient	2.27	XXX
99343		A	Home visit, new patient	2.96	XXX
99351		A	Home visit, established patient	1.34	XXX
99352		A	Home visit, established patient	1.71	XXX
99353		A	Home visit, established patient	2.19	XXX
99361		B	Physician/team conference	.00	XXX
99362		B	Physician/team conference	.00	XXX
99371		B	Physician phone consultation	.00	XXX
99372		B	Physician phone consultation	.00	XXX
99373		B	Physician phone consultation	.00	XXX

H. Procedure code numbers A4190 to Q0092 relate to miscellaneous services and supplies.

CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
A4190		P	Transparent film	.00	XXX
A4200		P	Gauze pads, sterile or nonsterile	.00	XXX
A4202		P	Gauze bandage, elastic	.00	XXX
A4203		P	Gauze bandage, nonelastic	.00	XXX
A4204		P	Absorptive dressing	.00	XXX
A4205		P	Nonabsorptive dressing	.00	XXX
A4206		P	Syringe with needle, sterile 1 cc	.00	XXX
A4207		P	Syringe with needle, sterile 2 cc	.00	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
A4208		P	Syringe with needle, sterile 3 cc	.00	XXX
A4209		P	Syringe with needle, sterile 5 + cc	.00	XXX
A4211		P	Supplied for self-Adm injection	.00	XXX
A4212		P	Huber-type needle, each	.00	XXX
A4213		P	Syringe, sterile, 20 cc or greater	.00	XXX
A4214		P	Sterile saline or water, 30 cc	.00	XXX
A4215		P	Needles only, sterile, any size	.00	XXX
A4216		P	Hemostatis cellulose any size	.00	XXX
A4244		P	Alcohol or peroxide, per pint	.00	XXX
A4245		P	Alcohol wipes, per box	.00	XXX
A4246		P	Betidine or Phisohex solution	.00	XXX
A4247		P	Betadine or iodine swabs/wipes	.00	XXX
A4253		P	Blood glucose test	.00	XXX
A4256		P	Normal, low and high cal solution	.00	XXX
A4259		P	Lancets, per box	.00	XXX
A4265		P	Paraffin	.00	XXX
A4305		P	Disposable drug delivery system	.00	XXX
A4306		P	Disposable drug delivery system	.00	XXX
A4310		P	Insertion tray w/o drainage bag	.00	XXX
A4311		P	Insertion tray w/o drainage bag	.00	XXX
A4312		P	Insertion tray w/o drainage bag	.00	XXX
A4313		P	Insertion tray w/o drainage bag	.00	XXX
A4314		P	Insertion tray with drainage bag	.00	XXX
A4315		P	Insertion tray with drainage bag	.00	XXX
A4316		P	Insertion tray with drainage bag	.00	XXX
A4320		P	Irrigation tray for bladder	.00	XXX
A4322		P	Irrigation syringe, bulb or piston	.00	XXX
A4323		P	Sterile saline irrigation solution	.00	XXX
A4326		P	Male external catheter	.00	XXX
A4327		P	Female external urinary collection	.00	XXX
A4328		P	Female external urinary collection	.00	XXX
A4329		P	External catheter starter set	.00	XXX
A4330		P	Perianal fecal collection pouch	.00	XXX
A4335		P	Incontinence supply; miscellaneous	.00	XXX
A4338		P	Indwelling catheter; foley type	.00	XXX
A4340		P	Indwelling catheter; spec type	.00	XXX
A4344		P	Indwelling catheter; foley type	.00	XXX
A4346		P	Indwelling catheter; foley type	.00	XXX
A4347		P	Male external catheter	.00	XXX
A4351		P	Intermittent urinary catheter	.00	XXX
A4352		P	Intermittent urinary catheter	.00	XXX
A4354		P	Insertion tray with drainage bag	.00	XXX
A4355		P	Irrigation tubing set	.00	XXX
A4356		P	External urethral clamp device	.00	XXX
A4357		P	Bedside drainage bag, day or night	.00	XXX
A4358		P	Urinary leg bag; vinyl	.00	XXX
A4359		P	Urinary suspensory without leg bag	.00	XXX
A4361		P	Ostomy faceplate	.00	XXX
A4362		P	Skin barrier; solid, 4 x 4	.00	XXX
A4363		P	Skin barrier; liquid, powder	.00	XXX
A4364		P	Adhesive for ostomy or catheter	.00	XXX
A4367		P	Ostomy belt	.00	XXX
A4397		P	Irrigation supply; sleeve	.00	XXX
A4398		P	Irrigation supply; bags	.00	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
A4399		P	Irrigation supply; cone/catheter	.00	XXX
A4400		P	Ostomy irrigation set	.00	XXX
A4402		P	Lubricant	.00	XXX
A4404		P	Ostomy rings	.00	XXX
A4421		P	Ostomy supply; miscellaneous	.00	XXX
A4454		P	Tape, all types, all sizes	.00	XXX
A4455		P	Adhesive remover or solvent	.00	XXX
A4460		P	Elastic bandage	.00	XXX
A4470		P	Gravlee jet washer	.00	XXX
A4480		P	Vabra aspirator	.00	XXX
A4550		A	Surgical trays	.94	XXX
A4556		P	Electrodes, (e.g., apnea monitor	.00	XXX
A4557		P	Lead wires, (e.g., apnea monitor	.00	XXX
A4558		P	Conductive paste or gel	.00	XXX
A4647		B	Paramagnetic contrast material	.00	XXX
A4649		B	Surgical supply; miscellaneous	.00	XXX
A5051		P	Pouch, closed; with barrier	.00	XXX
A5052		P	Pouch, closed; without barrier	.00	XXX
A5053		P	Pouch, closed; use on faceplate	.00	XXX
A5054		P	Pouch, closed; use on barrier	.00	XXX
A5055		P	Stoma cap	.00	XXX
A5061		P	Pouch, drainable; with barrier	.00	XXX
A5062		P	Pouch, drainable; without barrier	.00	XXX
A5063		P	Pouch, drainable; use on barrier	.00	XXX
A5064		P	Pouch, drainable; with faceplate	.00	XXX
A5065		P	Pouch, drainable; use on faceplate	.00	XXX
A5071		P	Pouch, urinary; with barrier	.00	XXX
A5072		P	Pouch, urinary; without barrier	.00	XXX
A5073		P	Pouch, urinary; use on barrier	.00	XXX
A5074		P	Pouch, urinary; with faceplate	.00	XXX
A5075		P	Pouch, urinary; use on faceplate	.00	XXX
A5081		P	Continent device; plug	.00	XXX
A5082		P	Continent device; catheter	.00	XXX
A5093		P	Ostomy accessory; convex insert	.00	XXX
A5102		P	Bedside drainage bottle	.00	XXX
A5105		P	Urinary suspensory; with leg bag	.00	XXX
A5112		P	Urinary leg bag; latex	.00	XXX
A5113		P	Leg strap; latex, per set	.00	XXX
A5114		P	Leg strap; foam or fabric	.00	XXX
A5119		P	Skin barrier; wipes, box per 50	.00	XXX
A5121		P	Skin barrier; solid, 6 x 6	.00	XXX
A5122		P	Skin barrier; solid, 8 x 8	.00	XXX
A5123		P	Skin barrier; with flange	.00	XXX
A5126		P	Adhesive; disc or foam pad	.00	XXX
A5131		P	Appliance cleaner	.00	XXX
A5149		P	Incontinence/ostomy supply	.00	XXX
M0064		A	Monitoring drug prescription visits	.58	XXX
M0101		A	Cutting or removal of corns	.73	XXX

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CPT/HCPCS Procedure Code	Tech/Prof. MOD	Status	CPT/HCPCS Description	Total RVU	Global Period
M0702		A	Brief, osteopathic manip therapy	.71	000
M0704		A	Limited, osteopathic manip therapy	1.08	000
M0706		A	Intermediate osteopathic manip therapy	1.29	000
M0708		A	Extended osteopathic manip therapy	1.51	000
M0710		A	Comprehensive osteopathic manip	1.62	000
M0722		A	Brief inpatient hospital OMT	1.08	000
M0724		A	Limited inpatient hospital OMT	1.53	000
M0726		A	Intermediate inpatient hospital OMT	1.71	000
M0728		A	Extended inpatient hospital OMT	1.41	000
M0730		A	Comprehensive inpatient hospital OMT	1.76	000
M0900		A	Excision, revision of A-V shunt	8.06	000
Q0035	26	A	Cardiokymography	.29	XXX
Q0035		A	Cardiokymography	.68	XXX
Q0035	TC	A	Cardiokymography	.38	XXX
Q0068		A	Extracorporeal plasmapheresis	3.09	000
Q0091		A	Screening pap smear, obtaining	.66	XXX
Q0092		A	Set-up portable X-ray equipment	.30	XXX

5221.4032 PROFESSIONAL/TECHNICAL COMPONENTS FOR MEDICAL/SURGICAL SERVICES.

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

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

Subp. 3. **One billing for both components.** If the same health care provider renders both the professional and technical components of the service, the maximum fee is calculated for the complete service by using the RVUs corresponding to the service code listed without a modifier in part 5221.4030, subpart 2, and the formula in part 5221.4020.

5221.4033 OUTPATIENT LIMITATION FOR MEDICAL/SURGICAL SERVICES.

Procedures whose codes are listed below are predominantly performed in office settings and, therefore, no additional facility fees are payable unless it is medically necessary to perform the procedure in a nonoffice setting.

CPT/HCPCS Procedure Code	CPT/HCPCS Description
10040	Acne surgery
10060	Drainage of skin abscess
10061	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10121	Remove foreign body
10140	Drainage of hematoma
10160	Puncture drainage of lesion
11000	Surgical cleansing of skin
11001	Additional cleansing of skin
11040	Surgical cleansing, abrasion
11041	Surgical cleansing of skin
11050	Trim skin lesion

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
11051	Trim 2 to 4 skin lesions
11052	Trim over 4 skin lesions
11100	Biopsy of lesion
11101	Biopsy, each additional lesion
11200	Removal of skin tags
11201	Removal of added skin tags
11300	Shaving of skin lesion
11301	Shaving of skin lesion
11302	Shaving of skin lesion
11303	Shaving of skin lesion
11306	Shaving of skin lesion
11307	Shaving of skin lesion
11310	Shaving of skin lesion
11311	Shaving of skin lesion
11312	Shaving of skin lesion
11400	Removal of skin lesion
11401	Removal of skin lesion
11402	Removal of skin lesion
11403	Removal of skin lesion
11420	Removal of skin lesion
11421	Removal of skin lesion
11422	Removal of skin lesion
11423	Removal of skin lesion
11440	Removal of skin lesion
11441	Removal of skin lesion
11442	Removal of skin lesion
11443	Removal of skin lesion
11600	Removal of skin lesion
11601	Removal of skin lesion
11602	Removal of skin lesion
11603	Removal of skin lesion
11620	Removal of skin lesion
11621	Removal of skin lesion
11622	Removal of skin lesion
11623	Removal of skin lesion
11640	Removal of skin lesion
11641	Removal of skin lesion
11642	Removal of skin lesion
11643	Removal of skin lesion
11700	Surgical cleansing of nails
11701	Surgical cleansing of nails
11710	Surgical cleansing of nails
11711	Surgical cleansing of nails
11730	Removal of nail plate
11731	Removal of second nail plate
11732	Remove nail plate, additional
11740	Drain blood from under nail
11750	Removal of nail bed

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
11760	Reconstruction of nail bed
11762	Reconstruction of nail bed
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Skin lesion injections, additional
15851	Removal of sutures
16000	Initial treatment of burn(s)
16010	Treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
17000	Destruction of face lesion
17001	Destruction of added lesions
17002	Destruction of added lesions
17010	Destruction skin lesion(s)
17100	Destruction of skin lesions
17101	Destruction of 2nd lesion
17102	Destruction of added lesions
17104	Destruction of skin lesions
17105	Destruction of skin lesions
17110	Destruction of skin lesions
17200	Electrocautery of skin tags
17201	Electrocautery added lesions
17250	Chemical cautery of wound
17304	Chemosurgery of skin lesion
17305	2nd stage chemosurgery
17306	3rd stage chemosurgery
17307	Follow-up skin lesion therapy
17310	Extensive skin chemosurgery
17340	Cryotherapy of skin
17360	Skin peel therapy
19000	Drainage of breast lesion
20000	Incision of abscess
20500	Injection of sinus tract
20520	Removal of foreign body
20550	Injection treatment
20600	Drainage joint/bursa/cyst
20605	Drainage joint/bursa/cyst
20610	Inject/drain joint/bursa
20615	Treatment of bone cyst
21030	Removal of face bone lesion
24650	Treat radius fracture
25500	Treat fracture of radius
25600	Treat fracture radius/ulna
26010	Drainage of finger abscess
26600	Treat metacarpal fracture
26720	Treat finger fracture, each
28001	Drainage of bursa of foot
28010	Incision of toe tendon
28108	Removal of toe lesions
28124	Partial removal of toe
28126	Partial removal of toe
28153	Partial removal of toe
28160	Partial removal of toe
28190	Removal of foot foreign body

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
28230	Incision of foot tendon(s)
28232	Incision of toe tendon
28234	Incision of foot tendon
28270	Release of foot contracture
28272	Release of toe joint, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29200	Strapping of chest
29260	Strapping of elbow or wrist
29345	Application of long leg cast
29355	Application of long leg cast
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle
29550	Strapping of toes
29580	Application of paste boot
29700	Removal/revision of cast
29705	Removal/revision of cast
30100	Intranasal biopsy
30110	Removal of nose polyp(s)
30200	Injection treatment of nose
30210	Nasal sinus therapy
30901	Control of nosebleed
31000	Irrigation maxillary sinus
31250	Nasal endoscopy, diagnostic
31505	Diagnostic laryngoscopy
31575	Fiberscopic laryngoscopy
36400	Establish access to vein
36425	Establish access to vein
36470	Injection therapy of vein
36471	Injection therapy of veins
36500	Insertion of catheter, vein

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
40490	Biopsy of lip
40808	Biopsy of mouth lesion
40810	Excision of mouth lesion
40812	Excise/repair mouth lesion
41100	Biopsy of tongue
41108	Biopsy of floor of mouth
42100	Biopsy roof of mouth
42330	Removal of salivary stone
42650	Dilation of salivary duct
42800	Biopsy of throat
45300	Proctosigmoidoscopy
45302	Proctosigmoidoscopy
45303	Proctosigmoidoscopy
45330	Sigmoidoscopy
46083	Incise external hemorrhoid
46221	Ligation of hemorrhoid(s)
46230	Removal of anal tabs
46320	Removal of hemorrhoid clot
46500	Injection into hemorrhoids
46600	Diagnostic anoscopy
46602	Diagnostic anoscopy
46604	Anoscopy and dilation
46614	Anoscopy; control bleeding
46900	Destruction, anal lesion(s)
46934	Destruction of hemorrhoids
46936	Destruction of hemorrhoids
46945	Ligation of hemorrhoids
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
53600	Dilate urethra stricture
53601	Dilate urethra stricture
53620	Dilate urethra stricture
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53670	Insert urinary catheter
54235	Penile injection
55000	Drainage of hydrocele
56501	Destruction, vulva lesion(s)
57100	Biopsy of vagina
57150	Treat vagina infection
57160	Insertion of pessary
57452	Examination of vagina
57454	Vagina examination and biopsy
57500	Biopsy of cervix
57505	Endocervical curettage
57510	Cauterization of cervix
57511	Cryocautery of cervix
58100	Biopsy of uterus lining
60100	Biopsy of thyroid
64400	Injection for nerve block
64405	Injection for nerve block
64413	Injection for nerve block

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
64418	Injection for nerve block
64425	Injection for nerve block
64440	Injection for nerve block
64441	Injection for nerve block
64445	Injection for nerve block
64450	Injection for nerve block
64505	Injection for nerve block
64550	Apply neurostimulator
64565	Implant neuroelectrodes
64640	Injection treatment of nerve
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65435	Curette/treat cornea
66761	Revision of iris
67145	Treatment of retina
67210	Treatment of retinal lesion
67228	Treatment of retinal lesion
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67801	Remove eyelid lesions
67810	Biopsy of eyelid
67820	Revise eyelashes
67825	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
68020	Incise/drain eyelid lining
68110	Remove eyelid lining lesion
68200	Treat eyelid by injection
68440	Incise tear duct opening
68760	Close tear duct opening
68761	Close tear duct system
68800	Dilate tear duct opening(s)
68820	Explore tear duct system
68830	Reopen tear duct channel
68840	Explore/irrigate tear ducts
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69100	Biopsy of external ear
69200	Clear outer ear canal
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
69222	Clean out mastoid cavity
69400	Inflate middle ear canal

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CPT/HCPCS Procedure Code	CPT/HCPCS Description
69401	Inflate middle ear canal
69420	Incision of eardrum
69433	Create eardrum opening
69610	Repair of eardrum
92002	Eye exam and treatment, new
92004	Eye exam and treatment, new
92012	Eye exam and treatment, established
92014	Eye exam and treatment, established
92018	Eye exam and treatment, new
92020	Special eye evaluation
92070	Fitting of contact lens
92100	Serial tonometry exam(s)
92120	Tonography and eye evaluation
92130	Water provocation tonography
92140	Glaucoma provocative tests
92225	Extended ophthalmoscopy, new
92226	Extended ophthalmoscopy
92230	Ophthalmoscopy/angioscopy
92311	Special contact lens fitting
92312	Special contact lens fitting
92352	Special spectacles fitting
92353	Special spectacles fitting
92504	Ear microscopy examination
92506	Speech and hearing evaluation
92507	Speech/hearing therapy
92511	Nasopharyngoscopy
92516	Facial nerve function test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95831	Limb muscle testing, manual
93832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
95857	Tensilon test
96440	Chemotherapy, intracavitary
99201	Office and other outpatient, new patient, level 1
99202	Office and other outpatient, new patient, level 2
99203	Office and other outpatient, new patient, level 3
99204	Office and other outpatient, new patient, level 4
99205	Office and other outpatient, new patient, level 5
99211	Office and other outpatient, established patient, level 1
99212	Office and other outpatient, established patient, level 1
99213	Office and other outpatient, established patient, level 1
99214	Office and other outpatient, established patient, level 1
99215	Office and other outpatient, established patient, level 1

5221.4034 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **Global surgery fee.** Except as described in item B, codes for surgical procedures and their coprresponding maximum fees include all services normally furnished by the surgeon or the surgeon's designee before, during, and after the procedure within a predetermined postoperative period. This concept is referred to as the "global surgery package" or "global surgery fee." Services included in the global surgery package for a given procedure include: Preoperative visits related to the surgery on the day before surgery and the day of surgery; the hospital admission workup; the primary operation; local infiltration, digital block or topical

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anesthesia when used; immediate postoperative care including conferences with the family and other health care providers and evaluations of the patient in the recovery room; postoperative hospital and office visits, as well as all additional medical or surgical services required of the surgeon because of complications, which do not require additional trips to the operating room. Also included in the global surgery fee are all written reports and records normally maintained by the surgeon during the preoperative, intraoperative, and postoperative periods.

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

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

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

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

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

E. ZZZ: these procedures are part of other services and fall within the global definition of the major service. No separate payment is made for these procedures.

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

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

A. For purposes of the global surgery package, preoperative care does not include any care administered before the provider determines that surgery is required, nor does it include an initial evaluation or consultation by the surgeon during which the decision to have surgery is made. These visits shall be paid separately at maximum fees calculated according to the formula in part 5221.4020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Except as provided in part 5221.0410, subpart 7, the physician may separately bill a reasonable amount for supplementary reports and services directly related to the employee's ability to return to work, fitness for job offers, and opinions as to whether or not the condition was related to a work-related injury. Fees for these services are governed by parts 5221.0410, subpart 7, 5221.0420, subpart 3, and 5221.0500, subpart 2.

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

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

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

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

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

Example:

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

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

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

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

Procedure code number 27372-51 is used for billing.

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

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

Procedure code number 28193-51 is used for billing.

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

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

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

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

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

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

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

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

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

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

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

Subp. 6. **Assistant-at-surgery.**

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

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

(1) 10000, 10001, 10002, 10003, 10020, 10040, 10060, 10061, 10080, 10100, 10101, 10120, 10121, 10140, 10141, 10160, 10180, 11000, 11001, 11040, 11041, 11042, 11043, 11044, 11050, 11051, 11052, 11100, 11101, 11200, 11201, 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11450, 11451, 11462, 11463, 11470, 11471, 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643,

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11644, 11646, 11700, 11701, 11710, 11711, 11730, 11731, 11732, 11740, 11750, 11752, 11760, 11762, 11765, 11770, 11771, 11772, 11900, 11901, 11920, 11950, 11951, 11952, 11954, 11960, 11970, 11971, 12001, 12002, 12004, 12005, 12006, 12007, 12011, 12013, 12014, 12015, 12016, 12017, 12018, 12020, 12021, 12031, 12032, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13100, 13101, 13120, 13121, 13131, 13132, 13150, 13151, 13152, 13160, 13300, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 15000, 15050, 15100, 15200, 15201, 15220, 15240, 15241, 15260, 15261, 15400, 15416, 15505, 15510, 15515, 15555, 15580, 15600, 15610, 15620, 15625, 15630, 15700, 15720, 15730, 15734, 15736, 15738, 15740, 15760, 15775, 15780, 15781, 15782, 15783, 15786, 15787, 15790, 15791, 15810, 15811, 15819, 15820, 15821, 15822, 15823, 15824, 15825, 15828, 15833, 15834, 15836, 15837, 15838, 15839, 15841, 15842, 15850, 15851, 15852, 15860, 15875, 15879, 15920, 15931, 15940, 15950, 15960, 15961, 15964, 15966, 15967, 15970, 15972, 15973, 15975, 15980, 15982, 15983, 16000, 16010, 16015, 16020, 16025, 16030, 16035, 16040, 16041, 16042, 17000, 17001, 17002, 17010, 17100, 17101, 17102, 17104, 17105, 17110, 17200, 17201, 17250, 17300, 17303, 17304, 17305, 17306, 17307, 17310, 17340, 17360, 17380, 19000, 19001, 19020, 19030, 19100, 19101, 19110, 19112, 19120, 19290, 19291, 19324, 19350, 19355, 19370, 19396;

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

(3) 30000, 30020, 30100, 30110, 30115, 30117, 30120, 30124, 30125, 30130, 30140, 30200, 30210, 30220, 30300, 30310, 30320, 30400, 30410, 30420, 30430, 30435, 30450, 30520, 30540, 30545, 30560, 30580, 30600, 30620, 30630, 30800, 30805, 30820, 30901, 30903, 30905, 30906, 30915, 30920, 30930, 31000, 31002, 31020, 31030, 31032, 31033, 31050, 31051, 31070, 31090, 31200, 31201, 31250, 31252, 31254, 31255, 31256, 31258, 31260, 31263, 31265, 31267, 31268, 31270, 31275,

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31277, 31500, 31505, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579, 31580, 31582, 31585, 31586, 31590, 31595, 31600, 31601, 31603, 31605, 31611, 31612, 31613, 31614, 31615, 31622, 31625, 31628, 31629, 31630, 31631, 31635, 31640, 31641, 31645, 31646, 31656, 31659, 31700, 31708, 31710, 31715, 31717, 31719, 31720, 31725, 31766, 31781, 31820, 31825, 31830, 32000, 32002, 32005, 32020, 32400, 32405, 32420, 32700, 32705, 32810, 32960, 33010, 33011, 33015, 33207, 33208, 33210, 33212, 33216, 33218, 33219, 33222, 33232, 33250, 33471, 33478, 33694, 33738, 33739, 33762, 33764, 33774, 33779, 33780, 33786, 33803, 33813, 33851, 33940, 33971, 33972, 34471, 35450, 36000, 36010, 36100, 36101, 36120, 36140, 36145, 36160, 36200, 36215, 36230, 36245, 36261, 36262, 36400, 36405, 36406, 36410, 36415, 36420, 36425, 36430, 36440, 36450, 36455, 36470, 36471, 36488, 36489, 36490, 36491, 36495, 36496, 36497, 36500, 36510, 36520, 36600, 36620, 36625, 36640, 36660, 36680, 36800, 36810, 36815, 36832, 36840, 36845, 36860, 36861, 37565, 37606, 37609, 37616, 37785, 38200, 38230, 38240, 38300, 38305, 38308, 38500, 38505, 38510, 38520, 38525, 38790, 38794, 39400;

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

(5) 50080, 50200, 50390, 50392, 50393, 50394, 50395, 50396, 50398, 50551, 50553, 50555, 50557, 50559, 50561, 50570, 50572, 50574, 50576, 50590, 50684, 50686, 50688, 50690, 50951, 50953, 50955, 50957, 50959, 50961, 50970, 50972, 50974, 50976, 50978, 50980, 51000, 51005, 51010, 51065, 51600, 51605, 51610, 51700, 51705, 51710, 51720, 51725, 51726, 51727, 51736, 51739, 51741, 51772, 51785, 51792, 51795, 51797, 51820, 51940, 52000, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52550, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52283, 52285, 52290, 52300, 52305, 52310, 52315, 52317, 52318, 52320, 52325, 52330, 52332, 52334, 52335, 52336, 52337, 52338, 52340, 52500, 52601, 52606, 52612, 52614, 52620, 52630, 52640, 52650, 52700, 53000, 53010, 53020, 53025, 53040, 53060, 53080, 53200, 53220, 53235, 53240, 53250, 53260, 53265, 53270, 53275, 53420, 53450, 53460, 53502, 53520, 53600, 53601, 53605, 53621, 53640, 53660, 53661, 53665, 53670, 53675, 54000, 54001, 54015, 54050, 54055, 54056, 54057, 54060, 54065, 54100, 54105, 54150, 54152, 54160, 54161, 54200, 54220, 54230, 54235, 54240, 54250, 54300, 54308, 54318, 54328, 54332, 54336, 54340, 54344, 54348, 54352, 54380, 54385, 54435, 54450, 54500, 54505, 54520, 54600, 54620, 54660, 54670, 54700, 54800, 54860, 54900, 55000, 55100, 55120, 55180, 55200, 55250, 55450, 55600, 55651, 55700, 55705, 55720, 55740, 55980, 56000, 56100, 56400, 56405, 56420, 56440, 56501, 56600, 56605, 56606, 56685, 56700, 56710, 56720, 56740, 57000, 57010, 57020, 57061, 57065, 57100, 57105, 57135, 57150, 57160, 57170, 57180, 57291, 57311, 57400, 57410, 57415, 57450, 57451, 57452, 57454, 57500, 57505, 57510, 57511, 57513, 57520, 57700, 57800, 57820, 58100, 58101, 58102, 58120, 58300, 58301, 58310, 58320, 58340, 58345, 58820, 58970, 58980, 58982, 58983, 58986, 58987, 58988, 58990, 58992, 58994, 59000, 59015, 59020, 59025, 59030, 59050, 59130, 59135, 59140, 59150, 59151, 59160, 59200, 59300, 59325, 59400, 59410, 59412, 59420, 59430, 59812, 59820, 59840, 59841, 59850, 59851, 59852;

(6) 60000, 60100, 61000, 61001, 61020, 61026, 61050, 61055, 61070, 61105, 61107, 61108, 61120, 61151, 61334,

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

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

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

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

Modifier 54 is used to identify these services.

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

Maximum fee = .14 x (total RVUs x CF).

Modifier 55 is used to identify these services.

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

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

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

5221.4040 PATHOLOGY AND LABORATORY PROCEDURE CODES

Subpart 1. Key to abbreviations and terms.

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

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

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

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

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
80007	7 Clinical chemistry tests	.78

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CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
80500	Lab pathology consultation	.48
80502	Lab pathology consultation	1.41
81000	Urinalysis with microscopy	.23
81002	Urinalysis without scope	.13
82565	Assay blood creatinine	.09
82947	Assay body fluid, glucose	.37
84132	Assay blood potassium	.23
84295	Assay blood sodium	.30
85007	Differential WBC count	.28
85014	Hematocrit	.15
85018	Hemoglobin, colorimetric	.18
85021	Automated hemogram	.24
85022	Automated hemogram	.42
85023	Automated hemogram	.53
85024	Automated hemogram	.45
85025	Automated hemogram	.65
85031	Manual hemogram, complete CBC	.47
85048	White blood cell (WBC) count	.16
85060	Blood smear interpretation	.58
85095	Bone marrow aspiration	1.51
85097	Bone marrow interpretation	1.23
85100	Bone marrow examination	2.99
85101	Aspirate, stain bond marrow	1.70
85102	Bone marrow biopsy	2.35
85103	Bone marrow biopsy and exam	1.34
85105	Bone marrow, interpretation	.95
85109	Bone marrow preparation	1.04
85580	Blood platelet count	.36
85610	Prothrombin time	.26
85651	RBC sedimentation rate	.18
85730	Thromboplastin time, partial	.36
86068	Blood compatibility test	.58
86077	Physician blood bank service	.56
86078	Physician blood bank service	1.09
86079	Physician blood bank service	.59
86083	Blood typing; antibody screen	.79
86455	Reduced allergy skin test	.35
86490	Coccidioidomycosis skin test	.24
86510	Histoplasmosis skin test	.26
86540	Mumps skin test	.22
86580	TB intradermal test	.21
86585	TB tine test	.16
87040	Blood culture for bacteria	.94
87070	Culture specimen, bacteria	.48
88104	Microscopic exam of cells	.87
88106	Microscopic exam of cells	.80
88107	Microscopic exam of cells	1.06
88108	Microscopic exam of cells	.89

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CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
88125	Forensic cytopathology	.31
88160	Cytopathology	.72
88161	Cytopathology	.77
88162	Cytopathology, extensive	1.34
88170	Fine needle aspiration	1.33
88171	Fine needle aspiration	2.08
88172	Evaluation of smear	1.12
88173	Interpretation of smear	1.68
88180	Cell marker study	.59
88182	Cell marker study	1.44
88300	Tissue exam by pathologist	.25
88302	Tissue exam by pathologist	.53
88304	Tissue exam by pathologist	.79
88305	Tissue exam by pathologist	1.56
88307	Tissue exam by pathologist	2.70
88309	Tissue exam by pathologist	3.62
88311	Decalcify tissue	.38
88312	Special stains	.68
88313	Special stains	.38
88314	Histochemical stain	.92
88318	Chemical histochemistry	.56
88319	Enzyme histochemistry	.88
88321	Microslide consultation	1.47
88323	Microslide consultation	1.78
88325	Comprehensive review of data	2.32
88329	Pathology consult in surgery	.89
88331	Pathology consult in surgery	1.99
88332	Pathology consult in surgery	.99
88342	Immunocytochemistry	1.27
88346	Immunofluorescent study	1.23
88347	Immunofluorescent study	1.10
88348	Electron microscopy	3.28
88349	Scanning electron microscopy	2.01
88355	Analysis, skeletal muscle	3.10
88356	Analysis, nerve	4.90
88358	Analysis, tumor	4.44
88362	Nerve teasing preparations	3.56
88365	Tissue hybridization	1.44
89100	Sample intestinal contents	.88
89105	Sample intestinal contents	.78
89130	Sample stomach contents	.74
89132	Sample stomach contents	.33
89135	Sample stomach contents	1.19
89136	Sample stomach contents	.37
89140	Sample stomach contents	1.52
89141	Sample stomach contents	1.37
89350	Sputum specimen collection	.34
89360	Collect sweat for test	.38

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

Subpart 1. **General.** Fees for pathology and laboratory services shall be adjusted when the professional and technical components of the service are performed by different individuals or entities. The professional component of the service represents the care rendered by the health care provider, such as examination of the patient, performance and supervision of the procedure, and consultation with

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other practitioners. The technical component of the service represents all other costs associated with the service, such as the cost of equipment, the salary of technicians, and supplies normally used in delivering the service. The maximum fee for the professional component of the service is calculated according to the following formula:

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

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

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

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

Subp. 5. **Services performed in an independent laboratory.** The maximum fee for physician pathology services performed in an independent laboratory is that calculated for the complete service, using the RVUs corresponding to the service code listed without a modifier in part 5221.4040, subpart 2, and the formula in part 5221.4020.

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES

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

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

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

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

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

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
97010	Hot and cold packs therapy	.36
97012	Mechanical traction therapy	.33
97014	Electric stimulation therapy	.33
97016	Vasopneumatic device therapy	.39
97018	Paraffin bath therapy	.40
97020	Microwave therapy	.30
97022	Whirlpool therapy	.32
97024	Diathermy treatment	.32
97026	Infrared therapy	.33
97028	Ultraviolet therapy	.29
97039	Physical therapy treatment	.44
97110	Therapeutic exercises 30 min.	.41
97112	Neuromuscular reeducation	.39
97114	Functional activity therapy	.32
97116	Gait training therapy	.34
97118	Manual electric stimulation	.40
97120	Electric current therapy	.41

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CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
97122	Manual traction therapy	.32
97124	Massage therapy	.32
97126	Contrast baths therapy	.32
97128	Ultrasound therapy	.33
97139	Physical medicine procedure	.52
97145	Extended physiotherapy	.21
97220	Hydrotherapy	.62
97221	Extended hydrotherapy	.20
97240	Hydrotherapy	.69
97241	Extended hydrotherapy	.18
97260	Regional manipulation	.32
97261	Supplemental manipulations	.19
97500	Orthotics training	.49
97501	Supplemental training	.27
97520	Prosthetic training	.56
97521	Supplemental training	.32
97530	Kinetic therapy	.57
97531	Added kinetic therapy	.28
97540	Training for daily living	.67
97541	Supplemental training	.30
97700	Training checkout	.62
97701	Supplemental checkout	.30
97720	Extremity testing	.64
97721	Supplemental limb testing	.34
97752	Muscle testing with exercise	.89
H5300	Occupational therapy	.47
Q0103	Physical therapy evaluation	1.17
Q0104	Physical therapy evaluation	.46

5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES

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

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
97010	Hot or cold packs therapy	
97012	Mechanical traction therapy	
97014	Electric stimulation therapy	
97016	Vasopneumatic device therapy	
97018	Paraffin bath therapy	
97020	Microwave therapy	
97022	Whirlpool therapy	
97024	Diathermy treatment	
97026	Infrared therapy	
97028	Ultraviolet therapy	
97039	Physical therapy treatment	
97118	Manual electric stimulation	
97120	Electric current therapy	
97122	Manual traction therapy	
97124	Massage therapy	
97126	Contrast baths therapy	

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CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
97128	Ultrasound therapy	
97139	Physical medicine procedure	
97145	Extended physiotherapy	
97220	Hydrotherapy	
97221	Extended hydrotherapy	
97240	Hydrotherapy	
97241	Extended hydrotherapy	

5221.4060 CHIROPRACTIC PROCEDURE CODES.

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

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

B. Column 2 in subpart 2 is labeled "CPT/HCPCS description." This is a short narrative description of the procedure code. Complete descriptions of included chiropractic services appear either in the CPT or HCPCS manual in effect on the date the service was rendered or in subpart 3.

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

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

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
72010	X-ray exam of spine	1.06
72020	X-ray exam of spine	.53
72040	X-ray exam of neck spine	.85
72050	X-ray exam of neck spine	.79
72052	X-ray exam of neck spine	.97
72070	X-ray exam of thorax spine	1.06
72074	X-ray exam of thoracic spine	.73
72080	X-ray exam of trunk spine	1.06
72090	X-ray exam of trunk spine	.64
72100	X-ray exam of lower spine	.59
72110	X-ray exam of lower spine	1.71
72114	X-ray exam of lower spine	1.00
72120	X-ray exam of lower spine	.71
72170	X-ray exam of pelvis	.45
72190	X-ray exam of pelvis	.58
73020	X-ray exam of shoulder	.41
73030	X-ray exam of shoulder	.50
73070	X-ray exam of elbow	.44
73100	X-ray exam of wrist	.43
73500	X-ray exam of hip	.43
73562	X-ray exam of knee	.50
73610	X-ray exam of ankle	.47
81000	Urinalysis with microscopy	.12
81002	Without microscopy	.07
X2005	Chiropractic visit with manipulation/adjustment, initial; office	.39
X2006	Subsequent; office	.43
X2009	Each additional manipulation/adjustment on same day; office, home, or nursing	.26

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CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
X2100	New patient; brief examination	.44
X2120	Extensive examination	1.15
X2125	Established patient; brief examination	.53
X2130	Intermediate examination	.71
X2135	Extensive examination	1.06
X2201	Application of hot pack	.21
X2202	Application of cold pack	.19
X2205	Diathermy	.26
X2210	Electrical stimulation	.21
X2212	Intersegmental motorized mobilization	.25
X2214	Muscle stimulation, manual	.22
X2220	Ultrasound therapy	.21
X2225	Traction	.23
X2230	Acupressure, manual or mechanical	.25
X2245	Infrared - heat lamp	.21
X2255	Trigger point therapy	.25
X2392	Exercise consultation/instruction	.26
X9557	Medical conference up to 25 minutes	.89

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

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

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

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

5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

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

CPT/HCPCS Procedure Code	CPT/HCPCS Description	Total RVU
X2201	Application of hot pack	
X2202	Application of cold pack	
X2205	Diathermy	
X2210	Electrical stimulation	
X2212	Intersegmental motorized mobilization	
X2214	Muscle stimulation, manual	
X2220	Ultrasound therapy	
X2225	Traction	
X2230	Acupressure, manual or mechanical	
X2245	Infrared—heat lamp	
X2250	Ultraviolet	
X2255	Trigger point therapy	

5221.4070 PHARMACY.

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

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

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

C. the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally ordered.

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

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

Subp. 3. **Maximum fee.**

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

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

REPEALER. (a) *Minnesota Rules*, parts 5220.2590; and 5221.0100, subparts 7, 8, 13, and 14, are repealed.

(b) *Minnesota Rules*, parts 5221.0550; 5221.0700, subpart 5; 5221.0800; 5221.1000; 5221.1100; 5221.1200; 5221.1210; 5221.1215; 5221.1220; 5221.1300; 5221.1410; 5221.1450; 5221.1500; 5221.1600; 5221.1800; 5221.1900; 5221.1950; 5221.2000; 5221.2050; 5221.2070; 5221.2100; 5221.2150; 5221.2200; 5221.2250; 5221.2300; 5221.2400; 5221.2500; 5221.2600; 5221.2650; 5221.2750; 5221.2800; 5221.2900; 5221.3000; 5221.3150; 5221.3155; 5221.3160; 5221.3200; 5221.3300; and 5221.3500, are repealed.

(c) *Minnesota Rules*, parts 5221.1000 to 5221.3500, are repealed only for services after the effective date of parts 5221.4000 to 5221.4300.

EFFECTIVE DATE. All parts are effective five working days after the notice of adoption is published in the *State Register*, except that parts 5221.0410, subpart 6, and 5221.0700, subparts 2, 2a, 2b, and 2c are effective January 1, 1994.

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Proposed Permanent Rules Relating to Workers' Compensation; Independent Contractors

Rules as Proposed

5224.0010 PURPOSE.

The purpose of this chapter is to establish standards for distinguishing between an employee and an independent contractor for purposes of workers' compensation coverage under *Minnesota Statutes*, ~~section 176.012, paragraph (e)~~ sections 176.021 and 176.041. For those occupations specifically discussed in parts 5224.0020 to 5224.0312, this chapter establishes a "safe harbor" for assuring either independent contractor or employee status in those occupations. Where a worker is within the scope of the definition of a part, but does not meet the safe harbor criteria for either independent contractor or employee status, the determination shall be made as described in part 5224.0320.

"Employee" as used in this chapter means a worker who is not an independent contractor. The employee safe harbor criteria are not intended to define "employee" under *Minnesota Statutes*, section 176.011, subdivision 9, for any purpose other than distinguishing workers who are not independent contractors.

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Department of Education

Adopted Permanent Rules Relating to Special Education; Revision of Certain Criteria

The rules proposed and published at *State Register*, Volume 17, Number 17, pages 885-888, October 26, 1992 (16 SR 885), are adopted as proposed.

Department of Revenue

Proposed Permanent Rules Relating to Income and Franchise Tax; Income Apportionment

Notice of Intent to Adopt a Rule Without a Public Hearing

The Department of Revenue intends to adopt a permanent rule without a public hearing following the procedures set forth in the Administrative Procedure Act, *Minnesota Statutes*, sections 14.22 to 14.28. You have 30 days to submit written comments on the proposed rule and may also submit a written request that a hearing be held on the rule.

Agency Contact Person: Comments or questions on the rule and written requests for a public hearing on the rule must be submitted to:

Stephen E. Krenkel
Department of Revenue
Appeals, Legal Services, and Criminal Investigation Division
10 River Park Plaza
St. Paul, MN 55146
Telephone number 612-296-1902 Extension 135

Subject of Rule and Statutory Authority. The proposed rule is about the use of apportionment formulas other than those prescribed by *Minnesota Statutes* section 290.191 (1992). The statutory authority to adopt this rule is *Minnesota Statutes* section 270.06, clause (13) (1992). A copy of the proposed rule is published in the *State Register* and attached to this notice as mailed.

Comments. You have until 4:30 p.m., July 21, 1993, to submit written comment in support of or in opposition to the proposed rule and any part or subpart of the rule. Your comment must be in writing and received by the agency contact person by the due date. Comment is encouraged. Your comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Request for a Hearing. In addition to submitting comments, you may also request that a hearing be held on the rule. Your request for a public hearing must be in writing and must be received by the agency contact person by 4:30 p.m. on July 21, 1993. Your written request for a public hearing must include your name and address. You are encouraged to identify the portion of the proposed rule which caused your request, the reason for the request, and any changes you want made to the proposed rule. If 25 or more persons submit a written request for a hearing, a public hearing will be held unless a sufficient number withdraw their requests in writing. If a public hearing is required, the agency will follow the procedures in *Minnesota Statutes*, section 14.131 to 14.20.

Modifications. The proposed rule may be modified as a result of public comment. The modifications must be supported by data and views submitted to the agency and may not result in a substantial change in the proposed rule as attached and printed in the *State Register*. If the proposed rule affects you in any way, you are encouraged to participate in the rulemaking process.

Statement of Need and Reasonableness. A statement of need and reasonableness is now available from the agency contact person. This statement describes the need for and reasonableness of each provision of the proposed rule and identifies the date and information relied upon to support the proposed rule.

Small Business Considerations. Small businesses which petition for application of other than the prescribed apportionment formula may be impacted by the procedures required in the proposed rule. Small businesses, as all members of the public, are encouraged to participate in this rule making proceeding.

Expenditure of Public Money by Local Public Bodies, Impact on Agriculture Lands. The adoption of this rule will neither require the expenditures of public monies by local bodies nor have any impact on agricultural land, therefore, *Minnesota Statutes* section 14.11, subdivisions 1 and 2 are inapplicable.

Adoption and Review of Rule. If no hearing is required, after the end of the comment period the agency may adopt the rule. The rule and supporting documents will then be submitted to the attorney general for review as to legality and form to the extent form relates to legality. You may request to be notified of the date the rule is submitted to the attorney general or be notified of the attorney

general's decision on the rule. If you wish to be so notified, or wish to receive a copy of the adopted rule, submit your request to the agency contact person listed above.

Dated: 4 June 1993

Morris J. Anderson
Commissioner of Revenue

Rules as Proposed (all new material)

8020.0100 PETITION FOR APPLICATION OF OTHER THAN PRESCRIBED APPORTIONMENT FORMULA.

Subpart 1. **In general.** *Minnesota Statutes*, section 290.20, subdivision 1, permits a departure from the apportionment provisions of *Minnesota Statutes*, section 290.191. If the methods of apportionment required by that section do not fairly reflect all or any part of the taxable net income allocable to this state, the taxpayer may petition for the determination of net income by use of another method. The taxpayer must petition for use of another method of determining taxable net income allocable to this state and receive approval of the method, in accordance with this part, before using any method that is not prescribed by *Minnesota Statutes*, section 290.191.

Subp. 2. **Time of petition.** *Minnesota Statutes*, section 290.20, requires that any taxpayer applying for a deviation from the apportionment methods prescribed by *Minnesota Statutes*, section 290.191, must file a petition in the form required by the commissioner. The petition must be filed before or at the same time as the return or amended return is filed using a method other than the methods prescribed by *Minnesota Statutes*, section 290.191.

Subp. 3. **Form of petition.** The petition filed under this part shall be in the form required by the commissioner and shall include:

A. the name, address, and tax identification number of the taxpayer;

B. in the case of a corporation, the state of incorporation and the location of the principal office or place of business;

C. the tax year of the petition. If more than one year is covered by the petition, the summary statement required by item E must demonstrate the ongoing necessity of departure from the apportionment provisions prescribed by *Minnesota Statutes*, section 290.191;

D. a statement of the kind or kinds of business activity in which the taxpayer is engaged and from which the income was derived for the taxable year stated in the petition;

E. a summary statement of the facts upon which the taxpayer relies to demonstrate that the application of the methods prescribed by *Minnesota Statutes*, sections 290.17 and 290.191, will be unfair as applied to the taxpayer, and that the method proposed will fairly reflect the taxable net income properly allocable to this state; and

F. a hypothetical computation of Minnesota taxable net income in accordance with the proposed method of apportioning income.

Subp. 4. **Additional information.** The commissioner may, after receipt and review of the petition, require additional information from the taxpayer which is necessary to determine whether the apportionment provisions prescribed by *Minnesota Statutes*, section 290.191, will be unfair when applied to the taxpayer. The 45-day period for approval or rejection of the petition, contained in subpart 5, is suspended from the date of the letter requiring additional information to the date of receipt by the commissioner of the required information.

Subp. 5. **Approval or rejection of petition.** The commissioner shall approve or reject a petition filed under this part within 45 days after the date of receipt of the petition. However, failure of the commissioner to act within 45 days does not constitute approval of a petition. If the petition is approved more than 15 days prior to the due date of the first estimated tax return, the taxpayer must file that return and each return thereafter in the year or years covered by the petition using the approved method and attaching thereto a copy of the approved petition with its first payment. If the petition is rejected or if the taxpayer has not received an order approving or rejecting the petition prior to the due date of the first estimated tax payment, the taxpayer must file estimated tax payments using the apportionment methods prescribed by *Minnesota Statutes*, section 290.191. If the taxpayer's petition is approved after an estimated tax payment is made or a return is filed, the taxpayer may amend its return, estimated tax filings, and payments using the approved method and attaching thereto a copy of the approved petition.

Subp. 6. **Appeals.** An order by the commissioner rejecting any petition filed under this part constitutes an order from which an appeal may be made to the tax court pursuant to *Minnesota Statutes*, section 271.06.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

8020.0150 APPORTIONMENT FORMULAS REQUIRED BY COMMISSIONER.

Minnesota Statutes, section 290.20, subdivision 1, grants the commissioner the authority to require a taxpayer to use a method of apportionment other than that prescribed in *Minnesota Statutes*, section 290.191, if:

A. the statutory method does not fairly reflect all or any part of the taxable net income apportionable to Minnesota; and

B. the commissioner's method fairly reflects net income. For purposes of this part, the statutory method shall be presumed to not fairly reflect a taxpayer's taxable net income if the statutory method does not fairly represent the extent of the taxpayer's net income in this state.

When the commissioner has determined that the statutory apportionment formulas do not fairly reflect net income as applied to a specific industry, the commissioner may adopt apportionment rules for uniform application to that industry. If rules have been adopted with respect to a specific industry, a taxpayer's petition under part 8020.0100 must demonstrate the unfairness of the application of the industry-specific rule as applied to it.

REPEALER. *Minnesota Rules*, part 8017.4000, is repealed.

Department of Revenue

Proposed Permanent Rules Relating to Sales and Use Tax; Aircraft Registration

Notice of Intent to Adopt a Rule Without a Public Hearing

The Department of Revenue intends to adopt a permanent rule without a public hearing following the procedures set forth in the Administrative Procedure Act, *Minnesota Statutes*, sections 14.22 to 14.28. You have 30 days to submit written comments on the proposed amendments to the rule and may also submit a written request that a hearing be held on the proposed amendments.

Agency Contact Person: Comments or questions on the proposed amendments to the rule and written requests for a public hearing on the proposed amendments must be submitted to:

Stephen E. Krenkel
Department of Revenue
Appeals, Legal Services, and Criminal Investigation Division
10 River Park Plaza
St. Paul, MN 55146
Telephone number 612-296-1902 Extension 135

Subject of Rule and Statutory Authority. The proposed amendments to the rule are regarding the sales and use taxation of aircraft prior to registration as required by *Minnesota Statutes* section 297A.255. The statutory authority to adopt these amendments is *Minnesota Statutes* section 270.06, clause (13). A copy of the proposed amendments is published in the *State Register* and attached to this notice as mailed.

Comments. You have until 4:30 p.m., July 21, 1993, to submit written comment in support of or in opposition to the proposed amendments to the rule and any part or subpart of the amendments. Your comment must be in writing and received by the agency contact person by the due date. Comment is encouraged. Your comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Request for a Hearing. In addition to submitting comments, you may also request that a hearing be held on the proposed amendments to the rule. Your request for a public hearing must be in writing and must be received by the agency contact person by 4:30 p.m. on July 21, 1993. Your written request for a public hearing must include your name and address. You are encouraged to identify the portion of the proposed amendments which caused your request, the reason for the request, and any changes you want made to the proposed amendments. If 25 or more persons submit a written request for a hearing, a public hearing will be held unless a sufficient number withdraw their requests in writing. If a public hearing is required, the agency will follow the procedures in *Minnesota Statutes*, section 14.131 to 14.20.

Modifications. The rule and the proposed amendments to the rule may be modified as a result of public comment. The modifications must be supported by data and views submitted to the agency and may not result in a substantial change in the proposed rule as attached and printed in the *State Register*. If the proposed amendments affects you in any way, you are encouraged to participate in the rulemaking process.

Statement of Need and Reasonableness. A statement of need and reasonableness is now available from the agency contact person. This statement describes the need for and reasonableness of each provision of the proposed amendments to the rule and identifies the data and information relied upon to support the proposed amendments.

Small Business Considerations. The proposed amendments to the rule are not expected to have an impact on small businesses because the requirements to file returns and remit taxes set forth in this rule are statutory. No additional recordkeeping or administrative duties are required by the amendments.

Expenditure of Public Money by Local Public Bodies, Impact on Agriculture Lands. The proposed amendments to the rule are neither expected to require the expenditures of public monies by local public bodies, nor have any impact on agricultural lands, therefore, *Minnesota Statutes* section 14.11, subdivisions 1 and 2 are inapplicable.

Adoption and Review of Rule. If no hearing is required, after the end of the comment period the agency may adopt the amended rule. The rule and supporting documents will then be submitted to the attorney general for review as to legality and form to the extent form relates to legality. You may request to be notified of the date the amended rule is submitted to the attorney general or be notified of the attorney general's decision on the amended rule. If you wish to be so notified, or wish to receive a copy of the adopted rule, submit your request to the agency contact person listed above.

Dated: 4 June 1993

Morris J. Anderson
Commissioner of Revenue

Rules as Proposed

8130.9500 AIRCRAFT REGISTRATION.

Subpart 1. **In general.** *Minnesota Statutes*, section 297A.255, requires persons who wish to license or register an aircraft in Minnesota to furnish proof to the Minnesota Department of Transportation, Office of Aeronautics ~~Division~~, that the Minnesota sales or use tax has been paid, or that the purchase or acquisition of the aircraft was not subject to the Minnesota sales or use tax. The ~~effect of~~ seller of the aircraft may furnish proof that the Minnesota sales or use tax has been paid as the agent of the purchaser of the aircraft. This law ~~is to impose~~ imposes a use tax on an occasional or isolated ~~sales~~ sale of an aircraft ~~in those cases involving sales to individuals~~ or an interest in an aircraft by persons not in the business of selling aircraft. ~~The law is effective for registrations applied for after June 30, 1973.~~

The necessary forms (form UT-1 and form ST-24) for reporting and paying the use tax or for claiming exemption are available upon request from the Minnesota Department of Revenue ~~and~~ or the Minnesota Department of Transportation, Office of Aeronautics ~~Division~~.

This statute does not affect the exemption provided by *Minnesota Statutes*, section 297A.25, subdivision 14, for purchases of ~~air flight~~ airflight equipment by ~~airlines~~ airline companies taxed under *Minnesota Statutes*, sections 270.071 to 270.079.

When the sales tax has not been paid to the dealer as set forth in subpart 2, item A, the Department of Revenue will forward a completed certificate of tax payment or exemption, form ST-24, to the Department of Transportation, Office of Aeronautics ~~Division~~.

Subp. 1a. **Commercial use, defined.** "Commercial use" means any operation of an aircraft for consideration or hire, any services performed incidental to the operation of any aircraft for which a fee is charged or consideration received, the servicing, maintaining, and repairing of aircraft, or the charter of aircraft, the operation of flight or ground schools, the operation of aircraft for the application or distribution of chemicals or other substances, aerial photography and surveys, air shows or expositions, and the operation of aircraft for fishing. Commercial use is any use by a dealer other than the sale or lease of an aircraft or personal use of an aircraft.

Subp. 2. **Registration of aircraft by ~~individuals~~ purchasers.** When the sales tax is paid or not paid:

A. Minnesota sales tax paid to dealer. When a purchaser pays the Minnesota sales tax for the purchase of an aircraft or an interest in an aircraft to a Minnesota aircraft dealer who holds a Minnesota sales and use tax permit, the dealer shall furnish the purchaser with a statement showing that the sales tax has been paid. The aircraft dealer ~~will~~ must report and pay the sales tax to the Minnesota Department of Revenue ~~as in the past~~. If a dealer licensed by the Office of Aeronautics states to the Office of Aeronautics that sales tax was collected, it is not necessary for the purchaser of the aircraft to obtain a certificate of tax payment or exemption, form ST-24, from the Minnesota Department of Revenue. The purchaser or the purchaser's agent, for example the licensed dealer, should present the statement, which ~~he~~ the purchaser or purchaser's agent received from the aircraft dealer, directly to the Department of Transportation, Office of Aeronautics ~~Division~~, in order to license or register the aircraft.

B. No Minnesota sales tax paid to seller. When the purchaser does not pay a Minnesota sales tax to the seller on ~~his~~ the purchase of an aircraft or an interest in an aircraft, ~~he~~ the purchaser must obtain a certificate of tax payment or exemption, form ST-24, from the Minnesota Department of Revenue. If a use tax is due, the purchaser must complete a consumer's use tax return, form

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UT-1, and file it along with ~~his~~ the purchaser's tax payment when applying for the certificate form ST-24. If the purchaser claims exemption from the tax, ~~he~~ the purchaser must furnish ~~a copy of his purchase invoices or bill of sale along with necessary~~ proof showing that ~~he~~ the purchaser is entitled to the exemption when applying for the certificate. Illustrative exemptions ~~are allowed for~~ include purchases ~~by governmental units and~~ by organizations that are organized and operated exclusively for charitable, religious, or educational purposes; ~~for~~ purchases of aircraft ~~purchased~~ outside Minnesota by a nonresident and later brought into Minnesota for use; and ~~for~~ aircraft purchased for resale or lease.

Subp. 3. **Registration of aircraft by dealers who are licensed in accordance with *Minnesota Statutes*, section 360.63.** When a licensed dealer purchases an aircraft for resale ~~and places it in a withholding status~~, no certificate of tax payment or exemption is required. When a licensed dealer ~~registers~~ puts an aircraft ~~for~~ to commercial use, ~~he must present a certificate of tax payment or exemption to the Minnesota Department of Transportation, Aeronautics Division. He will be~~ the dealer is required to pay a use tax on ~~his~~ the dealer's purchase price of the aircraft unless ~~he~~ the dealer makes application to the commissioner of revenue for an aircraft commercial use permit, on form ~~ST-23~~ ST-22, and pays a $20 fee (see *Minnesota Statutes*, section 360.654). By obtaining an aircraft commercial use permit~~,~~ ~~form ST-23~~ from the commissioner, a licensed dealer may purchase an aircraft for resale and put it to commercial use ~~such as crop dusting, charter service, freight transportation, and flight instruction,~~ for up to one year without paying a sales or use tax on ~~his~~ the dealer's purchase. While the aircraft commercial use permit is in effect, use tax is imposed on the fair market value of the commercial use. When ~~he~~ the dealer sells the aircraft, ~~he~~ the dealer is required to collect a sales tax. If ~~he~~ the dealer keeps the aircraft for more than one year after purchase or makes personal use of ~~such~~ the aircraft, a use tax is also due on ~~his~~ the purchase price. ~~A licensed aircraft dealer who obtains a commercial use permit, form ST-23, should check the box of section B of form ST-24 which indicates that the aircraft was purchased for resale or lease by the holder of a Minnesota sales and use tax permit.~~ If the sole use by the dealer of the aircraft that is exempt from use tax is leasing the aircraft while holding it for sale, sales tax is due on the taxable rent and lease payments.

Subp. 4. **Registration by dealers who are not licensed in accordance with *Minnesota Statutes*, section 360.63.** ~~This type of~~ A dealer who is not licensed in accordance with *Minnesota Statutes*, section 360.63, is required to file form ST-24, ~~and should check the box of section B~~ which indicates the aircraft was purchased for resale or lease by the holder of a Minnesota sales and use tax permit. The dealer is further required to provide evidence that the dealer conducts business regularly selling or leasing aircraft. However, if the dealer purchases an aircraft ~~for~~ or puts the aircraft to personal or commercial use, ~~he~~ the dealer is required to file form ST-24 and form UT-1 and to pay the use tax on the purchase price.

Subp. 5. **Registration of aircraft by lessor or lessee.** When a lessor registers an aircraft in ~~his~~ the lessor's name, ~~he may~~ the lessor must furnish his or her sales and use tax account number when applying for the certificate of tax payment or exemption, form ST-24, and claim exemption for resale. Leases are defined as resales. ~~He~~ The lessor must ~~continue to~~ collect and remit sales tax on lease payments ~~he~~ the lessor receives~~, as in the past~~. The lessor must report all lease payments received as gross sales and collect and remit tax on all sales, net of exempt sales. An example of an exempt sale is the lease of an aircraft to a fixed base operator who rents the aircraft to others at retail.

When a lessee registers an aircraft in ~~his~~ the lessee's name, and the lessor does not hold a Minnesota sales and use tax permit, the ~~lessee~~ lessor is required to obtain a permit. If the lessee ~~must~~ is leasing the same aircraft to others, the lessee must also obtain a permit, file returns, and pay the sales and use tax ~~on the amount of his lease payments~~ in the same manner as all other Minnesota permit holders ~~who are required to file sales and use tax returns~~.

Subp. 6. [See repealer.]

REPEALER. *Minnesota Rules*, parts 8130.9500, subpart 6; and 8130.9996, are repealed.

Adopted Rules

The adoption of a rule becomes effective after the requirements of Minn. Stat. §14.14-14.28 have been met and five working days after the rule is published in *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strikeouts and new language will be underlined. The rule's previous *State Register* publication will be cited.

An emergency rule becomes effective five working days after the approval of the Attorney General as specified in Minn. Stat. §14.33 and upon the approval of the Revisor of Statutes as specified in §14.36. Notice of approval by the Attorney General will be published as soon as practicable, and the adopted emergency rule will be published in the manner provided for adopted rules under §14.18.

Department of Education

Adopted Permanent Rules Relating to Special Education; Revision of Certain Criteria

The rules proposed and published at *State Register*, Volume 17, Number 17, pages 885-888, October 26, 1992 (17 SR 885), are adopted as proposed.

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Safety Account Grant and Loan Program

The rules proposed and published at *State Register*, Volume 17, Number 25, pages 1494-1500, December 21, 1992 (17 SR 1494) and Volume 17, Number 27, page 1716, January 4, 1993 (17 SR 1716), are adopted as proposed.

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Safety and Health Committees

The rules proposed and published at *State Register*, Volume 17, Number 25, pages 1500-1501, December 21, 1992 (17 SR 1494), are adopted as proposed.

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Rehabilitation Services

The rules proposed and published at *State Register*, Volume 17, Number 25, pages 1571-1588, December 21, 1992 (17 SR 1494), and Volume 17, Number 27, page 1716, January 4, 1993 (17 SR 1716) are adopted with the following modifications:

Rules as Adopted

5220.0100 DEFINITIONS.

Subp. 22. **Qualified employee.** "Qualified employee" means an employee who, because of the effects of a work-related injury or disease, whether or not combined with the effects of a prior injury or disability:

C. can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability.

Subp. 26. **Rehabilitation consultation.** "Rehabilitation consultation" means a meeting of the employee and assigned qualified rehabilitation consultant to determine whether the employee is a qualified employee, as defined in subpart 22 to receive rehabilitation services, as defined in subpart 29, considering the treating physician's opinion of the employee's work ability.

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5220.0110 REHABILITATION REQUEST; DISABILITY STATUS REPORT.

Subp. 7. **Disability status report.** The insurer shall file a disability status report to notify the commissioner of a referral for rehabilitation or to request a waiver of rehabilitation services.

A. When an employee has not returned to work following a workplace injury, the insurer shall complete a disability status report ~~and~~, file it with the commissioner, and serve a copy on the employee:

(3) within 14 calendar days after receiving a request for rehabilitation consultation, whichever is earlier.

Another disability status report shall be filed by the insurer 180 days after the injury if no party has requested a rehabilitation consultation and the employee has not returned to work. A disability status report is also required following each request for rehabilitation consultation.

B. The disability status report shall contain the following:

(8) a current treating physician's work ability report must be attached to the form.

Subp. 8. **Commissioner's authority.** If a disability status report is not filed according to this part, the commissioner may ~~refer the employee for~~ order a rehabilitation consultation by a qualified rehabilitation consultant at the insurer's expense, according to *Minnesota Statutes*, section 176.102, subdivision 4, paragraphs (b) and (f).

5220.0120 WAIVER OF CONSULTATION AND REHABILITATION SERVICES.

Subp. 2. **Criteria.** A rehabilitation waiver is granted when the employer documents that the otherwise qualified employee will return to suitable gainful employment with the date-of-injury employer within 180 days after the injury. The waiver shall not be effective more than 180 days following the injury unless a renewal is granted under subpart 4.

Subp. 4. **Renewal of waiver.** If a waiver is in effect but the employee does not return to work within 180 days after the injury, the insurer may request a renewal of the waiver by filing another disability status report. A copy of the request for renewal shall be served on the employee who may object to the renewal by filing a rehabilitation request as provided in part 5220.0950. The renewal of a waiver ~~requires~~ will be granted only upon additional documentation that convinces the commissioner that a consultation is not necessary because the otherwise qualified ~~employee will~~ employee's return to suitable gainful employment with the date-of-injury employer is imminent.

Subp. 5. ~~**Referral**~~ **Commissioner's order.** If 180 days have passed since the date of injury and the employee has not returned to work, no rehabilitation consultation has taken place, and no waiver of rehabilitation services has been granted, the commissioner shall ~~refer the employee for~~ order a rehabilitation consultation at the insurer's expense under *Minnesota Statutes*, section 176.102, subdivision 4, paragraph (f), to be provided by the vocational rehabilitation unit of the department.

5220.0130 REHABILITATION CONSULTATION.

Subp. 2. **Criteria.** If the employer requests a rehabilitation consultation or receives a request for a rehabilitation consultation from the commissioner, the insurer shall arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within ~~14~~ 15 calendar days of the receipt of the request.

If the insurer receives a request for a rehabilitation consultation from an employee and does not request a waiver of rehabilitation services, the insurer shall arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within ~~14~~ 15 days of the receipt of the rehabilitation consultation request.

If the insurer ~~receives~~ requests a ~~request for a~~ waiver of rehabilitation ~~consultation~~ services, and no waiver of rehabilitation services ~~has been~~ is granted under part 5220.0120, the insurer shall arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within ~~14~~ 15 days of the notification that the waiver request has not been granted.

The rehabilitation consultation shall be held at a location not more than 50 miles from the employee's residence.

Subp. 3. **Consultation.** The procedure and documentation for a rehabilitation consultation are contained in items A to E.

A. Preconsultation actions. A copy of the first report of injury, the disability status report, and the accompanying current treating physician's work ability report shall be sent by the insurer to the assigned qualified rehabilitation consultant prior to the rehabilitation consultation.

C. Contents of report. The rehabilitation consultation shall be documented by the assigned qualified rehabilitation consultant on a rehabilitation consultation report form prescribed by the commissioner containing substantially the following:

(4) ~~the identification of barriers to successful completion of the rehabilitation plan and measures to be taken to overcome those barriers, and~~ an assessment of whether or not the employee is a qualified employee for rehabilitation services.

D. Time for filing. A rehabilitation consultation report shall be completed by the assigned qualified rehabilitation consultant in all cases. The assigned qualified rehabilitation consultant shall file the rehabilitation consultation report within ~~15~~ seven days of the first in-person meeting with the employee and concurrently mail a copy to the employer, the employee, and the insurer.

5220.0450 PLAN PROGRESS REPORT.

Subp. 2. **Requirements.** Three months after the assigned qualified rehabilitation consultant has filed an approved rehabilitation plan with the commissioner, three months thereafter, and every six months thereafter, the assigned qualified rehabilitation consultant shall complete a plan progress report on the form prescribed by the commissioner that contains the following:

C. the costs to date for rehabilitation services by all rehabilitation providers and the estimated costs to plan completion; ~~and~~

D. the duration of the rehabilitation plan to date and the estimated duration to plan completion; and

E. the identification of barriers to successful completion of the rehabilitation plan and measures to be taken to overcome those barriers.

Subp. 4. **Commissioner's actions.** Based on the information contained in the current plan progress report and in other reports available to the commissioner, the commissioner may decide to initiate further activities if the review indicates that the plan is inadequate to carry out the objectives of rehabilitation under *Minnesota Statutes*, section 176.102, subdivision 1, paragraph (b). These activities may include, but are not limited to the following:

B. conducting an on-site inspection during normal business hours of the assigned qualified rehabilitation consultant's records for documentation of service provision according to the rehabilitation plan; and

5220.0710 EMPLOYEE CHOICE OF QUALIFIED REHABILITATION CONSULTANT; CHANGE OF QUALIFIED REHABILITATION CONSULTANT.

Subpart 1. **Employee right to choose.** Pursuant to *Minnesota Statutes*, section 176.102, subdivision 4, the qualified employee has a right to choose a qualified rehabilitation consultant as defined in part 5220.0100, subpart 23, once~~:~~

~~A.~~ during the period commencing before a referral by the insurer or commissioner to a qualified rehabilitation consultant, or before a first in-person visit between a qualified rehabilitation consultant and the employee~~; or~~

~~B. when the employee selects a qualified rehabilitation consultant within~~ and continuing until 60 days after filing of the rehabilitation plan ~~to replace~~. If the employee chooses a qualified rehabilitation consultant ~~selected by the insurer, in which case~~ under this part, the employee shall notify the insurer in writing of the name, address, and telephone number of the qualified rehabilitation consultant chosen.

5220.1500 PROCEDURE FOR REGISTRATION AS QUALIFIED REHABILITATION CONSULTANT.

Subp. 3a. **Continuing education.** To retain registration, a qualified rehabilitation consultant or qualified rehabilitation consultant intern shall submit satisfactory documentation of current certification required by part 5220.1400, subpart 2. A qualified rehabilitation consultant or qualified rehabilitation consultant intern who is not yet certified shall submit satisfactory documentation of continuing education pertinent to the workers' compensation rehabilitation field equivalent to 20 contact hours each year at the time registration is renewed. Continuing education includes, but is not limited to, the following:

D. rehabilitation related training sponsored and approved by the commissioner.

Satisfactory documentation shall include legible certificates of attendance bearing the name of the participant that are signed and dated by the sponsoring institution or organization. Receipts for tuition are not acceptable as satisfactory documentation of attendance. Continuing education units must be obtained in the 12-month period immediately preceding the date on which registration renewal forms are due.

The department of labor and industry's ~~annual~~ rehabilitation provider update sessions when held are mandatory for all rehabilitation providers.

Nonattendance at the mandatory orientation or update sessions is prohibited conduct for rehabilitation providers, but may be allowed only for emergency situations and must be reported to the commissioner.

5220.1800 STANDARDS OF PERFORMANCE.

Monitoring and supervision of rehabilitation providers by the commissioner shall include an assessment of rehabilitation provider professional competence and effectiveness of ~~service~~ rehabilitation services based upon substantial noncompliance with prevailing norms of the profession to be established by rule from data collected by the department regarding duration of service, cost of service, and case outcomes.

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In addition, the standards of conduct described in parts 5220.1801 to 5220.1806 which establish minimum standards concerning the professional activities and services of rehabilitation providers shall be taken into account.

The administration of rehabilitation provider discipline under *Minnesota Statutes*, section 176.102, subdivision 3a, will also be based upon the standards in parts 5220.1801 to 5220.1806, as well as on adherence to *Minnesota Statutes*, chapter 176, rules adopted to administer it, and orders of the commissioner or a compensation judge.

5220.1801 PROFESSIONAL CONDUCT.

Subp. 2. **Assigned qualified rehabilitation consultant.** Only the assigned qualified rehabilitation consultant, or a qualified rehabilitation consultant designated by the assigned qualified rehabilitation consultant to function in an advisory capacity to the assigned consultant, shall be involved at any given time in the employee's rehabilitation plan, except as stated in subparts 5~~,~~ ~~6,~~ and 7. The assigned qualified rehabilitation consultant shall advise the insurer before involving or requesting advisory services from any other qualified rehabilitation consultant. No qualified rehabilitation consultant or qualified rehabilitation consultant firm shall provide rehabilitation services to a case that has an assigned qualified rehabilitation consultant employed by another qualified rehabilitation consultant firm. This subpart shall not apply to a qualified rehabilitation consultant acting on behalf of the reinsurance association in a monitoring or advisory capacity on a reinsurance claim file.

5220.1802 COMMUNICATIONS.

Subp. 4a. **Transfer of information.** Whenever there is a change of assigned qualified rehabilitation consultants or consultant firms, the former qualified rehabilitation consultant firm shall cooperate in transferring to the new assigned qualified rehabilitation consultant or qualified rehabilitation consultant firm all data, required rehabilitation reports, required progress records, and incurred rehabilitation cost information along with other relevant information within 15 days from the receipt of notice that a new consultant is assigned under part 5220.0710 and *Minnesota Statutes*, section 176.102. The former qualified rehabilitation consultant firm may not charge a party for the transfer of information to the new assigned qualified rehabilitation consultant or qualified consultant firm.

5220.1900 REHABILITATION SERVICE FEES AND COSTS.

Subp. 1c. **Consultants.** When billing on an hourly basis for the services of qualified rehabilitation consultants, a qualified rehabilitation consultant or qualified rehabilitation consultant ~~firms that bill~~ firm shall bill at an hourly rate not to exceed $65 per hour as adjusted under subpart 1b. A rehabilitation provider shall bill one-half of the hourly rate for travel and wait time. Travel time shall be prorated as outlined in part 5220.1805, item E.

Subp. 7. **Case activities requiring insurer consent for payment.** The rehabilitation provider must obtain the consent of the insurer before billing for the following case activities, however, the presence or absence of consent shall not preclude the commissioner or a compensation judge from determining the reasonable value or necessity of these case activities:

H. before a determination of eligibility, services rendered when a rehabilitation waiver has been requested and was not denied or when the ~~employer or~~ insurer disputes the employee's eligibility for rehabilitation services;

REPEALER. *Minnesota Rules*, parts 5220.0100, subpart 2; 5220.0110, subparts 1, 2, 3, and 4; ~~5220.0710;~~ 5220.0750, subpart 4; 5220.1801, subpart 6; and 5220.1910, are repealed.

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Insurance Verification

The rules proposed and published at *State Register*, Volume 17, Number 25, page 1504, December 21, 1992 (17 SR 1494) and Volume 17, Number 27, page 1716, January 4, 1993, are adopted as proposed.

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation Permanent Partial Disability Schedules

The rules proposed and published at *State Register*, Volume 17, Number 25, pages 1504-1571, December 21, 1992 (17 SR 1494), and Volume 17, Number 27, page 1716, January 4, 1993 (17 SR 1716), are adopted with the following modifications:

Rules as Adopted

5223.0310 DEFINITIONS.

Subp. 8. ~~**Appropriate, consistent, and reproducible clinical findings.**~~ ~~"Appropriate, consistent, and reproducible clinical findings" means that all of the following statements are true of the clinical findings as a whole in regard to the alleged organic pain syndrome:~~

~~A. the clinical findings are the same from one examination to another, that is, there is intraexaminer reliability;~~

~~B. the clinical findings are the same from one examiner to another, that is, there is interexaminer reliability;~~

~~C. the majority of those clinical findings expected in an instance of the alleged organic pain syndrome are found on examination, that is, the findings are sensitive;~~

~~D. there are few if any clinical findings that are not expected in an instance of the alleged organic pain syndrome, that is, the findings are specific.~~

~~Subp. 9.~~ **ANSI.** "ANSI" means the American National Standards Institute.

Subp. ~~10.~~ 9. **Articulation.** "Articulation" means the enunciation of words.

Subp. ~~11.~~ 10. **Banding.** "Banding" means a thick, ropelike cord of hypertrophic scarring.

Subp. ~~12.~~ 11. **Cardiopulmonary exercise testing.** "Cardiopulmonary exercise testing" means a standardized, graduated exercise test performed according to a protocol, for the purpose of determining maximum exercise capacity expressed as VO2 max.

Subp. ~~13.~~ 12. **Carpal instability.** "Carpal instability" means either an incompetence of the ligament support system of the wrist or a change in the joint contact surface configuration of the carpal bones such that there is abnormal alignment or movement of the proximal carpal row.

Subp. ~~14.~~ 13. **Category.** "Category" means a permanent partial impairment as described in parts 5223.0300 to 5223.0650 and the corresponding percent of disability to the whole body for that permanent partial impairment.

Subp. ~~15.~~ 14. **Chronic.** "Chronic" means the repeated or continuous occurrence of a specific condition or symptom.

Subp. ~~16.~~ 15. **Colostomy.** "Colostomy" means the surgical creation of a new opening of the colon on the surface of the body.

Subp. ~~17.~~ 16. **Coma.** "Coma" means a state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation.

Subp. ~~18.~~ 17. **Contracture.** "Contracture" means a condition of fixed resistance to passive movement at a joint resulting from fibrosis of the soft tissues. A contracture is named by the direction in which the fibrosis draws the joint, that is, a joint drawn into flexion has a flexion contracture and there is a fixed resistance to passive extension.

Subp. ~~19.~~ 18. **DCO.** "DCO" means the diffusion capacity of carbon monoxide as measured by a test performed as described in the A.M.A. Guide, 3rd edition, pp. 112-113. The measurement is expressed as a percentage of the normal value. The normal values used are those listed in the A.M.A. Guide, 3rd edition, pp. 114-115, incorporated by reference in part 5223.0300, subpart 4, item B.

Subp. ~~20.~~ 19. **Delirium.** "Delirium" means a mental disturbance marked by illusions, hallucinations, delusions, cerebral excitement, physical restlessness, and incoherence, and having a comparatively short course.

Subp. ~~21.~~ 20. **Desirable level of weight.** "Desirable level of weight" means preferred weights in the tables created by the Metropolitan Life Insurance Company. For purposes of parts 5223.0300 to 5223.0650, the following are the minimums of the preferred weights (in pounds) for men and women of various heights and builds:

Height	Small Frame		Medium Frame		Large Frame	
	Male	Female	Male	Female	Male	Female
4′ 10″		102		109		118
4′ 11″		103		111		120
5′		104		113		122
5′ 1″		106		115		125
5′ 2″	128	108	131	118	138	128
5′ 3″	130	111	133	121	140	131
5′ 4″	132	114	135	124	142	134
5′ 5″	134	117	137	127	144	137
5′ 6″	136	120	139	130	146	140
5′ 7″	138	123	142	133	149	143
5′ 8″	140	126	145	136	152	146

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Height	Small Frame Male	Small Frame Female	Medium Frame Male	Medium Frame Female	Large Frame Male	Large Frame Female
5′ 9″	142	129	148	139	155	149
5′ 10″	144	132	151	142	158	152
5′ 11″	146	135	154	145	161	155
6′	149	138	157	148	164	158
6′ 1″	152		160		168	
6′ 2″	155		164		172	
6′ 3″	158		167		176	
6′ 4″	162		171		181	

Subp. ~~22.~~ 21. **Disarticulation.** "Disarticulation" means an amputation occurring through a joint.

Subp. ~~23.~~ 22. **Distance vision.** "Distance vision" means the ability to distinguish letters at a distance of 20 feet according to any eye chart in which the 20/20 (6/6) letters subtend five minutes of arc.

Subp. ~~24.~~ 23. **Dysequilibrium.** "Dysequilibrium" means any derangement of proper balance.

Subp. ~~25.~~ 24. **Esophagostomy.** "Esophagostomy" means the creation of an artificial opening into the esophagus.

Subp. ~~26.~~ 25. **Executive functions.** "Executive functions" means such activities as managing a checkbook, entering into contracts, and making medium- and long-range financial plans.

Subp. ~~27.~~ 26. **Family member.** "Family member" means cohabitant and is not limited to those related by blood or marriage. In cases of institutionalization or similar nonhome environment, family member may include staff members who care for the individual on a regular basis.

Subp. ~~28.~~ 27. **FEV1.** "FEV1" means the forced expiratory volume in one second as measured by a spirometric test performed as described in the A.M.A. Guide, 3rd edition, pp. 111-112. The measurement used must be taken from the spirogram which is both technically acceptable and represents the best effort of the patient. The measurement is expressed as a percentage of the normal value. The normal values used are those listed in the A.M.A. Guide, 3rd edition, pp. 112-113, incorporated by reference in part 5223.0300, subpart 4, item B.

Subp. ~~29.~~ 28. **14/14 Snellen rating.** "14/14 Snellen rating" means a measurement of visual acuity for near vision. The numerator is the test distance in inches. The denominator is the distance at which the smallest letter on the test instrument can be seen.

Subp. ~~30.~~ 29. **Fusion.** "Fusion" means the operative formation of an ankylosis.

Subp. ~~31.~~ 30. **FVC.** "FVC" means the forced vital capacity as measured by a spirometric test performed as described in the A.M.A. Guide, 3rd edition, pp. 111-112. The measurement used must be taken from the spirogram which is both technically acceptable and represents the best effort of the patient. The measurement is expressed as a percentage of the normal value. The normal values used are those listed in the A.M.A. Guide, 3rd edition, pp. 110-111, incorporated by reference in part 5223.0300, subpart 4, item B.

Subp. ~~32.~~ 31. **Gastrostomy.** "Gastrostomy" means the creation of an artificial opening into the stomach.

Subp. ~~33.~~ 32. **Hypertrophic scar.** "Hypertrophic scar" means an elevated irregularly shaped mass of scar tissue.

Subp. ~~34.~~ 33. **Ileostomy.** "Ileostomy" means the creation of an artificial opening into the ileum.

Subp. ~~35.~~ 34. **Jejunostomy.** "Jejunostomy" means the creation of an artificial opening into the jejunum.

Subp. ~~36.~~ 35. **Lethargy.** "Lethargy" means in relation to an injury to the brain, that an individual is drowsy, but can be aroused.

Subp. ~~37.~~ 36. **Method of Lund and Browder.** "Method of Lund and Browder" means a method of estimating the body surface area of body parts as represented by the following values for adults:

Part	Surface Area (as a percentage of total body surface area)
Head	7
Neck	2
Anterior trunk	13
Posterior trunk	13
Right buttock	2.5
Left buttock	2.5
Genitals	1
Right upper arm	4

Part	Surface Area (as a percentage of total body surface area)
Left upper arm	4
Right lower arm (exclusive of hand)	3
Left lower arm (exclusive of hand)	3
Right hand	2.5
Left hand	2.5
Right thigh	9.5
Left thigh	9.5
Right leg (exclusive of foot)	7
Left leg (exclusive of foot)	7
Right foot	3.5
Left foot	3.5

Subp. ~~38.~~ 37. **Motility chart.** "Motility chart" means the chart of figure 3, p. 160 of the A.M.A. Guides, 3rd edition.

Subp. ~~39.~~ 38. **Near vision.** "Near vision" means the ability to read text or to distinguish letters at a distance of 14 inches as measured by any eye test for use at 14 inches and is measured using the appropriate optical correction for the 14-inch distance.

Subp. ~~40.~~ 39. **Nine hole peg test.** The "Nine hole peg test" is a commonly used, relatively inexpensive, and quickly administered measurement of finger dexterity as described in the "Adult Normal for the Nine Hole Peg Test of Finger Dexterity," incorporated by reference in part 5223.0300, subpart 4, item A.

Subp. ~~41.~~ 40. **Painful organic syndrome.** "Painful organic syndrome" means a musculoskeletal condition characterized by pain with use of the affected member which limits the voluntary active range of motion, without any limitation of forced passive range of motion, and attributed to a lesion in the soft tissues, that is, capsule, ligament, tendon, fascia, and muscle, and defined by a set of clinical findings.

Subp. ~~42.~~ 41. **Presbycusis.** "Presbycusis" means a decline in hearing acuity that occurs with the aging process.

Subp. ~~43.~~ 42. **Pseudophakia.** "Pseudophakia" means that the crystalline lens of the eye has been replaced with a surgically implanted lens.

Subp. ~~44.~~ 43. **Radicular pain.** "Radicular pain" means pain described as radiating distally into an extremity in the distribution of a nerve root and characterized by consistent findings on provocation testing, ~~that is~~ for example, the straight leg raising test.

Subp. ~~45.~~ 44. **Radicular paresthesia.** "Radicular paresthesia" means abnormal sensations, that is, burning or prickling, described as involving an extremity in the distribution of a nerve root.

Subp. ~~46.~~ 45. **Self cares.** "Self cares" means urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, and eating.

Subp. ~~47.~~ 46. **Speech intensity.** "Speech intensity" means the level of sound intensity of an individual's speech. Speech intensity determines the ability to be heard versus intelligibility which determines the ability to be understood.

Subp. ~~48.~~ 47. **Spinal stenosis.** "Spinal stenosis" means the narrowing of the spinal canal.

Subp. ~~49.~~ 48. **Spondylolisthesis.** "Spondylolisthesis" means the forward movement of one vertebral body on the vertebrae below it or upon the sacrum.

Subp. ~~50.~~ 49. **Spondylolisthesis grade 1.** "Spondylolisthesis grade 1" means forward movement from zero to 25 percent of the vertebral body as measured on standard X-ray view of the spine.

Subp. ~~51.~~ 50. **Spondylolisthesis grade 2.** "Spondylolisthesis grade 2" means forward movement from 25 to 50 percent of the vertebral body as measured on standard X-ray view of the spine.

Subp. ~~52.~~ 51. **Spondylolisthesis grade 3.** "Spondylolisthesis grade 3" means movement from 50 to 75 percent of the vertebral body as measured on standard X-ray view of the spine.

Subp. ~~53.~~ 52. **Spondylolisthesis grade 4.** "Spondylolisthesis grade 4" means forward movement from 75 to 100 percent of the vertebral body as measured on standard X-ray view of the spine.

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Subp. ~~54.~~ 53. **Stupor.** "Stupor" means, in relation to a nervous system injury to the brain, that a strong stimulus or pain is needed to arouse consciousness or response.

Subp. ~~55.~~ 54. **Table for loss of central visual acuity.** "Table for loss of central visual acuity" means the table of Table 2, p. 155 of the A.M.A. Guides, 3rd edition.

Subp. ~~56.~~ 55. **Tandem gait.** "Tandem gait" means walking by placing one foot directly in front of the other in a heel-to-toe fashion.

Subp. ~~57.~~ 56. **Tinnitus.** "Tinnitus" means a subjective sense of noises in the head or ringing in the ear for which there is no observable external cause.

Subp. ~~58.~~ 57. **Trigeminal neuralgia.** "Trigeminal neuralgia" means paroxysmal pain extending along the course of the trigeminal nerve.

Subp. ~~59.~~ 58. **20/20 Snellen rating.** "20/20 Snellen rating" means a measurement of visual acuity for distance vision. The numerator is the test distance in feet. The denominator is the distance at which the smallest letter discriminated by a patient would subtend five minutes of arc.

Subp. ~~60.~~ 59. **Vertigo.** "Vertigo" means a sensation of moving around in space or having objects move about the person. It is the result of a disturbance of the equilibratory apparatus.

Subp. ~~61.~~ 60. **Visual field chart.** "Visual field chart" means the charts of figure 1, p. 156 of the A.M.A. Guides, 3rd edition.

Subp. ~~62.~~ 61. **VO2 max.** "VO2 max" means the maximum exercise capacity of an individual as measured by cardiopulmonary exercise testing and expressed as oxygen consumption in milliliters/(kilograms x minutes).

Subp. ~~63.~~ 62. **Wrinkling.** "Wrinkling" means small ridges on the skin formed by shrinking or contraction of the skin.

5223.0315 PREEXISTING IMPAIRMENTS.

This part may be used only for the rating of preexisting impairments for determining apportionment under *Minnesota Statutes*, section 176.101, subdivision 4a. Ratings of permanent partial disability under *Minnesota Statutes*, section 176.101, subdivisions 3a and 3b, shall be determined under parts 5223.0300 to 5223.0310 and 5223.0320 to 5223.0650. If an impairment is subject to apportionment under *Minnesota Statutes*, section 176.101, subdivision 4a, the rating for the impaired condition under a category of the schedules of parts 5223.0300 to 5223.0650 must be reduced as provided in this part. As used in this part, "impaired condition" includes the preexisting impairment.

C. This item applies if the injury producing the preexisting impairment occurred prior to January 1, 1984, and the preexisting impairment is governed by *Minnesota Statutes*, section 176.101, subdivision 3; or if *Minnesota Statutes*, chapter 176, is inapplicable, the rating represents a percentage of disability of a member, and the rating was made prior to the current injury.

(1) From Table 1, determine the maximum whole body disability assignable to the preexisting impairment. Use Table 2 if impairment to an internal organ is rated as a percentage of disability to the particular organ rather than a percentage of disability to the internal organs as a whole. If the preexisting impairment is not listed in Table 1 or Table 2, the maximum whole body disability is the maximum disability assigned to the affected member by the schedules of parts 5223.0300 to 5223.0650.

Table 1

Member	Conversion Factor for Maximum Whole Body Disability (Percent)
Thumb	16
Index finger	~~11~~ 9
Middle finger	9
Ring finger	4
Little finger	~~2~~ 4
Great toe	5
Lesser toe	1
Hand	54
Hand and wrist	54
Arm	60
Foot	21
Foot and ankle	~~28~~ 26
Leg	40
Eye	24
Eyes (both)	85

Table 1

Member	Conversion Factor for Maximum Whole Body Disability (Percent)
Hearing loss (one ear)	6
Hearing loss (both ears)	35
Back	71
Voice	70
Burns and skin impairments, including disfigurement	70
Internal organs, excluding brain	85
Brain	100
Head	20

Table 2

Member	Conversion Factor for Maximum Whole Body Disability (Percent)
Stomach	65
Pancreas	65
Colon	50
Spleen	0
Bladder	30
Sexual organs or function	20
Circulatory system	90
Heart	85
Lungs	85
Liver	75
Solitary kidney	10
Kidney, excluding solitary kidney	77

5223.0320 FACE, NOSE, MOUTH, OR THROAT.

Subp. 3. **Articulation.** Signs or symptoms of organic disease of the face, nose, mouth, or throat are present or there is an objectively demonstrated neurological lesion of a type known to interfere with articulation, as defined in part 5223.0310, subpart ~~10~~ 9; and, in the case of organic disease of the face, nose, mouth, or throat, there is anatomic loss or alteration, and signs or symptoms have persisted despite treatment.

A. Speech intensity, as defined in part 5223.0310, subpart ~~47~~ 46, is sufficient and 95 percent or more of words, that is, nearly all words, are understood by persons who are not family members, but speech is distorted, three percent.

B. Speech intensity can be sustained but is insufficient in noisy environments, or 95 percent or more of words, that is, nearly all words, are understood by family members, as defined in part 5223.0310, subpart ~~27~~ 26, but strangers have difficulty understanding anything but basic communications, that is, name, address, or rote information, ten percent.

Subp. 7. **Complete loss of teeth.** Ratings under this subpart are not combinable with any other subpart under this part. Ratings under this part may not exceed a total of ten percent whole body impairment.

5223.0330 EYE.

Subp. 3. **Incomplete loss of vision.**

B. The primary coordinate factors of vision are central visual acuity, visual field efficiency, and ocular motility.

(1) The maximum limit for each coordinate function is established in units (a) to (c).

(a) The maximum limit of central visual acuity is the ability to recognize letters or characters which subtend an angle

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of five minutes, each unit part of which subtends a one-minute angle at the distance viewed. A 20/20 Snellen rating is 100 percent maximum central visual acuity for distance vision. A 14/14 Snellen rating is 100 percent maximum central visual acuity for near vision, as defined in part 5223.0310, subpart ~~39~~ 38.

C. The measurement of the coordinate factors of vision shall be performed as specified in subitems (1) to (3).

(1) Central visual acuity shall be measured in a 20/20 Snellen rating for distance vision and a 14/14 Snellen rating for near vision, with each eye being measured separately, with correction. Test illumination shall be at least five foot-candles.

(a) Using the corrected near vision and the corrected far vision for an eye, refer to the table for loss of central vision, as defined in part 5223.0310, subpart ~~55~~ 54, and locate the appropriate percentage of loss using the upper figure of the two provided. This is the percentage loss of central vision for that eye.

(b) In cases with aphakia, or pseudophakia as defined in part 5223.0310, subpart ~~43~~ 42, proceed as in unit (a), but use the lower figure of the two provided in the table. This is the percentage loss of central vision corrected for aphakia or pseudophakia for that eye.

(2) For each eye, the extent of the field of vision shall be determined by perimetric test methods. A three millimeter white disk that subtends a 0.5 degree angle under illumination of not less than seven foot-candles shall be used. For aphakia, a six millimeter white disk shall be used. The result shall be plotted on the visual field chart as defined in part 5223.0310, subpart ~~61~~ 60.

(3) Ocular motility shall be measured in all parts of the motor field with any useful correction applied.

(b) Plot the test results on a motility chart, as defined in part 5223.0310, subpart ~~38~~ 37.

5223.0340 EAR.

Subp. 4. **Procedure for determining binaural hearing loss.** The calculation for the percent of binaural hearing loss is done with the worksheet provided in subpart 5 and consists of the steps in items A to F.

D. For each ear, multiply the adjusted average four-frequency hearing level by 1.5 ~~percent~~. The product is the monaural hearing loss, expressed as a percentage. A product less than zero percent is deemed to be zero. A product greater than 100 percent is deemed to be 100 percent.

Subp. 5. **Worksheet for calculating percent of binaural hearing loss.**

Left Ear		Right Ear	
Hertz	Threshold	Hertz	Threshold
500	A. ____	500	A. ____
1,000	B. ____	1,000	B. ____
2,000	C. ____	2,000	C. ____
3,000	D. ____	3,000	D. ____
(A + B + C + D) ÷ 4 =	E. ____	(A + B + C + D) ÷ 4 =	E. ____
E − 25 = (if < 0 use 0)	F. ____	E − 25 = (if < 0 use 0)	F. ____
F x 1.5 =	G. ____	F x 1.5 =	G. ____

Make G(1) the lesser of the two G's

Make G(2) the greater of the two G's

[[G(1) x 5] + G(2)] ÷ 6 = H. ______ (binaural hearing loss) H converts to whole body impairment as provided in subpart 6

Subp. 8. **Tinnitus.** No additional percentage of permanent partial impairment for hearing loss shall be allowed for tinnitus, as defined in part 5223.0310, subpart ~~57~~ 56.

5223.0360 CENTRAL NERVOUS SYSTEM.

Subp. 2. **Trigeminal nerve.** For permanent partial impairment of the trigeminal nerve, the percent of disability is provided in items A to J.

E. intractable trigeminal neuralgia, as defined in part 5223.0310, subpart ~~58~~ 57, 20 percent;

Subp. 5. **Dysequilibrium or vertigo.** Signs or symptoms of dysequilibrium, as defined in part 5223.0310, subpart ~~24~~ 23, or vertigo, as defined in part 5223.0310, subpart ~~60~~ 59, are present and persistent despite therapy, and there is anatomic loss or alteration or objectively measurable neurologic deficit in the vestibular mechanism, ocular mechanism, proprioceptive sense organs, spinal cord, brain stem, cerebellum, or cerebral cortex of a type known to cause dysequilibrium or vertigo:

C. able to perform self cares, as defined in part 5223.0310, subpart ~~46~~ 45, independently but requires adaptive equipment for ambulation as defined in part 5223.0310, subpart 6, and is not capable of operating any motor vehicle, 40 percent;

Subp. 7. **Brain dysfunction.** Signs or symptoms of organic brain dysfunction due to illness or injury must be present and persistent with anatomic loss or alteration, or objectively measurable neurologic deficit. A rating under this part is the combination as described in part 5223.0300, subpart 3, item E, of the ratings assigned by items A to I.

C. Disturbances of consciousness or complex integrated cerebral function disturbances must be determined by medical observation, and in the case of complex integrated cerebral function, supported by psychometric testing. Functional overlay or primary psychiatric disturbances shall not be rated under this part. Disturbances of complex integrated cerebral function include defects in orientation, ability to abstract or understand concepts, memory, judgment, ability to initiate and perform planned activity, and acceptable social behavior. Disturbances of consciousness include lethargy, clouding of consciousness, delirium, stupor, and coma:

(2) mild impairment of complex integrated cerebral function is demonstrated by psychometric testing and able to live independently but requiring supervision with executive function, as defined in part 5223.0310, subpart ~~26~~ 25, 20 percent;

(5) severe impairment of complex integrated cerebral function is demonstrated by psychometric testing or there is delirium as defined in part 5223.0310, subpart ~~20~~ 19, and requires assistance as well as supervision in activities of daily living, 95 percent;

(6) stupor, as defined in part 5223.0310, subpart ~~54~~ 53; coma, as defined in part 5223.0310, subpart ~~17~~ 16; or persistent vegetative state, 99 percent.

E. Ataxia, movement disorder including tremor, or spasticity:

(3) in the lower extremity:

(a) normal tandem gait, as defined in part 5223.0310, subpart ~~56~~ 55, zero percent;

G. Episodic neurologic disorders, that is, syncope, epilepsy, or convulsive disorders:

(3) able to perform all self cares, as defined in part 5223.0310, subpart ~~46~~ 45, independently, but some supervision is required, 40 percent;

5223.0370 MUSCULOSKELETAL SCHEDULE; CERVICAL SPINE.

Subp. 2. **Fractures.**

A. Compression fracture of vertebral body, with no involvement of posterior elements, one or more vertebral bodies is rated by the greatest loss of vertebral height among the involved segments:

(1) decrease of ~~up to~~ no more than ten percent in vertebral height in any vertebral segment, zero percent;

(2) decrease of greater than ten percent but less than or equal to 25 percent in vertebral height in ~~all compressed vertebrae~~ at least one vertebral segment, six percent;

Subp. 3. **Cervical pain syndrome.**

C. Symptoms of pain or stiffness in the region of the cervical spine, substantiated by persistent objective clinical findings, that is, involuntary muscle tightness in the paracervical muscle or decreased passive range of motion in the cervical spine, and with any radiographic, myelographic, CT scan, or MRI scan abnormality ~~and is~~ not specifically addressed elsewhere in this part:

Subp. 4. **Radicular syndromes.**

A. Radicular pain or paresthesia, as defined in part 5223.0310, subpart ~~45~~ 44, with or without cervical pain syndrome, not substantiated by persistent objective clinical findings, regardless of radiographic findings, zero percent.

C. Radicular pain or paresthesia, with or without cervical pain syndrome, with persistent objective clinical findings confined to the region of the cervical spine, that is, involuntary muscle tightness in the paracervical muscle or decreased passive range of motion in the cervical spine, and with any radiographic, myelographic, CT scan, or MRI scan abnormality ~~and is~~ not specifically addressed elsewhere in this part:

E. Radicular pain or paresthesia, with or without cervical pain syndrome, and with objective radicular findings, that is, reflex changes or EMG abnormality or nerve root specific muscle weakness in the upper extremity, or myelopathic findings on examination and myelographic, CT scan, or MRI scan evidence of spinal stenosis, as defined in part 5223.0310, subpart ~~48~~ 47, that impinges on a cervical nerve root or spinal cord and the medical imaging findings correlate with the findings on neurological examination, ten percent with the addition of as many of subitems (1) to (4) as apply, but each may be used only once:

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Subp. 5. **Fusion.**

A. Fusion, as defined in part 5223.0310, subpart ~~30~~ 29, at one level performed as part or all of the surgical treatment of a cervical pain or radicular syndrome, add 2.5 percent to the otherwise appropriate category in subpart 3 or 4.

5223.0380 MUSCULOSKELETAL SCHEDULE; THORACIC SPINE.

Subp. 2. **Fractures.**

A. Compression fracture of vertebral body, with no involvement of posterior elements, one or more vertebral bodies is rated by the greatest loss of vertebral height among the involved segments:

(1) decrease of ~~up to~~ no more than ten percent of vertebral height in any vertebral segment, zero percent;

(2) decrease of greater than ten percent but less than or equal to 25 percent in vertebral height in ~~all compressed vertebrae~~ at least one vertebral segment, four percent;

Subp. 4. **Radicular syndromes.**

A. Radicular pain or radicular paresthesia, as defined in part 5223.0310, subparts ~~44~~ 43 and ~~45~~ 44, with or without thoracic pain syndrome, not substantiated by persistent objective clinical findings, regardless of radiographic findings, zero percent.

C. Radicular pain or radicular paresthesia, with or without thoracic pain syndrome, with persistent objective clinical findings confined to the region of the thoracic spine, that is, involuntary muscle tightness in the paradorsal muscles, and with any radiographic, myelographic, CT scan, or MRI scan abnormality ~~and is~~ not specifically addressed elsewhere in this part, five percent.

5223.0390 MUSCULOSKELETAL SCHEDULE; LUMBAR SPINE.

Subp. 2. **Fractures.**

A. Compression fracture of vertebral body, with no involvement of posterior elements, one or more vertebral bodies is rated by the greatest loss of vertebral height among the involved segments:

(1) decrease of ~~up to~~ no more than ten percent of vertebral height in any vertebral segment, zero percent;

(2) decrease of greater than ten percent but less than or equal to 25 percent in vertebral height in ~~all compressed vertebrae~~ at least one vertebral segment, four percent;

Subp. 3. **Lumbar pain syndrome.**

C. Symptoms of pain or stiffness in the region of the lumbar spine, substantiated by persistent objective clinical findings, that is, involuntary muscle tightness in the paralumbar muscles or decreased range of motion in the lumbar spine, and with any radiographic, myelographic, CT scan, or MRI scan abnormality ~~and is~~ not specifically addressed elsewhere in this part:

D. Symptoms of pain or stiffness in the region of the lumbar spine, substantiated by persistent objective clinical findings, that is, involuntary muscle tightness in the paralumbar muscles or decreased range of motion in the lumbar spine, and with radiographic evidence of spondylolisthesis, as defined in part 5223.0310, subpart ~~49~~ 48:

(1) grade 1, as defined in part 5223.0310, subpart ~~50~~ 49, seven percent;

(2) grade 2, as defined in part 5223.0310, subpart ~~51~~ 50, 14 percent;

(3) grade 3 or 4, as defined in part 5223.0310, subparts ~~52~~ 51 and ~~53~~ 52, 24.5 percent.

Subp. 4. **Radicular syndromes.**

A. Radicular pain or radicular paresthesia, as defined in part 5223.0310, subparts ~~44~~ 43 and ~~45~~ 44, with or without lumbar pain syndrome, not substantiated by persistent objective clinical findings, regardless of radiographic findings, zero percent.

E. Radicular pain or radicular paresthesia, with or without lumbar pain syndrome, and with objective radicular findings, that is, reflex changes or EMG abnormality or nerve root specific muscle weakness in the lower extremity, on examination and myelographic, CT scan, or MRI scan evidence of spinal stenosis, as defined in part 5223.0310, subpart ~~48~~ 47, that impinges on a lumbar nerve root, and the medical imaging findings correlate with the findings on neurological examination, ten percent with the addition of as many of subitems (1) to (4) as apply, but each may be used only once:

Subp. 5. **Fusion.**

A. Fusion, as defined in part 5223.0310, subpart ~~30~~ 29, at one level performed as part or all of the surgical treatment of a lumbar pain or radicular pain syndrome, add five percent to the otherwise appropriate category in subpart 3 or 4.

5223.0450 MUSCULOSKELETAL SCHEDULE; SHOULDER AND UPPER ARM.

Subp. 2. **Exclusive Categories.**

F. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, not elsewhere specified and substantiated by

appropriate, consistent, and reproducible clinical or medical imaging findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion but no limitation of passive range of motion, zero percent.

Subp. 4. **Categories describing loss of function.** Function at the shoulder is measured by the available passive range of motion in three arcs at the shoulder: flexion or extension, abduction or adduction, and rotation. Examination with goniometer is performed to determine the limits of passive range of motion in each arc. If there is an impairment in more than one arc, the ratings for each arc are added to determine the final impairment for loss of function.

(7) ankylosis, as defined in part 5223.0310, subpart 7, in flexion or extension occurs:

(b) between ~~one degree~~ zero degrees and 50 degrees of flexion, 14.5 percent;

(d) at greater than ~~101~~ 100 degrees of flexion, 18 percent.

B. Extent of range of abduction or adduction:

(5) ankylosis, as defined in part 5223.0310, subpart 7, in abduction or adduction occurs:

(b) between ~~one degree~~ zero degrees and 80 degrees of abduction, six percent;

C. Extent of range of rotation:

(3) external rotation is limited to between zero degrees and nine degrees and internal rotation is:

(b) ~~up~~ to between zero degrees and 20 degrees, two percent;

(4) external rotation is limited to between ten degrees and 20 degrees internal rotation, that is, there is an internal rotation contracture, and internal rotation is:

(b) to between ten degrees and 20 degrees, four percent;

5223.0460 MUSCULOSKELETAL SCHEDULE; ELBOW AND FOREARM.

Subp. 2. **Exclusive categories.**

C. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, including chronic epicondylitis, medial or lateral, not elsewhere specified, and substantiated by appropriate, consistent, and reproducible clinical findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion but no limitation of passive range of motion, zero percent.

D. Nerve entrapment syndrome of the radial, median, or ulnar nerve at the elbow or in the forearm:

(2) pain and paresthesia recurring or persisting despite treatment, but not substantiated by ~~objective~~ persistent findings on electrodiagnostic testing, zero percent;

Subp. 4. **Categories describing loss of function.** Function at the elbow or forearm is measured by the available passive range of motion at the elbow.

The passive range of motion is measured in two arcs: flexion or extension and supination or pronation. Examination with goniometer is performed to determine the limitation of passive range of motion in each arc. If there is impairment in more than one arc, the ratings for each arc added to determine the overall disability for loss of motion.

B. Extent of range of rotation:

(5) ankylosis, as defined in part 5223.0310, subpart 7, in rotation occurs:

(a) ~~between ten~~ at greater than 45 degrees of supination ~~and 45 degrees of pronation~~, ~~eight~~ 17 percent;

(c) ~~at greater than 45~~ between nine degrees of supination and 45 degrees of pronation, ~~17~~ eight percent;

5223.0470 MUSCULOSKELETAL SCHEDULE; WRIST.

Subp. 2. **Exclusive categories.**

A. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, including tendonitis syndrome and de Quervain syndrome, not elsewhere specified, and substantiated by appropriate, consistent, and reproducible clinical findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion but no limitation of passive range of motion, zero percent.

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B. Nerve entrapment syndrome of the ulnar, radial, or median nerve at the wrist:

(2) pain and paresthesia recurring or persisting despite treatment, but not substantiated by ~~objective~~ persistent findings on electrodiagnostic testing, zero percent;

Subp. 3. **Combinable categories.**

B. Carpal instability, as defined in part 5223.0310, subpart ~~13~~ 12, based on appropriate clinical, laboratory, and medical imaging findings:

Subp. 4. **Categories describing loss of function.** Function at the wrist is measured by the available passive range of motion at the wrist.

The passive range of motion is measured in two arcs: flexion or extension and deviation. Examination with goniometer is performed to determine the limits of passive range of motion in each arc. If there is impairment in more than one arc, the ratings for each arc are added to determine the overall disability for loss of motion.

A. Extent of range of flexion or extension:

(6) ankylosis, as defined in part 5223.0310, subpart 7, in flexion or extension occurs:

(a) ~~between~~ at greater than 30 degrees of extension ~~and five degrees of flexion~~, ~~15~~ 25 percent;

(b) between ~~six~~ 30 degrees of ~~flexion~~ extension and ~~30~~ five degrees of flexion, ~~20~~ 15 percent;

(c) ~~at greater than 30~~ between six degrees of ~~extension~~ flexion and 30 degrees of flexion, ~~25~~ 20 percent;

B. Extent of range of deviation:

(4) ankylosis, as defined in part 5223.0310, subpart 7, in deviation occurs:

(a) ~~between one degree of ulnar deviation and 15 degrees of ulnar~~ in radial deviation, ~~two~~ five percent;

(b) ~~at greater than 15~~ between zero degrees of ulnar deviation and 15 degrees of ulnar deviation, ~~five~~ two percent;

(c) ~~in radial~~ at greater than 15 degrees of ulnar deviation, five percent.

5223.0480 MUSCULOSKELETAL SCHEDULE; HAND AND FINGERS.

Subp. 3. **Combinable categories.**

A. Ulnar or radial deviation at a joint: permanent fixed deformity, measured with joint at neutral position:

(2) mild: ~~less than 20~~ ten degrees to 19 degrees, ten percent of the value of the digit;

Subp. 4. **Categories describing loss of function.** Function of the hand and fingers is measured by the available passive range of motion at each joint and by the quality and extent of tactile sensation in the hand. For injuries involving lacerated tendons, the available active range of motion is measured and applied to items A to H.

The passive range of motion at all joints of the digits excluding the carpometacarpal joint of the thumb is measured in one arc: flexion or extension. Examination with goniometer is performed to determine the limits of passive range of motion at each of these joints. The passive range of motion of the carpometacarpal joint of the thumb is measured by three movements of the thumb: extension or abduction, radial abduction, and opposition. Examination with a metric ruler is performed to determine the passive limitations of each of the movements of the carpometacarpal joint of the thumb.

For the thumb, all appropriate ratings for loss of motion at the interphalangeal, metacarpal, and carpometacarpal joints are added to determine the overall rating for loss of motion of the thumb. This overall rating for loss of motion of the thumb is multiplied by the value of the thumb to convert to the whole body disability for loss of motion of the thumb.

For the fingers, disability for loss of motion at different joints of the same finger are combined to determine the overall disability for loss of motion of the digit. Overall disabilities for loss of motion of a digit are multiplied by the value of the digit to find the whole body disability for loss of motion of that digit. The disabilities for loss of motion of digits are added to determine the overall disability for loss of motion of the hand when there is injury to more than one digit.

The quality and extent of tactile sensation is evaluated according to part 5223.0410, subpart 6.

Any disability for loss of sensation is combined with any overall disability for loss of range of motion to determine the final disability for loss of function.

A. Extent of range of flexion or extension at metacarpophalangeal joint for fingers excluding the thumb:

(7) ankylosis, as defined in part 5223.0310, subpart 7, of the metacarpophalangeal joint for the fingers excluding the thumb occurs:

(a) ~~between neutral and 30 degrees of flexion~~ in extension, ~~50~~ 60 percent of the value of the digit;

(b) ~~in extension~~ between neutral and 30 degrees of flexion, ~~60~~ 50 percent of the value of the digit;

B. Extent of range of flexion or extension and the proximal interphalangeal joint for fingers excluding the thumb:

(7) ankylosis, as defined in part 5223.0310, subpart 7, at the proximal interphalangeal joint for the fingers excluding the thumb occurs:

(a) ~~between zero degrees and 45 degrees of flexion~~ in extension, ~~55~~ 80 percent of the value of the digit;

(b) between ~~46~~ zero degrees and 45 degrees of flexion ~~and 90 degrees of flexion~~, ~~65~~ 55 percent of the value of the digit;

(c) ~~in extension~~ between 46 degrees of flexion and 90 degrees of flexion, ~~80~~ 65 percent of the value of the digit;

C. Extent of range of flexion or extension at the distal interphalangeal joint for fingers excluding the thumb:

(5) ankylosis, as defined in part 5223.0310, subpart 7, at the interphalangeal joint for the fingers excluding the thumb occurs:

(a) ~~between zero degrees and 45 degrees of flexion~~ in extension, ~~30~~ 45 percent of the value of the digit;

(b) ~~greater than~~ between zero degrees and 45 degrees of flexion, ~~45~~ 30 percent of the value of the digit;

(c) ~~in extension~~ greater than 45 degrees of flexion, 45 percent of the value of the digit.

E. Extent of range of flexion or extension at the interphalangeal joint for the thumb:

(5) ankylosis, as defined in part 5223.0310, subpart 7, at the interphalangeal joint of the thumb occurs:

(a) ~~between zero degrees and 40 degrees of flexion~~ in extension, ~~four~~ nine percent of the thumb;

(b) ~~greater than~~ between zero degrees and 40 degrees of flexion, ~~nine~~ four percent of the thumb;

(c) ~~in extension~~ greater than 40 degrees of flexion, nine percent of the thumb.

5223.0500 MUSCULOSKELETAL SCHEDULE; HIP AND UPPER LEG.

Subp. 2. **Exclusive categories.**

A. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, not elsewhere specified and substantiated by appropriate, consistent, and reproducible clinical or medical imaging findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion or persistent deviation of gait but no limitation of passive range of motion, zero percent.

B. Nerve entrapment syndrome of the femoral, obturator, or sciatic nerve at the pelvis, hip, or upper leg:

(2) pain and paresthesia recurring or persisting despite treatment, but not substantiated by ~~objective~~ persistent findings on electrodiagnostic testing, zero percent;

Subp. 4. **Categories describing loss of function.** Function of the hip is measured by the available passive range of motion in three arcs: flexion or extension, abduction or adduction, and rotation. Examination with goniometer is performed to determine the limits of passive range of motion in each arc.

If there is impairment in more than one arc, the rating for each arc is added to determine the final rating for loss of function.

A. Extent of range of flexion or extension:

(7) ankylosis, as defined in part 5223.0310, subpart 7, in flexion or extension occurs:

(a) ~~between zero degrees and 30 degrees flexion~~ in extension, ~~20~~ 40 percent;

(b) between zero degrees and 30 degrees flexion ~~and 60 degrees flexion~~, ~~24~~ 20 percent;

(c) ~~at greater than~~ between 31 degrees and 60 degrees flexion, ~~40~~ 24 percent;

(d) ~~in extension~~ at greater than 60 degrees flexion, 40 percent.

B. Extent of range of abduction or adduction:

(1) adduction is greater than 20 degrees and abduction is:

(b) limited to between ~~zero degrees~~ one degree and 20 degrees, one percent;

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(2) adduction is limited to between zero degrees and 20 degrees abduction and abduction is:

(b) limited to between ~~zero degrees~~ one degree and 20 degrees, two percent;

(5) ankylosis, as defined in part 5223.0310, subpart 7, in abduction or adduction occurs:

(a) ~~between zero degrees and 20 degrees abduction~~ in adduction, ~~five~~ eight percent;

(b) ~~at greater than~~ between zero degrees and 20 degrees abduction, ~~eight~~ five percent;

(c) ~~in adduction~~ at greater than 20 degrees abduction, eight percent.

C. Extent of range of rotation:

(1) external rotation is greater than 30 degrees and internal rotation is:

(b) limited to between ~~zero degrees~~ one degree and 20 degrees, two percent;

(2) external rotation is limited to between 21 degrees and 30 degrees and internal rotation is:

(b) limited to between ~~zero degrees~~ one degree and 20 degrees, two percent;

(3) external rotation is limited to between zero degrees and 20 degrees and internal rotation is:

(b) limited to between ~~zero degrees~~ one degree and 20 degrees, four percent;

(7) ankylosis, as defined in part 5223.0310, subpart 7, in rotation occurs:

(a) ~~between~~ at greater than 20 degrees internal rotation ~~and 20 degrees external rotation~~, ~~four~~ eight percent;

(b) ~~at greater than~~ between 20 degrees internal rotation and 20 degrees external rotation, ~~eight~~ four percent;

5223.0510 MUSCULOSKELETAL SCHEDULE; KNEE AND LOWER LEG.

Subp. 2. **Exclusive categories.**

G. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, not elsewhere specified and substantiated by appropriate, consistent, and reproducible clinical or medical imaging findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion or persistent deviation of gait but no limitation of passive range of motion, zero percent.

H. Nerve entrapment syndrome of the tibial or peroneal nerves at the knee or in the lower leg:

(2) pain and paresthesia recurring or persisting despite treatment, but not substantiated by ~~objective~~ persistent findings on electrodiagnostic testing, zero percent;

Subp. 4. **Categories describing loss of function.** Function of the knee is measured by the available passive range of motion in flexion or extension. Examination with goniometer is performed to determine the limits of passive range.

A. Extent of range of flexion or extension:

(5) extension is limited to between 51 degrees and 90 degrees flexion, that is, there is a flexion contracture, and flexion is:

(b) limited to less than ~~120~~ 121 degrees, 28 percent;

5223.0520 MUSCULOSKELETAL SCHEDULE; ANKLE.

Subp. 2. **Exclusive categories.**

C. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, not elsewhere specified and substantiated by appropriate, consistent, and reproducible clinical or radiographic findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion or persistent deviation of gait but no limitation of passive range of motion, zero percent.

D. Nerve entrapment syndrome of the plantar, sural, or peroneal nerve at the ankle or in the foot:

(2) pain and paresthesia recurring or persisting despite treatment, but not substantiated by ~~objective~~ persistent findings on electrodiagnostic testing, zero percent;

Subp. 4. **Categories describing loss of function.** Function of the ankle is measured by available passive range of motion in two arcs: flexion or extension and inversion or eversion. Examination with goniometer is performed to determine the limits of passive range in each arc. If there is impairment in both arcs, the ratings for loss of motion in the arcs are added to determine the final rating of disability for loss of function.

A. Extent of range of dorsoplantar flexion:

(6) ankylosis, as defined in part 5223.0310, subpart 7, in dorsiflexion or plantar flexion occurs:

(a) ~~between~~ at greater than ten degrees of dorsiflexion ~~and 20 degrees of plantar flexion~~, ~~eight~~ 20 percent;

(b) ~~at greater than~~ between ten degrees of dorsiflexion and 20 degrees of plantar flexion, ~~20~~ eight percent;

B. Extent of range of inversion or eversion:

(5) eversion is limited to between ten degrees and 20 degrees inversion, that is, there is an inversion contracture, and inversion is:

(b) limited to ~~between 16 degrees and 30~~ less than 31 degrees, five percent;

(7) ankylosis, as defined in part 5223.0310, subpart 7, in inversion or eversion occurs:

(a) ~~between~~ at greater than 20 degrees inversion ~~and ten degrees eversion~~, ~~one~~ eight percent;

(b) ~~at greater than~~ between 20 degrees inversion and ten degrees eversion, ~~seven~~ one percent;

(c) at greater than ~~20~~ ten degrees ~~inversion~~ eversion, ~~eight~~ seven percent.

5223.0530 MUSCULOSKELETAL SCHEDULE; FOOT AND TOES.

Subp. 2. **Exclusive categories.**

A. Painful organic syndrome, as defined in part 5223.0310, subpart ~~41~~ 40, not elsewhere specified and substantiated by appropriate, consistent, and reproducible clinical or radiographic findings~~, as defined in part 5223.0310, subpart 8,~~ which results in persistent limitation of active range of motion or persistent deviation of gait but no limitation of passive range of motion, zero percent.

5223.0540 MUSCULOSKELETAL SCHEDULE; AMPUTATIONS OF UPPER EXTREMITY.

Subpart 1. **Amputations.** Permanent partial impairment due to amputation of upper extremities is a disability of the whole body as follows:

B. disarticulation, as defined in part 5223.0310, subpart ~~22~~ 21, at shoulder joint, 60 percent;

5223.0550 MUSCULOSKELETAL SCHEDULE; AMPUTATIONS OF LOWER EXTREMITIES.

Subpart 1. **Amputations.** For permanent partial impairment due to amputation of lower extremities, the disability of the whole body is:

B. disarticulation, as defined in part 5223.0310, subpart ~~22~~ 21, at hip joint, 40 percent;

5223.0560 RESPIRATORY.

Subpart 1. **Evaluation procedures.** The procedures used in evaluating permanent partial impairment of the respiratory system includes the following:

A. performance of the following tests of ventilation, as defined in part 5223.0310, subparts ~~19~~ 18, ~~28~~ 27, and ~~31~~ 30:

B. performance of cardiopulmonary exercise testing. Cardiopulmonary exercise testing, as defined in part 5223.0310, subpart ~~12~~ 11, should be done when complaints of dyspnea and limitation of activity are more severe than spirometry or DCO would indicate, or there was incorrect or submaximum performance in the spirometry or DCO tests. Performance on cardiopulmonary exercise testing is measured by the VO2 max, as defined in part 5223.0310, subpart ~~62~~ 61.

Subp. 2. **Respiratory impairment.**

A. Class 1, zero percent:

(1) FEV1 greater than or equal to 80 percent of predicted, FVC greater than or equal to 80 percent of predicted, DCO greater than or equal to 80 percent of predicted, and FEV1/FVC greater than or equal to ~~80~~ 70 percent of predicted; or

B. Class 2, ten percent:

(1) FEV1 greater than 69 percent but less than 80 percent of predicted, or FVC greater than 69 percent but less than 80 percent of predicted, or DCO greater than 69 percent but less than 80 percent of predicted, or FEV1/FVC greater than ~~69~~ 59 percent but less than ~~80~~ 70 percent of predicted; or

C. Class 3, 25 percent:

(1) FEV1 greater than 59 percent but less than 70 percent of predicted, or FVC greater than 59 percent but less than 70 percent of predicted, or DCO greater than 59 percent but less than 70 percent of predicted, or FEV1/FVC greater than ~~59~~ 49 percent but less than ~~70~~ 60 percent of predicted; or

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D. Class 4, 50 percent:

(1) FEV1 greater than 41 percent but less than 60 percent of predicted, or FVC greater than 49 percent but less than 60 percent of predicted, or DCO greater than 41 percent but less than 60 percent of predicted, or FEV1/FVC greater than 41 percent but less than ~~60~~ 50 percent of predicted; or

Subp. 3. **Asthma and pulmonary conditions with an asthmatic component.** Asthma and pulmonary conditions with an asthmatic component may be rated only under this subpart. Ratings under subpart 2 may not be substituted for or combined with ratings under this subpart.

A. Ratings under this subpart are based on:

(1) the level of bronchial obstruction as measured by pulmonary function tests done when the individual is on an optimum treatment regimen but without the addition of inhaled bronchodilator immediately ~~proceeding~~ preceding the pulmonary function testings;

5223.0570 ORGANIC HEART DISEASE.

Subpart 1. **General.** For permanent partial impairment due to organic heart disease, the disability of the whole body is as provided in ~~subpart~~ subparts 2 and 3.

5223.0580 VASCULAR DISEASE AFFECTING EXTREMITIES.

Subp. 3. **Edema.** There is organic disease of the arterial, venous, or lymphatic system as demonstrated by an X-ray with or without contrast, computerized axial tomogram, sonogram, or radionuclide scan, or a volume study or a flow study. For purposes of rating under this subpart, the value of the upper extremity shall be 60 percent of the whole body and the value of the lower extremity shall be 40 percent of the whole body. The ratings for each limb involved are combined as described in part 5223.0300, subpart 3, item E, to determine the final rating under this subpart.

B. There is persistent mild to moderate edema of a limb that is incompletely controlled by treatment, ten percent of the value of the extremity, that is, six percent of the whole body for an upper extremity, four percent of the whole body for a lower extremity.

C. There is persistent severe edema of a limb that is incompletely controlled by treatment, 30 percent of the value of the extremity, that is, 18 percent of the whole body for an upper extremity, 12 percent of the whole body for a lower extremity.

D. There is persistent severe edema of a limb that is completely unamenable to treatment, 65 percent of the value of the extremity, that is, 39 percent of the whole body for an upper extremity, 26 percent of the whole body for a lower extremity.

Subp. 5. **Raynaud's Phenomenon.** There is organic disease of the arterial system in the upper extremity as demonstrated by a radiograph, X-ray with or without contrast, computerized axial tomogram, sonogram, or radionuclide scan, or a volume study or a flow study, or organic disease of the autonomic nervous system. The ratings for both upper extremities are combined as described in part 5223.0300, subpart 3, item E, to determine the final rating under this subpart.

A. Raynaud's Phenomenon occurs in a limb on exposure to ambient temperatures lower than zero degrees centigrade, or 32 degrees Fahrenheit, but is controlled by treatment, zero percent ~~of the value of the extremity~~.

5223.0590 GASTROINTESTINAL TRACT.

Subp. 2. **Upper digestive tract.** Esophagus, stomach, duodenum, small intestine, and pancreas.

A. Class 1, two percent. Signs or symptoms of organic upper digestive tract disorder are present; there is anatomic loss or alteration, but treatment is not required; and weight can be maintained at the desirable level, as defined in part 5223.0310, subpart ~~21~~ 20, by oral diet.

Subp. 3. **Colon and rectum.** Fiber supplements are not to be considered a special diet or a restriction of diet.

A. Class 1, two percent. Signs or symptoms of organic colonic or rectal disorder are infrequent; limitation of activities, special diet, or medication is not required; no systemic manifestations are present; and weight can be maintained at the desirable level, as defined in part 5223.0310, subpart ~~21~~ 20.

Subp. 5. **Liver.**

A. Class 1, five percent:

(1) there is objective evidence of persistent liver disorder even though no symptoms of liver disorder are present; there is no history of ascites, jaundice, or bleeding esophageal varices within five years; weight can be maintained at the desirable level, as defined in part 5223.0310, subpart ~~21~~ 20; and biochemical studies, that is, SGOT or SGPT, are less than four times the upper limit of normal;

Subp. 7. **Enterocutaneous fistulas.**

A. Esophagostomy, as defined in part 5223.0310, subpart ~~25~~ 24, ten percent.

B. Gastrostomy, as defined in part 5223.0310, subpart ~~32~~ 31, ten percent.

C. Jejunostomy, as defined in part 5223.0310, subpart ~~35~~ 34, 15 percent.

D. Ileostomy, as defined in part 5223.0310, subpart ~~34~~ 33, 15 percent.

E. Colostomy, as defined in part 5223.0310, subpart ~~16~~ 15, five percent.

5223.0600 REPRODUCTIVE AND URINARY TRACT SCHEDULE.

Subp. 7. **Testes, epididymides, and spermatic cords.**

~~D. Inguinal hernia, direct or indirect, unilateral or bilateral, recurrent after two or more herniorrhaphies, five percent.~~

5223.0640 HEAT AND COLD INJURIES.

Subpart 1. **General.** This part provides the percentage of disability of the whole body for permanent partial impairment due to heat and cold injuries.

Heat injuries may be due to radiant heat, flame, hot gases or fumes, electric current, friction, chemicals, or radiation. Cold injuries may be due to environmental conditions or from contact with cold solids, liquids, or gases.

The whole body disability due to heat or cold injuries is not directly equal to the percentage of body surface area involved. The percentage of body surface area involved is used, however, in certain items to categorize impairments. When required the percentage of body surface area affected must be determined according to the method of Lund and Browder, as defined in part 5223.0310, subpart ~~37~~ 36.

Any permanent partial impairment to other body parts or organs other than as provided in this part and directly resulting from a heat or cold injury must be rated as provided in the appropriate parts of this schedule. These ratings may be combined with each other and with any ratings under this part as described in part 5223.0300, subpart 3, item E.

Subp. 2. **Heat and cold injuries other than electrical conduction.** A rating under this part is the combination, as described in part 5223.0300, subpart 3, item E, of the ratings assigned by items A to E.

C. Systemic heat intolerance as evidenced by fatigue or malaise or nausea; an oral temperature of at least 100 degrees Fahrenheit upon exposure to an environmental temperature of 90 degrees Fahrenheit at 60 percent relative humidity; and an initial heat injury that involved at least 50 percent of the body surface area, as measured by the method of Lund and Browder, as defined in part 5223.0310, subpart ~~37~~ 36, five percent.

5223.0650 COSMETIC DISFIGUREMENT.

Subp. 2. **Face.**

B. The nose:

(1) deformity of nasal tip, or external deformity, thinning, or eversion of ala nasi, five percent;

F. The face, in areas other than those covered in items B to E:

(2) diffuse scarring, that is, secondary to burns:

(a) hypertrophic scarring, as defined in part 5223.0310, subpart ~~33~~ 32, affecting only forehead above the eyebrows, ten percent;

(3) wrinkling, as defined in part 5223.0310, subpart ~~63~~ 62, of face in areas covered in subitem (2), units (a) to (c), one-third of listed percentages;

Subp. 4. **Anterior neck.**

B. Hypertrophic scarring, as defined in part 5223.0310, subpart ~~33~~ 32, or banding, as defined in part 5223.0310, subpart ~~11~~ 10, of the anterior neck:

Subp. 5. **Hand.** The hand extends from the carpus distally. Loss of body parts and loss of function are rated in parts 5223.0400 to 5223.0550 and ratings as provided in those parts may be combined as described in part 5223.0300, subpart 3, item E, with ratings under this subpart.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

A. Hypertrophic scarring, as defined in part 5223.0310, subpart ~~33~~ 32, affecting less than 30 percent of dorsum of one hand, zero percent.

Subp. 6. **Other disfigurements.**

C. Disfigurement other than of the face, head, anterior neck, and hand rated in subparts 2 to 4, or loss of volume of female breast tissue or loss of nipple rated in items A and B. Visible loss of tissue, hypertrophic scarring, as defined in part 5223.0310, subpart ~~33~~ 32, and visible pigment changes are considered disfigurements under this item:

(1) less than five percent of body surface area according to the method of Lund and Browder, as defined in part 5223.0310, subpart ~~37~~ 36, zero percent;

Department of Labor and Industry

Adopted Permanent Rules Relating to Workers' Compensation; Fraud Unit

The rules proposed and published at *State Register*, Volume 17, Number 25, pages 1501-1504, December 21, 1992 (17 SR 1494) and Volume 17, Number 27, page 1716, January 4, 1993 (17 SR 1716), are adopted with the following modifications:

Rules as Adopted

5228.0100 DEFINITIONS.

Subp. 9. **Illegal activity.** "Illegal activity" for purposes of *Minnesota Statutes*, section 176.86, means acts, omissions, or material misrepresentations which are in violation of statutes or rules relating to workers' compensation, including *Minnesota Statutes*, section 176.178 or 609.52. The acts and omissions include, but are not limited to, the following:

D. making a knowingly false material statement or material representation regarding entitlement to benefits with the intent to discourage an injured worker from pursuing a claim or with the intent to encourage an employee to pursue a claim.

Pollution Control Agency

Adopted Permanent Rules Relating to Air Quality Amendments

The rules proposed and published at *State Register*, Volume 17, Number 35, pages 2104-2105, March 1, 1993 (17 SR 2104), are adopted as proposed.

Withdrawn Rules

Minnesota Department of Health

Notice of Withdrawal of Proposed Rules Relating to Ionizing Radiation

NOTICE IS HEREBY GIVEN that the Minnesota Department of Health withdraws the proposed amendments to part 4730.1691, subpart 5, items A to F as published in *State Register*, Volume 17, Number 31, page 1857, February 1, 1993 (17 S.R. 1855).

Revenue Notices

Effective July 1, 1991, the Department of Revenue has authority to issue revenue notices. A revenue notice is a policy statement made by the department that provides interpretation, details, or supplementary information concerning the application of law or rules. This authority was provided by the Legislature in *1991 Session Laws* Chapter 291, article 21, section 6 and will be codified at *Minnesota Statutes* section 270.0604.

Department of Revenue

Revenue Notice #93-12: Assessment for Collection of Mixed Municipal Solid Waste

General Information:

Minnesota Statutes § 116.07, subd. 10, effective July 1, 1993, provides that persons who collect mixed municipal solid waste shall

collect an assessment from each customer and remit it to the commissioner of revenue. Waste collectors are required to remit the assessments along with their regular remittance of sales tax on solid waste collection services. Local governments which bill for solid waste collection services are considered "waste collectors." The assessments will be deposited in the environmental fund, and will be used mainly for landfill cleanup.

Residential Customers

What is a residential customer? A residential customer is someone who pays for waste collection services for a building with one to four dwelling units. If the building has more than four dwelling units, the customer is considered a nonresidential customer. A home operated business will be treated as a nonresidential customer. If the building has four or less dwelling units, but also has one or more units not used for dwelling purposes, such as a store or a restaurant, then the customer is considered a nonresidential customer.

What is the assessment? Each waste collector must annually bill and collect a $2 solid waste assessment from each residential customer that the collector has as of July 1 of each year. A residential customer who receives collection services as of July 1 for more than one location, for example a primary dwelling and a vacation home, will be assessed $2 for each location.

When must the waste collector remit the assessments? To allow for different collection schedules, the waste collector is not required to remit the assessments until after October 1 of each year, along with the first remittance of sales tax on solid waste collection services. Any assessments collected after October 1 must be remitted along with the next remittance of sales tax.

Nonresidential Customers

What is a nonresidential customer? A nonresidential customer is someone who does not qualify as a residential customer. For example, the waste may be collected for industry or businesses, including home-operated-businesses such as day care, beauticians, or craft businesses; dwellings with more than four dwelling units; and such places as churches, nursing homes, nonprofit associations, and schools.

What is the assessment? Each waste collector must bill and collect an assessment of 12 cents per noncompacted cubic yard of periodic waste collection capacity purchased by each nonresidential customer. The capacity of a "noncompacted cubic yard" means the number of loose cubic yards of mixed municipal solid waste, and is based on the size of the waste collection container. "Periodic waste collection" means each time the container is emptied (for example, a 2 cubic yard dumpster will pay 24 cents each time it is emptied). The assessment must be collected as part of each statement for payment of waste collection charges. The following examples are helpful in understanding how the assessment is calculated:

Example 1: if the customer has contracted for collection of 2 noncompacted cubic yards of mixed municipal solid waste, 3 times a week, and is billed every 3 months, each statement will include an assessment of $9.36. That is, $0.12 X 2 (noncompacted cubic yard capacity) X 3 (times a week) X 13 weeks (i.e., 3 months) = $9.36.

Example 2: if the capacity is 2 noncompacted cubic yards, collected 2 times a week, and the customer is billed every month, the assessment is $2.08. That is, $0.12 X 2 (capacity) X 2 (times a week) X 4.33 weeks (i.e., 1 month) = $2.08.

Example 3: In example 2, if the capacity purchased is instead for 2 compacted cubic yards per week, then the capacity will be calculated based on an average compaction ratio of 3:1. Thus, each statement will include an assessment of $6.24. That is, 2.08 (the assessment amount based on a noncompacted cubic yard capacity) X 3 (the average compaction ratio) = $6.24.

When must the waste collector remit the assessments? The amount collected as part of each statement for payment of waste collection charges must be remitted along with the next remittance of sales tax. For monthly filers who collect on monthly statements, all assessments collected for July of 1993 are a part of the July return due in August, 1993. For quarterly filers, the waste assessments collected for July, August, and September of 1993 are a part of the quarterly return due October 20, 1993.

Assessments and the sales tax base

The solid waste assessments for either residential or nonresidential customers are not part of the sales tax base. Waste collectors must not charge their customers sales tax on the assessments.

Self-haulers

Some people do not use the services of waste collectors, but haul their own waste to the landfills. Do self-haulers have to pay a solid-waste assessment? No, the law applies only to those who collect and remit sales tax on solid waste collection services under *Minnesota Statutes* §297A.45. The assessment does not apply to self-haulers.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

<u>Out-of-state customers or landfills</u>

Waste collectors must collect the assessment from all customers, regardless of where the customer lives, or where the landfill is, unless both the customer and the landfill are out-of-state.

Dated: 21 June 1993

Official Notices

Pursuant to the provisions of Minnesota Statutes § 14.10, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Commerce

Minnesota Petroleum Tank Release Compensation Board

Notice of Intent to Solicit Outside Information or Opinions Regarding Proposed Rules Governing Reductions of Reimbursement, Reimbursement of Costs, Selection of the Board's Vice Chair, the Right to Appeal Decisions of the Board, Ineligible Costs, the Application Process and Definitions

NOTICE IS HEREBY GIVEN that the Minnesota Petroleum Tank Release Compensation Board (the "Board") is seeking information or opinions from outside sources in preparing to propose the amendment of rules governing the amount and manner of imposing reductions in reimbursement, the procedure for applying for reimbursement of costs, the definitions of parties performing clean-up work or applying for reimbursement of costs, the procedure for selecting a Vice Chair of the Board, and the appeals process for Board decisions. The amendment of the rules is authorized by *Minnesota Statutes* § 115C.07, subd. 3 (1992), which requires the Board to adopt the rules regarding the Board's practices and procedures, and the form and procedure for applications for compensation from the Minnesota Petroleum Tank Release Compensation Fund, and rules to ensure the reasonableness of reimbursed costs.

The Board requests information and opinions concerning the subject matter of the rules. Interested persons or groups may submit data or views in writing or orally. Written or oral statements or comments should be directed to:

Patricia L. Peterson
Minnesota Department of Commerce
133 East Seventh Street
St. Paul, MN 55101
Telephone: (612) 297-1119

Oral statements will be received during regular business hours, 9:00 a.m. to 4:30 p.m., Monday through Friday.

The proposed amendments to the rules of the Board will have an impact on small business. Many small businesses seek reimbursement of clean-up costs relating to releases of petroleum. The proposed amendments to the Board's rules may affect the total amount of money subtracted from reimbursement for clean-up costs and the manner in which the amount of that reduced reimbursement is calculated. The exact amount of the change in reduction of reimbursement for a small business will vary significantly based on the particular situation of each small business applicant for reimbursement.

All statements of information and opinion will be accepted until July 14, 1993. Any written materials received by the Board shall become part of the rulemaking record in the event that the rule is adopted, amended, or repealed.

Phil Troutwine, Chair
Minnesota Petroleum Tank Release
Compensation Board

Department of Health

Official Notice of Limit on the Rate of Growth of Health Care Expenditures for Calendar Year 1994

NOTICE IS HEREBY GIVEN to all group purchasers (as defined below), that under *Minnesota Laws*, chapter 345, Article 3,

Section 2, Subdivision 1, the projected annual limit on the rate of growth of public and private spending on health care services for Minnesota residents, for calendar year 1994, is 9.2 percent.

Group purchaser, as defined by *Minnesota Statutes 1992*, Section 62J.03, Subdivision 8, means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in the rules adopted by the commissioner. **Group purchaser** includes, but is not limited to, integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, *United States Code*, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Notice Regarding Quarterly Change in Regional and National Consumer Price Index

The change in the unadjusted regional urban-consumer price index for all items for the North Central Region, from 4th quarter 1992 to 1st quarter 1993 is 0.73 percent.

The change in the unadjusted national urban-consumer price index for all items, from 4th quarter 1992 to 1st quarter 1993 is 0.85 percent.

Notice Regarding Health Care Financing Administration Forecast of National Health Care Expenditures for 1993

The projected growth in aggregate national health care expenditures forecast by the health care financing administration, for the United States, for the period 1992-1993 is 10.2 percent.

Official Notice of Limit on the Rate of Growth of Health Care Expenditures for Calendar Year 1994

NOTICE IS HEREBY GIVEN to all group purchasers (as defined below), that under *Minnesota Laws*, chapter 345, Article 3, Section 2, Subdivision 1, the projected annual limit on the rate of growth of public and private spending on health care services for Minnesota residents, for calendar year 1994, is 9.2 percent.

Group purchaser, as defined by *Minnesota Statutes 1992*, Section 62J.03, Subdivision 8, means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in the rules adopted by the commissioner. **Group purchaser** includes, but is not limited to, integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, *United States Code*, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

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Notice Regarding Health Care Financing Administration Forecast of National Health Care Expenditures for 1993

The projected growth in aggregate national health care expenditures forecast by the health care financing administration, for the United States, for the period 1992-1993 is 10.2 percent.

Department of Health

Official Notice of New Data Collection Requirements for Health Care Providers in Minnesota

NOTICE IS HEREBY GIVEN to all health care providers (as defined below), that under *Minnesota Laws*, chapter 345, article 2 section 5 subdivision 4, and article 3 section 12, new data collection requirements apply for 1993. These summary reports are due during the first quarter of 1994.

The health care providers listed below are required to collect and submit descriptive and aggregate financial data on number of patients served (by state of residence and Minnesota county); site or sites where the health care provider provides services; the number of individuals employed, by type of employee, by the health care provider; the services and their costs for which no payment was received; total revenue by type of payer, including but not limited to, revenue from Medicare, Medical Assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, health maintenance organizations, and individual patients; revenue from research activities, educational activities, out-of-pocket payments by patients, donations, grants and/or government subsidies. Summary expenditure data must be provided at least for the following categories: salaries/wages and employee benefits, purchased services, other expenditures, and administrative costs, bad debt, and charity care deductions. Other information, including but not limited to, indicators of quality of services and outcomes of care will also be required.

Hospitals and Freestanding Outpatient Surgical Centers: The new information required under the 1993 legislative mandates will be incorporated into the existing reporting forms on aggregated financial and utilization information. Data for the calendar year 1993 must be submitted by the reporting date established by the Health Care Cost Information System (HCCIS), under *Minnesota Statutes* 144.695-703. Sample forms and instruction materials will be made available before July 1, 1993. Final forms with instructions and definitions will be mailed to all hospitals and freestanding outpatient surgical centers at least 60 days before the report due date. Questions about hospital and freestanding outpatient surgical center reporting requirements should be directed to Walter Suarez, Alternative Deliver Section, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, (612) 623-5666.

Physician group practices and Health Care Clinics: For health care clinics, the aggregated financial and utilization information required under these legislative mandates will be incorporated into new reporting forms. Data may be submitted for calendar year 1993, but must be submitted for at least the period July 1, 1993 to December 31, 1993. Sample forms and instruction materials will be mailed to each clinic before July 1, 1993 Final forms with instructions and definitions will be mailed no later than November 1, 1993. For questions regarding reporting requirements of health care clinics please contact Jerry Dalnes, Health Care Analysis Program, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, (612) 623-5597.

Any additional information regarding this notice may be obtained by writing to Virginia Weslowski, Health Care Delivery Systems Division, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, or calling (612) 623-5328.

Department of Health

Official Notice of New Data Collection Requirements for Group Purchasers of Health Care

NOTICE IS HEREBY GIVEN to all group purchasers of health care (as defined below), that under *Minnesota Laws*, chapter 345, article 2 section 4 subdivision 3, and article 3 section 10, new data collection requirements apply for 1993 summary reports due during the first quarter of 1994.

For purposes of these legislative mandates, ***group purchaser*** means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or service is paid for by the purchaser or by the persons receiving coverage or services. It includes, but is not limited to health insurance companies, health maintenance organizations (HMOs), nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1974, US CFR title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

The group purchasers listed below are required to collect and submit detailed data for calendar year 1993 on their revenue, expenses, and member months. Revenue data must distinguish between premium revenue and revenue from other sources, and must include information on the amount of revenue in reserves and changes in reserves. Summary expenditure data must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, and administrative costs. Other information, including but not limited to, indicators of quality of services and outcomes of care will also be required.

Health Maintenance Organizations: For health maintenance organizations already submitting aggregated financial and utilization information to the Department of Health, the new information required under these legislative mandates will be incorporated into the existing reporting forms. Data for the calendar year 1993 must be submitted by the reporting date established under *Minnesota Statutes* 62D.08, subd. 2. Sample forms and instruction materials will be made available during July 1993. Final forms with instructions and definitions will be mailed to all HMOs no later than November 1, 1993. Questions about HMO reporting requirements should be directed to Michelle Barnes, Alternative Delivery Section, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, (612) 623-5733.

Health Insurance Companies, Nonprofit Health Plan Corporations, and Employee Health Plans Offered by Self-Insured Employers: For these group purchasers, the aggregated financial and utilization information required under these legislative mandates will be incorporated into new reporting forms. Data for the calendar year 1993 must be submitted no later than April 1, 1994. Sample forms and instruction materials will be mailed to each large health insurance company, nonprofit health plan corporation and selected employee health plans offered by self-insured employers during July 1, 1993. Final forms with instructions and definitions will be mailed no later than November 1, 1993. For questions regarding reporting requirements of the group purchasers mentioned above please contact Ven Manda, Health Economics Program, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, (612) 623-5596.

Any additional information regarding this notice may be obtained by writing to Virginia Weslowski, Health Care Delivery Systems Division, Minnesota Department of Health, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, or calling (612) 623-5328.

Labor and Industry

Labor Standards Division

Notice of Prevailing Wage Certifications for Commercial Construction Projects

Effective June 21, 1993, prevailing wage rates are certified for commercial construction projects in: Blue Earth county: Mankato Welding Shop-Mankato. Brown county: New Ulm Elementary Middle & High Schools-New Ulm. Chippewa county: Chemical Storage Building Remodeling-Granite Falls. Clay county: Nemzek Fieldhouse Painting & Kise Commons Building Replace Concrete Walk-MSU. Dakota county: MN Veterans Home Power Plant Asbestos Removal-Hastings, ISD #196 Portable Classrooms Remodeling-Apple Valley. Hennepin county: Champlin Community Library-Champlin, ESS Pole Building at Fort Snelling-Minneapolis. Houston county: Caledonia Elementary School Reroofing-Caledonia. Nicollet county: St. Peter RTC Shanz Residential Building Chain Link Fence-St. Peter. Nobles county: Adrian School Remodeling-Adrian. St. Louis county: Water Treatment Plant Modifications-Hoyt Lakes, Nett Lake Housing Remodeling-Nett Lake. Renville county: MN/DOT Olivia Truck Station-Olivia. Winona county: ISD: #861 Fire Protection Sprinkler System-Winona. Wright county: MN/DOT Road Building-Monticello, Wastewater Treatment Facility Expansion Improvement-Albertville.

Copies of the certified wage rates for these projects may be obtained by writing the Minnesota Department of Labor and Industry, Prevailing Wage Section, 443 Lafayette Road, St. Paul, Minnesota 55155-4306. The charge for the cost of copying and mailing are $1.36 per project. Make check or money order payable to the State of Minnesota.

John B. Lennes, Jr.
Commissioner

Metropolitan Council

Notice of Preliminary Schedule for Amending the *Recreation Open Space Development Guide/Policy Plan*

The Metropolitan Council has received a request from the Ramsey County Board of Commissioners to amend the Council's *Recreation Open Space Development Guide/Policy Plan* to give a "regional trail" designation to a planned trail linking the Tamarack Nature Center in Bald Eagle-Otter Lake Regional Park to a proposed regional trail along Minnesota Highway 96 in the city of White Bear Lake and White Bear Township. The proposed regional trail addition is called the "Birch Lake Regional Bikeway/Walkway". Changes proposed in the revision may affect the standards for determining projects of metropolitan significance in the metropolitan significance rules, *Minnesota Rules*, Chapter 5800.

The Metropolitan Council will consider this proposed regional trail addition under the following schedule:

- Metropolitan Parks and Open Space Commission reviews trail master plan and associated draft amendment to *Recreation Open Space Development Guide/Policy Plan*—late June.
- Metropolitan Council adopts public hearing draft—late July.

- Metropolitan Council Committee of the Whole conducts public hearing—September.
- Metropolitan Council Committee of the Whole considers public hearing report and staff recommendations—late September.
- Metropolitan Council considers Committee of the Whole recommendations—October.

This review schedule is preliminary and interested persons should call to confirm dates and meeting schedules. Notice of a public hearing will be published. If you wish to present written or oral comments on the proposed regional trail addition or if you have any questions, call Arne Stefferud of the Council staff at 291-6360 or 291-0904 (TDD).

Pollution Control Agency

Public Notice of Intent to Issue a General Permit for the Discharge of Storm Water Associated with Construction Activity

NOTICE IS HEREBY GIVEN that the Minnesota Pollution Control Agency (MPCA) intends to issue a general permit under the provisions of *Minnesota Rules*, Part 7001.0210, for discharges of storm water associated with construction activity. Comments are requested from affected or interested parties regarding draft National Pollutant Discharge Elimination System (NPDES) General Permit Number MN R100000. Comments should be submitted in writing in accordance with the provisions of this notice.

Public notice for the NPDES Permit Program (Section 403, Clean Water Act, as amended, *Minnesota Statutes*, Chapters 115, and 116, as amended, and *Minnesota Rules*, Chapter 7001).

Draft NPDES General Permit to Discharge Storm Water Associated with Construction Activity into Waters of the State

Public Notice Issued On: June 21, 1993

Last Day to Submit Comments: July 21, 1993

Name, Address, and Location of Potential Applicant: Any Construction Activity in Minnesota disturbing five acres of land or more, and discharging storm water to waters of the state.

Receiving Waters: Surface Waters of the State.

NOTICE:

The MPCA proposes to issue a NPDES general permit to cover the discharge of storm water associated with construction activities to waters of the state. A general permit covers categories with operations, emissions, activities, discharges, or facilities that are the same or similar in context. The general permit will be issued by the MPCA for a term of approximately five years.

The draft general permit, and fact sheet, is available for review at the MPCA, 520 Lafayette Road North, St. Paul during regular business hours, Monday through Friday. If you have any questions regarding the draft general permit or if you would like to receive a copy of the draft general permit and fact sheet, please contact Dan Sullivan at (612) 296-7219 or Users of Telecommunications Device for the Deaf call (612) 297-5353.

The MPCA will conduct the following informational meeting on the draft general permit:

July 19, 1993
Meeting begins at 1:00 p.m.

MPCA
MPCA Board Room
520 Lafayette Road North
St. Paul, Minnesota

The authority to develop and issue a general permit is based on the 1979 U.S. Environmental Protection Agency (EPA) revisions to the NPDES program regulations which created a class of permits called general permits. General permits are issued in the State of Minnesota under 40 CFR 122.28 and *Minnesota Rules*, part 7001.0210. General permits can be issued in NPDES approved states if the state program includes general permit authority from EPA. MPCA's general permit program was approved by EPA on December 15, 1987. This general permit is based on federal requirements in 40 CFR 122.26.

The permit is proposed as a mechanism to regulate the discharge of storm water associated with construction activities disturbing five acres or more. This general permit will require permittees to develop and implement a storm water erosion control plan and a storm water management plan that eliminates or reduces the amount pollutants and sediment in storm water. The erosion control plan must be developed prior to the initiation of construction activities, and the storm water management plan must be in place prior to the completion of construction activity at the permitted site. This general permit will provide coverage for approximately 600 construction activities in the state per year.

Based on a review of applicable standards and regulations the Commissioner has made a tentative determination that a general permit is appropriate for regulating construction activities in the state. Interested persons are invited to submit written comments on

this proposed draft permit. Any comments received before the last day of the comment period will be considered before the permit is finalized.

Any comments on the draft permit should include the following information (*Minnesota Rules*, part 7001.0110):

1. A statement of the person's interest in the draft permit;
2. A statement of action the person would like the MPCA to take, including specific references to sections in the draft permit;
3. Reasons supporting the person's position.

The MPCA has scheduled one public informational meeting and any person may request additional informational meetings, or request a contested case hearing on the draft permit before the end of the public comment period. Any request for additional meetings or a contested case hearing must include information based on items 1 through 3 listed above.

Comments on the permit, requests for additional public informational meetings, or requests for a contested case hearing should be submitted to:

Dan Sullivan
Minnesota Pollution Control Agency
Water Quality Division
520 Lafayette Road North
St. Paul, Minnesota 55155-4194

In the absence of any requests for additional public informational meetings or a contested case hearing, the final decision to issue this permit will be made by the Manager of the Industrial Section of the Water Quality Division. Any person may request that this permit be considered by the MPCA Board prior to final permit action (in accordance with *Minnesota Rules*, part 7000.0500, subdivision 6.). The public is entitled, and welcome, to participate in the activities of MPCA Board and MPCA staff (in accordance with *Minnesota Rules*, parts 7000.1500 and 7000.1600).

State Grants

In addition to requests by state agencies for technical/professional services (published in the State Contracts section), the *State Register* also publishes notices about grant funds available through any agency or branch of state government. Although some grant programs specifically require printing in a statewide publication such as the *State Register*, there is no requirement for publication in the *State Register* itself.

Agencies are encouraged to publish grant notices, and to provide financial estimates as well as sufficient time for interested parties to respond.

Minnesota Department of Agriculture

Market Development and Promotion Division

Notice of Availability of Grant Funds for the Minnesota Aquaculture Development Program

I. General Information

The Minnesota Department of Agriculture (MDA) is seeking research and demonstration proposals for the Minnesota Aquaculture Development Program (MADP). A research grant program, the MADP is designed to support evaluation and development of environmentally and economically sound aquaculture systems.

The MADP is not a loan program. Nor is it a source for business start-up capital. MADP funds are not meant to be used for capital improvements or acquisition of expensive durable equipment where reasonable lease arrangements can be made for the term of a project. Funding for the MADP was appropriated by the Minnesota Legislature (*1993 Laws of Minnesota*, Chapter 172, Section 14, Subdivision 3g), as recommended by the Legislative Commission on Minnesota Resources (LCMR), from the Minnesota Future Resources Fund.

Preference will be given to applications which involve producer and research institution cooperation and those which request less than $30,000 of MADP funds. Requests in excess of $50,000 will likely not be considered.

This request for proposal does not obligate the state to complete the project, and the state reserves the right to cancel the solicitation if it is considered to be in its best interest.

II. Eligibility Requirements

Generally, proposals must meet all of the requirements listed below to be considered for MADP funding.

1. Proposals must contribute to the MADP goal of developing or evaluating environmentally and economically sound aquaculture production systems in Minnesota.

2. Applicants must provide at least a one-to-one match in project funding. Matching funds may include in-kind services and equipment, but may not include other state funds.

3. Proposals must benefit, or at least have a strong potential to benefit, Minnesota's aquaculture industry beyond the immediate clientele of the project's activities. All projects must facilitate *demonstration* of processes and results.

4. Projects must be completed by March 20, 1995 and a final report submitted by May 15, 1995.

5. Proposals must involve a private producer.

III. Target Areas

The following are target project areas. Adherence to a target area does not guarantee funding. Conversely, there may be projects funded which do not fall under any of the following categories.

Develop and demonstrate:

- waste management, treatment, or utilization technology for aquaculture application,
- practical technology to raise fish in indoor, water re-use systems in Minnesota,
- economical waste heat utilization technology for use in an aquaculture production system,
- intensive baitfish or sportfish fingerling production system technology,
- economical and efficient feed formulations/feeding strategies for Minnesota cultured fish.

IV. Application Procedures

Pre-applications are due **August 20, 1993.** For a copy of detailed guidelines and the pre-application form, call Tracy Hugunin at (612) 297-2301 or write to:

Minnesota Department of Agriculture
Aquaculture Development Program
90 West Plato Blvd.
St. Paul, MN 55107-2094

Professional, Technical & Consulting Contracts

Department of Administration procedures require that notice of any consultant services contract or professional and technical services contract which has an estimated cost of over $10,000 be printed in the *State Register*. These procedures also require that the following information be included in the notice: name of contact person, agency name and address, description of project and tasks, cost estimate, and final submission date of completed contract proposal. Certain quasi-state agencies are exempted from some of the provisions of this statute.

Department of Health

Office of Rural Health

Notice of Requests for Proposals: Study of Obstetrical Access

The Office of Rural Health is soliciting proposals from qualified parties to prepare a study of access to obstetrical services in rural areas. This project will quantify the number and location of family physicians and obstetricians providing OB services in rural Minnesota; quantify the volume of OB services delivered by rural providers; and identify reasons why rural family physicians and obstetricians may increase, decrease, or discontinue OB services in the next five years. Qualified parties should have expertise in rural health research, and the capability to develop a survey instrument and conduct phone interviews of over 500 rural physicians.

Proposals should cover the period of July 21, 1993 through October 29, 1993. The total cost of the proposal should not exceed $35,500.

This request for proposals does not obligate the State to complete this project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest.

All proposals must be submitted no later than 4:30 p.m., June 30, 1993. Inquiries may be directed to:

Michelle Casey, Senior Analyst
Office of Rural Health, MDH
717 Delaware Street SE, P.O. Box 9441
Minneapolis, MN 55440-9441
Phone: (612) 623-5616

Department of Human Services

St. Peter Regional Treatment Center

Notice of Request for a Proposal for General Practitioner Services

NOTICE IS HEREBY GIVEN that the St. Peter Regional Treatment Center, Residential Facilities Administration, Department of Human Services, is seeking services which are to be performed as requested by the Administration of the St. Peter Regional Treatment Center. The following contract will be written for the period August 1, 1993 through June 30, 1994.

1. General Practitioner services needed to serve the needs of the clients at St. Peter Regional Treatment Center.

Responses must be received by July 12, 1993. Direct inquiries to:

Cindy Zahratka, Contract Coordinator
St. Peter Regional Treatment Center
100 Freeman Drive
St. Peter, MN 56082
Phone: (507) 931-7715

Department of Jobs and Training

Division of Rehabilitation Services

Notice of Availability of Funds for Extended Employment Programs

Rehabilitation Facilities with certified Extended Employment Program(s) may apply for funds granted by the Division of Rehabilitation Services in accordance with *Minnesota Rules*, 3000.1950, 3300.3050. Application forms for funding Extended Employment Programs (Supported Employment, Long-Term Employment and Work Activity) are available from the Department of Jobs and Training, Division of Rehabilitation Services, Extended Employment Program, 390 North Robert Street, First Floor, St. Paul, MN 55101. Completed applications must be postmarked July 30, 1993, or delivered to the above address by 4:30 p.m. on that date.

Applications are required for funding Extended Employment programs currently receiving State Extended Employment funds from the Division of Rehabilitation Services, and are also required for new or expanded programs.

Any city, town, county, non-profit organization, or any combination of these which operates or proposes to operate a public or non-profit Extended Employment program may apply for funding.

For additional information contact David Sherwood-Gabrielson, Director, Extended Employment Program at (612) 296-9150.

Non-State Public Bids and Contracts

The *State Register* also serves as a central marketplace for contracts let out on bid by the public sector. The *Register* meets state and federal guidelines for statewide circulation of public notices. Any tax-supported institution or government jurisdiction may advertise contracts and requests for proposals from the private sector.

It is recommended that contracts and RFPs include the following: 1) name of contact person; 2) institution name, address, and telephone number; 3) brief description of project and tasks; 4) cost estimate; and 5) final submission date of completed contract proposal. Allow at least three weeks from publication date (four weeks from date article is submitted for publication). Surveys show that subscribers are interested in hearing about contracts for estimates as low as $1,000. Contact the editor for further details.

Metropolitan Council

Request for Proposals for a Congestion/Road Pricing Study

NOTICE IS HEREBY GIVEN that the Metropolitan Council is requesting proposals for conducting a study on Congestion/Road Pricing for the Metropolitan Area of Minneapolis and St. Paul. The contract will commence on or about September 1, 1993 and be completed by February 15, 1994. All proposals must be postmarked or received no later than July 16, 1993.

Copies of the Request for Proposals may be obtained from the Metropolitan Council, Mears Park Centre, 230 E. Fifth St., St. Paul, MN 55101. Proposals should be submitted to the same address (Attention: Dave Engstrom (612) 291-6320, Connie Kozlak (612) 291-6346 or (612) 291-0494 (TDD)).

Awards of State Contracts and Advertised Bids

Pursuant to the provisions of Minn. Stat. § 14.10, an agency must make reasonable effort to publicize the availability of any services contract or professional and technical services contract which has an estimated cost of over $2,000.

Commodities contracts with an estimated value of $15,000 or more are listed under the Materials Management Division, Department of Administration. All bids are open for 7-10 days before bidding deadline. For bid specifics, time lines, and other general information, contact the appropriate buyers whose initials appear in parentheses next to the commodity for bid, by calling (612) 296-6152.

Department of Administration

Contracts and Requisitions Open for Bid: Call 296-2600 for information on a specific bid, or to request a specific bid.

COMMODITY CODE KEY

A = Sealed Bid
B = Write for Price
C = Request for Proposal
D = Request for Information
E = $0-$1,500 Estimated Dollar Value
F = $1,500-$5,000 Estimated Dollar Value
G = $5,000-$15,000 Estimated Dollar Value
H = $15,000-$50,000 Sealed Bid
I = $50,000 and Over Sealed Bid/Human Rights Compliance Required
J = Targeted Vendors Only
K = Local Service Needed
L = No Substitute
M = Installation Needed
N = Pre-Bid Conference
O = Insurance or Bonding Required

Materials Management Division: Commodities and Requisitions Awarded

Item: Janitorial Equipment, Miscellaneous
Req.#: 02307-34375-01
Awarded to: Brotex Inc., St. Paul, MN
Awarded amount: $867.00
Awarded date: June 9, 1993
Expir/deliv date: June 15, 1993
Shipped to: Plant Management Operations

Item: Spectrophotmeter
Req.#: 12400-18996-01
Awarded to: Baxter Healthcare Corp., Minneapolis, MN
Awarded amount: $2,697.33
Awarded date: June 9, 1993
Expir/deliv date: June 15, 1993
Shipped to: Minnesota Department of Health

Item: Planer, Woodwork
Req.#: 21603-36325-01
Awarded to: Acme Elec. Motor, Inc., Grand Forks, ND
Awarded amount: $3,493.30
Awarded date: June 9, 1993
Expir/deliv date: June 30, 1993
Shipped to: Various Locations

Item: Tool, Hand, Carpenters, Electric Powered
Req.#: 21603-36325-03
Awarded to: Grainger W. W., Inc., St. Paul, MN
Awarded amount: $1,020.17
Awarded date: June 9, 1993
Expir/deliv date: June 30, 1993
Shipped to: Various Locations

Item: Sawing Machine, Woodwork
Req.#: 21603-36325-02
Awarded to: Sears Contract Sales, Cincinnati, OH
Awarded amount: $1,119.80
Awarded date: June 9, 1993
Expir/deliv date: June 30, 1993
Shipped to: Various Locations

Item: Audio/Visual/Video Supplies, Miscellaneous
Req.#: 26073-24752-01
Awarded to: Supreme Audio, Ridgewood, NJ
Awarded amount: $1,432.00
Awarded date: June 9, 1993
Expir/deliv date: June 17, 1993
Shipped to: St. Cloud State University

Item: Oscilloscope, Electronic Test
Req.#: 26073-24772-01
Awarded to: Stark Elec. Supply, Minneapolis, MN
Awarded amount: $5,809.60
Awarded date: June 9, 1993
Expir/deliv date: June 20, 1993
Shipped to: St. Cloud State University

Item: Laboratory/Science Equipment, Miscellaneous
Req.#: 32200-35166-01
Awarded to: Aerochem Metrics, Bushnell, FL
Awarded amount: $6,570.00
Awarded date: June 9, 1993
Expir/deliv date: September 14, 1993
Shipped to: Minnesota Pollution Control Agency

Item: Recorder, Video Tape (VCR)
Req.#: 78780-06036-01
Awarded to: EPA Audio Visual, Rockford, MN
Awarded amount: $259.00
Awarded date: June 9, 1993
Expir/deliv date: July 15, 1993
Shipped to: Thistledew Youth Camp

Item: Television/VCR Combination
Req.#: 78780-06037-01
Awarded to: EPA Audio Visual, Rockford, MN
Awarded amount: $520.00
Awarded date: June 9, 1993
Expir/deliv date: July 15, 1993
Shipped to: Thistledew Youth Camp

Item: Lumber, Softwood
Req.#: 78790-31010-01
Awarded to: Shaw Lumber Co., St. Paul, MN
Awarded amount: $3,061.20
Awarded date: June 9, 1993
Expir/deliv date: June 30, 1993
Shipped to: Minnesota Correctional Facility–Faribault

Item: Roller, Construction
Req.#: 79382-02644-01
Awarded to: Ziegler, Inc., Minneapolis, MN
Awarded amount: $5,950.00
Awarded date: June 9, 1993
Expir/deliv date: July 15, 1993
Shipped to: Minnesota Department of Transportation

Item: Spreader Attachment, Sand, Truck
Req.#: 79382-02635-01
Awarded to: Reach Equipment, Bloomington, MN
Awarded amount: $159,326.74
Awarded date: June 9, 1993
Expir/deliv date: September 8, 1993
Shipped to: Minnesota Department of Transportation

Item: Computer Equipment, Miscellaneous
Req.#: 79000-34025-01
Awarded to: Emcomm, Loretto, MN
Awarded amount: $7,331.40
Awarded date: June 9, 1993
Expir/deliv date: June 25, 1993
Shipped to: Minnesota Department of Transportation

Item: Audio/Visual/Video Equipment, Miscellaneous
Req.#: 99650-91266-01
Awarded to: Precision Business, Bloomington, MN
Awarded amount: $4,235.00
Awarded date: June 9, 1993
Expir/deliv date: June 24, 1993
Shipped to: Minnesota Office of Waste Management

Item: Cabinet, File, Fireproof
Req.#: 34000-07357-01
Awarded to: SPS Office Products, Inc., White Bear Lake, MN
Awarded amount: $2,556.00
Awarded date: June 10, 1993
Expir/deliv date: June 24, 1993
Shipped to: Minnesota Housing Finance Agency

Item: Computer, Personal
Req.#: 37106-17388-01
Awarded to: Parker Assoc., Wayzata, MN
Awarded amount: $4,675.45
Awarded date: June 10, 1993
Expir/deliv date: June 27, 1993
Shipped to: Minnesota Department of Education Receiving

Item: Printing, Envelope (Special Converting)
Req.#: 55000-60481-01
Awarded to: Curtis 1000, St. Paul, MN
Awarded amount: $3,502.50
Awarded date: June 10, 1993
Expir/deliv date: June 17, 1993
Shipped to: Department of Human Services

Item: Computer Equipment, Miscellaneous
Req.#: 67310-53707-01
Awarded to: Unique Software Corp., Eagan, MN
Awarded amount: $5,014.68
Awarded date: June 10, 1993
Expir/deliv date: July 20, 1993
Shipped to: Department of Revenue, Support

Item: Contractor, Refrigeration/Air Condition
Req.#: 75250-30314-01
Awarded to: McQuay Service, Plymouth, MN
Awarded amount: June 10, 1993
Awarded date: June 25, 1993
Expir/deliv date: Minnesota Veterans Home

Item: Food, Miscellaneous
Req.#: 78830-11864-01
Awarded to: Con Agra Frozen Foods, Omaha, NE
Awarded amount: $6,223.40
Awarded date: June 10, 1993
Expir/deliv date: June 30, 1993
Shipped to: Minnesota Correctional Facility

Item: Trees and Shrubs
Req.#: 79050-70175-03
Awarded to: Lee Nursery, Inc., Fertile, MN
Awarded amount: $309.75
Awarded date: April 13, 1993
Expir/deliv date: April 23, 1993
Shipped to: Various Locations

Item: Electrical Supplies, Miscellaneous
Req.#: 79000-34124-01
Awarded to: Northland Elec. Supply, Minneapolis, MN
Awarded amount: $1,618.27
Awarded date: June 10, 1993
Expir/deliv date: June 16, 1993
Shipped to: Various Locations

Item: Heat Exchanger Parts & Supplies
Req.#: 26070-15375-01
Awarded to: Acers James D., Ramsey, MN
Awarded amount: $2,339.00
Awarded date: June 10, 1993
Expir/deliv date: July 15, 1993
Shipped to: Bemidji State University

Item: Printer, Computer
Req.#: 26072-04195-01
Awarded to: Cedar Computer Center, Edina, MN
Awarded amount: $3,166.00
Awarded date: June 10, 1993
Expir/deliv date: June 30, 1993
Shipped to: Moorhead State University

Item: Computer, Mainframe
Req.#: 26073-24783-01
Awarded to: A I Systems, Inc., Minneapolis, MN
Awarded amount: $5,490.00
Awarded date: June 10, 1993
Expir/deliv date: June 30, 1993
Shipped to: St. Cloud State University

Item: Computer Network Equipment
Req.#: 26073-24791-01
Awarded to: Sun Microsystems, Bloomington, MN
Awarded amount: $22,695.12
Awarded date: June 10, 1993
Expir/deliv date: June 21, 1993
Shipped to: St. Cloud State University

Item: Service, Relocate Panel/Furniture, Modular
Req.#: 27138-54315-01
Awarded to: Facilities Group, Edina, MN
Awarded amount: $1,025.00
Awarded date: June 10, 1993
Expir/deliv date: June 10, 1993
Shipped to: Community College BD

Item: Computer, Personal
Req.#: 27152-47088-01
Awarded to: PC Express, Inc., Richfield, MN
Awarded amount: $30,582.00
Awarded date: June 10, 1993
Expir/deliv date: June 25, 1993
Shipped to: Anoka Ramsey Community College

Item: Computer, Personal
Req.#: 27152-47089-01
Awarded to: PC Express, Inc., Richfield, MN
Awarded amount: $3,898.00
Awarded date: June 10, 1993
Expir/deliv date: June 25, 1993
Shipped to: Anoka Ramsey Community College

Item: Service, Computer Related Maintenance Contract
Req.#: 32200-36008-01
Awarded to: Dytec North, Inc., St. Paul, MN
Awarded amount: $396.00
Awarded date: June 10, 1993
Expir/deliv date: July 1, 1993
Shipped to: Minnesota Pollution Control Agency

Item: Micrograhic Supplies
Req.#: 02443-30298-01
Awarded to: Abaci, Inc., St. Paul, MN
Awarded amount: $774.63
Awarded date: June 10, 1993
Expir/deliv date: June 15, 1993
Shipped to: Various Locations

Item: Micrographic Supplies
Req.#: 02443-30299-01
Awarded to: Micro Images, Eden Prairie, MN
Awarded amount: $1,573.00
Awarded date: June 10, 1993
Expir/deliv date: June 15, 1993
Shipped to: Various Locations

Item: Agricultural Test Equipment, Miscellaneous
Req.#: 04131-32493-02
Awarded to: Perstorp Analytical, Inc., Hawley, MN
Awarded amount: $13,325.00
Awarded date: June 10, 1993
Expir/deliv date: July 5, 1993
Shipped to: Minnesota Department of Agriculture

Item: Chromatograph, Gas
Req.#: 07300-52284-01
Awarded to: Hewlett Packard Co., St. Paul, MN
Awarded amount: $50,760.00
Awarded date: June 10, 1993
Expir/deliv date: August 30, 1993
Shipped to: Department of Public Safety

Item: Laboratory/Science Supplies
Req.#: 07300-62661-01
Awarded to: New England Nuclear, Boston, MA
Awarded amount: $5,733.00
Awarded date: June 10, 1993
Expir/deliv date: July 6, 1993
Shipped to: Department of Public Safety

Item: Computer Equipment Supplies
Req.#: 12800-19037-01
Awarded to: Unique Software Corp., Eagan, MN
Awarded amount: $2,741.04
Awarded date: June 10, 1993
Expir/deliv date: June 21, 1993
Shipped to: Minnesota Department of Health

Item: Printing, Form, Multipart, Carbon, Snapout
Req.#: 12400-19348-01
Awarded to: Standard Register 2, St. Paul, MN
Awarded amount: $2.87
Awarded date: June 10, 1993
Expir/deliv date: July 12, 1993
Shipped to: Minnesota Department of Health

Item: Projection Viewer, Computer
Req.#: 21200-54464-01
Awarded to: Blumberg Communications, Minneapolis, MN
Awarded amount: $3,795.00
Awarded date: June 10, 1993
Expir/deliv date: June 21, 1993
Shipped to: Minnesota Department of Jobs & Training

Item: Computer, Personal
Req.#: 02310-37224-01
Awarded to: A I Systems, Inc., Minneapolis, MN
Awarded amount: $1,402.70
Awarded date: June 11, 1993
Expir/deliv date: June 20, 1993
Shipped to: St. Peter Regional Treatment Center

Item: Furniture, Domestic/Dormatory, Miscellaneous
Req.#: 02305-37080-02
Awarded to: Johnsons P M, Inc., St. Paul, MN
Awarded amount: $695.60
Awarded date: June 11, 1993
Expir/deliv date: July 20, 1993
Shipped to: Minnesota Veterans Home

Item: Service, Relocation, Agency
Req.#: 04121-32656-01
Awarded to: Mini Movers, Grand Forks, ND
Awarded amount: $480.00
Awarded date: June 11, 1993
Expir/deliv date: June 15, 1993
Shipped to: Minnesota Department of Agriculture

Item: Chemicals, Biological, Miscellaneous
Req.#: 07300-52285-01
Awarded to: Cellmark Diagnostics, Germantown, MD
Awarded amount: $1,970.00
Awarded date: June 11, 1993
Expir/deliv date: June 17, 1993
Shipped to: Department of Public Safety

Item: Service, Auto Body Repairs; Non Metro Area
Req.#: 07500-42298-01
Awarded to: Otterson Ford Lincoln, Worthington, MN
Awarded amount: $1,797.64
Awarded date: June 11, 1993
Expir/deliv date: June 16, 1993
Shipped to: Various Locations

Item: Auto Repair/Maintenance Equipment, Specialized
Req.#: 07500-42297-01
Awarded to: Gerrys Southside Body, Redwood Falls, MN
Awarded amount: $2,326.02
Awarded date: June 11, 1993
Expir/deliv date: June 16, 1993
Shipped to: Various Locations

Item: Service, Auto Body Repair; Metro Area
Req.#: 07500-42304-01
Awarded to: White Bear Dodge, White Bear Lake, MN
Awarded amount: $3,656.09
Awarded date: June 11, 1993
Expir/deliv date: June 16, 1993
Shipped to: Department of Public Safety

Item: Service, Auto Body Repair; Non Metro Area
Req.#: 07500-42303-01
Awarded to: Genes Auto Repair, Elk River, MN
Awarded amount: $1,987.84
Awarded date: June 11, 1993
Expir/deliv date: June 16, 1993
Shipped to: Department of Public Safety

Item: Office Supplies, Miscellaneous
Req.#: 07300-52388-01
Awarded to: Mid Amer. Business Systems, Minneapolis, MN
Awarded amount: $1,966.30
Awarded date: June 11, 1993
Expir/deliv date: July 23, 1993
Shipped to: Department of Public Safety

Item: Computer, Personal
Req.#: 10000-05163-01
Awarded to: Unique Software Corp., Eagan, MN
Awarded amount: $71,699.00
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: Department of Finance

Item: Computer Equipment Supplies
Req.#: 21200-54463-01
Awarded to: Texas Instruments, Eden Prairie, MN
Awarded amount: $15,750.00
Awarded date: June 11, 1993
Expir/deliv date: June 21, 1993
Shipped to: Minnesota Department of Jobs & Training

Item: Computer Equipment, Used
Req.#: 21200-54448-01
Awarded to: Galaxy Computer Services, St. Paul, MN
Awarded amount: $15,840.00
Awarded date: June 11, 1993
Expir/deliv date: June 21, 1993
Shipped to: Minnesota Department of Jobs & Training

Item: Drive, Disk or Tape, Computer
Req.#: 26073-24749-01
Awarded to: A I Systems, Inc., Minneapolis, MN
Awarded amount: $1,943.00
Awarded date: June 11, 1993
Expir/deliv date: June 20, 1993
Shipped to: St. Cloud State University

Item: Printing Equipment, Miscellaneous
Req.#: 26073-24748-01
Awarded to: Olson Graphic Products, St. Paul, MN
Awarded amount: $9,792.00
Awarded date: June 11, 1993
Expir/deliv date: June 20, 1993
Shipped to: St. Cloud State University

Item: Office Supplies, Miscellaneous
Req.#: 26175-03375-01
Awarded to: Active Data System, Sioux Falls, SD
Awarded amount: $487.88
Awarded date: June 11, 1993
Expir/deliv date: June 29, 1993
Shipped to: Southwest State University

Item: Weight Training/Exercise Equipment
Req.#: 27156-11156-01
Awarded to: NordicTrack, Chaska, MN
Awarded amount: $1,899.95
Awarded date: June 11, 1993
Expir/deliv date: July 16, 1993
Shipped to: Normandale Community College

Item: Handicapped Device, Visual
Req.#: 27163-63220-01
Awarded to: Amer. Printing House, Louisville, KY
Awarded amount: $1,273.00
Awarded date: June 11, 1993
Expir/deliv date: July 16, 1993
Shipped to: Fond Du Lac Community

Item: Printing, Single Sheets, One Color
Req.#: 29000-61007-01
Awarded to: Print It Plus, Eagan, MN
Awarded amount: $425.00
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: Department of Natural Resources—Information & Education

Item: Marine Equipment, Miscellaneous
Req.#: 29004-18695-03
Awarded to: Nichols Net & Twine, Granite City, IL
Awarded amount: $1,962.60
Awarded date: June 11, 1993
Expir/deliv date:
Shipped to: Department of Natural Resources

Item: Marine Equipment, Miscellaneous
Req.#: 29004-18695-02
Awarded to: Nylon Net Company, Memphis, TN
Awarded amount: $1,359.05
Awarded date: June 11, 1993
Expir/deliv date: July 1, 1993
Shipped to: Department of Natural Resources

Item: Marine Equipment, Miscellaneous
Req.#: 29004-18695-01
Awarded to: Christiansen H. Company, Duluth, MN
Awarded amount: $23,535.52
Awarded date: June 11, 1993
Expir/deliv date: July 15, 1993
Shipped to: Department of Natural Resources

Item: Computer, Personal
Req.#: 42204-19049-01
Awarded to: PC Tailors, Roseville, MN
Awarded amount: $9,390.00
Awarded date: June 11, 1993
Expir/deliv date: August 1, 1993
Shipped to: Department of Labor & Industry

Item: Printing, Form, Multipart, No Carbon
Req.#: 42500-19023-01
Awarded to: Stuart Hooper Company, St. Paul, MN
Awarded amount: $668.70
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: Department of Labor & Industry

Item: Fish, Live
Req.#: 43000-70567-01
Awarded to: Spring Falls Trout Farm, Brownsville, MN
Awarded amount: $8,588.80
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: IRRRB Mineland Reclamation

Item: Printing Envelope (Special Converting)
Req.#: 55000-60481-02
Awarded to: Curtis 1000, St. Paul, MN
Awarded amount: $3,297.75
Awarded date: June 11, 1993
Expir/deliv date: June 17, 1993
Shipped to: Department of Human Services

Item: Cabinet, Storage Locker
Req.#: 78790-31023-01
Awarded to: Global Industrial Equipment, Hempstead, NY
Awarded amount: $2,095.04
Awarded date: June 11, 1993
Expir/deliv date: June 25, 1993
Shipped to: Minnesota Correctional Facility—Faribault

Item: Food, Miscellaneous
Req.#: 78830-11864-02
Awarded to: Con Agra Frozen Foods, Omaha, NE
Awarded amount: $7,074.40
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: Minnesota Correctional Facility

Item: Radio, 2-Way, Stationary Equipment (over $500)
Req.#: 79000-33939-01
Awarded to: Andrew Corp., Orland Park, IL
Awarded amount: $19,456.88
Awarded date: June 11, 1993
Expir/deliv date: September 1, 1993
Shipped to: Minnesota Department of Transportation

Item: Printing, Form, Continuous
Req.#: 79000-34098-01
Awarded to: Financial Forms, Minneapolis, MN
Awarded amount: $544.50
Awarded date: June 11, 1993
Expir/deliv date: June 21, 1993
Shipped to: Minnesota Department of Transportation

Item: Testing Equipment, Non Destructive
Req.#: 79000-34066-01
Awarded to: Resource Consultants, Ft. Collins, CO
Awarded amount: $10,160.61
Awarded date: June 11, 1993
Expir/deliv date: June 20, 1993
Shipped to: Minnesota Department of Transportation

Item: Fixture, Lighting, Indoor
Req.#: 79450-00804-01
Awarded to: Lachmansingh Carlo Sales, Minneapolis, MN
Awarded amount: $1,737.50
Awarded date: June 11, 1993
Expir/deliv date: June 30, 1993
Shipped to: Minnesota Department of Transportation

Item: Cabinet, File, Flat
Req.#: 99780-30950-01
Awarded to: JGC Equipment Company, Blaine, MN
Awarded amount: $1,053.60
Awarded date: June 11, 1993
Expir/deliv date: June 21, 1993
Shipped to: Various Locations

Item: Sign (Not Powered, Not Highway)
Req.#: 29000-61008-01
Awarded to: Hall Signs, Inc., Bloomington, IN
Awarded amount: $1,854.00
Awarded date: June 14, 1993
Expir/deliv date: July 1, 1993
Shipped to: Department of Natural Resources—Ecological Services

Item: Propulsion Unit, Outboard & I/O, Boat
Req.#: 29000-61006-01
Awarded to: Mercury Marine, Fond Du Lac, WI
Awarded amount: $1,624.00
Awarded date: June 14, 1993
Expir/deliv date: June 23, 1993
Shipped to: Department of Natural Resources—Southern Service Center

Item: Printing, ID Cards, Paper
Req.#: 29000-60976-01
Awarded to: Printing Enterprises, New Brighton, MN
Awarded amount: $10,360.00
Awarded date: June 14, 1993
Expir/deliv date: June 30, 1993
Shipped to: Department of Natural Resources—Forestry

Item: Compressor, Air
Req.#: 55304-09530-01
Awarded to: Foster John Henry Company, Eagan, MN
Awarded amount: $1,078.90
Awarded date: June 14, 1993
Expir/deliv date: June 21, 1993
Shipped to: Brainerd Regional Human Service Center

Item: Office Machine, Mailroom, Miscellaneous
Req.#: 67110-53755-01
Awarded to: Bell & Howell, Plymouth, MN
Awarded amount: $40,548.00
Awarded date: June 14, 1993
Expir/deliv date: July 27, 1993
Shipped to: Department of Revenue, Support

Item: Copy Machine, Medium Speed; 15 to 50 CPM
Req.#: 78000-42269-03
Awarded to: Stringer Business Systems, St. Paul, MN
Awarded amount: $21,207.24
Awarded date: June 14, 1993
Expir/deliv date: July 1, 1993
Shipped to: Various Locations

Item: Poultry
Req.#: 78630-12301-01
Awarded to: Professional Food Systems, South St. Paul, MN
Awarded amount: $904.50
Awarded date: July 14, 1993
Expir/deliv date: June 7, 1993
Shipped to: Minnesota Correctional Facility

Item: Meat
Req.#: 78830-11848-02
Awarded to: Quality Meats Seafood, West Fargo, ND
Awarded amount: $8,260.00
Awarded date: June 14, 1993
Expir/deliv date: July 12, 1993
Shipped to: Minnesota Correctional Facility

Item: Health Care Equipment, Miscellaneous
Req.#: 02305-37066-01
Awarded to: Stat Med., Inc., Eden Prairie, MN
Awarded amount: $50,970.00
Awarded date: June 14, 1993
Expir/deliv date: August 8, 1993
Shipped to: Minnesota Veterans Home

Item: Seating, Reception/Lobby
Req.#: 02307-34404-01
Awarded to: Johnson P M, Inc., St. Paul, MN
Awarded amount: $1,189.30
Awarded date: June 14, 1993
Expir/deliv date: August 27, 1993
Shipped to: State of Minnesota

Item: Service, Micrographic, Repair/ Maintenance
Req.#: 02443-40322-01
Awarded to: Amtech Equipment, St. Paul, MN
Awarded amount: $10,302.00
Awarded date: June 14, 1993
Expir/deliv date: July 1, 1993
Shipped to: State of Minnesota

Item: Rack, Literature Display
Req.#: 07100-42296-01
Awarded to: Skyline Displays Midwest, Burnsville, MN
Awarded amount: $4,589.00
Awarded date: June 14, 1993
Expir/deliv date: June 15, 1993
Shipped to: Department of Public Safety/Office

Item: Printing, Form, Multipart, Carbon, Snapout
Req.#: 12400-19348-01
Awarded to: Standard Register 2, St. Paul, MN
Awarded amount: $2,866.25
Awarded date: June 14, 1993
Expir/deliv date: July 12, 1993
Shipped to: Minnesota Department of Health

Item: Copy Machine, High Speed; Over 50 CPM
Req.#: 11018-02334-01
Awarded to: Copy Duplicating Products, Richfield, MN
Awarded amount: $100,170.00
Awarded date: June 14, 1993
Expir/deliv date: July 1, 1993
Shipped to: Various Locations

Item: Football Equipment
Req.#: 26073-24743-01
Awarded to: Fitzharris Athletic, St. Cloud, MN
Awarded amount: $1,516.00
Awarded date: June 14, 1993
Expir/deliv date: July 23, 1993
Shipped to: St. Cloud State University

Item: Shoe Repair/Maintenance Equipment, Specialized
Req.#: 26073-24800-01
Awarded to: Owens Service Company, Minneapolis, MN
Awarded amount: $2,256.85
Awarded date: June 14, 1993
Expir/deliv date: June 28, 1993
Shipped to: St. Cloud State University

Item: Meat
Req.#: 78830-11848-01
Awarded to: Professional Food Systems, South St. Paul, MN
Awarded amount: $11,130.00
Awarded date: June 14, 1993
Expir/deliv date: July 12, 1993
Shipped to: Minnesota Correctional Facility

Item: Mower, Commercial
Req.#: 79382-02632-01
Awarded to: Evergreen Equipment, Inc., Little Falls, MN
Awarded amount: $24,549.00
Awarded date: June 14, 1993
Expir/deliv date: June 23, 1993
Shipped to: Minnesota Department of Transportation

Item: Sign (Not Powered, Not Highway)
Req.#: 99780-30932-01
Awarded to: Hall Signs, Inc., Bloomington, IN
Awarded amount: $2,950.00
Awarded date: June 14, 1993
Expir/deliv date: June 30, 1993
Shipped to: Board of Water & Soil Resources

Good Business Decisions are Made with Good Information

Minnesota Manufacturer's Directory: More than 7,000 entries that include name, address, phone number, staff size, sales volume, market area, year of establishment, type of firm, C.E.O., Sales or Marketing Manager, Purchasing Manager and four major manufactured products. Code #40-2-SR, $95.00 plus tax.

Business and NonProfit Corporation Act 1992. A handy reference that contains all the state laws governing the establishment and conduct of corporations in Minnesota. Includes *Minnesota Statutes* Chapters 308A, 302A and 317A. Code #2-87-SR. $20.95 plus tax.

Minnesota Guidebook to State Agency Services 1992-95. Packed with information to help you cut through red tape for easy and fast dealing with state agencies, this treasure of information opens state government to you. Its 640 pages describe agencies, how they work, listing contacts, addresses, phones, and license requirements, grants, forms, reports, maps, publications and much more. Gives historical, statistical and important data useful in hundreds of ways. Code #1-11-SR. $16.90 plus tax. FAX: (612) 296-2265.

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Minnesota Guidebook to State Agency Services 1992-95. A treasure of helpful, useful, and interesting information about Minnesota state government. This important resource guides you through applications, fees, licenses, reports, history and travel highlights. Describes agencies in detail, giving addresses, phones and contact people. Code #1-11-SR, $16.90 plus tax. FAX: (612) 296-2265.

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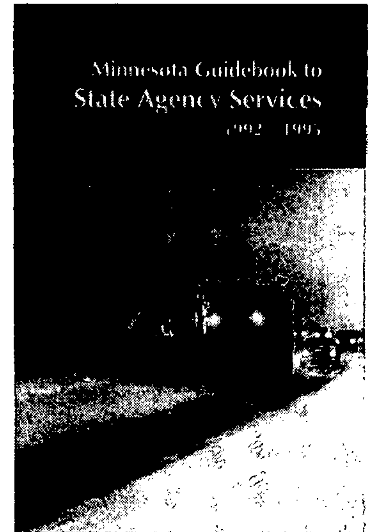
Access Your State Government:



Minnesota Guidebook to State Agency Services 1992-95

An obvious "headliner" on any list for the citizen's reference desk. The perfect "owner's manual" to Minnesota state government is a great reference tool for:

* applying for grants, bidding on contracts
* addresses, phone numbers and key contact people for each agency
* license requirements and fees
* gaining access to government services
* participating in state policy making and service delivery
* understanding the structure of Minnesota government with detailed descriptions of state agencies, their functions and services.

A MUST for Minnesota residents, business persons, professionals and educators. 710pp. ***Stock No. 1-11-SR*** ***$18.00***
(Price includes MN 6-1/2% sales tax)

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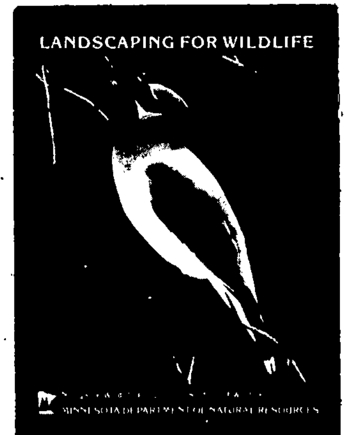
Welcome wildlife to your property



Landscaping for Wildlife. Attract wildlife to your land and gardens, farms and woodlots by spreading nature's welcome mat. Songbirds, butterflies, hummingbirds, pheasants, deer and other wildlife are drawn through these gardening tips and landscaping techniques that add natural beauty to your property and habitat for wildlife. Over 70 color photos and 144 pages give you simple, enjoyable, and inexpensive methods for adding the right touches for a "wildlife party" on your grounds, whether urban or rural. Stock #9-15-SR, $9.95 plus tax.

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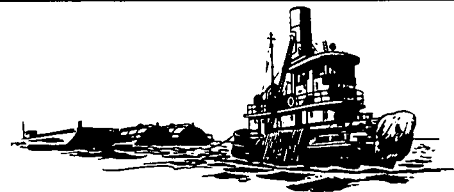
River Stories That Warm Your Heart



A Stretch on the River. 1950 novel about the son of a wealthy family who goes to work on a Mississippi River towboat to avoid being drafted. With power, gusto and humor, author Richard Bissel creates an energetic, rowdy, and delightful account of a typical trip up the river, accurately re-creating a colorful era of towboating on America's major waterway. Stock #17-6-SR, $8.95 plus tax.

High Water. During the worst flood on the Mississippi River anyone can remember, the mate of a towboat has his hands full on a perilous trip, working with an unhappy crew, an angry captain, and too many barges to push against too much river. A 1954 Richard Bissel novel reveals the drama, humor and charm of working on the river. Stock #17-8-SR. $8.95 plus tax.

Old Times on the Mississippi River. George Merrick's lively, loving, and humorous reminiscences of his steamboat life from the bottom up, as a pantry boy, apprentice engineer, second clerk, and "cub" pilot. First published in 1909, he describes steamboat operations—from machinery and personnel to the economics of the business—with vivid examples and rich detail. 323 pp. includes appendices and index. Stock #17-45-SR. $8.95 plus tax.

Canoeing with the Cree. Minnesota's distinguished newsman, Eric Sevareid, wrote his book in1935 about a canoe journey he and a classmate made to Hudson Bay. The classic recounts their trip on the Mississippi, Minnesota and Red River of the North Rivers into Lake Winnipeg, and then God's River to Hudson Bay. 209 pp. includes index, maps and photos. Stock #17-14-SR. $6.95 plus tax.

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Social workers', counselors' and therapists' guides and directories

Chemical Dependency Programs Directory 1993-94. Features comprehensive listings for programs ranging from prevention/intervention services to a wide range of treatment services. Each type of program includes a listing of facilities and description of programs. Stock No. 1-12-SR, $17.00 + tax.

Process parenting—Breaking the Addictive Cycle. This training manual provides parent education and treatment techniques for professionals working with recovering chemically dependent parents or dysfunctional families. Stock No. 5-4-SR, $15.00 + tax.

TO ORDER: Send to Minnesota's Bookstore, 117 University Avenue, St. Paul, MN 55155. Call (612) 297-3000, or toll-free in Minnesota: 1-800-657-3757. Minnesota residents please include 6½% sales tax. On all orders, add $2.00 per order for handling. Prepayment is required. Please include daytime phone. VISA/MasterCard, American Express and Discover orders accepted over phone and through mail. ***Prices are subject to change.*** FAX: (612) 296-2265.

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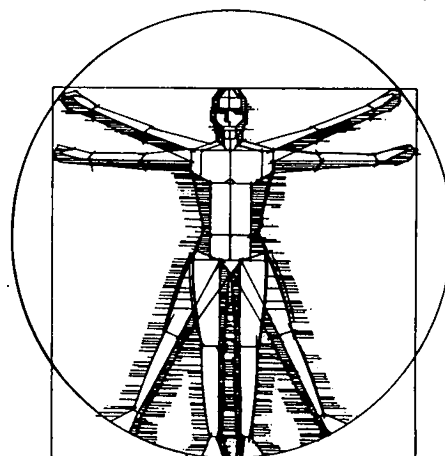
A Helping Hand for the Chemically Dependent

Directory of Chemical Dependency Programs in Minnesota.



This 250-page directory lists prevention and intervention programs including county social service agencies, mental health centers, other information and referral programs, self-help programs and employee assistance programs. It also lists DWI (Driving While Intoxicated) clinics and detoxification centers. Outlining Minnesota's continuum of care, the Minn. Dept. of Human Services Directory lists treatment services under three headings: **Primary Residential Programs**—freestanding facilities, hospital-based facilities and state regional treatment centers; **Intermediate/Extended Residential Programs**—halfway houses, extended care facilities, and board and lodging facilities; **Non-Residential Programs**—freestanding facilities and hospital-based facilities. Stock #1-12-SR. $17.00 + $1.10 tax.

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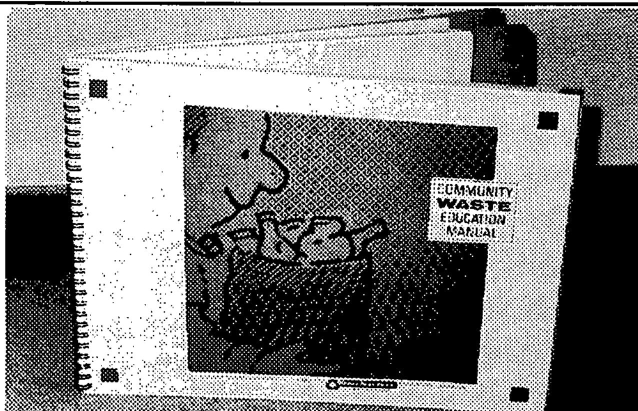

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