

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 727

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 9-30-83
DATE FOR REVIEW
DATE DUE 10-7-83

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved 10-7-83 Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State Revisor approved / disapproved

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✓ Rule as Adopted

✓ Rule as Proposed

✓ Order Adopting 9.30.83 Date combined with FofF.

✓ Notices of Intent to Solicit Outside Opinion 6.15.81 7.25.83

✓ Order for rulemaking
N/A date of Hearing

Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
8.31.83 At least ~~30~~ 20 days prior to ~~hearing~~/adoption

✓ Mailing list Certificate

✓ Publication in State Register
9.5.83 At least ~~30~~/20 days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

Statement of Need and Reasonableness

Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

N/A Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : Michael A. Hatch, Commissioner

DATE: 10/7/83

Attn: JOHN C. BJORK, Special Assistant Attorney General

FROM : MARTHA J. CASSERLY MJC
Legal Assistant

PHONE: 296-4347

SUBJECT: In the Matter of Adopted Temporary Rules Governing Reimbursement for Workers' Compensation Medical Services.

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.

MJC/ls

cc: Ms. Kathy Burek
Mr. Duane Harves

AG copy

Department of Commerce

Adopted Temporary Rules Governing Reimbursement for Workers' Compensation Medical Services

Temporary Rules as Adopted

4 MCAR S 1.0001 Authority.

Rules 4 MCAR SS 1.0001-1.0032 are promulgated under the authority of Minnesota Statutes, section 176.136.

4 MCAR S 1.0002 Purpose.

Rules 4 MCAR SS 1.0001-1.0032 are intended to prohibit providers of treatment of work related injuries from receiving excessive reimbursement for their services.

4 MCAR S 1.0003 Scope.

The following are subject to 4 MCAR SS 1.0001-1.0032: All entities responsible for payment and administration of medical claims compensable under Minnesota Statutes, chapter 176; and providers of medical services or supplies for work related injuries or diseases pursuant to Minnesota Statutes, section 176.135, subdivision 1.

4 MCAR S 1.0004 Definitions.

The following terms have the following meanings in 4 MCAR SS 1.0001-1.0032 unless the context clearly indicates a different meaning.

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

B. Charge or fee. "Charge" or "fee" means the payment requested by a provider on a bill for a particular service.

C. Code. "Code," in reference to the maximum fee schedule, means the alphabetic or numeric designation, including code modifiers if appropriate, for a particular type of service, or supply, or other reasonable method of categorizing provider charges.

D. Commissioner. "Commissioner" means the commissioner of the Department of Labor and Industry.

E. Compensable or compensability. "Compensable" or "compensability," in reference to a service, means an employer is liable for the service pursuant to Minnesota Statutes, chapter 176.

F. Excessive. "Excessive," in reference to a charge, means a charge which meets any of the standards of excessiveness described in 4 MCAR S 1.0005.

G. Injury. "Injury" includes all bodily harm or impairment from work related accidents, diseases, or other compensable causes.

H. Maximum fee schedule. "Maximum fee schedule" means the list of codes, services, and corresponding 75th percentile dollar amounts established pursuant to 4 MCAR S 1.0009.

I. Payer. "Payer" refers to all entities responsible for payment and administration of workers' compensation medical claims, including all insurer, self-insurer, and group self-insurer members of the workers' compensation reinsurance association, pursuant to Minnesota Statutes, section 79.34, subdivision 1, service companies licensed to provide claim administration services to self-insurers and group self-insurers pursuant to Minnesota Statutes, section 60A.23, subdivision 8, the reopened case fund, established by Minnesota Statutes, section 176.134, the special compensation fund established by Minnesota Statutes, section 176.129, and the assigned risk plan, established by Minnesota Statutes, sections 79.251 and 79.252. F of F 1

J. Provider. "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

K. Reasonable. "Reasonable," in reference to a charge, means a charge or portion of a charge which is not excessive.

L. Service or treatment. "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of an injury or occupational disease, pursuant to Minnesota Statutes, section

176.135, subdivision 1.

4 MCAR S 1.0005 Excessiveness.

A charge is excessive to the degree that any of the following conditions apply to it, or to the service for which the charge was submitted:

A. the charge exceeds the maximum reasonable amount for the type of service as specified in the maximum fee schedule of 4 MCAR SS 1.0010-1.0032;

B. the charge exceeds the employer's limits of liability specified in Minnesota Statutes, section 176.135, subdivision 3;

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

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

E. the charge or service does not comply with standards and requirements adopted pursuant to Minnesota Statutes, section 176.103 or 176.83, concerning the appropriateness, quality, coordination, and cost of treatment;

F. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, section 176.183;

G. the service does not comply with the requirements of Minnesota Statutes, section 176.135, subdivision 1a, concerning non-emergency surgery and a second surgical opinion;

H. the service does not comply with the requirements of rules adopted pursuant to Minnesota Statutes, section 176.135, subdivision 2, regulating change of physicians, podiatrists, or chiropractors; or

I. the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury.

4 MCAR S 1.0006 Payer responsibilities.

A. Compensability. Rules 4 MCAR SS 1.0001-1.0032 do not require a payer to pay a charge which is not compensable or a

charge which is the primary obligation of another payer.

B. Payment of charges. Before paying a charge, the payer shall determine whether it is excessive to any degree. To the degree that a charge is determined to be excessive, the payer shall not pay the charge. As soon as reasonably possible, and no later than 21 calendar days after receiving the bill and any necessary reports, the payer shall pay the charge or deny all or part of the charge on the basis of excessiveness or noncompensability, with written notification to the provider of the determination, the reason for the determination, and the options of appeal. Failure to comply with the requirements of this paragraph subjects the payer to the penalties provided in Minnesota Statutes, sections 176.221 and 176.225.

C. Determination of excessiveness. The payer shall ascertain whether a charge is excessive by evaluating the charge and service according to the standards of excessiveness specified in 4 MCAR S 1.0005. The payer shall also comply with the following procedures:

1. The payer shall ascertain whether or not a service is subject to the maximum fee schedule, pursuant to the maximum fee schedule instructions contained in 4 MCAR S 1.0010.

2. In determining whether the code or description submitted for a particular service is correct, the code to which a service should be assigned if no code or an incorrect code was submitted, or whether a charge is excessive because the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury; the payer shall consider the professional judgment and standards of the relevant healing art, as necessary to make a sound determination. Professional judgment and standards may include but are not limited to any of the following, provided that final determinations shall remain the responsibility of the payer:

a. the opinion of persons with expertise concerning the service;

b. the findings of peer review panels, professional associations, and other expert evaluators of a healing art; and

c. widely accepted publications concerning the procedures and standards of a healing art. These may include, but are not limited to, publications concerning the reasonable length of hospital stays for certain procedures, publications which compare the merits and necessity of inpatient and outpatient treatment for certain procedures, relative value scales, and other medical reference materials.

D. Collection of excessive payment. Any payment made to a provider which is determined to be wholly or partially excessive, according to the standards prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. A determination of excessiveness must be made within one year of the payment.

4 MCAR S 1.0007 Provider responsibilities.

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

B. Submission of information. Providers shall include on bills the patient's name, date of injury, and the employer's name, narratives and codes which accurately describe all services provided and all injuries or conditions treated, the date upon which each service was provided, and the providers' social security ~~or federal employer identification~~ number. FoF 2

Where applicable, FoF 3 codes from the maximum fee schedules in 4 MCAR SS 1.0011-1.0032 shall be used.

C. Cooperation with payer. Pursuant to Minnesota Statutes, section 176.138, providers shall comply promptly with payers' reasonable requests for information concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of a service's compensability or a charge's reasonableness.

D. Collection of excessive charges. No provider shall collect or attempt to collect payment from any party in excess of the amount determined to be reasonable by the payer or on appeal. If the determination of the payer is not upheld on

appeal, the provider may collect charges found to be reasonable, but only from the payer.

4 MCAR S 1.0008 Appeals procedure.

Pursuant to Minnesota Statutes, sections 176.103 and 176.271 and related statutes and rules, providers may appeal a payer's determination that a charge is excessive to the commissioner, with a further right of appeal to the medical services review board.

4 MCAR S 1.0009 Maximum fee schedule.

A. Contents. Rules 4 MCAR SS 1.0010-1.0032 are the maximum fee schedule. The maximum fee schedule shall contain codes and descriptions of services compensable under Minnesota Statutes, section 176.135 and dollar amounts which fairly represent the 75th percentile charges for those services in Minnesota during the preceding calendar year.

nonrule statement

B. Revisions. The commissioner shall revise the maximum fee schedule annually to incorporate charge data from the preceding calendar year. Until revisions are adopted the current maximum fee schedule remains in force. The commissioner may revise the maximum fee schedule at any time to (1) improve the schedule's accuracy, fairness, or equity; (2) ease the use and administration of the schedule; (3) lessen disincentives to providers to develop and deliver services; or (4) to accommodate improvements or correct deficiencies of the data base.

4 MCAR S 1.0010 Maximum fee schedule for reimbursement of workers' compensation medical services.

A. Maximum fee schedule instructions. The instructions in this rule and 4 MCAR SS 1.0001-1.0009 govern the use and application of fees in 4 MCAR SS 1.0011-1.0032.

B. Background. The codes and service descriptions contained in ~~this rule~~ rules 4 MCAR SS 1.0011-1.0024 are based primarily upon Physicians' Current Procedural Terminology, fourth edition, published by the American Medical Association. Payers may employ that publication in evaluating bills, provided that the codes and service descriptions of 4 MCAR SS ~~1.0010-1.0032~~

F&F 4

? non-rule

1.0011-1.0024 shall govern where differences exist between these rules and that publication.

C. Applicability of the fee schedule. The payer shall undertake investigations as it considers reasonable to ascertain whether a service is subject to the maximum fee schedule. A service is subject to the maximum fee schedule if it conforms to a description contained in the maximum fee schedule in the section for the appropriate kind of medical provider. The standards of excessiveness contained in 4 MCAR S 1.0005 apply whether or not a service is subject to the maximum fee schedule.

D. Coding. For services which are or which may be subject to the maximum fee schedule, the payer shall undertake investigations as it considers reasonable to ascertain whether or not the code assigned to a service by the provider is correct. If no code has been assigned the payer shall determine the appropriate code, and shall evaluate the service on the basis of that code. A broad, inclusive service description may be divided into its component services, charges, and codes, if the inclusive service is not subject to the maximum fee schedule but some of the component services are.

E. Ambiguity. If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service is subject to the maximum fee schedule or what the correct code for a particular service is, the payer shall decide the issue in favor of the provider or refer the issue to the commissioner for determination. FoF 5

F. Code modifiers. The codes for services in ~~this rule~~ rules 4 MCAR SS 1.0011-1.0024 FoF 4 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in 1.-18.

1. Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery, including the aid of an operating

microscope. This modifier is not warranted for surgery done with the aid of a magnifying loupe or magnifying binoculars worn by the surgeon. Services with this modifier are not subject to the maximum 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 maximum fee schedule.

4. Modifier number 26 denotes professional component. This modifier is appropriate to services which are a combination of a physician and a 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 multiple or bilateral procedures. This modifier is appropriate to secondary services when multiple or bilateral procedures are provided at the same operative session. The first major procedure shall be reported as listed. This modifier does not exempt the secondary services from the maximum fee for the five-digit code.

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

8. 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.

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

10. Modifier number 56 denotes preoperative management only. This modifier is appropriate to services where the physician provides preoperative managment, 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 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 maximum fee schedule.

12. Modifier number 75 denotes concurrrent 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. Modifier number 99 denotes multiple modifiers. This modifier is appropriate to services where two or more modifiers may be necessary to completely delineate 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 maximum fee schedule.

4 MCAR S 1.0011 Physician services; medicine.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to providers licensed as a doctor of medicine

or a doctor of osteopathy.

B. Definitions. The terms defined in B. have the meanings given them when used in C., D., and E. unless the context clearly indicates a different meaning.

1. New patient. "New patient" means a patient who is new to the physician and whose medical and administrative records need to be established.

2. Established patient. "Established patient" means a patient whose medical and administrative records are available to the physician.

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

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

a. routine immunization for tetanus;

b. removal of sutures from laceration; or

c. blood pressure determination for adequacy of control.

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

a. examination of a patient with subconjunctival hemorrhage;

b. examination of minor trauma;

c. review of recent x-ray report and abbreviated discussion with patient under study;

d. concurrent hospital care for a minor secondary diagnosis;

e. examination for acute tonsilitis; or

f. abbreviated evaluation of a hospitalized patient in stage of recovery from an uncomplicated renal colic.

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

a. treatment of acute respiratory infection;

b. review of interval history, physical status, and control of a diabetic patient;

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

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

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

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

7. Intermediate service. "Intermediate service" means a level of service pertaining to the evaluation of a new or

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

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

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

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

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

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

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

following in level:

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

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

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

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

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

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

9. Comprehensive service. "Comprehensive service" means a level of service providing an in-depth evaluation of a patient with a new or existing problem requiring the development or complete reevaluation of medical data. This procedure includes the recording of a chief complaint, the present illness, family history, past medical history, personal history, system review,

a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

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

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

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

C. Office services. The following codes, service descriptions and maximum fees apply to services provided at the physician's office.

Code	Service	Maximum Fee
90000	New patient - brief service	$ 23.00
90010	New patient - limited service	31.00
90015	New patient - intermediate service	43.00
90017	New patient - extended service	60.00

90020	New patient - comprehensive service	120.50
90030	Established patient - minimal service	14.00
90040	Established patient - brief service	17.75
90050	Established patient - limited service	20.00
90060	Established patient - intermediate service	25.00
90070	Established patient - extended service	35.00
90080	Established patient - comprehensive service	60.00

D. Hospital services. The following codes, service descriptions and maximum fees apply to services provided at a hospital. Initial hospital care shall be categorized under codes 90200 to 90220. Subsequent hospital care shall be categorized under codes 90240 to 90280.

Code	Service	Maximum Fee
90200	Brief initial hospital care	49.40
90215	Intermediate initial hospital care	65.00
90220	Comprehensive initial hospital care	90.00
90240	Subsequent hospital care - brief service	21.50
90250	Subsequent hospital care - limited service	25.00
90260	Subsequent hospital care - intermediate service	35.00
90270	Subsequent hospital care - extended service	55.00
90280	Subsequent hospital care - comprehensive service	88.00

E. Emergency department services. The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department.

Code	Service	Maximum Fee
90500	New patient - minimal service	27.50
90505	New patient - brief service	32.50
90510	New patient - limited service	35.50
90515	New patient - intermediate service	35.50

90517	New patient - extended service	46.00
90530	Established patient - minimal service	18.00
90540	Established patient - brief service	28.50
90550	Established patient - limited service	30.00
90560	Established patient - intermediate service	35.00
90570	Established patient - extended service	50.00

4 MCAR S 1.0012 Consultations.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to providers licensed as a doctor of medicine or a doctor of osteopathy.

B. Definitions. For the purposes of this rule the following terms have the meanings given them unless the context clearly indicates a different meaning.

1. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. A referral does not constitute a consultation if the effect of the referral is to transfer the total or specific care of the patient from one physician to another.

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

3. Intermediate consultation. "Intermediate consultation" means a consultation where the physician examines or evaluates an organ system, partially reviews the general

history, and prepares recommendations and a report, including, but not limited to, services similar in level to the evaluation of the abdomen for possible surgery that does not proceed to surgery.

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

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

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

care.

B. C. Fees. The following codes, service descriptions, and maximum fees apply to consultations.

Code	Service	Maximum Fee
90600	Limited consultation	50.00
90605	Intermediate consultation	59.00
90610	Extensive consultation	73.00
90620	Comprehensive consultation	105.00
90630	Complex consultation	129.00

4 MCAR S 1.0013 Psychiatric therapy.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to providers licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
90843	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	$ 45.00
90844	approximately 45 or 50 minutes	76.00

4 MCAR S 1.0014 Biofeedback.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to providers licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
90900	Biofeedback training; by electromyogram application, as with tension headache or muscle spasm	$ 45.00

4 MCAR S 1.0015 Ophthalmological services.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to providers licensed as a doctor of medicine or a doctor of osteopathy.

B. Definitions. The terms defined in this rule have the meanings given them for the purposes of this rule unless the context clearly indicates a different meaning.

1. New patient and established patient. "New patient" and "established patient" have the meanings given them in 4 MCAR S 1.0011.

2. Level of service. "Level of service" for the purpose of this rule has the meaning given it in 4 MCAR S 1.0011.

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

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

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

4. Comprehensive ophthalmological service. "Comprehensive ophthalmological service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external

and ophthalmological examination, gross visual fields, and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated. Comprehensive ophthalmological services include, but are not limited to, service similar to diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract, or retinal disease, or to rule out disease of the visual system, in a new or established patient.

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

~~B.~~ C. Ophthalmological services and fees. The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92014, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code.

Routine ophthalmoscopy, codes 92225 to 92250, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

General Services

Code	Service	Maximum Fee
92002	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program--new patient	$ 40.00
92004	Comprehensive ophtalmological service: medical evaluation with initiation of diagnostic and treatment program--new patient, one or more visits	44.00
92012	Intermediate ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program--established patient	33.00
92014	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program--established patient, one or more visits	45.00

Special Services

92020	Gonioscopy with medical diagnostic evaluation as a separate procedure not under general anesthesia	$ 25.00
92065	Orthoptic or pleoptic training, with continuing medical direction and evaluation	26.25
92081	Visual field examination with medical diagnostic evaluation; tangent screen, Autoplot or equivalent	32.00
92082	Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent	42.00
92100	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	18.00

92140	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00
	Opthalmoscopy	
92235	Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation	$ 110.00
92250	with fundus photography	20.00
92260	with ophthalmodynamometry	29.00
	Other Specialized Services	
92280	Visually evoked potential or response study, with medical diagnostic evaluation	$ 90.00

4 MCAR S 1.0016 Otorhinolaryngologic services.

The codes, service descriptions, and maximum fees in this rule apply to otorhinolaryngologic services, and to providers licensed as a doctor of medicine or a doctor of osteopathy. Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, which do not include the following, should be reported as an integrated medical service using the appropriate code from the 90000 series. Component services such as otoscopy, rhinoscopy, or tuning fork test, should not be itemized separately. All of the following services include medical diagnostic evaluation. Technical procedures, which may or may not be performed by the physician personally, are often part of the service, but do not constitute the service itself.

Code	Service	Maximum Fee
92506	Medical evaluation of speech, language, or hearing problems	$ 46.00
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	45.00
92544	Optokinetic nystagmus test, bidirectional,	

	foveal, or peripheral stimulation, with recording	30.00
92545	Oscillating tracking test, with recording	25.00

4 MCAR S 1.0017 Audiologic tests.

The codes, service descriptions, and maximum fees in this rule apply to audiologic function tests with medical diagnostic evaluation, and to providers licensed as a doctor of medicine or a doctor of osteopathy. The tests involve use of calibrated electronic equipment. Other hearing tests such as whispered voice, tuning fork which are usually included in a comprehensive otorhinolaryngologic evaluation or office visit shall not be itemized, but shall be included in the basic office visit or consultation. The following codes refer to testing of both ears.

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Basic Audiometry

Code	Service	Maximum Fee
92551	Screening test, pure tone, air only	$ 10.50
92552	Pure tone audiometry (threshold); air only	15.75
92553	air and bone	26.00
92555	Speech audiometry; threshold only	11.00
92556	threshold and discrimination	29.00
92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	45.50

Audiologic Tests

92562	Loudness balance test, alternate binaural or monaural	$ 15.50
92563	Tone decay test	12.00
92564	Short increment sensitivity index	13.00
92566	Impedance testing	16.50
92567	Tympanometry	14.00
92568	Acoustic reflex testing	16.50
92569	Acoustic reflex decay test	11.00
92575	Sensorineural acuity level test	7.50
92581	Evoked response audiometry	150.00
92582	Conditioning play audiometry	20.00

Code	Service	Maximum Fee
92583	Select picture audiometry	23.00

4 MCAR S 1.0018 Cardiography.

The codes, service descriptions, and maximum fees in this rule apply to cardiographic services, and to providers licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
93000	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	$ 33.00
93005	tracing only, without interpretation and report	23.00
93010	interpretation and report only	16.00
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continous electrocardiographic monitoring, with interpretation and report	132.00
93017	tracing only without interpretation and report	94.00
93018	interpretation and report only	67.00
93040	Rhythm ECG, one to three leads; with interpretation	15.45
93041	tracing only, without interpretation and report	14.00
93042	interpretation and report only	30.00
93220	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	33.70
93270	Electrocardiographic monitoring utilizing a system such as magnetic tape for up through 12 hours; includes recording, scanning anlysis, interpretation, and report	153.00
93274	Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis, interpretation, and report	171.00
93277	physician review and interpretation, with report	82.00

4 MCAR S 1.0019 Pulmonary

The codes, service descriptions, and maximum fees of this rule apply to pulmonary services, and to providers licensed as a doctor of medicine or a doctor of osteopathy. The services include laboratory procedures, interpretation, and physician services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement or maximal voluntary ventilation	$ 65.00
94060	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	40.00
94150	Vital capacity, total (separate procedure)	13.00
94160	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	15.00
94375	Respiratory flow volume loop	21.00
94620	Pulmonary stress testing, simple or complex	75.00
94656	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	90.00
94567	subsequent days	38.00

4 MCAR S 1.0020 Neurology/neuromuscular.

The codes, service descriptions, and maximum fees of this rule apply to neurology and neuromuscular services, and to providers licensed as a doctor of medicine or a doctor of osteopathy. Services performed as part of and included in the definition of an office visit, hospital visit, or consultation shall not be listed separately, but shall be submitted under the appropriate code.

Code	Service	Maximum Fee
95819	Electroencephalogram (EEG) including recording	

		awake, drowsy, and asleep, with hyperventilation or photic stimulation; standard or portable, same facility	$ 105.00
	95822	Electroencephalogram (EEG); sleep only	100.00
	95823	physical or pharmacological activation only	105.00
	95851	Range of motion measurements and report (separate procedure); each extremity, excluding hand	30.00
	95860	Electromyography; one extremity and related paraspinal areas	125.00
	95861	two extremities and related paraspinal areas	136.40
	95863	three extremities and related paraspinal areas	175.00
	95864	four extremities and related paraspinal areas	290.00
	95900	Nerve conduction, velocity, or latency study; motor, each nerve	40.00
	95904	sensory, each nerve	33.75
	95925	Somatosensory testing, for example, cerebral evoked potentials, one or more nerves	162.00
	95935	"H" reflex, by electrodiagnostic testing	35.00

4 MCAR S 1.0021 Physical medicine.

The following codes, service descriptions and maximum fees apply to physical medicine services, and to providers licensed as a doctor of medicine or a doctor of osteopathy. Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities require supervision by the physican, but constant attendance of the physician or therapist is not required. Procedures require supervision by the physician, and constant attendance by the physician or therapist.

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Modalities

Code	Service	Maximum Fee

97000	Office visit with one of the following modalities to one area:			
	1. Hot or cold packs			
	2. Traction, mechanical			
	3. Electrical stimulation (unattended)			
	4. Vasopneumatic devices			
	5. Paraffin bath			
	6. Microwave			
	7. Whirlpool			
	8. Diathermy			
	9. Infrared			
	10. Ultraviolet		$	12.75
97050	Office visit with two or more modalities to same area			23.25
	Procedures			
97100	Office visit with one of the following procedures to one area:			
	1. Therapeutic exercises			
	2. Neuromuscular reeducation			
	3. Functional activities			
	4. Gait training			
	5. Electrical stimulation (manual)			
	6. Iontophoresis			
	7. Traction, manual			
	8. Massage			
	9. Contrast baths			
	10. Ultrasound; initial 30 minutes		$	15.50
97101	each additional 15 minutes			16.00
97200	Office visit, including combination of any modality and procedure; initial 30 minutes			26.00
97201	each additional 15 minutes			15.00
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area			20.00

97261	each additional area	4.00

Tests and Measurements

97720	Extremity testing for strength, dexterity, or stamina; initial 30 minutes	$ 31.00

4 MCAR S 1.0022 Special services.

Critical care services (codes 99160 to 99173) apply to providers licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99000	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$ 7.00
99075	Medical testimony	Reasonableness of charges reviewable by department of labor and industry

99080	Special reports like insurance forms, or the review of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or standard reporting form		Reasonableness of charges reviewable by department of labor and industry
	Surgical Procedures		
99025	Initial, new patient visit when asterisk (*) surgical procedure constitutes major service at that visit	$	15.00
	Prolonged Services		
99155	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physican); approximately 25 minutes	$	44.00
99156	approximately 50 minutes		81.00
	Critical Care		
99160	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$	100.00
99172	Critical care, subsequent follow-up visit; limited examination, evaluation, or treatment for same or new illness		30.00
99173	intermediate examination, evaluation, or treatment, same or new illness		44.30

4 MCAR S 1.00225 Physican services--surgery.

A. Scope. The codes, service descriptions, and maximum fees of this rule apply to providers licensed as a doctor of medicine or a doctor of osteopathy.

B. Instructions. The instructions in 1.-5. govern the assignment of codes and the evaluation of services described in this rule.

1. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated follow-up care, both pre- and postoperative. This concept is referred to as a "package" for surgical procedures.

2. Follow-up care includes reports and records as the operation requires and the physician commonly provides. This includes special reports concerning the medical appropriateness of a service for services which are rarely provided, unusual, variable, or new. Information included in these reports are an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

3. Follow-up care for diagnostic procedures, such as endoscopy or injection procedures for radiography, includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

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

5. Certain minor surgical services involve a readily identifiable surgical procedure but include variable preoperative and postoperative services. Because of the indefinite pre- and postoperative services the usual package

concept for surgical services cannot be applied. These procedures are identified by an asterisk (*) following the code number. When an asterisk follows a surgical procedure code, the following rules apply.

a. The service as listed includes the surgical procedure only. Associated pre- and postoperative services are not included in the service as listed.

b. Preoperative services shall be listed when:

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

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

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

(4) the asterisk procedure requires hospitalization, an appropriate hospital visit is listed in addition to the asterisk procedure and its follow-up care.

c. All postoperative care is added on a service-by-service basis.

d. Complications are added on a service-by-service basis as with surgical procedures.

C. Integumentary system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system. Excision of benign lesions (codes 11200 to 11442) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital,

cystic lesions. Treatment of burns (codes 16000 to 16020) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12013) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12031 to 12051) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13121 to 13132) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in 1.-3. also apply to coding of repair services (codes 12001 to 13132):

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

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

3. Involvement of nerves, blood vessels, and tendons shall be reported under the appropriate system for repair of these structures. The repair of the associated wound shall be included in the primary procedure, unless it qualifies as a complex wound, in which case modifier number 50 applies. Simple

ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

Incision

Code	Service	Maximum Fee
10000*	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 40.00
10003*	Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity	42.50
10020*	Incision and drainage of furuncle	28.00
10060*	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	40.00
10100*	Incision and drainage of onychia or paronychia single or simple	38.00
10120*	Incision and removal of foreign body, subcutaneous tissues; simple	40.00
10160*	Puncture aspiration of abscess, hematoma, bulla, or cyst	33.50

Paring or Curettement

11050*	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 25.00
11051	two to four lesions	28.00
11052	more than four lesions	42.00

Biopsy

11100	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 49.00

		Excision--Benign Lesions	
11200*		Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 42.00
11400		Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	51.50
11401		lesion diameter 0.5 to 1.0 centimeter	60.00
11402		lesion diameter 1.0 to 2.0 centimeters	75.00
11403		lesion diameter 2.0 to 3.0 centimeters	87.00
11404		lesion diameter 3.0 to 4.0 centimeters	125.00
11420		Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	57.00
11421		lesion diameter 0.5 to 1.0 centimeter	70.00
11422		lesion diameter 1.0 to 2.0 centimeters	95.00
11423		lesion diameter 2.0 to 3.0 centimeters	105.00
11424		lesion diameter 3.0 to 4.0 centimeters	120.00
11440		Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	64.00
11441		lesion diameter 0.5 to 1.0 centimeter	85.00
11442		lesion diameter 1.0 to 2.0 centimeters	98.00
		Nails	
11700*		Debridement of nails, manual; five or less	$ 20.00
11710*		Debridement of nails, electric grinder; five or less	20.00
11730*		Avulsion of nail plate, partial or complete, simple; single	50.00
11740		Evacuation of subungual hematoma	28.00
		Repair--Simple	
12001*		Simple repair of superficial wounds of	

		scalp, neck, axillae, external genitalia,	
		trunk, or extremities, including hands and	
		feet; up to 2.5 centimeters	42.00
	12002*	2.5 to 7.5 centimeters	65.00
	12004*	7.5 to 12.5 centimeters	84.00
	12011*	Simple repair of superficial wounds of face,	
		ears, eyelids, nose, lips, or mucous	
		membranes; up to 2.5 centimeters	60.00
	12013*	2.5 to 5.0 centimeters	78.00
	12014	5.0 to 7.5 centimeters	80.00
	12015	7.5 to 12.5 centimeters	165.00
		Repair--Intermediate	
	12031*	Layer closure of wounds of scalp, axillae,	
		trunk, or extremities excluding hands	
		and feet; up to 2.5 centimeters	$ 59.50
	12032*	2.5 to 7.5 centimeters	85.00
	12034	7.5 to 12.5 centimeters	135.00
	12041*	Layer closure of wounds of neck, hands,	
		feet, or external genitalia; up to 2.5	
		centimeters	80.00
	12051*	Layer closure of wounds of face, ears,	
		eyelids, nose, lips, or mucous membranes	
		up to 2.5 centimeters	90.00
	12052	2.5 to 5.0 centimeters	135.00
		Repair--Complex	
	13150	Repair, complex, eyelids, nose, ears, or	
		lips; up to 1.0 centimeter	$152.00
	13151	1.0 to 2.5 centimeters	330.00
	13152	2.5 to 7.5 centimeters	440.00
		Adjacent Tissue Transfer or Rearrangement	
	14040	Adjacent tissue transfer or rearrangement,	
		forehead, cheeks, chin, mouth, neck, axillae,	
		genitalia, hands, or feet; defect up to	

		10 square centimeters	450.00
	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	660.00
		Free Skin Grafts	
	15050*	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area except on face, up to defect size 2 centimeters diameter	$125.00
	15100	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters, or each one percent of body area of infants and children (except 15050)	431.00
		Burns, Local Treatment	
	16000	Initial treatment, first degree burn, when no more than local treatment is required	$ 41.50
	16010	Dressings or debridement, initial or subsequent; under anesthesia, small	30.00
	16020*	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small	30.00
	16025*	without anesthesia, medium, for example, whole face or whole extremity	50.00
		Destruction	
	17000*	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 35.00
	17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	30.00
	17200*	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	35.00

17250*	Chemical cauterization of a wound	18.10
17300	Chemosurgery (Mohs type technique), malignancies of skin, including removal of lesion and microscopic delineation of margins and base; first stage--fulguration and application of chemicals	350.00
17340*	Cryotherapy (CO_2 slush, liquid N_2)	20.00

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

Excision--General

Code	Service	Maximum Fee
20220	Biopsy, muscle; deep	$ 190.00
29020	Biopsy, bone, trocar, or needle; superficial for example ilium, sternum, spinous process, ribs	110.00

Introduction or Removal--General

20501*	Injection of sinus tract; diagnostic (sinogram) (separate procedure)	$ 47.00
20520*	Removal of foreign body in muscle; simple	36.00
20550*	Injection, tendon sheath, ligament, or trigger points	35.00
20600*	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	40.00
20605*	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa	42.00
20610*	major joint or bursa, for example, shoulder,	

		hip, knee joint, subacromial bursa	40.00
20670*		Removal of implant; superficial for example buried wire, pin or rod (separate procedure)	60.00
20680		deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate	242.50

Head--Fracture or Dislocation

21315*	Manipulative treatment, nasal bone fracture; without stabilization	$ 88.00
21320	with stablization	219.00
21360	Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod	530.00

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

Code	Service	Maximum Fee
21800	Treatment of rib fracture; closed, uncomplicated, each	$ 50.00

Spine (Vertebral Column)--Manipulation

22500*	Manipulation of spine, any region	$ 28.00

Shoulders--Fracture or Dislocation

23505	Treatment of closed clavicular fracture; with manipulation	$162.00
23605	Treatment of closed humeral (surgical or anatomical neck) fracture; with manipulation	300.00
23650	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	80.00
23655	requiring anesthesia	165.00

Shoulder--Manipulation

23700*	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	$150.00

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

24505	Treatment of closed humeral shaft fracture; with manipulation	$290.00

Forearm and Wrist--Excision

25111	Excision of ganglion, wrist (dorsal or volar); primary		$279.00
	Forearm and Wrist--Fracture or Dislocation		
25505	Treatment of closed radial shaft fracture; with manipulation		$235.00
25565	Treatment of closed radial and ulnar shaft fractures; with manipulation		326.00
25600	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation		125.00
25605	with manipulation		242.50
25610	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal external skeletal fixation or percutaneous pinning		310.00
25611	with external skeletal fixation or percutaneous pinning		350.00
	Hand and Fingers--Repair, Revision, or Reconstruction		
26410	Extensor tendon repair, dorsum of hand, single, primary, or secondary; without free graft, each tendon		169.00
26418	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free free graft, each tendon		233.00
	Hands and Fingers--Fractures or Dislocations		
26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone		$ 70.00
26605	with manipulation, each bone		144.00
26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone		383.00
26720	Treatment of closed phalangeal shaft fracture,		

		proximal or middle phalanx, finger or thumb;	
		without manipulation, each	56.00
	26725	with manipulation, each	92.80
	26750	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	37.50
	26770	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	45.00
		Hand and Fingers--Amputation	
	26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	205.00
	26952	with local advancement flaps (V-Y, hood)	300.00
		Pelvis and Hip Joint--Fracture or Dislocations	
	27236	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	$1,329.00
	27244	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,200.00
		Femur (Thigh Region) and Knee Joint--Excision	
	27331	Arthrotomy, knee; with joint exploration, with or without biopsy, with or without removal of loose bodies	831.00
	27332	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial or lateral	820.00
	27345	Excision of synovial cyst of popliteal space (Baker's cyst)	460.00
		Femur (Thigh Region) and Knee Joint--Introduction or Removal	
	27370	Injection procedure for knee arthrography	$ 55.00
	27373	Arthroscopy, knee, diagnostic (separate procedure)	330.00
	27374	Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium	1,080.00

27377	with removal of loose body		900.00
27378	with partial meniscectomy		1,200.00
27379	with plica resection or shelf resection		1,012.50
	Femur (Thigh Region) and Knee Joint--		
	Repair, Revision, or Reconstruction		
27409	Suture, primary, torn, ruptured, or severed ligament, with or without meniscectomy, knee; collateral and cruciate ligaments		1,100.00
27422	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)		952.00
27444	Arthroplasty, knee, total; fascial		2,810.00
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing ("total knee replacement")		2,340.00
	Femur (Thigh Region) and Knee Joint--Manipulation		
27570*	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)		$ 76.00
	Leg (Tibula and Fibula) and Ankle Joint--		
	Fractures or Dislocations		
27752	Treatment of closed tibial shaft fracture; with manipulation		$279.00
27766	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation		618.85
27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation		120.00
27788	with manipulation		195.00
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation		394.00
27814	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation		671.00

	external skeletal fixation	671.00
27822	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	861.00
	Foot--Fracture or Dislocation	
28470	Treatment of closed metatarsal fracture; without manipulation, each	90.00
28475	with manipulation, each	119.00
28490	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	41.00
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	41.00
28515	with manipulation, each	63.50

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

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29035	Application of body cast, shoulder to hips	$150.00
29065	shoulder to hand (long arm)	65.00
29075	elbow to finger (short arm)	54.00
29085	hand and lower forearm (gauntlet)	53.00
	Splints	
29105	Aplication of long arm splint (shoulder to hand)	$ 38.00
29125	Application of short arm splint (forearm to hand); static	30.00
29130	Application of finger splint; static	22.00
	Strapping--Any Age	

29220	low back	20.00
29260	elbow or wrist	18.00
29280	hand or finger	20.00
	Lower Extremity Casts	
29345	Application of long leg cast (thigh to toes)	$ 90.50
29355	walker or ambulatory type	90.00
29358	Application of long leg cast brace	$250.00
29365	Application of cylinder cast (thigh to ankle)	70.00
29405	Application of short leg cast (below knee to toes)	65.00
29425	walking or ambulatory type	73.00
29435	Application of patellar tendon bearing (PTB) cast	96.00
29450	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	40.50
29455	bilateral	82.00
	Splints	
29505	Application of long leg splint (thigh to ankle or toes)	$ 40.00
29515	Application of short leg splint (calf to foot)	38.00
	Strapping--Any Age	
29530	Strapping; knee	$ 24.00
29540	ankle	20.00
29580	Unna boot	25.00
	Removal or Repair	
29700	Removal or bivalving; gauntlet, boot, or body cast	$ 18.00
29720	Repair of spica, body cast, or jacket	15.00

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

Nose--Removal Foreign Body

Code	Service	Maximum Fee
30300*	Removal foreign body, intranasal; office	

	type procedure	$ 29.00
	Nose--Repair	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip	$1,332.00
30420	including major septal repair	1,540.00
30520	Septoplasty with or without cartilage implant (separate procedure)	781.00

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

Vascular Injection Procedures--Intravenous

Code	Service	Maximum Fee
36000*	Introduction of needle or intracatheter, vein; unilateral	$ 49.00
	Vascular Injection Procedures--Intra-Arterial; Intra-Aortic	
36101	Introduction of needle or intracatheter, carotid, or vertebral artery; bilateral	$213.50
	Vascular Injection Procedures--Venous	
36410*	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	$ 39.50
36470*	Injection of sclerosing solution; single vein	24.00
36471	multiple veins, same leg	30.00
36480*	Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous	100.00

Vascular Injection Procedures--Arterial

36620	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	$100.00

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

Abdomen, Peritoneum, and Omentum--
Repair, Hernioplasty, Herniorrhaphy, Herniotomy

Code	Service	Maximum Fee
49505	Repair inguinal hernia, age 5 or over; unilateral	$560.00
49506	bilateral	918.00
49510	Repair inguinal hernia, age 5 or over; unilateral, with orchiectomy, with or without implantation of prosthesis	600.00
49515	with excision of hydrocele or spermatocele	673.30
49520	recurrent	672.00
49560	Repair ventral (incisional) hernia (separate procedure)	610.00
49565	recurrent	756.00
49581	Repair umbilical hernia; age 5 or over	480.00

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

Spine and Spinal Cord--
Puncture for Injection, Drainage, or Aspiration

Code	Service	Maximum Fee
62270*	Spinal puncture lumbar diagnostic	$ 65.00
62273*	Injection lumbar epidural, of blood or clot patch	100.00
62274*	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural simple	65.00
62278*	epidural or caudal single	125.00
62284*	Injection procedure for myelography	

	and computerized axial tomography,	
	spinal or posterior fossa	130.00

Spine and Spinal Cord--
Laminectomy or Laminotomy, for Exploration or Decompression

Code	Service	Maximum Fee
63017	Laminectomy for decompression of spinal cord or cauda eguina, more than two segments; lumbar	$2,160.00
63020	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, cervical, unilateral	1,382.00
63030	one interspace, lumbar, unilateral	1,562.00
63042	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or re-exploration; lumbar	2,000.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System--Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic, Somatic Nerves

Code	Service	Maximum Fee
64450*	Injection, anesthetic agent; other peripheral nerve or branch	$ 61.00

Sympathetic Nerves

64510*	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	$100.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System--Exploration, Neurolysis, or Nerve Decompression (Neuroplasty)

64718	Neurolysis or transposition; ulnar nerve at elbow	$750.00
64721	median nerve at carpal tunnel	528.00

Eye and Ocular Adnexa--Removal of Ocular Foreign Body

65205*	Removal foreign body, external eye; conjunctival superficial	$ 30.00

65210*	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	38.00
65220*	corneal, without slit lamp	40.00
65222*	corneal, with slit lamp	49.00

J. Auditory system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the auditory system.

External Ear--Removal Foreign Material

Code	Service	Maximum Fee
69200	Removal foreign body from external auditory canal; without general anesthesia	$ 25.00

4 MCAR S 1.0023 Physician services--radiology.

A. General. The following codes, service descriptions, and maximum fees apply to providers licensed as a doctor of medicine and persons licensed as a doctor of osteopathy. The suffix number 26 modifier indicates only the professional component of a combined technical and professional procedure applies. Absence of the suffix indicates the complete procedure, professional and technical.

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

Head and Neck

Code	Service	Maximum Fee
70110	Radiologic examination, mandible; complete, minimum of four views	$ 53.80
70110-26	professional component only	17.40
70130	Radiologic examination, mastoids; complete, minimum of three views per side	65.00
70130-26	professional component only	20.00
70140	Radiologic examination, facial bones; less than three views	40.00
70140-26	professional component only	17.80
70150	complete, minimum of three views	52.00
70150-26	professional component only	17.40

70160	Radiologic examination, nasal bones, complete, minimum of three views		37.50
70160-26	professional component only		10.75
70200	Radiologic examination; orbits, complete, minimum of four views		53.00
70200-26	professional component only		17.80
70210	Radiologic examination, sinuses, paranasal, less than three views		29.80
70210-26	professional component only		12.00
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies		51.30
70220-26	professional component only		17.25
70250	Radiologic examination, skull; less than four views, with or without stereo		38.95
70250-26	professional component only		16.50
70260	complete, minimum of four views, with or without stereo		66.00
70260-26	professional component only		22.90
70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral		53.50
70330-26	professional component only		20.00
70355-26	Orthopantogram; professional component only		9.75
70360	Radiologic examination; neck, soft tissue		25.00
70360-26	professional component only		10.75
70450	Computerized axial tomography, head; without contrast material		255.00
70450-26	professional component only		66.00
70460	with contrast material		289.00
70460-26	professional component only		71.50
70470	without intravenous contrast material, followed by contrast material and further sections		336.00
70470-26	professional component only		90.00
	Chest		
71000	Radiologic examination, chest, minifilm		$ 25.00

71010	Radiologic examination, chest; single view, posteroanterior		28.25
71010-26	professional component only		9.75
71015	stereo, posteroanterior		27.30
71015-26	professional component only		13.50
71020	two views, posteroanterior and lateral		39.00
71020-26	professional component only		15.25
71021	apical lordotic procedure		31.70
71100	Radiologic examination, ribs, unilateral; two views		42.00
71100-26	professional component only		14.95
71101-26	including posteroanterior chest, minimum of three views, professional component only		21.50
71110	Radiologic examination, ribs, bilateral; three views		52.00
71250-26	Computerized axial tomography, thorax; without contrast material, professional component only		71.50
	Spine and Pelvis		
72010	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral		$108.50
72010-26	professional component only		25.00
72020	Radiologic examination, spine, single view, specify level		30.45
72020-26	professional component only		15.00
72040	Radiologic examination, spine, cervical; anteroposterior and lateral		41.50
72040-26	professional component only		13.00
72050	minimum of four views		60.50
72050-26	professional component only		20.40
72052	complete, including oblique and flexion or extension studies		65.00
72052-26	professional component only		25.50
72070	Radiologic examination, spine; thoracic,		

		anteroposterior and lateral	44.00
	72070-26	professional component only	19.00
	72080	thoracolumbar, anteroposterior and lateral	44.00
	72080-26	professional component only	11.50
	72090	scoliosis study, including supine and erect studies	43.00
	72090-26	professional component only	17.50
	72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	50.00
	72100-26	professional component only	17.90
	72110	complete, with oblique views	64.00
	72110-26	professional component only	25.00
	72114	complete, including bending views	81.00
	72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	60.00
	72120-26	professional component only	16.00
	72145	Computerized axial tomography, spine; with or without contrast material	350.00
	72145-26	professional component only	99.00
	72170	Radiologic examination, pelvis; anteroposterior only	33.00
	72170-26	professional component only	12.50
	72180	stereo	36.20
	72180-26	professional component only	14.75
	72190	complete, minimum of three views	49.50
	72190-26	professional component only	20.00
	72220	Radiologic examination, sacrum and coccyx, minimum of two views	39.00
	72220-26	professional component only	15.50
	72241-26	Myelography, cervical; complete procedure professional component only	193.40
	72265-26	Myelography, lumbosacral; supervision and interpretation only, professional component only	58.50

72266-26		complete procedure, professional component only	178.20
		Upper Extremities	
73000		Radiologic examination; clavicle, complete	$ 29.00
73000-26		professional component only	9.75
73010		scapula, complete	33.00
73010-26		professional component only	11.00
73020		Radiologic examination, shoulder; one view	28.50
73020-26		professional component only	9.00
73030		complete, minimum of two views	37.70
73030-26		professional component only	11.00
73040-26		Radiologic examination, shoulder, arthrography; supervision and interpretation only, professional component only	11.25
73050		Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	45.00
73050-26		professional component only	13.25
73060		humerous, minimum of two views	32.00
73060-26		professional component only	11.00
73070		Radiologic examination, elbow; anteroposterior and lateral views	30.90
73070-26		professional component only	11.00
73080		complete, minimum of three views	33.25
73080-26		professional component only	13.25
73090		Radiologic examination; forearm, anteroposterior and lateral views	31.00
73090-26		professional component only	11.00
73100		Radiologic examination, wrist; anteroposterior and lateral views	30.00
73100-26		professional component only	11.00
73110		complete, minimum of three views	37.00
73110-26		professional component only	13.25
73120		Radiologic examination, hand; two views	30.00
73120-26		professional component only	11.00

73130	minimum of three views		34.00
73130-26	professional component only		11.00
73140	Radiologic examination, finger or fingers, minimum of two views		28.00
73140-26	professional component only		9.25
	Lower Extremities		
73500	Radiologic examination, hip; unilateral, one view		$ 28.70
73500-26	professional component only		10.60
73510	complete, minimum of two views		44.00
73510-26	professional component only		15.50
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis		50.00
73520-26	professional component only		18.75
73550	Radiologic examination, femur, anteroposterior, and lateral views		36.50
73550-26	professional component only		11.00
73560	Radiologic examination, knee; anteroposterior and lateral views		33.35
73560-26	professional component only		11.00
73562	anteroposterior and lateral, with oblique, minimum of three views		43.00
73562-26	professional component only		12.00
73564	complete, including oblique, or tunnel, or patellar, or standing views		44.00
73564-26	professional component only		16.50
73580-26	Radiologic examination, knee, arthrography; supervision and interpretation only, professional component only		85.00
73581	complete procedure		100.00
73581-26	professional component only		110.25
73590	Radiologic examination; tibia and fibula, anteroposterior and lateral views		35.00

73590-26	professional component only		11.00
73600	Radiologic examination, ankle; anteroposterior and lateral views		30.00
73600-26	professional component only		11.00
73610	complete, minimum of three views		36.00
73610-26	professional component only		12.00
73620	Radiologic examination, foot; anteroposterior and lateral views		30.00
73620-26	professional component only		11.00
73630	complete, minimum of three views		34.10
73630-26	professional component only		11.50
73650	Radiologic examination; calcaneus, minimum of two views		30.00
73650-26	professional component only		9.25
73660	toe or toes, minimum of two views		28.00
73660-26	professional component only		9.00

Abdomen

Code	Service	Maximum Fee
74000	Radiologic examination, abdomen; single anteroposterior view	$ 32.50
74000-26	professional component only	13.00
74010	anteroposterior and additional oblique and cone views	37.50
74010-26	professional component only	16.55
74020	complete, including decubitus or erect views	44.00
74020-26	professional component only	16.75
74150-26	Computerized axial tomography, abdomen; without contrast material, professional component only	73.25
74170	without contrast material followed by contrast material and further sections	402.00
74170-26	professional component only	88.95

Gastrointestinal Tract

74220	Radiologic examination; esophagus	$ 72.00
74220-26	professional component only	37.10

74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB		82.00
74240-26	professional component only		40.00
74241	with or without delayed films, with KUB		48.00
74241-26	professional component only		32.50
74245	with small bowel, includes multiple serial films		119.00
74245-26	professional component only		66.00
74250	Radiologic examination, small bowel, includes multiple serial films		85.90
74250-26	professional component only		36.50
74270	Radiologic examination, colon; barium enema		83.50
74270-26	professional component only		38.60
74280	air contrast with specific high density barium, with or without glucagon		99.00
74280-26	professional component only		58.75
74290	Cholecystography, oral contrast		59.50
74290-26	professional component only		20.00
74291	additional, repeat examination or, multiple day examination		35.50
74291-26	professional component only		12.50
74300-26	Cholangiography; during surgery, professional component only		30.00
74305-26	postoperative, professional component only		36.00
	Urinary Tract		
74400	Urography (pyelography), intravenous, including kidneys, ureters, and bladder		$ 98.00
74400-26	professional component only		35.20
74405	with special hypertensive contrast concentration or clearance studies		99.60
74405-26	professional component only		38.25
74410	Urography, infusion, drip technique;		71.00
74410-26	professional component only		30.00

74415	with nephrotomography		115.80
74415-26	professional component only		45.00
74429-26	Urography, retrograde, with or without kidneys, ureters, and bladder, professional component only		16.50
74430-26	Cystography, minimum of three views; supervision and interpretation only, professional component only		14.50
74431	complete procedure		109.40
74431-26	professional component only		50.00
74450-26	Urethrocystography, retrograde; supervision and interpretation only, professional component only		14.25
74455	Urethrocystography, voiding; supervision and interpretation only		60.00
	professional component only		22.70
74456	complete procedure		94.50
74456-26	professional component only		48.00
	Aorta and Arteries		
75754-26	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only, professional component only		$152.00
	Veins and Lymphatics		
75821-26	Venography, extremity, unilateral; complete procedure professional component only		$121.50
	Miscellaneous		
76000-26	Fluoroscopy (separate procedure), other than 71034 professional component only		$ 34.85
76020	Bone age studies		31.00
76020-26	professional component only		20.00
76040	Bone length studies (orthoroentgenogram, scanogram)		47.50

76040-26	professional component only	19.75
76090	Mammography; unilateral	55.00
76090-26	professional component only	24.00
76091	bilateral	86.75
76091-26	professional component only	37.50
76100	Radiologic examination, single plane body section (for example, tomography), other than kidney	94.00
76100-26	professional component only	49.00

C. Diagnostic ultrasound. The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

Head and Neck

Code	Service	Maximum Fee
76505-26	Echoencephalography, A-mode; complete (diencephalic midline and ventricular size), professional component only	$ 75.00
76506-26	Echoencephalography, B-mode (gray scale) complete (for determination of ventricular size, delineation of cerebral contents and detection of fluid, masses, or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated, professional component only	85.00
76516	Echography, opthalmic, ultrasonic biometry; A-mode, professional component only	126.00

76535-26	Echography, thyroid; B-scan, professional component only	51.75
	Chest	
76620	Echocardiography, M-mode; complete	$194.50
76620-26	professional component only	60.00
	Abdomen and Retroperitoneum	
76700	Echography, abdominal, B-scan; complete	$133.00
76700-26	professional component only	65.00
76705	limited (for example, follow-up or limited study)	105.00
76705-26	professional component only	36.25
76770-26	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; complete	51.75
	Pelvis	
76805	Echography, pelvic, B-scan (for example, real-time), in obstetrics, gynecology, or transplants; complete	$ 85.00
76805-26	professional component only	47.50
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	65.00
76815-26	professional component only	27.50
76855	Echography, pelvic area (Doppler)	55.00
76855-26	professional component only	53.05
76856	Echography, pelvic, real-time	75.00
76856-26	professional component only	54.50

D. Therapeutic radiology. The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

Except where specified, clinical treatment management assumes treatment on a daily basis (four or five fractions per week) with the use of megavoltage photon or high energy particle

sources. Daily and weekly clinical treatment management are mutually exclusive for the same dates. "Simple" means a single treatment area, single port or parallel opposed ports, simple blocks. "Intermediate" means two separate treatment areas, three or more ports on a single treatment area, use of special blocks. "Complex" means three or more separate treatment areas and highly complex blocking (mantle, inverted Y, tangential ports, wedges, compensators, or other special beam considerations).

Code	Service	Maximum Fee
77400-26	Daily megavoltage treatment management; simple professional component only	$ 30.75
77405	intermediate	10.50
77405-26	professional component only	10.00
77410	complex	28.50
77410-26	professional component only	27.50
77415-26	Therapeutic radiology treatment port film interpretation and verification, per treatment course, professional component only	11.25
77420	Weekly megavoltage treatment management; simple	17.50
77465	Daily kilovoltage treatment management	79.50

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

Diagnostic--Endocrine System

Code	Service	Maximum Fee
78000	Thyroid uptake; single determination	$ 14.00
78000-26	professional component only	17.50
78006-26	Thyroid imaging, with uptake; single determination, professional component only	48.00
78010-26	Thyroid imaging; only, professional	

	component only	36.50
	Diagnostic--Gastrointestinal System	
78201-26	Liver imaging only; professional component only	$ 64.30
78215-26	Liver and spleen imaging; professional component only	66.00
	Diagnostic--Musculoskeletal System	
78300-26	Bone imaging; limited area (for example, skull, pelvis), professional component only	66.00
78305-26	multiple areas, professional component only	66.50
78306	whole body	222.40
78306-26	professional component only	64.40
	Diagnostic--Cardiovascular System	
78403-26	Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion (for example, gated blood pool images), professional component only	55.00
	Diagnostic--Respiratory System	
78580-26	Pulmonary perfusion imaging; particulate, professional component only	$ 64.40
	Diagnostic--Nervous System	
78601-26	Brain imaging, limited procedure; with vascular flow professional component only	$ 55.00
	Diagnostic--Genitourinary System	
78704-26	Kidney imaging; with function study (imaging renogram), professional component only	$ 64.30

4 MCAR S 1.0024 Physician services; pathology and laboratory.

A. Scope. The following codes, service descriptions, and maximum fees apply to providers licensed as a doctor of medicine or as a doctor of osteopathy.

B. Automated, multichannel tests. The following codes,

service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003-80019 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

Albumin	Lactic dehydrogenase (LDH)
Albumin/globulin ratio	Phosphatase, alkaline
Bilirubin, direct	Phosphorus (inorganic phosphate)
Bilirubin, total	Potassium
Calcium	Protein, total
Carbon dioxide content	Sodium
Chloride	Transaminase, glutamic oxaloacetic (SGOT)
Cholesterol	Transaminase, glutamic pyruvic (SGPT)
Creatinine	Urea nitrogen (BUN)
Globulin	Uric acid
Glucose (sugar)	

Automated Multichannel Tests

Code	Service	Maximum Fee
80003	Automated multichannel tests; 3 clinical chemistry tests	$ 29.00
80004	4 clinical chemistry tests	22.00
80005	5 clinical chemistry tests	22.00
80006	6 clinical chemistry tests	28.00
80007	7 clinical chemistry tests	25.00
80008	8 clinical chemistry tests	30.00
80009	9 clinical chemistry tests	31.00
80010	10 clinical chemistry tests	28.50
80011	11 clinical chemistry tests	27.50
80012	12 clinical chemistry tests	27.00
80016	13-16 clinical chemistry tests	30.00
80018	17-18 clinical chemistry tests	31.00

Code	Service	Maximum Fee
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	30.00

C. Urinalysis. The following codes, service descriptions, and maximum fees apply to urinalysis procedures.

Code	Service	Maximum Fee
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$ 8.35
81002	routine, without microscopy	5.25
81004	components, single, not otherwise listed, specify	4.50
81005	chemical, qualitative, any number of constituents	4.50
81010	concentration and dilution test	6.00
81015	microscopic only	7.00

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

Code	Service	Maximum Fee
82011	Acetylsalicylic acid; quantitative	$ 17.50
82012	qualitative	15.25
82150	Amylase, serum;	16.10
82250	Bilirubin; blood, total OR direct	11.00
82270	Blood; occult, feces, screening	5.25
82310	Calcium, blood; chemical	11.70
82372	Carbamazepine, serum	27.50
82375	Carbon monoxide, (carboxyhemoglobin); quantitative	22.00
82435	Chlorides; blood (specify chemical or electrometric	12.10
82465	Cholesterol, serum; total	12.00
82480	Cholinesterase; serum	17.00
82565	Creatinine; blood	12.00

82570		urine	12.00
82575		clearance	24.20
82607	Cyanocobalamin (Vitamin B-12); RIA		31.50
82643	Digoxin, RIA		30.00
82660	Drug screen (amphetamines, barbiturates, alkaloids		30.20
82756	Free thyroxine indes (T-7)		26.00
82947	Glucose; except urine (for example, blood, spinal fluid, joint fluid)		11.00
82948		blood, stick test	8.00
82950		post glucose dose (includes glucose)	11.00
82951		tolerance test (GTT), three specimens (includes glucose)	36.00
82977	Glutamyl transpeptidase, gamma (GGT)		12.00
82996	Gonadotropin, chorionic, bioassay; qualitative		13.00
82997		quantitative	16.00
82998	Gonadotropin, chorionic, RIA		25.00
83000	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay		35.00
83001	RIA		37.25
83002	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA		38.00
83020	Hemoglobin; electrophoresis		6.00
83540	Iron, serum; chemical		20.25
83545		automated	12.25
83550	Iron binding capacity, serum; chemical		25.00
83555		automated	20.00
83725	Lithium, blood, quantitative		16.50
84030	Phenylalanine (PKU), blood; Guthrie		8.50
84035	Phenylketones; blood, qualitative		6.50
84037		urine, qualitative	4.00
84045	Phenytoin		28.80
84060	Phosphatase, acid; blood		18.50
84065		prostatic fraction	22.00
84075	Phosphatase, alkaline, blood;		13.00

84078	heat stable (total not included)	18.60
84080	isoenzymes, electrophoretic method	34.63
84100	Phosphorus (phosphate); blood	13.00
84105	urine	12.60
84132	Potassium; blood	11.00
84133	urine	9.00
84136	Pregnanediol; other method (specify)	16.00
84139	Pregnanetriol; other method (specify)	10.00
84165	Protein, total, serum; electrophoretic fractionation and quantitation	24.00
84180	Protein, urine; quantitative, 24-hour specimen	12.50
84190	electrophoretic fractionation and quantitation	19.90
84295	Sodium; blood	10.80
84300	urine	12.00
84420	Theophylline, blood, or saliva	29.00
84442	Thyroxine binding globulin (TBG)	30.00
84443	Thyroid stimulating hormone (TSH), RIA	33.00
84450	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method	12.90
84455	colorimetric or fluorometric	12.00
84460	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	16.50
84478	Triglycerides, blood	14.00
84520	Urea nitrogen, blood (BUN); quantitative	11.00
84550	Uric acid; blood, chemical	12.00
84555	uricase, ultraviolet method	12.50
84560	Uric acid, urine	12.00

E. Hematology. The following codes, service descriptions, and maximum fees apply to hematology procedures.

Code	Service	Maximum Fee
85005	Blood count; basophil count, direct	$ 10.00
85007	differential WBC count (includes RBC	

	morphology and platelet estimation)	8.00
85009	differential WBC count, buffy coat	9.00
85012	eosinophil count, direct	11.00
85014	hematocrit	6.00
85018	hemoglobin, colorimetric	6.50
85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)	14.00
85027	hemogram, automated, with platelet count	20.00
85022	hemogram, automated, and differential WBC count (CBC)	19.00
85031	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	18.50
85041	red blood cell (RBC)	6.10
85044	reticulocyte count	9.50
85095	Bone marrow; aspiration only	48.50
85102	biopsy core (needle)	67.20
85210	Clotting; factor 11, prothrombin, specific	10.00
85580	Platelet; count (Rees-Ecker)	10.90
85585	estimation on smear, only	9.00
85590	phase microscopy	11.00
85595	electronic technique	10.40
85610	Prothrombin time;	10.00
85650	Sedimentation rate (ESR); Wintrobe type	8.00
85651	Westergren type	7.50
85660	Sickling of RBC, reduction, slide method	7.00

F. Immunology. The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86006	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	$ 14.00
86008	Antibody, quantitative titer, not otherwise specified; first antigen	15.00
86016	Antibodies, RBC, saline; high protein and antihuman globulin technique	13.50

86017		with ABO + Rh(D) typing (for holding blood instead of complete crossmatch)	15.00
86060		Antistreptolysin O; titer	16.00
86063		screen	14.00
86080		Blood typing; ABO only	9.00
86096		Blood typing, RBC antigens other than ABO or Rho(D); direct, slide or tube, including Rh subtypes, each antigen	13.50
86100		Blood typing; Rho(D) only	11.00
86105		Rh genotyping, complete	14.00
86140		C-reactive protein	11.25
86255		Fluorescent antibody; screen	25.60
86256		titer	25.00
86280		Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral)	27.50
86287		Hepatitis B surface antigen (HB_xAg) (Australian antigen, HAA); RIA method	19.00
86300		Heterophile antibodies; screening (includes monotype test), slide or tube	10.25
86305		quantitative titer	14.70
86430		Rheumatoid factor, latex fixation	13.00
86580		Skin test; tuberculosis, patch, or intradermal	7.00
86585		tuberculosis, tine test	6.00

G. Microbiology. The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
87040	Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen)	$ 14.00
87045	stool	20.00
87060	throat or nose	9.20
87072	Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine	19.00

87076	Culture, bacterial, any source; definitive identification, including gas chromatography in addition to anaerobic culture		16.00
87081	Culture, bacterial, screening only, for single organisms		10.00
87082	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms		10.00
87083	multiple organisms		6.00
87084	with colony estimation from density chart (includes throat cultures)		14.00
87086	Culture, bacterial, urine; quantitative, colony count		15.00
87087	commercial kit		8.00
87088	identification, in addition to quantitative or commercial kit		16.80
87101	Culture, fungi, isolation; skin		14.00
87102	other source		7.25
87106	definitive identification, by culture, per organism, in addition to skin or other source		15.00
87140	Culture, typing; fluorescent method, each antiserum		12.65
87163	Culture, special extensive definitive diagnostic studies, beyond usual definitive studies		23.00
87164	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection		6.00
87181	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic		20.00
87184	disc method, each plate (12 or less discs)		14.00
87186	microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics		20.00

87188		tube dilution method, each antibiotic	17.50
87205		Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	9.00
87206		fluorescent and/or acid fast stain for bacteria, fungi, or cell types	11.00
87210		wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites	8.90
87211		wet and dry mount, with interpretation, for ova and parasites	9.80
87220		Tissue examination for fungi (for example, KOH slide)	7.75

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

Cytopathology

Code	Service	Maximum Fee
88104	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 20.00
88109	smears and cell block with interpretation	33.00

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

Code	Service	Maximum Fee
88300	Surgical pathology, gross examination only	$ 24.00
88302	Surgical pathology, gross and microscopic; examination for identification and record purposes (for example, uterine tubes,	

	vas deferens, sympathetic ganglion)	28.00
88304	diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy)	30.00
88305	diagnostic exam, larger specimen or multiple small specimens (for example, prostate clippings, uterine curetings segment of stomach)	29.00
88307	complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides	43.50
88312	Special stains; Group I stains for microorganisms (for example, Gridley, acid fast, methenamine silver, Levaditi)	9.00
88313	Group II, all other special stains, except immunoperoxidase stains	11.00

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

Code	Service	Maximum Fee
89007	Test combinations assigned individual procedure numbers for secretarial convenience only; CBC, urinalysis, serology, blood typing, and Rh grouping (includes codes 85022 or 85031, 81000, 86592, 86082, and 86100)	$ 38.50
89050	Cell count, miscellaneous body fluids (for example, CSF, joint fluid, except blood)	$14.00
89180	Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify)	10.00

4 MCAR S 1.0025 Dentists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to persons licensed as doctors of dental

surgery or a comparable degree.

B. Diagnostic. The following codes, service descriptions, and maximum fees apply to diagnostic services.

Clinical Oral Examinations

Code	Service	Maximum Fee
00110	Initial oral examination	$ 10.00
00120	Periodic oral examination	10.00
00130	Emergency oral examination	11.50

Radiographs

00210	Intraoral complete series (including bitewings)	$ 30.00
00220	Intraoral; periapical, single, first film	5.00
00230	periapical, each additional film	3.00
00240	occlusal, film	7.00
00250	Extraoral; single, first film	5.00
00260	each additional film	4.00
00270	Bitewing; single film	6.00
00272	two films	9.00
00274	four films	12.00
00330	Panoramic; maxilla and mandible, film	30.00
00335	maxilla and mandible, film, with bitewings	35.00
00340	Cephalometric film	34.00

Tests and Laboratory Examinations

00460	Pulp vitality tests	$ 12.00
00470	Diagnostic casts, with report	20.00
00471	Diagnostic photographs	17.00

C. Restorative. The following codes, service descriptions, and maximum fees apply to restorative procedures. Amalgam restorations include polishing.

Amalgam Restorations

Code	Service	Maximum Fee
02110	Amalgam; one surface, deciduous	$ 19.00
02120	two surfaces, deciduous	30.00
02130	three surfaces, deciduous	39.00
02131	four surfaces, deciduous	45.00
02140	one surface, permanent	20.00

02150	two surfaces, permanent	30.00
02160	three surfaces, permanent	40.00
02161	four or more surfaces, permanent	49.00
02190	Pin retention, exclusive of amalgam	10.00
	Silicate Restorations	
02210	Silicate cement per restoration	$ 15.00
	Acrylic or Plastic Restorations	
02310	Acrylic or plastic	$ 21.00
02330	Composite resin; one surface	25.00
02331	two surfaces	36.00
02332	three surfaces	50.00
02334	Pin retention, exclusive of composite resin	10.00
02335	Composite resin (involving incisal angel)	46.00
	Crowns--Single Restorations Only	
02711	Plastic, prefabricated	$ 85.00
02830	Stainless steel	55.00
02840	Temporary (fractured tooth)	45.00
02892	Steel post and composite or amalgam in addition to crown	65.00
	Other Restorative Services	
02910	Recement inlays	$ 20.00
02920	Recement crowns	18.00
02940	Fillings (sedative)	20.00
02950	Crown buildups, pin retained	54.00

D. Endodontics. The following codes, service descriptions, and maximum fees apply to endodontic procedures. Pulpotomy procedures exclude final restoration. Root canal therapy includes treatment plan, clinical procedures, and follow-up care.

	Pulpotomy	
Code	Service	Maximum Fee
03220	Vital pulpotomy	$ 30.00
	Root Canal Therapy	
03310	Anterior (excludes final restoration)	$ 140.00
03320	Bicuspid (excludes final restoration)	165.00
03330	Molar (excludes final restoration)	215.00
	Periapical Services	

03410	Apicoectomy; performed as separate surgical procedure (per root)	$ 85.00
03420	performed in conjunction with endodontic procedure (per root)	70.00
03430	Retrograde filling	50.00
03440	Apical curettage	75.00

E. Periodontics. The following codes, service descriptions, and maximum fees apply to periodontic procedures. Surgical services include usual post-operative services.

Surgical Services

Code	Service	Maximum Fee
04210	Gingivectomy or gingivoplasty, per quadrant	$ 90.00
04220	Gingival curettage and root planing	50.00
04260	Osseous surgery (including flap entry and closure), per quadrant	200.00

Adjunctive Periodontal Services

04330	Occlusal adjustment; limited	$ 30.00
04331	complete	75.00

F. Prosthodontics, removable. The following codes, service descriptions, and maximum fees apply to removable prosthodontics. Complete and partial denture procedures include six months post-delivery care.

Complete Dentures

Code	Service	Maximum Fee
05110	Complete upper	$ 385.00
05120	Complete lower	385.00
05130	Immediate upper	395.00
05140	Immediate lower	385.00
05151	Identification, upper prosthesis	10.00
05161	Identification, lower prosthesis	10.00

Partial Dentures

05211	Upper, without clasps, acrylic base	$ 200.00
05212	Lower, without clasps, acrylic base	300.00
05216	Upper, with two chrome clasps with rests, acrylic base	385.00
05218	Lower, with chrome clasps with rests,	

		acrylic base	420.00
	05231	Lower, with chrome lingual bar and two clasps, acrylic base	400.00
	05241	Lower, with chrome lingual bar and two clasps, cast base	450.00
	05251	Upper, with chrome palatal bar and two clasps, acrylic base	425.00
	05261	Upper, with chrome palatal bar and two clasps, cast base	450.00
	05292	Full cast partial, with two chrome clasps (upper)	450.00
	05294	Full cast partial, with two chrome clasps (lower)	450.00
		Adjustments to Dentures	
	05410	Complete denture	$ 12.00
	05421	Partial denture (upper)	15.00
	05422	Partial denture (lower)	15.00
		Repairs to Dentures	
	05610	Repair broken complete or partial denture, no teeth damaged	$ 45.00
	05620	Repair broken complete or partial denture, replace one broken tooth	50.00
	05630	Replace additional teeth, each tooth	20.00
	05640	Replace broken tooth or denture, no other repairs	40.00
	05650	Adding tooth to partial denture to replace extracted tooth; each tooth (not involving clasp or abutment tooth)	51.00
	05660	each tooth (involving clasp or abutment tooth)	75.00
	05670	Reattaching damaged clasp on denture	50.00
	05680	Replacing broken clasp with new clasp on denture	60.00
	05690	Each additional clasp with rest	50.00
		Denture Duplication	
	05710	Duplicate upper or lower complete denture	$ 175.00

05720	Duplicate upper or lower partial denture		150.00
	Denture Relining		
05730	Relining upper or lower complete denture (office recline)	$	110.00
05740	Relining upper or lower partial denture (office recline)		110.00
05750	Relining upper or lower complete denture (laboratory)		125.00
05760	Relining upper or lower partial denture (laboratory)		125.00
	Other Prosthetic Services		
05820	Denture, temporary (partial-stayplate), upper	$	150.00
05850	Tissue conditioning		23.00

G. Prosthodontics, fixed. The following codes, service descriptions, and maximum fees apply to fixed prosthodontics.

Repairs

Code	Service	Maximum Fee
06620	Replace broken facing where post is intact	$ 50.00
06640	Replace broken facing with acrylic	40.00
	Other Prosthetic Services	
06930	Recement bridge	$ 25.00

H. Oral surgery. The following codes, service descriptions, and maximum fees apply to oral surgery procedures. Surgical extractions include local anesthesia and routine post-operative care. Surgical excisions apply to excision of reactive inflammatory lesions (scar tissue or localized congenital lesions).

Extractions

Code	Service	Maximum Fee
07110	Single tooth	$ 22.00
07120	Each additional tooth	20.00
	Surgical Extractions	
07210	Extraction of tooth, erupted	$ 50.00
07220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	68.00
07230	Impaction that requires incision of overlying	

		soft tissue, elevation of a flap, removal	
		of bone and the removal of the tooth	85.00
	07240	Impaction that requires incision of overlying	
		soft tissue, elevation of a flap, removal of	
		bone and sectioning of the tooth for removal	95.00
	07241	Impaction that requires incision of overlying	
		soft tissue, elevation of a flap, removal of	
		bone, sectioning of the tooth for removal,	
		and presents unusual difficulties and	
		circumstances	100.00
	07250	Root recovery (surgical removal of residual	
		root)	45.00
		Other Surgical Procedures	
	07280	Surgical exposure of impacted or unerupted	
		tooth for orthodontic reasons, including wire	
		attachment where indicated	$ 80.00
	07285	Biopsy of oral tissue (hard)	75.00
	07286	Biopsy of oral tissue (soft)	60.00
		Alveoloplasty	
		(surgical preparation of ridge for dentures)	
	07310	Per quadrant, in conjunction with extractions	$ 50.00
	07320	Per quadrant, not in conjunction with	
		extractions	65.00
		Surgical Excision	
	07410	Radical excision; lesion diameter up to	
		1.25 centimeters	$ 50.00
	07425	Excision pericoronal gingiva	25.00
		Removal of Cysts and Neoplasms	
	07450	Removal of odontogenic cyst or tumor, up to	
		1.25 centimeters diameter	$ 100.00
		Surgical Incision	
	07510	Incision and drainage of abscesses, intraoral	$ 28.00
		Other Repair Procedures	
	07960	Frenulectomy, separate procedure (frenectomy	
		or frenotomy)	$ 60.00

I. Orthodontics. The following codes, service descriptions,

and maximum fees apply to orthodontic procedures.

Diagnostic Procedures

Code	Service	Maximum Fee
08010	Examination, OIS sheet, photos	$ 25.00
08020	Full ortho case study	75.00

J. Miscellaneous. The following codes, service descriptions, and maximum fees apply to miscellaneous dental procedures not listed elsewhere.

Code	Service	Maximum Fee
09110	Palliative (emergency) treatment of dental pain, minor procedures	15.00
	Anesthesia	
09220	General	$ 40.00
09230	Analgesia	10.00
	Professional Consultation	
09310	Consultation, per session	$ 20.00
	Professional Visits	
09410	House calls	$ 15.00
09420	Hospital calls	12.00
09430	Office visit, during regularly scheduled office hours (no operative services performed)	11.00
09440	Office visit, after regularly scheduled office hours (no operative services performed and no other services rendered)	28.00
	Drugs	
09610	Therapeutic drug injection (excluding drug cost)	$ 13.50
	Miscellaneous Other Services	
09910	Application of desensitizing medicaments (where not included or implied in associated procedure)	$ 10.00

4 MCAR S 1.0026 Optometrists, opticians.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed optometrists and opticians.

B. Basic optometric services. The following codes, service

descriptions, and maximum fees apply to basic optometric services.

Code	Service	Maximum Fee
80101	Basic vision examination and diagnosis, to include the following minimum procedures: case history; visual acuity, distance and near; internal and external eye health examination; subjective refraction for distance and near; phorometric tests of accommodation, convergence, and binocular coordination at far and near point; visual skills; and case analysis and presentation	$ 30.00
80102	Basic vision examination and diagnosis, presbyopic (over 30) to include the following procedures: all included in 80101, except visual skills may be deleted; and tonometry and field screening	35.00
80103	Single vision prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	24.43
80104	Single vision dispensing services (includes frame selection, fitting, and servicing)	22.98
80113	Multifocal prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	29.80
80114	Multifocal dispensing services (includes frame selection, fitting, and servicing)	24.50
80105	Office call: visual screening or evaluation of patient's complaint to determine need for further examination	12.00
80106	Out of office call	10.00

C. Low vision prescription device. The following codes, service descriptions, and maximum fees apply to low vision prescription devices. The services and codes listed are to be

employed in place of 80103 and 80104.

Code	Service	Maximum Fee
80403	Prescription services, including: frame measurement, vertex distance measurement; computation of lens specifications; and verification of completed prescription	$ 51.00
80404	Dispensing services, including: frame selection; and fitting and servicing	27.00

D. Miscellaneous services. The following codes, service descriptions, and maximum fees apply to miscellaneous services not listed elsewhere. The services listed shall not be employed for follow-up services included in prior charges to established patients. The services listed do not include laboratory or materials charges.

Code	Service	Maximum Fee
80801	Minor refitting	$ 5.00
80811	Complete refitting	4.60
80802	Frame replacements with necessary adjustments	16.00
80803	Front replacements with necessary adjustments	12.00
80804	One or both temple replacements with necessary adjustments	6.10
80805	Hinge repair	5.00
80807	Minor frame repair and readjustment of frame, including: replacement of screws; supply of new nose pads; supply of temple covers; supply of pad covers; soldering; and other miscellaneous minor repairs	4.30
80808	Neutralization of lenses for copy of prescription	4.00
80809	Lens replacement; one lens, single vision	12.00
80810	both lenses, single vision	21.40
80819	one lens, multifocal vision	19.81
80820	both lenses, multifocal vision	42.10

E. Materials, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office

visits or other professional services.

Code	Service	Maximum Fee
80107	Frames	$ 16.00
80108	Single vision lenses	17.20
80111	Multifocal lenses	32.60
80118	Lenses for aphakia	61.00

4 MCAR S 1.0027 Audiologists and speech pathologists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to audiologists and to speech pathologists certified by the American Speech and Hearing Association.

B. Audiology. The following codes, service descriptions, and maximum fees apply to audiology services.

Code	Service	Maximum Fee
21010	Basic hearing evaluation	$ 40.00
21021	Limited hearing evaluation	32.00
21022	Extended hearing evaluation	64.00
21031	Limited site of auditory lesion evaluation	16.00
21032	Extended site of auditory lesion evaluation	32.00
21050	Basic prescription hearing aid evaluation	45.00
21052	Extended prescription hearing aid evaluation	45.00
21053	Performance evaluation of specific hearing aid	20.00
21081	Hearing screening, group	9.50

C. Speech pathology. The following codes, service descriptions, and maximum fees apply to speech pathology services.

Code	Service	Maximum Fee
22010	Basic speech, language, or voice evaluation	$ 70.00
22012	Extended speech, language, or voice evaluation	20.00
22013	Speech, language, or voice reevaluation	7.50
22060	Basic consultation	30.00
22070	Rehabilitation one-fourth hour, individual	15.00
22071	Rehabilitation one-half hour, individual	30.00
22072	Rehabilitation one hour, individual	45.00
22073	Rehabilitation one-half hour, group	15.00

22074	Rehabilitation one hour, group		30.00

4 MCAR S 1.0028 Physical therapists and occupational therapists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to registered physical therapists and occupational therapists.

B. Physical therapy. The following codes, service descriptions, and maximum fees apply to physical therapy procedures.

Evaluations

Code	Service	Maximum Fee
24001	Physical function evaluation; initial 15-minute unit	$ 22.00
24010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	15.00
24011	additional 15-minute units	15.00
24015	Activities of daily living evaluation; initial 15-minute unit	25.00
24016	additional 15-minute units	25.00

Physical Restoration Procedures

09440	Office visit with one of the following modalities to one area;	
	1. Hot or cold packs	
	2. Traction, mechanical	
	3. Electrical stimulation	
	4. Ultrasound	
	5. Vasopneumatic devices	
	6. Paraffin bath	
	7. Microwave	
	8. Whirlpool	
	9. Diathermy	
	10. Infrared	
	11. Ultraviolet	$ 25.00
09441	Office visit with two or more modalities to the same area	32.00
09444	Office visit with one of the following procedures to one area; initial 30 minutes	

		1. Therapeutic exercises	
		2. Neuromuscular reeducation	
		3. Functional activities	
		4. Gait training	
		5. Orthotics training	
		6. Prosthetics training	
		7. Electrical stimulation (manual)	
		8. Iontophoresis	
		9. Traction, manual	
		10. Massage	
		11. Contract baths	19.00
	09445	each additional 15 minutes	6.00
	09447	Office visit including combination of any modality and procedure;	
		initial 30 minutes	26.00
	09448	each additional 15 minutes	11.50
		Maintenance Therapy Procedures	
	24201	Maintenance therapy procedures;	
		initial 15-minute unit	$ 7.50
	24202	additional 15-minute units	7.50
	24203	one hour	14.50
	24301	Consultation with report--for specific individual patient; initial 15-minute unit	7.50
	24302	additional 15-minute units	7.50

C. Occupational therapy. The following codes, service descriptions, and maximum fees apply to occupational therapy procedures.

Evaluations

Code	Service	Maximum Fee
23010	Perceptual, sensory, or motor evaluation;	
	initial 15-minute unit	$ 27.00
23011	additional 15-minute units	27.00
23015	Activities of daily living evaluation;	
	initial 15-minute unit	12.00
23016	additional 15-minute units	12.00

Physical Restoration Procedures

23100	Activities of daily living training;		
	initial 15-minute unit	$	12.00
23101	additional 15-minute units		12.00
23115	Dexterity or coordination training;		
	initial 15-minute unit		12.00
23116	additional 15-minute units		12.00
23135	Neurodevelopmental training;		
	initial 15-minute unit		12.00
23136	additional 15-minute units		12.00
23150	Perceptual, sensory, or motor training;		
	one hour group session		24.00
23151	initial 15-minute unit, individual		12.00
23152	additional 15-minute units, individual		12.00
	Consultation Services		
23300	Consultation with report, for specific		
	individual patient; initial 15-minute unit	$	7.50
23301	additional 15-minute units		12.00

4 MCAR S 1.0029 Chiropractors.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed doctors of chiropractic medicine.

B. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
09510	Routine initial examination, history and diagnosis	$ 30.00
09501	Intermediate examination, history and diagnosis	30.00
09502	Extensive examination with history and diagnosis, complete history and physical examination of one or more systems, with report.	50.00
09506	Intermediate examination or evaluation, same illness, established patient, progress examination, with report	27.00
09509	Home or nursing home visit with routine chiropractic examination or treatment	

		which includes adjustment, manipulation or one unit of conjunctive therapy for the same or new condition	42.00
	09503	Office visit with cast application to one area, for example, short arm, short leg, knee, or elbow, excluding materials	22.00
	09508	Office visit with cast application to one area, for example, long leg, thoracolumbar, lumbosacral, or full body corset type, excluding materials	32.00
	09009	Same visit, each additional conjunctive or manipulative therapy per anatomical area of diagnosis, for example, neck, back, extremities --anatomical areas include associated soft tissues and nerves	10.00
	09504	Treatment, one unit of manipulative or conjunctive therapy (specify)	18.00
	09505	Treatment, one unit of manipulative and one-half unit of conjunctive therapy (specify)	24.00
	09194	Thermography, initial or subsequent, used for evaluative purposes	15.00
	09507	Ambulation traction application	11.00

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

Chest

Code	Service	Maximum Fee
71010	Radiologic examination, chest; (single view, posteroanterior)	$ 42.00

Spine and Pelvis

72010	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral)	$ 50.00
72040	Radiologic examination, spine, cervical; limited (anteroposterior and lateral)	30.00
72050	comprehensive (minimum of four views)	30.00

72052	comprehensive (minimum of seven views including flexion and extension)		30.00
72070	Radiologic examination, spine; thoracic, (anteroposterior and lateral)		36.00
72080	thoracic, limited (anteroposterior and lateral)		40.00
72090	scoliosis study, comprehensive		34.00
72100	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral)		40.00
72110	lumbosacral, comprehensive (minimum of five views)		51.00
72120	Radiologic examination, spine, lumbosacral, bending views only (minimum of four views)		40.00
72170	Radiologic examination, pelvis; limited (minimum of two views)		44.00
72190	complete (minimum of three views)		70.00
	Upper Extremeties		
73020	Radiologic examination, shoulder; limited (one projection)	$	22.50
73030	comprehensive, complete study		22.00
73070	Radiologic examination, elbow; limited (anteroposterior and lateral)		30.00
73100	Radiologic examination, wrist; limited (anteroposterior and lateral)		25.00
73120	Radiologic examination, hand		20.00
	Lower Extremities		
73500	Radiologic examination, hip; limited (one view)	$	24.50
73560	Radiologic examination, knee; limited (two views)		30.00
73570	Radiologic examination, knee; comprehensive (minimum of three views)		36.00
73600	Radiologic examination, ankle; limited (two views)		22.50
73610	comprehensive (minimum of three views)		22.50
73620	Radiologic examination, foot;		

		limited (two views)	20.00
	73630	complete routine study (minimum of three views)	25.00
		Miscellaneous	
	76140	Consultation on x-ray examination made elsewhere, written report	$ 25.00

D. Laboratory. The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles (codes 8003-80019) include the following tests:

Albumin	Phosphorus
Bilirubin, direct	Potassium
Bilirubin, total	Protein, total
Calcium	Red blood cell count
Carbon dioxide content	Sodium
Cephalin flocculation	Sugar (glucose)
Chlorides	Thymol turbidity
Cholesterol	Transaminase, gluten, exalic (SGOT)
Creatinine	Transaminase, gluten, pyruvic (SGPT)
Hemoglobin	Triglycerides
Hematocrit	Urea nitrogen
Lactic dehydrogenase	Uric acid
Phosphatase, acid	White blood cell count
Phosphatase, alkaline	

Code	Service	Maximum Fee
80003	Standard profile (up to and including 12 tests) for arthritic, bone, lipid and thyroid	$ 40.00
80016	13-16 clinical chemistry tests	35.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	55.00
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	10.00
81002	routine, without microscopy	10.00
85022	Blood count; hemogram, automated (CBC) with	

	differential WBC count	17.00

4 MCAR S 1.0030 Podiatrists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed doctors of podiatric medicine.

B. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Patient Visits

Code	Service	Maximum Fee
09000	Initial office visit, routine, new patient or new illness, history and examination	$ 25.00
09003	Follow-up office visit, brief, for example, routine injection, minimal dressing	15.00
09004	Follow-up office visit, routine	17.00
09005	Follow-up office visit necessitating professional care over and above routine visit	23.50
09006	Follow-up office visit, prolonged, over and above 09005	18.00
09001	Initial hospital visit, limited	35.00
09002	Comprehensive hospital visit	22.00
09010	Initial home or convalescent home visit, routine, new patient or new illness, history and examination	17.00
09013	Follow-up home or convalescent home visit, brief, for example, routine injection, minimal dressing	13.00
09014	Intermediate home or convalescent home examination, evaluation, or treatment, new illness or same illness	20.00
09028	Consultation requiring limited examination or evaluation of a given system but not requiring a complete diagnostic history and examination	25.00

Physical Medicine

09440	Office visit with one or more of the following modalities to one area:	
	Hot or cold packs	Paraffin bath

Traction, mechanical Microwave
Electrical stimulation Whirlpool
Ultrasound Diathermy
Vasopneumatic devices Infrared
Ultraviolet $ 16.00

C. Surgery. The following codes, service descriptions, and maximum fees apply to surgical services. An asterisk (*) indicates that the service includes the surgical procedure only. All other services include the operation per se, and normal uncomplicated pre- and postoperative follow-up care.

Integumentary System

Code	Service	Maximum Fee
00125*	Drainage of onychia or paronychia	$ 20.00
00160*	Debridement of extensively eczematized or infected skin up to ten percent of the body surface	18.00
00162*	Debridement of nails, any method; five or less	13.00
00163*	each additional five nails or major portion thereof	8.00
00164	Debridement of abrasions	20.00
00171	Biopsy, excision of skin, subcutaneous tissue or mucus membrane for biopsy including simple closure as an independent procedure	25.00
00175	Excision of benign cicatrical, fibrous inflammatory, congenital, cystic, and other lesion of skin, subcutaneous tissue or mucous membrane; one lesion, diameter up to one-fourth inch (0.6 centimeter)	10.00
00225*	Avulsion, nail, partial or complete, simple	17.00
00228	Excision of nail or nail matrix, partial or complete, for example, ingrown or deformed nail for permanent removal	150.00
00403*	Electro-surgical destruction or cemocantery or cryocautery of benign or pre-malignant lesion with or without curettement, one lesion	20.00

D. Radiology. The following codes, service descriptions,

and maximum fees apply to radiology services.

Code	Service	Maximum Fee
07307	Radiologic examination, ankle; two views	$ 28.00
07308	complete, minimum of three views	30.00
07309	Radiologic examination, foot; two views	29.00
07310	complete routine study, minimum of three views	42.00

E. Material, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services, unless explicitly stated.

Code	Service	Maximum Fee
01209	Fitted orthotic balanced appliance: metal, thermoplastic, or other; unilateral	$ 75.00
01259	bilateral	150.00
01309	Fitted orthotic balanced appliance: leather, cork celastic; unilateral	60.00
01359	bilateral	135.00
01409	Latex shield or urethane mold	30.00
01509	Negative impression for fitted orthotic, unilateral	20.00
01609	Shoe therapy, adding, fiberglass, modification; unilateral	25.00
01659	bilateral	35.00
01809	Post-surgical splint (Reece surgical shoe)	17.50
01909	Strappings for partial immobilization of foot or ankle	15.00
02009	Foot, ankle, leg measurements (bio-mechanical evaluation) for orthotics, prosthetics for foot deformities	25.00
06600	Sterile surgical tray set-up (supplies)	40.00

4 MCAR S 1.0031 Psychologists and social workers.

A. Scope. The codes, service descriptions, and maximum fees of this rule apply to licensed psychologists and social workers with the master of social work degree or a comparable degree.

B. Psychological services. The following codes, service

descriptions, and maximum fees apply to psychological services.

Code	Service	Maximum Fee
09046	Initial office visit with evaluation and history, one hour	$ 65.00
09048	Initial inpatient hospital visit, including history and evaluation, per hour	62.50
09066	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour	65.00
09067	Psychotherapy, group (maximum ten persons per group) 1-1/2 hours per person	35.00
09068	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour	40.00
09070	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge)	60.00

C. Social workers counseling. The following codes, service descriptions, and maximum fees apply to counseling by social workers.

Code	Service	Maximum Fee
25210	Individual client counseling; initial 30-minute unit	$ 30.00
25211	additional 30-minute units	30.00
25215	Family counseling; initial 30-minute unit	21.00
25216	additional 30-minute units	21.00

4 MCAR S 1.0032 Hospital--semi-private room charges.

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

daily room charge.

B. Group 1. The following hospitals make up group 1:

Abbott Northwestern Hospital, Minneapolis
Bethesda Lutheran Medical Center, St. Paul
The Children's Hospital, St. Paul
Divine Redeemer Memorial Hospital, South St. Paul
Eitel Hospital, Minneapolis
Fairview Hospital, Minneapolis
Fairview-Deaconess Hospital, Minneapolis
Fairview-Southdale Hospital, Minneapolis
Gillette Children's Hospital, St. Paul
Golden Valley Health Center, Golden Valley
Mercy Medical Center, Coon Rapids
Methodist Hospital, St. Louis Park
Metropolitan Medical Center, Minneapolis
Midway Hospital, St. Paul
Miller-Dwan Medical Center, Duluth
Minneapolis Children's Hospital, Minneapolis
Mounds Park Hospital, St. Paul
Mount Sinai Hospital, Minneapolis
North Memorial Medical Center, Robbinsdale
Saint Cloud Hospital, St. Cloud
St. John's Hospital, St. Paul
St. Joseph's Hospital, St. Paul
St. Luke's Hospital, Duluth
St. Mary's Hospital, Duluth
St. Mary's Hospital, Minneapolis
The Samaritan Hospital, St. Paul
Sister Kenny Institute, Minneapolis
United Hospital, St. Paul
Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semi-private room charge for one day	$ 175.00

C. Group 2. The following hospitals make up group 2:

A. L. Vadheim Memorial Hospital, Tyler
Ada Municipal Hospital, Greenbush

Aitkin Community Hospital, Aitkin
Albany Community Hospital, Albany
Appleton Municipal Hospital, Appleton
Arlington Municipal Hospital, Arlington
Arnold Memorial Hospital, Adrian
Buffalo Memorial Hospital, Buffalo
Caledonia Community Hospital, Caledonia
Canby Community Hospital, Canby
Central Mesabi Medical Center, Hibbing
Chippewa County-Montevideo Hospital, Montevideo
Chisago Lakes Hospital, Chisago City
Clarkfield Memorial Hospital, Clarkfield
Clearwater County Memorial Hospital, Bagley
Cloquet Community Memorial Hospital, Cloquet
Comfrey Hospital, Comfrey
Community Hospital--Cannon Falls, Cannon Falls
Community Hospital--St. Peter, St. Peter
Community Memorial Hospital--Deer River, Deer River
Community Memorial Hospital--Spring Valley, Spring Valley
Community Memorial Hospital--Winona, Winona
Community Mercy Hospital--Onamia, Onamia
Cook Community Hospital, Cook
Cook County Northshore Hospital, Grand Marais
Cuyuna Range District Hospital, Crosby
Dr. Henry Schmidt Memorial Hospital, Westbrook
District Memorial Hospital--Forest Lake, Forest Lake
Divine Providence Hospital, Ivanhoe
Douglas County Hospital, Alexandria
Ely-Bloomenson Community Hospital, Ely
Eveleth Fitzgerald Community Hospital, Eveleth
Fairmont Community Hospital, Fairmont
Fairview Princeton Hospital, Princeton
Fosston Municipal Hospital, Fosston
Gaylord Community Hospital, Gaylord
Glacial Ridge Hospital, Glennwood
Glencoe Municipal Hospital, Glencoe

Granite Falls Municipal Hospital, Granite Falls
Grant County Hospital, Elbow Lake
Greenbush Community Hospital, Greenbush
Harmony Community Hospital, Harmony
Hendricks Community Hospital, Hendricks
Heron Lake Municipal Hospital, Heron Lake
Holy Trinity Hospital, Graceville
Hutchinson Community Hospital, Hutchinson
Immanuel-St.Joseph's Hospital, Mankato
International Falls Memorial Hospital, International Falls
Itasca Memorial Hospital, Grand Rapids
Jackson Municipal Hospital, Jackson
Johnson Memorial Hospital, Dawson
Kanabec Hospital, Mora
Karlstad Health Facilities, Karlstad
Kittson Memorial Hospital, Hallock
Lake City Hospital, Lake City
Lake Region Hospital, Fergus Falls
Lake View Memorial Hospital, Two Harbors
Lakefield Municipal Hospital, Lakefield
Lakeview Memorial Hospital, Stillwater
Littlefork Municipal Hospital, Littlefork
Long Prairie Memorial Hospital, Long Prairie
Luverne Community Hospital, Luverne
Madelia Community Hospital, Madelia
Madison Hospital, Madison
Mahnomen County-Village Hospital, Mahnomen
Meeker County Memorial Hospital, Litchfield
Melrose Hospital, Melrose
Memorial Hospital--Cambridge, Cambridge
Memorial Hospital--Perham, Perham
Memorial Community Hospital--Bertha, Bertha
Mercy Hospital, Moose Lake
Milaca Area Hospital, Milaca
Minnesota Valley Memorial Hospital, Le Sueur
Minnewaska District Hospital, Starbuck

Monticello-Big Lake Community Hospital, Monticello
Mountain Lake Community Hospital, Mountain Lake
Murray County Memorial Hospital, Slayton
Naeve Hospital, Albert Lea
North Country Hospital, Bemidji
Northern Itasca Hospital, Big Fork
Northfield City Hospital, Northfield
Northwestern Hospital, Thief River Falls
Olmsted Community Hospital, Rochester
Ortonville Hospital, Ortonville
Owatonna City Hospital, Owatonna
Parkers Prairie District Hospital, Parkers Prairie
Paynesville Community Hospital, Paynesville
Pelican Valley Health Center, Pelican Valley
Pipestone County Hospital, Pipestone
Queen of Peace Hospital, New Prague
Redwood Falls Municipal Hospital, Redwood Falls
Regina Memorial Hospital, Stillwater
Renville County Hospital, Olivia
Rice County District One Hospital, Faribault
Rice Memorial Hospital, Willmar
Riverview Hospital, Crookston
Roseau Area Hospital, Roseau
Rush City Hospital, Rush City
St. Ansgar Hospital, Moorhead
St. Elizabeth Hospital, Wabasha
St. Francis Hospital, Breckenridge
St. Francis Regional Medical Center, Shakopee
St. Gabriel's Hospital, Little Falls
St. John's Hospital, Browerville
St. John's Hospital, Red Lake Falls
St. John's Hospital, Red Wing
St. Joseph's Hospital, Brainerd
St. Joseph's Hospital, Park Rapids
St. Mary's Hospital, Detroit Lakes
St. Mary's Hospital, Winstead

St. Michael's Hospital, Sauk Centre
St. Olaf Hospital, Austin
Sandstone Area Hospital, Sandstone
Sanford Memorial Hospital, Farmington
Sioux Valley Hospital, New Ulm
Sleepy Eye Municipal Hospital, Sleepy Eye
Springfield Community Hospital, Springfield
Stevens County Memorial Hospital, Morris
Swift County-Benson Hospital, Benson
Tracy Municipal Hospital, Tracy
Tri-County Hospital, Wadena
Trimont Community Hospital, Trimont
Trinity Hospital, Baudette
Tweeten Memorial Hospital, Spring Grove
United District Hospital, Staples
United Hospital, Blue Earth
Virginia Regional Medical Center, Virginia
Waconia Ridgeview Hospital, Waconia
Warren Community Hospital, Warren
Waseca Area Memorial Hospital, Waseca
Weiner Memorial Medical Center, Marshall
Wells Municipal Hospital, Wells
White Community Hospital, Aurora
Windom Area Hospital, Windom
Zumbrota Community Hospital, Zumbrota

Service	Maximum Fee
Group 2 semi-private room charge for one day	$ 138.00

D. Group 3. The following hospitals make up group 3:
Hennepin County Medical Center, Minneapolis
St. Paul Ramsey Medical Center, St. Paul
University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semi-private room charge for one day	$ 210.00

E. Group 4. The following hospitals make up group 4:
Rochester Methodist Hospital, Rochester
St. Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semi-private room charge for one day	$ 138.63

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT 10 1983
Jean Hoover
Secretary of State

3:56 pm

APPROVED AS TO FORM AND LEGALITY
October 7 1983
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY Martha J Cassedy
~~SPECIAL ASSISTANT ATTORNEY GENERAL~~
Legal assistant

The state's investigation of appellant's business operations pursuant to Minn. Stat. § 8.31 (1982) is not discriminatory enforcement and does not violate the equal protection clause of the fourteenth amendment.

Affirmed in part, reversed in part, and remanded for further proceedings. Simonett, J.

C8-82-1062 State of Minnesota, Appellant, vs. Donald Marvil Yahnke. Scott County.

Affidavit in support of application for search warrant established probable cause to justify the search of defendant's residence; trial court erred in ruling that the search was illegal and in suppressing evidence as the fruit of that search.

Reversed and remanded for trial. Kelley, J.

C4-82-765 St. Paul Fire Fighters, Local 21, vs. City of St. Paul, Appellant. Ramsey County.

The decision to establish a training program in which all fire captains must participate in an inherent managerial policy decision which a public employer is not required to negotiate.

A public employer is required to negotiate those aspects of implementation of a managerial policy decision which affect working conditions and are neither essential to the basic decision nor inimical to public safety and welfare.

Affirmed as modified. Coyne, J.

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, 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.

Commerce Department

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Medical Fee Review for Workers' Compensation

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate new rules governing medical fee review for workers' compensation. Promulgation of these rules is authorized by Minnesota Statutes 1982, section 176.136.

The Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing to: John Klein, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101, (612) 297-3238.

All statements of information and comment shall be accepted until August 20, 1983. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

Reynaud L. Harp
Deputy Commissioner of Commerce

Commerce Department

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Joint Self-Insurance Employee Health Plans

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate new rules governing joint self-insurance employee health plans. Promulgation of these rules is authorized by Minnesota Statutes, section 62H.06 (Laws 1983, Ch. 241, § 6).

file

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, 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 Insurance Division

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Medical Fee Review for Workers' Compensation

Notice is hereby given that the Insurance Division is seeking information or opinion from sources outside the agency in preparing to promulgate new rules governing medical fee review for workers' compensation. The promulgation of these rules is authorized by Laws of Minnesota 1981, Chapter 346, § 87. This section requires this agency to establish by rule procedures to "limit the charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135, to the 75th percentile of usual and customary fees or charges based upon billings for each class of health care provider during all of the calendar year preceding the year in which the determination is made of the amount to be paid the health care provider for the billing."

The Insurance Division requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statement of information or comment orally or in writing. Written statements should be addressed to:

William R. Howard
Assistant Commissioner of Insurance
500 Metro Square Building
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at 297-2852 and in person at the above address.

All statements of information and comment shall be accepted until July 15, 1981. Any written material received by the Insurance Division shall become part of the record in the event that the rules are promulgated.

June 5, 1981

William R. Howard
Assistant Commissioner of Insurance

Department of Commerce Insurance Division

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Exempting Insurers from Certain Filing Requirements for Commercial Lines of Insurance

Notice is hereby given that the Insurance Division is seeking information or opinion from sources outside the agency in preparing to promulgate new rules exempting insurers and rate service organizations from certain filing requirements for commercial lines of insurance. The promulgation of these rules is authorized by Minn. Stat. § 70A.02, subd. 3. This subdivision permits the Commissioner of Insurance to exempt specific kinds of insurance from any of the provisions of Chapter 70A if he finds the application of those provisions unnecessary to achieve the purposes of that chapter.

The Insurance Division requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing. Written statements should be addressed to:

Matthew Glover
Insurance Division
500 Metro Square Building
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at 297-2854 and in person at the above address.

Any written material received by the Insurance Division shall become part of the record in the event that the rules are promulgated.

June 8, 1981

William R. Howard
Assistant Commissioner of Insurance

Energy Agency
Alternative Energy Development Division

Notice of Intent to Solicit Outside Opinion Concerning Rules Relating to the District Heating Bonding Act

Notice is hereby given that the Minnesota Energy Agency (hereinafter "agency") is soliciting information and opinions from sources outside the agency for the purpose of making rules authorized under the District Heating Bonding Act, Chapter 334, Laws of Minnesota 1981 (hereinafter "act").

The agency is considering promulgating rules covering three related but separate areas of district heating financing: 1) design loans; 2) planning grants; 3) design and construction loans. The first mentioned area will be subject to temporary rules until permanent rules can be prepared and adopted. The latter two areas will be subject only to permanent rules. Data and opinions in all areas are invited.

Temporary rules will be promulgated for the purpose of allowing those projects that have already completed comprehensive engineering, economic and design studies to quickly make proper application for, and in due course receive design loans. The temporary rules may differ substantially from the permanent rules. Information the agency is considering to require in the rule includes but is not limited to, the following:

A. The method and procedure by which a municipality makes application for financial aid under the act. Applicants may be required to provide, for example, a comprehensive business plan that contains no less than:

1. A preliminary engineering design of the heat source, distribution and transmission system, and customer conversions of selected major loads;

2. A market study that includes detailed information of fuel consumption and building heating system for 90% of the proposed thermal load;

3. A preliminary plan that shows how the system might be expanded to serve other parts of the community;

4. An economic analysis that includes: cash flow, income and balance sheet for a 20-year planning period;

5. Letters of intent from major customers (representing 50% of thermal load), to the owner of the heat source or the proposed system owner/operator;

6. An opinion by a registered professional engineer that the system described by the preliminary designs is technically feasible and that the preliminary engineering design and cost estimate is within standard engineering practice;

7. An opinion by a Certified Management Consultant that based on the assumptions in the preliminary economic analysis proceeding with the final planning phase of the projects is justified;

8. A resolution in support of the project from the governing body of the municipality;

9. A Negative Declaration from an Environmental Assessment Worksheet.

B. The criteria by which an application for financial aid under this act is reviewed. Priority may be given, for example, to those applications that:

1. Utilize coal or presently wasted heat,

2. Use hot water as a transfer medium.

All persons desiring to submit information or views on these or related subjects may do so either orally or in writing. Written or oral comment should be addressed to:

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Temporary Rules Governing Reimbursement for Workers' Compensation Medical Services

ORDER FOR PUBLICATION OF TEMPORARY RULES

IT IS ORDERED this 22nd day of August, 1983 that the proposed temporary rules in the above-entitled matter be published in the State Register.

Michael A. Hatch
Commissioner of Commerce

Department of Commerce

Proposed Temporary Rules Governing
Reimbursement for Workers' Compensation
Medical Services

Notice of Intent to Adopt Temporary Rules

Notice is hereby given that the Department of Commerce is proposing to adopt temporary rules to govern reinbursement for workers' compensation medical services as authorized by Minn. Stat. § 176.136. The proposed rules establish limits for charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment services as defined and compensable under Minn. Stat. § 176.135, to the 75th percentile of usual and customary fees or charges based upon billings for each class of health care provider during 1982. The proposed temporary rules follow this notice.

All interested parties are hereby afforded the opportunity to submit data and views on the proposed temporary rules for 20 days immediately following publication of this material in the State Register. Comments should be submitted in writing to:

John Klein
Department of Commerce
500 Metro Square Building
St. Paul, MN 55101

The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the Department.

After the 20 day comment period, the proposed temporary rules with modifications, if any, will be sent to the Office of the Attorney General for final approval as to form and legality. The temporary rules shall take effect immediately upon the Attorney General's approval.

The temporary rules shall remain in effect until permanent rules are adopted or for 180 days. The temporary rules may also be extended for an additional 180 days.

Dated: August 22, 1983

Michael A. Hatch
Commissioner of Commerce

In the Matter of the Proposed Adoption of
Temporary Rules Relating to Reimbursement
for Workers' Compensation Medical Services

AFFIDAVIT OF
MAILING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Debbi J. Lindlief, being first duly sworn, deposes and says:

That on the 31st day of August, 1983, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Rules Without Public Hearing by depositing in the State of Minnesota Central Mail System for United States mailing at said City of St. Paul, a copy properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules.

A copy of the proposed rules is attached.

Debbi J. Lindlief

Subscribed and sworn to before me this
31st day of August, 1983.

Samuel F. Johnson

SAMUEL F. JOHNSON
NOTARY PUBLIC—MINNESOTA
HENNEPIN COUNTY
My Commission Expires Sept. 29, 1985

STATE OF MINNESOTA

COUNTY OF RAMSEY

CERTIFICATE

In the Matter of the Proposed Adoption of
Temporary Rules Governing Reimbursement
for Workers' Compensation Medical Services

I certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, that their names be placed on file with and maintained by the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules is accurate and complete as of 12:00 P.M., this 31st day of August, 1983.

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AMERICAN FAMILY INSURANCE
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AMERICAN FAMILY MUTUAL INSURANCE COMPANY
AMERICAN STANDARD INSURANCE COMPANY OF WISCONSIN
AMERICAN FAMILY LIFE INSURANCE COMPANY
AMERICAN FAMILY FINANCIAL SERVICES, INC

August 25, 1983

State of Minnesota
AUG 26 1983
Department of Commerce

Michael Hatch, Commissioner
Department of Commerce
500 Metro Square Building
St. Paul, MN 55101

Dear Mr. Hatch:

I am interested in the development of your Review Board as it relates to medical services and Workers' Compensation cases. It is my understanding that this Review Board is being established to assure usual and customary charges for doctor and hospital costs.

Please send me a copy of the rules as they pertain to this committee and its activities since I am involved in medical cost control activities for American Family Insurance.

Sincerely,

Linda Davis

LINDA DAVIS
Medical Services

LD/kaj

return to Dale

STATE REGISTER

STATE OF MINNESOTA



VOLUME 8, NUMBER 10

September 5, 1983

Pages 345-420

STATE REGISTER

Printing Schedule for Agencies

Issue Number	*Submission deadline for Executive Orders, Adopted Rules and **Proposed Rules	*Submission deadline for State Contract Notices and other **Official Notices	Issue Date
	SCHEDULE FOR VOLUME 8		
11	Monday Aug 29	Monday Sept 5	Monday Sept 12
12	Monday Sept 5	Monday Sept 12	Monday Sept 19
13	Monday Sept 12	Monday Sept 19	Monday Sept 26
14	Monday Sept 19	Monday Sept 26	Monday Oct 3

*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 Office of the State Register, 506 Rice Street, St. Paul, Minnesota 55103, (612) 296-0930.

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The *State Register* is the official publication of the State of Minnesota, containing executive orders of the governor, proposed and adopted rules of state agencies, and official notices to the public. Judicial notice shall be taken of material published in the *State Register*.

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PROPOSED RULES

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NOTICE

How to Follow State Agency Rulemaking Action in the *State Register*

State agencies must publish notice of their rulemaking action in the *State Register*. If an agency seeks outside opinion before promulgating new rules or rule amendments, it must publish a NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION. Such notices are published in the OFFICIAL NOTICES section. Proposed rules and adopted rules are published in separate sections of the magazine.

The PROPOSED RULES section contains:

- Calendar of Public Hearings on Proposed Rules.
- Proposed new rules (including Notice of Hearing and/or Notice of Intent to Adopt Rules without A Hearing).
- Proposed amendments to rules already in existence in the Minnesota Code of Agency Rules (MCAR).
- Proposed temporary rules.

The ADOPTED RULES section contains:

- Notice of adoption of new rules and rule amendments (those which were adopted without change from the proposed version previously published).
- Adopted amendments to new rules or rule amendments (changes made since the proposed version was published).
- Notice of adoption of temporary rules.
- Adopted amendments to temporary rules (changes made since the proposed version was published).

ALL ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES published in the *State Register* and filed with the Secretary of State before September 15, 1982, are published in the *Minnesota Code of Agency Rules 1982 Reprint*. ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES filed after September 15, 1982, will be included in a new publication, *Minnesota Rules*, scheduled for publication in spring of 1984. In the MCAR AMENDMENT AND ADDITIONS listing below, the rules published in the *MCAR 1982 Reprint* are identified with an asterisk. Proposed and adopted TEMPORARY RULES appear in the *State Register* but are not published in the *1982 Reprint* due to the short-term nature of their legal effectiveness.

The *State Register* publishes partial and cumulative listings of rule action in the MCAR AMENDMENTS AND ADDITIONS list on the following schedule:

Issues 1-13, inclusive
Issues 14-25, inclusive
Issue 26, cumulative for 1-26
Issue 27-38, inclusive
Issue 39, cumulative for 1-39
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EXECUTIVE ORDERS

Executive Order No. 83-33

Providing for Creation of a Minnesota Tax Study Commission

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, the tax system of Minnesota is complex, many-layered, often controversial and sometimes inequitable; and

WHEREAS, there has been no thorough review of the tax system, including both state and local taxes, for more than twenty-five years; and

WHEREAS, tax changes have been made piecemeal, without regard to the system as a whole and sometimes without knowledge of long-term effects; and

WHEREAS, public confidence in the Minnesota tax system has suffered; and

WHEREAS, the citizens of Minnesota deserve a systematic and learned review of tax and economic policies in order to provide goals and directions for Minnesota into the twenty-first century;

NOW, THEREFORE, I order:

1. There is hereby created a Minnesota Tax Study Commission, its chairperson and members to be appointed by the Governor.

2. It shall be the duty of this Commission to obtain funds from private and public sources in order to hire a staff and perform the research necessary for an extensive study of state and local taxes and economic goals.

3. Funds received by the Commission shall, upon their acceptance by the State Treasurer and Commissioner of Finance pursuant to Minnesota Statutes Chapter 7, become the property of the State of Minnesota. Such funds shall be subject to all standard state accounting methods and procedures and shall further be subject to all appropriate auditing requirements and mechanisms.

4. The Commission is charged with providing the citizens and policymakers of Minnesota a descriptive and analytical survey of the Minnesota economy and of the tax structure as it now exists. The Commission is expected to synthesize research already completed, but perform new research when required.

5. The Commission's goal will be, after extensive research and discussions with citizens throughout the state, to recommend tax policies which will remove inequities, promote economic growth, stabilize revenues for state and local governments, meet the needs of Minnesota's people, and provide Minnesota with a competitive position among the states.

6. The Commission's study shall include, but shall not be limited to, the interrelationships of state and local governments through taxes and state-aid payments, the relationship between taxes and business expansion, the need for and usage of property tax relief programs, the state sales tax and its base, simplification of the income tax system, optional local taxes, the effect of tax policy on development of jobs, the use of tax policy to foster growth industries, tax policy relating to agricultural land, the problems of border areas because of interstate tax differences, the relationship of state spending levels to tax revenues, the appropriate mix of taxes, and the effect of taxes on Minnesota's position among state rankings.

7. The Commission may issue reports as it deems fit, but shall make a full report and recommendation to the Governor and Legislature by December 15, 1984.

8. The Commission may adopt its own rules for the conduct of meetings, hearings, and deliberations, but the goal will be to invite wide public participation and enhancement of the public's knowledge about the Minnesota tax system.

Pursuant to Minnesota Statutes 1982, Section 4.035, this Order shall be effective 15 days after publication in the *State Register* and filing with the Secretary of State and shall remain in effect until it is rescinded by proper authority or it expires in accordance with Section 4.035, Subdivision 3.

IN TESTIMONY WHEREOF, I hereunto set my hand this 8th day of August, 1983.



Executive Order No. 83-34

Providing for the Establishment of the Governor's Task Force on the Minnesota Sports Festival

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, Minnesotans take pride in their quality of life; and

WHEREAS, quality of life is enhanced by physical well-being; and

WHEREAS, the state should encourage physical activity on behalf of all its citizens; and

WHEREAS, a Minnesota Sports Festival would actively promote the concept of lifelong physical activity; and

WHEREAS, the concept of a Minnesota Sports Festival has been endorsed by the United States Olympic Committee and Minnesota sports and fitness groups;

NOW, THEREFORE, I order:

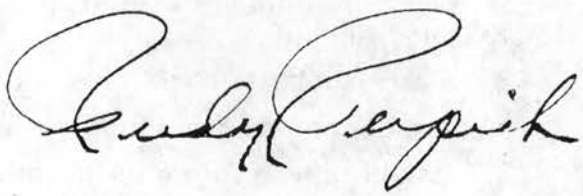
1. That there be established the Governor's Task Force on the Minnesota Sports Festival, consisting of fifteen members to be appointed by the Governor. Members shall be composed of citizens representing the various geographical areas of the state with a commitment to and interest in fitness and sports. The Governor shall appoint a chair from among the Task Force members.

2. That the Task Force serve as a coordinating and administrative body to provide direction for the various groups in the Festival. The Task Force will also be authorized to seek public and private financial support and will operate within the financial resources that are generated.

3. The chair may, subject to approval by the Task Force members, appoint advisory committees composed of individuals who have interest or expertise to assist it in its work.

Pursuant to Minnesota Statutes 1982, Section 4.035, this Order shall be effective 15 days after publication in the *State Register* and filing with the Secretary of State and shall remain in effect until it is rescinded by proper authority or it expires in accordance with Section 4.035, Subdivision 3.

IN TESTIMONY WHEREOF, I hereunto set my hand this 8th day of August, 1983.



Executive Order No. 83-35

Providing for the Establishment of the Governor's Council on Youth

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, it is vital for State government to identify important concerns of youth and to provide the best possible services to the people of the State of Minnesota; and

WHEREAS, to achieve this goal requires a concerted effort to focus on existing delivery systems of state, federal and local levels of government and to provide new services and new directions for addressing concerns of youth; and

WHEREAS, there exists a great number of agencies and institutions involved in the delivery of services to Minnesota youth; and

WHEREAS, no single state agency presently has the function of coordinating the delivery of services to Minnesota youth for which the state is responsible; and

WHEREAS, a council with diverse representation and interdepartmental cooperation can improve the coordination, quantity and quality of services delivered.

NOW, THEREFORE, I order:

1. Creation of the Governor's Council on Youth, hereinafter referred to as the "Council," to consist of fifteen members, not less than one-third of them youth hereinafter defined as all individuals between the approximate ages of 9 and 21 (pre-adolescence through adolescence).

1.1 The Governor shall appoint each member of the Council and designate a member to serve as chair.

1.2 The Council shall create a Youth Advisory Committee and appoint youth as its members. Each Council Youth Member shall also be a member of the Youth Advisory Committee.

1.3 The Council shall create a Technical Advisory Committee and appoint representatives from state agencies, departments, and private organizations serving youth.

1.4 The members of the Council and Youth Advisory Committee shall be entitled to reimbursement of expenses from the Council as permitted by Minnesota Statutes, Section 15.0593.

1.5 The Council Members and Advisory Committee Members shall meet at the call of the Chairperson of their respective bodies and operate pursuant to bylaws adopted by the Council.

2. The Council shall seek funding and resources from private as well as public agencies. An interagency agreement shall be negotiated with state agencies serving youth to provide at least one-half of the support needed by the Council.

3. All actions of the Council shall be by majority vote and shall be taken with the advice of the advisory committees. Duties of the Council shall include:

3.1 The identification of ways and strategies of taking advantage of youth as a resouce.

3.2 Promoting and generating money and other assets in support of programs for youth.

3.3 Establishing a forum for debate and policy advocacy in matters related to youth.

3.4 Coordination of programs in state departments, public and private agencies, and corporations serving youth.

3.5 Providing research and development of opportunities for youth locally, nationally, and internationally.

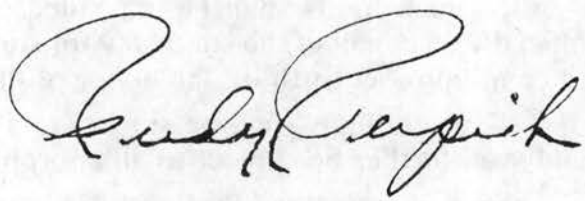
3.6 Providing leadership in innovation and implementation of new programs, designed to best meet the needs of youth in Minnesota.

4. The Lieutenant Governor, with the approval of the Council Chairperson, shall hire an Executive Director who will be in the unclassified state service.

5. The terms of the Council Members and Committee Members shall begin with the effective date of this order and shall expire June 30, 1984. All Members' terms after June 30, 1984 shall be one year terms beginning on July 1 of each new year and ending on June 30 of the following year.

Pursuant to Minnesota Statutes 1982, Section 4.035, this Order shall be effective 15 days after publication in the *State Register* and filing with the Secretary of State and shall remain in effect until it is rescinded by proper authority or it expires in accordance with Section 4.035, Subdivision 3.

IN TESTIMONY WHEREOF, I hereunto set my hand this 17th day of August, 1983.



Executive Order No. 83-36

Providing for the Establishment of the Governor's Council on Economic Development

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Minnesota Constitution and Minn. Stat. 1982, §§ 4.035 and 15.0593, hereby issue this Executive Order:

WHEREAS, it is vital for the State of Minnesota, through its Governor, other state officials and concerned citizens, to take all steps necessary to encourage business presently residing in Minnesota to continue to maintain and expand their business operations in the state; and

WHEREAS, it is also vital for state officials and interested citizens to make thoroughgoing efforts to attract new commercial enterprises to the State of Minnesota; and

WHEREAS, the foregoing economic development activities require the generation of necessary funds and the promulgation of necessary goals and objectives; and

WHEREAS, members of the Minnesota business community should be encouraged and allowed to formally participate in the state's economic development efforts;

NOW, THEREFORE, I order:

1. Creation of the Governor's Council on Economic Development, hereinafter referred to as the "Council," which shall be composed of 15 persons from Minnesota's business community appointed by the Governor.

1.1 The Governor shall appoint a Chairperson and a Vice Chairperson for the Council.

1.2 Members of the Council, including the Chairperson, shall serve one year terms and shall be eligible for reappointment.

1.3 Council members shall be entitled to reimbursement of expenses from the funds discussed in Paragraph 3 of this Order to the extent permitted by Minn. Stat. 1982, § 15.0593.

1.4 The Council shall meet at the call of the Governor, and, with respect to its fund solicitation function, at the call of the Chairperson.

2. The duties of the Council shall be to:

2.1 Solicit funds from private sources for use to promote the economic interest of Minnesota;

2.2 Assist, at the Governor's request, in the establishment of economic development goals, activities and objectives for Minnesota;

2.3 Undertake such other economic development tasks as requested by the Governor

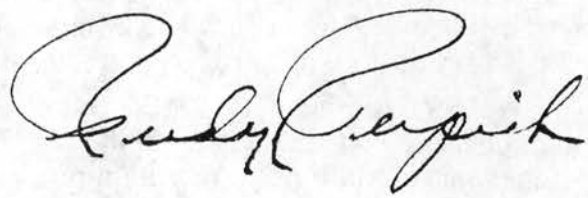
3. Funds received by the Council shall, upon their acceptance by the State Treasurer and Commissioner of Finance pursuant to Minn. Stat. Ch. 7, become the property of the State of Minnesota.

3.1 Such funds shall be expended by the Governor, First Lady or other person acting officially on behalf of the state only for state economic development activities and only pursuant to conditions set forth by the donor of the funds.

3.2 Such funds shall be subject to all standard state accounting methods and procedures and shall further be subject to all appropriate auditing requirements and mechanisms.

Pursuant to Minn. Stat. § 4.035, this Order shall be effective fifteen (15) days after its publication in the *State Register* and filing with the Secretary of State and shall remain in effect until it is rescinded by proper authority or it expires in accordance with either Minn. Stat. 1982, §§ 4.035, subd. 3, or 15.0593.

IN TESTIMONY WHEREOF, I hereunto set my hand this 16th day of August, 1983.



PROPOSED RULES

Pursuant to Minn. Stat. of 1980, §§ 14.21, 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 seven 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 modifications are supported by the data and views submitted.

If, during the 30-day comment period, seven 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 §§ 14.13-14.20 which state that if an agency decides to hold a public hearing, it must publish in the *State Register* a notice of its intent to do so. This notice must appear at least 30 days prior to the date set for the hearing, along with the full text of the proposed rules. (If the agency has followed the provisions of subd. 4h and has already published the proposed rules, a citation to the prior publication may be substituted for republication.)

Pursuant to Minn. Stat. § 14.29, when a statute, federal law or court order to adopt, suspend or repeal a rule does not allow time for the usual rulemaking process, temporary rules may be proposed. Proposed temporary rules are published in the *State Register*, and for at least 20 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Commerce
Board of Architecture, Engineering, Land Surveying and Landscape Architecture

Proposed Rules Amending Fees

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the State Board of Architecture, Engineering, Land Surveying, and Landscape Architecture proposes to adopt the above-entitled rule without a public hearing. The board has determined that the proposed adoption of this rule will be noncontroversial in nature and has elected to follow the procedures set forth in Minn. Stat. §§ 14.21-14.28.

Persons interested in this rule shall have 30 days to submit comments on the proposed rule. The proposed rule may be modified if the modifications are supported by the data and views submitted to the board and do not result in a substantial change in the proposed language.

Unless seven or more persons submit written requests for a public hearing on the proposed rule within the 30-day comment period, a public hearing will not be held. In the event a public hearing is required, the board will proceed according to the provisions of Minn. Stat. §§ 14.13-14.20.

Persons who wish to submit comments or a written request for a public hearing should submit such comments or request to:

Lowell E. Torseth
Executive Secretary
Board of Architecture, Engineering, Land
Surveying and Landscape Architecture
162 Metro Square
Saint Paul, Minnesota 55101
(612) 296-2388

Authority for the adoption of this rule is contained in Minn. Stat. §§ 214.06 and 326.06. Additionally, a statement of need and reasonableness that describes the need and reasonableness of each provision of the proposed rule, and that identifies the data and information relied upon to support the proposed rule, has been prepared and is available from Mr. Torseth upon request.

Upon adoption of the final rule without a public hearing, the proposed rule, this notice, the statement of need and reasonableness, all written comments received, and the final rule as adopted will be delivered to a designee of the Attorney

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.

General who will review the rule as to its legality, including the issue of substantial change, and its form as it relates to legality. Persons who wish to be advised of the submission of this rule for approval, or who wish to receive a copy of the final rule as adopted, should submit a written statement of such request to Mr. Torseth.

A copy of the proposed rule is attached to this notice. Additional copies of this notice and the proposed rule are available and may be obtained by contacting Mr. Torseth.

Please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10 A.01, subd. 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250.00, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) who spends more than $250.00, not including his own traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 40 State Office Building, Saint Paul, Minnesota 55155, telephone (612) 296-5615.

Lowell E. Torseth
Executive Secretary

Rule as Proposed

4 MCAR § 7.004 Fees.

A. Requirements. Application for examination for certification as an engineer-in-training, landscape architect-in-training, or licensure, including renewal of licensure, as an architect, professional engineer, land surveyor, or landscape architect, shall be accompanied by a fee in the amount provided for in this rule. The fee for examination for certification as land surveyor-in-training shall be paid upon approval of the application by the board.

B. Refunds; validity of application. Examination or registration fees may not be refunded. Applications for examination shall be valid for a period of one year following notification of the date of examination, except as hereinafter provided. An applicant who fails to appear for examination shall be required to resubmit his application, together with an examination fee, unless his failure to appear is due to circumstances which, in the opinion of the board, justify relief from the requirement. Any application which is still pending three years after the date of its receipt by the board shall be void.

C. Initial licensure and renewal. The fee for licensure, or renewal of licensure, as an architect, professional engineer, land surveyor, or landscape architect is ~~$17~~ $22.50 per year. The initial license fee is prorated at six-month intervals during each biennium. The fee for months 24 to 18 is ~~$34~~ $45; for months 18 to 12, ~~$25.50~~ $33.75; for months 12 to 6, ~~$17~~ $22.50; and for months 6 to 0, ~~$8.50~~ $11.25. The renewal fee shall be paid biennially on or before June 30 of each even-numbered year. The board may delete from the roster the name of any licensee who fails to timely pay the required renewal fee. The renewal fee, when paid by mail, is not timely paid unless it is postmarked on or before June 30 of each even-numbered year.

D. Delayed renewal fee. A renewal fee is a ~~"~~delayed renewal fee~~"~~ within the meaning of ~~Minn. Stat. §~~ Minnesota Statutes, section 326.10, ~~subd.~~ subdivision 5 if it is not postmarked on or before June 30 of the year specified in C. The delayed renewal fee is $5 per month, or any portion thereof, not to exceed $15. It is in addition to the renewal fee provided in C. The delayed renewal fee is computed from July 1 of any even-numbered year.

E. Certification or licensure examination fee. The fee for examination for certification or licensure as an architect, professional engineer, land surveyor, or landscape architect is as follows:

1. Architect:
   a. Application for admission to examination, $25~~.00~~;
   b. ~~Qualifying Test in 1982 and thereafter $60.00~~ Uniform Architecture Registration Examination, $220.
   ~~c. Section A, Professional Examination in 1982 and thereafter $50.00~~
   ~~d. Section B, Professional Examination in 1982 and thereafter $75.00~~
2. Professional engineer:
   a. Fundamentals of Engineering Examination, $30~~.00~~;
   b. Principles and Practice of Engineering Examination, $100~~.00~~.

The fee for the Fundamentals of Engineering Examination taken for the board will be credited to the applicant toward the fee for application for the Principles and Practice of Engineering Examination for up to ten years.

An applicant for examination in more than one branch of engineering shall submit a separate examination fee for each additional branch of engineering for which the applicant has applied for examination.

3. Land surveyor:
   a. Fundamentals of Land Surveying Examination, $30~~.00~~;
   b. Principles and Practice of Land Surveying Examination, $100~~.00~~.
4. Landscape architect:
   a. Application for admission to examination, $25~~.00~~;
   b. Uniform National Examination ~~in 1982 and 1983 $150.00~~, $105.
   ~~c. Uniform National Examination in 1984 and 1985 $165.00~~

F. Reexamination fees. The fee for retaking all or any part of any examination for certification or registration is as follows each time the examination, or any part of it, is retaken:

1. Architect; Uniform Architect Registration Examination:
   ~~a. Qualifying Test per part retaken $15.00~~
   ~~b. Section A, Professional Examination in 1982 and thereafter $50.00~~
   ~~c. Section B, Professional Examination in 1982 and thereafter $75.00~~
   a. Division A, Pre-Design, $33;
   b. Division B, Site Design, $33;
   c. Division C, Building Design, $55;
   d. Division D, Structural Technology, General, $16.50;
   e. Division E, Structural Technology, Lateral Forces, $12.50;
   f. Division F, Structural Technology, Long Span, $8.50;
   g. Division G, Mechanical, Plumbing, Electrical, and Life Safety, $16.50;
   h. Division H, Materials and Methods, $21;
   i. Division I, Construction Documents and Services, $24.
2. Professional engineer:
   a. Fundamentals of Engineering, $20~~.00~~;
   b. Principles and Practice of Engineering, $20~~.00~~.
3. Land surveyor:
   a. Fundamentals of Land Surveying, $20~~.00~~;
   b. Principles and Practice of Land Surveying:
      (1) Part III, $15~~.00~~;
      (2) Part IV, $30~~.00~~;
      (3) Parts III and IV, $45~~.00~~.
4. Landscape architect:
   a. Subject A—History, $15~~.00~~;
   b. Subject B—Professional Practice, $15~~.00~~;

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c. Subject C—Design ~~$60.00~~, $37.50;

d. Subject D—Design Implementation ~~$60.00~~, $37.50.

G. Additional fees. In addition to all other fees for examination or registration, as provided in this rule or ~~Minn. Stat. §~~ Minnesota Statutes, section 326.10, ~~subd.~~ subdivision 1, the following schedule of fees is applicable:

1. For each application for registration by comity under ~~the provisions of Minn. Stat. §~~ Minnesota Statutes, section 326.10, ~~subd.~~ subdivision 1, clause (2), applicable to any person registered in another state or territory of the United States, or in any province of Canada, a fee of $100;

2. For reissuance of a revoked, lost, destroyed, or mutilated certificate of licensure or certificate as an engineer-in-training, land surveyor-in-training, or landscape architect-in-training, ~~$5~~ $10;

3. For certified copies or reproduction of any document required to be supplied on behalf of any applicant for registration in another state, the cost of reproducing the document, as the board determines;

4. For monitoring licensing examinations for applicants of boards of other states at overseas test sites, the fee shall be $10, payable by the applicant.

Department of Health

Proposed Amendments to Rules Relating to Services for Children With Handicaps

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Minnesota Commissioner of Health (hereinafter "commissioner") proposes to amend 7 MCAR § 1.651 B.26. and 7 MCAR § 1.654 B. of the Rules of the Minnesota Department of Health relating to the services for children with handicaps and adults with cystic fibrosis and hemophilia for eligibility, cost-sharing and reimbursement. A copy of the proposed amendments is attached.

The commissioner has determined that these proposed amendments will be noncontroversial in nature. Therefore, the commissioner has elected to follow the procedures set forth in Minn. Stat. §§ 14.21 through 14.28 (1982) which provides for an expedited process for the adoption of noncontroversial administrative rule changes without the holding of a public hearing. The amendment is proposed in order to update the amount of the gross median income and the cost-share schedule on which family cost-shares for services are computed.

The public is hereby advised that:

1. There is a period of 30 days in which to submit comment on the proposed rule;

2. No public hearing will be held on this matter unless seven or more persons make a written request for a hearing within the 30 day comment period;

3. All comments and any written requests for a public hearing shall be submitted to Alpha Adkins, Assistant Director, Services for Children with Handicaps, Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440;

4. The proposed amendments may be modified if modifications are supported by the data and views submitted, and do not result in a substantial change in the proposed language;

5. Authority to amend 7 MCAR § 1.651 B.26. and 7 MCAR § 1.654 B. is contained in Minn. Stat. §§ 144.07, 144.12, 144.05, 144.10 and 144.11 (1982). Additionally, a statement of need and reasonableness that describes the need for and reasonableness of each provision of the proposed amendments has been prepared and is now available. Anyone wishing to receive a copy of this document may contact Alpha Adkins at the above-listed address;

6. Under this expedited procedure, the agency must submit any action on its rules to the Attorney General for review of the form and legality of the rule change. Notice of the submission of this matter to the Attorney General will be made to all persons who request to be informed of the submission. Requests to be informed must be submitted to Alpha Adkins at the above-listed address;

7. If seven or more persons request a public hearing on this matter, notice of any such hearing will be given in the same manner as has this notice and the agency will then proceed pursuant to Minn. Stat. §§ 14.13-14.20 (1982);

8. Any rule change made pursuant to this proceeding shall be effective five working days after publication in the *State Register* of notice of the adoption of the change.

July 15, 1983

Sister Mary Madonna Ashton
Commissioner of Health

Rules as Proposed

7 MCAR § 1.651 General.

A. [Unchanged.]

B. Definitions. For the purposes of these rules, the following terms shall have the meaning given them:

1.-25. [Unchanged.]

26. "State gross median income" ~~means the income level at which 50% of the people in the state have incomes higher than the median and 50% of the people have incomes which are lower, as computed by the Minnesota Department of Employment Services in 1977~~ is $25,394 annually for a family of four as developed by the Bureau of the Census and released by the Social Security Administration (Information Memorandum 82-13, September 24, 1982). "State gross median income" adjusted for households of different sizes in accordance with 45 FR 56710 (Code of Federal Regulations, title 45, section 1396.60, removed) is: households of one, $13,205; two, $17,268; three, $21,331; five, $29,457; six, $33,520; seven, $34,282; eight, $35,044; nine, $35,806; ten, $36,567; more than ten, 144 percent of $25,394 plus three percent of $25,394 for each household member in excess of ten.

27.-30. [Unchanged.]

7 MCAR § 1.654 Application and cost-sharing for applicant(s).

A. [Unchanged.]

B. Cost-sharing.

1.-3. [Unchanged.]

4. The amount of cost-sharing required of an applicant is determined in the following manner:

Step No. 1: The includable assets are totalled. If applicable, the household member deduction is subtracted from this total.

Step No. 2: The amount derived in Step No. 1 is then added to the adjusted gross income.

Step No. 3: The total of the allowable deductions is subtracted from the amount derived in Step No. 2. This figure indicates the SCH adjusted income.

Step No. 4: The percentage that the applicant must share in the cost of treatment is based on the applicant's SCH adjusted income level and on the number of members in the household. This percentage is calculated according to the following ~~chart~~ schedule.

SCH Cost-sharing Schedule

~~For each number of household members, the beginning income level on the schedule represents the range of income from 0 to 60% of the state gross median income. Increments of $1,000 have been used to establish each succeeding income level for that size household in 1977. The percentage at the left of the schedule rises 1% for every $1,000 rise in the SCH adjusted income level~~ The applicant's share is one percent of cost for each $1,000 or fraction of $1,000 of income above 60 percent of the state gross median income for a household of the same size as the applicant's. The applicant's percent share is found on the schedule by looking under the number which is the number of members of applicant's household to find the income level which includes the applicant's annual household income. The applicant's percent share is shown to the far left of that income level. To extend the schedule to households of more than ten members add $457 for each household member in excess of ten to the income levels for a household of ten members.

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Percentage which eligible applicants share in the costs of treatment	Income Levels by Number of Members in the Household			
	1	2	3	4
0	0-$5,606	0-$7,332	0-$9,057	0-$10,782
1	5,607- 6,606	7,333-8,332	9,058-10,057	10,783- 11,782
2	6,607- 7,606	8,333- 9,332	10,058-11,057	11,783- 12,782
3	7,607- 8,606	9,333-10,332	11,058-12,057	12,783- 13,782
4	8,607- 9,606	10,333-11,332	12,058-13,057	13,783- 14,782
5	9,607-10,606	11,333-12,332	13,058-14,057	14,783- 15,782
6	10,607-11,606	12,333-13,332	14,058-15,057	15,783- 16,782
7	11,607-12,606	13,333-14,332	15,058-16,057	16,783- 17,782
8	12,607-13,606	14,333-15,332	16,058-17,057	17,783- 18,782
9	13,607-14,606	15,333-16,332	17,058-18,057	18,783- 19,782
10	14,607-15,606	16,333-17,332	18,058-19,057	19,783- 20,782
11	15,607-16,606	17,333-18,332	19,058-20,057	20,783- 21,782
12	16,607-17,606	18,333-19,332	20,058-21,057	21,783- 22,782
11	15,607-16,606	17,333-18,332	19,058-20,057	20,783- 21,782
12	16,607-17,606	18,333-19,332	20,058-21,057	21,783- 22,782
13	17,607-18,606	19,333-20,332	21,058-22,057	22,783- 23,782
14	18,607-19,606	20,333-21,332	22,058-23,057	23,783- 24,782
15	19,607-20,606	21,333-22,332	23,058-24,057	24,783- 25,782
16	20,607-21,606	22,333-23,332	24,058-25,057	25,783- 26,782
17	21,607-22,606	23,333-24,332	25,058-26,057	26,783- 27,782
18	22,607-23,606	24,333-25,332	26,058-27,057	27,783- 28,782
	5	6	7	8
0	0-$12,507	0-14,232	0-14,556	0-14,879
1	12,508 13,507	14,233 15,232	14,557-15,556	14,880-15,879
2	13,508 14,507	15,233 16,232	15,557-16,556	15,880-16,879
3	14,508 15,507	16,233-17,232	16,557-17,556	16,880-17,879
4	15,508 16,507	17,233-18,232	17,557-18,556	17,880-18,879
5	16,508 17,507	18,233-19,232	18,557-19,556	18,880-19,879
6	17,508 18,507	19,233-20,232	19,557-20,556	19,880-20,879
7	18,508 19,507	20,233-21,232	20,557-21,556	20,880-21,879
8	19,508 20,507	21-233-22,232	21,557-22,556	21,880-22,879
9	20,508 21,507	22,233-23,232	22,557-23,556	22,880-23,879
10	21,508 22,507	23,233-24,232	23,557-24,556	23,880-24,879
11	22,508 23,507	24,233-25,232	24,557-25,556	24,880-25,879
12	23,508 24,507	25,233-26,232	25,557-26,556	25,880-26,879
13	24,508 25,507	26,233-27,232	26,557-27,556	26,880-27,879
14	25,508 26,507	27,233-28,232	27,557-28,556	27,880-28,879
15	26,508 27,507	28,233-29,232	28,557-29,556	28,880-29,879
16	27,508 28,507	29,233-30,232	29,557-30,556	29,880-30,879
17	28,508 29,507	30-233-31,232	30,557-31,556	30,880-31,879
18	29,508 30,507	31,233-32,232	31,557-32,556	31,880-32,879
	9	10		
0	0-15,203	0-15,526		
1	15,204-16,203	15,527-16,526		
2	16,204-17,203	16,527-17,526		
3	17,204-18,203	17,527-18,526		
4	18,204-19,203	18,527-19,526		
5	19,204-20,203	19,527-20,526		
6	20,204-21,203	20,527-21,526		
7	21,204-22,203	21,527-22,526		
8	22,204-23,203	22,527-23,526		

~~9~~	~~23,204-24,203~~	~~23,527-24,526~~
~~10~~	~~24,204-25,203~~	~~24,527-25,526~~
~~11~~	~~25,204-26,203~~	~~25,527-26,526~~
~~12~~	~~26,204-27,203~~	~~26,527-27,526~~
~~13~~	~~27,204-28,203~~	~~27,527-28,526~~
~~14~~	~~28,204-29,203~~	~~28,527-29,526~~
~~15~~	~~29,204-30,203~~	~~29,527-30,526~~
~~16~~	~~30,204-31,203~~	~~30,527-31,526~~
~~17~~	~~31,204-32,203~~	~~31,527-32,526~~
~~18~~	~~32,204-33,203~~	~~32,527-33,526~~

	1	2-	3	4
0	0-$7,923	0-$10,361	0-$12,799	0-$15,236
1	7,924- 8,923	10,362- 11,361	12,800- 13,799	15,237- 16,236
2	8,924- 9,923	11,362- 12,361	13,800- 14,799	16,237- 17,236
3	9,924-10,923	12,362- 13,361	14,800- 15,799	17,237- 18,236
4	10,924-11,923	13,362- 14,361	15,800- 16,799	18,237- 19,236
5	11,924-12,923	14,362- 15,361	16,800- 17,799	19,237- 20,236
6	12,924-13,923	15,362- 16,361	17,800- 18,799	20,237- 21,236
7	13,924-14,923	16,362- 17,361	18,800- 19,799	21,237- 22,236
8	14,924-15,923	17,362- 18,361	19,800- 20,799	22,237- 23,236
9	15,924-16,923	18,362- 19,361	20,800- 21,799	23,237- 24,236
10	16,924-17,923	19,362- 20,361	21,800- 22,799	24,237- 25,236
11	17,924-18,923	20,362- 21,361	22,800- 23,799	25,237- 26,236
12	18,924-19,923	21,362- 22,361	23,800- 24,799	26,237- 27,236
13	19,924-20,923	22,362- 23,361	24,800- 25,799	27,237- 28,236
14	20,924-21,923	23,362- 24,361	25,800- 26,799	28,237- 29,236
15	21,924-22,923	24,362- 25,361	26,800- 27,799	29,237- 30,236
16	22,924-23,923	25,362- 26,361	27,800- 28,799	30,237- 31,236
17	23,924-24,923	26,362- 27,361	28,800- 29,799	31,237- 32,236
18	24,924-25,923	27,362- 28,361	29,800- 30,799	32,237- 33,236

	5	6	7	8
0	0-17,674	0-20,112	0-20,569	0-21,026
1	17,675-18,674	20,113-21,112	20,570-21,569	21,027-22,026
2	18,675-19,674	21,113-22,112	21,570-22,569	22,027-23,026
3	19,675-20,674	22,113-23,112	22,570-23,569	23,027-24,026
4	20,675-21,674	23,113-24,112	23,570-24,569	24,027-25,026
5	21,675-22,674	24,113-25,112	24,570-25,569	25,027-26,026
6	22,675-23,674	25,113-26,112	25,570-26,569	26,027-27,026
7	23,675-24,674	26,113-27,112	26,570-27,569	27,027-28,026
8	24,675-25,674	27,113-28,112	27,570-28,569	28,027-29,026
9	25,675-26,674	28,113-29,112	28,570-29,569	29,027-30,026
10	26,675-27,674	29,113-30,112	29,570-30,569	30,027-31,026
11	27,675-28,674	30,113-31,112	30,570-31,569	31,027-32,026
12	28,675-29,674	31,113-32,112	31,570-32,569	32,027-33,026
13	29,675-30,674	32,113-33,112	32,570-33,569	33,027-34,026
14	30,675-31,674	33,113-34,112	33,570-34,569	34,027-35,026
15	31,675-32,674	34,113-35,112	34,570-35,569	35,027-36,026
16	32,675-33,674	35,113-36,112	35,570-36,569	36,027-37,026
17	33,675-34,674	36,113-37,112	36,570-37,569	37,027-38,026
18	34,675-35,674	37,113-38,112	37,570-38,569	38,027-39,026

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	9	10
0	0-21,484	0-21,940
1	21,485-22,484	21,941-22,940
2	22,485-23,484	22,941-23,940
3	23,485-24,484	23,941-24,940
4	24,485-25,484	24,941-25,940
5	25,485-26,484	25,941-26,940
6	26,485-27,484	26,941-27,940
7	27,485-28,484	27,941-28,940
8	28,485-29,484	28,941-29,940
9	29,485-30,484	29,941-30,940
10	30,485-31,484	30,941-31,940
11	31,485-32,484	31,941-32,940
12	32,485-33,484	32,941-33,940
13	33,485-34,484	33,941-34,940
14	34,485-35,484	34,941-35,940
15	35,485-36,484	35,941-36,940
16	36,485-37,484	36,941-37,940
17	37,485-38,484	37,941-38,940
18	38,485-39,484	38,941-39,940

5.-7. [Unchanged.]

Department of Commerce

Proposed Temporary Rules Governing Reimbursement for Workers' Compensation Medical Services

Notice of Intent to Adopt Temporary Rules

Notice is hereby given that the Department of Commerce is proposing to adopt temporary rules to govern reinbursement for workers' compensation medical services as authorized by Minn. Stat. § 176.136. The proposed rules establish limits for charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment services as defined and compensable under Minn. Stat. § 176.135, to the 75th percentile of usual and customary fees or charges based upon billings for each class of health care provider during 1982. The proposed temporary rules follow this notice.

All interested parties are hereby afforded the opportunity to submit data and views on the proposed temporary rules for 20 days immediately following publication of this material in the *State Register*. Comments should be submitted in writing to:

John Klein
Department of Commerce
500 Metro Square Building
St. Paul, MN 55101

The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the Department.

After the 20 day comment period, the proposed temporary rules with modifications, if any, will be sent to the Office of the Attorney General for final approval as to form and legality. The temporary rules shall take effect immediately upon the Attorney General's approval.

The temporary rules shall remain in effect until permanent rules are adopted or for 180 days. The temporary rules may also be extended for an additional 180 days.

August 22, 1983

Michael A. Hatch
Commissioner of Commerce

Temporary Rules as Proposed (all new material)

4 MCAR § 1.0001 Authority.

Rules 4 MCAR §§ 1.0001-1.0032 are promulgated under the authority of Minnesota Statutes, section 176.136.

4 MCAR § 1.0002 Purpose.

Rules 4 MCAR §§ 1.0001-1.0032 are intended to prohibit providers of treatment of work related injuries from receiving excessive reimbursement for their services.

4 MCAR § 1.0003 Scope.

The following are subject to 4 MCAR §§ 1.0001-1.0032: All entities responsible for payment and administration of medical claims compensable under Minnesota Statutes, chapter 176; and providers of medical services or supplies for work related injuries or diseases pursuant to Minnesota Statutes, section 176.135, subdivision 1.

4 MCAR § 1.0004 Definitions.

The following terms have the following meanings in 4 MCAR §§ 1.0001-1.0032 unless the context clearly indicates a different meaning.

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

B. Charge or fee. "Charge" or "fee" means the payment requested by a provider on a bill for a particular service.

C. Code. "Code," in reference to the maximum fee schedule, means the alphabetic or numeric designation, including code modifiers if appropriate, for a particular type of service, or supply, or other reasonable method of categorizing provider charges.

D. Commissioner. "Commissioner" means the commissioner of the Department of Labor and Industry.

E. Compensable or compensability. "Compensable" or "compensability," in reference to a service, means an employer is liable for the service pursuant to Minnesota Statutes, chapter 176.

F. Excessive. "Excessive," in reference to a charge, means a charge which meets any of the standards of excessiveness described in 4 MCAR § 1.0005.

G. Injury. "Injury" includes all bodily harm or impairment from work related accidents, diseases, or other compensable causes.

H. Maximum fee schedule. "Maximum fee schedule" means the list of codes, services, and corresponding 75th percentile dollar amounts established pursuant to 4 MCAR § 1.0009.

I. Payer. "Payer" refers to all entities responsible for payment and administration of workers' compensation medical claims, including all insurer, self-insurer, and group self-insurer members of the workers' compensation reinsurance association, pursuant to Minnesota Statutes, section 79.34, subdivision 1, service companies licensed to provide claim administration services to self-insurers and group self-insurers pursuant to Minnesota Statutes, section 60A.23, subdivision 8, the reopened case fund, established by Minnesota Statutes, section 176.134, and the assigned risk plan, established by Minnesota Statutes, sections 79.251 and 79.252.

J. Provider. "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

K. Reasonable. "Reasonable," in reference to a charge, means a charge or portion of a charge which is not excessive.

L. Service or treatment. "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of an injury or occupational disease, pursuant to Minnesota Statutes, section 176.135, subdivision 1.

4 MCAR § 1.0005 Excessiveness.

A charge is excessive to the degree that any of the following conditions apply to it, or to the service for which the charge was submitted:

A. the charge exceeds the maximum reasonable amount for the type of service as specified in the maximum fee schedule of 4 MCAR §§ 1.0010-1.0032;

B. the charge exceeds the employer's limits of liability specified in Minnesota Statutes, section 176.135, subdivision 3;

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

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

E. the charge or service does not comply with standards and requirements adopted pursuant to Minnesota Statutes, section 176.103 or 176.83, concerning the appropriateness, quality, coordination, and cost of treatment;

F. the service was performed by a provider prohibitied from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, section 176.183;

G. the service does not comply with the requirements of Minnesota Statutes, section 176.135, subdivision 1a, concerning non-emergency surgery and a second surgical opinion;

H. the service does not comply with the requirements of rules adopted pursuant to Minnesota Statutes, section 176.135, subdivision 2, regulating change of physicians, podiatrists, or chiropractors; or

I. the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury.

4 MCAR § 1.0006 Payer responsibilities.

A. Compensability. Rules 4 MCAR §§ 1.0001-1.0032 do not require a payer to pay a charge which is not compensable or a charge which is the primary obligation of another payer.

B. Payment of charges. Before paying a charge, the payer shall determine whether it is excessive to any degree. To the degree that a charge is determined to be excessive, the payer shall not pay the charge. As soon as reasonably possible, and no later than 21 calendar days after receiving the bill and any necessary reports, the payer shall pay the charge or deny all or part of the charge on the basis of excessiveness or noncompensability, with written notification to the provider of the determination, the reason for the determination, and the options of appeal. Failure to comply with the requirements of this paragraph subjects the payer to the penalties provided in Minnesota Statutes, sections 176.221 and 176.225.

C. Determination of excessiveness. The payer shall ascertain whether a charge is excessive by evaluating the charge and service according to the standards of excessiveness specified in 4 MCAR § 1.0005. The payer shall also comply with the following procedures:

1. The payer shall ascertain whether or not a service is subject to the maximum fee schedule, pursuant to the maximum fee schedule instructions contained in 4 MCAR § 1.0010.

2. In determining whether the code or description submitted for a particular service is correct, the code to which a service should be assigned if no code or an incorrect code was submitted, or whether a charge is excessive because the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury; the payer shall consider the professional judgment and standards of the relevant healing art, as necessary to make a sound determination. Professional judgment and standards may include but are not limited to any of the following, provided that final determinations shall remain the responsibility of the payer:

a. the opinion of persons with expertise concerning the service;

b. the findings of peer review panels, professional associations, and other expert evaluators of a healing art; and

c. widely accepted publications concerning the procedures and standards of a healing art. These may include, but are not limited to, publications concerning the reasonable length of hospital stays for certain procedures, publications which compare the merits and necessity of inpatient and outpatient treatment for certain procedures, relative value scales, and other medical reference materials.

D. Collection of excessive payment. Any payment made to a provider which is determined to be wholly or partially excessive, according to the standards prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. A determination of excessiveness must be made within one year of the payment.

4 MCAR § 1.0007 Provider responsibilities.

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

B. Submission of information. Providers shall include on bills the patient's name, date of injury, and the employer's name, narratives and codes which accurately describe all services provided and all injuries or conditions treated, the date upon which each service was provided, and the providers' social security or federal employer identification number. Codes from the maximum fee schedules in 4 MCAR §§ 1.0011-1.0032 shall be used.

C. Cooperation with payer. Pursuant to Minnesota Statutes, section 176.138, providers shall comply promptly with payers' reasonable requests for information concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of a service's compensability or a charge's reasonableness.

D. Collection of excessive charges. No provider shall collect or attempt to collect payment from any party in excess of the amount determined to be reasonable by the payer or on appeal. If the determination of the payer is not upheld on appeal, the provider may collect charges found to be reasonable, but only from the payer.

4 MCAR § 1.0008 Appeals procedure.

Pursuant to Minnesota Statutes, sections 176.103 and 176.271 and related statutes and rules, providers may appeal a payer's determination that a charge is excessive to the commissioner, with a further right of appeal to the medical services review board.

4 MCAR § 1.0009 Maximum fee schedule.

A. Contents. Rules 4 MCAR §§ 1.0010-1.0032 are the maximum fee schedule. The maximum fee schedule shall contain codes and descriptions of services compensable under Minnesota Statutes, section 176.135 and dollar amounts which fairly represent the 75th percentile charges for those services in Minnesota during the preceding calendar year.

B. Revisions. The commissioner shall revise the maximum fee schedule annually to incorporate charge data from the preceding calendar year. Until revisions are adopted the current maximum fee schedule remains in force. The commissioner may revise the maximum fee schedule at any time to (1) improve the schedule's accuracy, fairness, or equity; (2) ease the use and administration of the schedule; (3) lessen disincentives to providers to develop and deliver services; or (4) to accommodate improvements or correct deficiencies of the data base.

4 MCAR § 1.0010 Maximum fee schedule for reimbursement of workers' compensation medical services.

A. Maximum fee schedule instructions. The instructions in this rule and 4 MCAR §§ 1.0001-1.0009 govern the use and application of fees in 4 MCAR §§ 1.0011-1.0032.

B. Background. The codes and service descriptions contained in this rule are based primarily upon Physicians' Current Procedural Terminology, fourth edition, published by the American Medical Association. Payers may employ that publication in evaluating bills, provided that the codes and service descriptions of 4 MCAR §§ 1.0010-1.0032 shall govern where differences exist between these rules and that publication.

C. Applicability of the fee schedule. The payer shall undertake investigations as it considers reasonable to ascertain whether a service is subject to the maximum fee schedule. A service is subject to the maximum fee schedule if it conforms to a description contained in the maximum fee schedule in the section for the appropriate kind of medical provider. The standards of excessiveness contained in 4 MCAR § 1.0005 apply whether or not a service is subject to the maximum fee schedule.

D. Coding. For services which are or which may be subject to the maximum fee schedule, the payer shall undertake investigations as it considers reasonable to ascertain whether or not the code assigned to a service by the provider is correct. If no code has been assigned the payer shall determine the appropriate code, and shall evaluate the service on the basis of that code. A broad, inclusive service description may be divided into its component services, charges, and codes, if the inclusive service is not subject to the maximum fee schedule but some of the component services are.

E. Ambiguity. If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service is subject to the maximum fee schedule or what the correct code for a particular service is, the payer shall decide the issue in favor of the provider.

F. Code modifiers. The codes for services in this rule may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in 1.-18.

1. Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery, including the aid of an operating microscope. This modifier is not warranted for surgery done with the aid of a magnifying loupe or magnifying binoculars worn by the surgeon. Services with this modifier are not subject to the maximum 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

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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 maximum fee schedule.

4. Modifier number 26 denotes professional component. This modifier is appropriate to services which are a combination of a physician and a technical component, (for example, laboratory, radiology, electrocardiogram, specific diagnostic and therapeutic services), where the physican 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 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 multiple or bilateral procedures. This modifier is appropriate to secondary services when multiple or bilateral procedures are provided at the same operative session. The first major procedure shall be reported as listed. This modifier does not exempt the secondary services from the maximum fee for the five-digit code.

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

8. 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.

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

10. 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.

11. 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 maximum fee schedule.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. Modifier number 99 denotes multiple modifiers. This modifier is appropriate to services where two or more modifiers

may be necessary to completely delineate 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 maximum fee schedule.

4 MCAR § 1.0011 Physician services; medicine.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to providers licensed as a doctor of medicine or a doctor of osteopathy.

B. Definitions. The terms defined in B. have the meanings given them when used in C., D., and E. unless the context clearly indicates a different meaning.

1. New patient. "New patient" means a patient who is new to the physician and whose medical and administrative records need to be established.

2. Established patient. "Established patient" means a patient whose medical and administrative records are available to the physician.

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

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

a. routine immunization for tetanus;

b. removal of sutures from laceration; or

c. blood pressure determination for adequacy of control.

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

a. examination of a patient with subconjunctival hemorrhage;

b. examination of minor trauma;

c. review of recent x-ray report and abbreviated discussion with patient under study;

d. concurrent hospital care for a minor secondary diagnosis;

e. examination for acute tonsilitis; or

f. abbreviated evaluation of a hospitalized patient in stage of recovery from an uncomplicated renal colic.

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

a. treatment of acute respiratory infection;

b. review of interval history, physical status, and control of a diabetic patient;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Intermediate initial hospital care. "Intermediate initial hospital care" includes intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records. It is a service involving the evaluation or reevaluation of a patient with an acute or active problem that requires hospitalization. This procedure includes the recording of the chief complaint, present illness or current medical history, and an appropriate physical examination related to the acute or

active problem in a patient who has had a previously documented evaluation current and available to the physician, and the ordering of appropriate medical diagnostic tests and procedures.

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

C. Office services. The following codes, service descriptions and maximum fees apply to services provided at the physician's office.

Code	Service	Maximum Fee
90000	New patient—brief service	$ 23.00
90010	New patient—limited service	31.00
90015	New patient—intermediate service	43.00
90017	New patient—extended service	60.00
90020	New patient—comprehensive service	120.50
90030	Established patient—minimal service	14.00
90040	Established patient—brief service	17.75
90050	Established patient—limited service	20.00
90060	Established patient—intermediate service	25.00
90070	Established patient—extended service	35.00
90080	Established patient—comprehensive service	60.00

D. Hospital services. The following codes, service descriptions and maximum fees apply to services provided at a hospital. Initial hospital care shall be categorized under codes 90200 to 90220. Subsequent hospital care shall be categorized under codes 90240 to 90280.

Code	Service	Maximum Fee
90200	Brief initial hospital care	49.40
90215	Intermediate initial hospital care	65.00
90220	Comprehensive initial hospital care	90.00
90240	Subsequent hospital care—brief service	21.50
90250	Subsequent hospital care—limited service	25.00
90260	Subsequent hospital care—intermediate service	35.00
90270	Subsequent hospital care—extended service	55.00
90280	Subsequent hospital care—comprehensive service	88.00

E. Emergency department services. The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department.

Code	Service	Maximum Fee
90500	New patient—minimal service	27.50
90505	New patient—brief service	32.50
90510	New patient—limited service	35.50
90515	New patient—intermediate service	35.50
90517	New patient—extended service	46.00
90530	Established patient—minimal service	18.00
90540	Established patient—brief service	28.50
90550	Established patient—limited service	30.00
90560	Established patient—intermediate service	35.00
90570	Established patient—extended service	50.00

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4 MCAR § 1.0012 Consultations.

A. Definitions. For the purposes of this rule the following terms have the meanings given them unless the context clearly indicates a different meaning.

1. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. A referral does not constitute a consultation if the effect of the referral is to transfer the total or specific care of the patient from one physician to another.

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

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

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

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

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

B. Fees. The following codes, service descriptions, and maximum fees apply to consultations.

Code	Service	Maximum Fee
90600	Limited consultation	50.00
90605	Intermediate consultation	59.00
90610	Extensive consultation	73.00
90620	Comprehensive consultation	105.00
90630	Complex consultation	129.00

4 MCAR § 1.0013 Psychiatric therapy.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures.

Code	Service	Maximum Fee
90843	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	$ 45.00
90844	approximately 45 or 50 minutes	76.00

4 MCAR § 1.0014 Biofeedback.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures.

Code	Service	Maximum Fee
90900	Biofeedback training; by electromyogram application, as with tension headache or muscle spasm	$ 45.00

4 MCAR § 1.0015 Ophthalmological services.

A. Definitions. The terms defined in this rule have the meanings given them for the purpose of this rule unless the context clearly indicates a different meaning.

1. New patient and established patient. "New patient" and "established patient" have the meanings given them in 4 MCAR § 1.0011.

2. Level of service. "Level of service" for the purpose of this rule has the meaning given it in 4 MCAR § 1.0011.

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

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

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

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

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

B. Ophthalmological services and fees. The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92014, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92250, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

General Services

Code	Service	Maximum Fee
92002	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program—new patient	$ 40.00
92004	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program—new patient, one or more visits	44.00

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92012	Intermediate ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program—established patient	33.00
92014	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program— established patient, one or more visits	45.00
	Special Services	
92020	Gonioscopy with medical diagnostic evaluation as a separate procedure not under general anesthesia	$ 25.00
92065	Orthoptic or pleoptic training, with continuing medical direction and evaluation	26.25
92081	Visual field examination with medical diagnostic evaluation; tangent screen, Autoplot or equivalent	32.00
92082	Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent	42.00
92100	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	18.00
92140	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00
	Opthalmoscopy	
92235	Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation	$ 110.00
92250	with fundus photography	20.00
92260	with ophthalmodynamometry	29.00
	Other Specialized Services	
92280	Visually evoked potential or response study, with medical diagnostic evaluation	$ 90.00

4 MCAR § 1.0016 Otorhinolaryngologic services.

The codes, service descriptions, and maximum fees in this rule apply to otorhinolaryngologic services. Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, which do not include the following, should be reported as an integrated medical service using the appropriate code from the 90000 series. Component services such as otoscopy, rhinoscopy, or tuning fork test, should not be itemized separately. All of the following services include medical diagnostic evaluation. Technical procedures, which may or may not be performed by the physician personally, are often part of the service, but do not constitute the service itself.

Code	Service	Maximum Fee
92506	Medical evaluation of speech, language, or hearing problems	$ 46.00
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	45.00
92544	Optokinetic nystagmus test, bidirectional, foveal, or peripheral stimulation, with recording	30.00
92545	Oscillating tracking test, with recording	25.00

4 MCAR § 1.0017 Audiologic tests.

The codes, service descriptions, and maximum fees in this rule apply to audiologic function tests with medical diagnostic evaluation. The tests involve use of calibrated electronic equipment. Other hearing tests such as whispered voice, tuning fork which are usually included in a comprehensive otorhinolaryngologic evaluation or office visit shall not be itemized, but shall be included in the basic office visit or consultation. The following codes refer to testing of both ears.

Basic Audiometry

Code	Service	Maximum Fee
92551	Screening test, pure tone, air only	$ 10.50
92552	Pure tone audiometry (threshold); air only	15.75
92553	air and bone	26.00
92555	Speech audiometry; threshold only	11.00
92556	threshold and discrimination	29.00

92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	45.50
	Audiologic Tests	
92562	Loudness balance test, alternate binaural or monaural	15.50
92563	Tone decay test	12.00
92564	Short increment sensitivity index	13.00
92566	Impedance testing	16.50
92567	Tympanometry	14.00
92568	Acoustic reflex testing	16.50
92569	Acoustic reflex decay test	11.00
92575	Sensorineural acuity level test	7.50
92581	Evoked response audiometry	150.00
92582	Conditioning play audiometry	20.00
92583	Select picture audiometry	23.00

4 MCAR § 1.0018 Cardiography.

The codes, service descriptions, and maximum fees in this rule apply to cardiographic services.

Code	Service	Maximum Fee
93000	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	$ 33.00
93005	tracing only, without interpretation and report	23.00
93010	interpretation and report only	16.00
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	132.00
93017	tracing only without interpretation and report	94.00
93018	interpretation and report only	67.00
93040	Rhythm ECG, one to three leads; with interpretation	15.45
93041	tracing only, without interpretation and report	14.00
93042	interpretation and report only	30.00
93220	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	33.70
93270	Electrocardiographic monitoring utilizing a system such as magnetic tape for up through 12 hours; includes recording, scanning analysis, interpretation, and report	153.00
93274	Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis, interpretation, and report	171.00
93277	physician review and interpretation, with report	82.00

4 MCAR § 1.0019 Pulmonary

The codes, service descriptions, and maximum fees of this rule apply to pulmonary services. The services include laboratory procedures, interpretation, and physician services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement or maximal voluntary ventilation	$ 65.00
94060	Bronchospasm evlauation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	40.00
94150	Vital capacity, total (separate procedure)	13.00
94160	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	15.00

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94375	Respiratory flow volume loop	21.00
94620	Pulmonary stress testing, simple or complex	75.00
94656	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	90.00
94567	subsequent days	38.00

4 MCAR § 1.0020 Neurology/neuromuscular.

The codes, service descriptions, and maximum fees of this rule apply to neurology and neuromuscular services. Services performed as part of and included in the definition of an office visit, hospital visit, or consultation shall not be listed separately, but shall be submitted under the appropriate code.

Code	Service	Maximum Fee
95819	Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation; standard or portable, same facility	$ 105.00
95822	Electroencephalogram (EEG); sleep only	100.00
95823	physical or pharmacological activation only	105.00
95851	Range of motion measurements and report (separate procedure); each extremity, excluding hand	30.00
95860	Electromyography; one extremity and related paraspinal areas	125.00
95861	two extremities and related paraspinal areas	136.40
95863	three extremities and related paraspinal areas	175.00
95864	four extremities and related paraspinal areas	290.00
95900	Nerve conduction, velocity, or latency study; motor, each nerve	40.00
95904	sensory, each nerve	33.75
95925	Somatosensory testing, for example, cerebral evoked potentials, one or more nerves	162.00
95935	"H" reflex, by electrodiagnostic testing	35.00

4 MCAR § 1.0021 Physical medicine.

The following codes, service descriptions and maximum fees apply to physical medicine services. Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities require supervision by the physician, but constant attendance of the physician or therapist is not required. Procedures require supervision by the physician, and constant attendance by the physician or therapist.

Modalities

Code	Service	Maximum Fee
97000	Office visit with one of the following modalities to one area: 1. Hot or cold packs 2. Traction, mechanical 3. Electrical stimulation (unattended) 4. Vasopneumatic devices 5. Paraffin bath 6. Microwave 7. Whirlpool 8. Diathermy 9. Infrared 10. Ultraviolet	$ 12.75
97050	Office visit with two or more modalities to same area	23.25

Procedures

97100	Office visit with one of the following procedures to one area: 1. Therapeutic exercises 2. Neuromuscular reeducation 3. Functional activities 4. Gait training 5. Electrical stimulation (manual) 6. Iontophoresis 7. Traction, manual 8. Massage	

	9. Contrast baths	
	10. Ultrasound;	
	initial 30 minutes	$ 15.50
97101	each additional 15 minutes	16.00
97200	Office visit, including combination of any modality and procedure; initial 30 minutes	26.00
97201	each additional 15 minutes	15.00
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area	20.00
97261	each additional area	4.00
	Tests and Measurements	
97720	Extremity testing for strength, dexterity, or stamina; initial 30 minutes	$ 31.00

4 MCAR § 1.0022 Special services.

Critical care services (codes 99160 to 99173) include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when crtical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99000	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$ 7.00
99075	Medical testimony	Reasonableness of charges reviewable by department of labor and industry
99080	Special reports like insurance forms, or the review of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or standard reporting form	Reasonableness of charges reviewable by department of labor and industry
	Surgical Procedures	
99025	Initial, new patient visit when asterisk (*) surgical procedure constitutes major service at that visit	$15.00
	Prolonged Services	
99155	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes	$44.00
99156	approximately 50 minutes	81.00

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Critical Care

99160	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$100.00
99172	Critical care, subsequent follow-up visit; limited examination, evaluation, or treatment for same or new illness	30.00
99173	intermediate examination, evaluation, or treatment, same or new illness	44.30

4 MCAR § 1.00225 Physician services—surgery.

A. Scope. The codes, service descriptions, and maximum fees of this rule apply to providers licensed as a doctor of medicine or a doctor of osteopathy.

B. Instructions. The instructions in 1.-5. govern the assignment of codes and the evaluation of services described in this rule.

1. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated follow-up care, both pre- and postoperative. This concept is referred to as a "package" for surgical procedures.

2. Follow-up care includes reports and records as the operation requires and the physician commonly provides. This includes special reports concerning the medical appropriateness of a service for services which are rarely provided, unusual, variable, or new. Information included in these reports are an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

3. Follow-up care for diagnostic procedures, such as endoscopy or injection procedures for radiography, includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

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

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

a. The service as listed includes the surgical procedure only. Associated pre- and postoperative services are not included in the service as listed.

b. Preoperative services shall be listed when:

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

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

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

(4) the asterisk procedure requires hospitalization, an appropriate hospital visit is listed in addition to the asterisk procedure and its follow-up care.

c. All postoperative care is added on a service-by-service basis.

d. Complications are added on a service-by-service basis as with surgical procedures.

C. Integumentary system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system. Excision of benign lesions (codes 11200 to 11442) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, cystic lesions. Treatment of burns (codes 16000 to 16020) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12013) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12031 to 12051) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the

extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13121 to 13132) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in 1.-3. also apply to coding of repair services (codes 12001 to 13132):

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

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

3. Involvement of nerves, blood vessels, and tendons shall be reported under the appropriate system for repair of these structures. The repair of the associated wound shall be included in the primary procedure, unless it qualifies as a complex wound, in which case modifier number 50 applies. Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

Code	Service	Maximum Fee
	Incision	
10000*	Incision and drainage of infected or noninfected sebaceous cyst; one	$ 40.00
10003*	Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity	42.50
10020*	Incision and drainage of furuncle	28.00
10060*	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	40.00
10100*	Incision and drainage of onychia or paronychia single or simple	38.00
10120*	Incision and removal or foreign body, subcutaneous tissues; simple	40.00
10160*	Puncture aspiration of abscess, hematoma, bulla, or cyst	33.50
	Paring or Curettement	
11050*	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 25.00
11051	two or four lesions	28.00
11052	more than four lesions	42.00
	Biopsy	
11100	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 49.00
	Excision—Benign Lesions	
11200*	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 42.00
11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	51.50
11401	lesion diameter 0.5 to 1.0 centimeter	60.00
11402	lesion diameter 1.0 to 2.0 centimeters	75.00
11403	lesion diameter 2.0 to 3.0 centimeters	87.00
11404	lesion diameter 3.0 to 4.0 centimeters	125.00
11420	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	57.00
11421	lesion diameter 0.5 to 1.0 centimeter	70.00
11422	lesion diameter 1.0 to 2.0 centimeters	95.00
11423	lesion diameter 2.0 to 3.0 centimeters	105.00
11424	lesion diameter 3.0 to 4.0 centimeters	120.00

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11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	64.00
11441	lesion diameter 0.5 to 1.0 centimeter	85.00
11442	lesion diameter 1.0 to 2.0 centimeters	98.00
	Nails	
11700*	Debridement of nails, manual; five or less	$ 20.00
11710*	Debridement of nails; electric grinder; five or less	20.00
11730*	Avulsion of nail plate, partial or complete, simple; single	50.00
11740	Evacuation of subungual hematoma	28.00
	Repair—Simple	
12001*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	42.00
12002*	2.5 to 7.5 centimeters	65.00
12004*	7.5 to 12.5 centimeters	84.00
12011*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	60.00
12013*	2.5 to 5.0 centimeters	78.00
12014	5.0 to 7.5 centimeters	80.00
12015	7.5 to 12.5 centimeters	165.00
	Repair—Intermediate	
12031*	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 59.50
12032*	2.5 to 7.5 centimeters	85.00
12034	7.5 to 12.5 centimeters	135.00
12041*	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	80.00
12051*	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	90.00
12052	2.5 to 5.0 centimeters	135.00
	Repair—Complex	
13150	Repair, complex, eyelids, nose, ears, or lips; up to 1.0 centimeter	$152.00
13151	1.0 to 2.5 centimeters	330.00
13152	2.5 to 7.5 centimeters	440.00
	Adjacent Tissue Transfer or Rearrangement	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters	450.00
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	660.00
	Free Skin Grafts	
15050*	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area except on face, up to defect size 2 centimeters diameter	$125.00
15100	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters, or each one percent of body area of infants and children (except 15050)	431.00
	Burns, Local Treatment	
16000	Initial treatment, first degree burn, when no more than local treatment is required	$ 41.50
16010	Dressings or debridement, initial or subsequent; under anesthesia, small	30.00
16020*	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small	30.00
16025*	without anesthesia, medium, for example, whole face or whole extremity	50.00

Destruction

17000*	Destruction by any method, with or without surgical curettement; all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 35.00
17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	30.00
17200*	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	35.00
17250*	Chemical cauterization of a wound	18.10
17300	Chemosurgery (Mohs type technique), malignancies of skin, including removal of lesion and microscopic delineation of margins and base; first stage—fulguration and application of chemicals	350.00
17340*	Cryotherapy (CO_2 slush, liquid N_2)	20.00

D. Musculoskeletal system.[1] The following codes, service descriptions and maximum fees apply to surgical procedures of the musculoskeletal system. Rereduction of a fracture or dislocation performed by the primary physician may be identified by the addition of the modifer number 76 to the usual procedure number to indicate "repeat procedure by same physician."

Excision—General

Code	Service	Maximum Fee
20220	Biopsy, muscle; deep	$ 190.00
29020	Biopsy, bone, trocar, or needle; superficial for example ilium, sternum, spinous process, ribs	110.00

Introduction or Removal—General

20501*	Injection of sinus tract; diagnostic (sinogram) (separate procedure)	$ 47.00
20520*	Removal of foreign body in muscle; simple	36.00
20550*	Injection, tendon sheath, ligament, or trigger points	35.00
20600*	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	40.00
20605*	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa	42.00
20610*	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa	40.00
20670*	Removal of implant; superficial for example buried wire, pin or rod (separate procedure)	60.00
20680	deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate	242.50

Head—Fracture or Dislocation

21315*	Manipulative treatment, nasal bone fracture; without stabilization	$ 88.00
21320	with stabilization	219.00
21360	Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod	530.00

Neck (Soft Tissues) and Thorax—Fracture or Dislocation

Code	Service	Maximum Fee
21800	Treatment of rib fracture; closed, uncomplicated, each	$ 50.00

Spine (Vertebral Column)—Manipulation

22500*	Manipulation of spine, any region	$ 28.00

Shoulders—Fracture or Dislocation

23505	Treatment of closed clavicular fracture; with manipulation	$162.00
23605	Treatment of closed humeral (surgical or anatomical neck) fracture; with manipulation	300.00

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23650	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	80.00
23655	requiring anesthesia	165.00
	Shoulder—Manipulation	
23700*	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	$150.00
	Humesus (Upper Arm) and Elbow—Fracture or Dislocation	
24505	Treatment of closed humeral shaft fracture; with manipulation	$290.00
	Forearm and Wrist—Excision	
25111	Excision of ganglion, wrist (dorsal or volar); primary	$279.00
	Forearm and Wrist—Fracture and Dislocation	
25505	Treatment of closed radial shaft fracture; with manipulation	$235.00
25565	Treatment of closed radial and ulnar shaft fractures; with manipulation	326.00
25600	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, without manipulation	125.00
25605	with manipulation	242.50
25610	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture or ulnar styloid, requiring manipulation; without external skeletal external skeletal fixation or percutaneous pinning	310.00
25611	with external skeletal fixation or percutaneous pinning	350.00
	Hand and Fingers—Repair, Revision, or Reconstruction	
26410	Extensor tendon repair, dorsum of hand, single, primary, or secondary; without free graft, each tendon	169.00
26418	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	233.00
	Hands and Fingers—Fractures or Dislocations	
26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 70.00
26605	with manipulation, each bone	144.00
26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone	383.00
26720	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	56.00
26725	with manipulation, each	92.80
26750	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	37.50
26770	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	45.00
	Hand and Fingers—Amputation	
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	205.00
26952	with local advancement flaps (V-Y, hood)	300.00
	Pelvis and Hip Joint—Fracture or Dislocations	
27236	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	$1,329.00
27244	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,200.00
	Femur (Thigh Region) and Knee Joint—Excision	
27331	Arthrotomy, knee; with joint exploration, with or without biopsy, with or without removal or loose bodies	831.00

27332	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial or lateral	820.00
27345	Excision of synovial cyst of popliteal space (Baker's cyst)	460.00
	Femur (Thigh Region) and Knee Joint—Introduction or Removal	
27370	Injection procedure for knee arthrography	$ 55.00
27373	Arthroscopy, knee, diagnostic (separate procedure)	330.00
27374	Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium	1,080.00
27377	with removal of loose body	900.00
27378	with partial meniscectomy	1,200.00
27379	with plica resection or shelf resection	1,012.50
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27409	Suture, primary, torn, ruptured, or severed ligament, with or without meniscectomy, knee; collateral and cruciate ligaments	1,100.00
27422	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	952.00
27444	Arthroplasty, knee, total; fascial	2,810.00
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (''total knee replacement'')	2,340.00
	Femur (Thigh Region) and Knee Joint—Manipulation	
27570*	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	$ 76.00
	Leg (Tibula and Fibula) and Ankle Joint— Fractures or Dislocations	
27752	Treatment of closed tibial shaft fracture; with manipulation	$279.00
27766	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation	618.85
27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	120.00
27788	with manipulation	195.00
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation	394.00
27814	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	671.00
27822	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	861.00
	Foot—Fracture or Dislocation	
28470	Treatment of closed metatarsal fracture; without manipulation, each	90.00
28475	with manipulation, each	119.00
28490	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	41.00
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	41.00
28515	with manipulation, each	63.50

E. Casts and strapping. The following codes, service descriptions, and maximum fees apply to procedures associated with the application of casts and strapping. The services include the application and removal of the first cast or traction device only.

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Subsequent replacement of cast or traction device may require an additional listing. Codes for cast removal should be employed only for casts applied by another physician.

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29035	Application of body cast, shoulder to hips	$150.00
29065	shoulder to hand (long arm)	65.00
29075	elbow to finger (short arm)	54.00
29085	hand and lower forearm (gauntlet)	53.00

Splints

29105	Application of long arm splint (shoulder to hand)	$ 38.00
29125	Application of short arm splint (forearm to hand); static	30.00
29130	Application of finger splint; static	22.00

Strapping—Any Age

29200	Strapping; thorax	$ 20.00
29220	low back	20.00
29260	elbow or wrist	18.00
29280	hand or finger	20.00

Lower Extremity Casts

29345	Application of long leg cast (thigh to toes)	$ 90.50
29355	walker or ambulatory type	90.00
29358	Application of long leg cast brace	$250.00
29365	Application of cylinder cast (thigh to ankle)	70.00
29405	Application of short leg cast (below knee to toes)	65.00
29425	walking or ambulatory type	73.00
29435	Application of patellar tendon bearing (PTB) cast	96.00
29450	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	40.50
29455	bilateral	82.00

Splints

29505	Application of long leg splint (thigh to ankle or toes)	$ 40.00
29515	Application of short leg splint (calf to foot)	38.00

Strapping—Any Age

29530	Strapping; knee	$ 24.00
29540	ankle	20.00
29580	Unna boot	25.00

Removal or Repair

29700	Removal or bivalving; gauntlet, boot, or body cast	$ 18.00
29720	Repair of spica, body cast, or jacket	15.00

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

Nose—Removal Foreign Body

Code	Service	Maximum Fee
30300*	Removal foreign body, intranasal; office type procedure	$ 29.00

Nose—Repair

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip	$1,332.00
30420	including major septal repair	1,540.00
30520	Septoplasty with or without cartilage implant (separage procedure)	781.00

G. Cardiovascular system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the cardiovascular system. Injection procedures include necessary local anesthesia, introduction of needles or catheter, injection of

contrast medium with or without automatic power injection, or necessary pre- and postinjection care specifically related to the injection procedure. Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.

Vascular Injection Procedures—Intravenous

Code	Service	Maximum Fee
36000*	Introduction of needle or intracatheter, vein; unilateral	$ 49.00

Vascular Injection Procedures—Intra-Arterial; Intra-Aortic

36101	Introduction of needle or intracatheter, carotid, or vertebral artery; bilateral	$213.50

Vascular Injection Procedures—Venous

36410*	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	$ 39.50
36470*	Injection of sclerosing solution; single vein	24.00
36471	multiple veins, same leg	30.00
36480*	Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous	100.00

Vascular Injection Procedures—Arterial

36620	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	$100.00

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

Abdomen, Peritoneum, and Omentum—
Repair, Hernioplasty, Herniorrhaphy, Herniotomy

Code	Service	Maximum Fee
49505	Repair inguinal hernia, age 5 or over; unilateral	$560.00
49506	bilateral	918.00
49510	Repair inguinal hernia, age 5 or over; unilateral, with orchiectomy, with or without implantation of prosthesis	600.00
49515	with excision of hydrocele or spermatocele	673.30
49520	recurrent	672.00
49560	Repair ventral (incisional) hernia (separate procedure)	610.00
49565	recurrent	756.00
49581	Repair umbilical hernia; age 5 or over	480.00

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

Spine and Spinal Cord—
Puncture for Injection, Drainage, or Aspiration

Code	Service	Maximum Fee
62270*	Spinal puncture lumbar diagnostic	$ 65.00
62273*	Injection lumbar epidural, of blood or clot patch	100.00
62274*	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural simple	65.00
62278*	epidural or caudal single	125.00
62284*	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa	130.00

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Spine and Spinal Cord—
Laminectomy or Laminotomy, for Exploration or Decompression

Code	Service	Maximum Fee
63017	Laminectomy for decompression of spinal cord or cauda eguina, more than two segments; lumbar	$2,160.00
63020	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, cervical, unilateral	1,382.00
63030	one interspace, lumbar, unilateral	1,562.00
63042	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or re-exploration; lumbar	2,000.00

Extracranial Nerves, Peripheral Nerves, and
Autonomic Nervous System—Introduction/Injection
of Anesthetic Agent (Nerve Block), Diagnostic or
Therapeutic, Somatic Nerves

Code	Service	Maximum Fee
64450*	Injection, anesthetic agent; other peripheral nerve or branch	$ 61.00

Sympathetic Nerves

64510*	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	$100.00

Extracranial Nerves, Peripheral Nerves, and Autonomic
Nervous System—Exploration, Neurolysis,
or Nerve Decompression (Neuroplasty)

64718	Neurolysis or transposition; ulnar nerve at elbow	$750.00
64721	median nerve at carpal tunnel	528.00

Eye and Ocular Adnexa—Removal of Ocular Foreign Body

65205*	Removal foreign body, external eye; conjunctival superficial	$ 30.00
65210*	conjunctival, embedded (includes concretions), subconjunctival, or scleral nonperforating	38.00
65220*	corneal, without slit lamp	40.00
65222*	corneal, with slit lamp	49.00

J. Auditory system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the auditory system.

External Ear—Removal Foreign Material

Code	Service	Maximum Fee
69200	Removal foreign body from external auditory canal; without general anesthesia	$ 25.00

4 MCAR § 1.0023 Physician services—radiology.

A. General. The following codes, service descriptions, and maximum fees apply to providers licensed as a doctor of medicine and persons licensed as a doctor of osteopathy. The suffix number 26 modifier indicates only the professional component of a combined technical and professional procedure applies. Absence of the suffix indicates the complete procedure, professional and technical.

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

Head and Neck

Code	Service	Maximum Fee
70110	Radiologic examination, mandible; complete, minimum of four views	$ 53.80
70110-26	professional component only	17.40
70130	Radiologic examination, mastoids; complete, minimum of three views per side	65.00
70130-26	professional component only	20.00
70140	Radiologic examination, facial bones; less than three views	40.00
70140-26	professional component only	17.80

70150	complete, minimum of three views	52.00
70150-26	professional component only	17.40
70160	Radiologic examination, nasal bones, complete, minimum of three views	37.50
70160-26	professional component only	10.75
70200	Radiologic examination; orbits, complete, minimum of four views	53.00
70200-26	professional component only	17.80
70210	Radiologic examination, sinuses, paranasal, less than three views	29.80
70210-26	professional component only	12.00
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies	51.30
70220-26	professional component only	17.25
70250	Radiologic examination, skull; less than four views, with or without stereo	38.95
70250-26	professional component only	16.50
70260	complete, minimum of four views, with or without stereo	66.00
70260-26	professional component only	22.90
70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	53.50
70330-26	professional component only	20.00
70355-26	Orthopantogram; professional component only	9.75
70360	Radiologic examination; neck, soft tissue	25.00
70360-26	professional component only	10.75
70450	Computerized axial tomography, head; without contrast material	255.00
70450-26	professional component only	66.00
70460	with contrast material	289.00
70460-26	professional component only	71.50
70470	without intravenous contrast material, followed by contrast material and further sections	336.00
70470-26	professional component only	90.00
	Chest	
71000	Radiologic examination, chest, minifilm	$ 25.00
71010	Radiologic examination, chest; single view, posteroanterior	28.25
71010-26	professional component only	9.75
71015	stereo, posteroanterior	27.30
71015-26	professoinal component only	13.50
71020	two views, posteroanterior and lateral	39.00
71020-26	professional component only	15.25
71021	apical lordotic procedure	31.70
71100	Radiologic examination, ribs, unilateral; two views	42.00
71100-26	professional component only	14.95
71101-26	including posteroanterior chest, minimum of three views, professional component only	21.50
71110	Radiologic examination, ribs, bilateral; three views	52.00
71250-26	Computerized axial tomography, thorax; without contrast material, professional component only	71.50
	Spine and Pelvis	
72010	Radiologic examination, spine, entire, survey study,anteroposterior, and lateral	$108.50
72010-26	professional component only	25.00
72020	Radiologic examination, spine, single view, specify level	30.45
72020-26	professional component only	15.00
72040	Radiologic examination, spine, cervical; anteroposterior and lateral	41.50

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72040-26	professional component only	13.00
72050	minimum of four views	60.50
72050-26	professional component only	20.40
72052	complete, including oblique and flexion or extension studies	65.00
72052-26	professional component only	25.50
72070	Radiologic examination, spine; thoracic, anteroposterior and lateral	44.00
72070-26	professional component only	19.00
72080	thoracolumbar, anteroposterior and lateral	44.00
72080-26	professional component only	11.50
72090	scoliosis study, including supine and erect studies	43.00
72090-26	professional component only	17.50
72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	50.00
72100-26	professional component only	17.90
72110	complete, with oblique views	64.00
72110-26	professional component only	25.00
72114	complete, including bending views	81.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	60.00
72120-26	professional component only	16.00
72145	Computerized axial tomography, spine; with or without contrast material	350.00
72145-26	professional component only	99.00
72170	Radiologic examination, pelvis; anteroposterior only	33.00
72170-26	professional component only	12.50
72180	stereo	36.20
72180-26	professional component only	14.75
72190	complete, minimum of three views	49.50
72190-26	professional component only	20.00
72220	Radiologic examination, sacrum and coccyx, minimum of two views	39.00
72220-26	professional component only	15.50
72241-26	Myelography, cervical; complete procedure professional component only	193.40
72265-26	Myelography, lumbosacral; supervision and interpretation only, professional component only	58.50
72266-26	complete procedure, professional component only	178.20

Upper Extremities

73000	Radiologic examination; clavicle, complete	$ 29.00
73000-26	professional component only	9.75
73010	scapula, complete	33.00
73010-26	professional component only	11.00
73020	Radiologic examination, shoulder; one view	28.50
73020-26	professional component only	9.00
73030	complete, minimum of two views	37.70
73030-26	professional component only	11.00
73040-26	Radiologic examination, shoulder, arthrography; supervision and interpretation only, professional component only	11.25
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	45.00
73050-26	professional component only	13.25
73060	humerous, minimum of two views	32.00
73060-26	professional component only	11.00
73070	Radiologic examination, elbow; anteroposterior and lateral views	30.90
73070-26	professional component only	11.00
73080	complete, minimum of three views	33.25
73080-26	professional component only	13.25
73090	Radiologic examination; forearm, anteroposterior and lateral views	31.00
73090-26	professional component only	11.00
73100	Radiologic examination, wrist; anteroposterior and lateral views	30.00

73100-26	professional component only	11.00
73110	complete, minimum of three views	37.00
73110-26	professional component only	13.25
73120	Radiologic examination, hand; two views	30.00
73120-26	professional component only	11.00
73130	minimum of three views	34.00
73130-26	professional component only	11.00
73140	Radiologic examination, finger or fingers, minimum of two views	28.00
73140-26	professional component only	9.25

Lower Extremities

73500	Radiologic examination, hip; unilateral, one view	$ 28.70
73500-26	professional component only	10.60
73510	complete, minimum of two views	44.00
73510-26	professional component only	15.50
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	50.00
73520-26	professional component only	18.75
73550	Radiologic examination, femur, anteroposterior, and lateral views	36.50
73550-26	professional component only	11.00
73560	Radiologic examination, knee; anteroposterior and lateral views	33.35
73560-26	professional component only	11.00
73562	anteroposterior and lateral, with oblique, minimum of three views	43.00
73562-26	professional component only	12.00
73564	complete, including oplique, or tunnel, or patellar, or standing views	44.00
73564-26	professional component only	16.50
73580-26	Radiologic examination, knee, anthrography; supervision and interpretation only, professional component only	85.00
73581	complete procedure	100.00
73581-26	professional component only	110.25
73590	Radiologic examination; tibia and fibula, anteroposterior and lateral views	35.00
73590-26	professional component only	11.00
73600	Radiologic examination, ankle; anteroposterior and lateral views	30.00
73600-26	professional component only	11.00
73610	complete, minimum of three views	36.00
73610-26	professional component only	12.00
73620	Radiologic examination, foot; anteroposterior and lateral views	30.00
73620-26	professional component only	11.00
73630	complete, minimum of three views	34.10
73630-26	professional component only	11.50
73650	Radiologic examination; calcaneus, minimum of two views	30.00
73650-26	professional component only	9.25
73660	toe or toes, minimum of two views	28.00
73660-26	professional component only	9.00

Abdomen

Code	Service	Maximum Fee
74000	Radiologic examination, abdomen; single anteroposterior view	$ 32.50
74000-26	professional component only	13.00
74010	anteroposterior and additional oblique and cone views	37.50
74010-26	professional component only	16.55

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74020	complete, including decubitus or erect views	44.00
74020-26	professional component only	16.75
74150-26	Computerized axial tomography, abdomen; without contrast material, professional component only	73.25
74170	without contrast material followed by contrast material and further sections	402.00
74170-26	professional component only	88.95
	Gastrointestinal Tract	
74220	Radiologic examination; esophagus	$ 72.00
74220-26	professional component only	37.10
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	82.00
74240-26	professional component only	40.00
74241	with or without delayed films, with KUB	48.00
74241-26	professional component only	32.50
74245	with small bowel, includes multiple serial films	119.00
74245-26	professional component only	66.00
74250	Radiologic examination, small bowel, includes multiple serial films	85.90
74250-26	professional component only	$ 36.50
74270	Radiologic examination, color; barium enema	83.50
74270-26	professional component only	38.60
74280	air contrast with specific high density barium, with or without glucagon	99.00
74280-26	professional component only	58.75
74290	Cholecystography, oral contrast	59.50
74290-26	professional component only	20.00
74291	additional, repeat examination or, multiple day examination	35.50
74291-26	professional component only	12.50
74300-26	Cholangiography; during surgery, professional component only	30.00
74305-26	postoperative, professional component only	36.00
	Urinary Tract	
74400	Urography (pyelography), intravenous, including kidneys, ureters, and bladder	$ 98.00
74400-26	professional component only	35.20
74405	with special hypertensive contrast concentration or clearance studies	99.60
74405-26	professional component only	38.25
74410	Urography, infusion, drip technique;	71.00
74410-26	professional component only	30.00
74415	with nephrotomography	115.80
74415-26	professional component only	45.00
74429-26	Urography, retrograde, with or without kidneys, ureters, and bladder, professional component only	16.50
74430-26	Cystography, minimum of three views; supervision and interpretation only, professional component only	14.50
74431	complete procedure	109.40
74431-26	professional component only	50.00
74450-26	Urethrocystography, retrograde; supervision and interpretation only, professional component only	14.25
74455	Urethrocystography, voiding; supervision and interpretation only	60.00
	professional component only	22.70
74456	complete procedure	94.50
74456-26	professional component only	48.00
	Aorta and Arteries	
75754-26	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only, professional component only	$152.00
	Veins and Lymphatics	
75821-26	Venography, extremity, unilateral; complete procedure professional component only	$121.50

	Miscellaneous	
76000-26	Fluoroscopy (separate procedure), other than 71034 professional component only	$ 34.85
76020	Bone age studies	31.00
76020-26	professional component only	20.00
76040	Bone length studies (orthoroentgenogram, scanogram)	47.50
76040-26	professional component only	19.75
76090	Mammography; unilateral	55.00
76090-26	professional component only	24.00
76091	bilateral	86.75
76091-26	professional component only	37.50
76100	Radiologic examination, single plane body section (for example, tomogrpahy), other than kidney	94.00
76100-26	professional component only	49.00

C. Diagnostic ultrasound. The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

	Head and Neck	
Code	Service	Maximum Fee
76505-26	Echoencephalography, A-mode; complete (diencephalic midline and ventricular size), professional component only	$ 75.00
76506-26	Echoencephalography, B-mode (gray scale) complete (for determination of ventricular size, delineation of cerebral contents and detection of fluid, masses, or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated, professional component only	85.00
76516	Echography, opthalmic, ultrasonic biometry; A-mode, professional component only	126.00
76535-26	Echography, thyroid; B-scan, professional component only	51.75
	Chest	
76620	Echocardiography, M-mode; complete	$194.00
76620-26	professional component only	60.00
	Abdomen and Retroperitoneum	
76700	Echography, abdominal, B-scan; complete	$133.00
76700-26	professional component only	65.00
76705	limited (for example, follow-up or limited study)	105.00
76705-26	professional component only	36.25
76770-26	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; complete	51.75
	Pelvis	
76805	Echography, pelvic, B-scan (for example, real-time), in obstetrics, gynecology, or transplants; complete	$ 85.00
76805-26	professional component only	47.50
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	65.00
76815-26	professional component only	27.50
76855	Echography, pelvic area (Doppler)	55.00

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76855-26	professional component only	53.05
76856	Echography, pelvic, real-time	75.00
76856-26	professional component only	54.50

D. Therapeutic radiology. The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion. Except where specified, clinical treatment management assumes treatment on a daily basis (four or five fractions per week) with the use of megavoltage photon or high energy particle sources. Daily and weekly clinical treatment management are mutually exclusive for the same dates. "Simple" means a single treatment area, single port or parallel opposed ports, simple blocks. "Intermediate" means two separate treatment areas, three or more ports on a single treatment area, use of special blocks. "Complex" means three or more separate treatment areas and highly complex blocking (mantle, inverted Y, tangential ports, wedges, compensators, or other special beam considerations).

Code	Service	Maximum Fee
77400-26	Daily megavoltage treatment management; simple professional component only	$ 30.75
77405	intermediate	10.50
77405-26	professional comopnent only	10.00
77410	complex	28.50
77410-26	professional component only	27.50
77415-26	Therapeutic radiology treatment port film interpretation and verification, per treatment course, professional component only	11.25
77420	Weekly megavoltage treatment management; simple	17.50
77465	Daily kilovoltage treatment management	79.50

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

Diagnostic—Endocrine System

Code	Service	Maximum Fee
78000	Thyroid uptake; single determination	$ 14.00
78000-26	professional component only	17.50
78006-26	Thyroid imaging, with uptake; single determination, professional component only	48.00
78010-26	Thyroid imaging; only, professional component only	36.50

Diagnostic—Gastrointestinal System

78201-26	Liver imaging only; professional component only	$ 64.30
78215-26	Liver and spleen imaging; professional component only	66.00

Diagnostic—Musculoskeletal System

78300-26	Bone imaging; limited area (for example, skull, pelvis), professional component only	66.00
78305-26	multiple areas, professional component only	66.50
78306	whole body	222.40
78306-26	professional component only	64.40

Diagnostic—Cardiovascular System

78403-26	Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion (for example, gated blood pool images), professional component only	55.00

Diagnostic—Respiratory System

78580-26	Pulmonary perfusion imaging; particulate, professional component only	$ 64.40

Diagnostic—Nervous System

78601-26	Brain imaging, limited procedure; with vascular flow professional component only	$ 55.00

Diagnosic—Genitourinary System

78704-26	Kidney imaging; with function study (imaging renogram), professional component only	$ 64.30

4 MCAR § 1.0024 Physician services; pathology and laboratory.

A. Scope. The following codes, service descriptions, and maximum fees apply to providers licensed as a doctor of medicine or as a doctor of osteopathy.

B. Automated, multichannel tests. The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003-80019 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

Albumin	Lactic dehydrogenase (LDH)
Albumin/globulin ratio	Phosphatase, alkaline
Bilirubin, direct	Phosphorus (inorganic phosphate)
Bilirubin, total	Potassium
Calcium	Protein, total
Carbon dioxide content	Sodium
Chloride	Transaminase, glutamic oxaloacetic (SGOT)
Cholesterol	Transaminase, glutamic pyruvic (SGPT)
Creatinine	Urea nitrogen (BUN)
Globulin	Uric acid
Glucose (sugar)	

Automated Multichannel Tests

Code	Service	Maximum Fee
80003	Automated multichannel tests; 3 clinical chemistry tests	$ 29.00
80004	4 clinical chemistry tests	22.00
80005	5 clinical chemistry tests	22.00
80006	6 clinical chemistry tests	28.00
80007	7 clinical chemistry tests	25.00
80008	8 clinical chemistry tests	30.00
80009	9 clinical chemistry tests	31.00
80010	10 clinical chemistry tests	28.50
80011	11 clinical chemistry tests	27.50
80012	12 clinical chemistry tests	27.00
80016	13-16 clinical chemistry tests	30.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	30.00

C. Urinalysis. The following codes, service descriptions, and maximum fees apply to urinalysis procedures.

Code	Service	Maximum Fee
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$ 8.35
81002	routine, without microscopy	5.25
81004	components, single, not otherwise listed, specify	4.50
81005	chemical, qualitative, any number of constituents	4.50
81010	concentration and dilution test	6.00
81015	microscopic only	7.00

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

Code	Service	Maximum Fee
82011	Acetylsalicylic acid; quantitative	$ 17.50
82012	qualitative	15.25
82150	Amylase, serum;	16.10
82250	Bilirubin; blood, total OR direct	11.00
82270	Blood; occult, feces, screening	5.25
82310	Calcium, blood; chemical	11.70
82372	Carbamazepine, serum	27.50
82375	Carbon monoxide, (carboxyhemoglobin); quantitative	22.00
82435	Chlorides; blood (specify chemical or electrometric)	12.10
82465	Cholesterol, serum; total	12.00
82480	Cholinesterase; serum	17.00
82565	Creatinine; blood	12.00
82570	urine	12.00
82575	clearance	24.20
82607	Cyanocobalamin (Vitamin B-12); RIA	31.50
82643	Digoxin, RIA	30.00
82660	Drug screen (amphetamines, barbiturates, alkaloids)	30.20
82756	Free thyroxine indes (T-7)	26.00
82947	Glucose; except urine (for example, blood, spinal fluid, joint fluid)	11.00
82948	blood, stick test	8.00
82950	post glucose dose (includes glucose)	11.00
82951	tolerance test (GTT), three specimens (includes glucose)	36.00
82977	Glutamyl transpeptidase, gamma (GGT)	12.00
82996	Gonadotropin, chorionic, bioassay; qualitative	13.00
82997	quantitative	16.00
82998	Gonadotropin, chorionic, RIA	25.00
83000	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	35.00
83001	RIA	37.25
83002	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	38.00
83020	Hemoglobin; electrophoresis	6.00
83540	Iron, serum; chemical	20.25
83545	automated	12.25
83550	Iron binding capacity, serum; chemical	25.00
83555	automated	20.00
83725	Lithium, blood, quantitative	16.50
84030	Phenylalanine (PKU), blood; Guthrie	8.50
84035	Phenylketones; blood, qualitative	6.50
84037	urine, qualitative	4.00
84045	Phenytoin	28.80
84060	Phosphatase, acid; blood	18.50
84065	prostatic fraction	22.00
84075	Phosphatase, alkaline, blood;	13.00
84078	heat stable (total not included)	18.60
84080	isoenzymes, electrophoretic method	34.63
84100	Phosphorus (phosphate); blood	13.00
84105	urine	12.60
84132	Potassium; blood	11.00
84133	urine	9.00
84136	Pregnanediol; other method (specify)	16.00
84139	Pregnanetriol; other method (specify)	10.00
84165	Protein, total, serum; electrophoretic fractionation and quantitation	24.00
84180	Protein, urine; quantitative, 24-hour specimen	12.50

84190	electrophoretic fractionation and quantitation	19.90
84295	Sodium; blood	10.80
84300	urine	12.00
84420	Theophylline, blood, or saliva	29.00
84442	Thyroxine binding globulin (TBG)	30.00
84443	Thyroid stimulating hormone (TSH), RIA	33.00
84450	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	12.90
84455	colorimetric or fluorometric	12.00
84460	transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	16.50
84478	Triglycerides, blood	14.00
84520	Urea nitrogen, blood (BUN); quantitative	11.00
84550	Uric acid; blood, chemical	12.00
84555	uricase, ultraviolet method	12.50
84560	Uric acid, urine	12.00

E. Hematology. The following codes, service descriptions, and maximum fees apply to hematology procedures.

Code	Service	Maximum Fee
85005	Blood count; basophil count, direct	$ 10.00
85007	differential WBC count (includes RBC morphology and platelet estimation)	8.00
85009	differential WBC count, buffy coat	9.00
85012	eosinophil count, direct	11.00
85014	hematocrit	6.00
85018	hemoglobin, colorimetric	6.50
85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)	14.00
85027	hemogram, automated, with platelet count	20.00
85022	hemogram, automated, and differential WBC count (CBC)	19.00
85031	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	18.50
85041	red blood cell (RBC)	6.10
85044	reticulocyte count	9.50
85095	Bone marrow; aspiration only	48.50
85102	biopsy core (needle)	67.20
85210	Clotting; factor 11, prothrombin, specific	10.00
85580	Platelet; count (Rees-Ecker)	10.90
85585	estimation on smear, only	9.00
85590	phase microscopy	11.00
85595	electronic technique	10.40
85610	Prothrombin time;	10.00
85650	Sedimentation rate (ESR); Wintrobe type	8.00
85651	Westergren type	7.50
85660	Sickling of RBC, reduction, slide method	7.00

F. Immunology. The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86006	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	$ 14.00
86008	Antibody, quantitative titer, not otherwise specified; first antigen	15.00
86016	Antibodies, RBC, saline; high protein and antihuman globulin technique	13.50
86017	with ABO + Rh(D) typing (for holding blood instead of complete crossmatch)	15.00
86060	Antistreptolysin O; titer	16.00
86063	screen	14.00

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86080	Blood typing; ABO only	9.00
86096	Blood typing, RBC antigens other than ABO or Rho(D); direct, slide or tube, including Rh subtypes, each antigen	13.50
86100	Blood typing; Rho(D) only	11.00
86105	Rh genotyping, complete	14.00
86140	C-reactive protein	11.25
86255	Fluorescent antibody; screen	25.60
86256	titer	25.00
86280	Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral)	27.50
86287	Hepatitis B surface antigen (HB_xAg) (Australian antigen, HAA); RIA method	19.00
86300	Heterophile antibodies; screening (includes monotype test), slide or tube	10.25
86305	quantitative titer	14.70
86430	Rheumatoid factor, latex fixation	13.00
86580	Skin test; tuberculosis, patch, or intradermal	7.00
86585	tuberculosis, tine test	6.00

G. Microbiology. The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
87040	Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen)	$ 14.00
87045	stool	20.00
87060	throat or nose	9.20
87072	Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine	19.00
87076	Culture, bacterial, any source; definitive identification, including gas chromatography in addition to anaerobic culture	16.00
87081	Culture, bacterial, screening only, for single organisms	10.00
87082	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	10.00
87083	multiple organisms	6.00
87084	with colony estimation from density chart (includes throat cultures)	14.00
87086	Culture, bacterial, urine; quantitative, colony count	15.00
87087	commercial kit	8.00
87088	identification, in addition to quantitative or commercial kit	16.80
87101	Culture, fungi, isolation; skin	14.00
87102	other source	7.25
87106	definitive identification, by culture, per organism, in addition to skin or other source	15.00
87140	Culture, typing; fluorescent method, each antiserum	12.65
87163	Culture, special extensive definitive diagnostic studies, beyond usual definitive studies	23.00
87164	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection	6.00
87181	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	20.00
87184	disc method, each plate (12 or less discs)	14.00
87186	microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics	20.00
87188	tube dilution method, each antibiotic	17.50
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	9.00
87206	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	11.00
87210	wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites	8.90
87211	wet and dry mount, with interpretation, for ova and parasites	9.80
87220	Tissue examination for fungi (for example, KOH slide)	7.75

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

Cytopathology

Code	Service	Maximum Fee
88104	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 20.00
88109	smears and cell block with interpretation	33.00

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

Code	Service	Maximum Fee
88300	Surgical pathology, gross examination only	$ 24.00
88302	Surgical pathology, gross and microscopic; examination for identification and record purposes (for example, uterine tubes, vas deferens, sympathetic ganglion)	28.00
88304	diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy)	30.00
88305	diagnostic exam, larger specimen or multiple small specimens (for example, prostate clippings, uterine curetings segment of stomach)	29.00
88307	complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides	43.50
88312	Special stains; Group I stains for microorganisms (for example, Gridley, acid fast, methenamine silver, Levaditi)	9.00
88313	Group II, all other special stains, except immunoperoxidase stains	11.00

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

Code	Service	Maximum Fee
89007	Test combinations assigned individual procedure numbers for secretarial convenience only; CBC, urinalysis, serology, blood typing, and Rh grouping (includes codes 85022 or 85031, 81000, 86592, 86082, and 86100)	$ 38.50
89050	Cell count, miscellaneous body fluids (for example, CSF, joint fluid, except blood)	$ 14.00
89180	Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify)	10.00

4 MCAR § 1.0025 Dentists.

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

B. Diagnostic. The following codes, service descriptions, and maximum fees apply to diagnostic services.

Clinical Oral Examinations

Code	Service	Maximum Fee
00110	Initial oral examination	$ 10.00
00120	Periodic oral examination	10.00
00130	Emergency oral examination	11.50

Radiographs

00210	Intraoral complete series (including bitewings)	$ 30.00
00220	Intraoral; periapical, single, first film	5.00
00230	periapical, each additional film	3.00
00240	occlusal, film	7.00

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00250	Extraoral; single, first film	5.00
00260	each additional film	4.00
00270	Bitewing; single film	6.00
00272	two films	9.00
00274	four films	12.00
00330	Panoramic; maxilla and mandible, film	30.00
00335	maxilla and mandible, film, with bitewings	35.00
00340	Cephalometric film	34.00

Tests and Laboratory Examinations

00460	Pulp vitality tests	$ 12.00
00470	Diagnostic casts, with report	20.00
00471	Diagnostic photographs	17.00

C. Restorative. The following codes, service descriptions, and maximum fees apply to restorative procedures. Amalgam restorations include polishing.

Amalgam Restorations

Code	Service	Maximum Fee
02110	Amalgam; one surface, deciduous	$ 19.00
02120	two surfaces, deciduous	30.00
02130	three surfaces, deciduous	39.00
02131	four surfaces, deciduous	45.00
02140	one surface, permanent	20.00
02150	two surfaces, permanent	30.00
02160	three surfaces, permanent	40.00
02161	four or more surfaces, permanent	49.00
02190	Pin retention, exclusive of amalgam	10.00

Silicate Restorations

02210	Silicate cement per restoration	$ 15.00

Acrylic or Plastic Restorations

02310	Acrylic or plastic	$ 21.00
02330	Composite resin; one surface	25.00
02331	two surfaces	36.00
02332	three surfaces	50.00
02334	Pin retention, exclusive of composite resin	10.00
02335	Composite resin (involving incisal angel)	46.00

Crowns—Single Restorations Only

02711	Plastic, prefabricated	$ 85.00
02830	Stainless steel	55.00
02840	Temporary (fractured tooth)	45.00
02892	Steel post and composite or amalgam in addition to crown	65.00

Other Restorative Services

02910	Recement inlays	$ 20.00
02920	Recement crowns	18.00
02940	Fillings (sedative)	20.00
02950	Crown buildups, pin retained	54.00

D. Endodontics. The following codes, service descriptions, and maximum fees apply to endodontic procedures. Pulpotomy procedures exclude final restoration. Root canal therapy includes treatment plan, clinical procedures, and follow-up care.

Pulpotomy

Code	Service	Maximum Fee
03220	Vital pulpotomy	$ 30.00

Root Canal Therapy

03310	Anterior (excludes final restoration)	$ 140.00
03320	Bicuspid (excludes final restoration)	165.00
03330	Molar (excludes final restoration)	215.00

Periapical Services

03410	Apicoectomy; performed as separate surgical procedure (per root)	$ 85.00
03420	performed in conjunction with endodontic procedure (per root)	70.00
03430	Retrograde filling	50.00
03440	Apical curettage	75.00

E. Periodontics. The following codes, service descriptions, and maximum fees apply to periodontic procedures. Surgical services include usual post-operative services.

Surgical Services

Code	Service	Maximum Fee
04210	Gingivectomy or gingivoplasty, per quadrant	$ 90.00
04220	Gingival curettage and root planing	50.00
04260	Osseous surgery (including flap entry and closure), per quadrant	200.00

Adjunctive Periodontal Services

04330	Occlusal adjustment; limited	$ 30.00
04331	complete	75.00

F. Prosthodontics, removable. The following codes, service descriptions, and maximum fees apply to removable prosthodontics. Complete and partial denture procedures include six months post-delivery care.

Complete Dentures

Code	Service	Maximum Fee
05110	Complete upper	$ 385.00
05120	Complete lower	385.00
05130	Immediate upper	395.00
05140	Immediate lower	385.00
05151	Identification, upper prosthesis	10.00
05161	Identification, lower prosthesis	10.00

Partial Dentures

05211	Upper, without clasps, acrylic base	$ 200.00
05212	Lower, without clasps, acrylic base	300.00
05216	Upper, with two chrome clasps with rests, acrylic base	385.00
05218	Lower, with chrome clasps with rests, acrylic base	420.00
05231	Lower, with chrome lingual bar and two clasps, acrylic base	400.00
05241	Lower, with chrome lingual bar and two clasps, cast base	450.00
05251	Upper, with chrome palatal bar and two clasps, acrylic base	425.00
05261	Upper, with chrome palatal bar and two clasps, cast base	450.00
05292	Full cast partial, with two chrome clasps (upper)	450.00
05294	Full cast partial, with two chrome clasps (lower)	450.00

Adjustments to Dentures

05410	Complete denture	$ 12.00
05421	Partial denture (upper)	15.00
05422	Partial denture (lower)	15.00

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Repairs to Dentures

05610	Repair broken complete or partial denture, no teeth damaged	$ 45.00
05620	Repair broken complete or partial denture, replace one broken tooth	50.00
05630	Replace additional teeth, each tooth	20.00
05640	Replace broken tooth or denture, no other repairs	40.00
05650	Adding tooth to partial denture to replace extracted tooth; each tooth (not involving clasp or abutment tooth)	51.00
05660	each tooth (involving clasp or abutment tooth)	75.00
05670	Reattaching damaged clasp on denture	50.00
05680	Replacing broken clasp with new clasp on denture	60.00
05690	Each additional clasp with rest	50.00

Denture Duplication

05710	Duplicate upper or lower complete denture	$ 175.00
05720	Duplicate upper or lower partial denture	150.00

Denture Relining

05730	Relining upper or lower complete denture (office recline)	$ 110.00
05740	Relining upper or lower partial denture (office recline)	110.00
05750	Relining upper or lower complete denture (laboratory)	125.00
05760	Relining upper or lower partial denture (laboratory)	125.00

Other Prosthetic Services

05820	Denture, temporary (partial-stayplate), upper	$ 150.00
05850	Tissue conditioning	23.00

G. Prosthodontics, fixed. The following codes, service descriptions, and maximum fees apply to fixed prosthodontics.

Repairs

Code	Service	Maximum Fee
06620	Replace broken facing where post is intact	$ 50.00
06640	Replace broken facing with acrylic	40.00

Other Prosthetic Services

06930	Recement bridge	$ 25.00

H. Oral surgery. The following codes, service descriptions, and maximum fees apply to oral surgery procedures. Surgical extractions include local anesthesia and routine post-operative care. Surgical excisions apply to excision of reactive inflammatory lesions (scar tissue or localized congenital lesions).

Extractions

Code	Service	Maximum Fee
07110	Single tooth	$ 22.00
07120	Each additional tooth	20.00

Surgical Extractions

07210	Extraction of tooth, erupted	$ 50.00
07220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	68.00
07230	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the removal of the tooth	85.00
07240	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal	95.00
07241	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and presents unusual difficulties and circumstances	100.00
07250	Root recovery (surgical removal of residual root)	45.00

	Other Surgical Procedures	
07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including wire attachment where indicated	$ 80.00
07285	Biopsy of oral tissue (hard)	75.00
07286	Biopsy of oral tissue (soft)	60.00
	Alveoloplasty (surgical preparation of ridge for dentures)	
07310	Per quadrant, in conjunction with extractions	$ 50.00
07320	Per quadrant, not in conjunction with extractions	65.00
	Surgical Excision	
07410	Radical excision; lesion diameter up to 1.25 centimeters	$ 50.00
07425	Excision periocoronal gingiva	25.00
	Removal of Cysts and Neoplasms	
07450	Removal of odontogenic cyst or tumor, up to 1.25 centimeters diameter	$ 100.00
	Surgical Incision	
07510	Incision and drainage of abscesses, intraoral	$ 28.00
	Other Repair Procedures	
07960	Frenulectomy, separate procedure (frenectomy or frenotomy)	$ 60.00

I. Orthodontics. The following codes, service descriptions, and maximum fees apply to orthodontic procedures.

	Diagnostic Procedures	
Code	Service	Maximum Fee
08010	Examination, OIS sheet, photos	$ 25.00
08020	Full ortho case study	75.00

J. Miscellaneous. The following codes, service descriptions, and maximum fees apply to miscellaneous dental procedures not listed elsewhere.

Code	Service	Maximum Fee
09110	Palliative (emergency) treatment of dental pain, minor procedures	15.00
	Anesthesia	
09220	General	$ 40.00
09230	Analgesia	10.00
	Professional Consultation	
09310	Consultation, per session	$ 20.00
	Professional Visits	
09410	House calls	$ 15.00
09420	Hospital calls	12.00
09430	Office visit, during regularly scheduled office hours (no operative services performed)	11.00
09440	Office visit, after regularly scheduled office hours (no operative services performed and no other services rendered)	28.00
	Drugs	
09610	Therapeutic drug injection (excluding drug cost)	$ 13.50

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Miscellaneous Other Services

09910	Application of desensitizing medicaments (where not included or implied in associated procedure)	$ 10.00

4 MCAR § 1.0026 Optometrists, opticians.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed optometrists and opticians.

B. Basic optometric services. The following codes, service descriptions, and maximum fees apply to basic optometric services.

Code	Service	Maximum Fee
80101	Basic vision examination and diagnosis, to include the following minimum procedures: case history; visual acuity, distance and near; internal and external eye health examination; subjective refraction for distance and near; phorometric tests of accommodation, convergence, and binocular coordination at far and near point; visual skills; and case analysis and presentation	$ 30.00
80102	Basic vision examination and diagnosis, presbyopic (over 30) to include the following procedures: all included in 80101, except visual skills may be deleted; and tonometry and field screening	35.00
80103	Single vision prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	24.43
80104	Single vision dispensing services (includes frame selection, fitting, and servicing)	22.98
80113	Multifocal prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	29.80
80114	Multifocal dispensing services (includes frame selection, fitting, and servicing)	24.50
80105	Office call: visual screening or evaluation of patient's complaint to determine need for further examination	12.00
80106	Out of office call	10.00

C. Low vision prescription device. The following codes, service descriptions, and maximum fees apply to low vision prescription devices. The services and codes listed are to be employed in place of 80103 and 80104.

Code	Service	Maximum Fee
80403	Prescription services, including: frame measurement, vertex distance measurement; computation of lens specifications; and verification of completed prescription	$ 51.00
80404	Dispensing services, including: frame selection; and fitting and servicing	27.00

D. miscellaneous services. The following codes, service descriptions, and maximum fees apply to miscellaneous services not listed elsewhere. The services listed shall not be employed for follow-up services included in prior charges to established patients. The services listed do not include laboratory or materials charges.

Code	Service	Maximum Fee
80801	Minor refitting	$ 5.00
80811	Complete refitting	4.60
80802	Frame replacements with necessary adjustments	16.00
80803	Front replacements with necessary adjustments	12.00
80804	One or both temple replacements with necessary adjustments	6.10
80805	Hinge repair	5.00
80807	Minor frame repair and readjustment of frame, including: replacement of screws; supply of new nose pads; supply of temple covers; supply of pad covers; soldering; and other miscellaneous minor repairs	4.30
80808	Neutralization of lenses for copy of prescription	4.00
80809	Lens replacement; one lens, single vision	12.00
80810	both lenses, single vision	21.40
80819	one lens, multifocal vision	19.81
80820	both lenses, multifocal vision	42.10

E. Materials, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services.

Code	Service	Maximum Fee
80107	Frames	$ 16.00
80108	Single vision lenses	17.20
80111	Multifocal lenses	32.60
80118	Lenses for aphakia	61.00

4 MCAR § 1.0027 Audiologists and speech pathologists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to audiologists and to speech pathologists certified by the American Speech and Hearing Association.

B. Audiology. The following codes, service descriptions, and maximum fees apply to audiology services.

Code	Service	Maximum Fee
21010	Basic hearing evaulation	$ 40.00
21021	Limited hearing evaluation	32.00
21022	Extended hearing evaluation	64.00
21031	Limited site of auditory lesion evaluation	16.00
21032	Extended site of auditory lesion evaluation	32.00
21050	Basic prescription hearing aid evaluation	45.00
21052	Extended prescription hearing aid evaluation	45.00
21053	Performance evaluation of specific hearing aid	20.00
21081	Hearing screening, group	9.50

C. Speech pathology. The following codes, service descriptions, and maximum fees apply to speech pathology services.

Code	Service	Maximum Fee
22010	Basic speech, language, or voice evaluation	$ 70.00
22012	Extended speech, language, or voice evaluation	20.00
22013	Speech, language, or voice reevaluation	7.50
22060	Basic consultation	30.00
22070	Rehabilitation one-fourth hour, individual	15.00
22071	Rehabilitation one-half hour, individual	30.00
22072	Rehabilitation one hour, individual	45.00
22073	Rehabilitation one-half hour, group	15.00
22074	Rehabilitation one hour, group	30.00

4 MCAR § 1.0028 Physical therapists and occupational therapists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to registered physical therapists and occupational therapists.

B. Physical therapy. The following codes, service descriptions, and maximum fees apply to physical therapy procedures.

Evaluations

Code	Service	Maximum Fee
24001	Physical function evaluation; initial 15-minute unit	$ 22.00
24010	Perceptual, sensory, or motor evaluation; initial 15-minute units	15.00
24011	additional 15-minute units	15.00
24015	Activities of daily living evaluation; initial 15-minute unit	25.00
24016	additional 15-minute units	25.00

Physical Restoration Procedures

09440	Office visit with one of the following modalities to one area: 1. Hot or cold packs 2. Traction, mechanical	

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	3. Electrical stimulation	
	4. Ultrasound	
	5. Vasopneumatic devices	
	6. Paraffin bath	
	7. Microwave	
	8. Whirlpool	
	9. Diathermy	
	10. Infrared	
	11. Ultraviolet	$ 25.00
09441	Office visit with two or more modalities to the same area	32.00
09444	Office visit with one of the following procedures to one area; initial 30 minutes	
	1. Therapeutic exercises	
	2. Neuromuscular reeducation	
	3. Functional activities	
	4. Gait training	
	5. Orthotics training	
	6. Prosthetics training	
	7. Electrical stimulation (manual)	
	8. Iontophoresis	
	9. Traction, manual	
	10. Massage	
	11. Contract baths	19.00
09445	each additional 15 minutes	6.00
09447	Office visit including combination of any modality and procedure; initial 30 minutes	26.00
09448	each additional 15 minutes	11.50

Maintenance Therapy Procedures

24201	Maintenance therapy procedures; initial 15 minute unit	$ 7.50
24202	additional 15-minute units	7.50
24203	one hour	14.50
24301	Consultation with report—for specific individual patient; initial 15-minute unit	7.50
24302	additional 15-minute units	7.50

C. Occupational therapy. The following codes, service descriptions, and maximum fees apply to occupational therapy procedures.

Evaluations

Code	Service	Maximum Fee
23010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	$ 27.00
23011	additional 15-minute units	27.00
23015	Activities of daily living evaluation; initial 15-minute unit	12.00
23016	additional 15-minute units	12.00

Physical Restoration Procedures

23100	Activities of daily living training; initial 15-minute unit	$ 12.00
23101	additional 15-minute units	12.00
23115	Dexterity or coordination training; initial 15-minute unit	12.00
23116	additional 15-minute units	12.00
23135	Neurodevelopmental training; initial 15-minute unit	12.00
23136	additional 15-minute units	12.00
23150	Perceptual, sensory, or motor training; one hour group session	24.00
23151	initial 15-minute unit, individual	12.00
23152	additional 15-minute units, individual	12.00

Consultation Services

23300	Consultation with report, for specific individual patient; initial 15-minute unit	$ 7.50
23301	additional 15-minute units	12.00

4 MCAR § 1.0029 Chiropractors.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed doctors of chiropractic medicine.

B. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
09510	Routine initial examination, history and diagnosis	$ 30.00
09501	Intermediate examination, history and diagnosis	30.00
09502	Extensive examination with history and diagnosis, complete history and physical examination of one or more systems, with report	50.00
09506	Intermediate examination or evaluation, same illness, established patient, progress examination, with report	27.00
09509	Home or nursing home visit with routine chiropractic examination or treatment which includes adjustment, manipulation or one unit of conjunctive therapy for the same or new condition	42.00
09503	Office visit with cast application to one area, for example, short arm, short leg, knee, or elbow	22.00
09508	Office visit with cast applicaton to one area, for example, long leg, thoracolumbar, lumbosacral, or full body corset type	32.00
09009	Same visit, each additional conjunctive or manipulative therapy per anatomical area of diagnosis, for example, neck, back, extremities—anatomical areas include associated soft tissues and nerves	10.00
09504	Treatment, one unit of manipulative or conjunctive therapy (specify)	18.00
09505	Treatment, one unit of manipulative and one-half unit of conjunctive therapy (specify)	24.00
09194	Thermography, initial or subsequent, used for evaluative purposes	15.00
09507	Ambulation traction application	11.00

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

Code	Service	Maximum Fee
	Chest	
71010	Radiologic examination, chest; (single view, posteroanterior)	$ 42.00
	Spine and Pelvis	
72010	Radiologic examination, spine, entire, survey study (14 × 36, anteroposterior and lateral)	$ 50.00
72040	Radiologic examination, spine, cervical; limited (anteroposterior and lateral)	30.00
72050	comprehensive (minimum of four views)	30.00
72052	comprehensive (minimum of seven views including flexion and extension)	30.00
72070	Radiologic examination, spine; thoracic, (anteroposterior and lateral)	36.00
72080	thoracic, limited (anteroposterior and lateral)	40.00
72090	scoliosis study, comprehensive	34.00
72100	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral)	40.00
72110	lumbosacral, comprehensive (minimum of five views)	51.00
72120	Radiologic examination, spine, lumbosacral, bending views only (minimum of four views)	40.00
72170	Radiologic examination, pelvis; limited (minimum of two views)	44.00
72190	complete (minimum of three views)	70.00
	Upper Extremeties	
73020	Radiologic examination, shoulder; limited (one projection)	$ 22.50
73030	comprehensive, complete study	22.00

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73070	Radiologic examination, elbow; limited (anteroposterior and lateral)	30.00
73100	Radiologic examination, wrist; limited (anteroposterior and lateral)	25.00
73120	Radiologic examination, hand	20.00
	Lower Extremities	
73500	Radiologic examination, hip; limited (one view)	$ 24.50
73560	Radiologic examination, knee; limited (two views)	30.00
73570	Radiologic examination, knee; comprehensive (minimum of three views)	36.00
73600	Radiologic examination, ankle; limited (two views)	22.50
73610	comprehensive (minimum of three views)	22.50
73620	Radiologic examination, foot; limited (two views)	20.00
73620	Radiologic examination, foot; limited (two views)	20.00
73630	complete routine study (minimum of three views)	25.00
	Miscellaneous	
76140	Consultation on x-ray examination made elsewhere, written report	$ 25.00

D. Laboratory. The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles (codes 8003-80019) include the following tests:

Albumin
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Cephalin flocculation
Chlorides
Cholesterol
Creatinine
Hemoglobin
Hematocrit
Lactic dehydrogenase
Phosphatase, acid
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Red blood cell count
Sodium
Sugar (glucose)
Thymol turbidity
Transaminase, gluten, exalic (SGOT)
Transaminase, gluten, pyruvic (SGPT)
Triglycerides
Urea nitrogen
Uric acid
White blood cell count

Code	Service	Maximum Fee
80003	Standard profile (up to and including 12 tests) for arthritic, bone, lipid and thyroid	$ 40.00
80016	13-16 clinical chemistry tests	35.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	55.00
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	10.00
81002	routine, without microscopy	10.00
85022	Blood count; hemogram, automated (CBC) with differential WBC count	17.00

4 MCAR § 1.0030 Podiatrists.

A. Scope. The codes, service descriptions, and maximum fees in this rule apply to licensed doctors of podiatric medicine.

B. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Patient Visits

Code	Service	Maximum Fee
09000	Initial office visit, routine, new patient or new illness, history and examination	$ 25.00
09003	Follow-up office visit, brief, for example, routine injection, minimal dressing	15.00
09004	Follow-up office visit, routine	17.00
09005	Follow-up office visit necessitating professional care over and above routine visit	23.50
09006	Follow-up office visit, prolonged, over and above 09005	18.00

09001	Initial hospital visit, limited	35.00
09002	Comprehensive hospital visit	22.00
09010	Initial home or convalescent home visit, routine, new patient or new illness, history and examination	17.00
09013	Follow-up home or convalescent home visit, brief, for example, routine injection, minimal dressing	13.00
09014	Intermediate home or convalescent home examination, evaluation, or treatment, new illness or same illness	20.00
09028	Consultation requiring limited examination or evaluation of a given system but not requiring a complete diagnostic history and examination	25.00

Physical Medicine

09440	Office visit with one or more of the following modalities to one area:	

Hot or cold packs	Paraffin bath
Traction, mechanical	Microwave
Electrical stimulation	Whirlpool
Ultrasound	Diathermy
Vasopneumatic devices	Infrared
Ultraviolet	

$ 16.00

C. Surgery. The following codes, service descriptions, and maximum fees apply to surgical services. An asterisk (*) indicates that the service includes the surgical procedure only. All other services include the operation per se, and normal uncomplicated pre- and postoperative follow-up care.

Integumentary System

Code	Service	Maximum Fee
00125*	Drainage of onychia or paronychia	$ 20.00
00160*	Debridement of extensively eczamatized or infected skin up to ten percent of the body surface	18.00
00162*	Debridement of nails, any method; five or less	13.00
00163*	each additional five nails or major portion thereof	8.00
00164	Debridement of abrasions	20.00
00171	Biopsy, excision of skin, subcutaneous tissue or mucus membrane for biopsy including simple closure as an independent procedure	25.00
00175	Excision of benign cicatrical, fibrous inflammatory, congenital, cystic, and other lesion of skin, subcutaneous tissue or mucous membrane; one lesion, diameter up to one-fourth inch (0.6 centimeter)	10.00
00225*	Avulsion, nail, partial or complete, simple	17.00
00228	Excision of nail or nail matrix, partial or complete, for example, ingrown or deformed nail for permanent removal	150.00
00403*	Electro-surgical destruction or cemocantery or cryocautery of benign or pre-malignant lesion with or without curettement, one lesion	20.00

D. Radiology. The following codes, service descriptions, and maximum fees apply to radiology services.

Code	Service	Maximum Fee
07307	Radiologic examination, ankle; two views	$ 28.00
07308	complete, minimum of three views	30.00
07309	Radiologic examination, foot; two views	29.00
07310	complete routine study, minimum of three views	42.00

E. Material, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services, unless explicitly stated.

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Code	Service	Maximum Fee
01209	Fitted orthotic balanced appliance: metal, thermoplastic, or other; unilateral	$ 75.00
01259	bilateral	150.00
01309	Fitted orthotic balanced appliance: leather, cork celastic; unilateral	60.00
01359	bilateral	135.00
01409	Latex shield or urethane mold	30.00
01509	Negative impression for fitted orthotic, unilateral	20.00
01609	Shoe therapy, adding, fiberglass, modification; unilateral	25.00
01659	bilateral	35.00
01809	Post-surgical splint (Reece surgical shoe)	17.50
01909	Strappings for partial immobilization of foot or ankle	15.00
02009	Foot, ankle, leg measurements (bio-mechanical evaluation) for orthotics, prosthetics for foot deformities	25.00
06600	Sterile surgical tray set-up (supplies)	40.00

4 MCAR § 1.0031 Psychologists and social workers.

A. Scope. The codes, service descriptions, and maximum fees of this rule apply to licensed psychologists and social workers with the master of social work degree or a comparable degree.

B. Psychological services. The following codes, service descriptions, and maximum fees apply to psychological services.

Code	Service	Maximum Fee
09046	Initial office visit with evaluation and history, one hour	$ 65.00
09048	Initial inpatient hospital visit, including history and evaluation, per hour	62.50
09066	Psythotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour	65.00
09067	Psychotherapy, group (maximum ten persons per group) 1-½ hours per person	35.00
09068	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour	40.00
09070	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge)	60.00

C. Social workers counseling. The following codes, service descriptions, and maximum fees apply to counseling by social workers.

Code	Service	Maximum Fee
25210	Individual client counseling; initial 30-minute unit	$ 30.00
25211	additional 30-minute units	30.00
25215	Family counseling; initial 30-minute unit	21.00
25216	additional 30-minute units	21.00

4 MCAR § 1.0032 Hospital—semi-private room charges.

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

B. Group 1. The following hospitals make up group 1:

Abbott Northwestern Hospital, Minneapolis
Bethesda Lutheran Medical Center, St. Paul
The Children's Hospital, St. Paul
Divine Redeemer Memorial Hospital, South St. Paul
Eitel Hospital, Minneapolis
Fairview Hospital, Minneapolis
Fairview-Deaconess Hospital, Minneapolis
Fairview-Southdale Hospital, Minneapolis
Gillette Children's Hospital, St. Paul
Golden Valley Health Center, Golden Valley

Mercy Medical Center, Coon Rapids
Methodist Hospital, St. Louis Park
Metropolitan Medical Center, Minneapolis
Midway Hospital, St. Paul
Miller-Dwan Medical Center, Duluth
Minneapolis Children's Hospital, Minneapolis
Mounds Park Hospital, St. Paul
Mount Sinai Hospital, Minneapolis
North Memorial Medical Center, Robbinsdale
Saint Cloud Hospital, St. Cloud
St. John's Hospital, St. Paul
St. Joseph's Hospital, St. Paul
St. Luke's Hospital, Duluth
St. Mary's Hospital, Duluth
St. Mary's Hospital, Minneapolis
The Samaritan Hospital, St. Paul
Sister Kenny Institute, Minneapolis
United Hospital, St. Paul
Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semi-private room charge for one day	$ 175.00

C. Group 2. The following hospitals make up group 2:

A. L. Vadheim Memorial Hospital, Tyler
Ada Municipal Hospital, Greenbush
Aitkin Community Hospital, Aitkin
Albany Community Hospital, Albany
Appleton Municipal Hospital, Appleton
Arlington Municipal Hospital, Appleton
Arnold Memorial Hospital, Adrian
Buffalo Memorial Hospital, Buffalo
Caledonia Community Hospital, Caledonia
Canby Community Hospital, Canby
Central Mesabi Medical Center, Hibbing
Chippewa County-Montevideo Hospital, Montevideo
Chisago Lakes Hospital, Chisago City
Clarkfield Memorial Hospital, Clarkfield
Clearwater County Memorial Hospital, Bagley
Cloquet Community Memorial Hospital, Cloquet
Comfrey Hospital, Comfrey
Community Hospital—Cannon Falls, Cannon Falls
Community Hospital—St. Peter, St. Peter
Community Memorial Hospital—Deer River, Deer River
Community Memorial Hospital—Spring Valley, Spring Valley
Community Memorial Hospital—Winona, Winona
Community Mercy Hospital—Onamia, Onamia
Cook Community Hospital, Cook
Cook County Northshore Hospital, Grand Marais
Cuyuna Range District Hospital, Crosby
Dr. Henry Schmidt Memorial Hospital, Westbrook

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District Memorial Hospital—Forest Lake, Forest Lake
Divine Providence Hospital, Ivanhoe
Douglas County Hospital, Alexandria
Ely-Bloomenson Community Hospital, Ely
Eveleth Fitzgerald Community Hospital, Eveleth
Fairmont Community Hospital, Fairmont
Fairview Princeton Hospital, Princeton
Fosston Municipal Hospital, Fosston
Gaylord Community Hospital, Gaylord
Glacial Ridge Hospital, Glennwood
Glencoe Municipal Hospital, Glencoe
Granite Falls Municipal Hospital, Granite Falls
Grant County Hospital, Elbow Lake
Greenbush Community Hospital, Greenbush
Harmony Community Hospital, Harmony
Hendricks Community Hospital, Hendricks
Heron Lake Municipal Hospital, Heron Lake
Holy Trinity Hospital, Graceville
Hutchinson Community Hospital, Hutchinson
Immanuel-St. Joseph's Hospital, Mankato
International Falls Memorial Hospital, International Falls
Itasca Memorial Hospital, Grand Rapids
Jackson Municipal Hospital, Jackson
Johnson Memorial Hospital, Dawson
Kanabec Hospital, Mora
Karlstad Health Facilities, Karlstad
Kittson Memorial Hospital, Hallock
Lake City Hospital, Lake City
Lake Region Hospital, Fergus Falls
Lake View Memorial Hospital, Two Harbors
Lakefield Municipal Hospital, Lakefield
Lakeview Memorial Hospital, Stillwater
Littlefork Municipal Hospital, Littlefork
Long Prairie Memorial Hospital, Long Prairie
Luverne Community Hospital, Luverne
Madelia Community Hospital, Madelia
Madison Hospital, Madison
Mahnomen County-Village Hospital, Mahnomen
Meeker County Memorial Hospital, Litchfield
Melrose Hospital, Melrose
Memorial Hospital—Cambridge, Cambridge
Memorial Hospital—Perham, Perham
Memorial Community Hospital—Bertha, Bertha
Mercy Hospital, Moose Lake
Milaca Area Hospital, Milaca
Minnesota Valley Memorial Hospital, Le Sueur
Minnewaska District Hospital, Starbuck
Monticello-Big Lake Community Hospital, Monticello
Mountain Lake Community Hospital, Mountain Lake
Murray County Memorial Hospital, Slayton
Naeve Hospital, Albert Lea
North Country Hospital, Bemidji
Northern Itasca Hospital, Big Fork
Northfield City Hospital, Northfield
Northwestern Hospital, Thief River Falls
Olmsted Community Hospital, Rochester
Ortonville Hospital, Ortonville

Owatonna City Hospital, Owatonna
Parkers Prairie District Hospital, Parkers Prairie
Paynesville Community Hospital, Paynesville
Pelican Valley Health Center, Pelican Valley
Pipestone County Hospital, Pipestone
Queen of Peace Hospital, New Prague
Redwood Falls Municipal Hospital, Redwood Falls
Regina Memorial Hospital, Stillwater
Renville County Hospital, Olivia
Rice County District One Hospital, Faribault
Rice Memorial Hospital, Willmar
Riverview Hospital, Crookston
Roseau Area Hospital, Roseau
Rush City Hospital, Rush City
St. Ansgar Hospital, Moorhead
St. Elizabeth Hospital, Wabasha
St. Francis Hospital, Breckenridge
St. Francis Regional Medical Center, Shakopee
St. Gabriel's Hospital, Little Falls
St. John's Hospital, Browerville
St. John's Hospital, Red Lake Falls
St. John's Hospital, Red Wing
St. Joseph's Hospital, Brainerd
St. Joseph's Hospital, Park Rapids
St. Mary's Hospital, Detroit Lakes
St. Mary's Hospital, Winstead
St. Michael's Hospital, Sauk Centre
St. Olaf Hospital, Austin
Sandstone Area Hospital, Sandstone
Sanford Memorial Hospital, Farmington
Sioux Valley Hospital, New Ulm
Sleepy Eye Municipal Hospital, Sleepy Eye
Springfield Community Hospital, Springfield
Stevens County Memorial Hospital, Morris
Swift County-Benson Hospital, Benson
Tracy Municipal Hospital, Tracy
Tri-County Hospital, Wadena
Trimont Community Hospital, Trimont
Trinity Hospital, Baudette
Tweeten Memorial Hospital, Spring Grove
United District Hospital, Staples
United Hospital, Blue Earth
Virginia Regional Medical Center, Virginia
Waconia Ridgeview Hospital, Waconia
Warren Community Hospital, Warren
Waseca Area Memorial Hospital, Waseca
Weiner Memorial Medical Center, Marshall
Wells Municipal Hospital, Wells
White Community Hospital, Aurora
Windom Area Hospital, Windom
Zumbrota Community Hospital, Zumbrota

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Service	Maximum Fee
Group 2 semi-private room charge for one day	$ 138.00

D. Group 3. The following hospitals make up group 3:

Hennepin County Medical Center, Minneapolis
St. Paul Ramsey Medical Center, St. Paul
University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semi-private room charge for one day	$ 210.00

E. Group 4. The following hospitals make up group 4:

Rochester Methodist Hospital, Rochester
St. Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semi-private room charge for one day	$ 138.63

SUPREME COURT

Decisions Filed Friday, August 26, 1983

Compiled by Wayne O. Tschimperle, Clerk

C0-83-143 State of Minnesota, Appellant v. Wayne Donald King. Washington County.

Defendant's particular amenability to probation justified dispositional departure in the form of stay of execution of presumptively executed sentence.

Affirmed. Amdahl, C.J.

C6-82-69 West American Insurance Company, Appellant v. Westin, Inc., etc. Ramsey County.

Defendant, a Wisconsin border city vendor of intoxicating liquor, does not, on the record before this court, have the requisite "minimum contacts" with Minnesota that would permit the constitutional exercise of personal jurisdiction over it by a Minnesota court.

Affirmed. Peterson, J. Concurring specially, Wahl, J.

Dissenting, Scott, Yetka and Todd, JJ.

C3-82-1485 Susan K. England, petitioner v. Steven J. England, Appellant. Carver County.

The revised Uniform Reciprocal Enforcement of Support Act (URESA), Minn. Stat. ch. 518C (1982), may be employed to determine and enforce the duty of a parent to support minor children of a marriage even though there exists no prior or pending action affecting the marital relationship or affecting child custody, visitation, or support.

Deprivation of custody or visitation is not a proper factor to consider in determining or enforcing interstate support obligations under the revised Uniform Reciprocal Enforcement of Support Act, Minn. Stat. ch. 518C (1982).

Affirmed. Peterson, J.

C9-82-1510 Michael R. McQuarrie and Sandra McQuarrie v. Waseca Mutual Insurance Company, Appellant. Goodhue County.

Although appellant insurer did not cancel its fire insurance policy with respondents homeowners in compliance with the terms of the policy, the policy was rescinded by mutual agreement when, after notice of the insurer's intent to cancel, the insured obtained substitute coverage.

Reversed. Peterson, J.

C2-83-46 Cleveland Wallace, Relator v. Commissioner of Economic Security. Department of Economic Security.

Remanded and jurisdiction retained. Peterson, J.

C4-81-562 State of Minnesota v. Harlan K. Kindem, Appellant. Hennepin County.

Defendant received a fair trial, was properly convicted of third-degree murder, and was properly sentenced to a prison term nearly two times the length of the maximum presumptive sentence established by the Sentencing Guidelines.

Affirmed. Simonett, J.

C7-82-713 State of Minnesota v. Charles B. Williams, Appellant. Hennepin County.

Defendant received a fair trial, was properly convicted of second-degree murder as well as assault in the first degree, and is not entitled to a reduction of his sentence.

Affirmed. Simonett, J.

C2-82-1509 Jeff Schermerhorn and Perry Schermerhorn v. B. H. Hoiland, etc., *et al.*, Defendants and Raymond Johnson, Appellant. Becker County.

Denial of a motion to dismiss for lack of personal jurisdiction over a defendant nonresident was proper where plaintiffs have alleged facts which, if true, are sufficient to establish the minimum constitutional contacts of the defendant nonresident with Minnesota.

Affirmed. Simonett, J.

STATE CONTRACTS

Pursuant to the provisions of Minn. Stat. § 16.098, subd. 3, an agency must make reasonable effort to publicize the availability of any consultant services contract or professional and technical services contract which has an estimated cost of over $2,000.

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.

Department of Economic Security Governor's Job Training Office

Notice of Request for Proposals for Operation of Job Training Programs for Older Individuals

The Minnesota Department of Economic Security, Governor's Job Training Office, is requesting proposals from appropriate organizations and units of government to provide employment and training services to older workers. The program, authorized by Section 124 of the Job Training Partnership Act, is designed "to provide for the training and placement of low income persons 55 years of age and older in employment opportunities with private business concerns."

Approximately $520,000 will be available for the period from November 1, 1983 to June 30, 1984.

Request for Proposal and the application forms are available upon request. Inquiries and request should be directed to:

Jim Korkki
Governor's Job Training Office
690 American Center Building
150 East Kellogg Boulevard
St. Paul, Minnesota 55101
(612) 297-2059

Proposals must be received by the Governor's Job Training Office no later than Friday, September 30, 1983 at 4:30 p.m.

Department of Health
Health Systems Division

Notice of Request for Proposal for Consultant Services for Development of Cost Containment Policy Options

The Minnesota Department of Health is seeking proposals for development of policy options for state government programs pertaining to cost containment for institutional acute care health services. Phase 1 of the project is scheduled to be completed within 3½ months. A second phase, initiated at the State's discretion, is scheduled to be completed in 4 months.

Estimated cost: Phase 1: $25,000 Phase 2: $15,000

Submission deadline: No later than 4 p.m., October 7, 1983.

To obtain a copy of the formal Request for Proposal document, contact:

Marianne Miller, Director
Health Economics Program
Minnesota Department of Health
717 Delaware St. S.E.
Minneapolis, Minnesota 55440
(612) 623-5520

Department of Natural Resources
Division of Waters

Notice of Request for Proposals for Professional Services to Expedite Hydropower Development

The Department of Natural Resources is seeking proposals for professional and technical services to assist with the development of hydroelectric facilities at Minnesota dam sites. These services should include project coordination, engineering, and environmental review consistent with federal and state regulatory programs affecting hydropower development. Familiarity with public and private financing for hydropower development is required. The agency or individual awarded the contract will provide such services on behalf of the state to local municipalities, developers, and other units of government involved with the development of hydroelectric sites. Such services will expedite hydropower development.

The project is intended to run from October 10, 1983 to October 10, 1984.

Contact Person:

James F. Cooper
Minnesota Department of Natural Resources
Division of Waters, Development Section
Third Floor, Space Center Building
444 Lafayette Road
St. Paul, Minnesota 55101
Phone (612) 296-0510

Estimated cost: Not to exceed $40,000

Submission deadline: 4:30 p.m., September 30, 1983

Interested persons may submit proposals to the above state contact person. The engineering consultant contractor must have experience in hydropower development. This experience should be documented in the consultant's proposal.

Department of Public Safety
Office of Public Information

Notice of Availability of a Graphic Arts and Illustration Contract

The Department of Public Safety is seeking proposals for graphic arts and illustration layouts to effectively support written

material used in brochures, etc. to increase Minnesota citizens' knowledge about public safety. Details of the plan for producing graphic arts and illustrations are contained in a Request for Proposal. Copies of the Request for Proposal may be obtained at the Department of Public Safety, Office of Public Information, 318 Transportation Building, St. Paul, MN 55155.

Estimated cost of the contract is $8,500.

Final date for requesting the RFP is September 23, 1983.

Department of Public Welfare
Long Term Care Rates Division

Notice of Request for Proposals to Develop a Property-Related Cost Reimbursement Formula

The Department of Public Welfare is seeking proposals for researching and developing a nursing home reimbursement formula based on a rental concept of payment for property-related costs as defined in Minnesota Session Laws 1983, chapter 199. The project includes development of different rental formulas, development and validation of analytical models to test the effect of different formulas, the testing of different formulas, the determination of the short-range and long-range fiscal and programmatic impact of each formula, recommendations for implementation and a written summary report among other tasks.

The purpose of the project is to develop a nursing home reimbursement formula based on a rental concept which considers at a minimum the following factors:

1. simplify the administrative procedures for determining payment rates for property-related costs;
2. minimize discretionary or appealable decision;
3. eliminate any incentives to sell nursing homes;
4. recognize legitimate costs of preserving and replacing property;
5. recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;
6. address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;
7. establish an investment per bed limitaton;
8. reward efficient management of capital assets;
9. provide equitable treatment of facilities;
10. consider a variable rental rate; and
11. phase in implementation of the rental reimbursement method.

The anticipated results are: a review of alternatives used by other states, reimbursement formulas based on these concepts, testing of selected formulas, recommendations for implementation, a written report and supporting analysis.

The department has estimated that the cost of this project should not exceed $300,000 for proposed services and expenses including the appraisal of a representative sample of nursing homes.

Any interested party may obtain the department's Request For Proposal document by calling or writing:

Maria R. Gomez
Department of Public Welfare
Support Services Bureau
Centennial Office Building — 4th Floor
St. Paul, MN 55155
(612) 296-5724

The deadline for submitting formal proposals to the department is September 26, 1983 at 4:30 p.m. Formal proposals must be submitted to Maria R. Gomez at the address above.

STATE CONTRACTS

Minnesota Racing Commission

Notice of Change of Submission Date for Proposals in Response to Solicitation for Services of a Rulemaking Consultant

In the *State Register* published on August 29, 1983 (8 S.R. 337), in the Notice of Solicitation for Services of a Rulemaking Consultant, the deadline for submission of proposals was erroneously stated as September 9, 1983. The correct date is September 16, 1983.

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, 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 Administration Data Privacy Division

Notice of Intent to Consider an Application for Temporary Classification for Statewide Applicability

The Commissioner of Administration has received an application for temporary classification of data submitted by the City of East Grand Forks, Minnesota. The commissioner has determined that it is advisable to consider this application for statewide applicability under the authority vested in her by Minnesota Statutes § 13.06, subdivision 4. The commissioner hereby gives notice of her intent to approve or disapprove, for the use of all political subdivisions in the State of Minnesota, a *nonpublic* classification of data for

1. Applications for Economic Development Assistance Fund loans and interest reductions;
2. Attachments to the applications, including but not limited to business and personal financial records; and
3. Letters to businesses disapproving applications for funds.

Any political subdivision, other government agency, association or member of the public who wishes to submit comments on this application must do within 30 days of the publication of this notice. Comments received after 30 days need not be considered by the commissioner. Comments should be submitted to the Commissioner of Administration, c/o Data Privacy Division, 203A State Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155. A copy of the application may also be obtained from the Data Privacy Division.

Department of Agriculture Soil and Water Conservation Board

Notice of Change in Meeting Place

The Minnesota Soil and Water Conservation Board has changed the meeting place for their September 13, 1983 meeting from the Department of Agriculture Building, 90 W. Plato Boulevard, St. Paul, MN, to the Villa Maria Center, Frontenac, MN. The meeting will begin at 1:00 p.m.

The board will meet again at the Department of Agriculture Building on October 11, 1983.

Minnesota State Arts Board

Notice of Special Meeting

The Minnesota State Arts Board will hold a special meeting to receive public comment on a request of the Catholic League for

Religious and Civil Rights to withhold public funding from artists and arts organizations whose work is considered defamatory to religious and ethnic minorities.

The meeting will be held on Monday, September 12, from 7:00 to 9:30 p.m., at the State Office Building Auditorium, St. Paul.

Speakers will be asked to limit their comments to five minutes in length. Nevertheless, because of time limitations, not all who wish to comment may be heard. For that reason, all written comments received by the Arts Board on that day, or before 4:30 p.m. September 13, will become part of the official record. That record will be considered by Arts Board members prior to their final decision on the request at their regular meeting on September 23.

Written testimony may be brought to the meeting, or delivered to the Minnesota State Arts Board office at 432 Summit Avenue, St. Paul, Minnesota 55102.

Minnesota State Board of Chiropractic Examiners

Announcement of Advertising Meeting

TO:	All Interested Persons
FROM:	The Minnesota Board of Chiropractic Examiners
SUBJECT:	Advertising Meeting
DATE:	September 13, 1983
TIME:	2:00 P.M.
PLACE:	Minnesota Department of Health Building, Room 105 717 S.E. Delaware Street, Minneapolis, Minnesota 55414

The board has received newspaper clippings and other forms of advertisement by Minnesota chiropractors. Some of the advertising is in violation of the statutes and rules; consequently, the violators have been and continue to be disciplined by the board.

There is a necessity for the board to consider changes in its present rules concerning advertising. With this thought in mind, the board members invite you to the informal open meeting as defined above. The board would appreciate your valued input and further consider same in its proposed rule changes on advertising.

In the event you are unable to attend and would like to express your views, please send your response in writing prior to September 10th, to the above address.

Thank you for your cooperation.

Department of Commerce

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Unfair Trade Practices—Marketing Standards in Regard to Insurance

Notice is hereby given that the Policy Analysis Division of the Department of Commerce is seeking information or opinions from sources outside the agency in preparing to promulgate new rules governing unfair trade conduct in regard to marketing of insurance in the State of Minnesota. The promulgation of these rules is authorized by Minnesota Statute §§ 72A.20 and 60A.17.

The Policy Analysis Division of the Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comments orally. Written statements should be addressed to:

Richard G. Gomsrud
Department of Commerce
500 Metro Square Building
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at (612) 296-5689 and in person at the above address.

All statements of information and comment shall be accepted until the close of the business day on September 30, 1983. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

State Department of Education Instruction Division

Public Meeting Notice

The Minnesota Special Education Advisory Council will hold its first meeting of the 83-84 school year on September 12 and 13. The meeting is scheduled to begin at 9:00 a.m. at the Sheraton-Midway Motor Hotel in St. Paul. Agenda items include: Evaluation of LEA Programs on Variance; Effectiveness/Evaluation Study; Discretionary, Low Incidence and Severely Handicapped Projects, Updates on State Plan, Rules, etc.

For additional information contact Barbara S. Burke, Special Education Section, at (612) 296-8588.

Department of Finance

Notice of Maximum Interest Rate for Municipal Obligations for September 1983

Pursuant to Laws of Minnesota 1982, chapter 523, Commissioner of Finance Gordon M. Donhowe announced today that the maximum interest rate for municipal obligations in the month of September will be eleven (11) percent per annum. Obligations which are payable wholly or in part from the proceeds of special assessments or which are not secured by general obligations of the municipality may bear an interest rate of up to twelve (12) percent per annum.

Metropolitan Council

Notice of Metropolitan Council Intent to Review Racetrack Site Proposals

Notice is hereby given that the Metropolitan Council intends to begin review of proposed racetrack sites within the Twin Cities Metropolitan Area. Local governments that have racetrack sites under consideration in their communities should submit site proposals to the Metropolitan Council for review by October 1, 1983. Under the state racetrack law, the council must comment on the consistency of each of the proposed sites with regional plans. Other state laws may require additional council consideration of track development plans. Through the review process, the council will identify for the Minnesota Racing Commission those sites which in the council's opinion are consistent with regional plans and policies. The Racing Commission is authorized to locate one Class A racetrack in the Twin Cities Metropolitan Area. For more information about the review process, contact Barbara Senness of the Metropolitan Council staff at 291-6419.

Minnesota Pollution Control Agency

Notice of Public Meeting Regarding Revisions to Minnesota's State Implementation Plan

Notice is hereby given that on October 25, 1983, the Minnesota Pollution Control Agency (hereinafter referred to as "agency") will hold a regularly scheduled agency meeting in the Agency Board Room, located at 1935 West County Road B-2, Roseville, Minnesota, 55113. The agency is currently scheduled to consider, among other things, a proposed revision to the State Implementation Plan (hereinafter referred to as "SIP") for the inclusion of revised state ambient air quality standards. These standards are contained in 6 MCAR § 4.0001 (hereinafter referred to as "APC 1"), and pertain to acceptable ambient concentrations of hydrogen sulfide, ozone, carbon monoxide, hydrocarbons, sulfur dioxide, particulate matter, and nitrogen dioxide.

Notice is also hereby given that the public is invited to attend the agency meeting on October 25, 1983, and to comment at that meeting on the proposed SIP revision. Written comment on the inclusion of APC 1 in the SIP may be submitted prior to the meeting and should be addressed to Douglas M. Benson, Division of Air Quality, Minnesota Pollution Control Agency, 1935 West County Road B-2, Roseville, Minnesota, 55113.

The October 25, 1983 agency meeting will be held in the Agency Board Room, at the address noted above and will begin at 9:00 a.m. An agenda for the meeting will be available by October 14, 1983. Questions regarding the proposed revision of the SIP should be directed to Douglas M. Benson at the address noted above or at 612/296-7743. A copy of the agenda may be obtained from Jeanine Willenbring, also at the address noted above, and at 612/296-7351.

The SIP is designed to attain and maintain the National Ambient Air Quality Standards for criteria pollutants, as contained in the Clean Air Act Amendments of 1977. The original SIP refers to the state ambient air quality standards in APC 1, as amended

on April 13, 1972. The Minnesota Pollution Control Agency amended APC on November 15, 1982. Several of the state air quality standards were changed at that time, following an extensive review process. The purpose of this SIP revision is to include in the SIP the current state air quality standards. Copies of the proposed SIP revision are available for public review during regular office hours at the above noted address.

Dated this 26th of August, 1983.

J. Michael Valentine, Director
Division of Air Quality

Department of Transportation

Petition of the City of Coon Rapids for a Variance from State Aid Standards for Street Width

Notice is hereby given that the City Council of the City of Coon Rapids has made a written request to the Commissioner of Transportation for a variance from minimum design standards for street width for MSAS 107 (Robinson Drive) from Hanson Boulevard to 113th Lane.

The request is for a variance from 14 MCAR § 1.5032 H.1.c., Rules for State Aid Operations under Minnesota Statute, chapters 161 and 162 (1978) as amended, so as to permit a 52 feet width with parking on both sides instead of the required 52 feet street width with no parking permitted on either side.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

Dated this 25th day of August, 1983

Richard P. Braun
Commissioner of Transportation

Water Resources Board

Notice of Special Meeting to Consider an Increase in the Number of Managers for the Coon Creek and Rice Creek Watershed Districts

The Water Resources Board will hold a special meeting on September 19, 1983 in Conference Room A of the Capitol Square Building at 550 Cedar Street, St. Paul, Minnesota 55101, for the purpose of receiving input on the issues of whether the number of managers of the Coon Creek and Rice Creek Watershed Districts should be increased as authorized by Minnesota Statutes section 112.42, subdivision 3a and 112.37, subdivision 7. Consideration of the Coon Creek Watershed District will begin at 9:30 a.m. and consideration of the Rice Creek Watershed District will begin at 1:30 p.m. Persons interested in these issues who do not wish to appear at the meeting are encouraged to submit written recommendations before September 19, 1983 to:

Mel Sinn
Water Resources Board
555 Wabasha Street
Room 206
St. Paul, Minn. 55102
612/296-2840

STATE OF MINNESOTA

State Register and Public Documents Division
117 University Avenue
St. Paul, Minnesota 55155

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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:

Briefly/Preview—Senate news and committee calendar; published weekly during legislative sessions. Contact Senate Public Information Office, Room B29 State Capitol, St. Paul MN 55155, (612) 296-0504.

Perspectives—Publication about the Senate. Contact Senate Information Office.

Weekly Wrap-Up—House committees, committee assignments of individual representatives, news on committee meetings and action, House action and bill introductions. Contact House Information Office, Room 8 State Capitol, St. Paul, MN, (612) 296-2146.

This Week—weekly interim bulletin of the House. Contact House Information Office.

STATE OF MINNESOTA
COMMISSIONER OF COMMERCE

In the Matter of Adopted Temporary Rules Governing Reimbursement for Workers' Compensation Medical Services.

FINDINGS OF FACT, CONCLUSIONS AND ORDER ADOPTING TEMPORARY RULES

Notice of Intent to Adopt Temporary Rules to govern reimbursement for workers' compensation medical services was published September 5, 1983, at 8 State Register 362-410. The twenty-day comment period has now expired.

After affording interested persons an opportunity to present written and oral data, statements and documents, having considered all of the files and proceedings herein and applicable statutory standards or criteria, and confirming the need for and reasonableness of the above-captioned rules, I find the following:

FINDINGS OF FACT

1. The reason for the change between 4 MCAR § 1.0004.I as proposed for adoption and the same rule as adopted is because the special compensation fund also pays workers' compensation benefits on behalf of uninsured employers. p. 2

2. The reason for deleting the language in 4 MCAR § 1.0007.B is to make a positive identification of each provider easier. If the federal identification number could be used, a provider's performance could be difficult to trace if they changed clinics or firms. p. 5

3. The reason for the additional language in 4 MCAR § 1.0007.B is to clarify that the fee schedule codes need be submitted only where applicable. There will be many situations where a service is not included in the fee schedule but should be submitted with an appropriate code from another code system. p. 5

4. The reason for the changes in 4 MCAR § 1.0010.B. and F. is to clarify that only 4 MCAR §§ 1.0011-1.0024 and not the entire fee schedule are based on Current Procedural Terminology, Fourth Edition. p. 6, 7

5. The reason for the change in 4 MCAR § 1.0010.E is to clarify that the payer also has an option of referring the matter to the Commissioner pursuant to Minn. Laws 1983, ch. 290, § 84. p. 7

6. The reason for the changes in 4 MCAR §§ 1.0012-1.0022 is to clarify the scope of 4 MCAR §§ 1.0012-1.0022. As originally drafted by the Department of Commerce and submitted to the Revisor's Office, the amended sections were one large section. Thereafter, the one large section was divided into 4 MCAR §§ 1.0012-1.0022 without inserting scope language for each of the new sections. Every other section in the fee schedule has scope language. p. 17 et seq

7. The reason for the changes in 4 MCAR § 1.0029.B is to clarify that the maximum fee for cast services excludes the cost of materials. p. 83

Based upon the foregoing Findings of Fact, I make the following:

CONCLUSIONS

1. Pursuant to 9 MCAR § 2.111, the amendments to the rules that have been made after publication of the proposed rules in the State Register do not result in rules that are substantially different from the proposed rules published in the State Register.

2. Any Findings which might properly be termed Conclusions and any Conclusions which might properly be termined Findings are hereby adopted as such.

NOW, THEREFORE, IT IS HEREBY ORDERED that these temporary rules identified as 4 MCAR §§ 1.0001-10032 are adopted this 30th day of September, 1983, pursuant to the authority invested in me by Minn. Stat. § 176.136 (1982), as amended.

MICHAEL A. HATCH
Commissioner of Commerce

500 Metro Square Building
St. Paul, Minnesota 55101
Telephone: (612) 296-6848

In the Matter of the Proposed Adoption
of Temporary Rules Governing Reimbursement
for Workers' Compensation Medical Services
4MCAR §§ 1.0001 - 1.0032

STATEMENT OF
COMPLIANCE WITH
RULEMAKING PROCEDURES

I, John Bjork, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

John C. Bjork
Special Assistant Attorney General

Dated: September 30, 1983