

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

CBE

RULE REVIEW CHECKLIST

File No. 1578 — Docket No. 05.0009.0600

DATE RECEIVED 3-20-89 — ADOPTED W/O HEARING X

REVIEW DATE 3-29-89 — EMERGENCY RULE _____

DUE DATE 4-3-89 — REVISOR APPROVED _____

APPROVED _____ — REVISOR DISAPPROVED _____

DISAPPROVED _____ — FILED W/SEC. OF STATE _____

WITHDRAWN 4-3-89 — RETURNED TO AGENCY _____

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)
- 7/25/88 Date published in State Register
- _____ Comments

_____ ~~Petition for Adoption of a Rule (if applicable)~~

_____ ~~Board's Authorizing Resolution~~
- _____ ~~Date adopted~~

✓ Proposed Rule
- yes Revisor's Certificate

✓ Notice of Intent to Adopt Rule
- 176.136 + 176.83 Statutory Authority
- yes Small Business Statement
- yes Expenditure of public money statement
- yes Signature

✓ Statement of Need and Reasonableness (if applicable)
- yes Small Business Statement
- no Fees - § 16A.128

✓ Affidavit of Mailing Notice of Intent to Adopt Rule
- 12/23/88 Date 30/25 days before adoption
- yes Notice attached
- _____ ~~Copy of rule or summary attached~~

✓ Publication in State Register
- 12/26/88 Date 30/25 days before adoption

_____ 180-day deadline from:
- n/a Effective date of law requiring rule (14.12) (both rules)
- 1/25/89 end of comment period (§ 14.26) (rules without hearing)
- _____ ~~effective date of statutory authority (§ 14.29) (emergency rules)~~

_____ ~~Resolution Adopting~~
- _____ ~~Date adopted~~

✓ Findings of Fact, Conclusions & Order Adopting
- 3/13/89 Date

✓ Written requests, submissions or comments (30, 6 withdrawn)

✓ Declaration of attorney
- S. Gunn Name of SAAG representing agency

_____ ~~Notice of Submission to Atty. Gen. (if applicable)~~

_____ ~~Aff. of Mailing Notice to Atty. Gen. (if applicable)~~

Department of Labor and Industry

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

Rules as Adopted

5221.0100 DEFINITIONS.

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

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

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

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

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

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

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

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

Subp. 9. **Injury.** "Injury" is as defined in Minnesota

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Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

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

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

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

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

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

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

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

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

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

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

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

5221.0200 AUTHORITY.

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

5221.0300 PURPOSE.

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

5221.0400 SCOPE.

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

5221.0500 EXCESSIVE CHARGES.

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

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

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

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

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

E. the charge does not comply with standards and

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requirements adopted pursuant to Minnesota Statutes, section 176.83, concerning the cost of treatment; or

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

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

5221.0600 PAYER RESPONSIBILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

D. a request for an appropriate record and/or the specific information requested to allow for proper determination

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of the bill under this part.

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

Subp. 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

5221.0700 PROVIDER RESPONSIBILITIES.

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

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

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

A. Approved billing codes. Billing codes must be found in the most recent edition of the following: Physician's Current Procedural Terminology; Blue Cross/Blue Shield specialty procedure codes; HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS); Code on Dental

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Procedures and Nomenclature maintained by the Council on Dental Care Programs; and for audiology and speech therapy, the "home-grown" codes specified by the Department of Human Services or any other code listed in the medical fee schedule.

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

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

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

25105	Arthrotomy, wrist joint; for synovectomy	

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness. ~~A provider may not require prepayment for costs of copies of existing medical records.~~

Subp. 5. **Collection of excessive charges.** No provider shall collect or attempt to collect payment from an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

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5221.0800 DISPUTE RESOLUTION.

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

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

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

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

D. to accommodate improvements or correct data base deficiencies. The Medical Services Review Board shall advise

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the commissioner regarding these revisions.

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

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

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

Subp. 6. **Ambiguity.** If, despite the payer's reasonable

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

Subp. 7. **Code modifiers.** The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in items A to T.

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

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

C. Modifier number 23 denotes unusual anesthesia.

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

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

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

F. Modifier number 50 denotes bilateral procedures. ~~This modifier does not exempt the secondary services from the maximum fee for the five-digit code.~~ Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session shall be identified by the appropriate five-digit code describing the first procedure. The second bilateral procedure shall be identified by adding modifier 50 to the procedure number.

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

H. Modifier number 52 denotes reduced services. This

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modifier is appropriate where the service provided is significantly less than is usually required for the listed procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

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

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

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

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

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

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

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

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

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

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

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

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

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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physician.

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

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

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

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

D. to L. [Unchanged.]

M. Referral. "Referral" means a transfer of the total care or specific care of a patient from one physician to another and does not constitute a consultation.

N. Hospital discharge day management. "Hospital discharge day management" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge record.

Subp. 3. **Office services.** The following codes, service descriptions, and maximum fees apply to services provided at the physician's office, or if provided in an outpatient hospital clinic setting, for nonemergency services.

Code	Service	Maximum Fee
90000-00	Office services; new patient;	

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

Subp. 3a. **Home services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a home setting if provided in a private residence as a "house call." They do not apply to physician services provided at a nursing home, boarding home, domiciliary (temporary lodging), or custodial care involving periodic services provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90100-00	Home medical service, new patient; brief service	$ 44.00
90110-00	limited service	48.00
90115-00	intermediate service	50.00
~~90130-00~~		
90140-00	Home medical service, established patient; ~~minimal~~ brief service	~~30.30~~ 42.90
~~90140-00~~	~~--brief service~~	~~42.90~~
90150-00	limited service	45.00
90160-00	intermediate service	50.00
90170-00	extended service	57.80

Subp. 4. **Hospital services.** The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under codes 90240 to ~~90270~~ 90292.

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

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

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care facilities. The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long-term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 45.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	70.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	96.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.00
90350-00	limited service	27.25
90360-00	intermediate service	40.00
90370-00	extended service	50.00

Subp. 6. **Nursing home, boarding home, domiciliary, or custodial care medical services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a domiciliary or custodial care facility involving periodic services, provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	$ ~~50.00~~ 37.00
90415-00	intermediate service	81.50
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	20.75
90440-00	brief service	25.00
90450-00	limited service	33.00
90460-00	intermediate service	44.00
90470-00	extended service	55.00

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

Code	Service	Maximum Fee

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

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

Code	Service	Maximum Fee
90590-00	Physician direction of Emergency Medical Systems (EMS), emergency care advanced life support	$ 112.00

5221.1200 CONSULTATIONS.

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

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

A. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient and the preparation of an appropriate record. When as a result of the consultation the consulting physician assumes responsibility for the continuing

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care of the patient, any subsequent service rendered by the physician cannot be billed as a consultation.

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

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

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

(4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to a consultation for a young person with fever,

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arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a record with recommendations.

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

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

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

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

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

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

Confirmatory (Additional Opinion) Consultation

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

5221.1210 IMMUNIZATION INJECTIONS.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include the supply of materials.

Code	Service	Maximum Fee
90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP) (MD/DO)	$ 20.00
90702-00	diphtheria and tetanus toxoids (DT) (MD/DO)	11.00
90703-00	tetanus toxoid (MD/DO)	10.50
90704-00	mumps virus vaccine, live (MD/DO)	19.00
90705-00	measles virus vaccine, live, attenuated (MD/DO)	16.50
90706-00	rubella virus vaccine, live (MD/DO)	17.00
90707-00	measles, mumps, and rubella virus vaccine, live (MD/DO)	26.75
90708-00	measles and rubella virus vaccine, live	24.00
90712-00	polio virus vaccine, live, oral; any type(s) (MD/DO)	15.00
90713-00	poliomyelitis vaccine (MD/DO)	15.00
90714-00	typhoid vaccine	11.00
90717-00	yellow fever vaccine	30.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD) (MD/DO)	10.00
90719-00	diphtheria toxoid (MD/DO)	9.50
90724-00	influenza virus vaccine (MD/DO)	11.25
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	115.52
90731-00	hepatitis B vaccine	61.25
90732-00	pneumococcal vaccine, polyvalent (MD/DO)	17.00
90733-00	meningococcal polysaccharide vaccine; any group(s) (MD/DO)	16.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	16.00
90741-00	Immunization, passive; immune serum globulin, human (ISG)	15.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	50.00

5221.1220 THERAPEUTIC INJECTIONS.

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

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90788-00 Intramuscular injection of antibiotic (specify) 14.25

5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
90801-00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the patient). (MD/DO)	$ 112.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	70.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	111.50
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes (MD/DO)	55.00
90844-00	approximately 45 or 50 minutes (MD/DO)	85.00
90847-00	Family medical psychotherapy (conjoint psychotherapy) (MD/DO)	85.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	57.00
90853-00	Group medical psychotherapy (other than of a multiple-family group) (MD/DO)	40.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	~~120.00~~ 50.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	120.00

Other Psychiatric Therapy

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

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	management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	70.00
90887-00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (MD/DO)	78.00

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

Subp. 2. **Definitions.** The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient" and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in part 5221.1100, except for item C regarding intermediate opthalmological service and item D regarding comprehensive opthalmological service.

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

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

(2) review of interval history, external

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examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with a known cataract not requiring comprehensive ophthalmological services.

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

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

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reevaluation.

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92020, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92235, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

Code	Service	Maximum Fee
	General Services	
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient (MD/DO)	$ 51.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient, one or more visits (MD/DO)	58.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient (MD/DO)	40.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient, one or more visits (MD/DO)	55.00
92019-00	limited	26.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure) (MD/DO)	29.30
	Special Services	
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 37.00
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	41.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	140.00
92081-00	Visual field examination with medical diagnostic evaluation; limited examination (for example, tangent screen), Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	31.31
92082-00	intermediate examination (for example, multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel,	

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	full field automated test, such as Octopus program 33 or 34 equivalent)	50.00
92083-00	extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41) (MD/DO)	59.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day (MD/DO)	24.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography (MD/DO)	25.00

Ophthalmoscopy

92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial (MD/DO)	$ 37.00
92226-00	subsequent (MD/DO)	30.00
92230-00	Opthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	34.00
92235-00	with fluorescein angiography (includes multiframe photography) (MD/DO)	150.00
92250-00	with fundus photography	33.00
92260-00	with opthalmodynamometry	30.00

Other Specialized Services

92275-00	Electroretinography, with medical diagnostic evaluation	$ 154.00
92285-00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (for example, close-up photography, slit lamp photography, goniophotography, stereo-photography	40.00
92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00

Contact Lenses

92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, one eye	$ 80.00
92314-00	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	16.00
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	30.00
92326-00	Replacement of contact lens	65.00

Spectacle Services

92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	147.35
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

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5221.1600 OTORHINOLARYNGOLOGIC SERVICES.

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

Code	Service	Maximum Fee
92504-00	Binocular microscopy (separate diagnostic procedure (MD/DO)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	42.00
92508-00	Speech, language, or hearing therapy with continuing medical supervision; group (MD/DO)	16.00
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	58.00
92512-00	Nasal function studies, for example, rhinomanometry	71.50
92532-00	Positional nystagmus	21.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	30.00
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	41.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	43.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (MD/DO)	55.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (MD/DO)	26.00
92545-00	Oscillating tracking test, with recording (MD/DO)	26.00
92546-00	Torsion swing test, with recording	31.00

5221.1800 CARDIOVASCULAR.

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

Code	Service	Maximum Fee

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92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external (MD/DO)	244.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,080.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads (MD/DO)	42.50
93005-00	tracing only, without interpretation and/or report (MD/DO)	37.00
93010-00	interpretation and report only (MD/DO)	17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	50.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report (MD/DO)	195.00
93017-00	tracing only, without interpretation and report (MD/DO)	99.00
93018-00	interpretation and report only (MD/DO)	100.00
93024-00	Ergonovine provocation test	175.00
93040-00	Rhythm ECG, one to three leads; with interpretation (MD/DO)	22.00
93041-00	tracing only without interpretation and report (MD/DO)	12.00
93042-00	Rhythm ECG, tracing with interpretation and report only (MD/DO)	18.00
93210-00	Phonocardiogram, intracardiac	45.50
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report (MD/DO)	105.00
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	185.70
93262-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	200.00
	without superimposition scanning	219.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis)	215.75
93268-00	Patient demand single event ECG recording; pre-symptom memory loop and transmission	34.00
93269-00	post-symptom memory loop and transmission	30.00
93300-00	Echocardiography, M-mode; complete	79.00
93308-00	Echocardiograph, real-time with image documentation (2D); limited (MD/DO)	105.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D) (MD/DO)	250.00
93320-00	Doppler echocardiography (MD/DO)	105.00

Cardiac Catheterization

93501-00	Right heart catheterization only	$ 685.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography (MD/DO)	351.00
93505-00	Endomyocardial biopsy	330.00
93547-00	Combined left heart catheterization, selective coronary angiography and	

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		selective left ventricular angiography (MD/DO)	760.00
	93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (MD/DO)	1,166.00
	93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	79.00
		Other Vascular Studies	
	93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	$ 54.00
	93732-00	with reprogramming	45.00
	93733-00	telephone analysis	40.50
	93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	40.00
	93735-00	with reprogramming	50.00
	93736-00	telephonic analysis	35.50
	93784-00	Ambulatory blood pressure monitoring, using a system such as magnetic tape and/or computer disc, for 24 hours; including recording, scanning analysis, interpretation and report	225.00
		Noninvasive Peripheral Vascular Diagnostic Studies	
		Cerebrovascular Arterial Studies	
	93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periobital flow direction with arterial compression, periobital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)	$ 79.00
	93870-00	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis) (MD/DO)	185.20
		Venous Studies	
	93950-00	Noninvasive studies of extremity veins; (MD/DO)	$ 80.00
	93960-00	Quantitative venous flow studies (e.g., capacitance and outflow measurement or calf, measurement of calf venous reflux, quantitative photoplethysmography)	100.00

5221.1900 PULMONARY.

The codes, service descriptions, and maximum fees of this part apply to pulmonary services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The services include laboratory procedures, interpretation, and physician

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services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010-00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements, and/or maximal voluntary ventilation	$ 30.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after broncodilator (aerosol or parenteral) or exercise	50.00
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	65.70
94150-00	Vital capacity, total	18.00
94160-00	Vital capacity screening tests; total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity, maximal voluntary ventilation	20.00
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	79.00
94260-00	Thoric gas volume	11.00
94350-00	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including a alveolar nitrogen or helium equilibration time	46.45
94360-00	Determination of resistance to airflow, oscillatory or plethysmographic methods	10.00
94375-00	Respiratory flow volume loop	24.00
94640-00	Nonpressurized inhalation treatment for acute airway obstruction (MD/DO)	22.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (MD/DO)	20.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	128.50
94657-00	subsequent days	56.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	20.50
94665-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	21.50
94680-00	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	35.00
94681-00	including CO_2 output, percentage oxygen extracted	94.60
94700-00	Analysis of arterial blood gas (oxygen saturation, pO_2, pCO_2, CO_2, pH); rest only	33.30

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

Subpart 1. **Allergy sensitivity tests.** Allergy sensitivity tests are the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the

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same number of sensitivity tests.

Subp. 2. **Immunotherapy (desensitization, hyposensitization).** Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

Subp. 3. **Other therapy.** Other therapy for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see 95105-00. (For definitions of Levels of Service see the Introduction.) (For Medical Service Procedures, see 90000-90699.)

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

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

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

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

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

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

5221.2050 CHEMOTHERAPY INJECTIONS.

The codes, service descriptions, and maximum fees of this part apply to chemotherapy injections, and to a provider licensed as a doctor of medicine, a doctor of osteopathy, or by a qualified assistant under supervision of the physician.

Code	Service	Maximum Fee
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 60.00
96505-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by infusion technique	55.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	37.00
96509-00	by infusion technique	90.00
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	81.50
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	321.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	48.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	217.30
96540-00	Chemotherapy injection, intrathecal via reservoir, single or multiple agents, administered by physician	107.00

5221.2070 DERMATOLOGICAL PROCEDURES.

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

Subp. 2. **Services.** Dermatologic services are typically consultative, and any of the levels of consultation described in part 5221.1200 may be appropriate. In addition, physician services for dermatological procedures are the same as the definitions described in part 5221.1100.

Code	Service	Maximum Fee

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96900-00	Actinotherapy (ultraviolet light)	$ 7.50
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	25.00
96912-00	psoralens and ultraviolet A (PUVA)	30.00

5221.2100 PHYSICAL MEDICINE.

The following codes, service descriptions, and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
	Modalities	
97260-00	Manipulation (cervical, thoracic, lumbosacral, socroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	$ 30.00
97261-00	each additional area (MD/DO)	8.40

5221.2200 SPECIAL SERVICES AND REPORTS.

Special services and reports apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include a means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. (See part 5221.1100 for definitions on levels of services.

Code	Service	Maximum Fee
	Miscellaneous Services	
99000-00	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory (MD/DO)	$ 9.25
99001-00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated) (MD/DO)	11.00
99014-00	Telephone calls for consultation or medical management; intermediate	15.00
99025-00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit (MD/DO)	25.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	27.10
99054-00	Services requested on Sundays and holidays in addition to basic services	25.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	55.00
99058-00	Office services provided on an emergency basis (MD/DO)	40.00
99062-00	Emergency care facility services; when the nonhospital-based physician	

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		is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	52.00
	99064-00	Emergency care facility services; when the nonhospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	50.00
	99065-00	during regular office hours	50.50
	99075-00	Medical testimony (MD/DO)	Reasonableness of charges reviewable by commissioner
	99080-00	Special reports like insurance forms, or the review of medical data to clarify a patient's status; more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner (MD/DO)	Reasonableness of charges reviewable by commissioner
	99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00
		Prolonged Services	
	99150-00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour (MD/DO)	$ 114.00
	99151-00	more than one hour	191.00
		Medical Conferences	
	99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes (MD/DO)	73.70
	99156-00	approximately 50 minutes	100.00
		Critical Care Services	

Critical care services (codes 99162-00 to 99173-00) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include,

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

Code	Service	Maximum Fee
99160-00	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour (MD/DO)	$ 151.50
99162-00	additional 30 minutes (MD/DO)	76.50
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	75.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness (MD/DO)	60.00
99172-00	limited examination, evaluation, or treatment for same or new illness (MD/DO)	53.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness (MD/DO)	78.00
99174-00	Extended reexamination, reevaluation and/or treatment, same or new illness (MD/DO)	150.00
	Other Services	
99195-00	Phlebotomy, therapeutic (separate procedure)	35.00

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. [Unchanged.]

Subp. 2. **Instructions.** The instructions in items A to F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in-hospital follow-up care, provided by the surgeon both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. The surgical package includes the assistant surgeons if any are

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

B. to D. [Unchanged.]

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

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

(2) Preoperative services shall be listed when:

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

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

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

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

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(3) All postoperative care is added on a service-by-service basis.

(4) Complications are added on a service-by-service basis as with surgical procedures.

F. Special situations.

(1) Multiple procedures (more than one procedure is performed at a single operative session through the same incision.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 50 percent of the Medical Fee Schedule, whichever is less.

(2) Multiple procedures (more than one procedure is performed at a single operative session through different incisions.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 65 <u>75</u> percent of the Medical Fee Schedule, whichever is less.

(3) Bilateral procedures (pertaining to two sides and requiring separate incisions.)

(a) When bilateral procedures are performed

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at the same operative session and the descriptor for the procedure code specifies bilateral procedures, the procedures must be reported using the applicable procedure code listed in the Medical Fee Schedule. Reimbursement must be at the provider's usual charge or the Medical Fee Schedule, whichever is less.

(b) When the descriptor of the procedure code does not specify that it is bilateral, the primary procedure must be reported twice using the applicable procedure codes.

For the first procedure, the applicable 5-digit procedure code must be billed without a modifier. Reimbursement will be at the provider's usual rate or the rate set in the Medical Fee Schedule, whichever is less.

For the second procedure, the applicable 5-digit code must be billed with modifier 50. Reimbursement must be at the provider's usual rate or 75 percent of the rate set in the Medical Fee Schedule, whichever is less.

Subp. 3. **Integumentary system.**

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200 to 11441) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions.

(2) Treatment of burns (codes 16000 to 16030) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001 to 12014) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit.

(b) Intermediate repair (codes 12031 to 12052) shall be used for the repair of wounds that, in addition

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to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure.

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

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

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

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

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

B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

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

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11406-00	lesion diameter over 4.0 centimeters	200.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter (MD/DO)	77.00
11421-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	96.60
11422-00	lesion diameter 1.0 to 2.0 centimeters (MD/DO)	120.00
11423-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	144.00
11424-00	lesion diameter 3.1 to 4.0 centimeters	160.00
11426-00	lesion diameter over 4.0 centimeters	300.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter (MD-DO)	90.00
11441-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	113.00
11442-00	lesion diameter 1.1 to 2.0 centimeters	135.00
11443-00	lesion diameter 2.1 to 3.0 centimeters	89.00

Excision -- Malignant Lesions

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

Nails

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

Miscellaneous

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

Introduction

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

Repair -- Simple

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12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters (MD/DO)	$	55.50
12002*00	2.5 to 7.5 centimeters (MD/DO)		82.00
12004*00	7.5 to 12.5 centimeters (MD/DO)		120.00
12005*00	12.5 to 20.0 centimeters (MD/DO)		175.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters (MD/DO)		83.00
12013*00	2.5 to 5.0 centimeters		115.00
12014-00	5.1 to 7.5 centimeters		75.00
	Repair -- Intermediate		
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters (MD/DO)	$	84.00
12032*00	2.5 to 7.5 centimeters (MD/DO)		118.00
12034-00	7.6 to 12.5 centimeters (MD/DO)		168.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters (MD/DO)		98.00
12042-00	2.5 to 7.5 centimeters (MD/DO)		140.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters (MD/DO)		112.00
12052-00	2.5 to 5.0 centimeters (MD/DO)		160.00
	Repair -- Complex		
13100-00	Repair, complex, trunk; 1.1 to 2.5 centimeters	$	140.00
13101-00	2.6 to 7.5 centimeters		275.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters		280.00
13121-00	2.6 to 7.5 centimeters		234.00
13131-00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters		350.00
13132-00	2.6 to 7.5 centimeters		490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less		210.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters (MD/DO)		420.00
13152-00	2.5 to 7.5 centimeters (MD/DO)		630.00
	Adjacent Tissue Transfer or Rearrangement		
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters (MD/DO)	$	725.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters (MD/DO)		1,000.00
	Free Skin Grafts		
15100-00	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters or less, or each one percent of body area of infants and children (MD/DO)	$	635.00
	Burns, Local Treatment		

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16000-00	Initial treatment, first degree burn, when no more than local treatment is required (MD/DO)	$ 47.50
16020*00	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small (MD/DO)	42.50
16025*00	without anesthesia, medium, for example, whole face or whole extremity (MD/DO)	71.00
	Destruction	
17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion (MD/DO)	$ 46.50
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (MD/DO)	43.00
17101-00	second lesion (MD/DO)	22.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	40.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions (MD/DO)	50.00
17304-00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to 5 horizontal, microscopic specimens	460.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2) (MD/DO)	30.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)	31.00

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

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

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20610*00	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa (MD/DO)	61.00
20670*00	Removal of implant; superficial, (e.g. buried wire, pin, or rod)	86.50
20680-00	Removal of implant; deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate (MD/DO)	344.00
	Head Repair, Revision, or Reconstruction	
21116-00	Injection procedure for temporomandibular joint arthrography	$162.00
21310-00	Treatment of closed or open nasal fracture without manipulation (MD/DO)	55.00
21315-00	mandible (includes obtaining graft)	120.00
21320-00	Manipulative treatment, nasal bone fracture; with stabilization (MD/DO)	300.00
	Neck (Soft Tissues) and Thorax -- Fracture or Dislocation	
21800-00	Treatment of rib fracture; closed, uncomplicated, each	$ 65.00
	Spine	
22555-00	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) (MD/DO)	$ 2,300.00
	Shoulders -- Fracture or Dislocation	
23350-00	Injection procedure for shoulder arthrography (MD/DO)	$ 58.00
23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) (MD/DO)	1,515.00
23450-00	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation (MD/DO)	1,359.00
23500-00	Treatment of closed clavicular fracture; without manipulation (MD/DO)	100.00
23540-00	Treatment of closed acromioclavicular dislocation; without manipulation	75.00
23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	202.25
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia (MD/DO)	138.00
23655-00	requiring anesthesia (MD/DO)	213.00
	Humerus (Upper Arm) and Elbow -- Fracture or Dislocation	
24500-00	Treatment of closed humeral shaft fracture; without manipulation	$233.70
24600-00	Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	168.00
24650-00	Treatment of closed radial head or neck fracture without manipulation (MD/DO)	160.00
	Forearm and Wrist -- Incision and Excision	
25000-00	Tendon sheath incision; at radial styloid for de Quervain's disease	$395.00
25111-00	Excision of ganglion, wrist (dorsal or volar); primary (MD/DO)	400.00

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		Forearm and Wrist -- Fracture or Dislocation	
	25505-00	Treatment of closed radial shaft fracture; with manipulation (MD/DO)	$ 345.00
	25560-00	Treatment of closed radial and ulnar shaft fractures; without manipulation	211.50
	25565-00	Treatment of closed radial and ulnar shaft fractures; with manipulation (MD/DO)	435.00
	25600-00	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation (MD/DO)	176.00
	25605-00	with manipulation (MD/DO)	322.00
	25610-00	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning (MD/DO)	460.00
	25611-00	with external skeletal fixation or percutaneous pinning (MD/DO)	643.00
	25622-00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	185.00
		Hand and Fingers -- Incision, Excision, Repair, Revision, or Reconstruction	
	26010*00	Draining of finger abscess; simple	$ 55.00
	26055-00	Tendon sheath incision for trigger finger (MD/DO)	400.00
	26115-00	Excision, tumor, hand or finger; subcutaneous	315.00
	26116-00	deep, subfascial, intramuscular	537.50
	26122-00	Fasciectomy, palmar, simple for Dupuytren's contracture; up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,309.00
	26160-00	Excision of lesion of tendon sheath or capsule (MD/DO)	231.00
	26418-00	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon (MD/DO)	333.00
		Hands and Fingers -- Fractures or Dislocations	
	26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone (MD/DO)	$ 116.00
	26605-00	with manipulation, each bone (MD/DO)	196.00
	26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (MD/DO)	77.00
	26725-00	with manipulation, each (MD/DO)	150.00
	26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each	400.00
	26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each (MD/DO)	55.50
	26755-00	with manipulation, each	112.00
	26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	100.00
	26770-00	Treatment of closed interphalangeal	

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	joint dislocation, single, with manipulation; without anesthesia (MD/DO)	65.00
	Hand and Fingers -- Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (MD/DO)	$ 295.50
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)	$2,098.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple (MD/DO)	3,050.00
27134-00	Revision of total hip arthroplasty; both components	4,100.00
27235-00	Treatment of closed or open femoral fracture, in situ pinning of undisplaced or impacted fracture	1,493.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (MD/DO)	1,700.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation (MD/DO)	1,496.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	381.00
	Femur (Thigh Region) and Knee Joint -- Introduction or Removal	
27370-00	Injection procedure for knee arthrography (MD/DO)	$ 55.64
	Femur (Thigh Region) and Knee Joint -- Repair, Revision, or Reconstruction	
27422-00	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	$ 1,203.00
27425-00	Lateral retinacular release, any method	1,235.00
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,400.00
27447-00	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement) (MD/DO)	3,000.00
27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation (MD/DO)	1,482.00
	Amputation	
27590-00	Amputation, thigh, through femur, any level	$1,050.40
	Leg (Tibula and Fibula) and Ankle Joint -- Fractures or Dislocations	
27750-00	Treatment of closed tibial shaft fracture; without manipulation	$275.00

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

Foot

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

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

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physician.

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

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

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

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

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

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

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

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Vascular Injection Procedures

36000*00	Introduction of needle or intracatheter, vein; unilateral (MD/DO)	$ 63.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery (MD/DO)	331.00
36140-00	Introduction of needle or intracatheter; extremity artery	274.61
36200-00	Introduction of catheter, aorta (arch, abdominal, midstream renal, aortioliac run-off) or selective; initial placement	330.50
36215-00	each additional selective thoracic and/or cerebral artery catheter placement (e.g. vertebral or carotid)	448.00
36230-00	coronary artery, selective, unilateral or bilateral	449.28
36245-00	each additional selective abdominal artery catheter placement (e.g. celiac artery, gastroduodenal artery, inferior mesenteric artery, renal artery)	441.00
36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	44.10
36415*00	Routine venipuncture for collection of specimen(s) (MD/DO)	7.60
36430-00	Transfusion, blood or blood components (MD/DO)	70.50
36470*00	Injection of sclerosing solution; single vein	42.00
36471*00	Injection of sclerosing solution; multiple veins, same leg (MD/DO)	50.00
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	133.20
36520-00	Therapeutic apheresis (plasma and/or cell exchange) (MD/DO)	156.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	47.00
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	117.00
36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	410.00
36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,255.00
37609-00	Ligation or biopsy, temporal artery	280.00
37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	650.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	921.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	830.00
37731-00	bilateral	1,256.00

Subp. 8. **Hemic and lymphatic systems.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the hemic (blood) and lymphatic systems.

Code	Service	Maximum Fee

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38100-00	Splenectomy; total	$ 1,500.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	180.00
38510-00	deep cervical nodes	366.00
	Mediastinum and Diaphragm	
39400-00	Mediastinoscopy, with or without biopsy	$ 540.00

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

Code	Service	Maximum Fee
40490-00	Biopsy of lip	$ 102.00
40808-00	Biopsy, vestibule of mouth	70.00
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	151.50
41010-00	Incision of lingual frenum (frenotomy)	41.50
42330-00	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	120.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,795.00
42700*00	Incision and drainage abscess; peritonsillar	103.75
42809-00	Removal of foreign body from pharynx	72.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	462.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	475.00
	Esophagus	
43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 304.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	490.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	439.16
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	350.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	406.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	508.00
43246-00	for directed placement of percutaneous gastrostomy tube	695.00
43247-00	for removal of foreign body	500.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	473.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with	

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

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

Subp. 10. **Urinary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the urinary system.

Code	Service	Maximum Fee
	Kidney	
50200*00	Renal biopsy, percutaneous trocar or needle (MD/DO)	$ 353.50
50230-00	Nephrectomy, including partial ureterectomy, any approach including resection; radical, with regional lymphadenectomy	1,821.00
50360-00	Renal homotransplantation, implantation	

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	of graft; excluding donor and recipient nephrectomy	3,094.00
50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	50.00
50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure	30.50
51600*00	Injection procedure for cystography or voiding urethrocystography (MD/DO)	18.56
51605-00	Injection procedure and placement of chain for contrast and/or chain urethrocystrography	49.51
51610-00	Injection procedure for retrograde urethrocystography	29.00
51700*00	Bladder irrigation, simple, lavage and/or instillation	34.00
51705*00	Change of cystostomy tube; simple (MD/DO)	39.40
51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	81.20
51726-00	Complex cystometrogram (for example, calibrated electronic equipment) (MD/DO)	104.00
51741-00	Complex uroflowmetry	60.00
51840-00	Anterior vesicourethropexy, or urethropexy; simple	1,113.00
51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,250.00
51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,400.00
52000-00	Cystourethroscopy (separate procedure) (MD/DO)	131.00
52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	250.00
52204-00	Cystourethroscopy with biopsy	186.00
52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of of trigone bladder neck, prostatic fossa, urethra, or periurethral glands)	297.00
52224-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 centimeter) lesion(s) with or without biopsy	290.00
52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters) ~~530.00~~	430.00
52235-00	MEDIUM bladder tumor(s) (2.0 to 5.0 centimeters)	820.00
52240-00	LARGE bladder tumor(s)	1,200.00
52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	216.00
52281-00	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office (MD/DO)	227.00
52310-00	Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate	

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

Subp. ~~10~~ 11. **Reproductive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the reproductive system.

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

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

Subp. 12. **Endocrine system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the endocrine (glandular) system.

Code	Service	Maximum Fee
60100-00	Biopsy thyroid, percutaneous needle	$ 123.50

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

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

Code	Service	Maximum Fee
61310-00	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial (MD/DO)	$ 2,625.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,845.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,690.00
	Spine and Spinal Cord -- Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic (MD/DO)	$ 100.00
62273*00	Injection lumbar epidural, of blood or clot patch (MD/DO)	240.00
62274*00	Injection of anesthetic substance diagnostic or therapeutic; subarachnoid or subdural simple (MD/DO)	100.00
62278*00	epidural or caudal single (MD/DO)	195.00
62279*00	epidural or caudal, continuous	275.00
62284*00	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa (MD/DO)	135.20
62289*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal (MD/DO)	256.00
	Spine and Spinal Cord -- Laminectomy or Laminotomy, for Exploration or Decompression	
63005-00	Laminectomy for exploration/decompression of spinal cord and/or cauda, equina, one or two segments; lumbar, except for spondylolisthesis (MD/DO)	$ 2,420.00
63020-00	Laminotomy (hemilaminectomy), for decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral (MD/DO)	2,075.00
63030-00	one interspace, lumbar, unilateral (MD/DO)	2,005.00
63042-00	reexploration; lumbar (MD/DO)	2,586.00
	Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System	
64405*00	Injection, anesthetic agent; greater occipital nerve	$ 114.00
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	130.00
64442-00	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level	120.00

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

Subp. 14. **Eye and ocular adnexa.** The following codes, service descriptions and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

Code	Service	Maximum Fee
65205*00	Removal foreign body, external eye; conjunctival superficial (MD/DO)	$ 45.00
65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating (MD/DO)	50.00
65220*00	corneal, without slit lamp (MD/DO)	52.00
65222*00	corneal, with slit lamp (MD/DO)	61.80
65420-00	Excision or transposition of pterygium; without graft (MD/DO)	545.00
65435*00	Removal of corneal epithelium; with or without chemo-cauterization (abrasion, curettage)	51.90
65855-00	Trabeculoplasty by laser surgery, (1 or more sessions) (defined treatment series)	693.00
66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)	650.00
66762-00	Coreoplasty by photocoagulation (1 or more sessions) (e.g., for improvement of vision)	600.00
66802-00	Discission of lens capsule; laser surgery (one or more stages)	600.00
66820-00	Discission of secondary membranous cataract ("after cataract"), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)	547.00
66821-00	laser surgery (one or more stages)	700.00
66940-00	Extraction of lens with or without iridectomy; extracapsular	1,682.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,770.00
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) (MD/DO)	1,763.50
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,287.50
67036-00	Vitrectomy, mechanical, pars plana approach	3,025.00
67105-00	Repair of retinal detachment, 1 or more sessions, same hospitalization; photocoagulation (laser or xenon arc, 1 or more sessions) with drainage of subretinal fluid	556.00
67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,080.00
67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration)	

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	without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	700.00
67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), 1 or more sessions; photocoagulation (laser or xenon arc)	975.00
67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), 1 or more sessions; cryotherapy, diathermy	818.00
67228-00	photocoagulation (laser or xenon arc)	778.00
67311-00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); 1 muscle	900.00
67312-00	2 muscles, 1 or both eyes	968.00
67515*00	Injection of therapeutic agent into Tenon's capsule	49.00
67700*00	Blepharotomy, drainage of abscess, eyelid	57.00
67800-00	Excision of chalazion; single	75.00
67801-00	multiple, same lid	110.00
67805-00	multiple, different lids	135.00
67810*00	Biopsy of eyelid	106.00
67820*00	Correction of trichiasis; epilation, by forceps only	31.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	87.00
67921-00	Repair of entropion; suture	700.00
67938-00	Removal of embedded foreign body; eyelid	40.00
68200*00	Subconjunctival injection	48.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral (MD/DO)	37.00
68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring general anesthesia	260.00

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

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 55.00
69200-00	Removal foreign body from external auditory canal; without general anesthesia	27.24
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	20.75
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	38.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	84.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral (MD/DO)	150.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	240.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral (MD/DO)	252.00
69437-00	bilateral (MD/DO)	350.00
69440-00	Middle ear exploration through postauricular or ear canal incision (MD/DO)	897.00

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

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 1. **General.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine, a doctor of osteopathy, or a technician under the supervision of a doctor of medicine or osteopathy.

A. Single charge including both professional and technical component. The maximum fee represents the appropriate charges for professional services plus expenses of nonradiologist personnel, materials, facilities, and space used and for diagnostic or therapeutic services rendered, but excludes the cost of radio-isotopes. This value is applicable in any situation in which a single charge is made to include both professional services and the cost involved in providing that service.

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

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When the physician component is billed separately, the procedure may be identified by adding the modifier "-26" to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 40 percent of the fee maximum.

(2) Technical component: certain procedures (e.g., laboratory, radiology, electrocardiogram, specific diagnostic, and therapeutic services) are a combination of a physician component and a technical component. When the technical component is billed separately, the procedure may be identified by adding the modifier "T.C." to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 60 percent of the fee maximum.

Subp. 2. **Diagnostic radiology.** The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Code	Service	Maximum Fee
	Head and Neck	
70100-00	Radiologic examination, mandible; partial, less than four views (MD/DO)	$ 47.25
70120-00	Radiologic examination, mastoids; less than three views per side (MD/DO)	72.00
70130-00	complete, minimum of three views per side (MD/DO)	90.00
70140-00	Radiologic examination, facial bones; less than three views (MD/DO)	41.70
70150-00	complete, minimum of three views (MD/DO)	55.00
70160-00	Radiologic examination, nasal bones; complete, minimum of three views (MD/DO)	47.00
70200-00	Radiologic examination; orbits, complete, minimum of four views (MD/DO)	46.30
70210-00	Radiologic examination, sinuses, paranasal, less than three views (MD/DO)	37.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views (MD/DO)	69.50
70240-00	Radiologic examination, sella ~~turcia~~ turcica (MD/DO)	48.25
70250-00	Radiologic examination, skull, less than four views, with or without stereo (MD/DO)	48.00
70260-00	complete, minimum of four views, with or without stereo (MD/DO)	74.00
70300-00	Radiologic examination, teeth; single view	14.20
70310-00	partial examination, less than full mouth	18.90
70320-00	complete, full mouth	55.00
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	81.00
70332-00	Temporomandibular joint arthrography; supervision and interpretation only	250.00
70333-00	complete procedure	180.00
70355-00	Orthopantogram	35.00
70360-00	Radiologic examination, neck, soft	

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		tissue (MD/DO)	33.75
70380-00		Radiologic examination, salivary gland for calculus	48.50
70390-00		Sialography; supervision and interpretation only	99.00
~~70450-00~~		~~Computerized axial tomography, head or brain (MD/DO)~~	~~120.90~~
~~70480-00~~		~~Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear, without contrast material~~	~~150.00~~
~~70481-00~~		~~--with contrast material~~	~~139.00~~
~~70486-00~~		~~Computerized axial tomography, maxillofacial area, without contrast material~~	~~91.40~~
~~70491-00~~		~~Computerized axial tomography, soft tissue neck, with contrast material(s)~~	~~132.00~~
70540-00		Magnetic resonance (e.g., proton) imaging; orbit, face, and neck	600.00
		Chest	
71010-00		Radiologic examination, chest; single view, frontal (MD/DO)	$ 34.00
71015-00		stereo, posteroanterior (MD/DO)	35.00
71020-00		Radiologic examination, chest, two views, frontal and lateral (MD/DO)	47.25
71021-00		with apical lordotic procedure (MD/DO)	44.00
71022-00		with oblique projections (MD/DO)	22.50
71030-00		Radiological examination, chest, complete, minimum of four views (MD/DO)	45.00
71034-00		Radiologic examination, chest, complete, minimum of four views; with fluoroscopy	56.00
71035-00		Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies	23.50
71100-00		Radiologic examination, ribs, unilateral; two views (MD/DO)	53.00
71101-00		Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views	60.00
71110-00		Radiologic examination, ribs, bilateral; three views (MD/DO)	62.00
71111-00		Radiologic examination, ribs, bilateral; including postero-anterior chest, minimum of four views	73.00
71120-00		Radiologic examination; sternum, minimum of two views (MD/DO)	38.00
71130-00		Radiologic examination; sternoclavicular joint or joints, minimum of three views	60.00
~~71260-00~~		~~--with contrast material~~	~~142.20~~
		Spine and Pelvis	
72010-00		Radiologic examination, spine, entire, survey study, anteroposterior, and lateral (MD/DO)	$ 86.00
72020-00		Radiologic examination, spine, single view, specify level (MD/DO)	37.00
72040-00		Radiologic examination, spine, cervical; anteroposterior and lateral (MD/DO)	50.50
72050-00		minimum of four views (MD/DO)	80.40
72052-00		Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	89.00
72070-00		Radiologic examination, spine; thoracic, anteroposterior and lateral (MD/DO)	57.50
72072-00		Thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction (MD/DO)	58.50
72074-00		Radiologic examination, spine; thoracic, complete, including obliques, minimum of	

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

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

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

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	localization	$ 83.10
74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	42.00
74740-00	Hysterosalpingography; supervision and interpretation only	101.00
74741-00	complete procedure	137.20

Vascular System

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

Veins and Lymphatics

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75820-00	Venography, extremity, unilateral; supervision and interpretation only	$ 98.50
75821-00	Venography, extremity, unilateral; complete procedure (MD/DO)	130.15
75897-00	Transcatheter therapy, infusion (e.g., thrombolysis other than coronary), including angiography; complete procedure	375.00
75962-00	Percutaneous transluminal angioplasty, peripheral artery; supervision and interpretation only	68.00
75985-00	Change of percutaneous drainage catheter with contrast monitoring (i.e., biliary tract, urinary tract); complete procedure	199.00

Miscellaneous

76000-00	Fluoroscopy (separate procedure), up to one hour physician time	$ 40.00
76020-00	Bone age studies	36.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	69.00
76061-00	Radiologic examination, osseous survey: limited (e.g., for metastases)	139.00
76062-00	Radiologic examination, osseous survey; complete (MD/DO)	195.50
76066-00	Joint survey, single view, one or more joints (specify)	23.00
76080-00	Radiologic examination, fistula or sinus tract study; supervision and interpretation only	61.00
76081-00	Radiologic examination, fistula or sinus tract study; complete procedure (MD/DO)	76.70
76100-00	Radiologic examination, single plane body section (MD/DO)	101.30
76101-00	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	93.60
76102-00	bilateral	100.00
76150-00	Xeroradiography	50.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	436.00
~~76370-00~~	~~Computerized tomography guidance for placement of radiation therapy fields~~	~~74.25~~
~~76375-00~~	~~Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction~~	~~45.00~~

Subp. 3. **Diagnostic ultrasound.** The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

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

Subp. 4. **Therapeutic radiology.** The following codes,

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

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

Code	Service	Maximum Fee
77262-00	Therapeutic radiology treatment planning; intermediate	$ 295.00
77263-00	complex	345.00
77280-00	Therapeutic radiology simulation-aided field setting; simple (MD/DO)	100.04
77285-00	intermediate	125.00
77290-00	complex	175.00
77300-00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment (MD/DO)	60.00
77305-00	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	125.00
77310-00	intermediate (three or more treatment ports directed to a single area of interest)	150.00
77315-00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	280.00
77334-00	Treatment devices, design and construction; complex (MD/DO)	150.00
77336-00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance (MD/DO)	61.50
77400-00	Daily megavoltage treatment	

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

Subp. 5. **Nuclear medicine.** The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

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

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78593-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection (MD/DO)	98.00
78594-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views)	81.50
	Nervous System	
78660-00	Dacryocystography (lacrimal flow study)	$ 15.00
	Genitourinary System	
78700-00	Kidney imaging; static only	$ 68.00
78704-00	Kidney imaging; with function study (e.g., imaging renogram) (MD/DO)	81.00
78715-00	Kidney vascular flow only	54.60
78725-00	Kidney function study only	152.00
78727-00	Kidney transplant evaluation	95.00
78740-00	Ureteral reflux study (radionuclide voiding cystogram)	80.00
78805-00	Radionuclide localization of abscess; limited area	483.80
78890-00	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	121.50

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

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

Subp. 2. **Automated, multichannel tests.** The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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

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

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

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

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descriptions, and maximum fees apply to urinalysis procedures.

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy (MD/DO)	$ 12.00
81002-00	routine, without microscopy (MD/DO)	7.00
81004-00	components, single, not otherwise listed, specify (MD/DO)	6.00
81005-00	chemical, qualitative, any number of constituents (MD/DO)	6.50
81010-00	concentration and dilution test (MD/DO)	5.00
81015-00	microscopic only (MD/DO)	8.00
81020-00	two or three glass test	10.00

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

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

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

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

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

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

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke (MD/DO)	$ 8.00
85002-00	Ivy or template (MD/DO)	21.40
85007-00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation) (MD/DO)	11.25
85009-00	differential WBC count, buffy coat	19.00
85012-00	eosinophil count, direct (MD/DO)	14.00
85014-00	hematocrit (MD/DO)	9.00
85018-00	hemoglobin, colorimetric (MD/DO)	9.50
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only) (MD/DO)	19.00
85022-00	hemogram, automated, and manual differential WBC count (CBC) (MD/DO)	24.25
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	31.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	23.00
85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	27.20
85027-00	hemogram, and platelet count, automated (MD/DO)	15.25
85029-00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram; 1-3 indices	10.50
85030-00	4 or more indices	15.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes) (MD/DO)	22.00
85041-00	red blood cell (RBC) only	8.00
85044-00	reticulocyte count (MD/DO)	13.50
85048-00	White blood cell (WBC) (MD/DO)	10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	50.50
85095-00	Bone marrow smear and/or cell block; aspiration only	87.00
85097-00	Bone marrow smear and/or cell block; smear interpretation only MD/DO)	75.00
85100-00	aspiration, staining, and interpretation (MD/DO)	114.00
85102-00	Bone marrow needle biopsy (MD/DO)	94.00
85103-00	staining and interpretation (MD/DO)	115.00
85105-00	interpretation only (MD/DO)	81.50
85210-00	Clotting; factor II, prothrombin, specific	14.00
85240-00	factor VIII (AHG), 1 stage	77.20
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	14.00
85368-00	Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)	11.00
85540-00	Leukocyte alkaline phosphatase with count	27.00
85544-00	Lupus erythematosus (LE) cell prep (MD/DO)	20.00
85548-00	Morphology of red blood cells only	

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

Subp. 6. **Immunology.** The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86000-00	Agglutinins; febrile, each antigen (MD/DO)	$ 19.00
86004-00	warm	15.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube (MD/OD)	16.00
86007-00	each additional antigen (MD/DO)	25.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	20.00
86009-00	each additional antigen	37.00
86012-00	Antibody absorption, cold auto absorption; per serum	15.50
86013-00	Antibody absorption, cold auto absorption; differential (MD/DO)	8.00
86016-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	27.00
86017-00	with ABO+Rh(D) typing (for blood instead of complete crossmatch	15.00
86018-00	enzyme technique, including antihuman globulin	10.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique (MD/DO)	26.00
86028-00	Saline or high protein, each (MD/DO)	27.50
86031-00	Antihuman globulin test; direct, 1-3 dilutins (MD/DO)	15.25
86032-00	indirect, qualitative (MD/DO)	17.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.00
86038-00	Antinuclear antibodies (ANA), RIA	30.00
86060-00	Antistreptolysin O; titer (MD/DO)	23.00
86063-00	screen (MD/DO)	15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	21.00
86067-00	other method (specify)	54.50
86069-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; each additional unit	35.50
86075-00	Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening first unit	18.25
86080-00	Blood typing; ABO only (MD/DO)	11.75
86082-00	ABO and Rho(D) (MD/DO)	21.30
86095-00	Blood typing, RBC, antigens other	

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

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

Subp. 7. **Microbiology.** The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
87015-00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	27.00
87045-00	stool	28.40
87060-00	throat or nose	12.50
87070-00	any other source	23.00
87072-00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	16.20
87075-00	Culture, bacterial, any source; anaerobic (isolation)	29.00
87081-00	Culture, bacterial, screening only, for single organisms	14.50
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083-00	multiple organisms	17.25
87084-00	with colony estimation from density chart	10.00
87085-00	with colony count	29.00
87086-00	Culture, bacterial, urine; quantitative, colony count (MD/DO)	19.00
87087-00	commercial kit	11.25
87088-00	identification, in addition to quantitative or commercial kit	23.00
87101-00	Culture, fungi, isolation; skin	18.00
87102-00	other source (except blood)	13.50
87106-00	Culture, fungi, definitive identification of each fungus	27.60
87109-00	Culture, mycoplasma, any source	43.50

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

Subp. 8. **Anatomic pathology.** The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

Code	Service	Maximum Fee
	Cytopathology	
88104-00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation (MD/DO)	$ 30.00
88106-00	filter method only with interpretation	31.70
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	37.00

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

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

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

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88321-00	Consultation and report on referred slides prepared elsewhere	67.95
88323-00	Consultation and report on referred material requiring preparation of slides	52.50
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	48.00
88331-00	with frozen section(s); single specimen	100.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	42.00

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

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

5221.2500 DENTISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

Subp. 2. **Diagnostic.** The following codes, service descriptions, and maximum fees apply to diagnostic services.

Code	Service	Maximum Fee
	Restorative	
02140-00	Amalgam; one surface, permanent (DDS)	$ 28.00
02150-00	two surfaces, permanent (DDS)	40.00
02160-00	three surfaces, permanent (DDS)	53.00
02161-00	four or more surfaces, permanent (DDS)	64.00
	Acrylic or Plastic Restorations	
02330-00	Resin; one surface, anterior (DDS)	$ 38.00

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

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

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06545-00	Cast metal retainer for acid etch bridge	$ 132.00

Prosthodontics, Fixed

06640-00	Replace broken facing with acrylic (DDS)	$ 70.00

Bridge Retainers -- Crowns

06750-00	Crown; porcelain fused to high noble metal	$ 377.00
06751-00	porcelain fused to predominantly base metal	360.00
06752-00	porcelain fused to noble metal	355.00
06790-00	full cast high noble metal	355.00
06791-00	full cast predominantly base metal	295.00
06792-00	full cast noble metal	300.00
06801-00	Diagnostic exam and DXL	20.00
06802-00	Prevention	25.00
06803-00	Restorative	52.50
06804-00	Endodontics	285.00
06808-00	Dental oral surgery	45.00
06809-00	Unlisted dental procedures	24.00

Other Fixed Prosthetic Services

06930-00	Recement bridge (DDS)	$ 40.00

Oral Surgery Extractions -- Includes Local Anesthesia and Routine Postoperative Care

07110-00	Single tooth (DDS)	$ 35.00
07120-00	Each additional tooth (DDS)	35.00

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

07210-00	Surgical removal of tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth (DDS)	$ 75.00
07220-00	Removal of impacted tooth; soft tissue (DDS)	86.00
07230-00	Removal of the impacted tooth; partially bony (DDS)	119.00
07240-00	Removal of impacted tooth; completely bony (DDS)	140.00
07241-00	Removal of impacted tooth; completely bony, with unusual surgical complications (DDS)	150.00
07250-00	Surgical removal of residual tooth roots (DDS)	75.00

Other Surgical Procedures

07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments) (DDS)	$ 125.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	140.00
07286-00	Biopsy of oral tissue; soft	90.00

Alveoplasty - Surgical Preparation of Ridge For Dentures

07310-00	Alveoloplasty (per quadrant) in conjunction with extractions (DDS)	$ 75.00

Surgical Incision

07510-00	Incision and drainage of	

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	abscess, intraoral soft tissue (DDS)	$ 45.00
	Other Repair Procedures	
07960-00	Frenulectomy	$ 90.00
	Adjunctive General Services	
	Unclassified Treatment	
09110-00	Palliative (emergency) treatment of dental pain; minor procedures	25.00
	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 8.00
09211-00	Regional block anesthesia	10.00
09220-00	General; first 30 minutes (DDS)	90.00
09230-00	Analgesia (DDS)	12.00
	Professional Consultation	
09310-00	Consultation; per session	35.00
09420-00	Hospital call	14.00
09430-00	Office visit during regularly scheduled office hours	15.00
	Drugs	
09610-00	Therapeutic drug injection, by report	15.00
09630-00	Other drugs and/or medicaments	15.00
	Miscellaneous Services	
09910-00	Application of desensitizing medicaments (DDS)	$ 15.00
~~09991-00~~		~~25.00~~
~~09993-00~~		~~30.00~~
	Surgery	
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	2,960.00
21203-00	mandibular ramus (osteotomy)	2,950.00
21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,400.00
40808-00	Biopsy, vestibule of mouth	107.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	100.00
41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	150.00
~~42150-00~~		
42150-00	Removal of exostosis, bony palate	280.00
	Radiology -- Dental	
70320-00	Radiologic examination, teeth; complete, full mouth	45.00
70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	35.00
70330-00	bilateral	90.00
70350-00	Caphalogram, orthodontic	40.00
70355-00	Orthopantogram	35.00
76100-00	Radiologic examination, single plane body section (e.g., tomography)	73.00
	Surgical Pathology -- Dental	
88304-00	Surgical pathology, gross and microscopic	

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

5221.2600 OPTOMETRISTS~~,-OPTICIANS~~.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of optometry, and to procedures performed within the scope of practice in accordance with Minnesota Statutes, sections 148.52 to 148.62.

~~Subp.-2.--Definitions.--The-terms-defined-in-this-part-have the-meanings-given-them-for-the-purposes-of-this-part-unless-the context-clearly-indicates-a-different-meaning.~~

~~A.--"New-patient"-and-"established-patient"-have-the meanings-given-them-in-part-5221.1100.~~

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

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

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

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

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

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

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

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

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

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

5221.2650 OPTICIANS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to certified opticians.

Subp. 2. **Basic optician services.** The following codes, service descriptions, and maximum fees apply to basic optician services and supplies:

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 53.00
06502-00	Bifocal eyeglass lenses (one lens)	69.95
06503-00	Trifocal eyeglass lenses (one lens)	85.00
06504-00	Lenticular eyeglass lenses (one lens)	24.00
06506-00	Eyeglass frames	80.00
06510-00	Tinting for lenses	12.00
06587-00	Contact lenses, soft (one lens)	109.00
06588-00	Contact lenses, hard (one lens)	61.00
06593-00	Dispensing fee, frames for lenses	70.20

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Office Services

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

5221.2700 AUDIOLOGISTS.

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

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

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

5221.2750 SPEECH PATHOLOGISTS.

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

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competency (CCC-SP) or to speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subp. 2. **~~Physical therapy.~~ Definitions.** The terms defined in this subpart have the meanings given to them when used in subpart 4 unless the context clearly indicates a different meaning.

A. "Therapeutic exercise" (code 97110) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular re-education" (code 97112) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident and systemic neurological disease.

C. "Functional activities" (code 97114) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work-related activities.

D. "Gait training" (code 97116) means teaching individuals with neurological or musculoskeletal disorders to

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ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how to prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

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

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

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

Subp. 3. **Physical and occupational therapy instructions.**

A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration. ~~The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.~~

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

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C. Occupational therapy services must be provided by a nationally registered occupational therapist or certified occupational therapy assistant under the direction of a nationally registered occupational therapist.

Subp. 4. **Scope** **Physical therapy and occupational therapy services.** The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed within the physical or occupational therapist's scope of practice in an independent clinic, or a doctor's office~~, a hospital satellite clinic, or hospital out-patient setting~~.

Code	Service	Maximum Fee
	Modalities	
97010-00	Physical medicine treatment to one area; hot or cold packs ~~(RPT/OTR)~~	$ 17.00
97012-00	traction, mechanical ~~(RPT/OTR)~~	16.00
97014-00	electrical stimulation (unattended) ~~(RPT/OTR)~~	15.00
97016-00	vasopneumatic devices ~~(RPT/OTR)~~	16.00
97018-00	paraffin bath ~~(RPT/OTR)~~	20.00
97022-00	whirlpool ~~(RPT/OTR)~~	17.00
97024-00	diathermy ~~(RPT/OTR)~~	16.00
97028-00	ultraviolet ~~(RPT/OTR)~~	25.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises ~~(RPT/OTR)~~	$ 22.00
97112-00	neuromuscular reeducation ~~(RPT/OTR)~~	25.00
97114-00	functional activities ~~(RPT/OTR)~~	19.00
97116-00	gait training ~~(RPT/OTR)~~	23.00
97118-00	electrical stimulation (manual) ~~(RPT/OTR)~~	16.25
97120-00	iontophoresis ~~(RPT/OTR)~~	20.00
97122-00	traction, manual ~~(RPT/OTR)~~	18.00
97124-00	massage ~~(RPT/OTR)~~	17.25
97126-00	contrast baths	18.00
97128-00	ultrasound ~~(RPT/OTR)~~	16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	13.00
97220-00	Hubbard tank; initial 30 minutes each visit ~~(RPT/OTR)~~	45.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit ~~(RPT/OTR)~~	30.00
97500-00	Orthotics training (dynamic bracing, splinting), ~~upper~~ upper/lower extremities; initial 30 minutes, each visit ~~(RPT/OTR)~~	21.00
97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit ~~(RPT/OTR)~~	25.00
97531-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit ~~(RPT/OTR)~~	20.00
97541-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50

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

5221.2900 CHIROPRACTORS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of chiropractic medicine.

Subp. 1a. **Definitions.** For purposes of this part, the following terms have the meaning given them unless the content clearly indicates a different meaning.

A. "Examination/consultation" means inspection of the patient, review of diagnostic tests to diagnose disease or evaluate progress and preparation of an appropriate record.

(1) "Brief examination" means a condition requiring only a routine history and examination.

(2) "Intermediate examination" means a condition involving a diagnostic or management problem and a history and examination.

(3) "Extensive examination" means an unusual amount of effort or judgment and a detailed history and examination of multiple body systems.

B. "Initial office visit with manipulation/adjustment" means the first time a patient is seen for a brief evaluation to determine the appropriate treatment on that date and all necessary spinal manipulative/adjustment procedures rendered.

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C. "Subsequent office visit with manipulation/adjustment" means all office visits, except the first one, where a brief evaluation is done to determine appropriate treatment on that day and all necessary spinal manipulation/adjustment procedures rendered.

D. "New patient" means a patient new to the chiropractor or a known patient with a new industrial injury or condition, whose medical and administrative record needs to be established.

E. "Established patient" means a patient whose medical and administrative records are available to the chiropractor.

Subp. 1b. **Chiropractor instructions.**

A. Use code 09542 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation ~~on-the-same-day~~.

Subp. 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Examinations - Includes History and Diagnosis, Office	
09520-00	New patient; brief examination (CHIRO/DC)	$ 30.00
09521-00	intermediate examination (CHIRO/DC)	40.00
09522-00	extensive examination (CHIRO/DC)	60.00
09530-00	Established patient; brief examination (CHIRO/DC)	25.00
09531-00	intermediate examination (CHIRO/DC)	40.00
09532-00	extensive examination (CHIRO/DC)	60.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office (CHIRO/DC)	$ 20.00
09541-00	subsequent; office (CHIRO/DC)	22.00
09542-00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00
	Home/Nursing Home Visits	
09550-00	Chiropractic visit with manipulation/adjustment (CHIRO/DC)	$ 40.00
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00

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

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

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

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	limited (one projection) (CHIRO/DC)	$ 30.00
73030-00	complete, minimum of two views	54.00
73070CHR	Radiologic examination, elbow; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73100CHR	Radiologic examination, wrist; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73110-00	complete, minimum of three views	50.00
73120CHR	Radiologic examination, hand (CHIRO/DC)	36.00
	Lower Extremities	
73500CHR	Radiologic examination, hip; limited (one view) (CHIRO/DC)	$ 35.00
73510CHR	Radiologic examination, hip; complete, minimum of two views (CHIRO/DC)	53.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	40.00
73562CHR	anteroposterior and lateral, with oblique(s), minimum of three views (CHIRO/DC)	55.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	70.00
73600CHR	Radiologic examination, ankle; limited (two views) (CHIRO/DC)	35.00
73610CHR	Radiologic examination, ankle; comprehensive (minimum of three views (CHIRO/DC)	50.00
73620-00	Radiologic examination; foot; anteroposterior and lateral views	32.00
73630-00	complete, minimum of three views	55.00
	Miscellaneous	
76140-00	Consultation on x-ray examination made elsewhere, written report	25.00

Subp. 4. **Laboratory.** The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles include the following tests.

Code	Service	Maximum Fee
	Automated Multichannel Test	
80019CHR	Automated multichannel tests; 19 or more clinical chemistry tests (indicate instrument use and number of tests performed) (CHIRO/DC)	$ 60.00
	Urinalysis	
81000-00	Urinalysis; routine (pH, specific gravity, protein tests for reducing substances such as glucose), with microscopy	$ 12.00
81002-00	routine, without microscopy	12.00
81015CHR	Urinalysis; microscopic only (CHIRO/DC)	12.00
	Hematology	
85022CHR	Blood count; hemogram, automated, and differential WBC count (CBC)	$ 29.00
85031CHR	hemogram, manual, complete CBC	

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

5221.3000 PODIATRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. **Ancillary services.** Services performed by podiatric assistants must be by order of and under the direct on-site supervision of a licensed doctor of podiatric medicine.

Subp. 3. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

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

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17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (POD/DPM)	$	28.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions (POD/DPM)		30.00
17340*00	Cryotherapy (CO2 slush, liquid N2)		22.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst		42.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)		50.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)		45.00
28080-00	Excision of Morton neuroma, single, each		465.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe		325.00
28126-00	Concylectomy, phalangeal base, single toe, each		350.00
28153-00	Resection, head of phalanx, toe		375.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)		400.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)		593.00
28292-00	Keller, McBride, or Mayo type procedure		930.00
28308-00	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal		614.00
29405-00	Application of short leg cast (below knee to toes) (POD/DPM)		100.00
29425-00	Application of short leg case (below knee to toes); walking or ambulatory type		125.00
29540-00	Strapping; ankle (POD/DPM)		22.00
29550-00	toes (POD/DPM)		23.00
29580-00	Unna boot (POD/DPM)		35.00
29590-00	Dennis Browne splint strapping		25.00
36415*00	Routine venipuncture for collection of specimens		10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch (POD/DPM)		30.00

Radiology

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

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

Patient Visits

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

Hospital Medical Services

90115-00	Home medical service, new patient; intermediate service	$ 25.00
90140POD	Home medical service, established patient; brief service (POD/DPM)	15.00
90200POD	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	70.00
90215POD	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	40.00
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	35.00
90350-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; limited service	15.00
90360-00	intermediate service	25.00
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	16.00
90410-00	limited service	15.00

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

5221.3100 PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

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

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

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

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

5221.3160 SOCIAL WORKERS.

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

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of social work (MSW) degree or a comparable degree.

Subp. 2. **Social worker services.** The following codes, service descriptions, and maximum fees apply to social worker services performed by persons meeting the requirements of the board of social work.

Code	Service	Maximum Fee
06043-00	Independent behavior and/or other analysts, counselors, and other therapists (MSW)	$ 45.00
06046-00	Independent social worker services (MSW)	70.00

~~5221.3170~~ 5221.1410 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider ~~certified by the Biofeedback Certification Institute of America (BCIA). Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP)~~ licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
90900-00	Biofeedback training; by electromyogram application (e.g., in tension headache muscle spasm) (BCIA/LCP)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow (BCIA/LCP)	45.00

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. [Unchanged.]

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

A. to P. [Unchanged.]

Q. Mount Sinai Hospital, Minneapolis

R. North Memorial Medical Center, Robbinsdale

S. Saint Cloud Hospital, Saint Cloud

T. St. John's Hospital Northeast, Saint Paul

U. Saint Joseph's Hospital, Saint Paul

V. Saint Luke's Hospital, Duluth

W. Saint Mary's Hospital, Duluth

X. Saint Mary's Hospital, Minneapolis

Y. The Samaritan Hospital, Saint Paul

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Z. United Hospital, Saint Paul

AA. Unity Medical Center, Fridley

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

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

A. to JJJJJJ. [Unchanged.]

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

Subp. 4. **Group 3.** The following hospitals make up group 3:

A. Hennepin County Medical Center, Minneapolis

B. Saint Paul Ramsey Medical Center, Saint Paul

C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	$ 400.18

Subp. 5. **Group 4.** The following hospitals make up group 4:

A. Rochester Methodist Hospital, Rochester

B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	$ 180.80

5221.3310 EFFECTIVE DATE.

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

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

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

Approved by Revisor _____

(20).

Approved
by Revisor _____

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

APR 14 1989

Joan Anderson Growe
Secretary of State
3:26 pm

APPROVED AS TO FORM AND LEGALITY
April 14 1989
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY Christie B Eller
ASSISTANT ATTORNEY GENERAL

1. Graduate degree in anthropology with a specialization in archaeology plus at least 5 years of experience in archaeological research, administration and cultural resource management

2. A specialization in prehistoric and historic archaeology of the upper midwest

3. Demonstrated ability to successfully manage complex research programs

4. Demonstrated ability in oral and written communications

5. Demonstrated ability to work with a diverse public and government agencies

6. Not an employee of the Minnesota Historical Society

Duties of the State Archaeologist are stipulated in *Minnesota Statutes* 138.31 to 138.42 and 307.08.

Nominations should be addressed to Selection Committee—State Archaeologist, c/o Robert Clouse, Head, Archaeology Department, Fort Snelling History Center, St. Paul, MN 55111. Application deadline is August 5, 1988.

Department of Labor and Industry

Workers' Compensation Division

Notice of Solicitation of Outside Information or Opinions in the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry Governing Fees for Medical Services, Charges for Medical Reports, and Charges for Copies of Medical Records.

Notice is hereby given that the Minnesota Department of Labor and Industry, Workers' Compensation Division, is seeking information or opinions from sources outside the agency in preparing to propose the amendment of rules governing fees for medical services, charges for medical reports and charges for copies of medical records in workers' compensation cases. The adoption of the rules is authorized by *Minnesota Statutes* § 176.136 (Supp. 1987); section 176.135, subd. 7 (Supp. 1987) and section 176.83 (Supp. 1987).

The Minnesota Department of Labor and Industry, Workers' Compensation Division, requests information and opinions concerning the subject matter of the rules. Interested or affected persons or groups may submit data or views on the subject matter of concern in writing to:

Mary Jo O'Brien
Director of Rehabilitation and Medical Affairs
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road
St. Paul, Minnesota 55101

Any written material received by the Minnesota Department of Labor and Industry, Workers' Compensation Division, shall become part of the rulemaking record to be submitted to the Attorney General or Administrative Law Judge in the event that the rule is adopted.

Information and opinions will be accepted until August 22, 1988.

Dated: 18 July 1988

Ray Bohn, Commissioner
of the Department of Labor and Industry

Department of Labor and Industry

Labor Standards Division

Notice of Intent to Solicit Outside Opinion in the Matter of the Proposed Adoption by the Minnesota Department of Labor and Industry, Labor Standards Division, of Amendments to Rules Governing Employment Agencies

NOTICE IS HEREBY GIVEN that the State Department of Labor and Industry, Labor Standards Division, is seeking information

NOTICE OF SOLICITATION OF OUTSIDE INFORMATION OR OPINIONS

Department of Labor and Industry
Workers' Compensation Division

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry Governing Fees for Medical Services, Charges for Medical Reports, and Charges for Copies of Medical Records.

Notice is hereby given that the Minnesota Department of Labor and Industry, Workers' Compensation Division, is seeking information or opinions from sources outside the agency in preparing to propose the amendment of rules governing fees for medical services, charges for medical reports and charges for copies of medical records in workers' compensation cases. The adoption of the rules is authorized by Minn. Stat. § 176.136 (Supp. 1987); section 176.135, subd. 7 (Supp. 1987) and section 176.83 (Supp. 1987).

The Minnesota Department of Labor and industry, Workers' Compensation Division, requests information and opinions concerning the subject matter of the rules. Interested or affected persons or groups may submit data or views on the subject matter of concern in writing to:

Mary Jo O'Brien
Director of Rehabilitation and Medical Affairs
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road
St. Paul, Minnesota 55101

Any written material received by the Minnesota Department of Labor and Industry, Workers' Compensation Division, shall become part of the rulemaking record to be submitted to the Attorney General or Administrative Law Judge in the event that the rule is adopted.

Information and opinions will be accepted until August 22, 1988.

7-18-88
Date

Ray Bohn, Commissioner
of the Department of Labor and Industry

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

NOTICE OF INTENT TO AMEND A RULE WITHOUT A PUBLIC HEARING

Notice is hereby given that the Minnesota Department of Labor and Industry, Workers' Compensation Division intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minn. Stat. sec. 176.136 (Supp. 1987), and section 176.83 (Supp. 1987).

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule address, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Gloria Gebhard
Acting Director of Rehabilitation
and Medical Affairs, Workers' Compensation Division
443 Lafayette Road
St. Paul, Minnesota 55101
(612) 296-8213

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The rules proposed for amendment relate to medical charges and reimbursement in workers' compensation cases. The rules add, clarify or modify definitions of terms used in the rules, clarify or modify provider and payer responsibilities, and summarize dispute resolution procedures. The rules also modify, delete or add codes, service descriptions and maximum fees in the medical fee schedule. A free copy of the rules is available from Janice Kramer at the above address and phone number upon request.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Janice Kramer at the above address and phone number upon request.

The Statement of Need and Reasonableness concludes that the impact on small business need not be considered because these rules concern service businesses regulated by government bodies. Nevertheless, the impact on small business is minimal.

The rules do not require an additional expenditure of public monies by local public bodies, but instead limit expenditures.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Janice Kramer at the above address and phone number.

12-14-88
Date

Ken Peterson, Commissioner

STATE OF MINNESOTA
DEPARTMENT OR LABOR AND INDUSTRY

In the Matter of the Proposed
Amendment of Rules of the Minnesota
Department of Labor and Industry,
Workers' Compensation Division,
Governing Medical Charges and
Reimbursement

STATEMENT OF NEED
AND
REASONABLENESS

Part 5221.0100 Definitions

Subpart 3. Charge.

The proposed amendment deletes the word "fee" to clarify and simplify the language. The word "charge" is used throughout the rules in reference to the provider's billing, while the word "fee" only occurs in the context of the Medical Fee Schedule. Accordingly, the use of the word "fee" as synonymous with "charge" may be misleading.

Subpart 4. Code

The proposed amendment deletes the reference to the maximum fee schedule because proposed Rule 5221.0700, Subp. 3(a) requires providers to bill using approved codes, including codes not listed in the fee schedule. This provides payers with accurate information about the nature of the service and helps prevent confusion caused by the use of provider generated codes for internal office use. The proposed rule also clarifies and simplifies language.

Subpart 6. Compensable Injury.

This amendment deletes language which defines compensability only in reference to liability for a service, and clarifies the definition of a compensability injury to mean that it is the injury or condition, rather that the service, for which the payer is liable under Chapter 176. This is necessary because rules referencing excessive service and excessive charges limit the use of those terms to injuries or conditions for which liability has been accepted or established under Chapter 176. The addition of the word "condition" clarifies that the term "excessiveness" does not apply to a service for treatment of a condition which has not been causally related to an admitted or established work injury.

Subpart 7. Excessive Charge.

These changes clarify that the use of the term "excessive charge" applies only to charges for treatment once it has been established that a work injury has occurred for which liability has been established under Chapter 176 because an excessive workers' compensation charge cannot be collected form an employee. Other changes simplify or clarify existing language. The word "conditions" replaces "standards" to provide consistency with the use of that word in part 5221.0500.

Subpart 8. Excessive Services.

This definition is added to distinguish excessive services from excessive charges. A separate definition is necessary because a charge can be excessive when a service is not, and a service can be excessive even though the charge is reasonable. Also, under M.S. 176.136, subd. (2) a provider can request a determination from the Commissioner only as to whether a charge is excessive, not a service. Therefore, a separate rule, Part 5221.0550, setting forth the conditions of an excessive service has been proposed. This proposed rule presumes that a service can only be excessive if it has been established that the injury or condition is compensable under Chapter 176.

Subpart 10. Medical Fee Schedule.

This definition clarifies the statutory authority for establishing the Medical Fee Schedule and changes the rule citation to conform with the revised re-numbering. The term "Maximum Fee Schedule" is changed to "Medical Fee Schedule" because that is the term commonly used by providers and payers. The "75th percentile" is deleted because that standard is set by statute and it is more useful to reflect the dollar amount and specific rule citation.

Subpart 11. Payer.

The changes in this subpart simplify the language to provide for ease in understanding. The changes are not intended as a substantive change in meaning. The word "medical" is eliminated as unnecessary. The itemization of insurers is also deleted as unnecessary, because all deleted entities are payers within the revised definition.

Subpart 13. Reasonable Charge.

The changes simplify language and clarify that a charge cannot be defined as reasonable unless liability for the injury or condition has been admitted or established under Chapter 176 and the charge is not excessive. The additional language provides consistency with other definitional changes proposed.

Subpart 14. Reasonable Service.

This definition is added to distinguish between a reasonable charge and a reasonable service. This is necessary to ensure that the term reasonable service is not confused with reasonable charge, as previous definitions and later rules distinguish between the terms "charge" and "service". The definition also clarifies that a service cannot be defined as reasonable unless the service is not excessive and was rendered for treatment of an admitted or established work injury or condition pursuant to Chapter 176, because there is no rulemaking authority to define services for treatment of non-work related conditions as reasonable or unreasonable.

Subpart 15. Service or Treatment.

The phrase "curing and relieving" is changed to "curing or relieving" to reflect caselaw which establishes that treatment may be compensable if it cures or if it relieves the effects of an injury. The word "compensable" is added to clarify that unless the rules indicate otherwise, the use of term "service" relates to a service provided to treat an injury or condition for which liability under Chapter 176 has been established or admitted.

Subpart 16. Appropriate Record.

This subpart defines "appropriate record" according to the type of provider. M.S. 176.135, Subd. (7) requires that substantiating information accompany a bill. This subpart establishes what type of record satisfies this requirement. The definition varies by provider to reflect the varying nature of services and type of record typically generated for each.

After the proposed rules were submitted to the State Register for publication the Minnesota Hospital Association proposed the elimination of Item "B", a separate section for hospitals. Because hospitals need not supply an appropriate record under M.S. 176.135, subd. 7, to document a bill, unless one is requested, and the existing language could suggest that submission by hospitals of an appropriate

record is required with the bill, the Department agrees with this change. Item C, defining an appropriate record for chiropractors, is proposed to be merged with Item A at the request of the Minnesota Chiropractic Association. Initially, that group had requested a separate provision due to the differing nature of the services provided. These proposed modifications will be submitted to the Attorney General or Administrative Law Judge for approval.

Part 5221.0300. Purpose.

Without intending to change the substantive meaning of the rule, the amendments clarify that the rules do not apply to services for treatment of conditions that are not compensable as work-related under Chapter 176. Such charges are beyond the scope of these rules and the workers' compensation act. The term compensable is used for consistency with that term as defined in Part 5221.0100. The changes also reflect the distinction in other proposed amendments between excessive charges and services.

Part 5221.0400. Scope.

Again, the proposed changes clarify for consistency that the rules apply to compensable injuries as defined in Part 5221.0100. The substance of the rule is unaffected.

Part 5221.0500. Excessive charges.

This rule sets the conditions under which a charge may be determined to be excessive. The deleted language in reference to services is necessary because a new rule, 5221.0550, sets the conditions for an excessive service.

Item A. The changes do not substantively alter the meaning, but merely simplify the language and reflect the more common usage of the term "medical fee schedule."

Item B. Clarifies that when a service is not included in the medical fee schedule, the charge for the service is excessive if it exceeds the charge that prevails in the community for services provided under similar circumstances. This rule is necessary to eliminate confusion as to the extent of the payer's liability when a service is not included in the Medical Fee Schedule. The community charge standard applied is found in Minn. Stat. 176.135, subd. 3.

Item E. The deletions concerning standards of appropriateness, quality and coordination of treatment under M.S. 176.83 are necessary because these are standards of excessive service and not standards of excessive charges. A similar provision is now found in Part 5221.0550 (A), the rule on excessive services.

Item F. Previous language, deleted as it refers to an excessive service and not an excessive charge, has been moved to the new rule setting forth the conditions of an excessive service.

Item G. This item has been deleted because it concerns services and not excessive charges, and because Minn. Stat. 176.135, subd. 1a does not provide a basis for denial of payment for failure to obtain a second surgical opinion.

Item H. This item has been deleted because it concerns excessive services, not excessive charges, and because caselaw does not support a denial of payment soley on the grounds that procedural requirements for change of physician have not been met.

Item I. This item has been deleted as not an excessive charge, and moved to the rule setting forth the conditions of an excessive service. The new language provides that an incorrect charge or billing code for the service is an excessive charge. This may occur, for example, when there is a dispute as to which code under the fee schedule applies or whether a fee schedule code applies at all. It is characterized as an excessive charge because the underlying dispute concerns the amount for which the insurer is liable under the medical fee schedule.

Part 5221.0550. Excessive Services.

This is a new proposed rule, created to distinguish between excessive services and charges under Part 5221.0500. This distinction is necessary because a service can be excessive even though the charge is not, and a charge for a reasonable service can be excessive. Further, when the insurer has determined that a charge is excessive, M.S. 176.136 permits the provider to initiate an action to resolve the dispute. When the insurer determines that a service is excessive, only the employee, employer or insurer, may file the claim.

Item A. Identifies an excessive service as one which does not comply with requirements adopted pursuant to M.S. 176.83 concerning the reasonableness and necessity, quality coordination and frequency of services. A similar provision was included in the former rule on excessiveness. The rule will apply to any standards that are adopted pursuant to M.S. 176.83, subd. 5. The rule is necessary because the statute provides that services that do not comply with adopted standards should not be compensable. This assures appropriate treatment is provided.

Item B, previously included under the general excessiveness rule, is now more appropriately classified an excessive service. This condition refers to services provided by health care providers whom the Medical Services Review Board has determined have consistently performed procedures or provided services at an excessive level or cost in the past under M.S. 176.83.

Item C identifies as excessive those services that have been determined to be not reasonably required for the cure or relief of a work-related injury by the insurer, commissioner or compensation judge under M.S. 176.135. This is necessarily defined as an excessive service because under Minn. Stat. 176.135 and caselaw, the payer is not liable for services that are not reasonably required.

Part 5221.0600. Payer Responsibilities.

Subpart 1. Compensability.

These changes clarify that the rules do not require a payer to pay a charge for a service that is for the treatment of an injury or condition which is not work-related under Chapter 176. This is necessary to provide consistency with the definitions and because a workers' compensation insurer is not required to pay for services that are for the treatment of an injury or condition for which it is not liable under Chapter 176.

Subpart 2. Determination of Excessiveness.

The subparts have been restructured so that payers' responsibilities are set forth chronologically for ease in following. Subpart 2 provides that the initial payer responsibility is to evaluate whether any service or charge is excessive under the conditions of excessiveness in Parts 5221.0500 and 5221.0550. Deleted language concerning determination of excessiveness is revised and restated for clarity. Other deleted portions have been moved to later subparts for a more chronological progression.

Subpart 3. Determination of Charges.

This subpart deletes language in the first paragraph, now found as modified in subpart 2, regarding a determination of excessiveness. The subpart now identifies the payer's responsibilities for payment of charges.

Item A reflects the statutory requirement in M.S. 176.136, subd. 6, that the payer must pay or deny the bill or request additional information within 30 calendar days after receiving the bill. Where an appropriate record or additional information is needed to make a determination, 3A (3) requires the payer to respond within 30 days of receipt of the information. This rule is necessary to ensure that payers make timely and prompt determinations.

Item B. The changes in this item clarify and expand on the former Item C. Where the service is not included in the Medical Fee Schedule, the payer may pay no less than the provider's charge, as long as the charge does not exceed the charge that prevails in the same geographic community for similar services. Where the provider's charge exceeds the prevailing charge in the community, the payer must pay the prevailing charge. This is necessary because there has been confusion among payers concerning whether the payer need only pay 75% of the provider's charges. Because this interpretation is inconsistent with Minn. Stat. 176.135, subd. 3, the rule clarifies that the 75th percentile applies only to services included in the medical fee schedule.

In what was formerly Item B, language is deleted requiring the payer to consider the professional judgment and standards of the healing arts in determining excessiveness. This language is deleted because it is impractical to enforce. The deletion of this language is not intended to suggest that payers may no longer consider professional judgment and standards in making a payment determination; such consideration is encouraged and expected. The deletions are simply a recognition that enforcing the rule is difficult, impractical and unnecessary; whether the payer's denial of a claim is based on a reasonable medical standard is most appropriately determined by the commissioner or compensation judge if the denial is contested.

Subpart 4. Notification.

This rule requires the payer to notify the employee and provider in writing of the basis for and amounts of charges denied. The rule also requires notification of any specific additional information requested. This subpart is necessary to ensure that the employee and provider are informed of the amounts and bases of denial as required by M.S. 176.135, subd. 6. This allows the provider to re-evaluate the service and charges and encourages early resolution of disputes. The rule also ensures that employees are kept informed of information the payer is requesting from the provider.

Subpart 5. Penalties.

Formerly included in subpart 2, this provision is renumbered to provide for a more chronological structure. This subpart identifies the statutory penalties to which a payer may be subjected, and adds for completeness the prohibited practices penalties enacted by the 1987 legislature.

Subpart 6. Collection of Excessive Payment.

The changes clarify that a payer, who has determined that payment previously made to a provider was for an excessive charge or service, must demand reimbursement from the provider within one year of the payment. This change is necessary so that the provider, not the employee, is initially notified of the demand for reimbursement.

Part 5221.0700. Provider Responsibilities.

Subpart 2. Submission of Information.

The changes in this subpart clarify that the provider must supply the tax identification number, not social security number, because it is the tax identification number by which providers are generally professionally identified.

The rule also requires providers to supply a copy of an appropriate record to substantiate the bill. This ensures that payers have adequate information by which to determine the compensability of the charge or services.

Language referring to the use of codes found in the Medical Fee Schedule has been deleted because providers are required to use codes on all billings, not just those where the service is included in the medical fee schedule. This is so payers can accurately determine the nature of the service in all billings.

Subpart 3. Billing Code

Item A of this subpart sets out a list of approved billing code schedules. The use of billing codes is necessary so that payers can accurately determine the nature of the service even when the service is not included in the fee schedule. The schedules in Item A are familiar to and typically used by providers, and cover virtually all medical services by provider group.

Item B clarifies a CPT Coding procedure when the code refers back to a common procedure. The example is given to assist payers and providers determine how the fee schedule code and description should be read, or identified on a bill, to provide the most information efficiently.

Item C will list the code modifiers now listed as amended in Part 5221.1000, Subpart 7, items A-T. This is being re-numbered because the code modifiers are to be used along with the general approved codes in all billings, not just for those services found in the medical fee schedule. The modifiers are more appropriately listed under the general code rule.

Subpart 4. Cooperation with Payer.

This subpart has been renumbered from Subpart 3 to Subpart 4 to provide a more chronological structure.

The proposed changes clarify that providers must comply within seven working days with payer's requests for copies of existing medical data. These changes are needed to comply with M.S. 176.138. The deletions are necessary to simplify the language for clarity and consistency with changes in the definitions. The prohibition against prepayment for costs of copies of existing medical records is necessary to prevent delay in processing charges.

Subpart 5. Collection of Excessive Charges.

Formerly Subpart 4, re-numbered to provide for a more chronological structure, this provision prohibits the provider from attempting to collect from the employee or any other insurer or governmental entity when the payer has determined that a charge is excessive. This change is necessary to conform to Minn. Stat. 176.136, Subd. 2. Providers are not without a remedy if they disagree with a payer's determination because under M.S. 176.136, Subd. 2, the payer may initiate an action for a determination by the commissioner or compensation judge as to whether a charge is excessive. This subpart is limited to collection of excessive charges. (The employee or payer must file a claim for excessive services.) Prior to a determination by the commissioner or compensation judge, this provision does not prohibit a provider from attempting to collect from the employee for <u>services</u> which the payer has determined are excessive.

This subpart also requires that a charge which the payer has determined is excessive must be removed from the provider's billing statement if a claim is not filed with the commissioner or if it is determined excessive by the commissioner, compensation judge or on appeal. This is added to ensure that injured workers are not unnecessarily brought into a dispute regarding the reasonable amount of a charge, a dispute which the provider has standing to initiate pursuant to M.S. 176.136, subd. 2.

Part 5221.0800. Dispute Resolution.

The new language identifies the statutory authority and the procedure for requesting a determination as to whether a charge or service is excessive. The changes reflect statutory changes made since the rules were initially promulgated; M.S. 176.106 governing dispute resolution procedures, and 176.136, subd. 2, of the provider's right to initiate a proceeding. Again, a distinction is made between excessive service and excessive charge disputes. The rule clarifies that at any time an employee, employer or insurer may request a determination regarding whether a charge or service is reasonable, while under M.S. 176.136, subd. 2, the provider has statutory standing only to request a determination of whether a charge is reasonable. The rule also identifies the procedure to request a formal hearing when there is a disagreement with the initial commissioner's or compensation judge's determination. Language regarding appeals to the Medical Services Review Board is deleted as the Board no longer adjudicates disputes.

Part 5221.0900. Maximum Fee Schedule.

Subparts 1 and 2 of this part have been renumbered as Part 5221.1000, Subparts 1 and 2, with no language changes. This renumbering was done to consolidate the general fee schedule provisions under one heading for ease in referencing. See below for a discussion of standards used in the proposed fee schedule.

Part 5221.1000. Instructions for Application of the Medical Fee Schedule for Reimbursement of Workers' Compensation Medical Charges.

(Subpart 1, Contents, and Subpart 2, Revisions, have been renumbered from Part 5221.0900, Subparts 1 & 2 - see above).

Standards for Inclusion and Exclusion of Service in the Proposed (1989) Medical Fee Schedule

Minn. Stat. 176.136, subd. 5 provides that where the data base for the Workers' Compensation Medical Fee Schedule meets certain criteria, the fee schedule can be updated simply by publication in the State Register. The criteria are:

(a) The data base includes at least three different providers of the service.

(b) The data base contains at least 20 billings for the service.

(c) The standard deviation as a percentage of the mean of billings for the service is 50 percent or less.

(d) The means of the Blue Cross and Blue Shield data base and of the department of human services data base for the service are within 20 percent of each other.

(e) The data is taken from the data base of Blue Cross and Blue Shield or the department of human services.

However, when the data base for the fee schedule does not meet all of the above statutory criteria, the fee schedule must be adopted by following the rulemaking procedures set forth in the Administrative Procedures Act. Because the data base for the proposed fee schedule does not meet all the statutory criteria, the fee schedule is published as a proposed rule and is being taken through the rulemaking process.

The data base differs from the statutory criteria in three ways. First, the data is taken exclusively from Blue Cross, Blue Shield of Minnesota.

The task force on the Medical Fee Schedule set up by the Medical Services Review Board recommended that the data base from Blue Cross/Blue Shield be used exclusively for the information compiled for the specific fees for the Minnesota Workers' Compensation Fee Schedule. The committee heard presentations from Blue Cross/Blue Shield and the Department of Human Services concerning the source of their data and the way it is presented.

After hearing presentations from Blue Cross/Blue Shield and Human Services, the committee recommended that the Department use only the data base of Blue Cross/Blue Shield for the following reasons:

1. Blue Cross/Blue Shield data offered the widest possible source of data which was representative of statewide providers. It was pointed out that the Department of Human Services restricts access to certain providers and requires their recipients of medical care to go to designated providers. It was also pointed out that St. Paul Ramsey Hospital and Hennepin County Medical Center were often designated providers and it has been shown that their rates are higher than others.

2. The committee felt that the demographics of the Blue Cross/Blue Shield data were less skewed than those of the Department of Human Services. The Department of Human Services data contain a greater proportion of Medicaid and Medicare charges and a large population of children. The committee felt that the group that we are primarily interested in, the working population, was not proportionally included in this data. There was also a concern that the Twin City area was more heavily represented than the outstate Minnesota area.

3. There was also concern that the Human Services data would reflect either much higher or much lower costs for certain services. Specifically, the concern expressed was that since Human Services data contained a large number of elderly and nursing home patients, the physical therapy services conducted in a nursing home would be billed at a higher rate than the same codes as those conducted for the more mobile, healthier working age person. There was also a concern that Human Services Department did not correct unusually high fees, for instance, due to input errors or inappropriate charges, in their report to the Department of Labor and Industry.

In summary, it was felt that the Blue Cross/Blue Shield data gave a more representative, broader and compatible data base and that at this time, it should be the primary source of data for the Medical Fee Schedule.

Second, the comparison between BCBSM and Department of Human Services data is not a criteria because only BCBSM data is used.

The third manner in which the data base differs from the statutory criteria is that an additional formula was utilized to determine whether the charges included in the data base approximate a normal distribution of charges. This formula, developed by the Research and Education Unit of the Department, minimizes the effects of a few unusually high or low charges and permits the inclusion of more services. This formula was used in addition to the statutory formula for comparing the distribution of charges. Both formulas are more fully explained in number 2.A. below (under "Utilization").

The following standards, when analyzed as a whole, determine whether or not a service was included in the medical fee schedule. Our goal was to create a fee schedule that was both comprehensive and fair. The data set used to derive the 1989 fee schedule was purchased from Blue Cross Blue Shield of Minnesota (BCBSM) and contains 1987 charges for each service (procedural code) and provider type. The fee schedule sets the maximum charge at the 75th percentile of the BCBSM data. All charges, up to and including the rate of the 75th percentile, will be paid in full. The remaining charges, which exceed the 75th percentile, will be reduced.

A procedural code was included in the fee schedule if it met two sets of criteria which were based on utilization and the distribution of charges. The following are the criteria for a code's inclusion in the fee schedule:

Utilization

1. The service had at least 3 unique providers and occurred at least 20 times in the BCBSM data set.

2. The distribution of charges for each procedural code had to meet either one of two statistical criteria:

A. The standard deviation of the distribution of charges was less than one half of the average (mean) value (the statutory formula). For example, a code with a mean value of $100 needed a standard deviation of $50 or less to meet this criterion. This criterion led to inclusion of a code in the fee schedule when most of the charges were clustered around the mean and the variation in charges was due to the value of the extreme charges. It excluded the code if there was considerable variation in the distribution of charges. A few extreme cases with higher or lower values can exclude a code from the schedule.

B. The value of the 75th percentile charge was less than or equal to three times the value of the 25th percentile charge regardless of the standard deviation of the distribution (the formula developed by the Research and Education Unit). For example, a code with a 25th percentile charge of $50 needed a 75th percentile charge of $150 or less to meet this criterion. This criterion led to inclusion of a code in the fee schedule when the majority of charges clustered around the median (50th percentile) and the variation in charges was due to the number of extreme charges. It excluded the code if the range of values between the 25th and 75th percentiles is too great. A few extreme cases with much higher or lower values would not exclude the code from the schedule.

In the special case where a surgical procedure was performed on both an out-patient and in-patient basis, the following criteria were used to determine the maximum allowable fee:

A. If either the in-patient or out-patient surgical charges accounted for at least 75 percent of the services performed in that category and it met the two criteria above, it was included in the fee schedule.

B. If neither the in-patient or out-patient surgical charges accounted for 75 percent of the services then:

(a) the code with the higher charge at the 75th percentile was tested to meet the two criteria. If the criteria were met, the service was included in the fee schedule.

(b) if the code with the higher charge did not meet the two criteria, then the service with the lower charge was tested against the two criteria. If the criteria were met, the service was included in the fee schedule.

Subpart 4. Applicability of the Fee Schedule.

This subpart clarifies that the Medical Fee Schedule applies when an approved code under 5221.0700, Subp. 3(A) is included in the fee schedule for the appropriate provider group. This change is reasonable because the codes in the fee schedule are taken from the list of approved code schedules in 5221.0700 3(A). The references to charges are added because the charge for a service is what is affected by the fee schedule.

This subpart also explains the payer's payment responsibilities when a service is not included in the medical fee schedule. This is the same language found in 5221.0600, subp. 3 (B) and is included again for easy accessibility to payers and providers; it can reasonably be looked for as a "payers" responsibility" under 5221.0600 3(B) or this Part.

Subpart 5. Coding.

The new language in this subpart clarifies the payer's obligation to evaluate whether a code has been correctly assigned and is subject to the fee schedule. This subpart also prohibits providers or payers from dividing a broad inclusive service into component services if the broad service is subject to the fee schedule, but permits division if the broad service is not subject to the fee schedule and the component services are. The proposed changes are reasonable to help ensure that the services subject to the fee schedule are reimbursed accordingly and to discourage coding a service in such a way that the provider receives a greater or lesser fee than allowed under the schedule.

Subpart 6. Ambiguity.

The changes in this subpart require the parties to first try to resolve disputes over the applicability of the fee schedule themselves to decrease litigation. Because unresolved disputes concern whether a charge is excessive under the fee schedule, either the payer or provider may file a request with the commissioner for a determination. These changes reflect M.S. 176.135, subd. 2, which permits a provider to file a request for a determination on cases of excessive charges.

Subpart 7. Code Modifiers.

The proposed amendments move this subpart to 5221.0700, subp. 3C, as the modifiers are required for services even not included in the fee schedule and are more appropriately described with the rule that requires the use of approved codes. (See Part 5221. 0700, subp. 3C above). In addition to changes which clarify and simplify the language and reflect the common use of the term "medical" fee schedule, the amendments propose the following changes:

Item A (to be renumbered as 5221.0700 3C (1)). Modifier 20. Language is modified to conform to the definition of modifier 20 in the current edition of the CPT manual.

Item D (to be renumbered as 5221.0700 3C (4)), Modifier 26. This modifier is used only when the professional component is reported separately. The previous language could be interpreted as allowing the use of the modifier whenever a service includes both a professional and technical component, whether or not the components are billed separately. See also discussion of Part 5221.2300, subpart 1 A.

Item F & G (to be renumbered as 5221.0700 3C (6 & 7). Modifiers 50 and 51, Bilateral and Multiple Procedures. Both bilateral and multiple procedures were included under Modifier 50 in the previous fee schedule, leading to uncertainty as to when the modifier applies. Distinguishing and expanding the descriptions will enable providers to more accurately describe the services performed. See also, discussion of Part 5221.2250, subp. 2F. Since the rule was sent to the State Register the Department has discovered that language about the applicability of the maximum fee should have been deleted from the provision on code modifier 50. This language may conflict with, and at a minimum is confusing when compared to the additional modifier language proposed in Part 5221.2250, subp. 2F. This proposed modification will be submitted to the Attorney General or Chief Administrative Law Judge.

Item T (to be renumbered as 5221.0700 3C (20)). Modifier TC - Technical Component. This modifier is added for those services that include both a technical and professional component, where the technical component is reported separately. This is necessary because several types of services such as x-ray, include both professional and technical components, yet are often reported separately. This modifier permits an accurate description of the service being reported. See also discussion of Part 5221.2300, subp. 1A.

CATEGORY HEADINGS AND DESCRIPTIONS

The following new category descriptions in the fee schedule are added to correspond to new or existing codes for that category. The descriptive language corresponds for consistency to language in the Common Procedural Terminology manual. Discussion of changes in other headings or descriptive language can be found under the respective parts in this statement.

5221.1100, Subp. 3a Home Services

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

Subp. 6 Nursing home, boarding home, domiciliary or custodial care medical services.

Subp. 7 Emergency department services (portion pertaining to physician directed emergency care only.)

5221.1200, Subp. 2, item B Follow-up consultation
Subp. 2, item C Confirmatory (additional opinion) consultation

5221.1210 Immunization Injections

5221.1600 Otorhinolaryngologic Services

5221.1950 Allergy and Clinical Immunology

5221.2070, Subp. 2 Dermatological Procedures, Services

Part 5221.1100. Physician Services.

Subpart. 1. Scope.

This subpart adds language which ensures that services performed by or under the direct supervision of the physician are physician services. This is necessary because there has been confusion as to whether services performed under the direct supervision of a physician are physician services. For example, where a physician's assistant provides a service in the office under the supervision of the physician, that service is considered a physician service. To characterize the service otherwise would unnecessarily result in a severely limited fee schedule. These services are reported to Blue Cross and analyzed in the data base as physician services and the fee in the medical fee schedule is therefore appropriate.

Subpart 2. Definitions.

Item A. New Patient. This item identifies a new patient as one whose records for a work injury need to be established. This includes a known patient with a new work injury because it is not necessarily less work for a physician to initially evaluate a patient with a new work injury simply because the patient was previously seen for a different condition. In either case, the physician's efforts in evaluating and establishing new workers' compensation records may be the same.

Item B. Established Patient. The changes reflect that an established patient is one for whom the workers' compensation records are available to the physician. This further clarifies the distinction between a new patient and an established patient.

Item C. Level of Services. Language is added requiring the preparation of an appropriate record to document the level of service. This reflects that the level of service provided is an element which needs the same documentation as any other service in the fee schedule.

Item M. Referral. This new item defines a referral as distinguished from a consultation. When a referral is made, the new physician assumes part or total care of the patient. When there is no transfer of care, the service is characterized as a consultation and must be billed as such. This differentiation is necessary because the terms have been a source of confusion, which results in inaccurate application of the relevant fee schedule codes.

Item N. Hospital Discharge Day Management. This is the standard Common Procedural Terminology definition for Hospital Discharge Day Management and is included because the corresponding code is included in the fee schedule.

Subpart 3. Office Services.

Language recommended by the Medical Services Review Board is added establishing that non-emergency services provided in an outpatient hospital clinic setting are considered office services. This is reasonable because it is a more accurate characterization of the business practice of a patient and physician meeting at a hospital rather than the clinic where it is more convenient for the patient or physician, yet is not an emergency.

Subpart 3a. Home Services, and

Subpart 5. Skilled Nursing, Intermediate Care and Long-term Care Facilities, and

Subpart 6. Nursing Home, Boarding Home Domiciliary or Custodial Care Medical Services.

....See Category Headings, p. 16 of this statement.

Subpart 7. Emergency Department Services

As with subpart 3 (office services) this subpart clarifies that the emergency service codes do not apply when an emergency room is used as a substitute for office services. This change, recommended by the Medical Services Review Board, reflects the practice of patients and physician meeting at a hospital rather than a clinic for convenience. Because the nature of the service is more similar to an office service than an emergency service it is inappropriate to use the emergency codes. For discussion of the language pertaining to physician directed emergency care, see Category Headings, p. 16 of this statement.

Part 5221.1200 Consultations

Subpart 2, Item A.

The amendments to this item reflect the requirement of preparing an appropriate record, consistent with the definition of that term and provider responsibilities under Part 5221.0700. Language regarding referral is deleted because a similar definition of referral is established in Part 5221.1100, subp. 2.

Items B and C, Follow-up and Confirmatory Consultation, see Category Headings, p. 16 of this statement.

Part 5221.1210 Immunization Injections. See Category Headings, p. 16 of this statement.

Part 5221.1300 Psychiatry and Psychiatric Therapy

Language is added directing non-physician providers of psychiatric services to the appropriate section of the fee schedule, to avoid confusion and provide assistance to providers not covered by this section.

Part 5221.1400 Biofeedback

The Department has determined that this part is erroneously repealed. The codes and amounts for biofeedback services by a physician are erroneously placed in Part 5221.3170. Modifications to correct the error will be submitted for approval to the Attorney General or Administrative Law Judge.

Part 5221.1500 Ophthalmological Services, Subp. 2(B). Definitions, Level of Service.

The additional language clarifies, to avoid confusion, that items C and D are exceptions to the level of service descriptions in Part 5221.1100.

Part 5221.1600 Otorhinolaryngologic Services, See Category Headings, p. 16 of this statement.

Part 5221.1700 Audiologic Tests

Due to an error, this Part should have been repealed because these services are performed by an audiologist, not a physician. Since these services are provided by audiologists, it is more appropriate to include the services under Part 5221.2700. Repeal of Part 5221.1700 will be added as a proposed modification, and submitted to the Attorney General or Administrative Law Judge for approval.

Part 5221.1950 Allergy and Clinical Immunology. See Category Headings, p. 16 of this statement.

Part 5221.2050 Chemotherapy Injections

Data for this part was requested from BCBSM. These codes were not previously included because the services were thought unlikely to be provided in workers' compensation cases. However, these services may be provided in workers' compensation cases and inclusion is therefore appropriate. For instance, exposure to asbestos may cause a condition for which chemotherapy is necessary.

Part 5221.2070, Subp. 2 Dermatological Procedures, Services. See Category Headings, p. 16 of this statement.

Part 5221.2100 Physical Medicine

Physical therapy and occupational therapy language and codes are eliminated from this part and are now found in the section on Physical and Occupational Therapy in Part 5221.2800. This change is reasonable because the previous fee schedule distinguishes between services provided by a physical therapist in a clinic associated with a physician and an independent physical therapy clinic. There is no reasonable basis for this distinction.

Part 5221.2200 Special Services and Reports

The description of the critical care services category is moved from the beginning to the end of the part (between miscellaneous services and other services). This change is necessary to eliminate confusion because some payers have refused to pay the maximum fee for miscellaneous services unless provided in a critical care setting. Introductory language on the application of these codes corresponds to language in the CPT manual for the category.

Part 5221.2250 Physician Services, Surgery

Subpart 2. Instructions

Item A. The changes clarify that the follow-up care mentioned in the rule is in-hospital follow-up care, and clarifies that if an assistant surgeon assists during surgery, the primary surgeon is responsible for reimbursing the assistant surgeon out of the maximum fee received for the procedure under the fee schedule. These changes are in response to conflict among payers and providers as to the interpretation of this item. The changes are reasonable to resolve the confusion and to prevent reimbursement in excess of the medical fee schedule.

Item F. Special Situations. This item clarifies reimbursement for services corresponding to certain modifiers for multiple and bilateral procedures. This is in response to confusion as to how the fee schedule is applied in these circumstances. The billing instructions and reimbursement percentages represent standard billing practice by surgeons for these procedures. The Minnesota Medical Association task force on workers' compensation approved the descriptions and percentages, except that its recommendation for reimbursement, under 2(b) (multiple procedures/single operative session/different incisions, billing for the secondary procedure) is 75 percent rather than 65 percent. The Department agrees and modification will be proposed to the Attorney General or Administrative Law Judge in accordance with the MMA recommendation.

Subparts 3-15.

Specific subpart headings have been added to make this part easier to use. Subpart 10, Reproductive System, should be numbered Subpart 11, and will be modified accordingly.

Part 5221.2300 Physicians Services, Radiology

Subpart 1. General

The changes clarify that this rule applies to physicians and technicians under a physician's supervision, and specify that where the charge for a radiologic procedure is broken down into a professional and technical component the maximum fee for the procedure is divided accordingly. This is necessary because often charges for the technical and professional components of a radiological procedure are submitted separately. This rule ensures that the maximum

fee is fairly and accurately applied when the components are billed separately. To arrive at the 60/40 percent division as a fair proportion of the maximum fee, other states workers' compensation fee schedules were reviewed as to how the technical and professional components are generally proportioned.

Part 5221.2600 Optometrists

The amendments limit the application of this part to optometrists because they are licensed to prescribe eyeglasses and treat some eye conditions, while opticians, certified nationally rather than licensed in Minnesota, grind lenses and fit eyeglasses. Therefore, it is more appropriate to separate the codes for each provider group. The level of service descriptions correspond to those of the Minnesota Chapter of American Optometric Association. Line 8, Code 92285-00 should read "External" instead of "Extended". A modification to correct this error will be proposed.

Part 5221.2650 Opticians

As above, optician services are moved to a separate section because the services provided are different than those provided by optometrists.

Part 5221.2700 Audiologists

Part 5221.2750 Speech Pathologists.

Previously these two provider groups were included in the same part. Separate parts now reflect the different services provided by each. Part 5221.1700 pertaining to physician services, audiologic tests, should have been repealed as these services, now in Part 5221.2700, are performed by audiologists, not physicians. Line 7 on page 107 of the rules (audiology code 06045-00) was erroneously included and should have been deleted. A modification to delete this code will be submitted to the Attorney General or Administrative Law Judge, as that code no longer exists.

Part 5221.2800 Physical Therapist and Occupational Therapists

Physical therapy and occupational therapy codes are now included in one section. Previously, some physical and occupational therapy codes were found under physician services. They are consolidated in this part to eliminate confusion resulting from an artificial distinction between therapists in physician owned clinics and independent clinics. This part has always included occupational therapists but that group was erroneously omitted from the heading.

Subpart 1. Scope.

This subpart specifies that the codes and fee schedule apply only to therapists and assistants who possess the proper professional credentials.

Subpart 2. Definitions.

These definitions clarify terminology used in the codes in response to confusion over application of the various codes utilizing these terms. These definitions have been approved by the Minnesota Chapter of the American Physical Therapy Association (including occupational therapy representatives).

Subpart 3. Physical and Occupational Therapy Instructions.

Item A. This item requires the treatment plan to be in writing to document services so payers can adequately evaluate the service. No separate fee is allowed for preparation of the plan. This is reasonable as consistent with Minn. Stat. 176.135, subd. 7, which requires supporting documentation to be submitted with the bill.

Item B. This item requires the therapist to supply the license number on request. This is in response to concern expressed by payers and physical therapists that non-licensed persons have been billing under these codes.

Subpart 4. Scope.

This subpart clarifies the facilities that are covered by this section to ensure that comparable services and facilities are reimbursed comparatively. This has specifically been agreed to by the Minnesota Hospital Association. The heading should read "Physical Therapy and Occupational Therapy. Services," and will be changed accordingly.

Part 5221.2900 Chiropractors

Subpart 1a. Definitions.

These definitions are added to clarify the terms used in the code service descriptions, which have been a source of confusion. The language corresponds to the BCBSM definitions published in Provider Bulletin no. P-3-87 February 1987. Additionally, the Minnesota Chiropractic Association and the Minnesota Board of Chiropractic Examiners were consulted in drafting the language.

Subpart 1b. Chiropractor Instructions.

This language clarifies application of codes pertaining to additional manipulation and conjunctive therapy in response to confusion as to the application of these codes. The language is similar to language used by BCBSM Specialty Clinic Schedules.

Part 5221.3000 Podiatrists

Subpart 2. Ancillary Services.

Language is added clarifying that ancillary services provided by podiatric assistants must be under the direct on-site supervision of a physician. This is necessary to help ensure that services provided are appropriate and clarify that such services are reimbursable under the appropriate code.

Part 5221.3100 Psychologists and Rule 29 Facilities

Part 5221.3150 Licensed Consulting Psychologists and Rule 29 Facilities

Language is added to these two parts about Rule 29 Facilities because that is how the Department of Human Services characterizes them and the BCBSM data base is taken from these facilities. The language about the Minnesota Board of Psychology is added in each part because that is the licensing board for both groups of providers. Licensed Consulting Psychologists are given a separate section and separate codes because there are separate professional practice and licensure requirements for each.

Part 5221.3160 Social Workers

Social workers are given a separate section because they are a different profession, licensed by a different board than psychologists.

Part 5221.3170 Biofeedback

Biofeedback - Part 5221.3170 is inappropriately added, as the codes and amounts from the BCBSM data base are for physician services, and should be found in Part 5221.1700. Modifications to correct this error will be proposed and submitted to the Attorney General or Chief Administrative Law Judge for approval.

Part 5221.3310 Effective Date

This is added to reflect the statutory guidelines of the Administrative Procedures Act. Under that statute, unless otherwise provided in the rule, rules are effective 5 days after publication of the Notice of Adoption in the State Register.

These rules are not made retroactive because services may have already been paid for under two previous fee schedules. The effective date of these rules cannot reasonably be made retroactive.

5221.3400 (Previous effective date provision)

The repealing language for this provision was erroneously omitted. If not repealed, it would cause confusion as to the application of these rules. A modification to repeal this provision will be proposed and submitted to the Attorney General or Administrative Law Judge for approval.

Repealer:

Minnesota Rules Part 5221.1400 (Physician Services, Biofeedback) was erroneously repealed. A proposal to repeal Parts 5221.1700, (Physician Services, Audiologic Tests) and 5221.3400 will be submitted to the Attorney General or Administrative Law Judge as proposed modifications. Please see the discussion for these parts in this Statement of Need and Reasonableness.

Impact on Small Business:

Minn. Stat. sec. 14.115, subd. 7(c) provides that agencies must consider the impact of proposed rules on small business, unless the rules impact "Service businesses regulated by government bodies, for standards and costs, such as nursing homes long-term care facilities, hospitals, and providers of medical care...."

Because these rules affect workers' compensation insurers (generally not small businesses) and the above service business, such as health care providers, the impact on small business need not be considered.

Nonetheless, the Department has generally considered the potential impact on small businesses and has concluded that the impact is minimal.

In addition to modifications to the fee schedule, the amendments could affect small business providers of health care in two ways. First, they require submission of an appropriate record to substantiate the medical bills. Second, the rules require providers to use approved codes in submitting bills. The first requirement is already required by statute and should therefore require no additional financial expenditure. The rules simply clarify the providers' responsibilities under the statute. The second requirement should have minimal impact as providers are generally familiar with these codes and this rule in most cases reflects current practice.

The medical fee schedule assists small business by limiting medical costs and therefore contributing to lower workers' compensation premiums.

In addition to updating the fee schedule, the rules are designed to resolve problems brought to the Department's attention by payers and providers, and to encourage prompt handling and payment of reasonable charges and services with a minimum of litigation. To limit the application of the rules to only certain providers would be unfair and would defeat the general purpose.

FISCAL IMPACT ON LOCAL PUBLIC BODIES

The rules have an impact on municipalities who are self-insured for workers' compensation claims and on county hospitals, such as Hennepin and Ramsey County Hospitals. These rules do not require significant expenditure of money by local public bodies. Self-insured municipalities generally benefit by the limit on medical fees.

Administratively the rules require payers to respond to medical claims within 30 days and provide written notification of a denial or request for information. These changes were made to bring the rules into compliance with existing statutory provisions. Therefore, to the extent these are considered an increased level of service under M.S. 3.981, they are not new requirements. Furthermore, to the extent there is concern that any other provision may increase administrative costs, it should be noted that these rules are designed to streamline the processing of bills by both payers and providers. Any potentially increased administrative costs due to increased payer responsibilities should be offset by savings as a result of increased provider responsibilities. The same analysis would apply to a provider's claim of increased administrative costs.

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry Workers' Compensation Division, Governing Medical Charges and Reimbursement

AFFIDAVIT OF MAILING THE NOTICE OF INTENT TO AMEND A RULE WITHOUT A PUBLIC HEARING AND CERTIFICATE OF MAILING LIST

STATE OF MINNESOTA)
ss)
COUNTY OF RAMSEY)

Margaret Rico, being sworn says:

I hereby certify that the list of persons and associations who have requested, pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 or 14.30, that their names be placed on the State of Minnesota, Department of Labor and Industry, Workers' Compensation Division, rulemaking mailing list is accurate, complete, and current as of this 23rd day of Dec., 1988.

That on the 23rd day of Dec., 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Amend a Rule Without a Public Hearing by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid, to all persons and associations on the aforementioned mailing list.

Margaret Rico
Margaret Rico

Subscribed and sworn to before me this 23 day of December, 1988.

Jeanne Gehrman

JEANNE A. GEHRMAN
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES SEPTEMBER 18, 1991

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

NOTICE OF INTENT TO AMEND A RULE WITHOUT A PUBLIC HEARING

Notice is hereby given that the Minnesota Department of Labor and Industry, Workers' Compensation Division intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minn. Stat. sec. 176.136 (Supp. 1987), and section 176.83 (Supp. 1987).

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule address, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Gloria Gebhard
Acting Director of Rehabilitation
and Medical Affairs, Workers' Compensation Division
443 Lafayette Road
St. Paul, Minnesota 55101
(612) 296-8213

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

SEE REVERSE

The rules proposed for amendment relate to medical charges and reimbursement in workers' compensation cases. The rules add, clarify or modify definitions of terms used in the rules, clarify or modify provider and payer responsibilities, and summarize dispute resolution procedures. The rules also modify, delete or add codes, service descriptions and maximum fees in the medical fee schedule. A free copy of the rules is available from Janice Kramer at the above address and phone number upon request.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Janice Kramer at the above address and phone number upon request.

The Statement of Need and Reasonableness concludes that the impact on small business need not be considered because these rules concern service businesses regulated by government bodies. Nevertheless, the impact on small business is minimal.

The rules do not require an additional expenditure of public monies by local public bodies, but instead limit expenditures.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Janice Kramer at the above address and phone number.

12-14-88
Date

Ken Peterson, Commissioner

WORKERS' COMP. - COMMISSIONER LIST

12-23-88

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75750-~~2~~600	Angiography, coronary, root injection~~; professional component only~~ (MD/DO)	
75752-00	Angiography, coronary, unilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only	~~76.50~~ 83.80
75754-~~2~~600	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording~~; professional component only~~ (MD/DO)	50.00
75762-00	Angiography, coronary bypass, unilateral selective injection; supervision and interpretation only	~~131.25~~ 171.00
75766-00	Angiography, coronary bypass, multiple selective injection; supervision and interpretation only	50.50
		74.00
	Veins and Lymphatics	
75820-00	Venography, extremity, unilateral; supervision and interpretation only	
75821-~~2~~600	Venography, extremity, unilateral; complete procedure~~; professional component only~~ (MD/DO)	$ 98.50
75897-00	Transcatheter therapy, infusion (e.g., thrombolysis other than coronary), including angiography; complete procedure	$ ~~120.50~~ 130.15
75962-00	Percutaneous transluminal angioplasty, peripheral artery; supervision and interpretation only	375.00
75985-00	Change of percutaneous drainage catheter with contrast monitoring (i.e., biliary tract, urinary tract); complete procedure	68.00
		199.00
	Miscellaneous	
76000-00	Fluoroscopy (separate procedure), up to one hour physician time	
76020-00	Bone age studies	$ 40.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	36.00
76061-00	Radiologic examination, osseous survey; limited (e.g., for metastases)	69.00
76062-00	Radiologic examination, osseous survey; complete (MD/DO)	139.00
		$ ~~160.00~~ 195.50

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76066-00	Joint survey, single view, one or more joints (specify)	23.00
76080-00	Radiologic examination, fistula or sinus tract study; supervision and interpretation only	61.00
76081-~~26~~00	Radiologic examination, fistula or sinus tract study; complete procedure~~; professional component only~~ (MD/DO)	~~63.00~~ 76.70
76100-00	Radiologic examination, single plane body section (MD/DO)	~~96.50~~ 101.30
76101-00	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	93.60
76102-00	bilateral	100.00
76150-00	Xeroradiography	50.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	436.00
76370-00	Computerized tomography guidance for placement of radiation therapy fields	74.25
76375-00	Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction	45.00

Subp. 3. **Diagnostic ultrasound.** The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

Head and Neck

Code	Service	Maximum Fee
76506-00	Echoencephalography, B-scan and/or real-time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	$ 140.00
76511-00	Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification (MD/DO)	$ 150.00
76516-00	~~Echography,~~ Ophthalmic, biometry; by ultrasound echography, A-mode (MD/DO) ~~ultrasonic biometry;~~	~~150.00~~ 153.90
76519-00	~~Ophthalmic biometry by ultra sound echography, A-mode~~	~~168.00~~
	intraocular lens power calculation (MD/DO)	175.00
76536-00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid),	

	B-scan and/or real-time with image documentation	118.00
	Chest	
76604-00	Echography, chest B-scan (includes Mediastinum) and/or real time with image documentation (MD/DO)	S ~~63.75~~ 68.00
76620-~~26~~00	Echocardiography, M-mode; ~~professional component only~~ (MD/DO)	~~96.65~~ 120.00
76627-00	Echocardiography, real-time with image documentation (2D); complete	163.00
76629-00	Echocardiography, M-mode and real time with image documentation (MD/DO)	~~186.00~~ 225.00
76632-00	Doppler echocardiography	70.50
76700-~~26~~00	Echography, abdominal, B-scan; and/or real-time with image documentation (MD/DO) ~~professional component only~~	~~67.50~~ 110.00
76705-~~26~~00	limited; ~~professional component only~~ (MD/DO)	~~46.25~~ 98.00
76770-~~26~~00	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; ~~professional component only~~ (MD/DO)	~~63.75~~ 123.50
76775-~~26~~00	~~Echography, retroperitoneal, B-scan and/or real time with image documentation; complete; professional component only~~ limited (MD/DO)	~~62.25~~ 67.50
	Pelvis	
76805-~~26~~00	Echography, ~~pelvic~~ pregnant uterus, B-scan ~~(for example, and/or~~ real time~~), in obstetrics, gynecology, or transplants;~~ with image documentation; complete; ~~professional component only~~ (MD/DO)	S ~~105.00~~ 98.80
76815-00	Echography, pregnant uterus, B-scan and/or real-time with image documentation; limited (fetal growth rate, heart beat, anomalies, placental location)	73.00
76816-00	follow-up or repeat	65.00
76818-00	Fetal biophysical profile	106.00
76855-00	Echography, pelvic area (Doppler)	90.00
76856-00	Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; complete	90.00
76857-00	limited or follow-up (e.g., for follicles)	65.00
76870-00	Echography, scrotum and contents	137.40

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76880-00	Echography, extremity, B-scan and/or real-time with image documentation	88.00
76925-00	Imaging, peripheral (e.g., B-scan, Doppler or real-time scan	110.00
76943-00	Ultrasonic guidance for needle biopsy; complete procedure	249.25
76970-00	Ultrasound study follow-up (specify)	50.00
76986-00	Echography, intraoperative	62.00
76991-00	Intraluminal ultrasound study (e.g., transrectal, transvaginal)	200.00

Subp. 4. **Therapeutic radiology.** The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

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

Code	Service	Maximum Fee
77262-00	Therapeutic radiology treatment planning; intermediate	$ 295.00
77263-00	complex	345.00
77280-00	Therapeutic radiology simulation-aided field setting; simple (MD/DO)	100.04
77285-00	intermediate	125.00
77290-00	complex	175.00
77300-~~26~~00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment; ~~professional component only~~ (MD/DO)	$ ~~50.00~~ 60.00
77305-00	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	125.00
77310-00	intermediate (three or more treatment ports directed to a single area of interest)	150.00
77315-00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	280.00
77334-00	Treatment devices, design and construction; complex (MD/DO)	~~92.00~~ 150.00
77336-00	Continuing medical radiation physics consultation in support of therapeutic	

	radiologist, including continuing quality assurance (MD/DO)	~~90.00~~ 61.50
77400-~~26~~	~~professional component only~~ Daily megavoltage treatment management; simple (MD/DO)	~~34.75~~ 42.40
77405-00	intermediate	50.00
77410-~~26~~00	~~professional component only~~ complex (MD/DO)	~~48.00~~ 70.00
77420-~~26~~00	Weekly megavoltage treatment management: simple~~:~~ ~~professional component only~~ (MD/DO)	~~48.00~~ 25.00
77425-00	intermediate	95.83
77465-~~26~~00	Daily kilovoltage treatment management~~:~~ ~~professional component only~~ (MD/DO)	~~40.00~~ 31.50
~~77465-TC~~	~~technical component only~~	~~33.75~~

Subp. 5. Nuclear medicine. The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

Code	Service	Maximum Fee
78000-~~26~~00	thyroid uptake; single determination~~;~~ ~~professional component only~~ (MD/DO)	S ~~19.75~~ 21.00
78001-00	Thyroid uptake; multiple determinations	113.90
78003-00	stimulation, suppression or discharge (not including initial uptake studies)	65.25
78006-~~26~~00	Thyroid imaging, with uptake; single determination~~,~~ ~~professional component only~~ (MD/DO)	~~59.00~~ 63.00
78007-00	Thyroid imaging, with uptake; multiple determinations	88.00
78010-~~26~~00	Thyroid imaging; only~~:~~ ~~professional component only~~ (MD/DO)	~~49.60~~ 81.40
	Diagnostic - Gastrointestinal System	
78201-00	Liver imaging; static only (MD/DO)	S ~~69.00~~ 69.75
78215-~~26~~00	Liver and spleen imaging~~;~~ ~~professional component only~~ (MD/DO)	~~72.50~~ 207.40
78216-00	with vascular flow (MD/DO)	~~86.00~~ 90.00
~~78220-26~~	~~professional component only~~	~~63.00~~
78220-00	Liver function study with hepatobiliary agents, with serial images (MD/DO)	86.50
78223-~~26~~00	Hepatobiliary ductal system imaging, including gallbladder (MD/DO) ~~professional component only~~	~~85.00~~ 90.00

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78264-00	Gastric emptying study	65.25
78278-00	Acute gastrointestinal blood loss imaging	118.50
~~78280~~	~~Gastrointestinal blood loss study~~	~~74.90~~
78290-00	Bowel imaging (for example, ectopic gastric mucosa, Meckel's localization, volvulus (MD/DO)	~~72.50~~ 78.00
	Diagnostic - Musculoskeletal System	
78300-~~26~~00	Bone imaging; limited area (for, example, skull, pelvis)~~,~~ ~~professional component only~~ (MD/DO)	~~52.00~~ $ 80.00
	~~**Diagnostic - Musculoskeletal System**~~	
78305-~~26~~00	~~professional component only~~ multiple areas	~~$ 82.00~~ 87.50
~~78306-26~~	~~whole body; professional component only~~	~~79.38~~
~~78310~~	~~Bone imaging; vascular flow only~~	~~70.00~~
78350-00	Bone density (bone mineral content) study; single photon absorptiometry	78.00
	~~**Diagnostic - Cardiovascular System**~~	
~~78402~~	~~Cardiac blood pool imaging, with vascular flow assessment (sequential imaging with or without time activity curve evaluation)~~	~~$ 78.60~~
~~78403-26~~	~~Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion; professional component only~~	~~87.00~~
~~78411~~	~~Cardiac blood pool imaging by first pass technique, with determination of global or regional ventricular function (specify~~ right, left, or both) including but not ~~necessarily limited to ejection fraction and wall motion, at rest~~	~~107.50~~
~~78422~~	~~Myocardium imaging; regional Myocardial perfusion at rest for evaluation of infarction (infarct avid imaging)~~	~~75.00~~
~~78424~~	~~Myocardium imaging; with quantitive evaluation (for example, pharmacokinetic temporal assessment) regional myocardial perfusion (redistribution resting or postexercise study)~~	~~76.80~~
	Respiratory System	
78580-~~26~~00	Pulmonary perfusion imaging; particulate ~~professional component only~~ (MD/DO)	~~76.80~~ $ 81.50
	~~**Diagnostic - Respiratory System**~~	
78581-00	~~Pulmonary perfusion imaging;~~ gaseous (MD/DO)	~~$ 76.00~~ 80.00
78582-00	gaseous, with ventilation, rebreathing and washout (MD/DO)	~~78.10~~ 68.50

78585-00	rebreathing and washout, with or without single breath	114.75
78587-00	Pulmonary ventilation imaging; multiple projections (MD/DO)	~~73.50~~ 100.00
~~78587-26~~	~~professional component only~~	~~58.75~~
~~78591-26~~	~~Pulmonary ventilation imaging, gaseous single breath, single projection; professional component only~~	~~62.00~~
78593-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection (MD/DO)	~~65.00~~ 98.00
78594-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views)	81.50
	Nervous System	
~~78605~~	~~Brain imaging, complete study; static~~	~~$ 77.00~~
78660-00	Dacryocystography (lacrimal flow study	$ 15.00
	Genitourinary System	
78700-00	Kidney imaging; static only	$ 68.00
78704-00	Kidney imaging; with function study (e.g., imaging renogram) (MD/DO)	~~$ 76.00~~ 81.00
78715-00	Kidney vascular flow only	~~51.00~~ 54.60
~~78715-26~~	~~professional component only~~	~~45.00~~
~~78720-26~~	~~professional component only~~	~~69.88~~
78725-00	Kidney function study only	152.00
78727-00	Kidney transplant evaluation	95.00
78740-00	Ureteral reflux study (radionuclide voiding cystogram)	80.00
78805-00	Radionuclide localization of abscess; limited area	483.80
78890-00	Generation of automated data; interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	121.50

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

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

Subp. 2. **Automated, multichannel tests.** The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more

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tests among those listed below, the appropriate code from 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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

Automated Multichannel Tests

Code	Service	Maximum Fee
80002-00	Automated multichannel tests: 1 or 2 clinical chemistry tests (MD/DO)	S ~~14.75~~ 15.50
80003-00	~~Automated multichannel tests;~~ 3 clinical chemistry tests (MD/DO)	30.00
80004-00	4 clinical chemistry tests (MD/DO)	~~24.00~~ 25.70
80005-00	5 clinical chemistry tests (MD/DO)	~~31.50~~ 45.00
80006-00	6 clinical chemistry tests (MD/DO)	26.50
80007-00	7 clinical chemistry tests (MD/DO)	~~27.50~~ 29.25
80008-00	8 clinical chemistry tests (MD/DO)	30.00
80009-00	9 clinical chemistry tests (MD/DO)	33.50
80010-00	10 clinical chemistry tests (MD/DO)	~~32.00~~ 33.50
80011-00	11 clinical chemistry tests (MD/DO)	~~38.90~~ 35.50
80012-00	12 clinical chemistry tests (MD/DO)	~~35.00~~ 36.80
80016-00	13-16 clinical chemistry tests (MD/DO)	~~38.00~~ 40.00
80018-00	17-18 clinical chemistry tests (MD/DO)	44.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed) (MD/DO)	~~35.00~~ 32.00
	Therapeutic Drug Monitoring	
~~80031~~-00	Therapeutic quantitative drug monitoring in ~~blood and/or urine;~~ body fluids and or excreta; measurement one drug (MD/DO)	~~37.80~~ S 33.00
80032-00	two drugs measured	39.00

	Organ or Disease Oriented Panels	
80050-00	General health screen panel	$ 42.75
80053-00	Executive profile (MD/DO)	60.00
80055-00	Obstetric profile (MD/DO)	~~32.00~~ 35.00
~~80056~~	~~Amenorrhea profile~~	~~130.00~~
80058-00	Hepatic function panel (MD/DO)	~~28.00~~ 29.50
80059-00	Hepatitis panel (MD/DO)	~~57.25~~ 76.00
80060-00	Hypertension panel (MD/DO)	30.00
80061-00	Lipid profile (MD/DO)	30.00
80062-00	Cardiac evaluation (including coronary risk) panel (MD/DO)	~~32.00~~ 30.00
80063-00	Cardiac injury panel	51.00
80064-00	Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination (MD/DO)	25.00
80065-00	Metabolic panel (MD/DO)	~~48.75~~ 50.25
80070-00	Thyroid panel (MD/DO)	~~29.50~~ 30.50
80071-00	with thyrotropin releasing hormone (TRH) (MD/DO)	49.50
80072-00	Arthritis panel (MD/DO)	~~41.00~~ 43.00
80073-00	Renal panel	28.00
80085-00	Microcytic anemia panel	62.00
80086-00	Macrocytic anemia panel (MD/DO)	~~42.00~~ 37.60
80090-00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	74.00
	Consultations (Clinical Pathology)	
80500-00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 18.00

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

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy (MD/DO)	$ ~~11.00~~ 12.00
81002-00	routine, without microscopy (MD/DO)	7.00
81004-00	components, single, not otherwise listed, specify (MD/DO)	~~6.50~~ 6.00
81005-00	chemical, qualitative, any number of constituents (MD/DO)	~~5.50~~ 6.50

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81010-00	concentration and dilution test (MD/DO)	5.00
81015-00	microscopic only (MD/DO)	8.00
81020-00	two or three glass test	10.00

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

Code	Service	Maximum Fee
82009-00	Acetone, qualitative	7.25
82010-00	quantitative	6.00
82011-00	Acetylsalicylic acid; quantitative (MD/DO)	S ~~19.00~~ 20.50
82024-00	Adrenocorticotropic hormone (ACTH), RIA	101.20
82042-00	Albumin; urine, quantitative (specify method, e.g., Esbach)	2.90
~~82060~~	~~Alcohol, blood; by gas-liquid chromatography~~	~~36.10~~
82070-00	Alcohol (ethanol), urine; by gas-liquid chromatography	46.50
82085-00	Aldolase, blood; kinetic ultraviolet method	27.00
82088-00	Aldosterone; RIA, blood	132.30
82130-00	Amino acids, urine or plasma, chromatographic fractionation and quantitation; one or more	176.90
82137-00	Aminophylline (MD/DO)	~~32.50~~ 35.00
82138-00	Amitriptyline	51.40
82140-00	Ammonia; blood	31.50
82143-00	Amniotic fluic scan (spectrophotometric)	58.00
82150-00	Amylase, serum (MD/DO)	~~19.00~~ 20.30
82156-00	Amylase, urine (MD/DO)	~~20.30~~ 21.30
82157-00	Androstenedione, RIA	90.00
82164-00	Angiotensin-converting enzyme	35.50
82172-00	Apolipoprotein, immunoassay	25.00
82205-00	Barbiturates; quantitative (MD/DO)	~~32.75~~ 28.00
82210-00	quantitative and identification (MD/DO)	31.00
~~82245~~	~~Bile pigments, urine~~	~~6.00~~
82250-00	Bilirubin; blood, total OR direct (MD/DO)	15.00
82251-00	blood, total AND direct	22.00
82270-00	Blood; occult, feces, screening	8.00
82273-00	duodenal, gastric contents, qualitative	6.00
82306-00	Calcifediol (25-OH Vitamin D-3), chromatographic technique	133.50
82310-00	Calcium, blood; chemical (MD/DO)	~~13.75~~ 14.95
82330-00	fractionated diffusible	24.00
82340-00	Calcium, urine; quantitative, timed specimen (MD/DO)	~~17.10~~ 17.50

82355-00	Calculus (stone), qualitative, chemical	30.50
82360-00	Calculus (stone, quantitative; chemical	31.50
82372-00	Carbamazepine, serum (MD/DO)	~~30.00~~ 32.00
82374-00	Carbon dioxide, combining power or content	19.15
82375-00	Carbon monoxide, (carboxyhemoglobin); quantitative	42.10
82376-00	qualitative	10.00
82380-00	Carotene, blood	28.00
82382-00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine	66.00
82384-00	fractionated	77.00
82390-00	Ceruloplasmin, chemical (copper oxidase), blood	29.00
82435-00	Chlorides; blood (specify chemical or electrometric) (MD/DO)	~~17.00~~ 18.00
82465-00	Cholesterol, serum; total (MD/DO)	~~14.40~~ 15.00
82470-00	total and esters	15.35
82480-00	Cholinesterase; serum (MD/DO)	~~35.00~~ 39.00
82486-00	Chromatography; gas-liquid, compound and method not elsewhere specified	61.50
82507-00	Citrate	69.20
82512-00	Clonazepam (MD/DO)	~~39.40~~ 49.00
82525-00	Copper; blood	33.00
82529-00	Cortisol; fluorometric, plasma	39.85
82533-00	Cortisol; RIA, plasma (MD/DO)	~~41.00~~ 40.00
82534-00	RIA, urine	47.00
82540-00	Creatine; blood (MD/DO)	~~12.00~~ 15.00
82546-00	Creatine and creatinine	12.00
82550-00	Creatine phosphokinase (CPK), blood; timed kinet ultraviolet method	20.90
82552-00	isoenzymes	34.00
82555-00	Colorimetric (MD/DO)	~~18.00~~ 16.00
82565-00	Creatinine; blood (MD/DO)	~~13.75~~ 14.00
82570-00	urine	15.00
82575-00	clearance (MD/DO)	~~29.00~~ 30.50
82595-00	Cryoglobulin, blood	25.70

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82607-00	~~Cyanocobalamin (Vitamin B-12);~~ RIA (MD/DO)	~~33.00~~ 34.50
82615-00	Cystine and homocystine, urine; qualitative	51.00
82626-00	Dehydroepiandrosterone (DHEA), RIA	75.00
82628-00	Desipramine	50.00
82640-00	Digitoxin (digitalis); blood, RIA	33.00
82643-00	Digoxin, RIA	37.10
82660-00	Drug screen (amphetamines, barbiturates, alkaloids) (MD/DO)	40.00
82662-00	Immunoassay technique for drugs	31.50
82664-00	Electrophoretic technique, not elsewhere specified	110.00
82670-00	Estradiol, RIA (placental)	62.00
82671-00	Estrogens; fractionated	15.00
82672-00	total	70.50
82677-00	Estriol; RIA	49.00
82692-00	Ethosuximide	37.75
82705-00	Fat orllipids, feces; screening	19.50
82728-00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)	37.25
82730-00	Fibrinogen, quantitative	28.50
82745-00	Folic acid (folate), blood; bioassay	44.50
82746-00	RIA	40.00
82756-00	Free thyroxine index (T-7) (MD/DO)	~~25.00~~ 28.50
82784-00	Gammaglobulin, E (e.g., RIA, EIA)	44.00
82785-00	Gammaglobulin, E (MD/DO)	~~28.50~~ 32.50
82792-00	Gases, blood, oxygen saturation; by ~~oximetry~~ calculation from pO2 (MD/DO)	~~35.00~~ 35.90
82801-00	Gasses, blood; pCO2	10.50
82941-00	Gastrin, RIA	35.00
82946-00	Glucagon tolerance test	20.00
82947-00	Glucose; except urine (for example, blood, spinal fluid, joint fluid) (MD/DO)	14.00
82948-00	blood, stick test	10.50
82949-00	~~Glucose;~~ fermentation (MD/DO)	~~9.00~~ 10.25
82950-00	post glucose dose (includes glucose)	~~15.00~~ 16.00
82951-00	tolerance test (GTT), three specimens (includes glucose) (MD/DO)	~~42.00~~ 40.50
82952-00	tolerance test, each additional beyond three specimens	23.25
82954-00	Glucose, urine	7.00

82977-00	Glutamyl transpeptidase, gamma (GGT)	16.30
~~82996~~	~~Gonadotropin, chorionic, bioassay; qualitative~~	~~17.00~~
~~82997~~	~~quantitative~~	~~22.00~~
~~82998~~	~~Gonadotropin, chorionic, RIA~~	~~28.50~~
83000-00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	45.00
83001-00	RIA (MD/DO)	~~44.00~~ 45.90
83002-00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	50.00
83003-00	Growth hormone, human (HGH) (somatotropin); RIA	48.00
83010-00	Haptoglobin; chemical	37.00
83015-00	Heavy metal screen (arsenic, bismurth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)	90.00
83020-00	Hemoglobin; electrophoresis (includes A2, S, C, etc.)	10.00
83036-00	Hemoglobin; glycosylated	~~19.00~~ 22.50
83050-00	Methemoglobin, quantitative	~~8.00~~ 12.50
83051-00	plasma	14.55
83150-00	Homovanillic acid (HVA), urine	16.00
83497-00	Hydroxyindolacetic acid, 5-(HIAA), urine	44.80
83498-00	Hydroxyprogesterone, 17-d, RIA	68.95
83523-00	Imipramine (MD/DO)	~~52.40~~ 50.00
83540-00	Iron, serum: chemical (MD/DO)	~~15.00~~ 16.40
~~83545~~	~~automated~~	~~13.00~~
83550-00	Iron binding capacity, serum; chemical	21.25
83555-00	automated	~~26.30~~ 27.60
83565-00	~~Iron binding capacity, serum:~~ radioactive uptake method	~~26.50~~ 27.50
83582-00	Ketogenic steroids, urine; 17-(17-KGS)	43.90
83589-00	Ketosteroids, 17-(17-KS), urine; total	42.00
83615-00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method	20.50
83620-00	Lactic dehydrogenase (LDH), blood colorimetric or fluorometric (MD/DO)	~~11.55~~ 16.50
83625-00	isoenzymes, electrophoretic separation and quantitation	28.00
83631-00	Lactic dehydrogenase (LDH), CSF	11.00

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83645-00	Lead, screening; blood	11.00
83655-00	Lead, quantitative; blood	35.00
83690-00	Lipase, blood (MD/DO)	~~19.90~~ 22.00
83700-00	total	20.00
83705-00	~~Lipids, blood;~~ fractionated	~~19.20~~ 23.00
83715-00	Lipoprotein, blood; electrophoretic separation and quantitation (phenotyping)	30.00
83718-00	Lipoprotein high density cholesterol by precipitation method	~~17.90~~ 18.80
83719-00	Lipoprotein very low density cholesterol VLDL cholesterol) by ultracentrifugation	24.00
83720-00	Lipoprotein cholesterol fractionation calculation by formula	19.00
83725-00	Lithium, blood, quantitative (MD/DO)	~~18.75~~ 20.85
83735-00	Magnesium, blood; chemical (MD/DO)	~~17.10~~ 17.55
83750-00	atomic absorption	20.00
83835-00	Metanephrines, urine (MD/DO)	~~29.45~~ 49.00
83916-00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis	61.75
83930-00	Osmolality; blood (MD/DO)	~~9.80~~ 10.30
83945-00	Oxalate, urine	35.00
83947-00	Oxybutyric acid, beta	15.20
83970-00	Parathormone, RIA (MD/DO)	~~92.90~~ 108.50
~~84030~~	~~Phenylalanine (PKU), blood; Guthrie~~	~~13.00~~
84035-00	Phenylketones; blood, qualitative	15.00
84045-00	Phenytoin (MD/DO)	~~29.50~~ 31.00
84060-00	Phosphatase, acid; blood (MD/DO)	~~21.50~~ 22.00
84065-00	prostatic fraction (MD/DO)	~~24.00~~ 25.00
84066-00	prostatic fraction, RIA	48.00
84075-00	Phosphatase, alkaline, blood (MD/DO)	~~15.00~~ 15.80
84078-00	heat stable (total not included)	16.80
84080-00	isoenzymes, electrophoretic method (MD/DO)	~~39.00~~ 41.00
84100-00	Phosphorus (phosphate); blood (MD/DO)	~~11.40~~ 14.00
84105-00	urine (MD/DO)	~~11.50~~ 15.50
84126-00	Porphyrins, feces, quantitative	33.50
84132-00	Potassium; blood (MD/DO)	~~15.00~~ 14.25
84133-00	urine	11.00
84136-00	Pregnanediol; other method (specify)	15.00
84141-00	Primidone (MD/DO)	~~40.70~~ 40.50
84142-00	Procainamide	43.00
84144-00	Progesterone, any method (MD/DO)	~~45.00~~ 50.00
84146-00	Prolactin, RIA (MD/DO)	~~46.00~~ 50.00
84155-00	Protein, total, serum; chemical	14.10

84165-00	Protein, total, serum; electrophoretic fractionation and quantitation (MD/DO)	~~25.70~~ 27.00
84175-00	Protein, other sources, quantitative (MD/DO)	~~16.50~~ 19.50
84180-00	Protein, urine; quantitative, 24-hour specimen (MD/DO)	~~16.70~~ 18.00
84185-00	Bence-Jones	12.20
84190-00	electrophoretic fractionation and quantitation (MD/DO)	~~32.20~~ 27.35
84195-00	Protein, spinal fluid; semi-quantitative (Pandy)	19.00
84202-00	Protoporphyrin, RBC; quantitative (MD/DO)	13.00
84203-00	screen (MD/DO)	9.00
84207-00	Pyridoxine (Vitamin B-6)	6.00
84208-00	Pyrophosphate vs urate, crystals (polarization)	15.50
84220-00	Pyruvic Kinase, RBC	41.90
84230-00	Quinidine, blood	31.00
84231-00	Radioimmunoassay (RIA) not elsewhere specified	52.00
84233-00	Receptor assay; estrogen (estradiol)	58.00
84238-00	non-endocrine (e.g., acetylcholine) (specify receptor)	103.10
84244-00	Renin (angiotensin I); (RIA)	65.70
84275-00	Sialic acid, blood	78.00
84295-00	Sodium; blood (MD/DO)	~~12.00~~ 14.75
84300-00	urine	15.50
84403-00	Testosterone, blood, RIA (MD/DO)	~~84.00~~ 79.30
84408-00	Tetrahydrocannabinol THC (marijuana)	30.00
84420-00	Theophylline, blood, or saliva (MD/DO)	~~30.00~~ 32.00
84435-00	Thyroxine, CPB or resin uptake (MD/DO)	~~18.00~~ 16.00
84436-00	Thyroxine, true, RIA (MD/DO)	~~18.50~~ 19.25
84439-00	Thyroxine, free, RIA (MD/DO)	~~22.00~~ 20.00
84442-00	Thyroxine binding globulin (TBG) (MD/DO)	~~33.50~~ 35.20
84443-00	Thyroid stimulating hormone (TSH), RIA (MD/DO)	~~37.95~~ 40.00
84447-00	Toxicology, screen; general (MD/DO)	~~87.00~~ 68.30
84448-00	sedative (MD/DO)	40.00

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84450-00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method (MD/DO)	~~15.00~~ 16.00
84455-00	coloraimetric or fluorometric (MD/DO)	14.00
84460-00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method (MD/DO)	~~11.00~~ 16.00
84465-00	colorimetric or fluorometric	15.50
84478-00	Triglycerides, blood (MD/DO)	15.00
84479-00	Triiodothyronine (t-3), resin uptake	19.80
84480-00	Triiodothyronine, true, RIA (MD/DO)	50.00
84520-00	Urea nitrogen, blood (BUN); quantitative (MD/DO)	~~14.00~~ 14.50
84550-00	Uric acid; blood, chemical (MD/DO)	~~14.00~~ 15.00
84555-00	uricase, ultraviolet method (MD/DO)	~~13.20~~ 17.40
84560-00	Uric acid, urine (MD/DO)	~~17.50~~ 20.00
84580-00	Urobilinogen, urine; quantitative, timed specimen	12.00
84585-00	Vanillymandelic acid (VMA), urine	53.60
84630-00	Zinc, quantitative; blood	28.10
84702-00	Gonadotropin, chorionic; quantitative	28.30
84703-00	qualitative	20.00
84999-00	Unlisted chemistry or toxicology procedure	34.00

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke (MD/DO)	$ 8.00
85002-00	Ivy or template (MD/DO)	~~20.40~~ 21.40
85007-00	Blood count; ~~basophil count,~~ manual differential WBC count (includes RBC morphology and platelet estimation) (MD/DO)	~~11.00~~ 11.25
85009-00	differential WBC count, buffy coat	19.00
85012-00	eosinophil count, direct (MD/DO)	14.00
85014-00	hematocrit (MD/DO)	~~7.00~~ 9.00
85018-00	hemoglobin, colorimetric (MD/DO)	~~9.00~~ 9.50
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only) (MD/DO)	19.00
85022-00	hemogram, automated, ~~with platelet count~~ and manual differential WBC count (CBC) (MD/DO)	~~25.00~~ 24.25
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	31.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	23.00

85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	27.20
85027-00	hemogram, and platelet count, automated~~, and differential WBC count (CBC)~~ (MD/DO)	~~14.50~~ 15.25
~~85028~~	~~Hemogram, automated, and differential WBC count (CBC) with platelet count~~	~~26.00~~
85029-00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram; 1-3 indices	10.50
85030-00	4 or more indices	15.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes) (MD/DO)	~~21.00~~ 22.00
85041-00	red blood cell (RBC) only	8.00
85044-00	reticulocyte count (MD/DO)	~~13.25~~ 13.50
85048-00	White blood cell (WBC) (MD/DO)	~~9.00~~ 10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	50.50
85095-00	Bone marrow smear and/or cell block; aspiration only	87.00
85097-00	Bone marrow smear and/or cell block; smear interpretation only MD/DO)	~~80.00~~ 75.00
~~85097-26~~	~~professional component only~~	~~70.00~~
85100-00	aspiration, staining, and interpretation (MD/DO)	~~105.00~~ 114.00
85102-00	Bone marrow needle biopsy (MD/DO)	~~80.00~~ 94.00
85103-~~26~~00	~~Bone marrow needle biopsy;~~ staining and interpretation~~; professional component only~~ (MD/DO)	~~43.00~~ 115.00
85105-~~26~~00	~~professional component only~~ interpretation only (MD/DO)	~~70.00~~ 81.50
85210-00	Clotting; factor II, prothrombin, specific	14.00
85240-00	factor VIII (AHG), 1 stage	77.20
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	14.00
85368-00	Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)	11.00
85540-00	Leukocyte alkaline phosphatase with count	27.00

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85544-00	Lupus erythematosus (LE) cell prep (MD/DO)	24.00 20.00
85548-00	Morphology of red blood cells only (MD/DO)	27.00
85575-00	Platelet; adhesiveness (in vivo)	11.00
85580-00	~~Platelet;~~ count (Rees-Ecker) (MD/DO)	14.00
85585-00	~~Platelet;~~ estimation on smear only (MD/DO)	9.00
85590-00	phase microscopy (MD/DO)	15.00
85595-00	electronic technique (MD/DO)	14.00
85610-00	Prothrombin time; (MD/DO)	12.00 13.00
85618-00	Prothrombin-Proconvertin, P&P (Owren)	9.80
85630-00	Red blood cell size (Price-Jones)	12.00
85650-00	Sedimentation rate (ESR); Wintrobe type (MD/DO)	10.00 11.00
85651-00	Westergren type (MD/DO)	9.50 10.00
85660-00	Sickling of RBC, reduction, slide method (MD/DO)	14.00 12.00
85670-00	Thrombin time; plasma	25.00
85730-00	Thromboplastin time, partial; plasma or whole blood (MD/DO)	17.30 19.00

Subp. 6. **Immunology.** The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86000-00	Agglutinins; febrile, each antigen (MD/DO)	S 16.20 19.00
86004-00	warm	15.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube (MD/OD)	15.50 16.00
86007-00	~~Antibody, qualitative, not otherwise specified;~~ each additional antigen (MD/DO)	25.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	20.00
86009-00	each additional antigen	37.00
86012-00	Antibody absorption, cold auto absorption; per serum	15.50
86013-00	Antibody absorption, cold auto absorption; differential (MD/DO)	7.50 8.00
86-16-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	27.00
86017-00	with ABO + Rh(D) typing (for blood instead of complete crossmatch	15.00
86018-00	enzyme technique, including antihuman globulin	10.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique (MD/DO)	24.00 26.00

86028-00	Saline or high protein, each (MD/DO)	~~34.50~~ 27.50
86031-00	Antihuman globulin test; direct, 1-3 dilutins (MD/DO)	~~14.13~~ 15.25
86032-00	indirect, qualitative (MD/DO)	~~20.00~~ 17.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.00
86038-00	Antinuclear antibodies (ANA), RIA	30.00
86060-00	Antistreptolysin O; titer (MD/DO)	~~19.25~~ 23.00
86063-00	screen (MD/DO)	~~14.00~~ 15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	21.00
86067-00	other method (specify)	54.50
86069-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; each additional unit	35.50
~~86072~~	~~Blood crossmatch; enzyme technique~~	~~20.40~~
86075-00	Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening first unit	18.25
86080-00	Blood typing; ABO only (MD/DO)	~~8.00~~ 11.75
86082-00	ABO and Rho(D) (MD/DO)	~~20.30~~ 21.30
86095-00	Blood typing, RBC, antigens other than ABO or Rho(D); antiglobulin technique, each antigen (MD/DO)	20.00
86096-00	direct, slide or tube, including Rh subtypes, each antigen	13.50
86100-00	Blood typing; Rho(D) only	12.50
86105-00	Blood typing; Rh genotyping, complete (MD/DO)	~~8.00~~ 8.50
86115-00	anti-Rh immunoglobulin testing (RhoGAM type)	45.00
86128-00	Blood autotransfusion, including collection, processing, and storage	19.05
86140-00	C-reactive protein (MD/DO)	~~13.50~~ 14.00
86149-00	Carcinoembryonic antigen (CEA); gel diffusion	51.00
86151-00	Carcinoembryonic antigen (CEA); RIA or EIA (MD/DO)	60.00
86158-00	Complement; C'1 esterase	44.00
86162-00	total (CH 50)	56.60

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86163-00	Complement; C'3 esterase (MD/DO)	~~28.56~~ 30.00
86164-00	C'4 esterase	28.00
86171-00	Complement fixation tests, each (for example, cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis) (MD/DO)	~~15.50~~ 16.50
~~86185~~	~~Counterelectrophonesis, each antigen~~	~~81.50~~
86225-00	Deoxyribonucleic acid (DNA) antibody (MD/DO)	~~33.45~~ 40.00
86229-00	Enzyme immunoassay for chemical constituent	15.80
86235-00	Antibody to specific nuclear antigen, any method, each	65.50
86244-00	Feto-protein, alpha-1, RIA or EIA	49.70
86255-00	Fluorescent antibody; screen (MD/DO)	~~30.00~~ 28.00
86256-00	titer (MD/DO)	~~30.70~~ 34.00
86265-00	Frozen blood, preparation for freezing, each unit, including processing and collection	50.10
86277-00	Growth hormone, human (HGH), antibody, RIA	17.00
86280-00	Hemagglutination inhibition tests (HAI), each (for example, ~~amebiasis,~~ rubella, viral) (MD/DO)	~~16.00~~ 19.00
86282-00	Hemolysins and agglutinins, auto, screen, each	21.25
~~86286~~	~~Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA); counterelectrophoresis with concentration of serum~~	~~25.00~~
86287-00	Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA, RIA or EIA	26.70
86288-00	Hepatitis B core antigen (HBcAg), RIA	27.00
86289-00	Hepatitis B core antibody; RIA ~~or EIA~~ (HBcAg) (MD/DO)	~~15.00~~ 35.00
86291-00	Hepatitis B surface antibody (MD/DO)	~~25.40~~ 26.70
86293-00	Hepatitis Be antigen (MD/DO)	~~52.00~~ 33.00
86296-00	Hepatitis A antibody (MD/DO)	~~33.30~~ 33.74
86298-00	IgG antibody	40.00
86299-00	IgM antibody	35.40
86300-00	Heterophile antibodies; screening (includes monotype test), slide or tube (MD/DO)	~~14.50~~ 15.00
86305-00	~~Heterophile antibodies;~~ quantitative titer (MD/DO)	~~18.00~~ 20.00
86312-00	HIV (HTLV-III) antibody detection; immunoassay	22.00

86314-00	confirmatory test (e.g., Western blot)	47.00
86320-00	Immunoelectrophoresis; serum, each	65.50
86325-00	other fluids (e.g., urine) with concentration, each specimen	65.50
86329-00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify) (MD/DO)	~~40.00~~ 50.00
86335-00	Immunoglobulin typing (Gc, Gm, Inv), each	15.00
86357-00	Insulin antibodies, RIA	123.70
86376-00	Microsomal antibody (thyroid); RIA	29.40
86377-00	other method (specify)	47.70
86382-00	Neutralization test, viral	9.50
86403-00	Particle agglutination, rapid test for infectious agent, each antigen	14.00
86422-00	Radioallergosorbent test, in vitro testing for allergen-specific IgE (for example, RAST, MAST, FAST, IP, PRIST, etc.); 6 or more tests	15.50
86423-00	Radioimmunosorbent test IgE, quantitative (MD/DO)	35.00
86430-00	Rheumatoid factor, latex fixation	~~16.50~~ 18.40
86455-00	Skin test; anergy testing, 1 or more antigens	25.00
86490-00	coccidioidomycosis	14.00
86510-00	histoplasmosis	16.00
86580-00	Skin test; tuberculosis~~, patch,~~ or intradermal (MD/DO)	~~9.00~~ 9.50
86585-00	tuberculosis, tine test (MD/DO)	~~7.50~~ 8.00
86590-00	Streptokinase, antibody	~~10.00~~ 16.00
86592-00	Syphilis, ~~precipitation or flocculation tests,~~ test; qualitative ~~VDRL, RPR, ART~~	~~10.00~~ 12.75
86593-00	quantitative	12.00
86594-00	Thyroid autoantibodies	48.00
86595-00	Tissue culture	62.55
86600-00	Toxoplasmosis, dye test	16.00
86650	Treponema antibodies, fluorescent, absorbed (MD/DO)	~~37.50~~ 39.40
86800-00	Thyroglobulin antibody, RIA	42.40

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86812-00	Tissue typing; HLA typing, A, B, or C (for example, A10, B7, B27), single antigen	65.00

Subp. 7. Microbiology. The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
~~87040~~	~~Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen)~~	~~$ 23.00~~
87015-00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	27.00
87045-00	stool	~~27.50~~ 28.40
87060-00	~~Culture, bacterial, definitive, aerobic,~~ throat or nose	~~12.00~~ 12.50
87070-00	any other source	~~21.00~~ 23.00
87072-00	Culture~~, presumptive, pathogenic organisms~~ or direct bacterial identification method, each organism, by commercial kit. any source except urine	~~13.50~~ 16.20
87075-00	Culture, bacterial, any source; anaerobic (isolation)	29.00
87081-00	Culture, bacterial. screening only, for single organisms	~~12.70~~ 14.50
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type): for single organisms	~~12.00~~ 15.00
87083-00	multiple organisms	17.25
87084-00	with colony estimation from density chart	10.00
87085-00	with colony count	29.00
87086-00	Culture, bacterial, urine; quantitative, colony count (MD/DO)	~~17.60~~ 19.00
87087-00	commercial kit	11.25
87088-00	identification, in addition to quantitative or commercial kit	~~22.00~~ 23.00
87101-00	Culture, fungi, isolation; skin	18.00
87102-00	other source (except blood)	13.50
87106-00	Culture, fungi, ~~isolation; skin;~~ definitive identification~~, by culture, per organism, in addition to skin or other source~~ of each fungus	~~26.30~~ 27.60
87109-00	Culture, mycoplasma, any source	43.50
87116-00	Culture, tubercle or other acid-fast bacilli (for example, TB, AFB, mycobacteria); source, isolation only	31.00
87117-00	concentration plus isolation	36.40
87118-00	Culture, mycobacteria, definitive identification of each organism	25.00

87140-00	Culture, typing; fluorescent method, each antiserum	
87147-00	Serologic method, agglutination grouping, per antiserum (MD/DO)	14.50
87151-00	serologic method, speciation	~~15.00~~ 20.00
87158-00	other methods	19.00
87163-00	Culture, ~~special extensive definitive diagnostic studies, beyond usual definitive studies~~ any source, additional identification methods required (MD/DO)	52.40
87164-00	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection (MD/DO)	~~22.50~~ 25.00
87174-00	Endotoxin, bacterial (pyrogens); chemical	~~7.50~~ 8.00
87177-00	Ova and parasites, direct smears, concentration and identification (MD/DO)	40.00
87181-00	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic (MD/DO)	~~24.00~~ 25.30
87184-00	disc method, each plate (12 or less discs)	15.00
87186-00	microtiter, minimum inhibitory concentration (MIC), 8 or less any number of antibiotics (MD/DO)	~~17.50~~ 18.75
87188-00	macrotube dilution method, each antibiotic	~~21.05~~ 22.50
87205-00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types (MD/DO)	16.50
87206-00	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	~~13.00~~ 14.60
87207-00	special stain for inclusion bodies or intracellular parasites (for example, malaria, kala azar, herpes)	30.00
87208-00	direct or concentrated, dry, for ova and parasites (MD/DO)	31.00
87210-00	wet mount with simple stain ~~and interpretation,~~ for bacteria, fungi, ova, ~~or~~ and/or parasites (MD/DO)	~~12.50~~ 13.00
87211-00	wet and dry mount, ~~with interpretation,~~ for ova and parasites (MD/DO)	~~12.00~~ 12.25
87220-00	Tissue examination for fungi (for example, KOH slide) (MD/DO)	~~11.50~~ 12.00
		12.50

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87250-00	Virus identification: inoculation of embryonated eggs, or small animal, includes observation and dissection	39.00

Subp. 8. **Anatomic pathology.** The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

Cytopathology

Code	Service	Maximum Fee
88104-00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation (MD/DO)	$ ~~32.25~~ 30.00
~~88109~~	~~smears and cell block with interpretation~~	~~53.50~~
88106-00	filter method only with interpretation	31.70
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	37.00
88130-00	Sex chromatin identification: Barr bodies	15.50
88150-00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to 3 smears; screening by technical under physician supervision	16.75
88151-00	requiring interpretation by physician	19.25
88155-00	with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index)	
88160	Cytopathology, any other source; screening and interpretation (MD/DO	~~35.00~~ 28.50
88161-2600	preparation, screening, and ~~interpretation; professional component only~~ (MD/DO)	~~28.50~~ 40.90
88162-00	extended study involving over 5 slides and/or multiple stains	55.00
88170-00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	90.00
88172-00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	27.50
88173-00	interpretation and report	88.00
88260-00	Chromosome analysis; count 5 cells, screening, with banding	400.00
88262-00	count 15-20 cells, 2 karyotypes, with banding	363.40
88267-00	Chromosone analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotope, with banding	453.00

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

Code	Service	Maximum Fee
88300-00	Surgical pathology, gross examination only	25.00
88302-00	Surgical pathology, gross and microscopic; examination ~~for~~ of presumptively normal tissue, for identification and record purposes ~~(for example, uterine tubes, vas deferens, sympathetic ganglion)~~ (MD/DO)	$ ~~35.00~~ 36.00
~~88302-26~~	~~professional component only~~	~~31.00~~
88304-00	Surgical pathology, gross and microscopic; diagnostic ~~exam, small or~~ examination of presumptively abnormal tissue; uncomplicated specimen ~~(for example, skin lesion, needle biopsy)~~ (MD/DO)	45.00
88305-00	single complicated or multiple uncomplicated specimen(s), without complex dissection	73.90
88307-00	~~complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides~~ single complicated specimen requiring complex dissection or multiple complicated specimens	~~90.00~~ 128.90
88309-00	Complex diagnostic problem with or without extensive dissection (MD/DO)	~~150.00~~ 185.60
88311-00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	20.90
88312-00	Special stains; Group I stains for microorganisms (MD/DO)	25.00
88313-00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	18.50
88314-00	histochemical staining with frozen section(s)	10.00
88321-00	Consultation and report on referred slides prepared elsewhere	67.95
88323-00	Consultation and report on referred material requiring preparation of slides	52.50
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	48.00
~~88329-26~~	~~Consultation during surgery; professional component only~~	~~40.00~~
88331-00	with frozen section(s); single specimen	100.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	42.00

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Subp. 10. **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)~~	~~$ 25.00~~
89050-00	Cell count, miscellaneous body fluids (e.g., CSFm joint fluid), except blood	20.40
89051-00	Cell count, miscellaneous body fluids (e.g. CSF, joint fluid), except blood, with differential count	~~13.40~~ 15.50
89060-00	Crystal identification by compensated polarizing lens analysis, cynovial fluid	16.00
89125-00	Fat stain, feces, urine, or sputum	24.30
89130-00	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology (MD/DO)	~~42.10~~ 61.00
~~89180~~	~~Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify)~~	~~11.60~~
89190-00	Nasal smear for eosinophils (MD/DO)	~~11.25~~ 12.00
89205-00	Occult blood, any source except feces	11.00
89300-00	Semen analysis; presence and/or motility of sperm, including Huhner test	32.00
89310-00	motility and count	19.00
89320-00	Semen analysis; complete(volume count, motility and differential) (MD/DO)	~~39.75~~ 39.00
89325-00	Sperm antibodies	109.00
89330-00	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkheit test	32.00
89350-00	Sputum, obtaining specimen, aerosol induced technique (MD/DO)	~~54.00~~ 17.10

5221.2500 DENTISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

Subp. 2. **Diagnostic.** The following codes, service descriptions, and maximum fees apply to diagnostic services.

~~**Clinical Oral Examination**~~

Code	Service	Maximum Fee
~~00110~~	~~Initial oral examination~~	~~$ 15.00~~
~~00120~~	~~Periodic oral examination~~	~~12.00~~
~~00130~~	~~Emergency oral examination~~	~~15.00~~

~~**Radiographs**~~

~~00210~~	~~Intraoral complete series~~	~~$ 38.00~~

~~00220~~	~~Intraoral; periapical, single, first film~~	
~~00272~~	~~Bitewing; two films~~	~~6.00~~
~~00274~~	~~four films~~	~~10.00~~
~~00330~~	~~Panoramic; maxilla and mandible, film~~	~~16.00~~
~~00335~~	~~maxilla and mandible, film, with bitewings~~	~~35.00~~
~~00340~~	~~Cephalometric film~~	~~43.00~~
	~~Tests and Laboratory Examinations~~	~~38.00~~
~~00450~~	~~Histopathologic examination~~	~~$ 40.00~~
	Restorative	
~~02110~~	~~Amalgam; one surface, deciduous~~	
~~02120~~	~~Amalgam; two surfaces, deciduous~~	~~$ 25.00~~
~~02130~~	~~Amalgam; three surfaces, deciduous~~	~~35.00~~
~~02131~~	~~Amalgam; four surfaces, deciduous~~	~~45.00~~
02140-00	Amalgam; one surface, permanent (DDS)	~~54.00~~
02150-00	~~Amalgam;~~ two surfaces, permanent (DDS)	~~25.00~~ 28.00
02160-00	~~Amalgam;~~ three surfaces, permanent (DDS)	~~36.00~~ 40.00
02161-00	~~Amalgam;~~ four or more surfaces, permanent (DDS)	~~48.00~~ 53.00
	Acrylic or Plastic Restorations	~~58.00~~ 64.00
02330-00	~~Composite~~ resin; one surface, anterior (DDS)	
02331-00	~~Composite resin;~~ two surfaces, anterior (DDS)	$ ~~34.00~~ 38.00
02332-00	~~Composite resin;~~ three surfaces, anterior (DDS)	~~46.00~~ 54.00
02335-00	~~Composite resin~~ four or more surfaces or (involving incisal angle (DDS)	~~61.00~~ 70.00
	Inlay Restorations	~~60.00~~ 70.00
02530-00	Inlay - metallic; three surfaces	
02540-00	Onlay - metallic; per tooth (in addition to inlay)	310.00
	Crowns - Single Restoration Only	395.00
02711-00	Plastic, prefabricated	
02740-00	Crown; porcelain/ceramic substrate	$ ~~90.00~~ 135.00
02750-00	porcelain fused to high noble metal	420.00
02751-00	porcelain fused to predominantly base metal	375.00
02752-00	porcelain fused to noble metal	360.00
		360.00

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02790-00	full cast high noble metal	355.00
02791-00	full cast predominantly base metal	310.00
02792-00	full cast noble metal	305.00
02810-00	3/4 cast metallic	380.00
02815-00	Incision and drainage of abscess: intraoral	90.00
02824-00	Removal of tooth; bony impaction presenting unusual difficulties and circumstances	160.00
02825-00	Removal of tooth, soft tissue impaction (DDS)	~~80.00~~ 90.00
02826-00	~~Removal of tooth,~~ partial bony impaction (DDS)	88.00 115.00
02827-00	~~Removal of tooth,~~ complete bony impaction (DDS)	~~90.00~~ 140.00
02828-00	Dental root resection	96.00
02829-00	Apicoectomy: performed as separate surgical procedure (per root)	200.00
02830-00	stainless steel (DDS)	~~75.00~~ 85.00
02848-00	Osseous surgery: per quadrant	350.00
	Other Restorative Services	
02910-00	Recement inlays (DDS)	~~25.00~~ 28.00
02920-00	Recement crowns (DDS)	~~22.00~~ 25.00
02940-00	Sedative fillings (DDS)	~~21.00~~ 25.00
02950-00	Crown buildups, including any pins (DDS)	~~75.00~~ 80.00
02960-00	Labial veneer (laminate): chairside	165.00
	Endodontics	
03110-00	Pulp cap: direct (excluding final restoration)	20.00
03120-00	indirect (excluding final restoration)	20.00
03220-00	~~Vital~~ Therapeutic pulpotomy	12.00
	Root Canal Therapy	$ ~~40.00~~ 40.00
03310-00	~~Anterior~~ One canal (excludes final restoration) (DDS)	$ ~~171.75~~ 195.00
03320-00	~~Bicuspid~~ Two canals (excludes final restoration) (DDS)	~~200.00~~ 238.00
03330-00	~~Molar~~ Three canals (excludes final restoration) (DDS)	~~260.00~~ 325.00
	Periapical Services	
03410-00	Apicoectomy - (per tooth) first root ~~performed as separate surgical procedure (per root)~~ (DDS)	~~130.00~~ 200.00
	Other Endodontic Procedures	
03950-00	Canal preparation and fitting of preformed dowel or post	~~60.00~~ 85.00

03960-00	Bleaching of discolored tooth	40.00
	Prosthodontics, Removable	
	Complete Dentures - including ~~six months~~ routine post-delivery care	
05110-00	Complete upper (DDS)	$ ~~453.00~~ 495.00
05120-00	Complete lower (DDS)	~~455.00~~ 500.00
05130-00	Immediate upper (DDS)	~~450.00~~ 537.00
05140-00	Immediate lower (DDS)	~~450.00~~ 550.00
	Partial Dentures - including routine ~~six months~~ post-delivery care	
05212-00	Lower - ~~without clasps~~, partial: acrylic base (including any conventional clasps and rests	$ ~~498.75~~ 537.00
05213-00	Upper partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests	565.00
05214-00	Lower partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests)	575.00
05215-00	Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests	565.00
05216-00	~~Upper - with two chrome clasps with rests,~~ Lower; high noble cast base with acrylic ~~base~~ saddles (including any conventional clasps and rests (DDS)	~~485.00~~ 595.00
~~05218~~	~~Lower - with chrome clasps with rests, acrylic base~~	~~500.00~~
~~05231~~	~~Lower - with chrome lingual bar and two clasps, acrylic base~~	~~500.00~~
~~05241~~	~~Lower - with chrome lingual bar and two clasps, cast base~~	~~525.00~~
~~05251~~	~~Upper - with chrome palatal bar and two clasps, acrylic base~~	~~500.00~~
~~05261~~	~~Upper - with chrome palatal bar and two clasps, cast base~~	~~550.00~~
~~05292~~	~~Full cast partial - with two chrome clasps (upper)~~	~~520.00~~
~~05294~~	~~Full cast partial - with two chrome clasps (lower)~~	~~520.00~~
	Adjustments to Dentures	
05410-00	Adjust complete denture; upper	25.00
05421-00	Adjust partial denture; upper	30.00
05422-00	lower	25.00

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	Repairs to Dentures	
~~05610~~	~~Repair broken or complete or partial denture - no teeth damaged~~	
~~05620~~	~~Repair broken complete or partial denture - replace one broken tooth~~	~~$ 51.00~~
05610-00	Repair acrylic saddle or base	~~59.00~~
05620-00	Repair (DDS)	48.00
05630-00	Repair or replace broken clasp (DDS)	50.00
05640-00	Replace broken ~~tooth or denture - not other repairs~~ teeth; per tooth (DDS)	45.00
05650-00	~~Adding~~ Add tooth to existing partial denture ~~to replace extracted tooth - each tooth (not involving clasp or abutment tooth)~~ (DDS)	~~45.00~~ 48.00
05660-00	~~Adding tooth~~ Add clasp to existing partial denture ~~to replace extracted tooth - each tooth (involving clasp or abutment tooth)~~ (DDS)	65.00
~~05670~~	~~Reattaching damaged clasp on denture~~	~~92.25~~ 90.00
~~05680~~	~~Replacing broken clasp with new clasp on denture~~	~~65.00~~
~~05690~~	~~Each additional clasp with rest~~	~~75.00~~
	~~Denture Duplication~~	~~64.80~~
~~05710~~	~~Duplicate upper or lower complete denture~~	
~~05720~~	~~Duplicate upper or lower partial denture~~	~~$ 202.50~~
	Denture Relining	~~207.50~~
~~05740~~	~~Relining upper or lower partial denture (office reline)~~	
05730-00	Relining complete upper denture (chairside) (DDS)	~~$ 95.00~~
05750-00	Relining complete upper ~~or lower complete~~ denture (laboratory) (DDS)	$ 135.00
05760-00	Relining upper ~~or lower~~ partial denture (laboratory) (DDS)	~~150.00~~ 158.00
	Other Removable Prosthetic Services	~~144.50~~ 160.00
05820-00	~~Denture~~ Temporary (partial stayplate), denture upper (DDS)	
05850-00	Tissue Conditioning; per denture unit (DDS)	$ ~~160.00~~ 200.00
	Bridge Pontics	~~28.00~~ 39.00
06210-00	Pontic; cast high noble metal	
06240-00	porcelain fused to high noble metal	$ 135.00
06241-00	porcelain fused to predominantly base metal	363.00
06242-00	porcelain fused to noble metal	355.00
	Retainers	350.00
06545-00	Cast metal retainer for acid etch bridge	132.00

	Prosthodontics, ~~Fixes~~ Fixed	
06640-00	Replace broken facing with acrylic (DDS)	$ ~~54.00~~ 70.00
	Bridge Retainers—Crowns	
06750-00	Crown: porcelain fused to high noble metal	377.00
06751-00	porcelain fused to predominantly base metal	360.00
06752-00	porcelain fused to noble metal	355.00
06790-00	full cast high noble metal	355.00
06791-00	full cast predominantly base metal	295.00
06792-00	full cast noble metal	300.00
06801-00	Diagnostic exam and DXL	20.00
06802-00	Prevention	25.00
06803-00	Restorative	52.50
06804-00	Endodontics	285.00
06808-00	Dental oral surgery	45.00
06809-00	Unlisted dental procedures	24.00
	Other Fixed Prosthetic Services	
06930-00	Recement bridge (DDS)	40.00
	Oral Surgery	
	Extractions - includes local anesthesia and routine postoperative care	
07110-00	Single tooth (DDS)	$ ~~30.00~~ 35.00
07120-00	Each additional tooth (DDS)	~~28.00~~ 35.00
	Surgical Extractions - includes local anesthesia and routine postoperative care	
07210-00	~~Extraction~~ Surgical removal of tooth - ~~erupted~~ requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth (DDS)	~~70.00~~ 75.00
07220-00	~~Impaction that requires incision of overlying soft tissue and the~~ Removal of ~~the~~ impacted tooth; soft tissue (DDS)	~~80.00~~ 86.00
07230-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the~~ Removal of the impacted tooth; partially bony (DDS)	~~100.00~~ 119.00
07240-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, Removal of bone and sectioning of the tooth for~~ Removal of impacted tooth: completely bony (DDS)	~~120.00~~ 140.00

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07241-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the~~ Removal of impacted tooth ~~for removal, and presents~~ ; completely bony, with unusual ~~difficulties and circumstances~~ surgical complications (DDS)	~~135.00~~ 150.00
07250-00	~~Root recovery~~ (Surgical removal of residual ~~roots~~ tooth roots (DDS)	~~60.00~~ 75.00
	Other Surgical Procedures	
07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons - including ~~wire attachment~~ orthodontic attachments (DDS)	~~80.00~~ 125.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	140.00
07286-00	Biopsy of oral tissue; soft	90.00
	Alveoplasty - Surgical Preparation of Ridge For Dentures	
07310-00	Alveoloplasty (per quadrant) in conjunction with extractions (DDS)	~~60.00~~ 75.00
~~07320~~	~~per quadrant; not in conjunction with extractions~~	~~75.00~~
	~~Surgical Excision~~	
07425-00	~~Excision periocoronial gingiva~~	~~$ 30.60~~
	Surgical Incision	
07510-00	Incision and drainage of abscess, intraoral soft tissue (DDS)	~~44.50~~ 45.00
	Other ~~Oral Surgery~~ Repair Procedures	
07960-00	Frenulectomy	$ ~~80.00~~ 90.00
	Adjunctive General Services	
	Unclassified treatment	
09110-00	Palliative (emergency) treatment of dental pain: minor procedures	25.00
	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 8.00
09211-00	Regional block anesthesia	10.00
09220-00	General: first 30 minutes (DDS)	$ 90.00
09230-00	Analgesia (DDS)	12.00
	Professional Consultation	
09310-00	Consultation: per session	35.00
09420-00	Hospital call	14.00
09430-00	Office visit during regularly scheduled office hours	15.00
	Drugs	
09610-00	Therapeutic drug injection, by report	15.00
09630-00	Other drugs and/or medicaments	15.00

	Miscellaneous Services	
09910-00	Application of desensitizing medicaments (DDS)	$ 15.00
09991-00		25.00
09993-00		30.00
	Surgery	
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	2,960.00
21203-00	mandibular ramus (osteotomy)	2,950.00
21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,400.00
40808-00	Biopsy, vestibule of mouth	107.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	100.00
4215-00	Removal of exostosis, bony palate	280.00
	Radiology—Dental	
70320-00	Radiologic examination, teeth; complete, full mouth	45.00
70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	35.00
70330-00	bilateral	90.00
70350-00	Caphalogram, orthodontic	40.00
70355-00	Orthopantogram	35.00
76100-00	Radiologic examination, single plane body section (e.g., tomography)	73.00
	Surgical Pathology—Dental	
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	40.00
	Office Dental Services	
90000-00	Office dental service, new patient; brief service	25.00
90010-00	limited service	33.00
90020-00	comprehensive service	75.20
90030-00	Office dental service, established patient; minimal service	24.00
90040-00	brief service	25.00
90050-00	limited service	34.00
90060-00	intermediate service	44.00
90070-00	extended service	55.00

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90070-00	extended service	
90080-00	comprehensive service	45.00
92002-00	New patient; intermediate service	49.00
92004-00	comprehensive service, one or more visits	39.00
92012-00	Established patient; intermediate service (includes determination of the refractive state	50.00
92014-00	comprehensive service, one or more visits	38.00
92060-00	Sensorimotor examination with diagnostic evaluation	44.00
92065-00	Orthoptic and/or pleoptic training, with continuing direction and evaluation	50.00
92081-00	Visual field examination with medical diagnostic evaluation; tangent screen, autoplot or equivalent	40.00
92082-00	quantitative perimetry (for example, several isopters on Goldmann perimeter or equivalent	20.00
92083-00	static and kinetic perimetry, or equivalent	42.50
92100-00	Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day	60.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation	10.00
92225-00	Opthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomocroscopy), with medical diagnostic evaluation; initial	15.00
92250-00	Ophthalmoscopy, with medical diagnostic evaluation; with fundus photography	22.20
92285-00	Extended ocular photography for documentation of progress	15.00
92287-00	Specular endothelial microscopy with photographic documentation, evaluation and report; with flouroscein antiography	10.00
92310-00	Prescription and management of corneal contact lens, both eyes, except for aphakia	38.00
92312-00	corneal lens for aphakia, two eyes	50.00
92325-00	Modification of contact lens	130.00
92326-00	Replacement of contact lens	20.00
92340-00	Treatment with spectacles, except for aphakia; monofocal	58.00
92341-00	bifocal	49.00
92342-00	multifocal, other than bifocal	64.00
92370-00	Repair and adjusting spectacles; except for aphakia	84.00
92390-00	Supply of all spectacle lenses, except for aphakia and low vision aids (all	68.95

	combinations, nonspecific); one lens only (enter two units for a pair)	79.00
92391-00	Supply of contact lenses, except prosthesis for aphakia; one lens only (enter two units for a pair)	108.00
99056-00	Services provided at request of patient in a location other than optometrist's office that are normally provided in the office	6.00

5221.2650 OPTICIANS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to certified opticians.

Subp. 2. Basic optician services. The following codes, service descriptions, and maximum fees apply to basic optician services and supplies:

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 53.00
06502-00	Bifocal eyeglass lenses (one lens)	69.95
06503-00	Trifocal eyeglass lenses (one lens)	85.00
06504-00	Lenticular eyeglass lenses (one lens)	24.00
06506-00	Eyeglass frames	80.00
06510-00	Tinting for lenses	12.00
06587-00	Contact lenses, soft (one lens)	109.00
06588-00	Contact lenses, hard (one lens)	61.00
06593-00	Dispensing fee, frames for lenses	70.20
	Office Services	
92004-00	New patient; comprehensive service	$ 34.00
92012-00	Established patient; intermediate service	40.00
92340-00	Treatment with spectacles, except for aphakia; monofocal	50.00

5221.2700 AUDIOLOGISTS.

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

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

Code	Service	Maximum Fee
06665-00	Monaural dispensing fee (CCC-A/CFY)	190.00
21010-00	Basic hearing evaluation (CCC-A/CFY)	40.00
21020-00	Basic hearing evaluation (CCC-A/CFY)	45.00
21021-00	Limited hearing evaluation (CCC-A/CFY)	32.00
21022-00	Extended hearing evaluation (CCC-A/CFY)	64.00
21031-00	Limited site of auditory lesion evaluation (CCC-A/CFY)	16.00

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21032-00	Extended site of auditory lesion evaluation (CCC-A/CFY)	32.00
21050-00	Basic prescription hearing aid evaluation (CCC-A/CFY)	40.00
21052-00	Extended prescription hearing aid evaluation (CCC-A/CFY)	~~45.00~~
21053-00	Performance evaluation of specific hearing aid (CCC-A/CFY)	20.00
21081-00	Hearing screening group (CCC-A/CFY)	9.50
22010-00	Basic speech, language, or voice evaluation (CCC-A/CFY)	80.00
~~92506~~	~~Medical evaluation, speech, language and/or hearing problems~~	~~$ 51.00~~
~~92532~~	~~Positional nystagmus~~	~~20.00~~
~~92545~~	~~Oscillating tracking test, with recording~~	~~31.00~~
92551-00	Screening test, pure tone, air only (CCC-A/CFY)	~~12.50~~ 18.50
~~92552~~	~~Pure tone audiometry (threshold): air only~~	~~21.00~~
92553-00	air and bone (CCC-A/CFY)	~~35.00~~ 33.00
~~92555~~	~~Speech audiometry: threshold only~~	~~16.00~~
92556-00	threshold and discrimination (CCC-A/CFY)	~~32.00~~ 44.25
92557-00	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination) (CCC-A/CFY)	~~54.00~~ 60.00
~~92562~~	~~Loudness balance test, alternate binaural or monaural~~	~~18.00~~
~~92563~~	~~Tone decay test~~	~~15.00~~
92566-00	Impedance testing (CCC-A/CFY)	~~20.00~~ 18.00
92567-00	Tympanometry (CCC-A/CFY)	~~18.00~~ 22.00
~~92568~~	~~Acoustic reflex testing~~	~~16.00~~
~~92575~~	~~Sensorineural acuity level test~~	~~10.00~~
~~92581~~	~~Evoked response (EEG) audiometry~~	~~185.00~~
92582-00	Conditioning play audiometry (CCC-A/CFY)	30.00
92585-00	Brainstem evoked response recording (CCC-A/CFY)	~~182.00~~ .....
92590-00	Hearing and examination and selection; monaural (CCC-A/CFY)	~~53.50~~ 50.00
92591	binaural (CCC-A/CFY)	~~65.00~~ .....
92592-00	Hearing aid check; monaural (CCC-A//CFY)	53.50
92593	~~Hearing aid check;~~ binaural	30.00 .....

5221.2750 SPEECH PATHOLOGISTS.

The following codes, service description, and maximum fees apply to speech pathologists holding a certificate of clinical competency (CCC-SP) or to speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subp. 2. **Physical therapy.** ~~The following codes, service descriptions, and maximum fees apply to physical therapy procedures.~~ **Definitions.** The terms defined in this subpart have the meanings given to them when used in subpart 4 unless the context clearly indicates a different meaning.

A. "Therapeutic exercise" (code 97110) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular re-education" (code 97112) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident and systemic neurological disease.

C. "Functional activities" (code 97114) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work-related activities.

D. "Gait training" (code 97116) means teaching individuals with neurological or musculoskeletal disorders to ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how to prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

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

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

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

Subp. 3. **Physical and occupational therapy instructions.**

A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration. The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.

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

C. Occupational therapy services must be provided by a nationally registered occupational therapist or certified occupational therapy assistant under the direction of a nationally registered occupational therapist.

Subp. 4. Scope. The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed in an independent clinic, a doctor's office, a hospital satellite clinic, or hospital out-patient setting.

~~Evaluations~~

Code	Service	Maximum Fee
~~95831~~	~~Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report~~	~~$ 14.00~~
~~95851~~	~~Range of motion measurements and report (separate procedure): each extremity, excluding hand~~	~~9.25~~
	Modalities	
97010-00	Physical medicine treatment to one area: hot or cold packs (RPT/OTR)	$ ~~16.00~~ 17.00
97012-00	~~Physical medicine treatment to one area;~~ traction, mechanical (RPT/OTR)	~~15.50~~ 16.00
97014-00	electrical stimulation (unattended) (RPT/OTR)	15.00
97016-00	vasopneumatic devices (RPT/OTR)	~~15.00~~ 16.00
97018-00	paraffin bath (RPT/OTR)	~~15.00~~ 20.00
97022-00	whirlpool (RPT/OTR)	17.00
97024-00	diathermy (RPT/OTR)	~~15.00~~ 16.00
~~97026~~	~~infrared~~	~~11.50~~
97028-00	ultraviolet (RPT/OTR)	25.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises (RPT/OTR)	$ ~~20.00~~ 22.00
97112-00	neuromuscular reeducation (RPT/OTR)	~~20.00~~ 25.00
97114-00	functional activities (RPT/OTR)	~~26.00~~ 19.00
97116-00	ait training (RPT/OTR)	~~21.86~~ 23.00
97118-00	electrical stimulation (manual) (RPT/OTR)	16.25
97120-00	iontophoresis (RPT/OTR)	~~25.00~~ 20.00
97122-00	traction, manual (RPT/OTR)	~~15.50~~ 18.00
97124-00	massage (RPT/OTR)	~~15.50~~ 17.25
97126-00	contrast baths	~~16.00~~ 18.00
97128-00	ultrasound (RPT/OTR)	~~16.00~~ 16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	~~12.50~~ 13.00
97220-00	Hubbard tank; initial 30 minutes each visit (RPT/OTR)	45.00

97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit (RPT/OTR)	
~~97260~~	~~Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist)(separate procedure), performed by physician; one area~~	30.00
97500-00	Orthotics training (dynamic bracing, splinting), upper extremities; initial 30 minutes, each visit (RPT/OTR)	~~18.00~~
97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit (RPT/OTR)	~~26.00~~ 21.00
97531-00	each additional 15 minutes (RPT/OTR)	25.00
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit (RPT/OTR)	~~12.00~~ 18.50
97541-00	each additional 15 minutes (RPT/OTR)	~~33.00~~ 20.00
		18.50
	Tests and Measurements	
97700-00	Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes (RPT/OTR) a. Orthotic check-out; b. Prosthetic check-out; c. Activities of daily living check-out; d. Follow-up evaluation for extremity testing for strength, dexterity, or stamina	
97701-00	each additional 15 minutes	$ 21.00
97720-00	Initial evaluation for extremity testing for strength, dexterity, or stamina; initial 30 minutes, each visit (RPT/OTR)	21.00
97721-00	each additional 15 minutes (RPT/OTR)	$ ~~45.00~~ 32.00
97752-00	Muscle testing with torque curves during isometric and isokinetic exercise mechanized or computerized evalators with printout (e.g., by use of cybex or similar type machine); for extremities (RPT/OTR)	25.00
97753-00	for trunk/back	55.00
		134.40

5221.2900 CHIROPRACTORS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of chiropractic medicine.

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Subp. 1a. Definitions. For purposes of this part, the following terms have the meaning given them unless the content clearly indicates a different meaning.

A. "Examination/consultation" means inspection of the patient, review of diagnostic tests to diagnose disease or evaluate progress and preparation of an appropriate record.

(1) "Brief examination" means a condition requiring only a routine history and examination.

(2) "Intermediate examination" means a condition involving a diagnostic or management problem and a history and examination.

(3) "Extensive examination" means an unusual amount of effort or judgment and a detailed history and examination of multiple body systems.

B. "Initial office visit with manipulation/adjustment" means the first time a patient is seen for a brief evaluation to determine the appropriate treatment on that date and all necessary spinal manipulative/adjustment procedures rendered.

C. "Subsequent office visit with manipulation/adjustment" means all office visits, except the first one, where a brief evaluation is done to determine appropriate treatment on that day and all necessary spinal manipulation/adjustment procedures rendered.

D. "New patient" means a patient new to the chiropractor or a known patient with a new industrial injury or condition, whose medical and administrative record needs to be established.

E. "Established patient" means a patient whose medical and administrative records are available to the chiropractor.

Subp. 1b. Chiropractor instructions.

A. Use code 09542 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation on the same day.

Subp. 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Examinations - Includes History and Diagnosis, Office	
~~09509~~	~~Home or nursing home visit with routine chiropractic examination and/or treatment which includes adjustment, manipulation, and/or one unit of conjunctive therapy for the same or new condition~~	~~$ 50.00~~
09520-00	New patient; brief examination (CHIRO/DC)	$ 30.00
09521-00	intermediate examination (CHIRO/DC)	40.00
09522-00	extensive examination (CHIRO/DC)	~~65.00~~ 60.00
09530-00	Established patient: brief examination (CHIRO/DC)	25.00
09531-00	intermediate examination (CHIRO/DC)	~~36.00~~ 40.00
09532-00	extensive examination (CHIRO/DC)	~~65.00~~ 60.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office (CHIRO/DC)	$ 20.00
09541-00	~~Visit with manipulation/adjustment,~~ subsequent; office (CHIRO/DC)	22.00
09542-00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00

	Home/Nursing Home Visits	
09550-00	Chiropractic visit with manipulation/adjustment (CHIRO/DC)	40.00
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00
	Conjunctive Therapy/Modality - Office, Home, or Nursing Home	
09560-00	Application of hot pack (CHIRO/DC)	S 10.00
09561-00	Application of cold pack (CHIRO/DC)	~~10.00~~ 11.00
09562-00	Diathermy (CHIRO/DC)	~~20.00~~ 12.00
09563-00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic (CHIRO/DC)	12.00
09564-00	Intersegmental motorized mobilization (CHIRO/DC)	~~14.00~~ 12.00
09565-00	Muscle stimulation, manual (CHIRO/DC)	12.00
09566-00	Ultrasound therapy (CHIRO/DC)	~~12.00~~ 11.00
09567-00	Traction (CHIRO/DC)	~~13.00~~ 12.00
09568-00	Acupressure, manual or mechanical (CHIRO/DC)	~~10.00~~ 12.00
09569-00	Acupuncture (CHIRO/DC)	15.00
09570-00	Whirlpool	10.00
09572-00	Infrared - heat lamp (CHIRO/DC)	~~9.00~~ 7.00
09573-00	Ultraviolet (CHIRO/DC)	~~11.67~~ 10.00
09574-00	Trigger point therapy (CHIRO/DC)	~~12.00~~ 13.00
09591-00	Nutritional supplement	15.00
09592-00	Exercise consultation or instruction	25.00
09593-00	Diet consultation/instruction (CHIRO/DC)	25.00

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

Code	Service	Maximum Fee
	Chest	
71010CHR	Radiologic examination, chest; (single view, posteroanterior) (CHIRO/DC)	S 30.00
	Spine and Pelvis	
72010CHR	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral) (CHIRO/DC)	S 60.00

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* 72020CHR	Radiologic examination, spine; single view, (specify level) (CHIRO/DC)	~~10.00~~ 38.00
72040CHR	Radiologic examination, spine, cervical; limited (CHIRO/DC)	~~42.00~~ 44.00
~~72050~~	~~comprehensive (minimum four views)~~	~~80.00~~
72070CHR	Radiologic examination, spine; thoracic (CHIRO/DC)	~~50.00~~ 55.00
72080CHR	thoracic, limited (anteroposterior and lateral) (CHIRO/DC)	~~47.50~~ 52.00
72090CHR	scoliosis study, comprehensive (CHIRO/DC)	~~40.00~~ 52.00
72100CHR	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral) (CHIRO/DC)	~~51.00~~ 55.00
~~72114~~	~~Radiologic examination, spine, lumbosacral; complete, including bending views~~	~~170.00~~
72170CHR	Radiologic examination, pelvis; limited (minimum two views) (CHIRO/DC)	~~42.00~~ 44.00
~~72180~~	~~Radiologic examination, pelvis; stereo~~	~~35.00~~
72190CHR	complete; (minimum of three views (CHIRO/DC)	90.00
	Upper Extremities	
73020CHR	Radiologic examination, shoulder; limited (one projection) (CHIRO/DC)	S 30.00
73030-00	complete, minimum of two views	~~47.00~~ 54.00
73070CHR	Radiologic examination, elbow; limited (anteroposterior and lateral) (CHIRO/DC)	~~40.00~~ 35.00
73100CHR	Radiologic examination, wrist; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73110-00	complete, minimum of three views	50.00
73120CHR	Radiologic examination, hand (CHIRO/DC)	36.00
~~73140~~	~~Radiologic examination, finger or fingers, minimum of two views~~	~~30.00~~
	Lower Extremities	
73500CHR	Radiologic examination, hip; limited (one view) (CHIRO/DC)	S ~~30.00~~ 35.00
73510CHR	Radiologic examination, hip; complete, minimum of two views (CHIRO/DC)	53.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	40.00
73562CHR	anteroposterior and lateral, with oblique(s), minimum of three views (CHIRO/DC)	55.00

73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	70.00
73600CHR	Radiologic examination, ankle; limited (two views) (CHIRO/DC)	35.00
73610CHR	Radiologic examination, ankle; comprehensive (minimum of three views (CHIRO/DC)	50.00
73620-00	Radiologic examination; foot; anteroposterior and lateral views	32.00
	Miscellaneous	
76140-00	Consultation on x-ray examination made elsewhere, written report	25.00

Subp. 4. Laboratory. The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles include the following tests.

Code	Service	Maximum Fee
~~80016~~	~~Automated multichannel test; 13-16 clinical chemistry tests~~	~~$ 115.00~~
	Automated Multichannel Test	
80019CHR	Automated multichannel tests: 19 or more clinical chemistry tests (indicate instrument use and number of tests performed) (CHIRO/DC)	$ 60.00
	Urinalysis	
81000-00	Urinalysis: routine (pH, specific gravity, protein tests for reducing substances such as glucose), with microscopy	12.00
81002-00	routine, without microscopy	12.00
81015CHR	Urinalysis; microscopic only (CHIRO/DC)	12.00
	Hematology	
85022CHR	Blood count; hemogram, automated, and differential WBC count (CBC)	29.00
85031CHR	hemogram, manual, complete CBC (RBC, WBC, Hgb, HcT, differential and indices) (CHIRO/DC)	15.00
85548-00	Morphology of red blood cells, only	42.00
~~87164~~	~~Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection~~	~~35.00~~

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5221.3000 PODIATRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. **Ancillary services.** Services performed by podiatric assistants must be by order of and under the direct on-site supervision of a licensed doctor of podiatric medicine.

Subp. ~~2.~~ 3. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Surgery	
02229-00	.....	
10060-00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	200.00
10100*00	Incision and drainage of onychia or paronychia; single or simple (POD/DPM)	50.00
10101*00	multiple or complicated	~~$ 48.00~~ 55.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	75.00
11040-00	Debridement; skin, partial thickness	20.00
11050*00	Paring or curettement of benign lesion with or without chemical cauterization; single lesion (POD/DPM)	50.00
11051*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions	~~23.00~~ 25.00
11052-00	more than four lesions (POD/DPM)	21.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), hands, feet; lesion diameter up to 0.5 centimeter (POD/DPM)	~~25.45~~ 28.85
11421-00	lesion diameter 0.6 - 1.0 centimeters	85.00
11422-00	lesion diameter 1.1 - 2.0 centimeters	99.00
		125.00
	Nails	
11700*00	Debridement of nails, manual; five or less (POD/DPM)	
11701-00	each additional, five or less (POD/DPM)	$ ~~18.00~~ 20.00
11710*00	Debridement of nails, electric grinder; five or less (POD/DPM)	~~10.00~~ 15.00
11711-00	each additional, five or less (POD/DPM)	~~15.00~~ 26.00
11730*00	Avulsion of nail plate, partial or complete simple; single	9.00
11750-00	Excision of nail and nail matrix, partial or complete, for permanent removal (POD/DPM)	68.00
11900*00	Injection, intralesional; up to and including seven lesions	~~175.00~~ 200.00
		35.00

Other procedures

17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (POD/DPM)	~~35.00~~ 28.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions (POD/DPM)	~~24.00~~ 30.00
17340*00	Cryotherapy (CO2 slush, liquid N2)	22.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	42.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)	50.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)	45.00
28080-00	Excision of Morton neuroma, single, each	465.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe	325.00
28126-00	Concylectomy, phalangeal base, single toe, each	350.00
28153-00	Resection, head of phalanx, toe	375.00
28285	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	400.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)	593.00
28292-00	Keller, McBride, or Mayo type procedure	930.00
28308-00	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal	614.00
29405-00	Application of short leg cast (below knee to toes) (POD/DPM)	100.00
29425-00	Application of short leg case (below knee to toes); walking or ambulatory type	125.00
29540-00	Strapping; ankle (POD/DPM)	~~15.00~~ 22.00
29550-00	toes (POD/DPM)	~~18.00~~ 23.00

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29580-00	Unna boot (POD/DPM)	~~22.00~~ 35.00
29590-00	Dennis Browne splint strapping	25.00
36415*00	Routine venipuncture for collection of specimens	10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch (POD/DPM)	30.00
	Radiology	
73600-00	Radiologic examination, ankle; anteroposterior and lateral views (POD/DPM)	~~36.96~~ 40.00
73610-00	complete, minimum of three views	45.00
73620-00	Radiologic examination, foot; anteroposterior and lateral views (POD/DPM)	35.00
73630-00	complete, minimum of three views (POD/DPM)	~~50.00~~ 51.00
73650-00	Radiologic examination; calcaneus, minimum of two views	30.00
73660-00	toe or toes, minimum of two views (POD/DPM)	~~38.00~~ 30.00
80012-00	Automated multichannel test; 12 clinical chemistry tests	40.00
81000-00	Urinalysis; routine (pH, specify gravity, protein, tests for reducing substances such as glucose), with microscopy	11.00
81002-00	routine, without microscopy	13.00
82947-00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid) (POD/DPM)	13.00
82948-00	blood stick test	12.00
85000-00	Bleeding time; Duke	6.00
85014-00	Blood count; hematocrit	9.00
85018-00	Blood count; hemoglobin, colorimetric (POD/DPM)	~~6.50~~ 8.00
85022-00	hemogram, automated, and manual differential WBC count	40.00
85345-00	Coagulation time; Lee and White	7.50
87075-00	Culture, bacterial, any source; anaerobic (isolation)	14.00
87101-00	Culture, fungi, isolation; skin	18.00
88302-00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes	35.00
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	40.00

	Patient Visits	
90000POD	New patient; brief service (POD/DPM)	27.00
90010POD	~~New patient;~~ limited service (POD/DPM)	35.00
90015POD	~~New patient;~~ intermediate service (POD/DPM)	38.00
90017POD	extended service (POD/DPM)	45.00
90020POD	~~New patient;~~ comprehensive service (POD/DPM)	35.00
90030POD	Established patient: minimal service (POD/DPM)	~~16.00~~ 17.00
90040POD	~~Established patient;~~ brief service (POD/DPM)	22.00
90050POD	~~Established patient;~~ limited service (POD/DPM)	~~24.00~~ 25.00
90060POD	~~Established patient;~~ intermediate service (POD/DPM)	~~28.00~~ 29.00
90070POD	~~Established patient;~~ extended service (POD/DPM)	~~36.00~~ 27.00
90080POD	comprehensive service (POD/DPM)	40.00
	Hospital Medical Services	
90115-00	Home medical service, new patient: intermediate service	25.00
90140POD	Home medical service, established patient; brief service (POD/DPM)	15.00
90200POD	Initial hospital care: brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	S ~~65.00~~ 70.00
90215POD	Intermediate ~~examination~~ history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	40.00
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	35.00

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90350-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; limited service		
90360-00	intermediate service		15.00
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service		25.00
90410-00	limited service		16.00
90440-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient, brief service		15.00
90450-00	limited service		13.00
90600-00	Initial consultation; limited		12.00
90610-00	extensive		55.00
			35.00
	Therapeutic Injections		
90782POD	Therapeutic injection of medication (specify); subcutaneous or intramuscular (POD/DPM)		S 30.00
90784-00	intravenous		S ~~30.00~~ 20.00
90788POD	Intramuscular injection of antibiotic (specify) (POD/DPM)		20.00
			15.00
	Physical Medicine		
95851POD	Range of motion measurements and report (separate procedure); each extremity (POD/DPM)		
97022POD	whirlpool (POD/DPM)		S ~~37.50~~ 40.00
97128POD	ultrasound (POD/DPM)		~~17.44~~ 20.00
~~L1940~~	~~Ankle-foot orthoses, molded to patient model, plastic~~		~~14.00~~ 16.00
~~L3000~~	~~Foot, insert, removable, molded to patient model (UCB) type Berkeley Shell, each~~		~~79.00~~
L3010POD	Foot, insert, removable, molded to patient model, longitudinal arch support, each (POD/DPM)		~~82.50~~
			~~105.00~~ .....
	Other Procedures		
X1229POD	Radical excision of nail (POD/DPM)		
97700-00	Office visit, including one of the following tests or measurements, with report: a. Orthotic "check-out" b. Prosthetic "check-out" c. Activities of daily living "check-out"; initial 30 minutes, each visit		S ~~200.00~~ .....
99000-00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		25.00
			10.00

99025-00	Initial (new patient) visit when asterisked (*) surgical procedure constitutes major service at that visit	20.00

5221.3100 PSYCHOLOGISTS AND RULE 29 FACILITIES.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to licensed psychologists and ~~social workers with the master of social work degree or a comparable degree~~ Rule 29 facilities (mental health centers and clinics).

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

Code	Service	Maximum Fee
09046-00	Initial office visit with evaluation and history, one hour (PSYCH)	$ 80.00
09048-00	Initial inpatient hospital visit, including history and evaluation, per hour (POD/DPM)	90.00
09050-00	Initial consultation, one hour (POD/DPM)	85.00
09064-00	Biofeedback, per hour (PSYCH)	~~75.00~~ 80.00
09065-00	Biofeedback, per half hour (PSYCH)	~~45.00~~ 47.00
09066-00	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed ~~consulting~~ psychologist, one hour (PSYCH)	~~75.00~~ 80.00
09067-00	Psychotherapy, group (maximum ten persons per group), 1-1/2 hours per person (PSYCH)	40.00
09068-00	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour (PSYCH)	45.00
09070-00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge) (PSYCH)	~~70.00~~ 75.00

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

Code	Service	Maximum Fee
06042-00	Day treatment program (LCP)	$ 33.00
06043-00	Independent behavior and/or other analyst, counselors, and other therapists (LCP)	75.00

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

5221.3160 SOCIAL WORKERS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees of this part apply to social workers with a master of social work (MSW) degree or a comparable degree.

Subp. 2. Social worker services. The following codes, service descriptions, and maximum fees apply to social worker services performed by persons meeting the requirements of the board of social work.

Code	Service	Maximum Fee
06043-00	Independent behavior and/or other analysts, counselors, and other therapists (MSW)	$ 45.00
06046-00	Independent social worker services (MSW)	70.00

5221.3170 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider certified by the Biofeedback Certification Institute of America (BCIA). Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP).

Code	Service	Maximum Fee
90900-00	Biofeedback training; by electromyogram application (e.g., in tension headache muscle spasm) (BCIA/LCP)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow (BCIA/LCP)	45.00

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. [Unchanged.]

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

A. to P. [Unchanged.]

Q. ~~Mounds Park Hospital, Saint Paul~~

~~R.~~ Mount Sinai Hospital, Minneapolis

~~S.~~ R. North Memorial Medical Center, Robbinsdale

~~T.~~ S. Saint Cloud Hospital, Saint Cloud

~~U. Saint John's Hospital, Saint Paul~~

~~V.~~ T. St. John's Hospital Northeast, Saint Paul

~~W.~~ U. Saint Joseph's Hospital, Saint Paul

~~X.~~ V. Saint Luke's Hospital, Duluth

~~Y.~~ W. Saint Mary's Hospital, Duluth

~~Z.~~ X. Saint Mary's Hospital, Minneapolis

~~AA.~~ Y. The Samaritan Hospital, Saint Paul

~~BB.~~ Z. United Hospital, Saint Paul

~~CC.~~ AA. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	S ~~276.45~~ 293.10

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

A. to JJJJJJ. [Unchanged.]

Service	Maximum Fee
Group 2 semiprivate room charge for one day	S ~~202.57~~ 216.00

Subp. 4. **Group 3.** The following hospitals make up group 3:

A. Hennepin County Medical Center, Minneapolis

B. Saint Paul Ramsey Medical Center, Saint Paul

C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	S ~~332.56~~ 400.18

Subp. 5. **Group 4.** The following hospitals make up group 4:

A. Rochester Methodist Hospital, Rochester

B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	S ~~172.80~~ 180.80

5221.3310 EFFECTIVE DATE.

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

REPEALER. *Minnesota Rules*, parts 5221.0900 and 5221.1400, are repealed.

RENUMBER. *Minnesota Rules*, part 5221.1000, subpart 7, is renumbered as part 5221.0700, subpart 3, item C, subitems (1) to (20).

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	Female Reproductive System	
56420*00	Incision and drainage of Bartholin's gland abscess, unilateral	$ 104.00
56440-00	Marsupialization of Bartholin's gland cyst	347.00
56501-00	Destruction of lesion(s), vulva; simple, any method	40.00
56600*00	Biopsy of vulva (separate procedure)	77.00
57061-00	Destruction of vaginal lesion(s); simple, any method	48.00
57100*00	Biopsy of vaginal mucosa; simple, (separate procedure)	70.00
57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	18.00
57160*00	Insertion of pessary	25.00
57260-00	Combined anteroposterior colporrhaphy	1,030.00
57265-00	with enterocele repair	1,065.00
57452*00	Colposcopy (vaginoscopy); (separate procedure)	118.00
57454*00	with biopsies, or biopsy of the cervix	140.00
57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	72.00
57510-00	Cauterization of cervix; electro or thermal	72.00
57511*00	cryocautery, initial or repeat	81.00
57513-00	laser surgery	450.00
57520-00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair	466.00
57700-00	Cerclage of uterine cervix (tracheloplasty)	499.00
58100*00	Endometrial biopsy, suction type (separate procedure)	76.00
58102-00	Office endometrial curettage	103.00
58120-00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	320.00
58150-00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) (MD/DO)	~~1,199.25~~ 1,280.00
58152-00	with clopo-urethrocystopexy (Marshall-Marchetti-Krantz type)	1,875.00
58260-00	Vaginal hysterectomy (MD/DO)	~~1,116.00~~ 1,250.00
58265-00	with plastic repair of vagina, anterior and/or posterior colporrhaphy (MD/DO)	~~1,375.00~~ 1,450.00

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58340-00	Injection procedure for hysterosalpinography	85.30
58720-00	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (MD/DO)	~~860.00~~ 905.00
58925-00	Ovarian cystectomy, unilateral or bilateral	931.00
58940-00	Oophorectomy, partial or total, unilateral or bilateral	950.00
58980-00	Laparoscopy for visualization of pelvic viscera (MD/DO)	~~550.00~~ 585.00
58982-00	with fulguration of oviducts (with or without transection)	675.00
58983-00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	773.00
58984-00	with fulguration of ovarian or peritoneal lesions by any method	750.00
58985-00	with lysis of adhesions	686.00
58987-00	with aspiration (single or multiple)	926.00

Subp. 12. **Endocrine system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the endocrine (glandular) system.

Code	Service	Maximum Fee
60100-00	Biopsy thyroid, percutaneous needle	$ 123.50
60220-00	Total thyroid lobectomy, unilateral	1,100.00
60245-00	Thyroidectomy, subtotal or partial	1,223.00
60500-00	Parathyroidectomy or exploration of parathyroid(s)	1,602.00

Subp. ~~9.~~ 13. **Nervous system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the nervous system.

Code	Service	Maximum Fee
61310-00	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial (MD/DO)	$ 2,625.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,845.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,690.00
	Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic (MD/DO)	$ ~~90.00~~ 100.00
62273*00	Injection lumbar epidural, of blood or clot patch (MD/DO)	~~200.00~~ 240.00
62279*00	epidural or caudal, continuous	275.00
62284*00	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa (MD/DO)	135.20
62289*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal (MD/DO)	~~240.00~~ 256.00

~~62292~~	~~Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar~~	~~1,775.00~~

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

63005-00	Laminectomy for exploration/decompression of spinal cord and/or ~~cavda~~ cauda, equina, one or two segments; lumbar, except for spondylolisthesis (MD/DO)	~~$2,060.00~~ 2.420.00
63020-00	Laminotomy (hemilaminectomy), for ~~excision of herniated intervertebral disk, and/or~~ decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral (MD/DO)	~~2,025.00~~ 2,075.00
63030-00	~~Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root;~~ one interspace, lumbar, unilateral (MD/DO)	~~1,936.00~~ 2,005.00
63042-00	~~Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or~~ reexploration; lumbar (MD/DO)	~~2,150.00~~ 2,586.00

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

64405*00	Injection, anesthetic agent; greater occipital nerve	114.00
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	$ 130.00
64442-00	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level	120.00
64450*00	Injection, anesthetic agent; other peripheral nerve or branch (MD/DO)	~~110.00~~ 84.00
64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	255.00
64520*00	lumbar or thoracic (paravertebral sympathetic)	169.70

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64550-00	Application of surface (transcutaneous) neurostimulator (MD/DO)		45.00
64640-00	Destruction by neurolytic agent; other peripheral nerve or branch		324.00
64718-00	Neurolysis or transposition; ulnar nerve at elbow (MD/DO)	~~884.00~~	1,015.00
64721-00	median nerve at carpal tunnel (MD/DO)	~~645.00~~	728.00
~~64831~~	~~Suture of digital nerve, hand or foot; one nerve~~		~~450.00~~

~~Eye and Ocular Adnexa — Removal of Ocular Foreign Body~~

Subp. 14. **Eye and ocular adnexa.** The following codes, service descriptions and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

65205*00	Removal foreign body, external eye; conjunctival superficial (MD/DO)	S ~~40.80~~	45.00
65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating (MD/DO)		50.00
65220*00	corneal, without slit lamp (MD/DO)	~~50.00~~	52.00
65222*00	corneal, with slit lamp (MD/DO)	~~60.00~~	61.80
65420-00	Excision or transposition of pterygium: without graft (MD/DO)	~~437.50~~	545.00
65435*00	Removal of corneal epithelium; with or without chemo-cauterization (abrasion, curettage)		51.90
65855-00	Trabeculoplasty by laser surgery, (1 or more sessions) (defined treatment series)		693.00
66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)		650.00
66762-00	Coreoplasty by photocoagulation (1 or more sessions) (e.g., for improvement of vision)		600.00
66802-00	Discission of lens capsule; laser surgery (one or more stages)		600.00
66820-00	Discission of secondary membranous cataract (''after cataract''), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)		547.00
66821-00	laser surgery (one or more stages)		700.00
66940-00	Extraction of lens with or without iridectomy; extracapsular		1,682.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)		1,770.00
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) (MD/DO)	~~1,850.00~~	1,763.50
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)		1,287.50

67036-00	Vitrectomy, mechanical, pars plana approach	3,025.00
67105-00	Repair of retinal detachment, 1 or more sessions, same hospitalization; photocoagulation (laser or xenon arc, 1 or more sessions) with drainage of subretinal fluid	556.00
67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,080.00
67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	700.00
67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), 1 or more sessions; photocoagulation (laser or xenon arc)	975.00
~~67226~~	~~Destruction of progressive retinopathy, one or more stages; photocoagulation, laser~~	~~650.00~~
67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), 1 or more sessions; cryotherapy, diathermy	818.00
67228-00	photocoagulation (laser or xenon arc)	778.00
67311-00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); 1 muscle	900.00
67312-00	2 muscles, 1 or both eyes	968.00
67515*00	Injection of therapeutic agent into Tenon's capsule	49.00
67700*00	Blepharotomy, drainage of abscess, eyelid	57.00
67800-00	Excision of chalazion; single	75.00
67801-00	multiple, same lid	110.00
67805-00	multiple, different lids	135.00
67810*00	Biopsy of eyelid	106.00
67820*00	Correction of trichiasis; epilation, by forceps only	31.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	87.00
67921-00	Repair of entropion; suture	700.00
67938-00	Removal of embedded foreign body; eyelid	40.00

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68200*00	Subconjunctival injection	48.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral (MD/DO)	~~35.00~~ 37.00
68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring ~~hospitalization~~ general anesthesia	~~237.00~~ 260.00

~~Auditory System~~

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

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 55.00
69200-00	Removal foreign body from external auditory canal; without general anesthesia	27.24
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	20.75
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	38.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	84.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral (MD/DO)	$ ~~152.50~~ 150.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	240.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral (MD/DO)	~~210.00~~ 252.00
69437-00	bilateral (MD/DO)	350.00
69440-00	Middle ear exploration through postauricular or ear canal incision (MD/DO)	~~785.00~~ 897.00
69610-00	Tympanic membrane repair, with or without site preparation or perforation preparation for closure without patch	90.00
69620-00	Myringoplasty (MD/DO)	~~1,186.00~~ 1,305.00
69631-00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction (MD/DO)	~~1,785.75~~ 1,950.00
69632-00	with ossicular chain reconstruction (for example, postfenestration) (MD/DO)	~~2,006.00~~ 2,115.00
69641-00	Tympanoplasty with ~~antrotomy or~~ mastoidotomy; without ossicular chain reconstruction (MD/DO)	2,100.00

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 1. **General.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine ~~or~~, a doctor of osteopathy, or a technician under the supervision of a doctor of medicine or 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.~~

A. Single charge including both professional and technical component. The maximum fee represents the appropriate charges for professional services plus expenses of nonradiologist personnel, materials, facilities, and space used and for diagnostic or therapeutic services rendered, but excludes the cost of radio-isotopes. This value is applicable in any situation in which a single charge is made to include both professional services and the cost involved in providing that service.

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

When the physician component is billed separately, the procedure may be identified by adding the modifier "-26" to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 40 percent of the fee maximum.

(2) Technical component: certain procedures (e.g., laboratory, radiology, electrocardiogram, specific diagnostic, and therapeutic services) are a combination of a physician component and a technical component. When the technical component is billed separately, the procedure may be identified by adding the modifier "T.C." to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 60 percent of the fee maximum.

Subp. 2. **Diagnostic radiology.** The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Head and Neck

Code	Service		Maximum Fee
~~70050~~	~~Radiologic examination, eye; for detection and localization of foreign body~~		$ ~~22.40~~
70100-00	Radiologic examination, mandible; partial, less than four views (MD/DO)		~~45.00~~ 47.25
~~70100-26~~	~~professional component only~~		~~20.75~~
~~70110-26~~	~~professional component only~~		~~21.20~~
70120-00	Radiologic examination, mastoids; less than three views per side (MD/DO)	~~53.00~~	72.00
70130-00	~~Radiologic examination, mastoids;~~ complete, minimum of three views per side (MD/DO)		~~87.00~~ 90.00
~~70134~~	~~Radiologic examination, internal auditory meati, complete~~		~~78.00~~
70140-00	Radiologic examination, facial bones; less than three views (MD/DO)		~~56.91~~ 41.70
~~70140-26~~	~~professional component only~~		~~18.88~~
70150-~~26~~00	~~professional component only~~ complete, minimum of three views (MD/DO)		~~24.50~~ 55.00

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70160-00	Radiologic examination, nasal bones; complete, minimum of three views (MD/DO)	~~48.38~~ 47.00
~~70160-26~~	~~professional component only~~	~~15.00~~
70200-~~26~~00	~~professional component only~~	~~23.20~~
	Radiologic examination; orbits, complete, minimum of four views (MD/DO)	46.30
~~70210~~	Radiologic examination, sinuses, paranasal, less than three views (MD/DO)	~~35.00~~ 37.00
~~70210-26~~	~~professional component only~~	~~16.00~~
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views~~; without contrast studies~~ (MD/DO)	~~66.00~~ 69.50
~~70220-26~~	~~Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies; professional component only~~	~~23.25~~
70240-00	Radiologic examination, sella turcia (MD/DO)	48.25
~~70260-26~~		
70250-00	Radiologic examination, skull, less than four views, with or without stereo~~,~~ (MD/DO)	48.00
70260-00	complete, minimum of four views~~;~~, with or without stereo (MD/DO)	74.00
	~~professional component only~~	~~33.00~~
~~70260-TC~~	~~technical component only~~	~~57.50~~
~~70320~~	~~Radiologic examination, teeth; complete, full mouth~~	~~51.00~~
~~70328~~	~~Radiologic examination, temporomandibular joint, open and closed mouth; unilateral~~	~~67.50~~
70300-00	Radiologic examination, teeth; single view	14.20
70310-00	partial examination, less than full mouth	18.90
70320-00	complete, full mouth	55.00
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	81.00
70332-00	Temporomandibular joint arthrography; supervision and interpretation only	250.00
70333-00	complete procedure	180.00
70355-~~26~~00	Orthopantogram~~; professional component only~~	~~19.00~~ 35.00
70360-00	Radiologic examination, neck, soft tissue (MD/DO)	~~28.00~~ 33.75
~~70360-26~~	~~professional component only~~	~~13.50~~
~~70450-26~~	~~professional component only~~	~~77.00~~
~~70460-26~~	~~professional component only~~	~~86.25~~
~~70470-26~~	~~professional component only~~	~~105.50~~
70380-00	Radiologic examination, salivary gland for calculus	48.50
70390-00	Sialography; supervision and interpretation only	99.00

• 70450-00	Computerized axial tomography, head or brain (MD/DO)	120.90
70480-00	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	150.00
70481-00	with contrast material	139.00
70486-00	Computerized axial tomography, maxillofacial area; without contrast material	91.40
70491-00	Computerized axial tomography, soft tissue neck; with contrast material(s)	132.00
70540-00	Magnetic resonance (e.g., proton) imaging; orbit, face, and neck	600.00
	Chest	
71010-00	Radiologic examination, chest; single view, ~~posteroanterior~~ frontal (MD/DO)	~~$ 31.50~~ $34.00
~~71010-26~~	~~professional component only~~	~~13.50~~
~~71010-TC~~	~~technical component only~~	~~30.00~~
71015-00	stereo, posteroanterior (MD/DO)	~~33.30~~ 35.00
71020-00	Radiologic examination, chest, two views, ~~posteroanterior~~ frontal and lateral(MD/DO)	~~45.00~~ 47.25
~~71020-TC~~	~~technical component only~~	~~38.25~~
~~71020-26~~	~~professional component only~~	~~18.75~~
71021-00	~~Radiological examination, frontal and lateral;~~ with apical lordotic procedure (MD/DO)	~~41.50~~ 44.00
71022-00	~~Radiologic examination, chest:~~ with oblique projections (MD/DO)	~~21.00~~ 22.50
~~71022-26~~	~~professional component only~~	~~21.00~~
~~71030-26~~	~~professional component only~~	~~27.38~~
71030-00	Radiological examination, chest, complete, minimum of four views (MD DO)	45.00
71034-00	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy	56.00
71035-00	Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies	23.50
71100-~~26~~00	Radiologic examination, ribs, unilateral; two views; ~~professional component only~~ (MD/DO)	~~19.50~~ 53.00
~~71100-TC~~	~~technical component only~~	~~40.00~~
71101-00	Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views	60.00

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71110-00	Radiologic examination, ribs, bilateral; three views (MD/DO)	60.00 62.00
71110-26	professional component only	28.13
71111-00	Radiologic examination, ribs, bilateral; including postero-anterior chest, minimum of four views	73.00
71120-00	Radiologic examination; sternum, minimum of two views (MD/DO)	38.00
71120-26	professional component only	17.70
71130-00	Radiologic examination; sternoclavicular joint or joints, minimum of three views	60.00
71250-26	Computerized axial tomography, thorax; without contrast material; professional component only	126.00
71260-2600	professional component only	105.50
	with contrast material	142.20
	Spine and Pelvis	
72010-2600	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral; professional component only (MD/DO)	$ 42.25 $ 86.00
72020-2600	Radiologic examination, spine, single view, specify level; professional component only (MD/DO)	15.00 37.00
72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral (MD/DO)	47.00 50.50
72040-26	professional component only	20.00
72050-00	minimum of four views (MD/DO)	75.00 80.40
72050-26	professional component only	27.00
72050-TC	technical component only	55.50
72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	89.00
72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral (MD/DO)	53.00 57.50
72070-26	professional component only	22.00
72070-TC	technical component only	47.00
72072-2600	professional component only	22.10
	Thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction (MD/DO)	58.50
72074-00	Radiologic examination, spine; thoracic, complete, including obliques, minimum of four views	65.00
72080-00	thoracolumbar, anteroposterior and lateral (MD/DO)	62.00 58.00
72090-00	scoliosis study, including supine and erect studies (MD/DO)	50.00 50.75

72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral (MD/DO)	
~~72100-26~~	~~professional component only~~	~~57.95~~ 62.00
~~72110~~	~~complete, with oblique views~~	~~24.50~~
~~72110-26~~	~~professional component only~~	~~80.00~~
~~72110-TC~~	~~technical component only~~	~~30.00~~
72114-00	complete, including bending views (MD/DO)	~~62.00~~
72120-00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	95.00
~~72125-26~~	~~Computerized axial tomography, cervical spine; without contrast material; professional component only~~	61.20
72126-~~26~~00	~~professional component only~~	~~114.00~~
	Computerized axial tomography, cervical spine; with contrast material (MD/DO)	~~135.00~~
~~72128-26~~	~~Computerized axial tomography, thoracic spine; without contrast material; professional component only~~	174.40
~~72129~~	~~Computerized axial tomography, thoracic spine; with contrast material~~	~~111.75~~
~~72131~~	~~Computerized axial tomography, lumbar spine; without contrast material~~	~~120.00~~
~~72131-26~~	~~professional component only~~	~~465.00~~
~~72132-26~~	~~professional component only~~	~~100.00~~
72132-00	with contrast material (MD/DO)	~~104.00~~
72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents	163.00
72170-~~26~~00	Radiologic examination, pelvis anteroposterior only; ~~professional component only~~ (MD/DO)	790.00
72180-00	stereo (MD/DO)	~~16.00~~ 41.00
~~72180-26~~	~~professional component only~~	42.00
72190-00	complete, minimum of three views (MD/DO)	~~22.25~~
~~72190-26~~	~~professional component only~~	~~61.00~~ 65.00
72192-~~26~~00	Computerized axial tomography, pelvis; without contrast material; ~~professional component only~~ (MD/DO)	~~21.50~~
72193-~~26~~00	with contrast material(s); ~~professional component only~~ (MD/DO)	~~114.00~~ 212.50
72200-00	Radiologic examination, sacroiliac joints; less than three views (MD/DO)	~~97.00~~ 106.00
		~~45.00~~ 52.40

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72202-00	three or more views (MD/DO)	~~49.00~~ 58.75
~~72202-26~~	~~professional component only~~	~~19.90~~
72220-00	Radiologic examination, sacrum and coccyx, minimum of two views (MD/DO)	~~48.00~~ 50.00
~~72220-26~~	~~professional component only~~	~~17.70~~
72240-00	Myelography, cervical; supervision and interpretation only	213.90
72241-~~26~~00	Myelography, cervical, complete procedure~~; professional component only~~ (MD/DO)	~~245.06~~ 590.00
~~72265-26~~	~~Myelography, lumbosacral; supervision and interpretation only; professional component only~~	~~67.00~~
72266-~~26~~00	complete procedure~~; professional component only~~ (MD/DO)	~~198.69~~ 216.00
72270-00	Myelography, entire spinal canal; supervision and interpretation only (MD/DO)	~~194.40~~ 205.44
72271-00	complete procedure (MD/DO)	~~305.00~~ 340.30
~~72271-26~~	~~professional component only~~	~~303.50~~
	Upper Extremities	
73000-00	Radiologic examination; clavicle, complete (MD/DO)	S ~~33.00~~ 37.50
~~73000-26~~	~~professional component only~~	~~12.75~~
~~73000-TC~~	~~technical component only~~	~~42.00~~
73010-00	scapula, complete (MD/DO)	42.75
~~73010-26~~	~~professional component only~~	~~15.00~~
73020-00	Radiologic examination, shoulder; one view (MD/DO)	~~35.00~~ 37.00
~~73020-26~~	~~professional component only~~	~~13.25~~
73030-00	complete, minimum of two views (MD/DO)	48.00
~~73030-26~~	~~professional component only~~	~~15.00~~
~~73040-26~~	~~Radiologic examination, shoulder, arthrography; supervision and interpretation only; professional component only~~	~~14.00~~
73041-~~26~~00	complete procedure~~; professional component only~~ (MD/DO)	~~167.00~~ 154.00
73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (MD/DO)	~~48.50~~ 54.00
~~73050-26~~	~~professional component only~~	~~15.88~~
73060-00	humerus, minimum of two views (MD/DO)	~~39.00~~ 42.75
~~73060-26~~	~~professional component only~~	~~14.00~~
73070-00	Radiologic examination, elbow; anteroposterior and lateral views (MD/DO)	~~38.00~~ 41.00
~~73070-26~~	~~professional component only~~	~~13.50~~

~~73070-TC~~	~~technical component only~~	~~34.00~~
73080-00	complete, minimum of three views (MD/DO)	~~39.00~~ 44.00
~~73080-26~~	~~professional component only~~	~~15.75~~
~~73080-TC~~	~~technical component only~~	~~36.00~~
73090-00	Radiologic examination; forearm, anteroposterior and lateral views (MD/DO)	~~37.00~~ 41.00
~~73090-26~~	~~professional component only~~	~~14.00~~
~~73090-TC~~	~~technical component only~~	~~34.00~~
73100-00	Radiologic examination, wrist; anteroposterior and lateral views (MD/DO)	~~37.00~~ 40.00
~~73100-26~~	~~professional component only~~	~~13.50~~
~~73100-TC~~	~~technical component only~~	~~34.00~~
73110-00	complete, minimum of three views (MD/DO)	~~41.00~~ 44.00
~~73110-26~~	~~professional component only~~	~~15.75~~
~~73110-TC~~	~~technical component only~~	~~42.50~~
73115-00	Radiologic examination, wrist, arthography; supervision and interpretation only	49.00
73120-00	Radiologic examination, hand; two views (MD/DO)	~~36.50~~ 40.00
~~73120-26~~	~~professional component only~~	~~13.25~~
~~73120-TC~~	~~technical component only~~	~~23.75~~
73130-00	minimum of three views (MD/DO)	~~40.50~~ 44.24
~~73130-26~~	~~professional component only~~	~~14.00~~
~~73130-TC~~	~~technical component only~~	~~41.50~~
73140-00	Radiologic examination, finger or fingers, minimum of two views (MD/DO)	~~32.00~~ 35.00
~~73140-26~~	~~professional component only~~	~~12.00~~
~~73140-TC~~	~~technical component only~~	~~30.00~~
73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity	700.00
	Lower Extremities	
73500-00	Radiologic examination, hip; unilateral, one view (MD/DO)	S ~~36.56~~ 34.00
~~73500-26~~	~~professional component only~~	~~14.10~~
73510-00	complete, minimum of two views (MD/DO)	~~48.00~~ 51.00
~~73510-26~~	~~professional component only~~	~~20.00~~
~~73510-TC~~	~~technical component only~~	~~41.00~~
73520-00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis (MD/DO)	~~56.00~~ 50.00

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~~73520-26~~	~~professional component only~~		~~24.21~~
73530-~~26~~00	Radiologic examination, hip, during operative procedure; ~~professional component only~~ (MD/DO)	~~28.50~~	26.30
~~73540~~	~~Radiologic examination, pelvis and hips, infant or child, minimum of two views~~		~~48.00~~
~~73550~~	~~Radiologic examination, femur, anteroposterior, and lateral views~~		~~42.00~~
~~73550-26~~	~~professional component only~~		~~14.50~~
73560-00	Radiologic examination, knee; anteroposterior and lateral views (MD/DO)	~~40.00~~	42.00
~~73560-26~~	~~professional component only~~		~~14.00~~
~~73560-TC~~	~~technical component only~~		~~33.00~~
73562-00	anteroposterior and lateral, with oblique, minimum of three views (MD/DO)	~~50.00~~	54.00
~~73562-26~~	~~professional component only~~		~~14.50~~
~~73562-TC~~	~~technical component only~~		~~39.00~~
~~73564~~	~~complete, including oblique, or tunnel, or patellar, or standing views~~		~~55.75~~
~~73564-26~~	~~professional component only~~		~~18.00~~
~~73564-TC~~	~~technical component only~~		~~65.00~~
73580-00	Radiologic examination, knee, arthography; supervision and interpretation only (MD/DO)	~~120.00~~	130.00
73581-~~26~~00	~~Radiologic examination, knee, arthography;~~ complete procedure; ~~professional component only~~ (MD/DO)	~~144.50~~	154.00
73590-00	Radiologic examination, tibia and fibula, anteroposterior and lateral views (MD/DO)	~~40.00~~	43.70
~~73590-26~~	~~professional component only~~		~~14.00~~
~~73590-TC~~	~~technical component only~~		~~36.50~~
73600-00	Radiologic examination, ankle; anteroposterior and lateral views (MD/DO)	~~35.20~~	38.00
~~73600-26~~	~~professional component only~~		~~13.50~~
~~73600-TC~~	~~technical component only~~		~~30.10~~
73610-00	complete, minimum of three views (MD/DO)	~~41.00~~	45.60
~~73610-26~~	~~professional component only~~		~~15.00~~
~~73610-TC~~	~~technical component only~~		~~40.00~~
73620-00	Radiologic examination, foot; anteroposterior and lateral views (MD/DO)	~~35.00~~	39.00
~~73620-26~~	~~professional component only~~		~~14.00~~
~~73620-TC~~	~~technical component only~~		~~28.70~~
73630-00	complete, minimum of three views (MD/DO)	~~43.00~~	45.00
~~73630-26~~	~~professional component only~~		~~14.25~~

~~73630-TC~~	~~technical component only~~	
73650-00	Radiologic examination; calcaneus, minimum of two views (MD/DO)	~~41.00~~
~~73650-26~~	~~professional component only~~	~~36.00~~ 38.00
73660-00	toe or toes, minimum of two views (MD/DO)	~~13.00~~
~~73660-26~~	~~professional component only~~	~~32.00~~ 35.00
~~73660-TC~~	~~technical component only~~	~~11.70~~
73700-00	Computerized axial tomography, lower extremity; without contrast material	~~30.00~~
73720-00	Magnetic resonance (e.g., proton) imaging, lower extremity	130.00
	Abdomen	665.00
74000-2600	Radiologic examination, abdomen, single anteroposterior view; ~~professional component only~~ (MD/DO)	
~~74000-TC~~	~~technical component only~~	S ~~16.00~~ 37.00
74010-2600	anteroposterior and additional oblique and cone views; ~~professional component only~~ (MD/DO)	~~32.00~~
74020-2600	complete, including decubitus or erect views; ~~professional component only~~ (MD/DO)	~~20.25~~ 40.00
74022-00	Complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest (MD/DO)	~~22.50~~ 41.00
~~74022-26~~	~~professional component only~~	~~32.00~~ 34.00
74150-2600	Computerized axial tomography, abdomen; without contrast material; ~~professional component only~~ (MD/DO)	~~32.00~~
74160-2600	with contrast materials; ~~professional component only~~ (MD/DO)	~~108.50~~ 212.50
~~74170-26~~	~~without contrast material followed by contrast material and further sections; professional component only~~	~~114.00~~ 129.50
	Gastrointestinal Tract	~~136.00~~
74220-2600	Radiologic examination; esophagus; ~~professional component only~~ (MD/DO)	
74230-00	Swallowing function, paraynx and/or esophagus, with cineradiography and/or video	S ~~49.50~~ 78.00
74240-00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB (MD/DO)	56.00
		~~90.00~~ 103.00

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~~74240-26~~	~~professional component only~~	~~52.00~~
74241-00	with or without delayed films, with KUB (MD/DO)	~~58.00~~ 68.40
~~74241-26~~	~~professional component only~~	~~46.50~~
~~74241-TC~~	~~technical component only~~	~~58.00~~
74245-~~26~~00	with small bowel, includes multiple serial films; ~~professional component only~~ (MD/DO)	~~73.75~~ 142.50
74246-00	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without delayed films; without KUB	103.00
74247-00	with or without delayed films, with KUB (MD/DO)	~~57.00~~ 125.00
74250-~~26~~00	Radiologic examination, small bowel, includes multiple serial films; ~~professional component only~~ (MD/DO)	~~48.00~~ 97.50
74270-00	Radiologic examination, colon; barium enema (MD/DO)	~~90.00~~ 101.00
~~74270-26~~	~~professional component only~~	~~52.00~~
~~74270-TC~~	~~technical component only~~	~~72.00~~
74280-~~26~~00	air contrast with specific high density barium, with or without glucagon; ~~professional component only~~ (MD/DO)	~~69.00~~ 152.00
74290-00	Cholecystography, oral contrast (MD/DO)	~~64.00~~ 73.00
~~74290-26~~	~~professional component only~~	~~24.75~~
~~74290-TC~~	~~technical component only~~	~~57.00~~
74300-~~26~~00	Cholangiography and/or pancreatography: during surgery~~; professional component only~~ (MD/DO)	~~39.00~~ 41.50
74305-00	Cholangiography and/or pancreatography: postoperative	59.50
74328-00	Endoscopic catheterization of the biliary ductal system, fluoroscopic monitoring and radiography	43.75
74329-00	Endoscopic catheterization of the pancreatic ductal system, fluoroscopic monitoring and radiography	53.00
74330-00	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography (MD/DO)	~~59.00~~ 62.00
~~74330-26~~	~~professional component only~~	~~53.00~~
74340-00	Introduction of long gastrointestinal tube (e.g., Miller-Abbott) with multiple fluoroscopies and films	49.25
	Urinary Tract	
74400-~~26~~00	Urography, (pyelography) intravenous, with or without KUB (MD/DO)	

	~~including kidneys, ureters, and bladder; professional component only~~	
74405-~~26~~00	~~Urography (pyelography), intravenous, including kidneys, ureters, and bladder~~ with special hypertensive contrast concentration and/or or clearance studies; ~~professional component only~~ (MD/DO)	$ ~~52.50~~ 112.00
74410-~~26~~00	Urography, infusion, drip technique; ~~professional component only~~ (MD/DO)	~~48.00~~ 161.70
74415-00	Urography, infusion, drip technique and/or bolus technique; with nephrotomography	~~39.13~~ 90.00
74420-~~26~~00	Urography, retrograde, with or without kidneys, ureters, and bladder; ~~professional component only~~ (MD/DO)	161.70
74425-~~26~~00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); supervision and interpretation only (MD/DO) ~~professional component only~~	~~23.63~~ 55.00
74426-00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); complete procedure	~~43.00~~ 43.75
74430-~~26~~00	Cystography, minimum of three views; supervision and interpretation only; ~~professional component only~~ (MD/DO)	145.60
74431-00	Cystography, minimum of three views; complete procedure	~~27.00~~ 46.00
74451-00	Urethrocystography, retrograde; complete procedure	91.00
74455-~~26~~00	Urethrocystography, voiding; supervision and interpretation only (MD/DO) ~~professional component only~~	97.40
74456-~~26~~00	complete procedure (MD/DO) ~~professional component only~~	~~37.50~~ 69.50
74475-00	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, with fluoroscopic monitoring and radiography; supervision and interpretation only	~~56.25~~ 87.50
	Gynecological and Obstetrical	155.00
74710-00	Pelvimetry, with or without placental localization	
74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	$ 83.10
		42.00

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74740-00	Hysterosalpingography; supervision and interpretation only	
74741-00	complete procedure	101.00 137.20
	Vascular System	
75550-00	Angiocardiography by cineradiography; supervision and interpretation only	$144.50
75605-00	Aortography, thoracic, by serialography; supervision and interpretation only	106.00
75627-00	Aortography, abdominal catheter, by serialography; supervision and interpretation only	84.50
75628-2600	Aortography, abdominal, catheter by serialography; ~~professional component only~~ (MD/DO)	~~361.31~~ 288.00
75630-00	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; supervision and interpretation only	168.00
75631-2600	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; ~~professional component only~~ (MD/DO)	~~416.00~~ 436.25
75650-00	Angiography, cervicocerebral, catheter, including vessel origin; supervision and interpretation only	284.50
75655-2600	Angiography, cerviocerebral, selective catheter, including vessel origin; two vessels, complete procedure; ~~professional component only~~ (MD/DO)	~~474.50~~ 503.00
75656-00	Angiography, cervicocerebral, selective catheter, including vessel origin, three or four vessels, supervision and interpretation only	250.00
75657-2600	three or four vessels, complete procedure; ~~professional component only~~ (MD/DO)	~~551.25~~ 603.80
75671-00	Angiography, carotid, cerebral, bilateral; supervision and interpretation only	238.00
75673-00	Angiography, carotid cerebral, bilateral; catheter, complete procedure (MD/DO)	498.00
75710-00	Angiography, extremity, unilateral, supervision and interpretation only	77.50
75712-2600	Angiography, extremity, unilateral; by serialography, complete procedure; ~~professional component only~~ (MD/DO)	~~229.00~~ 334.80
75716-00	Angiography, extremity, bilateral; supervision and intrepretation only	95.50
75718-00	by serialography, complete procedure	267.00

43262-00	for sphincterotomy/papillotomy	1,023.00
43450*00	Dilation esophagus, by unguided sounds(s) or bougie(s), single or multiple passes; ~~indirect;~~ initial session	84.00
43451*00	subsequent session	~~64.00~~ 70.00
43520-00	Pyloromyotomy, cutting of pyloric muscle (Fredet-Tamstedt type operation)	965.00
43635-00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type	1,750.00

Stomach

Code	Service	Maximum Fee
43760*00	Change of gastrostomy tube; ~~simple~~ (MD/DO)	S ~~47.50~~ 50.00
43830-00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure); ~~neonatal, for feeding~~ (MD/DO)	~~632.00~~ 700.00
43846-00	Gastric bypass with Roux-en-Y gastroenterostomy for morbid obesity (MD/DO)	~~2,625.00~~ 2,593.00

Intestines

Code	Service	Maximum Fee
~~44000~~	~~Enterolysis, freeing of intestinal adhesion~~	~~$ 840.00~~
44005-00	Enterolysis (freeing of intestinal adhesion) ~~with~~ for acute bowel obstruction	~~1,094.25~~ 1,056.00
44100-00	Biopsy of intestine by capsule, tube, peroral (1 or more specimens)	208.00
44120-00	Enterectomy, resection of small intestine; with anastomosis	1,480.00
44140-00	Colectomy, partial; with anastomosis (MD/DO)	~~1,401.25~~ 1,550.00
44143-00	with end colostomy and closure of distal segment (Hartmann type procedure	1,544.00
44145-00	with coloproctostomy (low pelvic anastomosis)	1,901.00
44160-00	Colectomy with removal of terminal ileum and ileocolostomy	1,992.00
44950-00	Appendectomy (MD/DO)	~~700.00~~ 741.00
44960-00	for ruptured appendix with abscesses or generalized peritonitis (MD/DO)	~~850.00~~ 890.00

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45110-00	Proctectomy; complete, combined abdominoperineal, with colostomy, 1 or 2 stages	
45300-00	Proctosigmoidoscopy; diagnostic (MD/DO)	2,179.40
45305-00	for biopsy	~~63.00~~ 60.00
45310-00	Proctosigmoidoscopy; for removal of polyp or papilloma	100.00
45315-00	for removal of multiple excrescences, papillomata or polyps	130.00
45330-00	Sigmoidoscopy, flexible fiberoptic; diagnostic (MD/DO)	150.00
45331-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	~~100.00~~ 103.00
45333-00	Sigmoidoscopy, flexible fiberoptic; for removal of polypoid lesions(s)	~~147.00~~ 159.00
45355-00	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple	193.50
45378-00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure (MD/DO)	120.00
45380-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	~~475.00~~ 500.00
45383-00	Colonoscopy, fiberoptic, beyond splenic flexure; for ablation of tumor or musocal lesion (e.g., electrocoagulation, laser photocoagulation, hop biopsy/fulguration)	~~555.00~~ 601.00
45385-00	for removal of polypoid lesion(s) (MD/DO)	572.00
45505-00	Proctoplasty; for prolapse of mucous membrane (MD/DO)	~~620.00~~ 657.00
46040-00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	~~770.00~~ 750.00
46050*00	Incision and drainage, perianal abscess, superficial	280.00
46083-00	Incision of thrombosed hemorrhoid, external	105.00
46220-00	Papillectomy or excision of single tag, anus (separate procedure)	66.00
46221-00	Hemorrhoidectomy, by simple ligature (e.g. rubber band)	90.00
46230-00	Excision of external hemorrhoid tags and/or multiple papillae	97.00
46255-00	Hemorrhoidectomy, internal and external, simple (MD/DO)	96.00
46260-00	Hemorrhoidectomy, internal and external, complex or extensive	~~625.00~~ 609.50
46275-00	Fistulectomy; submuscular (MD/DO)	700.00 760.00

46320*~~0~~0	Enucleation or excision of external thrombotic hemorrhoid	~~70.43~~ 81.00
46500*00	Injection of sclerosing solution, hemorrhoids	55.00
46600-00	Anoscopy; diagnostic (separate procedure)	29.00
46910*00	Destruction of lesion(s), anus (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	85.00
46945-00	Ligation of internal hemorrhoids; single procedure	91.00
46946-00	multiple procedures	73.00

~~Liver~~

Code	Service	Maximum Fee
47000*00	Biopsy of Liver; percutaneous needle (MD/DO)	182.00
47600-00	Cholecystectomy	$ ~~1,071.75~~ 1,185.00
47605-00	with cholangiography (MD/DO)	~~1,250.00~~ 1,296.00
47610-00	Cholecystectomy with exploration of common duct (MD/DO)	~~1,330.00~~ 1,400.00
49000-00	Exploratory laparotomy, exploratory celiotomy (MD/DO)	~~719.75~~ 790.00
49080*00	Peritoneocentesis, abdominal paracentesis; initial	100.00
~~49420*~~	~~Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary~~	~~250.00~~
~~49500~~	~~Repair inguinal hernia, under age 5 years, with or without hydrocelectomy~~	~~608.00~~
49505-00	Repair inguinal hernia, age 5 or over~~;~~ ~~unilateral~~ (MD/DO)	~~695.00~~ 728.00
~~49515~~	~~with excision of hydrocele or spermatocele~~	~~900.00~~
49520-00	Repair inguinal hernia; recurrent (MD/DO)	~~805.00~~ 895.00
49525-00	sliding	920.50
49530-00	incarcerated	~~900.00~~ 870.00
49550-00	Repair femoral hernial groin incision (MD/DO)	~~672.00~~ 700.00
49560-00	Repair ventral (incisional) hernia (separate procedure) (MD/DO)	~~780.00~~ 805.00
49565-00	Repair ventral (incisional) hernia (separate procedure); recurrent (MD/DO)	~~931.00~~ 1,020.00
49580-00	Repair umbilical hernia; under age 5 years	510.00
49581-00	Repair umbilical hernia; age 5 or over	~~595.00~~ 640.00

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Subp. 10. **Urinary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the urinary system.

Kidney

Code	Service	Maximum Fee
50200*00	Renal biopsy, percutaneous trocar or needle (MD/DO)	$ ~~350.00~~ 353.50
50230-00	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy	1,821.00
50360-00	Renal homotransplantation, implantation of graft; excluding donor and recipient nephrectomy	3,094.00
50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	50.00
50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure	30.50
51600*00	Injection procedure for cystography or voiding urethrocystography (MD/DO)	~~17.00~~ 18.56
51605-00	Injection procedure and placement of chain for contrast and/or chain urethrocystrography	49.51
51610-00	Injection procedure for retrograde urethrocystography	29.00
51700*00	Bladder irrigation, simple, lavage and/or instillation	34.00
51705*00	Change of cystostomy tube; simple (MD/DO)	~~39.00~~ 39.40
51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	81.20
~~51725~~	~~Simple cystometrogram (CMG) (for example, spinal manometer)~~	~~70.00~~
51726-00	Complex cystometrogram (for example, calibrated electronic equipment) (MD/DO)	~~75.00~~ 104.00
~~51736~~	~~Simple uroflowmetry~~	~~70.00~~
51741-00	Complex uroflowmetry	60.00
51840-00	Anterior vesicourethropexy, or urethropexy; simple	~~1,098.00~~ 1,113.00
51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,250.00
51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,400.00
52000-00	Cystourethroscopy~~, office~~ (separate procedure) (MD/DO)	~~140.00~~ 131.00

~~52204.~~	~~Cystourethroscopy with biopsy; office~~	~~163.63~~
52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	250.00
52204-00	Cystourethroscopy with biopsy	186.00
52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands)	297.00
52224-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	290.00
52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of: SMALL bladder tumor(s) (0.5 to 2.0 cm)	530.00
52235-00	MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	820.00
52240-00	LARGE bladder tumor(s)	1,200.00
52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	216.00
52281-00	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office (MD/DO)	~~230.00~~ 227.00
52310-00	Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate procedure); simple	322.00
52320-00	Cystourethroscopy; with removal of ureteral calculus (MD/DO)	~~518.75~~ 517.00
52332-00	Cystourethroscopy, with insertion of indwelling ureteral stent (MD/DO)	~~319.00~~ 360.00
52336-00	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method; with removal or manipulation of calculus) (ureteral catheterization is included)	1,300.00
52340-00	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic musocal folds)	500.00

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52500-00	Transurethral resection of bladder neck (separate procedure)	785.00
52601-00	Transurethral resection of prostate, including control of post-operative bleeding, complete (vasectomy, meatotomy, cysto-urethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	1,325.50
53600*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial (MD/DO)	~~37.00~~ 36.00
53601*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent	27.80
53620*00	Dilation of urethral stricture by passage of filiform and follower, male; initial	57.60
53621*00	subsequent	35.35
53660*00	Dilation of female urethra including suppository and/or instillation; initial (MD/DO)	~~29.00~~ 28.00
53661-00	subsequent (MD/DO)	~~28.00~~ 30.00
53670*00	Catheterization; urethral; simple	~~35.00~~ 25.00

Subp. 10. **Reproductive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the reproductive system.

Male Reproductive System

Code	Service	Maximum Fee
54055*00	Destruction of lesions(s), penis (e.g., condyloma, papilloma molluscum contagiosum, herpetic vesical), simple; electrodesiccation	$65.00
54240-00	Penile plethysmography	80.00
54521-00	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral	550.00
54640-00	Orchiopexy, any type, with or without hernia repair; unilateral (MD/DO)	~~855.00~~ 890.00
54840-00	Excision of spermatocele, with or without epididymectomy	600.00
55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	39.00
55040-00	Excision of hydrocele; unilateral (MD/DO)	~~560.00~~ 550.00
55700-00	Biopsy, prostate; needle or punch, single or multiple, any approach	134.00
58980	Laparoscopy for visualization of pelvic viscera	550.00
55845-00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	2,500.00

	Femur (Thigh Region) and Knee Joint — Introduction or Removal	
27370-00	Injection procedure for knee arthrography (MD/DO)	S 55.64
~~27374~~	~~Arthroscopy, knee, surgical: debridement with cartilage shaving or drilling or resection of reactive synovium~~	~~1,450.00~~
~~27378~~	~~with partial meniscectomy~~	~~1,380.00~~
~~27379~~	~~with plica resection or shelf resection~~	~~1,225.00~~
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27422-00	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite. type procedure)	~~S1,156.00~~ 1,203.00
27425-00	Lateral retinacular release, any method	1,235.00
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,400.00
27447-00	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement) (MD/DO)	3,000.00
27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation (MD/DO)	~~1,580.88~~ 1,482.00
	Amputation	
27590-00	Amputation, thigh, through femur, any level	$1,050.40
	Leg (Tibula and Fibula) and Ankle Joint —Fractures or Dislocations	
~~27752~~	~~Treatment of closed tibial shaft fracture: with manipulation~~	~~$ 125.00~~
27750-00	Treatment of closed tibial shaft fracture; without manipulation	S275.00
27760-00	Treatment of closed distal tibial fracture (medial malleolus) without manipulation	190.00
27780-00	Treatment of closed proximal fibula or shaft fracture; without manipulation (MD/DO)	~~150.00~~ 141.00
27786-00	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation (MD/DO)	~~152.50~~ 176.00
~~27792~~	~~Open treatment of closed or open distal fibular fracture (lateral malleolus); with fixation~~	~~730.00~~

27800-00	Treatment of closed tibia and fibula fractures, shafts; without manipulation	315.00
27802-00	~~Treatment of closed tibia and fibula fractures, shafts;~~ with manipulation (MD/DO)	~~511.00~~ 540.00
27814-00	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation (MD/DO)	~~920.00~~ 950.00
27822-00	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only (MD/DO)	~~1.112.00~~ 1.153.00
27880-00	Amputation leg, through tibia and fibulat (MD/DO)	~~893.00~~ 918.00
	Foot — ~~Fracture or Dislocation~~	
28080-00	Excision of Morton neuroma; single each (MD/DO)	S ~~350.00~~ 381.00
28090-00	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot (MD/DO)	~~303.80~~ 316.30
28114-00	Ostectomy, complete excision; all metatarsal heads, with proximal phalangectomy, excluding first metatarsal (Clayton type procedure)	40.00
28190*00	Removal of foreign body, foot; subcutaneous	65.00
28285-00	Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy) (MD/DO)	~~385.00~~ 394.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure) (MD/DO)	~~425.00~~ 478.50
28292-00	Keller, McBride or Mayo type procedure	675.00
28296-00	with metatarsal osteotomy (Mitchell ~~or Lapidus~~, Chevron, or concentric type procedure)	~~760.00~~ 840.00
28470-00	Treatment of closed metatarsal fracture; without manipulation, each (MD/DO)	~~133.13~~ 128.25
28490-00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation (MD/DO)	~~50.00~~ 66.00

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28510-00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each (MD/DO)	~~51.25~~ 55.90

~~Amputation~~

28820-00	Amputation, toe; metatarso phalangeal joint	$ ~~300.00~~ 247.00

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

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29065-00	Application; shoulder to hand (long arm) (MD/DO)	S ~~82.50~~ 84.00
29075-00	elbow to finger (short arm) (MD/DO)	~~66.00~~ 70.00
29085-00	hand and lower forearm (gauntlet) (MD/DO)	~~67.00~~ 70.00

Splints

29105-00	Application of long arm splint (shoulder to hand) (MD/DO)	S ~~47.00~~ 49.00
29125-00	Application of short arm splint (forearm to hand); static (MD/DO)	42.00
29130-00	Application of finger splint; static	26.00

Strapping — Any Age

29220-00	Strapping; low back (MD/DO)	S ~~21.00~~ 30.00
29240-00	shoulder (e.g. Velpeau)	50.00
29260-00	elbow or wrist (MD/DO)	20.00
~~29325~~	~~Application of hip spica cast; bilateral, or one and one-half spica~~	~~282.00~~
29345-00	Application of long leg cast (thigh to toes) (MD/DO)	~~109.00~~ 111.00
29355-00	walker or ambulatory type (MD/DO)	~~124.00~~ 127.00
29365-00	Application of cylinder cast (thigh to ankle) (MD/DO)	~~85.00~~ 87.50
29405-00	Application of short leg cast (below knee to toes) (MD/DO)	~~82.00~~ 85.00
29425-00	walking or ambulatory type (MD/DO)	~~90.50~~ 96.00
29435-00	Application of patellar tendon bearing (PTB) cast (MD/DO)	~~119.00~~ 124.00
29440-00	Adding walker to previously applied cast (MD/DO)	~~32.25~~ 34.00
29450-00	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral (MD/DO)	~~52.00~~ 56.00
29455-00	bilateral	~~100.00~~ 103.00

	Splints	
29505-00	Application of long leg splint (thigh to ankle or toes) (MD/DO)	S ~~74.00~~ 62.00
29515-00	Application of short leg splint (calf to foot) (MD/DO)	~~45.00~~ 50.00
	Strapping — Any Age	
29530-00	Strapping: knee	S 48.00
29540-00	ankle (MD/DO)	25.00
29550-00	toes	20.00
29580-00	Unna boot (MD/DO)	34.00
	Removal or Repair	
29700-00	Removal or bivalving; gauntlet, boot or body cast	$33.20
29705-00	full arm or full leg cast	30.00
29720-00	Repair of spica, body cast, or jacket (MD/DO)	~~$ 20.00~~ 21.00
	Arthroscopy	
29870-00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$500.00
29874-00	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body (for example, osteochondritis dissecans fragmentation, chondral fragmentation) (MD/DO)	S 1,310.00
29875-00	synovectomy, limited (for example, plica or shelf resection) (MD/DO)	~~1,210.00~~ 1,225.00
29877-00	debridement/shaving of articular cartilage (chondroplasty) (MD/DO)	~~1,400.00~~ 1,416.00
29879-00	abrasion arthroplasty (includes chrondroplastywhere necessary) or multiple drilling	15.25
29881-00	with meniscectomy (medial or lateral including any meniscal shaving) (MD/DO)	1,450.00

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

Code	Service	Maximum Fee
30100-00	Biopsy, intranasal	88.50
30110-00	Excision, nasal polyp(s), simple; unilateral	120.00
30116-00	Excision, nasal polyp(s), extensive; bilateral	505.00
30200*00	Injection into turbinate(s), therapeutic	40.50
30300*00	Removal foreign body, intranasal; office type procedure(MD/DO)	S ~~35.00~~ 39.00

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	Nose — Repair	
~~30420~~-00	Rhinoplasty, primary; ~~complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip,~~ including major septal repair (MD/DO)	~~2,045.00~~ 2,250.00
30520-00	Septoplasty or submucous resection, with or without cartilage with or without cartilage ~~implant (separate procedure)~~ scoring, contouring, or replacement with graft (MD/DO)	~~921.00~~ 970.00
30800*00	Cauterization turbinates, unilateral or bilateral (separate procedure); superficial	30.00
	Other Procedures	
30901*00	Control nasal hemorrhage, anterior, simple (cauterization); unilateral (MD/DO)	S ~~49.00~~ 50.00
30902*00	bilateral	70.00
30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral (MD/DO)	~~95.00~~ 90.00
31000*00	Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium)	47.00
31021-00	Sinusotomy, maxillary (antrotomy); intranasal, bilateral	550.00
	Larynx	
31500-00	Intubation, endotracheal, emergency procedure (MD/DO)	S ~~95.00~~ 119.00
31505-00	Laryngoscopy, indirect; diagnostic (MD/DO)	~~35.00~~ 37.00
31525-00	Laryngoscopy, direct; diagnostic, except newborn (MD/DO)	~~291.00~~ 106.00
~~31535~~	~~Laryngoscopy, direct; operative, with biopsy~~	~~470.00~~
31536-00	Laryngoscopy, direct, operative, with biopsy; with operating microscope	560.50
31541-00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis	660.00
31575-00	Laryngoscopy, flexible fiberscopic; diagnostic (MD/DO)	~~74.00~~ 75.00
	Trachea and Bronchi	
31600-00	Tracheostomy, planned	
~~31620~~	(separate procedure) (MD/DO)	S ~~425.00~~ 505.00
31622-00	Bronchoscopy; diagnostic, (flexible or rigid), ~~Bronchoscope~~ with or without cell washing or brushing (MD/DO)	~~450.00~~ 465.00

~~31621~~	~~diagnostic, fiberoptic bronchoscope (flexible)~~	~~449.50~~
31625-00	with biopsy (MD/DO)	470.00
~~31626~~	~~with biopsy, fiberoptic bronchoscope (flexible)~~	~~470.00~~
~~31627~~	~~with brushing, fiberoptic bronchoscope (flexible)~~	~~450.00~~
31628-00	with transbronchial lung biopsy, ~~fiberoptic bronchoscope (flexible) under~~ with or without fluoroscopic guidance	~~493.75~~ 555.00

Lungs

32000*00	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (MD/DO)	$ ~~115.50~~ 120.00
32020-00	Tube thoracotomy with water seal (for example, pneumothorax, hemothorax, empyema)(separate procedure) (MD/DO)	~~420.00~~ 399.00
32100-00	Thoracotomy, major; with exploration and biopsy	1,600.00
32405-00	Biopsy, lung, percutaneous needle	313.00
32480-00	Lobectomy, total or segmental (MD/DO)	1,840.00
32500-00	Wedge resection of lung, single or multiple	1,480.00

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

Heart

Code	Service	Maximum Fee
33206-00	Insertion of permanent pacemaker with transvenous electrode(s): atrial	$1,480.00
33207-00	ventricular	1,552.00
33210-00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter (MD/DO)	$ ~~429.00~~ 506.00
33212-00	Insertion or replacement of pulse generator only	770.00
33405-00	Replacement, aortic valve, with cardiopulmonary bypass	4,259.00

Coronary Artery Procedures

33511-00	Coronary artery bypass, autogenous graft (e.g. saphenous vein or internal mammary artery); two coronary grafts (MD/DO)	$4,900.00

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33512-00	~~Coronary artery bypass, autogenous graft (for example, saphenous vein or internal mammary artery);~~ three coronary ~~arteries~~ grafts (MD/DO)	~~$4,970.00~~ 4.900.00
33513-00	four coronary grafts	5.570.00
33514-00	five coronary grafts	6.224.00
	Vascular Injection Procedures — ~~Venous~~	
36000*00	Introduction of needle or intracatheter, vein; unilateral (MD/DO)	$ ~~23.00~~ 63.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery (MD/DO)	331.00
36140-00	Introduction of needle or intracatheter; extremity artery	274.61
36200-00	Introduction of catheter, aorta (arch, abdominal, midstream renal, aortioliac run-off) or selective; initial placement	330.50
36215-00	each additional selective thoracic and/or cerebral artery catheter placement (e.g. vertebral or carotid)	448.00
36230-00	coronary artery, selective, unilateral or bilateral	449.28
36245-00	each additional selective abdominal artery catheter placement (e.g. celiac artery, gastroduodenal artery, inferior mesenteric artery, renal artery)	441.00
36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	44.10
36415*00	Routine venipuncture for collection of specimen(s) (MD/DO)	~~8.00~~ 7.60
36430-00	Transfusion, blood or blood (MD/DO) components;	70.50
~~36431~~	~~Transfusion, blood or blood components; direct~~	~~27.30~~
36470*00	Injection of sclerosing solution; single vein	42.00
36471*00	Injection of sclerosing solution; multiple veins, same leg (MD/DO)	~~36.50~~ 50.00
~~36480*~~	~~Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous~~	~~105.00~~
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	~~125.00~~ 133.20

~~36510~~	~~Catheterization of umbilical vein for diagnosis or therapy, newborn~~	~~100.00~~
36520-00	Therapeutic apheresis (plasma and/or cell exchange) (MD/DO)	~~150.00~~ 156.00
	~~Vascular Injection Procedures — Arterial~~	
36600*00	Arterial puncture, withdrawal of blood for diagnosis	47.00
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure): percutaneous	$ ~~125.00~~ 117.00
~~36660~~	~~Arterial catheterization, umbilical artery, newborn, for diagnosis or therapy~~	~~150.00~~
36800-00	Insertion of cannula for hemodialysis, other purpose: vein to vein	410.00
36830-00	Creation of arteriovenous fistula: nonautogenous graft	1,255.00
37609-00	Ligation or biopsy, temporal artery	280.00
37720-00	Interruption, partial or complele, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	650.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	921.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	830.00
37731-00	bilateral	1,256.00

Subp. 8. **Hemic and lymphatic systems.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the hemic (blood) and lymphatic systems.

Code	Service	Maximum Fee
38100-00	Splenectomy; total	$ 1,500.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	180.00
38510-00	deep cervical nodes	366.00
	Mediastinum and Diaphragm	
39400-00	Mediastinoscopy, with or without biopsy	540.00

Subp. ~~8.~~ 9. **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~~

~~Spleen~~

Code	Service	Maximum Fee
~~38100~~	~~Splenectomy; total~~	$ ~~1,015.00~~

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

Esophagus

Code	Service	Maximum Fee
~~43200~~-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	S ~~350.00~~ 304.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	490.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	439.16
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	~~343.00~~ 350.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	~~374.00~~ 406.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	508.00
43246-00	for directed placement of percutaneous gastrostomy tube	695.00
43247-00	for removal of foreign body	500.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	473.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection	536.00

A. to D. [Unchanged.]

Where the applicant undertakes no fee liability of any nature, the contract, as an alternative to items A to D, may read: "I understand that I am not liable for any fee and that compensation to the agency is to be settled between the employer and the agency."

Subp. 2. **Job listing.** Applicant contracts with job listing services shall contain the following statement: "I understand that a fee shall be due the job listing service at the time contractual arrangements are entered into and no other fee or portion of fee shall be collected by the job listing service for services rendered."

5200.0610 ACCEPTANCE FORM STANDARDS.

The acceptance form, with employment agencies engaged in placement activities, to be signed by the applicant shall contain the following information:

A. to K. [Unchanged.]

5200.0620 FEE DETERMINATION.

The following terms and methods shall be used in determining amount of fee due:

A. to D. [Unchanged.]

E. A fee based on a concurrent fee arrangement shall be uniform for all applicants serviced.

5200.0680 COLLECTION OF FEE FROM APPLICANT.

No fee or portion of a fee except a concurrent fee arrangement shall be collected from an applicant before the ~~agreed-upon~~ starting actual start date.

5200.0700 JOB ORDER FORM.

The following information must be contained on the job order form for each bona fide job order:

A. to S. [Unchanged.]

T. Fee status. One of the following terms shall be used to indicate the fee status for placement:

(1) to (6) [Unchanged.]

U. The term "concurrent fee" shall be used to indicate the fee status for job listing services only.

5200.0800 ANNUAL RECORD OF SERVICE REPORT.

Subpart 1. **Job placement.** A record of service shall be maintained in a separate ledger in the office of each employment agency for a period of three years and shall contain the information required by *Minnesota Statutes*, section 184.38, subdivision 5. Each agency shall submit annually to the department with its agency license renewal application, a summary of the above record which contains the following information for the preceding year:

A. total applicants placed;

B. total annual salaries of placements; and

C. total amount of fees collected.

The individual summary shall be used solely for compilation of statistical data for the employment industry as a whole.

The summary shall be submitted on a form provided by the department which shall make provision for its protection from usage inconsistent with its purpose.

Subp. 2. **Job listing.** Job listing service record of service report shall include:

A. total applicants serviced; and

B. total amount of fees collected.

Department of Labor and Industry

Proposed Rules Governing Workers' Compensation Medical Fees

Notice of Intent to Amend a Rule Without a Public Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Department of Labor and Industry, Workers' Compensation Division intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for

adopting rules without a public hearing in *Minnesota Statutes*, sections 14.22 to 14.28. The statutory authority to adopt the rule is *Minnesota Statutes* sec. 176.136 (Supp. 1987), and section 176.83 (*Supp. 1987*).

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule address, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Gloria Gebhard
Acting Director of Rehabilitation
and Medical Affairs, Workers' Compensation Division
443 Lafayette Road
St. Paul, Minnesota 55101
(612) 296-8213

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The rules proposed for amendment relate to medical charges and reimbursement in workers' compensation cases. The rules add, clarify or modify definitions of terms used in the rules, clarify or modify provider and payer responsibilities, and summarize dispute resolution procedures. The rules also modify, delete or add codes, service descriptions and maximum fees in the medical fee schedule. A free copy of the rules is available from Janice Kramer at the above address and phone number upon request.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Janice Kramer at the above address and phone number upon request.

The Statement of Need and Reasonableness concludes that the impact on small business need not be considered because these rules concern service businesses regulated by government bodies. Nevertheless, the impact on small business is minimal.

The rules do not require an additional expenditure of public monies by local public bodies, but instead limit expenditures.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Janice Kramer at the above address and phone number.

Dated: 14 December 1988

Ken Peterson, Commissioner

Rules as Proposed

5221.0100 DEFINITIONS.

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

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

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

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Subp. 4. **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~~ to categorize provider charges on a bill.

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

Subp. 6. **Compensable ~~or compensability~~ injury.** "Compensable injury" ~~or "compensability," in reference to a service,~~ means an ~~employer~~ injury or condition for which a payer is liable ~~for the service pursuant to~~ under Minnesota Statutes, chapter 176.

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

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

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

Subp. ~~9.~~ 10. **~~Maximum~~ Medical fee schedule.** "~~Maximum~~ Medical fee schedule" means the list of codes, service descriptions, and corresponding ~~75th percentile~~ dollar amounts ~~established pursuant to part 5221.0900~~ allowed under *Minnesota Statutes*, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

Subp. ~~10.~~ 11. **Payer.** "Payer" refers to ~~all entities~~ any entity 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 176.131, the special compensation fund established by *Minnesota Statutes,* section 176.129, and the assigned risk plan, established by~~ under *Minnesota Statutes,* ~~sections 79.251 and 79.252~~ chapter 176.

Subp. ~~11.~~ 12. **Provider.** "Provider" is as defined in *Minnesota Statutes*, section 176.011, subdivision 24.

Subp. ~~12.~~ 13. **Reasonable charge.** "Reasonable~~,~~ charge" ~~in reference to a charge,~~ means a charge or portion of a charge ~~which~~ for treatment of a compensable injury that is not excessive under part 5221.0500.

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

Subp. ~~13.~~ 15. **Service or treatment.** "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing ~~and~~ or relieving an injured worker from the effects of ~~an~~ a compensable injury ~~or occupational disease, pursuant to~~ under *Minnesota Statutes,* action 176.135, subdivision 1.

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

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

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

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

D. for outpatient treatment provided by other health care providers not specified in items A to C, legible information that substantiates the nature and necessity of a service or charge in the form of an initial report, an interim report, or a discharge/summary report.

5221.0200 AUTHORITY.

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

5221.0300 PURPOSE.

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

5221.0400 SCOPE.

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

5221.0500 ~~EXCESSIVENESS~~ EXCESSIVE CHARGES.

A charge is excessive if any of the following conditions apply to the charge~~, 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~~ allowed in the ~~maximum~~ medical fee schedule of this chapter; or

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

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

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

E. the charge ~~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; or

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

~~G. the service does not comply with the requirements of *Minnesota Statutes,* section 176.135, subdivision 1a, concerning nonemergency 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~~ the charge is described by a billing code that does not accurately reflect the actual service provided.

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

5221.0600 PAYER RESPONSIBILITIES.

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

Subp. 2. ~~**Payment of charges**~~ **Determination of excessiveness.** ~~Before paying a charge, the payer shall determine whether it is excessive. If a charge is determined to be excessive, the payer shall not pay the part that is excessive. As soon as reasonably possible, and no later than 21 calendar days after receiving the bill and necessary medical data, 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.~~ Subject to a determination of the commissioner or compensation judge, the payer shall determine whether a charge or service is excessive by evaluating the charge and service according to the conditions of excessiveness specified in parts 5221.0500 and 5221.0550.

Subp. 3. **Determination of ~~excessiveness~~ charges.** ~~Subject to the provider's right to appeal under part 5221.0800, the payer shall ascertain whether a charge is excessive by evaluating the charge and service according to the standards of excessiveness specified in part 5221.0500. The payer shall also comply with the following procedures:~~

A. ~~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 part 5221.1000.~~ As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the payer shall:

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

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

(3) request an appropriate record or specific additional information to determine whether the charge or service is excessive or whether the condition is compensable. No later than 30 calendar days following receipt of an appropriate record and additional information, the payer shall make a determination as set forth in this item.

B. ~~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:~~

~~(1) the opinion of persons with expertise concerning the service, including the provider whose charge is being evaluated;~~

~~(2) the findings of peer review panels, professional associations, and other expert evaluators of a healing art; and~~

~~(3) 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, coding and fee schedules, and other medical reference materials.~~

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

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

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

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

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

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

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

Subp. ~~4.~~ 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the ~~standards~~ conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

5221.0700 PROVIDER RESPONSIBILITIES.

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

Subp. 2. **Submission of information.** Providers shall include on bills the patient's name, date of injury, and the employer's name, service descriptions and codes which accurately describe ~~all~~ the services provided and ~~all~~ the injuries or conditions treated, the date ~~upon~~ on which each service was provided, and the providers' ~~social security~~ tax identification number. ~~Where applicable, codes from the maximum fee schedules in this chapter shall be used. This subpart shall not prohibit the use of other coding schedules where codes in the maximum fee schedule do not apply.~~ Providers must also supply a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge.

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

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

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

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

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

Code	Service	Maximum Fee
25105	Arthrotomy, wrist joint; for synovectomy	

Subp. ~~3.~~ 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply ~~promptly~~ within seven working days with payers' ~~reasonable~~ proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of ~~a service's~~ compensability or ~~a charge's reasonableness~~ excessiveness. A provider may not require prepayment for costs of copies of existing medical records.

Subp. ~~4.~~ 5. **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 finally upheld, the provider may collect charges found to be reasonable, but only from the payer, not from the injured employee, any other insurer, or government~~ an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

5221.0800 ~~APPEALS PROCEDURE~~ DISPUTE RESOLUTION.

Pursuant to *Minnesota Statutes,* sections ~~176.103~~ 176.106 and 176.271 and related statutes and rules, ~~providers~~ the employee, employer, or insurer may request ~~that the commissioner determine~~ a determination of whether a charge or service is excessive. ~~This determination may be appealed first to the medical services review board, and then to the workers' compensation court of appeals.~~ Such requests shall be made to the commissioner in writing on a form prescribed for that purpose. Under *Minnesota Statutes,* section 176.136, subdivision 2, a provider may request a determination of whether a charge is excessive under part 5221.0500. An employee, employer, insurer, health care provider, or intervenor who disagrees with a determination under *Minnesota Statutes,* section 176.106 or 176.305 may request a formal hearing before a compensation judge at the Office of Administrative Hearings. The request shall be made on a form prescribed by the commissioner.

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

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

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

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

~~Subpart 1.~~ Subp. 3. ~~Maximum~~ Medical fee schedule instructions. The instructions in this part and this chapter govern the use and application of fees in this chapter.

Subp. ~~2.~~ 4. **Applicability of the fee schedule.** The payer shall undertake reasonable investigations to ascertain whether a service and its corresponding charge is subject to the ~~maximum~~ medical fee schedule. A ~~service~~ charge is subject to the ~~maximum~~ medical fee schedule if it conforms to a ~~description contained in the maximum fee schedule in the section~~ code under part 5221.0700, subpart 3, item A, and is included in the medical fee schedule for the appropriate ~~kind of medical~~ provider group. ~~The standards of excessiveness contained in part 5221.0500 apply whether or not a service is subject to the maximum fee schedule.~~ If a service is not included in the medical fee schedule under parts 5221.1100 to 5221.3600, and the charge and service are not otherwise excessive under parts 5221.0500 and 5221.0550, the payer shall evaluate the charge against the usual and customary charges prevailing in the same geographic community for similar services in accordance with *Minnesota Statutes*, section 176.135, subdivision 3. If the charge submitted is less than or equal to the prevailing and customary charges, the payer shall pay the charge in full. If the charge exceeds the prevailing usual and customary charges, the payer shall pay an amount equal to the usual and customary charges for similar services.

Subp. ~~3.~~ 5. **Coding.** ~~For services which are or which may be subject to the maximum fee schedule,~~ The payer shall undertake reasonable investigations to ~~ascertain~~ determine whether or not the code ~~assigned to~~ listed for a service by the provider is correct under part 5221.0700, subpart 3, item A, and subject to the medical fee schedule. If ~~no~~ an incorrect code for a service has been ~~assigned~~ listed, the payer shall may determine the ~~appropriate~~ correct code for the service, and ~~shall~~ may evaluate the service on the basis of ~~that code~~ the proposed change. ~~A broad, inclusive service description~~ Neither the provider nor the payer may ~~be divided~~ divide a broad inclusive service into its component services, charges, and codes, if the broad inclusive service is ~~not~~ subject to the ~~maximum~~ medical fee schedule ~~but some of the component services are~~. If the broad inclusive service is not subject to the medical fee schedule, it may be divided into its component services if any of those components are subject to the medical fee schedule.

Subp. ~~4.~~ 6. **Ambiguity.** If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service and its corresponding charge is subject to the ~~maximum~~ medical 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. If the commissioner determines that a service is not subject to the maximum fee schedule, the commissioner shall order the payment of the reasonable value of that service pursuant to *Minnesota Statutes*, section 176.135, subdivision 3~~ contact the provider and attempt to resolve the ambiguity. The provider shall cooperate in resolving this ambiguity. If the parties are unable to come to an agreement, either party may file a request for a determination with the commissioner under part 5221.0800.

Subp. ~~5.~~ 7. **Code modifiers.** The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in items A to ~~R~~ T.

A. Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery. ~~including the aid~~ requiring the use of an operating microscope. This modifier ~~is~~ shall not ~~warranted~~ apply for surgery done with the aid of a magnifying surgical loupe ~~or magnifying binoculars worn by the surgeon~~ whether attached to the eyeglasses or a headband. Services with this modifier are not subject to the ~~maximum~~ medical fee schedule.

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

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

D. Modifier number 26 denotes professional component. This modifier is appropriate to services ~~which are a combination of a physician and a~~ when the professional services are reported separately and do not include the technical component, (for example, laboratory, radiology, electrocardiogram, specific diagnostic and therapeutic services), where the physician component only is provided.

This modifier does not exempt a service from the maximum fee for the five-digit code. If a separate maximum fee is provided for a five-digit code with the number 26 modifier, the separate maximum fee applies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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

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

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

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

D. to L. [Unchanged.]

M. Referral. "Referral" means a transfer of the total care or specific care of a patient from one physician to another and does not constitute a consultation.

N. Hospital discharge day management. "Hospital discharge day management" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge record.

Subp. 3. **Office services.** The following codes, service descriptions, and maximum fees apply to services provided at the physician's office, or if provided in an outpatient hospital clinic setting, for nonemergency services.

Code	Service	Maximum Fee
90000-00	Office services; new patient - brief service (MD/DO)	S ~~30.00~~ 33.00
90010-00	~~New patient~~ - limited service (MD/DO)	~~36.00~~ 40.00
90015-00	~~New patient~~ - intermediate service (MD/DO)	~~46.00~~ 49.00
90017-00	~~New patient~~ - extended service (MD/DO)	~~70.00~~ 65.00
90020-00	comprehensive service (MD/DO)	130.00
90030-00	Office services; established patient - minimal service (MD/DO)	~~16.00~~ 16.50
90040-00	~~Established patient~~ - brief service (MD/DO)	~~22.00~~ 23.50
90050-00	~~Established patient~~ - limited service (MD/DO)	~~25.00~~ 26.00
90060-00	~~Established patient~~ - intermediate service (MD/DO)	~~34.00~~ 35.70
90070-00	~~Established patient~~ - extended service (MD/DO)	55.00
90080-00	~~Established patient~~ - comprehensive service (MD/DO)	~~82.25~~ 88.30

Subp. 3a. **Home services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a home setting if provided in a private residence as a "house call." They do not apply to physician services provided at a nursing home, boarding home, domiciliary (temporary lodging), or custodial care involving periodic services provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90100-00	Home medical service, new patient: brief service	44.00
90110-00	limited service	48.00
90115-00	intermediate service	50.00
90130-00	Home medical service, established patient: minimal service	30.30
90140-00	brief service	42.90
90150-00	limited service	45.00
90160-00	intermediate service	50.00
90170-00	extended service	57.80

Subp. 4. **Hospital services.** The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under codes 90240 to 90270.

Code	Service	Maximum Fee
90200-00	~~Brief~~ Initial hospital care; brief (MD/DO)	S ~~62.50~~ 66.00
90215-00	Intermediate ~~initial hospital care~~ (MD/DO)	~~85.00~~ 87.50
90220-00	Comprehensive ~~initial hospital care~~ (MD/DO)	~~123.00~~ 127.00
90240-00	Subsequent hospital care - brief service (MD/DO)	~~26.50~~ 28.00
90250-00	~~Subsequent hospital care~~ - limited service (MD/DO)	~~37.00~~ 35.50
90260-00	Intermediate services (MD/DO)	50.00
90270-00	~~Subsequent hospital care~~ - extended service (MD/DO)	~~75.00~~ 69.00
90280-00	~~Subsequent hospital care~~ - comprehensive service (MD/DO)	~~75.00~~ 82.00
	Hospital Discharge Services	
90292-00	Hospital discharge day management (MD/DO)	S ~~52.00~~ 50.00

Subp. 5. **Skilled nursing, intermediate care, and long-term care facilities.** The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long-term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical	

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	examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 45.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	70.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	96.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility: brief service	25.00
90350-00	limited service	27.25
90360-00	intermediate service	40.00
90370-00	extended service	50.00

Subp. 6. **Nursing home, boarding home, domiciliary, or custodial care medical services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a domiciliary or custodial care facility involving periodic services, provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	$ 50.00
90415-00	intermediate service	81.50
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	20.75
90440-00	brief service	25.00
90450-00	limited service	33.00
90460-00	intermediate service	44.00
90470-00	extended service	55.00

Subp. ~~5.~~ 7. **Emergency department services.** The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department. They do not apply when physicians elect to use the emergency room as a substitute for their office and an actual emergency situation does not exist.

Code	Service	Maximum Fee
90500-00	Emergency department service New patient - minimal service (MD/DO)	$ ~~26.00~~ 31.50
90505-00	~~New patient~~ - brief service (MD/DO)	~~35.00~~ 37.50
90510-00	~~New patient~~ - limited service (MD/DO)	~~14.00~~ 47.00
90515-00	~~New patient~~ - intermediate service (MD/DO)	~~60.00~~ 65.00
90517-00	~~New patient~~ - extended service (MD/DO)	~~82.00~~ 95.00
90520-00	comprehensive service (MD/DO)	120.00
90530-00	Emergency department service, established patient; minimal service (MD/DO)	23.49

90540-00	~~Established patient~~ - brief service (MD/DO)	~~35.00~~ 37.00
90550-00	~~Established patient~~ - limited service (MD/DO)	~~39.00~~ 42.00
90560-00	~~Established patient~~ - intermediate service (MD/DO)	~~46.00~~ 49.00
90570-00	~~Established patient~~ - extended service (MD/DO)	~~52.50~~ 65.00
90580-00	comprehensive service	86.00

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

Code	Service	Maximum Fee
90590-00	Physician direction of Emergency Medical Systems (EMS), emergency care advanced life support	$112.00

5221.1200 CONSULTATIONS.

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

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

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

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

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

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

~~E.~~ (4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate ~~report~~ record. This includes, but is not limited to, services similar in level to a consultation for a

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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~~ record with recommendations.

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

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

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

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

Code	Service	Maximum Fee
90600-00	Initial consultation; limited (MD/DO)	$ ~~55.00~~ 58.00
90605-00	Intermediate consultation (MD/DO)	~~73.00~~ 76.50
90610-00	Extensive consultation (MD/DO)	~~89.00~~ 93.50
90620-00	Comprehensive consultation (MD/DO)	~~135.00~~ 139.50
90630-00	Complex consultation (MD/DO)	~~155.00~~ 160.00
	Follow-up Consultation	
90640-00	Follow-up consultation; brief visit (MD/DO)	$ ~~65.00~~ 39.50
90641-00	limited	~~53.00~~ 48.50
90642-00	intermediate	82.00
90643-00	complex	100.00
	Confirmatory (Additional Opinion) Consultation	
90650-00	Confirmatory consultation; limited (MD/DO)	$ ~~55.00~~ 63.00
90651-00	intermediate (MD/DO)	75.00
90652-00	extensive (MD/DO)	80.00
90653-00	comprehensive (MD/DO)	120.00
90654-00	complex (MD/DO)	~~175.00~~ 193.00
	~~**Immunization Injections**~~	
~~90701~~	~~Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)~~	~~$ 15.00~~
~~90702~~	~~— diphtheria and tetanus toxoids (DT)~~	~~10.00~~
~~90703~~	~~— tetanus toxoid~~	~~9.00~~
~~90704~~	~~— mumps virus vaccine, live~~	~~14.50~~
~~90705~~	~~— measles virus vaccine, live, attenuated~~	~~14.50~~
~~90706~~	~~— rubella virus vaccine, live~~	~~14.19~~
~~90707~~	~~— measles, mumps, and rubella virus vaccine, live~~	~~23.50~~
~~90712~~	~~— polio virus vaccine, live, oral; — any type(s)~~	~~12.65~~

~~90713~~	~~— poliomyelitis vaccine~~	~~10.00~~
~~90718~~	~~— tetanus and diphtheria toxoids absorbed, for adult use (Td)~~	~~9.50~~
~~90719~~	~~— diphtheria toxoid~~	~~9.00~~
~~90724~~	~~— influenza virus vaccine~~	~~11.00~~
~~90732~~	~~— pneumococcal vaccine, polyvalent~~	~~16.00~~
~~90733~~	~~— meningococcal polysaccharide vaccine; any group(s)~~	~~15.00~~

5221.1210 IMMUNIZATION INJECTIONS.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include the supply of materials.

90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP) (MD/DO)	$ 20.00
90702-00	diphtheria and tetanus toxoids (DT) (MD/DO)	11.00
90703-00	tetanus toxoid (MD/DO)	10.50
90704-00	mumps virus vaccine, live (MD/DO)	19.00
90705-00	measles virus vaccine, live, attenuated (MD/DO)	16.50
90706-00	rubella virus vaccine, live (MD/DO)	17.00
90707-00	measles, mumps, and rubella virus vaccine, live (MD/DO)	26.75
90708-00	measles and rubella virus vaccine, live	24.00
90712-00	polio virus vaccine, live, oral; any type(s) (MD/DO)	15.00
90713-00	poliomyelitis vaccine (MD/DO)	15.00
90714-00	typhoid vaccine	11.00
90717-00	yellow fever vaccine	30.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD) (MD/DO)	10.00
90719-00	diphtheria toxoid (MD/DO)	9.50
90724-00	influenza virus vaccine (MD/DO)	11.25
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	115.52
90731-00	hepatitis B vaccine	61.25
90732-00	pneumococcal vaccine, polyvalent (MD/DO)	17.00
90733-00	meningococcal polysaccharide vaccine; any group(s) (MD/DO)	16.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	16.00

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90741-00	Immunization, passive; immune serum globulin, human (ISG)	15.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	50.00

5221.1220 THERAPEUTIC INJECTIONS.

90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	10.00
90788-00	Intramuscular injection of antibiotic (specify)	14.25

5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
90801-00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants informants will be seen in lieu of the patient). (MD/DO)	$ ~~113.00~~ 112.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	70.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	111.50
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes (MD/DO)	55.00
90844-00	approximately 45 or 50 minutes (MD/DO)	~~95.00~~ 85.00
90847-00	Family medical psychotherapy (conjoint psychotherapy) (MD/DO)	~~90.00~~ 85.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	57.00

90853-00	Group medical psychotherapy (other than of a multiple-family group) (MD/DO)	~~45.00~~ 40.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	120.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	120.00
	Other Psychiatric Therapy	
90880-00	Medical hypnotherapy (MD/DO)	$ ~~55.00~~ 75.00
90882-00	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	70.00
90887-00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (MD/DO)	~~90.00~~ 78.00

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

Subp. 2. **Definitions.** The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient" and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in part 5221.1100, except for item C regarding intermediate opthalmological service and item D regarding comprehensive opthalmological service.

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

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

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

D. Comprehensive ophthalmological service. "Comprehensive ophthalmological service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological examination, gross visual fields, and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and

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treatment programs as indicated. Comprehensive ophthalmological services include, but are not limited to, service similar to diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract, or retinal disease, or to rule out disease of the visual system, in a new or established patient.

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

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92020, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92235, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

General Services

Code	Service	Maximum Fee
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient (MD/DO)	S ~~48.50~~ 51.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient, one or more visits (MD/DO)	~~54.00~~ 58.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient (MD/DO)	~~38.40~~ 40.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program - established patient, one or more visits (MD/DO)	~~53.00~~ 55.00
92019-00	limited	26.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure) (MD DO)	~~27.00~~ 29.30

Special Services

Code	Service	Maximum Fee
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	37.00
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	41.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	140.00
92081-00	Visual field examination with medical diagnostic evaluation; limited examination	

	(for example, tangent screen), Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	31.31
92082-00	intermediate examination (for example, multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel, full field automated test, such as Octopus program 33 or 34 equivalent)	50.00
92083-00	~~Visual field examination with medical diagnostic evaluation:~~ extended examination: quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31 + 41 or 32 + 41) (MD/DO)	S ~~54.00~~ 59.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day (MD/DO)	~~23.50~~ 24.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography (MD/DO)	25.00

Ophthalmoscopy

Code	Service	Maximum Fee
92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation: initial (MD/DO)	S ~~32.00~~ 37.00
92226-00	subsequent (MD/DO)	30.00
92230-00	Opthalmoscopy, with medical diagnostic evaluation: with fluorescein angioscopy (observation only)	34.00
92235-00	~~Ophthalmoscopy, including medical diagnostic~~ with fluorescein angiography ~~and~~ (includes multiframe photography) ~~and medical interpretation~~ (MD/DO)	~~143.00~~ 150.00
92250-00	with fundus photography	33.00
92260-00	with opthalmodynamometry	30.00

Other Specialized Services

Code	Service	Maximum Fee
92275-00	Electroretinography, with medical diagnostic evaluation	$ 154.00
92285-00	External ocular photography with medical diagnostic evaluation for	

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	documentation of medical progress (for example, close-up photography, slit lamp photography, goniophotography, stereo-photography	40.00
92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00

Contact Lenses

Code	Service	Maximum Fee
92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, 1 eye	$ 80.00
92314-00	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	16.00
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	30.00
92326-00	Replacement of contact lens	65.00

Spectacle Services

Code	Service	Maximum Fee
92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	147.35
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

5221.1600 OTORHINOLARYNGOLOGIC SERVICES.

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

Code	Service	Maximum Fee
92504-00	Binocular microscopy (separate diagnostic procedure (MD/DO)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	42.00
92508-00	Speech, language, or hearing therapy with continuing medical supervision; group (MD/DO)	16.00
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	58.00

92512-00	Nasal function studies, for example, rhinomanometry	71.50
92532-00	Positional nystagmus	21.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	30.00
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	41.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	43.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (MD/DO)	55.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (MD/DO)	26.00
92545-00	Oscillating tracking test, with recording (MD/DO)	26.00

5221.1800 ~~CARDIOGRAPHY~~ CARDIOVASCULAR.

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

Code	Service	Maximum Fee
92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external (MD/DO)	~~$202.50~~ 244.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,080.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads (MD/DO)	42.50
93005-00	tracing only, without interpretation and/or report (MD/DO)	~~29.50~~ 37.00
93010-00	interpretation and report only (MD/DO)	~~18.00~~ 17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	50.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report (MD/DO)	195.00

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~~93017~~-00	~~Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring.~~ tracing only, without interpretation and report (MD/DO)	~~91.00~~ 99.00
93018-00	interpretation and report only (MD/DO)	~~104.00~~ 100.00
93024-00	Ergonovine provocation test	175.00
93040-00	Rhythm ECG, one to three leads; with interpretation (MD/DO)	22.00
93041-00	tracing only without interpretation and report (MD/DO)	12.00
93042-00	Rhythm ECG, tracing with interpretation and report only (MD/DO)	~~15.00~~ 18.00
93210-00	Phonocardiogram, intracardiac	45.50
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report (MD/DO)	~~95.00~~ 105.00
~~93276~~	~~Scanning analysis with report~~	~~100.00~~
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout: with superimposition scanning	185.70
93262-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout: with superimposition scanning	200.00
	without superimposition scanning	219.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis	215.75
93268-00	Patient demand single event ECG recording: pre-symptom memory loop and transmission	34.00
93269-00	post-symptom memory loop and transmission	30.00
93300-~~26~~00	Echocardiography, M-mode; complete ~~professional component only~~	~~63.00~~ 79.00
93308-00	Echocardiograph, real-time with image documentation (2D); limited (MD/DO)	105.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D) (MD/DO)	250.00
93320-00	Doppler echocardiography (MD/DO)	105.00
	Cardiac Catheterization	
93501-00	Right heart catheterization only	$ ~~560.00~~ 685.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes,	

	collection of blood, and/or angiography (MD/DO)	~~360.00~~ 351.00
93505-00	Endomyocardial biopsy	330.00
~~93543~~	~~Injection procedure during cardiac catheterization; for pulmonary angiography for selective left ventricular or left atrial angiography~~	~~300.00~~
~~93544~~	~~for aortography~~	~~300.00~~
93547-00	Combined left heart catheterization, selective coronary angiography and selective left ventricular angiography (MD/DO)	~~750.00~~ 760.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (MD/DO)	~~994.50~~ 1,166.00
93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	79.00
	Other Vascular Studies	
93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	$ 54.00
93732-00	with reprogramming	45.00
93733-00	telephone analysis	40.50
93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	40.00
93735-00	with reprogramming	50.00
93736-00	telephonic analysis	35.50
93784-00	Ambulatory blood pressure monitoring, using a system such as magnetic tape and/or computer disc, for 24 hours; including recording, scanning analysis, interpretation and report	225.00
	Noninvasive Peripheral Vascular Diagnostic Studies	
	Cerebrovascular Arterial Studies	
93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periobital flow direction with arterial compression, periobital photoplethysmography with arterial compression,	

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	ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)	$ 79.00
93870-00	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis) (MD/DO)	~~$ 245.00~~ 185.20
	Venous Studies	
93950-~~2600~~	Noninvasive studies of extremity veins; ~~professional component only~~ (MD/DO)	$ ~~36.00~~ 80.00
93960-00	Quantitative venous flow studies (e.g., capacitance and outflow measurement or calf, measurement of calf venous reflux, quantitative photoplethysmography)	100.00

5221.1900 PULMONARY.

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

Code	Service	Maximum Fee
94010-00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements, and/or maximal voluntary ventilation	$ 30.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after broncodilator (aerosol or parenteral) or exercise	50.00
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	65.70
94150-00	Vital capacity, total	~~$ 15.00~~ 18.00
94160-00	Vital capacity screening tests: total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity, maximal voluntary ventilation	20.00
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	79.00
94260-00	Thoric gas volume	11.00
94350-00	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including a alveolar nitrogen or helium equilibration time	46.45
94360-00	Determination of resistance to airflow, oscillatory or plethysmographic methods	10.00
94375-00	Respiratory flow volume loop	24.00

94640-00	Nonpressurized inhalation treatment for acute airway obstruction (MD/DO)	~~21.00~~ 22.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (MD/DO)	20.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	128.50
94657-00	subsequent days	56.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	~~19.30~~ 20.50
	~~Allergy and Clinical Immunology~~	
~~95120~~	~~Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract: single antigen~~	~~$ 7.50~~
~~95125~~	~~Multiple antigens (specify number of injections)~~	~~9.25~~
94665-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	21.50
94680-00	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	35.00
94681-00	including CO2 output, percentage oxygen extracted	94.60
94700-00	Analysis of arterial blood gas (oxygen saturation, pO2, pCO2, CO2, pH); rest only	33.30

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

Subpart 1. **Allergy sensitivity tests.** Allergy sensitivity tests are the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests.

Subp. 2. **Immunotherapy (desensitization, hyposensitization).** Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

Subp. 3. **Other therapy.** Other therapy for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see 95105-00. (For definitions of Levels of Service see the Introduction.) (For Medical Service Procedures, see 90000-90699.)

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Code	Service	Maximum Fee
95000-00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; up to 30 tests	$ 2.50
95001-00	31-60 tests	2.05
95002-00	61-90 tests	2.00
95007-00	Percutaneous tests (scratch, puncture, prick) with antibiotics, biologicals, stinging insects; 11-15 tests	22.50
95011-00	more than 15 tests	50.00
95014-00	Intracutaneous (intradermal) tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 1-5 tests	15.00
95017-00	Intracutaneous (intradermal tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 11-15 tests	45.00
95021-00	Intracutaneous (intradermal tests with allergenic extracts, immediate reaction 15-20 minutes; 11-20 tests	4.00
95022-00	21-30 tests	3.30
95023-00	more than 30 tests	2.25
95027-00	Skin and point titration	6.00
95030-00	Intracutaneous (intradermal) tests with allergenic extracts, delayed reaction 24-72 hours, including reading; 2 tests	11.00
95031-00	3-4 tests	10.00
95042-00	Patch or application tests; 21-30 tests	3.33
95043-00	more than 30 tests	4.00
95070-00	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds	110.00
95078-00	Provocative testing (MD/DO)	14.00
95105-00	Medical conference services (e.g., use of mechanical and electric devices, climatotherapy, breathing exercises and/or postural drainage)	35.00
95120-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen (MD/DO)	8.00
95125-00	Multiple antigens (specify number of injections) (MD/DO)	9.00
95130-00	Single stinging insect venom (MD/DO)	23.50
95131-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 2 stinging insect venoms	22.00
95132-00	3 stinging insect venoms	27.50

95180-00	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, horse serum)	6.70

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

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

Code	Service	Maximum Fee
~~95819-26~~	~~Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation, standard or portable, same facility; professional component only~~	
~~95819-TC~~	~~technical component only~~	~~$ 55.00~~
~~95833~~	~~Muscle testing, manual; total evaluation of body, excluding hand~~	~~110.00~~
95821-00	Electroencephalogram (EEG); sleep only	~~10.00~~
95823-00	physical or pharmacological activation only	$145.00
95827-00	all night sleep recording only	100.00
95831-00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	300.00
95851-00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	25.00
95852-00	hand, with or without comparison with normal side	50.00
95857-00	Tensilon test for myasthenia gravis	16.00
95860-00	Electromyography; one extremity and related paraspinal areas (MD/DO)	57.00
~~95860-26~~	~~professional component only~~	~~170.00~~ 175.00
95861-00	two extremities and related paraspinal areas (MD/DO)	~~120.00~~
95863-00	three extremities and related paraspinal areas (MD/DO)	~~235.00~~ 250.00
95864-00	four extremities and related paraspinal areas (MD/DO)	~~155.70~~ 165.00
~~95864-26~~	~~professional component only~~	~~215.20~~ 226.00
95869-00	Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	~~152.00~~ 77.80

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95882-00	Assessment of higher cerebral function with medical interpretation; cognitive testing and others (MD/DO)	~~150.00~~ 45.00
95900-00	Nerve conduction, velocity, or latency study, motor, each nerve (MD/DO)	50.00
95904-00	Nerve conduction, velocity and/or latency study; sensory, each nerve	59.50
95935-00	"H" reflex, by electrodiagnostic testing	45.00
95950-00	Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; electroencephalographic (EEG) recording and interpretation, initial 24 hours	380.00
95951-00	combined electroencephalographic (EEG) and video recording and interpretation, initial 24 hours	1,000.00

5221.2050 CHEMOTHERAPY INJECTIONS.

The codes, service descriptions, and maximum fees of this part apply to chemotherapy injections, and to a provider licensed as a doctor of medicine, a doctor of osteopathy, or by a qualified assistant under supervision of the physician.

Code	Service	Maximum Fee
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 60.00
96505-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by infusion technique	55.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	37.00
96509-00	by infusion technique	90.00
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	81.50
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	321.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	48.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	217.30

96540-00	Chemotherapy injection, intrathecal via reservoir, single or multiple agents, administered by physician	107.00

5221.2070 DERMATOLOGICAL PROCEDURES.

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

Subp. 2. **Services.** Dermatologic services are typically consultative, and any of the levels of consultation described in part 5221.1200 may be appropriate. In addition, physician services for dermatological procedures are the same as the definitions described in part 5221.1100.

Code	Service	Maximum Fee
96900-00	Actinotherapy (ultraviolet light)	$ 7.50
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	25.00
96912-00	psoralens and ultraviolet A (PUVA)	30.00

5221.2100 PHYSICAL MEDICINE.

The following codes, service descriptions, and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. ~~Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities and procedures require supervision by the physician, and constant attendance by the physician or therapist.~~

Code	Service	Maximum Fee
	Modalities	
~~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~~	~~$ 18.00~~
~~97010~~	~~Physical medicine treatment to one area; hot or cold packs~~	~~24.50~~
~~97012~~	~~Physical medicine treatment to one area; traction mechanical~~	~~15.50~~
~~97014~~	~~Physical medicine treatment to one ea; electrical stimulation (unattended)~~	~~17.00~~
~~97020~~	~~Microwave~~	~~12.75~~
~~97024~~	~~Diathermy~~	~~14.75~~
~~97026~~	~~Infrared~~	~~7.50~~
~~97039~~	~~Unlisted modality (specify)~~	~~27.10~~

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	~~Procedures~~	
~~97110~~	~~Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises~~	~~$ 26.50~~
~~97116~~	~~Gait training~~	~~20.00~~
~~97118~~	~~Electrical stimulation (manual)~~	~~16.00~~
~~97124~~	~~Massage~~	~~17.00~~
~~97128~~	~~Ultrasound~~	~~17.00~~
~~97145~~	~~Physical medicine treatment to one area, each additional 15 minutes~~	~~12.50~~
~~97240~~	~~Pool therapy or Hubbard tank with therapeutic exercises; initial 30 minutes, each visit~~	~~32.00~~
97260-00	Manipulation (cervical, thoracic, lumbosacral, socroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	30.00
97261-00	~~Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician;~~ each additional area (MD/DO)	~~8.00~~ 8.40
~~97700~~	~~Office visit, including one of the following tests or measurements, with report: a. Orthotic checkout b. Prosthetic checkout c. Activities of daily living checkout; initial 30 minutes, each visit~~	~~45.00~~
~~97701~~	~~each additional 15 minutes~~	~~33.00~~

5221.2200 ~~CRITICAL CARE~~ SPECIAL SERVICES AND REPORTS.

~~Critical care services (codes 99162 to 99173) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations 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.~~ Special services and reports apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include a means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. (See part 5221.1100 for definitions on levels of services.

Code	Service	Maximum Fee
	Miscellaneous Services	
99000-00	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory (MD/DO)	$ ~~8.00~~ 9.25

99001-00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated) (MD/DO)	~~11.90~~ 11.00
99014-00	Telephone calls for consultation or medical management; intermediate	15.00
	~~Surgical~~ ~~Procedures~~	
99025-00	Initial, new patient visit; when ~~asterisk~~ asterisked (*) surgical procedure constitutes major service at that visit (MD/DO)	~~20.00~~ 25.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	27.10
99054-00	Services requested on Sundays and holidays in addition to basic services	25.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	55.00
99058-00	Office services provided on an emergency basis (MD/DO)	~~35.00~~ 40.00
99062-00	Emergency care facility services; when the nonhospital-based physician is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	52.00
99064-00	Emergency care facility services; when the nonhospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	50.00
99065-00	during regular office hours	50.50
99075-00	Medical testimony (MD/DO)	Reasonableness of charges reviewable by commissioner
99080-00	Special reports like insurance forms, or the review of medical data to clarify a patient's status; more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner (MD/DO)	Reasonableness of charges reviewable by commissioner

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99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00

Prolonged Services

99150-00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour (MD/DO)	S ~~100.00~~ 114.00
99151-00	more than one hour	191.00

Medical Conferences

99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes (MD/DO)	~~65.00~~ 73.70
99156-00	approximately 50 minutes	~~115.00~~ 100.00

Critical Care Services

Critical care services (codes 99162-00 to 99173-00) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99160-00	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour (MD/DO)	S ~~110.00~~ 151.50
99162-00	additional 30 minutes (MD/DO)	~~75.00~~ 76.50
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	75.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness (MD/DO)	~~55.00~~ 60.00
99172-00	~~Critical care, subsequent follow-up visit;~~ limited examination, evaluation, or treatment for same or new illness (MD/DO)	53.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness (MD/DO)	~~75.00~~ 78.00

99174-00	Extended reexamination, reevaluation and/or treatment, same or new illness (MD/DO)	~~131.00~~ 150.00
~~99175~~	~~Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison~~	~~62.00~~
	Other Services	
99195-00	Phlebotomy, therapeutic (separate procedure)	35.00

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. [Unchanged.]

Subp. 2. **Instructions.** The instructions in items A to ~~E~~ F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in-hospital follow-up care, provided by the surgeon both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. The surgical package includes the assistant surgeons if any are used. Reimbursement for the assistant surgeon is made from the fee collected for the surgical package and is the responsibility of the primary physician. For the purposes of this definition, preoperative care does not include any care administered before the provider determines that surgery is required.

B. to D. [Unchanged.]

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

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

(2) Preoperative services shall be listed when:

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

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

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

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

(3) All postoperative care is added on a service-by-service basis.

(4) Complications are added on a service-by-service basis as with surgical procedures.

F. Special situations.

(1) Multiple procedures (more than one procedure is performed at a single operative session through the same incision.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

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(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 50 percent of the Medical Fee Schedule, whichever is less.

(2) Multiple procedures (more than one procedure is performed at a single operative session through different incisions.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 65 percent of the Medical Fee Schedule, whichever is less.

(3) Bilateral procedures (pertaining to two sides and requiring separate incisions.)

(a) When bilateral procedures are performed at the same operative session and the descriptor for the procedure code specifies bilateral procedures, the procedures must be reported using the applicable procedure code listed in the Medical Fee Schedule. Reimbursement must be at the provider's usual charge or the Medical Fee Schedule, whichever is less.

(b) When the descriptor of the procedure code does not specify that it is bilateral, the primary procedure must be reported twice using the applicable procedure codes.

For the first procedure, the applicable 5-digit procedure code must be billed without a modifier. Reimbursement will be at the provider's usual rate or the rate set in the Medical Fee Schedule, whichever is less.

For the second procedure, the applicable 5-digit code must be billed with modifier 50. Reimbursement must be at the provider's usual rate or 75 percent of the rate set in the Medical Fee Schedule, whichever is less.

Subp. 3. **Integumentary system.** ~~The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.~~

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200 to 11441) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions.

(2) Treatment of burns (codes 16000 to 16030) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001 to 12014) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit.

(b) Intermediate repair (codes 12031 to 12052) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure.

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

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

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

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

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

B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

Incision

Code	Service		Maximum Fee
10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion (MD/DO)	S	~~50.00~~ 53.00
10003*00	Incision and drainage of infected or noninfected epithelial inclusion cyst (sebaceous cyst) with complete removal of sac and treatment of cavity (MD/DO)		~~59.00~~ 60.00
10020*00	Incision and drainage of furuncle (MD/DO)		~~35.00~~ 40.00
10040*00	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules		23.00
10060*00	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple (MD/DO)		~~51.50~~ 54.00
10061-00	complicated		130.00
10080*00	Incision and drainage of piloridial cyst; simple (MD/DO)		~~59.25~~ 60.00
10100*00	Incision and drainage of onychia or paronychia single or simple (MD/DO)		~~45.00~~ 47.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple (MD/DO)		~~50.00~~ 52.50
10121*00	complicated		112.20
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst (MD/DO)		45.00
10180-00	Incision and drainage, complex, postoperative wound infection		100.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface		35.00
11041-00	Debridement; skin, full thickness		35.00
11042-00	skin, and subcutaneous tissue		80.00

Paring or Curettement

11050*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	S	~~27.00~~ 28.00
11051-00	two to four lesions		40.00
11052-00	more than four lesions		52.00

Biopsy

11100-00	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion (MD/DO)	S	~~60.00~~ 63.00
~~11101~~	~~each additional lesion~~		~~31.50~~

	Excision — Benign Lesions	
11200*00	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions (MD/DO)	S ~~54.00~~ 55.00
11400-00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter (MD/DO)	~~68.00~~ 70.40
11401-00	lesion diameter 0.5 to 1.0 centimeter	~~78.00~~ 82.00
11402-00	lesion diameter 1.0 to 2.0 centimeters	~~96.50~~ 100.00
11403-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	115.00
11404-00	lesion diameter 3.0 to 4.0 centimeters (MD/DO)	~~130.00~~ 150.00
11406-00	lesion diameter over 4.0 centimeters	200.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter (MD/DO)	~~72.50~~ 77.00
11421-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	~~91.25~~ 96.60
11422-00	lesion diameter 1.0 to 2.0 centimeters (MD/DO)	~~110.00~~ 120.00
11423-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	~~140.00~~ 144.00
11424-00	lesion diameter 3.1 to 4.0 centimeters	160.00
11426-00	lesion diameter over 4.0 centimeters	300.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter (MD-DO)	~~87.00~~ 90.00
11441-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	~~108.80~~ 113.00
11442-00	lesion diameter 1.1 to 2.0 centimeters	135.00
11443-00	lesion diameter 2.1 to 3.0 centimeters	89.00
	Excision — Malignant Lesions	
16000-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	$ 111.00
11601-00	lesion diameter 0.6 to 1.0 centimeter	145.00
11602-00	lesion diameter 1.1 to 2.0 centimeters	204.00
11603-00	lesion diameter 2.1 to 3.0 centimeters	260.00
11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less	171.00
11621-00	lesion diameter 0.6 to 1.0 centimeter	220.00

11622-00	lesion diameter 1.1 to 2.0 centimeters	280.43
11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips, lesion diameter 0.5 centimeter or less	243.00
11641-00	lesion diameter 0.6 to 1.0 centimeter	292.90
	Nails	
11700*00	Debridement of nails, manual; 5 or less	$ 29.00
11710*00	Debridement of nails, electric grinder, 5 or less	25.00
11730*00	Avulsion of nail plate, partial or complete, simple; single (MD/DO)	~~$ 60.00~~ 64.00
11740-00	Evacuation of subungual hematoma (MD/DO)	~~35.00~~ 36.50
11750-00	Excision of nail and nail matrix, partial or complete, (e.g. ingrown or deformed nail) for permanent removal	125.00
11760-00	Reconstruction of nail bed; simple	77.00
	Miscellaneous	
11770-00	Excision of piloridial cyst or sinus; simple	$ 550.00
11771-00	extensive	600.00
11900*00	Injection, intralesional, up to and including seven lesions (MD/DO)	$ 35.00
	Introduction	
11901*00	Injection, intralesional; up to and including 7 lesions	$ 71.00
11954-00	Subcutaneous injection of "filling" material (e.g. silicone); over 10 cc	50.00
	Repair — Simple	
12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters (MD/DO)	$ ~~53.00~~ 55.50
12002*00	2.5 to 7.5 centimeters (MD/DO)	~~77.00~~ 82.00
12004*00	7.5 to 12.5 centimeters (MD/DO)	~~112.00~~ 120.00
12005*00	12.5 to 20.0 centimeters (MD/DO)	~~134.00~~ 175.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters (MD/DO)	~~78.00~~ 83.00
12013*00	2.5 to 5.0 centimeters	~~107.00~~ 115.00
12014-00	5.1 to 7.5 centimeters	75.00

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	Repair — Intermediate	
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters (MD/DO)	S ~~80.00~~ 84.00
12032*00	2.5 to 7.5 centimeters (MD/DO)	~~100.00~~ 118.00
12034-00	7.6 to 12.5 centimeters (MD/DO)	~~143.10~~ 168.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters (MD/DO)	98.00
12042-00	2.5 to 7.5 centimeters (MD/DO)	~~130.00~~ 140.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters (MD DO)	~~110.00~~ 112.00
12052-00	2.5 to 5.0 centimeters (MD/DO)	~~139.00~~ 160.00
	Repair — Complex	
13100-00	Repair, complex, trunk; 1.1 to 2.5 centimeters	S 140.00
13101-00	2.6 to 7.5 centimeters	275.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters	280.00
13121-00	2.6 to 7.5 centimeters	234.00
13131-00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters	350.00
13132-00	2.6 to 7.5 centimeters	490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less	210.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters (MD/DO)	~~S~~ 420.00
13152-00	2.5 to 7.5 centimeters (MD/DO)	~~697.00~~ 630.00
	Adjacent Tissue Transfer or Rearrangement	
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters (MD DO)	S ~~726.25~~ 725.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters (MD/DO)	~~850.00~~ 1,000.00
	Free Skin Grafts	
15100-00	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters or less, or each one percent of body area of infants and children (MD/DO)	S ~~583.00~~ 635.00

Burns, Local Treatment

16000-00	Initial treatment, first degree burn, when no more than local treatment is required (MD/DO)	$ ~~50.00~~ 47.50
16020*00	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small (MD/DO)	~~40.00~~ 42.50
16025*00	without anesthesia, medium, for example, whole face or whole extremity (MD/DO)	~~66.00~~ 71.00

Destruction

17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion (MD/DO)	S ~~47.50~~ 46.50
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (MD/DO)	~~36.50~~ 43.00
17101-00	second lesion (MD/DO)	~~20.25~~ 22.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	40.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions (MD/DO)	~~51.00~~ 50.00
~~17250*~~	~~Chemical cauterization of a wound~~	~~30.00~~
17304-00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to 5 horizontal, microscopic specimens	460.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2) (MD/DO)	~~28.00~~ 30.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)	31.00

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

Excision — General

Code	Service	Maximum Fee
20220-00	Biopsy, bone, trocar, or needle; superficial, for example ilium, sternum, spinous process, ribs	S ~~150.00~~ 175.00

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	Introduction or Removal — General		
~~20501*~~	~~Injection of sinus tract; diagnostic (sinogram) (separate procedure)~~		~~$ 48.88~~
20550*00	Injection, tendon sheath, ligament, or trigger points (MD/DO)		~~41.00~~ 46.00
20600*00	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes (MD/DO)		~~42.00~~ 50.00
20605*00	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa (MD/DO)		~~58.55~~ 60.25
20610*00	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa (MD/DO)		~~57.00~~ 61.00
20670*00	Removal of implant; superficial, (e.g. buried wire, pin, or rod)		86.50
20680-00	Removal of implant: deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate (MD/DO)		~~320.00~~ 344.00
	Head—~~Fracture or Dislocation~~ Repair, Revision, or Reconstruction		
~~21240~~	~~Arthroplasty, temporomandibular joint~~		~~$ 2,226.00~~
21116-00	Injection procedure for temporomandibular joint arthrography		$162.00
21310-00	Treatment of closed or open nasal fracture without manipulation (MD/DO)		~~45.00~~ 55.00
21315-00	mandible (includes obtaining graft)		120.00
21320-00	Manipulative treatment, nasal bone fracture; with stabilization (MD/DO)	~~278.00~~	300.00
~~21455~~	~~Closed manipulative treatment by interdental fixation of closed or open mandibular fracture~~		~~718.43~~
	Neck (Soft Tissues) and Thorax — Fracture or Dislocation		
21800-00	Treatment of rib fracture; closed, uncomplicated, each		65.00
	Spine		
Code	Service		Maximum Fee
22555-00	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) (MD/DO)		~~$2,261.00~~ 2,300.00
	Shoulders—Fracture or Dislocation		
23350-00	Injection procedure for shoulder arthrography (MD/DO)		$ 58.00

23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) (MD/DO)	~~1,563.50~~ 1,515.00
23450-00	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation (MD/DO)	~~1,355.00~~ 1,359.00
23500-00	Treatment of closed clavicular fracture; without manipulation (MD/DO)	100.00
~~23550~~	~~Open treatment of closed or open acromioclavicular dislocation, acute or chronic~~	~~852.00~~
23540-00	Treatment of closed acromioclavicular dislocation; without manipulation	75.00
23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	202.25
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia (MD/DO)	~~146.00~~ 138.00
23655-00	requiring anesthesia (MD/DO)	~~197.00~~ 213.00
	~~Shoulder — Manipulation~~	
~~23700*~~	~~Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)~~	~~$ 188.00~~
	Humerus (Upper Arm) and Elbow — Fracture or Dislocation	
~~24105~~	~~Excision, olecranon bursa~~	~~$ 375.00~~
24500-00	Treatment of closed humeral shaft fracture; without manipulation	$233.70
24600-00	Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	168.00
24650-00	Treatment of closed radial head or neck fracture without manipulation (MD/DO)	~~135.00~~ 160.00
	Forearm and Wrist — Incision and Excision	
25000-00	Tendon sheath incision; at radial styloid for de Quervain's disease	$395.00
25111-00	Excision of ganglion, wrist (dorsal or volar); primary (MD/DO)	~~$ 380.00~~ 400.00
~~25500~~	~~Treatment of closed radial shaft fracture; without manipulation~~	~~150.50~~
	Forearm and Wrist — Fracture or Dislocation	
25505-00	Treatment of closed radial shaft fracture; with manipulation (MD/DO)	$ ~~341.00~~ 345.00

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25560-00	Treatment of closed radial and ulnar shaft fractures; without manipulation	211.50
25565-00	Treatment of closed radial and ulnar shaft fractures; with manipulation (MD/DO)	~~406.00~~ 435.00
25600-00	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation (MD/DO)	~~189.00~~ 176.00
25605-00	with manipulation (MD/DO)	~~318.00~~ 322.00
25610-00	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning (MD/DO)	~~443.00~~ 460.00
25611-00	with external skeletal fixation or percutaneous pinning (MD/DO)	~~600.00~~ 643.00
25622-00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	185.00
	Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction	
26010*00	Draining of finger abscess; simple	$55.00
26055-00	Tendon sheath incision for trigger finger (MD/DO)	~~$383.00~~ 400.00
26115-00	Excision, tumor, hand or finger; subcutaneous	315.00
26116-00	deep, subfascial, intramuscular	537.50
26122-00	Fasciectomy, palmar, simple for Dupuytren's contracture; up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,309.00
26160-00	Excision of lesion of tendon sheath or capsule (MD/DO)	~~248.00~~ 231.00
26418-00	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon (MD/DO)	~~255.00~~ 333.00
	Hands and Fingers — Fractures or Dislocations	
26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone (MD/DO)	$ ~~126.00~~ 116.00
26605-00	with manipulation, each bone (MD/DO)	~~195.00~~ 196.00
~~26615~~	~~Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone~~	~~490.00~~

26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (MD/DO)	~~80.00~~ 77.00
26725-00	with manipulation, each (MD/DO)	~~137.00~~ 150.00
26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each	400.00
26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each (MD/DO)	~~56.00~~ 55.50
26755-00	with manipulation, each	112.00
26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	100.00
26770-00	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia (MD/DO)	~~62.00~~ 65.00
	Hand and Fingers — Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (MD/DO)	S ~~275.00~~ 295.50
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)	S2,098.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple (MD/DO)	3,050.00
~~27131~~	~~complex~~	~~3,628.00~~
27134-00	Revision of total hip arthroplasty; both components	4,100.00
27235-00	Treatment of closed or open femoral fracture,in situ pinning of undisplaced or impacted fracture	1,493.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (MD/DO)	~~1,629.00~~ 1,700.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation (MD/DO)	~~1,491.00~~ 1,496.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	381.00

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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

Notice of the Commissioner's intent to adopt the above-entitled rule was published in the State Register on December 27,1988 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 on December 23, 1988. The Statement of Need and Reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

All persons were given the opportunity to submit comment on the rule for 30 days after notice of proposed rulemaking. The agency received 30 requests for a public hearing, of which 6 were withdrawn in writing. Therefore, the agency did not receive requests for a public hearing from 25 or more persons which were not withdrawn.

No requests for notice of submission to the attorney general were received by the agency.

Based on the comments and evidence in the record before the agency, I find that the following nonsubstantial changes are appropriate:

FINDINGS OF FACT

1. Part 5221.0100 DEFINITIONS.

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

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

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

~~C. for outpatient treatment provided by a chiropractor, legible information that substantiates the nature~~

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

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

~~D. for outpatient treatment provided by other health care providers not specified in items A to C, legible information that substantiates the nature and necessity of a service or charge in the form of an initial report, an interim report, or a discharge/summary report.~~

This subpart is deleted upon request of hospitals, chiropractors and physicians as a result of disagreement over the definition of an appropriate record. Due to the extent of disagreement over the definition it is appropriate to delete the subpart, to be reproposed at a later time. This is not a substantial change because as proposed language this subpart was subject to public comment and reaction from interested persons and the deletion does not introduce a new subject matter or affect a new class of persons. Further, the deletion is not a major substantive change that would invite reaction because the deletion has been requested by health care provider groups and does not either preclude or require the documents identified from being submitted to substantiate a bill pursuant to M.S. 176.135, subd. (7).

2. Part 5221.0600 PAYER RESPONSIBILITIES.

Subp. 3. Determination of charges.

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

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

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

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

This modification is in response to concerns raised by health care providers about multiple payer requests for additional information to support a service or charge billed before making a payment determination. This is not a major substantial change because the language as proposed is ambiguous and the modification merely clarifies the point at which the initial determination to pay or deny must be made. The payer's right to later reverse the determination is not compromised if further information is requested and received from the provider.

3. Part 5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 4. Cooperation with payer. Pursuant to Minnesota Statutes, section 176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness. ~~A provider may not require prepayment for costs of copies of existing medical records.~~

This sentence is deleted in response to comments received that the subject is more appropriately covered by rules on cost of copies of existing medical records, which will be proposed shortly. It is not a substantial change because the sentence was initially proposed language, and as such subject to deletion after public comment and reaction. The deletion does not affect a new class of persons, introduce a new subject matter or affect existing rights or obligations.

4. Part 5221.1000. INSTRUCTIONS FOR APPLICATION OF THE MEDICAL FEE SCHEDULE.

Subpart 7. Code modifiers. Item F.

Modifier number 50 denotes bilateral procedures. ~~This modifier does not exempt the secondary services from the maximum fee for the five-digit code.~~ Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session shall be identified by the appropriate five-digit code describing the first procedure. The second bilateral procedure shall be identified by adding modifier 50 to the procedure number.

The sentence is deleted because it is confusing when read in conjunction with new language in Part 5221.2250, Subpart 2, item F, subitem 3, which sets out specific instructions for billing under the fee schedule for this modifier. It is not a substantial change because the subject matter is comprehensively addressed in the new rule, and as such was subject to public comment and reaction.

5. Part 5221.1100 PHYSICIAN SERVICES, MEDICINE.

Subpart 3a. Home services.

Code	Service	Maximum Fee
~~90130-00~~		
90140-00	Home medical service, established patient; ~~minimal~~ brief service	~~30.30~~ 42.90
~~90140-00~~	~~brief service~~	~~42.90~~

Subpart 4. Hospital services. The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under codes 90240 to ~~90270~~ 90292.

Subpart 6. Nursing home, boarding home, domiciliary, or custodial care medical services.

Code	Service	Maximum Fee
90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	~~50.00~~ 37.00

Code 90130 (minimal service) is deleted because it did not meet the statistical criteria for inclusion in the medical fee schedule and as such was erroneously included. This is not a substantial change because only codes meeting the statistical criteria can be included in the fee schedule. Public comment on codes which do not meet the statistical criteria would not result in inclusion. There has been opportunity for comment on the statistical criteria used in general. Health care providers who perform services not listed in the medical fee schedule are entitled to reimbursement of their usual and customary charge in accordance with Part 5221.0600, subp. 3(B).

The modification in Subpart 4 clarifies that the hospital codes listed include codes 90280 and 90292, thereby eliminating potential confusion as to the applicability of the codes listed. Because code 90292 is already included in the listed codes, this change is not substantial.

The change in Subpart 6 corrects an erroneous dollar amount listed in the proposed rules. The $37.00 figure meets the statistical criteria for inclusion in the medical fee schedule Corrections of maximum fee dollar amounts are not substantial changes because the public had the opportunity to comment on the statistical criteria used to determine which services should be included and the corresponding maximum allowable fees. Comment would not result in the inclusion of statistically invalid dollar amounts.

6. Part 5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

Code	Service	Maximum Fee
90862-00	Chemotherapy management, including prescription, use and review of medication with no more than minimal medical psychotherapy.	~~120.00~~ 50.00

This change corrects an erroneous dollar amount. The $50.00 figure meets the statistical criteria for inclusion in the medical fee schedule for the service.

7. Part 5221.1600 OTORHINOLARYOGOLOGIC SERVICES

Code	Service	Maximum Fee
92546-00	Torsion swing test, with recording	31.00

This code was erroneously omitted before publication. The service meets the statistical criteria for inclusion in the medical fee schedule.

8. Part 5221.2250 PHYSICIAN SERVICES, SURGERY.

Subpart 2. Instructions

Item F. Special Situations

Subitem (2). Multiple procedures (more than one procedure is performed at a single operative session through different incisions).

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or ~~65~~ 75 percent of the medical fee schedule, whichever is less.

Subpart 3. Integumentary system

Item B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

Code	Service	Maximum Fee
~~10040-00~~	~~Acne surgery (e.g. marsupialization opening or removal of multiple milia, comedones, cysts, pustules~~	~~23.00~~
~~11041-00~~		
11040-00	Debridement; skin, ~~full~~ partial thickness	35.00
11041-00	full thickness	35.00
~~16000-00~~		
11600-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	111.00

Subpart 5. Casts and strapping

Strapping - Any Age

Code	Service	Maximum Fee
29220-00	Strapping; low back (MD/DO)	30.00
~~29240-00~~	~~shoulder (e.g. Velpeau)~~	~~50.00~~

Arthroscopy

29879-00	Abrasion arthroplasty chrondroplasty where or multiple drilling	~~15.25~~ necessary)	1,525.00

Subpart 7. Cardiovascular system

Coronary Artery Procedures

Code	Service	Maximum Fee	
33512-00	Three coronary grafts (MD/DO)	~~4,900.00~~	5,400.00

Subpart 10. Urinary system

Code	Service	Maximum Fee	
52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters)	~~530.00~~	430.00

Subpart ~~10~~ 11 Reproductive system

Subpart 13. Nervous system

Code	Service	Maximum Fee
62274*00	Injection of anesthetic substance diagnostic or therapeutic; subarachnoid or subdural simple (MD/DO)	100.00
62278*00	epidural or caudal single (MD/DO)	195.00

Subpart 14. Auditory system

69660-00	Stapedectomy with restablishment of ossicular continuity, with or without use of foreign material (MD/DO)	1,985.00

The change in Subpart 2 is made in response to a recommendation from the Minnesota Medical Association Task Force on Workers' Compensation that 75 percent is a more accurate reflection of the percentage of reimbursement in non-workers' compensation cases. This merely modifies the proposed percentage, and is not a substantial modification as it does not present new subject matter, affect a new class of persons or result in a major substantive change.

Code 10040 was erroneously included in Subpart 3 as the code did not meet the statistical criteria for inclusion. Code 11040 (partial thickness) was erroneously excluded and is added because it meets the statistical criteria for inclusion. Code 11600 is correction of a typographical error made by the revisor's office, which identified the code as "16000".

Code 29240 in Subpart 5 was erroneously included as it does not meet statistical criteria for inclusion in the fee schedule. The dollar amount for code 29879 is inaccurate due to a clerical error. This change is not substantial because interested persons would recognize that $15.25 does not reflect the reasonable value of the service.

The dollar amounts for codes 33512 and 52234 in Subparts 7 and 10 are erroneous due to a clerical error. The new figures meet the statistical criteria for inclusion in the fee schedule.

The change from Subpart "10" to Subpart "11" merely corrects erroneous numbering of both the Urinary and Reproductive System subparts as "Subpart 10."

The added codes in Subparts 13 and 14 were erroneously omitted before publication of the proposed rules. The codes meet the statistical criteria for inclusion in the medical fee schedule.

9. Part 5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 2. Diagnostic radiology.

Head and Neck

Code	Service	Maximum Fee
70240-00	Radiological examination, sella ~~turcia~~ turcica (MD/DO)	48.25
~~70450-00~~	~~Computerized axial tomography, head or brain (MD/DO)~~	~~120.90~~
~~70480-00~~	~~Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material~~	~~150.00~~
~~70481-00~~	~~with contrast material~~	~~139.00~~
~~70486-00~~	~~Computerized axial tomography, maxillofacial area; without contrast material~~	~~91.40~~
~~70491-00~~	~~Computerized axial tomography, soft tissue neck; with contrast material(s)~~	~~132.00~~

Chest

~~71260-00~~	~~with contrast material~~	~~142.20~~

Spine and Pelvis

~~72126-00~~	~~Computerized axial tomography, cervical spine, with contrast material (MD/DO)~~	~~174.40~~
~~72132-00~~	~~with contrast material (MD/DO)~~	~~163.00~~
~~72192-00~~	~~Computerized axial tomography, pelvis; without contrast material (MD/DO)~~	~~212.50~~
~~72193-00~~	~~with contrast materials (MD/DO)~~	~~106.00~~
~~72266-00~~	~~complete procedure~~	~~216.00~~

Upper Extremities

~~73041-00~~	~~complete procedure~~	~~154.00~~

Lower Extremities

~~73581-00~~	~~complete procedure (MD/DO)~~	~~154.00~~
~~73700-00~~	~~Computerized axial tomography lower extremity; without contrast material~~	~~130.00~~

Abdomen

74020-00	(Radiologic examination, abdomen,) complete, including decubitus or and/or erect views (MD/DO)	40.00
~~74150-00~~	~~Computerized axial tomography, abdomen, without contrast material (MD/DO)~~	~~212.50~~
~~74160-00~~	~~with contrast material (MD/DO)~~	~~129.50~~
74181-00	Magnetic resonance (e.g. proton imaging, abdomen	790.00

Gastrointestional Tract

74230-00	Swallowing function, pharynx ~~paraynx~~ and/or esophagus, with cineradiography and/or video	78.00

Urinary Tract

~~74420-00~~	~~Urography, retrograde, with or without kidneys, ureters, and bladder (MD/DO)~~	~~55.00~~

Vascular System

~~75628-00~~	~~Aortography, abdominal, catheter by seriography (MD/DO)~~	~~288.00~~

Miscellaneous

~~76370-00~~	~~Computerized tomography guidance for placement of radiation therapy fields~~	~~74.25~~
~~76375-00~~	~~Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction~~	~~45.00~~

Subpart 4. Therapeutic radiology

Code	Service	Maximum Fee
77415-00	Therapeutic radiology treatment port film interpretation and verification, per treatment course	22.00

The deleted codes in Subpart 2 were erroneously included because, due to an incorrect data base, the amounts do not accurately reflect the value of the service. Several of these inaccurate amounts were identified by public comment. Code 74181 is added because the statistical criteria for inclusion have been met and the code was erroneously excluded. The changes in codes 70240, 74020 and 74230 merely correct spelling errors and inaccurate service descriptions for the codes.

Code 77415 in Subpart 4 was erroneously omitted and is added because it meets the statistical criteria for inclusion in the medical fee schedule.

10. Part 5221.2400 PHYSICIAN SERVICES, PATHOLOGY AND LABORATORY.

Subpart 2. Automated, multichannel tests

Therapeutic Drug Monitoring

Code	Service	Maximum Fee
80031-00	Therapeutic/quantitative drug monitoring in body fluids and/or excreta; measured on drug (MD/DO)	33.00

Subpart 8. Anatomic pathology

Cystopathology

Code	Service	Maximum Fee
88155-00	(Cytopathology) with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index)	13.50

Subpart 10. Miscellaneous

Code	Service	Maximum Fee
89360-00	Sweat collection by iontophoresis	41.00

The code number "80031" in Subpart 2 was inadvertently deleted in the rules as published in the State Register. This is not a substantial change because the original entry is simply completed for identification based on the service description.

The dollar amount for code 88155 in Subpart 8 was inadvertently omitted in the rules as published in the State Register.

Code 89360 is added in Subpart 10 because it meets the statistical criteria for inclusion in the medical fee schedule.

11. Part 5221.2500 DENTISTS.

Subpart 2. Diagnostic

Partial Dentures - Including Routine Post-Delivery Care

Code	Service	Maximum Fee
05214-00	Lower partial; predominantly base cast base with acrylic saddles (including any conventional clasps and vests)	~~575.00~~ 565.00
05215-00	Upper partial; high noble cast base with acrylic saddles, (including any conventional clasps and rests)	~~565.00~~ 575.00
	Bridge Pontics	
06210-00	Pontic; cast high nobel metal	~~135.00~~ 350.00
	Miscellaneous Services	
~~09991-00~~		~~25.00~~
~~09993-00~~		~~30.00~~
	Surgery	
41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	150.00
42150-00	Removal of exostosis, bony palate	280.00

The dollar amounts for codes 05214 and 05215 were erroneously transposed. The dollar amount for 06210 is also incorrect. The new amounts meet the statistical criteria for inclusion in the medical fee schedule. Codes 09991 and 09991 are deleted as neither the codes nor service descriptions can be identifed from any source available to the Department. As such the codes probably do not exist and merely reflect errors in bills submitted to Blue Cross and Blue Shield. Code 41825 was erroneously omitted, as it meets the statistical criteria for inclusion in the medical fee schedule. Code 42150 corrects a clerical transcribing error, which omitted the first "0" in the rules published in the State Register.

12. Part 5221.2600 OPTOMETRISTS. ~~OPTICIANS~~

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of optometry, and to procedures performed within the scope of practice in accordance with Minnesota Statutes, section 52 to 148.62.

~~Subp. 2. Definitions. The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.~~

~~A. "New patient" and "established patient" have the meanings given them in part 5221.1100.~~

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

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

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

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

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

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

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

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	48.00
06502-00	Biofocal eyeglass lenses (one lens)	70.20
06503-00	Trifocal eyeglass lenses (one lens)	90.00
06504-00	Lenticular eyeglass lenses (one lens)	21.00
06506-00	Eyeglass frames	67.00
06510-00	Tinting for lenses	15.00
06587-00	Contact lenses, soft (one lens)	80.00
06588-00	Contact lenses, hard (one lens)	70.00
06589-00	Dispensing fee; single vision lenses	25.00
06590-00	biofocal lenses	30.00
06591-00	trifocal lenses	32.00
09201-00	Eye examination with complete visual fields included	44.00
09213-00	Eye refraction	29.00

Office Services

90000-00 New patient; brief service ---------- 22.00
90010-00 ----- limited service ---------- 28.00
90015-00 ----- intermediate service ---------- 38.00
90017-00 ----- extended service ---------- 50.00
90020-00 ----- comprehensive service ---------- 50.00
90030-00 Established patient; minimal service ---- 15.00
90040-00 ----- brief service ---------- 19.00
90050-00 ----- limited service ---------- 25.00
90060-00 ----- intermediate service (does not include determination of the refractive state) ---------- 31.00
90070-00 ----- extended service ---------- 45.00
90080-00 ----- comprehensive service ---------- 49.00
92002-00 New patient; intermediate service ---------- 39.00
92004-00 ----- comprehensive service, one or more visits ---------- 50.00
92012-00 Established patient; intermediate service (includes determination of the refractive state) ---------- 38.00
92014-00 ----- comprehensive service, one or more visits ---------- 44.00
92060-00 Sensorimotor examination with diagnostic evaluation ---------- 50.00
92065-00 Orthoptic and/or pleoptic training, with continuing direction and evaluation ---------- 40.00
92081-00 Visual field examination with medical diagnostic evaluation; tangent screen, autoplot or equivalent ---------- 20.00
92082-00 ----- quantitative perimetry (e.g., several isopters on Goldmann perimeter or equivalent ---------- 42.50
92083-00 ----- static and kinetic perimetry, or equivalent ---------- 60.00
92100-00 Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day ---------- 10.00
92140-00 Provocative tests for glaucoma, with medical diagnostic evaluation ---------- 15.00
92225-00 Opthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomocroscopy), with medical diagnostic evaluation; initial ---------- 22.20
92250-00 Opthalmoscopy, with medical diagnostic evaluation; with fundus photography ------ 15.00
92285-00 Extended ocular photography for documentation of progress ---------- 10.00
92287-00 Specular endothelial microscopy with photographic documentation, evaluation and report; with fluorescein angiography ---------- 38.00

~~92310-00-Prescription-and-management-of-corneal contact-lens,-both-eyes,-except-for aphakia----------50.00~~
~~92312-00-----corneal-lens-for-aphakia,-two-eyes---130.00~~
~~92325-00-Modification-of-contact-lens----------20.00~~
~~92326-00-Replacement-of-contact-lens----------58.00~~
~~92340-00-Treatment-with-spectacles,-except-for aphakia,-monofocal----------49.00~~
~~92341-00-----bifocal----------64.00~~
~~92342-00-----multifocal,-other-than-bifocal--------84.00~~
~~92370-00-Repair-and-adjusting-spectacles,-except except-for-aphakia----------68.95~~
~~92390-00-Supply-of-all-spectacle-lenses,-except-for aphakia-and-low-vision-aids-(all-combinations, nonspecific),-one-lens-only.--(Enter-two-units for-a-pair)----------79.00~~
~~92391-00-Supply-of-contact-lenses,-except-prosthesis-for aphakia,-one-lens-only (enter-two-units-for-a-pair)----------108.00~~
~~99056-00-Services-provided-at-request-of-patient-in-a location-other-than-optometrist's-office-which are-normally-provided-in-the-office--------6.00~~

"Opticians" is omitted from the heading of this part because the codes apply only to optometrists. A new part, 5221.2650, was created for optician codes, and the heading was therefore misleading and confusing. Subpart 1 is modified to clarify that the fee schedule applies only to services performed within the optometrist's scope of practice, in response to concerns expressed by ophthalmologist's that some of the codes and definitions included are outside the scope of optometric practice. In response to the same concern, Subpart 2 containing the definitions and the codes listed under office services (codes 90000 to 99056) are also deleted. These modifications are not substantial changes because no new subject matter is raised, a new class of persons is not affected and optometrists are still entitled to their usual and customary charges in accordance with Part 5221.0600, Subpart 3(b) for codes not listed in the fee schedule. The deletion is necessary to further review the codes and service descriptions in light of the public comments. Additional codes may be added in future fee schedules after discussion with interested groups. The codes retained are either existing in the present fee schedule or undisputed.

13. Part 5221.2700 AUDIOLOGISTS.

Subpart 2. Audiology

Code	Service	Maximum Fee
~~92585-00~~	~~Brainstem-evoked-response recording-(CCC-A/CFY)~~	~~.....~~
92590-00	Hearing ~~and~~ aid examination and selection, monaural (CCC-A/CFY)	50.00
~~92591-00~~	~~-----binaural-(CCC-A/CFY)~~	~~.....~~

92592-00	Hearing aid check; monaural (CCC-ACFY)	53.50
~~92593-00~~	~~-----binaural~~	~~30.00~~

Codes 92585, 92591 and 92593 are deleted because they do not meet the statistical criteria for inclusion. Code 92590 is corrected to reflect a clerical spelling error.

14. Part 5221.2750 SPEECH PATHOLOGISTS.

Code	Service	Maximum Fee
~~06045-00~~	~~(CCC-SP/CFY)~~	~~35.00~~

The above code was erroneously included, because it does not meet the statistical criteria for inclusion in the medical fee schedule.

15. Part 5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subpart 2. ~~Physical therapy~~ Definitions. The terms defined in this subpart have the meanings given to them when used in Subpart 4 unless the context clearly indicates a different meaning.

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

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

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

Subpart 3. Physical and occupational therapy instructions.

Item A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration. ~~The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.~~

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

Subpart 4. ~~Scope~~ Physical therapy and occupational therapy services.

The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed within the physical or occupational therapist's scope of practice in an independent clinic, a doctor's office, a hospital satellite clinic, or hospital out-patient setting.

Code	Service	Maximum Fee
97010-00	Physical medicine treatment to one area; hot or cold packs ~~(RPT/OTR)~~	17.00
97012-00	traction, mechanical ~~(RPT/OTR)~~	16.00
97014-00	electrical stimulation (unattended) ~~(RPT/OTR)~~	15.00
97016-00	vasopneumatic devices ~~(RPT/OTR)~~	16.00
97018-00	paraffin bath ~~(RPT/OTR)~~	20.00
97022-00	Whirlpool ~~(RPT/OTR)~~	17.00
97024-00	diathermy ~~(RPT/OTR)~~	16.00
97028-00	ultraviolet ~~(RPT/OTR)~~	25.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises ~~(RPT/OTR)~~	22.00
97112-00	neuromuscular reeducation ~~(RPT/OTR)~~	25.00
97114-00	functional activities ~~(RPT/OTR)~~	19.00
97116-00	gait training ~~(RPT/OTR)~~	23.00
97118-00	electrical stimulation (manual) ~~(RPT/OTR)~~	16.25
97120-00	iontophoresis ~~(RPT/OTR)~~	20.00
97122-00	traction, manual ~~(RPT/OTR)~~	18.00
97124-00	massage ~~(RPT/OTR)~~	17.25

97126-00	contrast baths	18.00
97128-00	ultrasound ~~(RPT/OTR)~~	16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	13.00
97220-00	Hubbard tank; initial 30 minutes each visit ~~(RPT/OTR)~~	45.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit ~~(RPT/OTR)~~	30.00
97500-00	Orthotics training (dynamic bracing, splinting), ~~upper~~ upper/lower extremities; initial 30 minutes, each visit ~~(RPT/OTR)~~	21.00
97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit ~~(RPT/OTR)~~	25.00
97531-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit ~~(RPT/OTR)~~	20.00
97541-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50

Tests and Measurements

97700-00	Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes ~~(RPT/OTR)~~ a. Orthotic check-out; b. Prosthetic check-out; c. Activities of daily living check-out; d. Follow-up evaluation for extremity testing for strength, dexterity, or stamina	21.00
97701-00	each additional 15 minutes	21.00
97720-00	Initial evaluation for ~~extremity~~ testing for strength, dexterity, or stamina; initial 30 minutes, each visit ~~(RPT/OTR)~~	32.00
97721-00	each additional 15 minutes ~~(RPT/OTR)~~	25.00
97752-00	Muscle testing with torque curves during isometric and isokinetic exercises mechanized or computerized ~~evaluators~~ evaluations with printout (e.g., by use of cybex or similar type machine); for extremities ~~(RPT/OTR)~~	55.00
97753-00	for trunk/back	134.00

The word "licensed" in Subpart 1 is deleted because physical therapists are currently registered but not licensed. This is not a substantial change because it merely clarifies the professional qualifications for physical therapists in accordance with existing law and does not otherwise affect the substance or application of the rule.

The change in the heading of Subpart 2 deletes "Physical therapy," which was left in due to a State Register error. The definitions apply to occupational and physical therapists and it is misleading to suggest in the heading that they are only physical therapy definitions.

The change in Item G deletes "extremity" in response to public comment from physical therapists that the testing described is not limited to extremities, but may also include the back. Therefore, the data base for the code listed would also include testing on the back and a modification of the definition is appropriate.

The change in Item H deletes the last sentence in response to public comment because it confuses the delineation between the kinetic activities definition and therapeutic exercise, which is already defined in Item A.

Item I is deleted because there is no code 97705 for functional capacity evaluation and as such the definition is unnecessary and confusing.

The modifications in Subpart 2 are not substantial changes because they modify proposed language in response to public comment and eliminate confusing or inaccurate provisions. The changes are not major, and do not affect a new class of persons or introduce new subject matter.

In Subpart 3, the last sentence in Item A is deleted in response to public comment because it is more appropriately included in a rule defining an "appropriate record," which is also deleted and will be proposed at a later time. This change is not substantial because it was proposed language subject to public comment and does not affect a new class of persons or introduce new subject matter. Changes in Item B merely reflect the professional qualifications of physical therapists, who are registered but not licensed.

The heading of Subpart 4 is changed from "scope" because that is also the heading for Subpart 1. This change is to avoid confusion and is not substantive as it is within the revisor's discretion.

Language is added to Subpart 4 to clarify that the codes apply to procedures performed within the scope of practice in response to public concern that not all codes apply to both physical and occupational therapists. The "RPT/OTR" designators are accordingly removed after the service descriptions. This change places responsibility upon the physical or occupational therapist to act within the scope of practice and eliminates the potential implication that the medical fee schedule permits

reimbursement for procedures outside the scope of practice. It is not a substantial change as the modification does not affect a new class of persons or introduce new subject matter, and merely clarifies that the fee schedule applies only to procedures performed by providers authorized to do so.

Codes 97500, 97720 and 97752 are modified to correct inaccuracies in the service descriptions. The previous service descriptions are not consistent with the data base for the appropriate codes.

16. Part 5221.2900 CHIROPRACTORS.

Subpart 1(b). Chiropractor instructions.

Item B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation ~~on the same-day~~.

Subpart 2. Medicine

Home/Nursing Home Visits

Code	Service	Maximum Fee
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00
09556-00	(e.g., long leg, thorocolumbar, lumbosacral, or full body corset type)	28.50
09592-00	Exercise consultation or instruction ~~25.00~~	20.00

Subpart 3. Radiology.

72120-CHR	Radiologic exam, spine, lumbosacral, bending views only, minimum of four views	80.00
73630-00	(Radiologic examination; foot;) complete, minimum of three views	55.00

Subpart 4. Laboratory.

85031CHR	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices) (CHIRO/DC)	~~15.00~~	20.00

The language deletion in Subpart 1(b), Item B is in response to public comment that the language is more restrictive than the scope of practice for chiropractors. It is not reasonable to restrict reimbursement for procedures done within the scope of practice without justification. As this was proposed language subject to public comment and reaction and does not introduce a new subject matter or affect a new class of persons, it is not a substantial modification.

Codes erroneously excluded are added in Subparts 2 and 3 because they meet the statistical criteria for inclusion in the fee schedule. The correction in the dollar amounts for codes 09592 and 85031 reflect the statistically valid amounts for the codes.

17. Part 5221.3000 PODIATRISTS.

Subpart 3. Medicine

Surgery

Code	Service	Maximum Fee	
~~02229-00~~	~~.....~~	~~200.00~~	

Radiology

81002-00	(Urinalysis,) routine, without microscopy	~~13.00~~	10.00

Therapeutic Injections

90782POD	Therapeutic injection of medication (specify) subcutaneous or intramuscular POD(/DPM)	~~30.00~~	20.00

Physical Medicine

~~L3010POD~~	~~-----Foot, insert, removable, molded --- to patient model, longitudinal arch support, each (POD/DPM)~~	~~.....~~

Other Procedures

~~X1229POD~~	~~-----Radical excision of nail (POD/DPM)~~	~~.....~~

Code 02229 is deleted because there is no service description available for the code. The dollar amount originally listed for code 81002 is incorrect due to a clerical error. The new figure meets the statistical criteria for inclusion in the fee schedule. Codes L3010POD and X1229POD are excluded because there is no statistically valid maximum fee for the codes.

18. Part 5221.~~3170~~ 1410 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider ~~certified by the Biofeedback Certification Institute of America (BCIA).--Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP).~~ licensed as a doctor of medicine or a doctor of osteopathy.

The changes specify that the codes apply only to doctors of medicine and osteopathy, and not to providers certified by the Biofeedback Certification Institute. As the data base for these codes consists of physician services, this part is renumbered 5221.1410 to correspond with the numbering of other physician codes. This change is necessary to ensure statistically accurate application of these codes. This is not a substantial change as public comment or expectation does not determine whether a code meets the criteria, but only the validity of the statistical criteria generally. Furthermore, the language proposed initially is confusing as to whether the codes apply to physicians. Non-physician biofeedback providers are entitled to reimbursement of their usual and customary charge for services in accordance with Part 5221.0600, subp. 3(B).

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

A repeal of Part 5221.1700, "Physician Services, Audiologic Tests" was erroneously omitted. The codes found in Part 5221.1700 apply to audiologists rather than physicians and therefore were moved to Part 5221.2700. Because the data base for audiological test codes does not include physicians, Part 5221.1700, the audiology section for physicians, should have been repealed. This is not a substantial change because the codes appear under the new Part 5221.2700, and Part 5221.1700 does not appear in the published rules. Physicians who perform audiology services are entitled to reimbursement of their usual and customary charge in accordance with Part 5221.0600, subp. 3(B).

The repeal of Part 5221.3400 was also erroneously omitted due to a clerical error. The repeal is necessary because it addresses the effective date of the rules and is confusing when read with Part 5221.3310, the new effective date provision.

Based upon the Findings of Fact, I make the following:

Conclusions

1. That the Department gave proper notice of the proposed amendments to all interested persons and groups.

2. That the Department has fully complied with all procedural requirements of law or rule in adopting the proposed amendments.

3. That the Department has acted within its statutory authority in adopting these proposed amendments.

4. That the proposed amendments as modified are needed and reasonable and fully comply with substantive requirements imposed by law or rule.

NOW, THEREFORE, IT IS ORDERED that the rule identified as part 5221.0100 - 5221.3310 as modified is adopted this 13th day of March, 1989, pursuant to authority vested in me by Minnesota Statutes, sections 176.136 (1988) and 176.83 (1988).

Ken Peterson
Commissioner

SF-00006-05 (4/86)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : ATTORNEY GENERAL

DATE : April 14, 1989

TO : KATHRYN BERGER
Compensation Attorney

FROM : CHRISTIE B. ELLER
Assistant Attorney General

PHONE : 6-9421

SUBJECT : In the Matter of the Adopted Rule Relating to Worker's Compensation Medical Charges and Reimbursement

The above-referenced rule has been approved as to its legality by the Attorney General on April 14, 1989.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies with the Secretary of State who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accoradance with Minn. Stat. §14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. §14.34.

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

CBE:rer
Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

William Brown
Chief Administrative Law Judge

RULE REVIEW CHECKLIST
RESUBMITTED RULE

File No. 1578 Docket No. 05.0009.0600

RESUBMISSION DATE 4/3/89
DATE DUE 4/17/89 (see letter to AG)

APPROVED 3/14
DISAPPROVED
WITHDRAWM

ADOPTED W/O HEARING X
EMERGENCY RULE

REVISOR APPROVED X
REVISOR DISAPPROVED
FILED W/SEC. STATE
RETURNED TO AGENCY

____ **Does the revision raise significant new legal issues?**

____ Review date

✓ Rule as adopted (4 copies)

✓ Supplemental Findings of Fact, Conclusions & Order Adopting

____ ~~Board's Supplemental Resolution Adopting~~

____ ~~Notice of submission to Attorney General~~

____ ~~Affidavit of Mailing Notice to Attorney General~~

John Fuller

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

DECLARATION OF COUNSEL

I, Steven M. Gunn, ~~Special~~ Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0600.

~~Special~~ Assistant Attorney General

Dated: 3/17/89

KB/kh

Department of Labor and Industry

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

Rules as Adopted

5221.0100 DEFINITIONS.

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

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

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

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

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

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

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

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

Subp. 9. **Injury.** "Injury" is as defined in Minnesota

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Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

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

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

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

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

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

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

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

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

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

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

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

5221.0200 AUTHORITY.

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

5221.0300 PURPOSE.

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

5221.0400 SCOPE.

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

5221.0500 EXCESSIVE CHARGES.

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

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

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

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

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

E. the charge does not comply with standards and

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requirements adopted pursuant to Minnesota Statutes, section 176.83, concerning the cost of treatment; or

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

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

5221.0600 PAYER RESPONSIBILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

D. a request for an appropriate record and/or the specific information requested to allow for proper determination

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of the bill under this part.

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

Subp. 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

5221.0700 PROVIDER RESPONSIBILITIES.

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

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

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

A. Approved billing codes. Billing codes must be found in the most recent edition of the following: Physician's Current Procedural Terminology; Blue Cross/Blue Shield specialty procedure codes; HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS); Code on Dental

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Procedures and Nomenclature maintained by the Council on Dental Care Programs; and for audiology and speech therapy, the "home-grown" codes specified by the Department of Human Services or any other code listed in the medical fee schedule.

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

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

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

25105	Arthrotomy, wrist joint; for synovectomy	

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness. ~~A provider may not require prepayment for costs of copies of existing medical records.~~

Subp. 5. **Collection of excessive charges.** No provider shall collect or attempt to collect payment from an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

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5221.0800 DISPUTE RESOLUTION.

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

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

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

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

D. to accommodate improvements or correct data base deficiencies. The Medical Services Review Board shall advise

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the commissioner regarding these revisions.

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

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

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

Subp. 6. **Ambiguity.** If, despite the payer's reasonable

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

Subp. 7. **Code modifiers.** The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in items A to T.

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

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

C. Modifier number 23 denotes unusual anesthesia.

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

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

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

F. Modifier number 50 denotes bilateral procedures. ~~This modifier does not exempt the secondary services from the maximum fee for the five-digit code.~~ Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session shall be identified by the appropriate five-digit code describing the first procedure. The second bilateral procedure shall be identified by adding modifier 50 to the procedure number.

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

H. Modifier number 52 denotes reduced services. This

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modifier is appropriate where the service provided is significantly less than is usually required for the listed procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

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

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

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

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

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

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

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

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

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

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

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

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

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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physician.

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

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

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

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

D. to L. [Unchanged.]

M. Referral. "Referral" means a transfer of the total care or specific care of a patient from one physician to another and does not constitute a consultation.

N. Hospital discharge day management. "Hospital discharge day management" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge record.

Subp. 3. **Office services.** The following codes, service descriptions, and maximum fees apply to services provided at the physician's office, or if provided in an outpatient hospital clinic setting, for nonemergency services.

Code	Service	Maximum Fee
90000-00	Office services; new patient;	

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

Subp. 3a. **Home services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a home setting if provided in a private residence as a "house call." They do not apply to physician services provided at a nursing home, boarding home, domiciliary (temporary lodging), or custodial care involving periodic services provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90100-00	Home medical service, new patient; brief service	$ 44.00
90110-00	limited service	48.00
90115-00	intermediate service	50.00
~~90130-00~~		
90140-00	Home medical service, established patient; ~~minimal~~ brief service	~~30.30~~ 42.90
~~90140-00~~	~~--brief service~~	~~42.90~~
90150-00	limited service	45.00
90160-00	intermediate service	50.00
90170-00	extended service	57.80

Subp. 4. **Hospital services.** The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under codes 90240 to ~~90270~~ 90292.

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

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

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care facilities. The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long-term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 45.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	70.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	96.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.00
90350-00	limited service	27.25
90360-00	intermediate service	40.00
90370-00	extended service	50.00

Subp. 6. **Nursing home, boarding home, domiciliary, or custodial care medical services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a domiciliary or custodial care facility involving periodic services, provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	$ ~~50.00~~ 37.00
90415-00	intermediate service	81.50
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	20.75
90440-00	brief service	25.00
90450-00	limited service	33.00
90460-00	intermediate service	44.00
90470-00	extended service	55.00

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

Code	Service	Maximum Fee

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

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

Code	Service	Maximum Fee
90590-00	Physician direction of Emergency Medical Systems (EMS), emergency care advanced life support	$ 112.00

5221.1200 CONSULTATIONS.

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

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

A. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient and the preparation of an appropriate record. When as a result of the consultation the consulting physician assumes responsibility for the continuing

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care of the patient, any subsequent service rendered by the physician cannot be billed as a consultation.

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

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

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

(4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to a consultation for a young person with fever,

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arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a record with recommendations.

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

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

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

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

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

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

Confirmatory (Additional Opinion) Consultation

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

5221.1210 IMMUNIZATION INJECTIONS.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include the supply of materials.

Code	Service	Maximum Fee
90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP) (MD/DO)	$ 20.00
90702-00	diphtheria and tetanus toxoids (DT) (MD/DO)	11.00
90703-00	tetanus toxoid (MD/DO)	10.50
90704-00	mumps virus vaccine, live (MD/DO)	19.00
90705-00	measles virus vaccine, live, attenuated (MD/DO)	16.50
90706-00	rubella virus vaccine, live (MD/DO)	17.00
90707-00	measles, mumps, and rubella virus vaccine, live (MD/DO)	26.75
90708-00	measles and rubella virus vaccine, live	24.00
90712-00	polio virus vaccine, live, oral; any type(s) (MD/DO)	15.00
90713-00	poliomyelitis vaccine (MD/DO)	15.00
90714-00	typhoid vaccine	11.00
90717-00	yellow fever vaccine	30.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD) (MD/DO)	10.00
90719-00	diphtheria toxoid (MD/DO)	9.50
90724-00	influenza virus vaccine (MD/DO)	11.25
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	115.52
90731-00	hepatitis B vaccine	61.25
90732-00	pneumococcal vaccine, polyvalent (MD/DO)	17.00
90733-00	meningococcal polysaccharide vaccine; any group(s) (MD/DO)	16.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	16.00
90741-00	Immunization, passive; immune serum globulin, human (ISG)	15.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	50.00

5221.1220 THERAPEUTIC INJECTIONS.

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

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90788-00 Intramuscular injection of antibiotic (specify) 14.25

5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
90801-00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the patient). (MD/DO)	$ 112.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	70.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	111.50
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes (MD/DO)	55.00
90844-00	approximately 45 or 50 minutes (MD/DO)	85.00
90847-00	Family medical psychotherapy (conjoint psychotherapy) (MD/DO)	85.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	57.00
90853-00	Group medical psychotherapy (other than of a multiple-family group) (MD/DO)	40.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	~~120.00~~ 50.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	120.00

Other Psychiatric Therapy

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

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	management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	70.00
90887-00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (MD/DO)	78.00

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

Subp. 2. **Definitions.** The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient" and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in part 5221.1100, except for item C regarding intermediate opthalmological service and item D regarding comprehensive opthalmological service.

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

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

(2) review of interval history, external

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examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with a known cataract not requiring comprehensive ophthalmological services.

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

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

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reevaluation.

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92020, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92235, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

Code	Service	Maximum Fee
	General Services	
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient (MD/DO)	$ 51.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient, one or more visits (MD/DO)	58.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient (MD/DO)	40.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient, one or more visits (MD/DO)	55.00
92019-00	limited	26.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure) (MD/DO)	29.30
	Special Services	
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 37.00
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	41.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	140.00
92081-00	Visual field examination with medical diagnostic evaluation; limited examination (for example, tangent screen), Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	31.31
92082-00	intermediate examination (for example, multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel,	

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	full field automated test, such as Octopus program 33 or 34 equivalent)	50.00
92083-00	extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41) (MD/DO)	59.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day (MD/DO)	24.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography (MD/DO)	25.00
	Ophthalmoscopy	
92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial (MD/DO)	$ 37.00
92226-00	subsequent (MD/DO)	30.00
92230-00	Opthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	34.00
92235-00	with fluorescein angiography (includes multiframe photography) (MD/DO)	150.00
92250-00	with fundus photography	33.00
92260-00	with opthalmodynamometry	30.00
	Other Specialized Services	
92275-00	Electroretinography, with medical diagnostic evaluation	$ 154.00
92285-00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (for example, close-up photography, slit lamp photography, goniophotography, stereo-photography	40.00
92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00
	Contact Lenses	
92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, one eye	$ 80.00
92314-00	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	16.00
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	30.00
92326-00	Replacement of contact lens	65.00
	Spectacle Services	
92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	147.35
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

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5221.1600 OTORHINOLARYNGOLOGIC SERVICES.

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

Code	Service	Maximum Fee
92504-00	Binocular microscopy (separate diagnostic procedure (MD/DO)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	42.00
92508-00	Speech, language, or hearing therapy with continuing medical supervision; group (MD/DO)	16.00
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	58.00
92512-00	Nasal function studies, for example, rhinomanometry	71.50
92532-00	Positional nystagmus	21.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	30.00
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	41.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	43.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (MD/DO)	55.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (MD/DO)	26.00
92545-00	Oscillating tracking test, with recording (MD/DO)	26.00
92546-00	Torsion swing test, with recording	31.00

5221.1800 CARDIOVASCULAR.

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

Code	Service	Maximum Fee

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92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external (MD/DO)	244.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,080.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads (MD/DO)	42.50
93005-00	tracing only, without interpretation and/or report (MD/DO)	37.00
93010-00	interpretation and report only (MD/DO)	17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	50.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report (MD/DO)	195.00
93017-00	tracing only, without interpretation and report (MD/DO)	99.00
93018-00	interpretation and report only (MD/DO)	100.00
93024-00	Ergonovine provocation test	175.00
93040-00	Rhythm ECG, one to three leads; with interpretation (MD/DO)	22.00
93041-00	tracing only without interpretation and report (MD/DO)	12.00
93042-00	Rhythm ECG, tracing with interpretation and report only (MD/DO)	18.00
93210-00	Phonocardiogram, intracardiac	45.50
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report (MD/DO)	105.00
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	185.70
93262-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	200.00
	without superimposition scanning	219.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis)	215.75
93268-00	Patient demand single event ECG recording; pre-symptom memory loop and transmission	34.00
93269-00	post-symptom memory loop and transmission	30.00
93300-00	Echocardiography, M-mode; complete	79.00
93308-00	Echocardiograph, real-time with image documentation (2D); limited (MD/DO)	105.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D) (MD/DO)	250.00
93320-00	Doppler echocardiography (MD/DO)	105.00

Cardiac Catheterization

93501-00	Right heart catheterization only	$ 685.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography (MD/DO)	351.00
93505-00	Endomyocardial biopsy	330.00
93547-00	Combined left heart catheterization, selective coronary angiography and	

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	selective left ventricular angiography (MD/DO)	760.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (MD/DO)	1,166.00
93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	79.00
	Other Vascular Studies	
93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	$ 54.00
93732-00	with reprogramming	45.00
93733-00	telephone analysis	40.50
93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	40.00
93735-00	with reprogramming	50.00
93736-00	telephonic analysis	35.50
93784-00	Ambulatory blood pressure monitoring, using a system such as magnetic tape and/or computer disc, for 24 hours; including recording, scanning analysis, interpretation and report	225.00
	Noninvasive Peripheral Vascular Diagnostic Studies	
	Cerebrovascular Arterial Studies	
93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periobital flow direction with arterial compression, periobital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)	$ 79.00
93870-00	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis) (MD/DO)	185.20
	Venous Studies	
93950-00	Noninvasive studies of extremity veins; (MD/DO)	$ 80.00
93960-00	Quantitative venous flow studies (e.g., capacitance and outflow measurement or calf, measurement of calf venous reflux, quantitative photoplethysmography)	100.00

5221.1900 PULMONARY.

The codes, service descriptions, and maximum fees of this part apply to pulmonary services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The services include laboratory procedures, interpretation, and physician

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services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010-00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements, and/or maximal voluntary ventilation	$ 30.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after broncodilator (aerosol or parenteral) or exercise	50.00
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	65.70
94150-00	Vital capacity, total	18.00
94160-00	Vital capacity screening tests; total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity, maximal voluntary ventilation	20.00
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	79.00
94260-00	Thoric gas volume	11.00
94350-00	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including a alveolar nitrogen or helium equilibration time	46.45
94360-00	Determination of resistance to airflow, oscillatory or plethysmographic methods	10.00
94375-00	Respiratory flow volume loop	24.00
94640-00	Nonpressurized inhalation treatment for acute airway obstruction (MD/DO)	22.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (MD/DO)	20.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	128.50
94657-00	subsequent days	56.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	20.50
94665-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	21.50
94680-00	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	35.00
94681-00	including CO_2 output, percentage oxygen extracted	94.60
94700-00	Analysis of arterial blood gas (oxygen saturation, pO_2, pCO_2, CO_2, pH); rest only	33.30

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

Subpart 1. **Allergy sensitivity tests.** Allergy sensitivity tests are the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the

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same number of sensitivity tests.

Subp. 2. **Immunotherapy (desensitization, hyposensitization).** Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

Subp. 3. **Other therapy.** Other therapy for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see 95105-00. (For definitions of Levels of Service see the Introduction.) (For Medical Service Procedures, see 90000-90699.)

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

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

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

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

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

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

5221.2050 CHEMOTHERAPY INJECTIONS.

The codes, service descriptions, and maximum fees of this part apply to chemotherapy injections, and to a provider licensed as a doctor of medicine, a doctor of osteopathy, or by a qualified assistant under supervision of the physician.

Code	Service	Maximum Fee
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 60.00
96505-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by infusion technique	55.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	37.00
96509-00	by infusion technique	90.00
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	81.50
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	321.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	48.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	217.30
96540-00	Chemotherapy injection, intrathecal via reservoir, single or multiple agents, administered by physician	107.00

5221.2070 DERMATOLOGICAL PROCEDURES.

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

Subp. 2. **Services.** Dermatologic services are typically consultative, and any of the levels of consultation described in part 5221.1200 may be appropriate. In addition, physician services for dermatological procedures are the same as the definitions described in part 5221.1100.

Code	Service	Maximum Fee

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96900-00	Actinotherapy (ultraviolet light)	$ 7.50
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	25.00
96912-00	psoralens and ultraviolet A (PUVA)	30.00

5221.2100 PHYSICAL MEDICINE.

The following codes, service descriptions, and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
	Modalities	
97260-00	Manipulation (cervical, thoracic, lumbosacral, socroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	$ 30.00
97261-00	each additional area (MD/DO)	8.40

5221.2200 SPECIAL SERVICES AND REPORTS.

Special services and reports apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include a means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. (See part 5221.1100 for definitions on levels of services.

Code	Service	Maximum Fee
	Miscellaneous Services	
99000-00	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory (MD/DO)	$ 9.25
99001-00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated) (MD/DO)	11.00
99014-00	Telephone calls for consultation or medical management; intermediate	15.00
99025-00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit (MD/DO)	25.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	27.10
99054-00	Services requested on Sundays and holidays in addition to basic services	25.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	55.00
99058-00	Office services provided on an emergency basis (MD/DO)	40.00
99062-00	Emergency care facility services; when the nonhospital-based physician	

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	is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	52.00
99064-00	Emergency care facility services; when the nonhospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	50.00
99065-00	during regular office hours	50.50
99075-00	Medical testimony (MD/DO)	Reasonableness of charges reviewable by commissioner
99080-00	Special reports like insurance forms, or the review of medical data to clarify a patient's status; more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner (MD/DO)	Reasonableness of charges reviewable by commissioner
99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00

Prolonged Services

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

Medical Conferences

99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes (MD/DO)	73.70
99156-00	approximately 50 minutes	100.00

Critical Care Services

Critical care services (codes 99162-00 to 99173-00) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include,

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

Code	Service	Maximum Fee
99160-00	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour (MD/DO)	$ 151.50
99162-00	additional 30 minutes (MD/DO)	76.50
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	75.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness (MD/DO)	60.00
99172-00	limited examination, evaluation, or treatment for same or new illness (MD/DO)	53.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness (MD/DO)	78.00
99174-00	Extended reexamination, reevaluation and/or treatment, same or new illness (MD/DO)	150.00
	Other Services	
99195-00	Phlebotomy, therapeutic (separate procedure)	35.00

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. [Unchanged.]

Subp. 2. **Instructions.** The instructions in items A to F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in-hospital follow-up care, provided by the surgeon both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. The surgical package includes the assistant surgeons if any are

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

B. to D. [Unchanged.]

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

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

(2) Preoperative services shall be listed when:

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

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

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

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

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(3) All postoperative care is added on a service-by-service basis.

(4) Complications are added on a service-by-service basis as with surgical procedures.

F. Special situations.

(1) Multiple procedures (more than one procedure is performed at a single operative session through the same incision.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 50 percent of the Medical Fee Schedule, whichever is less.

(2) Multiple procedures (more than one procedure is performed at a single operative session through different incisions.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or ~~65~~ 75 percent of the Medical Fee Schedule, whichever is less.

(3) Bilateral procedures (pertaining to two sides and requiring separate incisions.)

(a) When bilateral procedures are performed

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at the same operative session and the descriptor for the procedure code specifies bilateral procedures, the procedures must be reported using the applicable procedure code listed in the Medical Fee Schedule. Reimbursement must be at the provider's usual charge or the Medical Fee Schedule, whichever is less.

(b) When the descriptor of the procedure code does not specify that it is bilateral, the primary procedure must be reported twice using the applicable procedure codes.

For the first procedure, the applicable 5-digit procedure code must be billed without a modifier. Reimbursement will be at the provider's usual rate or the rate set in the Medical Fee Schedule, whichever is less.

For the second procedure, the applicable 5-digit code must be billed with modifier 50. Reimbursement must be at the provider's usual rate or 75 percent of the rate set in the Medical Fee Schedule, whichever is less.

Subp. 3. **Integumentary system.**

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200 to 11441) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions.

(2) Treatment of burns (codes 16000 to 16030) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001 to 12014) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit.

(b) Intermediate repair (codes 12031 to 12052) shall be used for the repair of wounds that, in addition

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to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure.

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

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

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

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

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

B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

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

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11406-00	lesion diameter over 4.0 centimeters		200.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter (MD/DO)		77.00
11421-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)		96.60
11422-00	lesion diameter 1.0 to 2.0 centimeters (MD/DO)		120.00
11423-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)		144.00
11424-00	lesion diameter 3.1 to 4.0 centimeters		160.00
11426-00	lesion diameter over 4.0 centimeters		300.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter (MD-DO)		90.00
11441-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)		113.00
11442-00	lesion diameter 1.1 to 2.0 centimeters		135.00
11443-00	lesion diameter 2.1 to 3.0 centimeters		89.00
	Excision -- Malignant Lesions		
~~16000-00~~			
11600-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	$	111.00
11601-00	lesion diameter 0.6 to 1.0 centimeter		145.00
11602-00	lesion diameter 1.1 to 2.0 centimeters		204.00
11603-00	lesion diameter 2.1 to 3.0 centimeters		260.00
11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less		171.00
11621-00	lesion diameter 0.6 to 1.0 centimeter		220.00
11622-00	lesion diameter 1.1 to 2.0 centimeters		280.43
11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less		243.00
11641-00	lesion diameter 0.6 to 1.0 centimeter		292.90
	Nails		
11700*00	Debridement of nails, manual; 5 or less	$	29.00
11710*00	Debridement of nails, electric grinder, 5 or less		25.00
11730*00	Avulsion of nail plate, partial or complete, simple; single (MD/DO)		64.00
11740-00	Evacuation of subungual hematoma (MD/DO)		36.50
11750-00	Excision of nail and nail matrix, partial or complete, (e.g. ingrown or deformed nail) for permanent removal		125.00
11760-00	Reconstruction of nail bed; simple		77.00
	Miscellaneous		
11770-00	Excision of piloridial cyst or sinus; simple	$	550.00
11771-00	extensive		600.00
11900*00	Injection, intralesional, up to and including seven lesions (MD/DO)		35.00
	Introduction		
11901*00	Injection, intralesional; up to and including 7 lesions	$	71.00
11954-00	Subcutaneous injection of "filling" material (e.g. silicone); over 10 centimeters		50.00
	Repair -- Simple		

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12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters (MD/DO)		$ 55.50
12002*00	2.5 to 7.5 centimeters (MD/DO)		82.00
12004*00	7.5 to 12.5 centimeters (MD/DO)		120.00
12005*00	12.5 to 20.0 centimeters (MD/DO)		175.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters (MD/DO)		83.00
12013*00	2.5 to 5.0 centimeters		115.00
12014-00	5.1 to 7.5 centimeters		75.00
	Repair -- Intermediate		
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters (MD/DO)		$ 84.00
12032*00	2.5 to 7.5 centimeters (MD/DO)		118.00
12034-00	7.6 to 12.5 centimeters (MD/DO)		168.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters (MD/DO)		98.00
12042-00	2.5 to 7.5 centimeters (MD/DO)		140.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters (MD/DO)		112.00
12052-00	2.5 to 5.0 centimeters (MD/DO)		160.00
	Repair -- Complex		
13100-00	Repair, complex, trunk; 1.1 to 2.5 centimeters		$ 140.00
13101-00	2.6 to 7.5 centimeters		275.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters		280.00
13121-00	2.6 to 7.5 centimeters		234.00
13131-00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters		350.00
13132-00	2.6 to 7.5 centimeters		490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less		210.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters (MD/DO)		420.00
13152-00	2.5 to 7.5 centimeters (MD/DO)		630.00
	Adjacent Tissue Transfer or Rearrangement		
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters (MD/DO)		$ 725.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters (MD/DO)		1,000.00
	Free Skin Grafts		
15100-00	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters or less, or each one percent of body area of infants and children (MD/DO)		$ 635.00
	Burns, Local Treatment		

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16000-00	Initial treatment, first degree burn, when no more than local treatment is required (MD/DO)	$ 47.50
16020*00	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small (MD/DO)	42.50
16025*00	without anesthesia, medium, for example, whole face or whole extremity (MD/DO)	71.00
	Destruction	
17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion (MD/DO)	$ 46.50
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (MD/DO)	43.00
17101-00	second lesion (MD/DO)	22.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	40.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions (MD/DO)	50.00
17304-00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to 5 horizontal, microscopic specimens	460.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2) (MD/DO)	30.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)	31.00

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

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

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

Head Repair, Revision, or Reconstruction

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

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

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

Spine

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

Shoulders -- Fracture or Dislocation

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

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

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

Forearm and Wrist -- Incision and Excision

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

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		Forearm and Wrist -- Fracture or Dislocation	
	25505-00	Treatment of closed radial shaft fracture; with manipulation (MD/DO)	$ 345.00
	25560-00	Treatment of closed radial and ulnar shaft fractures; without manipulation	211.50
	25565-00	Treatment of closed radial and ulnar shaft fractures; with manipulation (MD/DO)	435.00
	25600-00	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation (MD/DO)	176.00
	25605-00	with manipulation (MD/DO)	322.00
	25610-00	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning (MD/DO)	460.00
	25611-00	with external skeletal fixation or percutaneous pinning (MD/DO)	643.00
	25622-00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	185.00
		Hand and Fingers -- Incision, Excision, Repair, Revision, or Reconstruction	
	26010*00	Draining of finger abscess; simple	$ 55.00
	26055-00	Tendon sheath incision for trigger finger (MD/DO)	400.00
	26115-00	Excision, tumor, hand or finger; subcutaneous	315.00
	26116-00	deep, subfascial, intramuscular	537.50
	26122-00	Fasciectomy, palmar, simple for Dupuytren's contracture; up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,309.00
	26160-00	Excision of lesion of tendon sheath or capsule (MD/DO)	231.00
	26418-00	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon (MD/DO)	333.00
		Hands and Fingers -- Fractures or Dislocations	
	26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone (MD/DO)	$ 116.00
	26605-00	with manipulation, each bone (MD/DO)	196.00
	26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (MD/DO)	77.00
	26725-00	with manipulation, each (MD/DO)	150.00
	26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each	400.00
	26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each (MD/DO)	55.50
	26755-00	with manipulation, each	112.00
	26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	100.00
	26770-00	Treatment of closed interphalangeal	

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	joint dislocation, single, with manipulation; without anesthesia (MD/DO)	65.00
	Hand and Fingers -- Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (MD/DO)	$ 295.50
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)	$2,098.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple (MD/DO)	3,050.00
27134-00	Revision of total hip arthroplasty; both components	4,100.00
27235-00	Treatment of closed or open femoral fracture, in situ pinning of undisplaced or impacted fracture	1,493.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (MD/DO)	1,700.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation (MD/DO)	1,496.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	381.00
	Femur (Thigh Region) and Knee Joint -- Introduction or Removal	
27370-00	Injection procedure for knee arthrography (MD/DO)	$ 55.64
	Femur (Thigh Region) and Knee Joint -- Repair, Revision, or Reconstruction	
27422-00	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	$ 1,203.00
27425-00	Lateral retinacular release, any method	1,235.00
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,400.00
27447-00	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement) (MD/DO)	3,000.00
27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation (MD/DO)	1,482.00
	Amputation	
27590-00	Amputation, thigh, through femur, any level	$1,050.40
	Leg (Tibula and Fibula) and Ankle Joint -- Fractures or Dislocations	
27750-00	Treatment of closed tibial shaft fracture; without manipulation	$275.00

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

Foot

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

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

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physician.

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

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

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

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

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

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

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

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Vascular Injection Procedures

36000*00	Introduction of needle or intracatheter, vein; unilateral (MD/DO)	$ 63.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery (MD/DO)	331.00
36140-00	Introduction of needle or intracatheter; extremity artery	274.61
36200-00	Introduction of catheter, aorta (arch, abdominal, midstream renal, aortioliac run-off) or selective; initial placement	330.50
36215-00	each additional selective thoracic and/or cerebral artery catheter placement (e.g. vertebral or carotid)	448.00
36230-00	coronary artery, selective, unilateral or bilateral	449.28
36245-00	each additional selective abdominal artery catheter placement (e.g. celiac artery, gastroduodenal artery, inferior mesenteric artery, renal artery)	441.00
36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	44.10
36415*00	Routine venipuncture for collection of specimen(s) (MD/DO)	7.60
36430-00	Transfusion, blood or blood components (MD/DO)	70.50
36470*00	Injection of sclerosing solution; single vein	42.00
36471*00	Injection of sclerosing solution; multiple veins, same leg (MD/DO)	50.00
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	133.20
36520-00	Therapeutic apheresis (plasma and/or cell exchange) (MD/DO)	156.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	47.00
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	117.00
36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	410.00
36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,255.00
37609-00	Ligation or biopsy, temporal artery	280.00
37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	650.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	921.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	830.00
37731-00	bilateral	1,256.00

Subp. 8. **Hemic and lymphatic systems.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the hemic (blood) and lymphatic systems.

Code	Service	Maximum Fee

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Code	Service	Maximum Fee
38100-00	Splenectomy; total	$ 1,500.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	180.00
38510-00	deep cervical nodes	366.00
	Mediastinum and Diaphragm	
39400-00	Mediastinoscopy, with or without biopsy	$ 540.00

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

Code	Service	Maximum Fee
40490-00	Biopsy of lip	$ 102.00
40808-00	Biopsy, vestibule of mouth	70.00
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	151.50
41010-00	Incision of lingual frenum (frenotomy)	41.50
42330-00	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	120.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,795.00
42700*00	Incision and drainage abscess; peritonsillar	103.75
42809-00	Removal of foreign body from pharynx	72.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	462.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	475.00
	Esophagus	
43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 304.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	490.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	439.16
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	350.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	406.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	508.00
43246-00	for directed placement of percutaneous gastrostomy tube	695.00
43247-00	for removal of foreign body	500.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	473.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with	

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

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

Subp. 10. **Urinary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the urinary system.

Code	Service	Maximum Fee
	Kidney	
50200*00	Renal biopsy, percutaneous trocar or needle (MD/DO)	$ 353.50
50230-00	Nephrectomy, including partial ureterectomy, any approach including resection; radical, with regional lymphadenectomy	1,821.00
50360-00	Renal homotransplantation, implantation	

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		of graft; excluding donor and recipient nephrectomy	3,094.00
	50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	50.00
	50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
	50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure	30.50
	51600*00	Injection procedure for cystography or voiding urethrocystography (MD/DO)	18.56
	51605-00	Injection procedure and placement of chain for contrast and/or chain urethrocystrography	49.51
	51610-00	Injection procedure for retrograde urethrocystography	29.00
	51700*00	Bladder irrigation, simple, lavage and/or instillation	34.00
	51705*00	Change of cystostomy tube; simple (MD/DO)	39.40
	51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	81.20
	51726-00	Complex cystometrogram (for example, calibrated electronic equipment) (MD/DO)	104.00
	51741-00	Complex uroflowmetry	60.00
	51840-00	Anterior vesicourethropexy, or urethropexy; simple	1,113.00
	51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,250.00
	51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,400.00
	52000-00	Cystourethroscopy (separate procedure) (MD/DO)	131.00
	52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	250.00
	52204-00	Cystourethroscopy with biopsy	186.00
	52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of of trigone bladder neck, prostatic fossa, urethra, or periurethral glands)	297.00
	52224-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 centimeter) lesion(s) with or without biopsy	290.00
	52234-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters)	~~530.00~~ 430.00
	52235-00	MEDIUM bladder tumor(s) (2.0 to 5.0 centimeters)	820.00
	52240-00	LARGE bladder tumor(s)	1,200.00
	52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	216.00
	52281-00	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office (MD/DO)	227.00
	52310-00	Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate	

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

Subp. ~~10~~ 11. **Reproductive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the reproductive system.

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

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

Subp. 12. **Endocrine system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the endocrine (glandular) system.

Code	Service	Maximum Fee
60100-00	Biopsy thyroid, percutaneous needle	$ 123.50

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

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

Code	Service	Maximum Fee
61310-00	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial (MD/DO)	$ 2,625.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,845.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,690.00
	Spine and Spinal Cord -- Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic (MD/DO)	$ 100.00
62273*00	Injection lumbar epidural, of blood or clot patch (MD/DO)	240.00
62274*00	Injection of anesthetic substance diagnostic or therapeutic; subarachnoid or subdural simple (MD/DO)	100.00
62278*00	epidural or caudal single (MD/DO)	195.00
62279*00	epidural or caudal, continuous	275.00
62284*00	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa (MD/DO)	135.20
62289*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal (MD/DO)	256.00
	Spine and Spinal Cord -- Laminectomy or Laminotomy, for Exploration or Decompression	
63005-00	Laminectomy for exploration/decompression of spinal cord and/or cauda, equina, one or two segments; lumbar, except for spondylolisthesis (MD/DO)	$ 2,420.00
63020-00	Laminotomy (hemilaminectomy), for decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral (MD/DO)	2,075.00
63030-00	one interspace, lumbar, unilateral (MD/DO)	2,005.00
63042-00	reexploration; lumbar (MD/DO)	2,586.00
	Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System	
64405*00	Injection, anesthetic agent; greater occipital nerve	$ 114.00
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	130.00
64442-00	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level	120.00

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

Subp. 14. **Eye and ocular adnexa.** The following codes, service descriptions and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

Code	Service	Maximum Fee
65205*00	Removal foreign body, external eye; conjunctival superficial (MD/DO)	$ 45.00
65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating (MD/DO)	50.00
65220*00	corneal, without slit lamp (MD/DO)	52.00
65222*00	corneal, with slit lamp (MD/DO)	61.80
65420-00	Excision or transposition of pterygium; without graft (MD/DO)	545.00
65435*00	Removal of corneal epithelium; with or without chemo-cauterization (abrasion, curettage)	51.90
65855-00	Trabeculoplasty by laser surgery, (1 or more sessions) (defined treatment series)	693.00
66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)	650.00
66762-00	Coreoplasty by photocoagulation (1 or more sessions) (e.g., for improvement of vision)	600.00
66802-00	Discission of lens capsule; laser surgery (one or more stages)	600.00
66820-00	Discission of secondary membranous cataract ("after cataract"), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)	547.00
66821-00	laser surgery (one or more stages)	700.00
66940-00	Extraction of lens with or without iridectomy; extracapsular	1,682.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,770.00
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) (MD/DO)	1,763.50
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,287.50
67036-00	Vitrectomy, mechanical, pars plana approach	3,025.00
67105-00	Repair of retinal detachment, 1 or more sessions, same hospitalization; photocoagulation (laser or xenon arc, 1 or more sessions) with drainage of subretinal fluid	556.00
67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,080.00
67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration)	

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	without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	700.00
67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), 1 or more sessions; photocoagulation (laser or xenon arc)	975.00
67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), 1 or more sessions; cryotherapy, diathermy	818.00
67228-00	photocoagulation (laser or xenon arc)	778.00
67311-00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); 1 muscle	900.00
67312-00	2 muscles, 1 or both eyes	968.00
67515*00	Injection of therapeutic agent into Tenon's capsule	49.00
67700*00	Blepharotomy, drainage of abscess, eyelid	57.00
67800-00	Excision of chalazion; single	75.00
67801-00	multiple, same lid	110.00
67805-00	multiple, different lids	135.00
67810*00	Biopsy of eyelid	106.00
67820*00	Correction of trichiasis; epilation, by forceps only	31.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	87.00
67921-00	Repair of entropion; suture	700.00
67938-00	Removal of embedded foreign body; eyelid	40.00
68200*00	Subconjunctival injection	48.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral (MD/DO)	37.00
68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring general anesthesia	260.00

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

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 55.00
69200-00	Removal foreign body from external auditory canal; without general anesthesia	27.24
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	20.75
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	38.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	84.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral (MD/DO)	150.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	240.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral (MD/DO)	252.00
69437-00	bilateral (MD/DO)	350.00
69440-00	Middle ear exploration through postauricular or ear canal incision (MD/DO)	897.00

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

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 1. **General.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine, a doctor of osteopathy, or a technician under the supervision of a doctor of medicine or osteopathy.

A. Single charge including both professional and technical component. The maximum fee represents the appropriate charges for professional services plus expenses of nonradiologist personnel, materials, facilities, and space used and for diagnostic or therapeutic services rendered, but excludes the cost of radio-isotopes. This value is applicable in any situation in which a single charge is made to include both professional services and the cost involved in providing that service.

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

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When the physician component is billed separately, the procedure may be identified by adding the modifier "-26" to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 40 percent of the fee maximum.

(2) Technical component: certain procedures (e.g., laboratory, radiology, electrocardiogram, specific diagnostic, and therapeutic services) are a combination of a physician component and a technical component. When the technical component is billed separately, the procedure may be identified by adding the modifier "T.C." to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 60 percent of the fee maximum.

Subp. 2. **Diagnostic radiology.** The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Code	Service	Maximum Fee
	Head and Neck	
70100-00	Radiologic examination, mandible; partial, less than four views (MD/DO)	$ 47.25
70120-00	Radiologic examination, mastoids; less than three views per side (MD/DO)	72.00
70130-00	complete, minimum of three views per side (MD/DO)	90.00
70140-00	Radiologic examination, facial bones; less than three views (MD/DO)	41.70
70150-00	complete, minimum of three views (MD/DO)	55.00
70160-00	Radiologic examination, nasal bones; complete, minimum of three views (MD/DO)	47.00
70200-00	Radiologic examination; orbits, complete, minimum of four views (MD/DO)	46.30
70210-00	Radiologic examination, sinuses, paranasal, less than three views (MD/DO)	37.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views (MD/DO)	69.50
70240-00	Radiologic examination, sella ~~turcia~~ turcica (MD/DO)	48.25
70250-00	Radiologic examination, skull, less than four views, with or without stereo (MD/DO)	48.00
70260-00	complete, minimum of four views, with or without stereo (MD/DO)	74.00
70300-00	Radiologic examination, teeth; single view	14.20
70310-00	partial examination, less than full mouth	18.90
70320-00	complete, full mouth	55.00
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	81.00
70332-00	Temporomandibular joint arthrography; supervision and interpretation only	250.00
70333-00	complete procedure	180.00
70355-00	Orthopantogram	35.00
70360-00	Radiologic examination, neck, soft	

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		tissue (MD/DO)	33.75
	70380-00	Radiologic examination, salivary gland for calculus	48.50
	70390-00	Sialography; supervision and interpretation only	99.00
	~~70450-00~~	~~Computerized axial tomography, head or brain (MD/DO)~~	~~120.90~~
	~~70480-00~~	~~Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material~~	~~150.00~~
	~~70481-00~~	~~--with contrast material~~	~~139.00~~
	~~70486-00~~	~~Computerized axial tomography, maxillofacial area; without contrast material~~	~~91.40~~
	~~70491-00~~	~~Computerized axial tomography, soft tissue neck; with contrast material(s)~~	~~132.00~~
	70540-00	Magnetic resonance (e.g., proton) imaging; orbit, face, and neck	600.00
		Chest	
	71010-00	Radiologic examination, chest; single view, frontal (MD/DO)	$ 34.00
	71015-00	stereo, posteroanterior (MD/DO)	35.00
	71020-00	Radiologic examination, chest, two views, frontal and lateral (MD/DO)	47.25
	71021-00	with apical lordotic procedure (MD/DO)	44.00
	71022-00	with oblique projections (MD/DO)	22.50
	71030-00	Radiological examination, chest, complete, minimum of four views (MD/DO)	45.00
	71034-00	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy	56.00
	71035-00	Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies	23.50
	71100-00	Radiologic examination, ribs, unilateral; two views (MD/DO)	53.00
	71101-00	Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views	60.00
	71110-00	Radiologic examination, ribs, bilateral; three views (MD/DO)	62.00
	71111-00	Radiologic examination, ribs, bilateral; including postero-anterior chest, minimum of four views	73.00
	71120-00	Radiologic examination; sternum, minimum of two views (MD/DO)	38.00
	71130-00	Radiologic examination; sternoclavicular joint or joints, minimum of three views	60.00
	~~71260-00~~	~~--with contrast material~~	~~142.20~~
		Spine and Pelvis	
	72010-00	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral (MD/DO)	$ 86.00
	72020-00	Radiologic examination, spine, single view, specify level (MD/DO)	37.00
	72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral (MD/DO)	50.50
	72050-00	minimum of four views (MD/DO)	80.40
	72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	89.00
	72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral (MD/DO)	57.50
	72072-00	Thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction (MD/DO)	58.50
	72074-00	Radiologic examination, spine; thoracic, complete, including obliques, minimum of	

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		four views	65.00
	72080-00	thoracolumbar, anteroposterior and lateral (MD/DO)	58.00
	72090-00	scoliosis study, including supine and erect studies (MD/DO)	50.75
	72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral (MD/DO)	62.00
	72114-00	complete, including bending views (MD/DO)	95.00
	72120-00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	61.20
	~~72126-00~~	~~Computerized axial tomography, cervical spine, with contrast material (MD/DO)~~	~~174.40~~
	~~72132-00~~	~~--with contrast material (MD/DO)~~	~~163.00~~
	72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents	790.00
	72170-00	Radiologic examination, pelvis anteroposterior only (MD/DO)	41.00
	72180-00	stereo (MD/DO)	42.00
	72190-00	complete, minimum of three views (MD/DO)	65.00
	~~72192-00~~	~~Computerized axial tomography, pelvis; without contrast material (MD/DO)~~	~~212.50~~
	~~72193-00~~	~~--with contrast material(s) (MD/DO)~~	~~106.00~~
	72200-00	Radiologic examination, sacroiliac joints; less than three views (MD/DO)	52.40
	72202-00	three or more views (MD/DO)	58.75
	72220-00	Radiologic examination, sacrum and coccyx, minimum of two views (MD/DO)	50.00
	72240-00	Myelography, cervical; supervision and interpretation only	213.90
	72241-00	Myelography, cervical, complete procedure (MD/DO)	590.00
	~~72266-00~~	~~--complete procedure (MD/DO)~~	~~216.00~~
	72270-00	Myelography, entire spinal canal; supervision and interpretation only (MD/DO)	205.44
	72271-00	complete procedure (MD/DO)	340.30

Upper Extremities

	73000-00	Radiologic examination; clavicle, complete (MD/DO)	$ 37.50
	73010-00	scapula, complete (MD/DO)	42.75
	73020-00	Radiologic examination, shoulder; one view (MD/DO)	37.00
	73030-00	complete, minimum of two views (MD/DO)	48.00
	~~73041-00~~	~~--complete procedure (MD/DO)~~	~~154.00~~
	73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (MD/DO)	54.00
	73060-00	humerus, minimum of two views (MD/DO)	42.75
	73070-00	Radiologic examination, elbow; anteroposterior and lateral views (MD/DO)	41.00
	73080-00	complete, minimum of three views (MD/DO)	44.00
	73090-00	Radiologic examination; forearm, anteroposterior and lateral views (MD/DO)	41.00
	73100-00	Radiologic examination, wrist; anteroposterior and lateral views (MD/DO)	40.00
	73110-00	complete, minimum of three views (MD/DO)	44.00
	73115-00	Radiologic examination, wrist, arthography; supervision and interpretation only	49.00
	73120-00	Radiologic examination, hand; two views (MD/DO)	40.00
	73130-00	minimum of three views (MD/DO)	44.24
	73140-00	Radiologic examination, finger or fingers, minimum of two views (MD/DO)	35.00
	73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity	700.00

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

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

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	localization	$ 83.10
74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	42.00
74740-00	Hysterosalpingography; supervision and interpretation only	101.00
74741-00	complete procedure	137.20

Vascular System

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

Veins and Lymphatics

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75820-00	Venography, extremity, unilateral; supervision and interpretation only	$ 98.50
75821-00	Venography, extremity, unilateral; complete procedure (MD/DO)	130.15
75897-00	Transcatheter therapy, infusion (e.g., thrombolysis other than coronary), including angiography; complete procedure	375.00
75962-00	Percutaneous transluminal angioplasty, peripheral artery; supervision and interpretation only	68.00
75985-00	Change of percutaneous drainage catheter with contrast monitoring (i.e., biliary tract, urinary tract); complete procedure	199.00

Miscellaneous

76000-00	Fluoroscopy (separate procedure), up to one hour physician time	$ 40.00
76020-00	Bone age studies	36.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	69.00
76061-00	Radiologic examination, osseous survey: limited (e.g., for metastases)	139.00
76062-00	Radiologic examination, osseous survey; complete (MD/DO)	195.50
76066-00	Joint survey, single view, one or more joints (specify)	23.00
76080-00	Radiologic examination, fistula or sinus tract study; supervision and interpretation only	61.00
76081-00	Radiologic examination, fistula or sinus tract study; complete procedure (MD/DO)	76.70
76100-00	Radiologic examination, single plane body section (MD/DO)	101.30
76101-00	Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	93.60
76102-00	bilateral	100.00
76150-00	Xeroradiography	50.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	436.00
~~76370-00~~	~~Computerized tomography guidance for placement of radiation therapy fields~~	~~74.25~~
~~76375-00~~	~~Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction~~	~~45.00~~

Subp. 3. **Diagnostic ultrasound.** The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

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

Subp. 4. **Therapeutic radiology.** The following codes,

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

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

Code	Service	Maximum Fee
77262-00	Therapeutic radiology treatment planning; intermediate	$ 295.00
77263-00	complex	345.00
77280-00	Therapeutic radiology simulation-aided field setting; simple (MD/DO)	100.04
77285-00	intermediate	125.00
77290-00	complex	175.00
77300-00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment (MD/DO)	60.00
77305-00	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	125.00
77310-00	intermediate (three or more treatment ports directed to a single area of interest)	150.00
77315-00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	280.00
77334-00	Treatment devices, design and construction; complex (MD/DO)	150.00
77336-00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance (MD/DO)	61.50
77400-00	Daily megavoltage treatment	

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

Subp. 5. **Nuclear medicine.** The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

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

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78593-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection (MD/DO)	98.00
78594-00	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views)	81.50
	Nervous System	
78660-00	Dacryocystography (lacrimal flow study)	$ 15.00
	Genitourinary System	
78700-00	Kidney imaging; static only	$ 68.00
78704-00	Kidney imaging; with function study (e.g., imaging renogram) (MD/DO)	81.00
78715-00	Kidney vascular flow only	54.60
78725-00	Kidney function study only	152.00
78727-00	Kidney transplant evaluation	95.00
78740-00	Ureteral reflux study (radionuclide voiding cystogram)	80.00
78805-00	Radionuclide localization of abscess; limited area	483.80
78890-00	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	121.50

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

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

Subp. 2. **Automated, multichannel tests.** The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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

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

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

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

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descriptions, and maximum fees apply to urinalysis procedures.

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy (MD/DO)	$ 12.00
81002-00	routine, without microscopy (MD/DO)	7.00
81004-00	components, single, not otherwise listed, specify (MD/DO)	6.00
81005-00	chemical, qualitative, any number of constituents (MD/DO)	6.50
81010-00	concentration and dilution test (MD/DO)	5.00
81015-00	microscopic only (MD/DO)	8.00
81020-00	two or three glass test	10.00

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

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

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

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

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

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

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke (MD/DO)	$ 8.00
85002-00	Ivy or template (MD/DO)	21.40
85007-00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation) (MD/DO)	11.25
85009-00	differential WBC count, buffy coat	19.00
85012-00	eosinophil count, direct (MD/DO)	14.00
85014-00	hematocrit (MD/DO)	9.00
85018-00	hemoglobin, colorimetric (MD/DO)	9.50
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only) (MD/DO)	19.00
85022-00	hemogram, automated, and manual differential WBC count (CBC) (MD/DO)	24.25
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	31.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	23.00
85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	27.20
85027-00	hemogram, and platelet count, automated (MD/DO)	15.25
85029-00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram; 1-3 indices	10.50
85030-00	4 or more indices	15.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes) (MD/DO)	22.00
85041-00	red blood cell (RBC) only	8.00
85044-00	reticulocyte count (MD/DO)	13.50
85048-00	White blood cell (WBC) (MD/DO)	10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	50.50
85095-00	Bone marrow smear and/or cell block; aspiration only	87.00
85097-00	Bone marrow smear and/or cell block; smear interpretation only MD/DO)	75.00
85100-00	aspiration, staining, and interpretation (MD/DO)	114.00
85102-00	Bone marrow needle biopsy (MD/DO)	94.00
85103-00	staining and interpretation (MD/DO)	115.00
85105-00	interpretation only (MD/DO)	81.50
85210-00	Clotting; factor II, prothrombin, specific	14.00
85240-00	factor VIII (AHG), 1 stage	77.20
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	14.00
85368-00	Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)	11.00
85540-00	Leukocyte alkaline phosphatase with count	27.00
85544-00	Lupus erythematosus (LE) cell prep (MD/DO)	20.00
85548-00	Morphology of red blood cells only	

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

Subp. 6. **Immunology.** The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86000-00	Agglutinins; febrile, each antigen (MD/DO)	$ 19.00
86004-00	warm	15.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube (MD/OD)	16.00
86007-00	each additional antigen (MD/DO)	25.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	20.00
86009-00	each additional antigen	37.00
86012-00	Antibody absorption, cold auto absorption; per serum	15.50
86013-00	Antibody absorption, cold auto absorption; differential (MD/DO)	8.00
86016-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	27.00
86017-00	with ABO+Rh(D) typing (for blood instead of complete crossmatch	15.00
86018-00	enzyme technique, including antihuman globulin	10.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique (MD/DO)	26.00
86028-00	Saline or high protein, each (MD/DO)	27.50
86031-00	Antihuman globulin test; direct, 1-3 dilutins (MD/DO)	15.25
86032-00	indirect, qualitative (MD/DO)	17.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.00
86038-00	Antinuclear antibodies (ANA), RIA	30.00
86060-00	Antistreptolysin O; titer (MD/DO)	23.00
86063-00	screen (MD/DO)	15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	21.00
86067-00	other method (specify)	54.50
86069-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; each additional unit	35.50
86075-00	Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening first unit	18.25
86080-00	Blood typing; ABO only (MD/DO)	11.75
86082-00	ABO and Rho(D) (MD/DO)	21.30
86095-00	Blood typing, RBC, antigens other	

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

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

Subp. 7. **Microbiology.** The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
87015-00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	27.00
87045-00	stool	28.40
87060-00	throat or nose	12.50
87070-00	any other source	23.00
87072-00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	16.20
87075-00	Culture, bacterial, any source; anaerobic (isolation)	29.00
87081-00	Culture, bacterial, screening only, for single organisms	14.50
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083-00	multiple organisms	17.25
87084-00	with colony estimation from density chart	10.00
87085-00	with colony count	29.00
87086-00	Culture, bacterial, urine; quantitative, colony count (MD/DO)	19.00
87087-00	commercial kit	11.25
87088-00	identification, in addition to quantitative or commercial kit	23.00
87101-00	Culture, fungi, isolation; skin	18.00
87102-00	other source (except blood)	13.50
87106-00	Culture, fungi, definitive identification of each fungus	27.60
87109-00	Culture, mycoplasma, any source	43.50

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

Subp. 8. **Anatomic pathology.** The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

Code	Service	Maximum Fee
	Cytopathology	
88104-00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation (MD/DO)	$ 30.00
88106-00	filter method only with interpretation	31.70
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	37.00

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

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

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

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88321-00	Consultation and report on referred slides prepared elsewhere	67.95
88323-00	Consultation and report on referred material requiring preparation of slides	52.50
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	48.00
88331-00	with frozen section(s); single specimen	100.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	42.00

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

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

5221.2500 DENTISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

Subp. 2. **Diagnostic.** The following codes, service descriptions, and maximum fees apply to diagnostic services.

Code	Service	Maximum Fee
	Restorative	
02140-00	Amalgam; one surface, permanent (DDS)	$ 28.00
02150-00	two surfaces, permanent (DDS)	40.00
02160-00	three surfaces, permanent (DDS)	53.00
02161-00	four or more surfaces, permanent (DDS)	64.00
	Acrylic or Plastic Restorations	
02330-00	Resin; one surface, anterior (DDS)	$ 38.00

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

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

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06545-00	Cast metal retainer for acid etch bridge	$ 132.00

Prosthodontics, Fixed

06640-00	Replace broken facing with acrylic (DDS)	$ 70.00

Bridge Retainers -- Crowns

06750-00	Crown; porcelain fused to high noble metal	$ 377.00
06751-00	porcelain fused to predominantly base metal	360.00
06752-00	porcelain fused to noble metal	355.00
06790-00	full cast high noble metal	355.00
06791-00	full cast predominantly base metal	295.00
06792-00	full cast noble metal	300.00
06801-00	Diagnostic exam and DXL	20.00
06802-00	Prevention	25.00
06803-00	Restorative	52.50
06804-00	Endodontics	285.00
06808-00	Dental oral surgery	45.00
06809-00	Unlisted dental procedures	24.00

Other Fixed Prosthetic Services

06930-00	Recement bridge (DDS)	$ 40.00

Oral Surgery Extractions -- Includes Local Anesthesia and Routine Postoperative Care

07110-00	Single tooth (DDS)	$ 35.00
07120-00	Each additional tooth (DDS)	35.00

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

07210-00	Surgical removal of tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth (DDS)	$ 75.00
07220-00	Removal of impacted tooth; soft tissue (DDS)	86.00
07230-00	Removal of the impacted tooth; partially bony (DDS)	119.00
07240-00	Removal of impacted tooth; completely bony (DDS)	140.00
07241-00	Removal of impacted tooth; completely bony, with unusual surgical complications (DDS)	150.00
07250-00	Surgical removal of residual tooth roots (DDS)	75.00

Other Surgical Procedures

07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments) (DDS)	$ 125.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	140.00
07286-00	Biopsy of oral tissue; soft	90.00

Alveoplasty - Surgical Preparation of Ridge For Dentures

07310-00	Alveoloplasty (per quadrant) in conjunction with extractions (DDS)	$ 75.00

Surgical Incision

07510-00	Incision and drainage of	

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	abscess, intraoral soft tissue (DDS)	$ 45.00
	Other Repair Procedures	
07960-00	Frenulectomy	$ 90.00
	Adjunctive General Services	
	Unclassified Treatment	
09110-00	Palliative (emergency) treatment of dental pain; minor procedures	25.00
	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 8.00
09211-00	Regional block anesthesia	10.00
09220-00	General; first 30 minutes (DDS)	90.00
09230-00	Analgesia (DDS)	12.00
	Professional Consultation	
09310-00	Consultation; per session	35.00
09420-00	Hospital call	14.00
09430-00	Office visit during regularly scheduled office hours	15.00
	Drugs	
09610-00	Therapeutic drug injection, by report	15.00
09630-00	Other drugs and/or medicaments	15.00
	Miscellaneous Services	
09910-00	Application of desensitizing medicaments (DDS)	$ 15.00
~~09991-00~~		~~25.00~~
~~09993-00~~		~~30.00~~
	Surgery	
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	2,960.00
21203-00	mandibular ramus (osteotomy)	2,950.00
21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,400.00
40808-00	Biopsy, vestibule of mouth	107.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	100.00
41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	150.00
~~42151-00~~		
42150-00	Removal of exostosis, bony palate	280.00
	Radiology -- Dental	
70320-00	Radiologic examination, teeth; complete, full mouth	45.00
70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	35.00
70330-00	bilateral	90.00
70350-00	Caphalogram, orthodontic	40.00
70355-00	Orthopantogram	35.00
76100-00	Radiologic examination, single plane body section (e.g., tomography)	73.00
	Surgical Pathology -- Dental	
88304-00	Surgical pathology, gross and microscopic	

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

5221.2600 OPTOMETRISTS~~,-OPTICIANS~~.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of optometry, and to procedures performed within the scope of practice in accordance with Minnesota Statutes, sections 148.52 to 148.62.

~~Subp. 2. Definitions. The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.~~

~~A. "New patient" and "established patient" have the meanings given them in part 5221.1100.~~

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

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

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

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

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

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

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

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

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

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~~92081-00~~	~~Visual field examination with medical diagnostic evaluation, tangent screen, autoplot or equivalent~~	~~20.00~~
~~92082-00~~	~~quantitative perimetry (for example, several isopters on Goldmann perimeter or equivalent~~	~~42.50~~
~~92083-00~~	~~static and kinetic perimetry, or equivalent~~	~~60.00~~
~~92100-00~~	~~Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day~~	~~10.00~~
~~92140-00~~	~~Provocative tests for glaucoma, with medical diagnostic evaluation~~	~~15.00~~
~~92225-00~~	~~Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomocroscopy), with medical diagnostic evaluation, initial~~	~~22.20~~
~~92250-00~~	~~Ophthalmoscopy, with medical diagnostic evaluation, with fundus photography~~	~~15.00~~
~~92285-00~~	~~Extended ocular photography for documentation of progress~~	~~10.00~~
~~92287-00~~	~~Specular endothelial microscopy with photographic documentation, evaluation and report, with flouroscein antiography~~	~~30.00~~
~~92310-00~~	~~Prescription and management of corneal contact lens, both eyes, except for aphakia~~	~~50.00~~
~~92312-00~~	~~corneal lens for aphakia, two eyes~~	~~130.00~~
~~92325-00~~	~~Modification of contact lens~~	~~20.00~~
~~92326-00~~	~~Replacement of contact lens~~	~~58.00~~
~~92340-00~~	~~Treatment with spectacles, except for aphakia, monofocal~~	~~49.00~~
~~92341-00~~	~~bifocal~~	~~64.00~~
~~92342-00~~	~~multifocal, other than bifocal~~	~~84.00~~
~~92370-00~~	~~Repair and adjusting spectacles, except for aphakia~~	~~68.95~~
~~92390-00~~	~~Supply of all spectacle lenses, except for aphakia and low vision aids (all combinations, nonspecific), one lens only (enter two units for a pair)~~	~~79.00~~
~~92391-00~~	~~Supply of contact lenses, except prosthesis for aphakia, one lens only (enter two units for a pair)~~	~~108.00~~
~~99056-00~~	~~Services provided at request of patient in a location other than optometrist's office that are normally provided in the office~~	~~6.00~~

5221.2650 OPTICIANS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to certified opticians.

Subp. 2. **Basic optician services.** The following codes, service descriptions, and maximum fees apply to basic optician services and supplies:

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 53.00
06502-00	Bifocal eyeglass lenses (one lens)	69.95
06503-00	Trifocal eyeglass lenses (one lens)	85.00
06504-00	Lenticular eyeglass lenses (one lens)	24.00
06506-00	Eyeglass frames	80.00
06510-00	Tinting for lenses	12.00
06587-00	Contact lenses, soft (one lens)	109.00
06588-00	Contact lenses, hard (one lens)	61.00
06593-00	Dispensing fee, frames for lenses	70.20

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Office Services

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

5221.2700 AUDIOLOGISTS.

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

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

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

5221.2750 SPEECH PATHOLOGISTS.

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

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competency (CCC-SP) or to speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subp. 2. **~~Physical therapy.~~ Definitions.** The terms defined in this subpart have the meanings given to them when used in subpart 4 unless the context clearly indicates a different meaning.

A. "Therapeutic exercise" (code 97110) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular re-education" (code 97112) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident and systemic neurological disease.

C. "Functional activities" (code 97114) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work-related activities.

D. "Gait training" (code 97116) means teaching individuals with neurological or musculoskeletal disorders to

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ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how to prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

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

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

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

Subp. 3. **Physical and occupational therapy instructions.**

A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration. ~~The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.~~

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

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C. Occupational therapy services must be provided by a nationally registered occupational therapist or certified occupational therapy assistant under the direction of a nationally registered occupational therapist.

Subp. 4. **~~Scope~~ Physical therapy and occupational therapy services.** The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed within the physical or occupational therapist's scope of practice in an independent clinic, a doctor's office, a hospital satellite clinic, or hospital out-patient setting.

Code	Service	Maximum Fee
	Modalities	
97010-00	Physical medicine treatment to one area; hot or cold packs ~~(RPT/OTR)~~	$ 17.00
97012-00	traction, mechanical ~~(RPT/OTR)~~	16.00
97014-00	electrical stimulation (unattended) ~~(RPT/OTR)~~	15.00
97016-00	vasopneumatic devices ~~(RPT/OTR)~~	16.00
97018-00	paraffin bath ~~(RPT/OTR)~~	20.00
97022-00	whirlpool ~~(RPT/OTR)~~	17.00
97024-00	diathermy ~~(RPT/OTR)~~	16.00
97028-00	ultraviolet ~~(RPT/OTR)~~	25.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises ~~(RPT/OTR)~~	$ 22.00
97112-00	neuromuscular reeducation ~~(RPT/OTR)~~	25.00
97114-00	functional activities ~~(RPT/OTR)~~	19.00
97116-00	gait training ~~(RPT/OTR)~~	23.00
97118-00	electrical stimulation (manual) ~~(RPT/OTR)~~	16.25
97120-00	iontophoresis ~~(RPT/OTR)~~	20.00
97122-00	traction, manual ~~(RPT/OTR)~~	18.00
97124-00	massage ~~(RPT/OTR)~~	17.25
97126-00	contrast baths	18.00
97128-00	ultrasound ~~(RPT/OTR)~~	16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	13.00
97220-00	Hubbard tank; initial 30 minutes each visit ~~(RPT/OTR)~~	45.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit ~~(RPT/OTR)~~	30.00
97500-00	Orthotics training (dynamic bracing, splinting), ~~upper~~ upper/lower extremities; initial 30 minutes, each visit ~~(RPT/OTR)~~	21.00
97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit ~~(RPT/OTR)~~	25.00
97531-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit ~~(RPT/OTR)~~	20.00
97541-00	each additional 15 minutes ~~(RPT/OTR)~~	18.50

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

5221.2900 CHIROPRACTORS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of chiropractic medicine.

Subp. 1a. **Definitions.** For purposes of this part, the following terms have the meaning given them unless the content clearly indicates a different meaning.

A. "Examination/consultation" means inspection of the patient, review of diagnostic tests to diagnose disease or evaluate progress and preparation of an appropriate record.

(1) "Brief examination" means a condition requiring only a routine history and examination.

(2) "Intermediate examination" means a condition involving a diagnostic or management problem and a history and examination.

(3) "Extensive examination" means an unusual amount of effort or judgment and a detailed history and examination of multiple body systems.

B. "Initial office visit with manipulation/adjustment" means the first time a patient is seen for a brief evaluation to determine the appropriate treatment on that date and all necessary spinal manipulative/adjustment procedures rendered.

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C. "Subsequent office visit with manipulation/adjustment" means all office visits, except the first one, where a brief evaluation is done to determine appropriate treatment on that day and all necessary spinal manipulation/adjustment procedures rendered.

D. "New patient" means a patient new to the chiropractor or a known patient with a new industrial injury or condition, whose medical and administrative record needs to be established.

E. "Established patient" means a patient whose medical and administrative records are available to the chiropractor.

Subp. 1b. **Chiropractor instructions.**

A. Use code 09542 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation ~~on the same day~~.

Subp. 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Examinations - Includes History and Diagnosis, Office	
09520-00	New patient; brief examination (CHIRO/DC)	$ 30.00
09521-00	intermediate examination (CHIRO/DC)	40.00
09522-00	extensive examination (CHIRO/DC)	60.00
09530-00	Established patient; brief examination (CHIRO/DC)	25.00
09531-00	intermediate examination (CHIRO/DC)	40.00
09532-00	extensive examination (CHIRO/DC)	60.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office (CHIRO/DC)	$ 20.00
09541-00	subsequent; office (CHIRO/DC)	22.00
09542-00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00
	Home/Nursing Home Visits	
09550-00	Chiropractic visit with manipulation/adjustment (CHIRO/DC)	$ 40.00
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00

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09556-00	(e.g., long leg, thoracolumbar lumbosocrol, or full-body corset type)	28.50

Conjunctive Therapy/Modality - Office, Home, or Nursing Home

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

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

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

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	limited (one projection) (CHIRO/DC)	$ 30.00
73030-00	complete, minimum of two views	54.00
73070CHR	Radiologic examination, elbow; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73100CHR	Radiologic examination, wrist; limited (anteroposterior and lateral) (CHIRO/DC)	35.00
73110-00	complete, minimum of three views	50.00
73120CHR	Radiologic examination, hand (CHIRO/DC)	36.00
	Lower Extremities	
73500CHR	Radiologic examination, hip; limited (one view) (CHIRO/DC)	$ 35.00
73510CHR	Radiologic examination, hip; complete, minimum of two views (CHIRO/DC)	53.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	40.00
73562CHR	anteroposterior and lateral, with oblique(s), minimum of three views (CHIRO/DC)	55.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	70.00
73600CHR	Radiologic examination, ankle; limited (two views) (CHIRO/DC)	35.00
73610CHR	Radiologic examination, ankle; comprehensive (minimum of three views (CHIRO/DC)	50.00
73620-00	Radiologic examination; foot; anteroposterior and lateral views	32.00
73630-00	complete, minimum of three views	55.00
	Miscellaneous	
76140-00	Consultation on x-ray examination made elsewhere, written report	25.00

Subp. 4. **Laboratory.** The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles include the following tests.

Code	Service	Maximum Fee
	Automated Multichannel Test	
80019CHR	Automated multichannel tests; 19 or more clinical chemistry tests (indicate instrument use and number of tests performed) (CHIRO/DC)	$ 60.00
	Urinalysis	
81000-00	Urinalysis; routine (pH, specific gravity, protein tests for reducing substances such as glucose), with microscopy	$ 12.00
81002-00	routine, without microscopy	12.00
81015CHR	Urinalysis; microscopic only (CHIRO/DC)	12.00
	Hematology	
85022CHR	Blood count; hemogram, automated, and differential WBC count (CBC)	$ 29.00
85031CHR	hemogram, manual, complete CBC	

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

5221.3000 PODIATRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. **Ancillary services.** Services performed by podiatric assistants must be by order of and under the direct on-site supervision of a licensed doctor of podiatric medicine.

Subp. 3. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

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

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17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (POD/DPM)	$ 28.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions (POD/DPM)	30.00
17340*00	Cryotherapy (CO2 slush, liquid N2)	22.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	42.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)	50.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)	45.00
28080-00	Excision of Morton neuroma, single, each	465.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe	325.00
28126-00	Concylectomy, phalangeal base, single toe, each	350.00
28153-00	Resection, head of phalanx, toe	375.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	400.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)	593.00
28292-00	Keller, McBride, or Mayo type procedure	930.00
28308-00	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal	614.00
29405-00	Application of short leg cast (below knee to toes) (POD/DPM)	100.00
29425-00	Application of short leg case (below knee to toes); walking or ambulatory type	125.00
29540-00	Strapping; ankle (POD/DPM)	22.00
29550-00	toes (POD/DPM)	23.00
29580-00	Unna boot (POD/DPM)	35.00
29590-00	Dennis Browne splint strapping	25.00
36415*00	Routine venipuncture for collection of specimens	10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch (POD/DPM)	30.00

Radiology

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

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

Patient Visits

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

Hospital Medical Services

90115-00	Home medical service, new patient; intermediate service	$ 25.00
90140POD	Home medical service, established patient; brief service (POD/DPM)	15.00
90200POD	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	70.00
90215POD	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	40.00
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	35.00
90350-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; limited service	15.00
90360-00	intermediate service	25.00
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	16.00
90410-00	limited service	15.00

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

5221.3100 PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

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

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

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

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

5221.3160 SOCIAL WORKERS.

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

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of social work (MSW) degree or a comparable degree.

Subp. 2. **Social worker services.** The following codes, service descriptions, and maximum fees apply to social worker services performed by persons meeting the requirements of the board of social work.

Code	Service	Maximum Fee
06043-00	Independent behavior and/or other analysts, counselors, and other therapists (MSW)	$ 45.00
06046-00	Independent social worker services (MSW)	70.00

~~5221.3170~~ 5221.1410 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider ~~certified by the Biofeedback Certification Institute of America (BCIA). Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP)~~ licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
90900-00	Biofeedback training; by electromyogram application (e.g., in tension headache muscle spasm) (BCIA/LCP)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow (BCIA/LCP)	45.00

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. [Unchanged.]

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

A. to P. [Unchanged.]

Q. Mount Sinai Hospital, Minneapolis

R. North Memorial Medical Center, Robbinsdale

S. Saint Cloud Hospital, Saint Cloud

T. St. John's Hospital Northeast, Saint Paul

U. Saint Joseph's Hospital, Saint Paul

V. Saint Luke's Hospital, Duluth

W. Saint Mary's Hospital, Duluth

X. Saint Mary's Hospital, Minneapolis

Y. The Samaritan Hospital, Saint Paul

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Z. United Hospital, Saint Paul

AA. Unity Medical Center, Fridley

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

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

A. to JJJJJJ. [Unchanged.]

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

Subp. 4. **Group 3.** The following hospitals make up group 3:

A. Hennepin County Medical Center, Minneapolis

B. Saint Paul Ramsey Medical Center, Saint Paul

C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	$ 400.18

Subp. 5. **Group 4.** The following hospitals make up group 4:

A. Rochester Methodist Hospital, Rochester

B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	$ 180.80

5221.3310 EFFECTIVE DATE.

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

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

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

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(20).

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Office of the Revisor of Statutes

Administrative Rules

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

AGENCY: Department of Labor and Industry

MINNESOTA RULES: Chapter 5221

The attached rules are approved for filing with the Secretary of State

John C. Fuller
Assistant Deputy Revisor

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Workers' Compensation; Medical Charges and Reimbursement

AGENCY: Department of Labor and Industry

MINNESOTA RULES: Chapter 5221

The attached rules are approved for publication in the State Register

John C. Fuller
Assistant Deputy Revisor

Department of Labor and Industry

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

Rules as Proposed

5221.0100 DEFINITIONS.

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

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

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

Subp. 4. **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~~ to categorize provider charges on a bill.

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

Subp. 6. **Compensable ~~or compensability~~ injury.** "Compensable injury" ~~or "compensability," in reference to a service,~~ means an ~~employer~~ injury or condition for which a payer is liable ~~for the service pursuant to~~ under Minnesota Statutes, chapter 176.

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

Subp. 8. **Excessive service.** "Excessive service" means any

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service rendered to treat a compensable injury that meets any of the conditions of excessiveness described in part 5221.0550.

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

Subp. ~~9.~~ 10. **~~Maximum~~ Medical fee schedule.** "~~Maximum~~ Medical fee schedule" means the list of codes, service descriptions, and corresponding ~~75th-percentile~~ dollar amounts ~~established-pursuant-to-part-5221.0900~~ allowed under Minnesota Statutes, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

Subp. ~~10.~~ 11. **Payer.** "Payer" refers to ~~all-entities~~ any entity 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~~ under Minnesota Statutes, ~~sections-79.251-and-79.252~~ chapter 176.

Subp. ~~11.~~ 12. **Provider.** "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

Subp. ~~12.~~ 13. **Reasonable charge.** "Reasonable, charge" ~~in-reference-to-a-charge,~~ means a charge or portion of a charge ~~which~~ for treatment of a compensable injury that is not excessive under part 5221.0500.

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

Subp. ~~13.~~ 15. **Service or treatment.** "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing ~~and~~ or relieving an injured worker from the

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effects of ~~an~~ a compensable injury ~~or occupational disease, pursuant to~~ under Minnesota Statutes, section 176.135, subdivision 1.

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

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

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

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

D. for outpatient treatment provided by other health care providers not specified in items A to C, legible information that substantiates the nature and necessity of a service or charge in the form of an initial report, an interim report, or a discharge/summary report.

5221.0200 AUTHORITY.

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

5221.0300 PURPOSE.

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

5221.0400 SCOPE.

The following are subject to this chapter: all entities responsible for payment and administration of medical claims

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compensable under Minnesota Statutes, chapter 176; and providers of medical services or supplies for ~~work-related~~ compensable injuries ~~or-diseases-pursuant-to~~ under Minnesota Statutes, section 176.135, subdivision 1.

5221.0500 ~~EXCESSIVENESS~~ EXCESSIVE CHARGES.

A charge is excessive if any of the following conditions apply to the charge~~,-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~~ allowed in the ~~maximum~~ medical fee schedule of this chapter; or

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

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

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

E. the charge ~~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; or

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

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

~~H.--the-service-does-not-comply-with-the-requirements of-rules-adopted-pursuant-to-Minnesota-Statutes,-section~~

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

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

5221.0600 PAYER RESPONSIBILITIES.

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

Subp. 2. ~~**Payment of charges**~~ Determination of excessiveness. ~~Before paying a charge, the payer shall determine whether it is excessive. If a charge is determined to be excessive, the payer shall not pay the part that is excessive. As soon as reasonably possible, and no later than 21 calendar days after receiving the bill and necessary medical data, 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~~

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~~Minnesota Statutes, sections 176.221 and 176.225.~~ Subject to a determination of the commissioner or compensation judge, the payer shall determine whether a charge or service is excessive by evaluating the charge and service according to the conditions of excessiveness specified in parts 5221.0500 and 5221.0550.

Subp. 3. **Determination of excessiveness** charges. ~~Subject to the provider's right to appeal under part 5221.0800, the payer shall ascertain whether a charge is excessive by evaluating the charge and service according to the standards of excessiveness specified in part 5221.0500. The payer shall also comply with the following procedures:~~

~~A. 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 part 5221.1000.~~ As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the payer shall:

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

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

(3) request an appropriate record or specific additional information to determine whether the charge or service is excessive or whether the condition is compensable. No later than 30 calendar days following receipt of an appropriate record and additional information, the payer shall make a determination as set forth in this item.

~~B. 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~~

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~~the following, provided that final determinations shall remain the responsibility of the payer:~~

~~(1) the opinion of persons with expertise concerning the service, including the provider whose charge is being evaluated;~~

~~(2) the findings of peer review panels, professional associations, and other expert evaluators of a healing art; and~~

~~(3) 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, coding and fee schedules, and other medical reference materials.~~

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

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

A. the basis for denial of all or part of a charge that the payer has determined is not for a compensable injury

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under part 5221.0100, subpart 6;

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

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

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

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

Subp. ~~4.~~ 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the ~~**standards**~~ conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

5221.0700 PROVIDER RESPONSIBILITIES.

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

Subp. 2. **Submission of information.** Providers shall include on bills the patient's name, date of injury, and the employer's name, service descriptions and codes which accurately describe ~~all~~ the services provided and ~~all~~ the injuries or conditions treated, the date ~~upon~~ on which each service was provided, and the providers' ~~social security~~ tax identification number. ~~Where applicable, codes from the maximum fee schedules in this chapter shall be used. This subpart shall not prohibit the use of other coding schedules where codes in the maximum fee~~

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~~schedule-do-not-apply.~~ Providers must also supply a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge.

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

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

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

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

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

25105	Arthrotomy, wrist joint; for synovectomy	

Subp. ~~3.~~ 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply ~~promptly~~ within seven working days with payers' ~~reasonable~~ proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of

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treatment, and other issues pertaining to the payer's determination of ~~a service's~~ compensability or ~~a charge's reasonableness~~ excessiveness. A provider may not require prepayment for costs of copies of existing medical records.

Subp. ~~4.~~ 5. **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 finally upheld, the provider may collect charges found to be reasonable, but only from the payer, not from the injured employee, any other insurer, or government~~ an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

5221.0800 ~~APPEALS PROCEDURE~~ DISPUTE RESOLUTION.

Pursuant to Minnesota Statutes, sections ~~176.103~~ 176.106 and 176.271 and related statutes and rules, ~~providers~~ the employee, employer, or insurer may request ~~that the commissioner determine~~ a determination of whether a charge or service is excessive. ~~This determination may be appealed first to the medical services review board, and then to the workers' compensation court of appeals.~~ Such requests shall be made to the commissioner in writing on a form prescribed for that purpose. Under Minnesota Statutes, section 176.136, subdivision 2, a provider may request a determination of whether a charge is excessive under part 5221.0500. An employee, employer, insurer, health care provider, or intervenor who disagrees with a determination under Minnesota Statutes, section 176.106 or 176.305 may request a formal hearing before a compensation judge at the Office of Administrative Hearings. The request shall be made on a form prescribed by the commissioner.

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

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

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

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

~~Subpart 1.~~ Subp. 3. **~~Maximum~~ Medical fee schedule instructions.** The instructions in this part and this chapter govern the use and application of fees in this chapter.

Subp. ~~2.~~ 4. **Applicability of the fee schedule.** The payer shall undertake reasonable investigations to ascertain whether a service and its corresponding charge is subject to the ~~maximum~~ medical fee schedule. A ~~service~~ charge is subject to the ~~maximum~~ medical fee schedule if it conforms to a ~~description contained in the maximum fee schedule in the section~~ code under part 5221.0700, subpart 3, item A, and is included in the medical fee schedule for the appropriate ~~kind of medical~~ provider group. ~~The standards of excessiveness contained in part 5221.0500 apply whether or not a service is subject to the~~

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

Subp. ~~3.~~ 5. **Coding.** ~~For-services-which-are-or-which-may-be-subject-to-the-maximum-fee-schedule,~~ The payer shall undertake reasonable investigations to ~~ascertain~~ determine whether or not the code ~~assigned-to~~ listed for a service by the provider is correct under part 5221.0700, subpart 3, item A, and subject to the medical fee schedule. If ~~no~~ an incorrect code for a service has been ~~assigned~~ listed, the payer shall may determine the ~~appropriate~~ correct code for the service, and ~~shall~~ may evaluate the service on the basis of ~~that-code~~ the proposed change. ~~A-broad,-inclusive-service-description~~ Neither the provider nor the payer may ~~be-divided~~ divide a broad inclusive service into its component services, charges, and codes, if the broad inclusive service is ~~not~~ subject to the ~~maximum~~ medical fee schedule ~~but-some-of-the-component-services-are~~. If the broad inclusive service is not subject to the medical fee schedule, it may be divided into its component services if any of those components are subject to the medical fee schedule.

Subp. ~~4.~~ 6. **Ambiguity.** If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service and its corresponding charge is subject to the ~~maximum~~ medical 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~~

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~~determination.--If-the-commissioner-determines-that-a-service-is not-subject-to-the-maximum-fee-schedule,-the-commissioner-shall order-the-payment-of-the-reasonable-value-of-that-service pursuant-to-Minnesota-Statutes,-section-176.135,-subdivision 3~~ contact the provider and attempt to resolve the ambiguity. The provider shall cooperate in resolving this ambiguity. If the parties are unable to come to an agreement, either party may file a request for a determination with the commissioner under part 5221.0800.

Subp. ~~5.~~ 7. **Code modifiers.** The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in items A to R T.

A. Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery, ~~including-the-aid~~ requiring the use of an operating microscope. This modifier ~~is~~ shall not ~~warranted~~ apply for surgery done with the aid of a magnifying surgical loupe ~~or-magnifying-binoculars-worn-by-the surgeon~~ whether attached to the eyeglasses or a headband. Services with this modifier are not subject to the ~~maximum~~ medical fee schedule.

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

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services or unusual circumstances may be reasonably expected to significantly increase the provider's cost.

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

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

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

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

G. Modifier number 51 denotes multiple procedures.

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

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

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

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

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

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

~~L.~~ M. Modifier number 75 denotes concurrent care. This modifier is appropriate to services where the patient's condition requires the additional services of more than one

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physician. This modifier does not exempt the service from the maximum fee for the five-digit code.

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

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

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

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

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

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

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

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professional component.

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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

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

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

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

D. to L. [Unchanged.]

M. Referral. "Referral" means a transfer of the total care or specific care of a patient from one physician to another and does not constitute a consultation.

N. Hospital discharge day management. "Hospital discharge day management" includes final examination of the

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patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge record.

Subp. 3. **Office services.** The following codes, service descriptions, and maximum fees apply to services provided at the physician's office, or if provided in an outpatient hospital clinic setting, for nonemergency services.

Code	Service	Maximum Fee
90000-00	Office services; new patient - brief service (MD/DO)	~~30.00~~ 33.00
90010-00	~~New patient~~-- limited service (MD/DO)	~~36.00~~ 40.00
90015-00	~~New patient~~-- intermediate service (MD/DO)	~~46.00~~ 49.00
90017-00	~~New patient~~-- extended service (MD/DO)	~~70.00~~ 65.00
90020-00	comprehensive service (MD/DO)	130.00
90030-00	Office services; established patient - minimal service (MD/DO)	~~16.00~~ 16.50
90040-00	~~Established patient~~-- brief service (MD/DO)	~~22.00~~ 23.50
90050-00	~~Established patient~~-- limited service (MD/DO)	~~25.00~~ 26.00
90060-00	~~Established patient~~-- intermediate service (MD/DO)	~~34.00~~ 35.70
90070-00	~~Established patient~~-- extended service (MD/DO)	55.00
90080-00	~~Established patient~~-- comprehensive service (MD/DO)	~~82.25~~ 88.30

Subp. 3a. **Home services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a home setting if provided in a private residence as a "house call." They do not apply to physician services provided at a nursing home, boarding home, domiciliary (temporary lodging), or custodial care involving periodic services provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee
90100-00	Home medical service, new patient; brief service	44.00
90110-00	limited service	48.00
90115-00	intermediate service	50.00
90130-00	Home medical service, established patient; minimal service	30.30
90140-00	brief service	42.90
90150-00	limited service	45.00
90160-00	intermediate service	50.00
90170-00	extended service	57.80

Subp. 4. **Hospital services.** The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under

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codes 90240 to 90270.

Code	Service	Maximum Fee
90200-00	~~Brief~~ Initial hospital care; brief (MD/DO)	$ ~~62.50~~ 66.00
90215-00	Intermediate ~~initial hospital care~~ (MD/DO)	~~85.00~~ 87.50
90220-00	Comprehensive ~~initial hospital care~~ (MD/DO)	~~123.00~~ 127.00
90240-00	Subsequent hospital care - brief service (MD/DO)	~~26.50~~ 28.00
90250-00	~~Subsequent hospital care~~-- limited service (MD/DO)	~~37.00~~ 35.50
90260-00	Intermediate services (MD/DO)	50.00
90270-00	~~Subsequent hospital care~~-- extended service (MD/DO)	~~75.00~~ 69.00
90280-00	~~Subsequent hospital care~~-- comprehensive service (MD/DO)	~~75.00~~ 82.00
	Hospital Discharge Services	
90292-00	Hospital discharge day management (MD/DO)	$ ~~52.00~~ 50.00

Subp. 5. **Skilled nursing, intermediate care, and long-term care facilities.** The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long-term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 45.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	70.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	96.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.00
90350-00	limited service	27.25
90360-00	intermediate service	40.00
90370-00	extended service	50.00

Subp. 6. **Nursing home, boarding home, domiciliary, or custodial care medical services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a domiciliary or custodial care facility involving periodic services, provided to a patient who is institutionalized on a long-term basis.

Code	Service	Maximum Fee

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90410-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; limited service	$ 50.00
90415-00	intermediate service	81.50
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	20.75
90440-00	brief service	25.00
90450-00	limited service	33.00
90460-00	intermediate service	44.00
90470-00	extended service	55.00

Subp. ~~5.~~ 7. **Emergency department services.** The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department. They do not apply when physicians elect to use the emergency room as a substitute for their office and an actual emergency situation does not exist.

Code	Service	Maximum Fee
90500-00	Emergency department service New patient - minimal service (MD/DO)	$ ~~26.00~~ 31.50
90505-00	~~New patient--~~ brief service (MD/DO)	~~35.00~~ 37.50
90510-00	~~New patient--~~ limited service (MD/DO)	~~44.00~~ 47.00
90515-00	~~New patient--~~ intermediate service (MD/DO)	~~60.00~~ 65.00
90517-00	~~New patient--~~ extended service (MD/DO)	~~82.00~~ 95.00
90520-00	comprehensive service (MD/DO)	120.00
90530-00	Emergency department service, established patient; minimal service (MD/DO)	23.49
90540-00	~~Established patient--~~ brief service (MD/DO)	~~35.00~~ 37.00
90550-00	~~Established patient--~~ limited service (MD/DO)	~~39.00~~ 42.00
90560-00	~~Established patient--~~ intermediate service (MD/DO)	~~46.00~~ 49.00
90570-00	~~Established patient--~~ extended service (MD/DO)	~~52.50~~ 65.00
90580-00	comprehensive service	86.00

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

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90590-00 Physician direction of Emergency Medical Systems (EMS), emergency care advanced life support $112.00

5221.1200 CONSULTATIONS.

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

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

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

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

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

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~~D.~~ (3) Extensive consultation.

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

~~E.~~ (4) Comprehensive consultation.

(90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate ~~report~~ record. This includes, but is not limited to, services similar in level to a consultation for a young person with fever, arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a ~~report~~ record with recommendations.

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

B. Follow-up consultation. "Follow-up consultation"

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

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

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

Code	Service	Maximum Fee
90600-00	Initial consultation; limited (MD/DO)	~~$ 55.00~~ 58.00
90605-00	Intermediate consultation (MD/DO)	~~73.00~~ 76.50
90610-00	Extensive consultation (MD/DO)	~~89.00~~ 93.50
90620-00	Comprehensive consultation (MD/DO)	~~135.00~~ 139.50
90630-00	Complex consultation (MD/DO)	~~155.00~~ 160.00
	Follow-up Consultation	
90640-00	Follow-up consultation; brief visit (MD/DO)	$ ~~65.00~~ 39.50
90641-00	limited	~~53.00~~ 48.50
90642-00	intermediate	82.00
90643-00	complex	100.00
	Confirmatory (Additional Opinion) Consultation	
90650-00	Confirmatory consultation; limited (MD/DO)	$ 55.00 63.00
90651-00	intermediate (MD/DO)	75.00
90652-00	extensive (MD/DO)	80.00
90653-00	comprehensive (MD/DO)	120.00
90654-00	complex (MD/DO)	~~175.00~~ 193.00
	~~Immunization Injections~~	
~~90701~~	~~Immunization, active, diphtheria and tetanus toxoids and pertussis vaccine (DTP)~~	~~$ 15.00~~
~~90702~~	~~--diphtheria and tetanus toxoids (DT)~~	~~10.00~~
~~90703~~	~~--tetanus toxoid~~	~~9.00~~
~~90704~~	~~--mumps virus vaccine, live~~	~~14.50~~
~~90705~~	~~--measles virus vaccine, live, attenuated~~	~~14.50~~
~~90706~~	~~--rubella virus vaccine, live~~	~~14.19~~
~~90707~~	~~--measles, mumps, and rubella virus --vaccine, live~~	~~23.50~~
~~90712~~	~~--polio virus vaccine, live, oral, --any type(s)~~	~~12.65~~
~~90713~~	~~--poliomyelitis vaccine~~	~~10.00~~
~~90718~~	~~--tetanus and diphtheria toxoids absorbed, --for adult use (Td)~~	~~9.50~~
~~90719~~	~~--diphtheria toxoid~~	~~9.00~~
~~90724~~	~~--influenza virus vaccine~~	~~11.00~~

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~~90732 --pneumococcal vaccine, polyvalent $6.00~~
~~90733 --meningococcal polysaccharide vaccine, any group(s) $5.00~~

5221.1210 IMMUNIZATION INJECTIONS.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include the supply of materials.

90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP) (MD/DO)	$ 20.00
90702-00	diphtheria and tetanus toxoids (DT) (MD/DO)	11.00
90703-00	tetanus toxoid (MD/DO)	10.50
90704-00	mumps virus vaccine, live (MD/DO)	19.00
90705-00	measles virus vaccine, live, attenuated (MD/DO)	16.50
90706-00	rubella virus vaccine, live (MD/DO)	17.00
90707-00	measles, mumps, and rubella virus vaccine, live (MD/DO)	26.75
90708-00	measles and rubella virus vaccine, live	24.00
90712-00	polio virus vaccine, live, oral; any type(s) (MD/DO)	15.00
90713-00	poliomyelitis vaccine (MD/DO)	15.00
90714-00	typhoid vaccine	11.00
90717-00	yellow fever vaccine	30.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD) (MD/DO)	10.00
90719-00	diphtheria toxoid (MD/DO)	9.50
90724-00	influenza virus vaccine (MD/DO)	11.25
90725-00	cholera vaccine	13.00
90726-00	rabies vaccine	115.52
90731-00	hepatitis B vaccine	61.25
90732-00	pneumococcal vaccine, polyvalent (MD/DO)	17.00
90733-00	meningococcal polysaccharide vaccine; any group(s) (MD/DO)	16.00
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	16.00
90741-00	Immunization, passive; immune serum globulin, human (ISG)	15.00
90742-00	specific hyperimmune serum globulin (for example, hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicellazoster	50.00

5221.1220 THERAPEUTIC INJECTIONS.

90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	10.00
90788-00	Intramuscular injection of antibiotic (specify)	14.25

5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

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General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
90801-00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants informants will be seen in lieu of the patient). (MD/DO)	~~$ 113.00~~ 112.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	70.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	111.50
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes (MD/DO)	55.00
90844-00	approximately 45 or 50 minutes (MD/DO)	~~95.00~~ 85.00
90847-00	Family medical psychotherapy (conjoint psychotherapy) (MD/DO)	~~90.00~~ 85.00
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	57.00
90853-00	Group medical psychotherapy (other than of a multiple-family group) (MD/DO)	~~45.00~~ 40.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	120.00
90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	120.00

Other Psychiatric Therapy

90880-00	Medical hypnotherapy (MD/DO)	~~$ 55.00~~ 75.00
90882-00	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	70.00
90887-00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (MD/DO)	~~90.00~~ 78.00

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

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Subp. 2. **Definitions.** The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient" and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in part 5221.1100, except for item C regarding intermediate opthalmological service and item D regarding comprehensive opthalmological service.

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

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

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

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

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

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

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92020, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels

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of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92235, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

General Services

Code	Service	Maximum Fee
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient (MD/DO)	$ ~~48.50~~ 51.00
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient, one or more visits (MD/DO)	~~54.00~~ 58.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient (MD/DO)	~~38.40~~ 40.00
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program - established patient, one or more visits (MD/DO)	~~53.00~~ 55.00
92019-00	limited	26.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure) (MD/DO)	~~27.00~~ 29.30

Special Services

Code	Service	Maximum Fee
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	37.00
92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	41.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	140.00
92081-00	Visual field examination with medical diagnostic evaluation; limited examination (for example, tangent screen), Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	31.31
92082-00	intermediate examination (for example, multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel, full field automated test, such as Octopus program 33 or 34 equivalent)	50.00
92083-00	~~Visual field examination with medical diagnostic evaluation;~~ extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41) (MD/DO)	$ ~~54.00~~ 59.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day (MD/DO)	~~23.50~~ 24.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without	

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	tonography (MD/DO)		25.00

Ophthalmoscopy

Code	Service	Maximum Fee
92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial (MD/DO)	$ ~~32.00~~ 37.00
92226-00	subsequent (MD/DO)	30.00
92230-00	Opthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	34.00
92235-00	~~Ophthalmoscopy, including medical diagnostic~~ with fluorescein angiography and (includes multiframe photography) ~~and medical interpretation~~ (MD/DO)	~~143.00~~ 150.00
92250-00	with fundus photography	33.00
92260-00	with opthalmodynamometry	30.00

Other Specialized Services

Code	Service	Maximum Fee
92275-00	Electroretinography, with medical diagnostic evaluation	$ 154.00
92285-00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (for example, close-up photography, slit lamp photography, goniophotography, stereo-photography	40.00
92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00

Contact Lenses

Code	Service	Maximum Fee
92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, 1 eye	$ 80.00
92314-00	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	16.00
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	30.00
92326-00	Replacement of contact lens	65.00

Spectacle Services

Code	Service	Maximum Fee
92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	147.35
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

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The codes, service descriptions, and maximum fees in this

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

Code	Service	Maximum Fee
92504-00	Binocular microscopy (separate diagnostic procedure (MD/DO)	$ 10.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	42.00
92508-00	Speech, language, or hearing therapy with continuing medical supervision; group (MD/DO)	16.00
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	58.00
92512-00	Nasal function studies, for example, rhinomanometry	71.50
92532-00	Positional nystagmus	21.00
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	30.00
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	41.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	43.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording (MD/DO)	55.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording (MD/DO)	26.00
92545-00	Oscillating tracking test, with recording (MD/DO)	26.00

5221.1800 ~~CARDIOGRAPHY~~ CARDIOVASCULAR.

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

Code	Service	Maximum Fee
92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 200.00
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external (MD/DO)	~~$202.50~~ 244.00

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92982-00	Percutaneous transluminal coronary angioplasty; single vessel		2,080.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads (MD/DO)		42.50
93005-00	tracing only, without interpretation and/or report (MD/DO)	~~29.50~~	37.00
93010-00	interpretation and report only (MD/DO)	~~18.00~~	17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip		50.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report (MD/DO)		195.00
93017-00	~~Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring,~~ tracing only, without interpretation and report (MD/DO)	~~94.00~~	99.00
93018-00	interpretation and report only (MD/DO)	~~104.00~~	100.00
93024-00	Ergonovine provocation test		175.00
93040-00	Rhythm ECG, one to three leads; with interpretation (MD/DO)		22.00
93041-00	tracing only without interpretation and report (MD/DO)		12.00
93042-00	Rhythm ECG, tracing with interpretation and report only (MD/DO)	~~15.00~~	18.00
93210-00	Phonocardiogram, intracardiac		45.50
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report (MD/DO)	~~95.00~~	105.00
~~93276~~	~~Scanning analysis with report~~		~~100.00~~
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning		185.70
93262-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning		200.00
	without superimposition scanning		219.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis		215.75
93268-00	Patient demand single event ECG recording; pre-symptom memory loop and transmission		34.00
93269-00	post-symptom memory loop and transmission		30.00
93300-~~26~~00	Echocardiography, M-mode; complete ~~professional component only~~	~~63.00~~	79.00
93308-00	Echocardiograph, real-time with image documentation (2D); limited (MD/DO)		105.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D) (MD/DO)		250.00
93320-00	Doppler echocardiography (MD/DO)		105.00

Cardiac Catheterization

93501-00	Right heart catheterization only	$ ~~560.00~~	685.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography (MD/DO)	~~360.00~~	351.00
93505-00	Endomyocardial biopsy		330.00
~~93543~~	~~Injection procedure during cardiac catheterization, for pulmonary angiography~~		

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	~~for selective left ventricular or left atrial angiography~~		~~300.00~~
~~93544~~	~~for aortography~~		~~300.00~~
93547-00	Combined left heart catheterization, selective coronary angiography and selective left ventricular angiography	~~750.00~~	760.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (MD/DO)	~~994.50~~	1,166.00
93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)		79.00
	Other Vascular Studies		
93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming		$ 54.00
93732-00	with reprogramming		45.00
93733-00	telephone analysis		40.50
93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming		40.00
93735-00	with reprogramming		50.00
93736-00	telephonic analysis		35.50
93784-00	Ambulatory blood pressure monitoring, using a system such as magnetic tape and/or computer disc, for 24 hours; including recording, scanning analysis, interpretation and report		225.00
	Noninvasive Peripheral Vascular Diagnostic Studies		
	Cerebrovascular Arterial Studies		
93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periobital flow direction with arterial compression, periobital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)		$ 79.00
93870-00	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis) (MD/DO)	~~$ 245.00~~	185.20
	Venous Studies		
93950-~~26~~00	Noninvasive studies of extremity veins; ~~professional component only~~ (MD/DO)	~~$ 36.00~~	80.00
93960-00	Quantitative venous flow studies (e.g., capacitance and outflow measurement or calf, measurement of calf venous reflux, quantitative photoplethysmography)		100.00

5221.1900 PULMONARY.

The codes, service descriptions, and maximum fees of this part apply to pulmonary services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The services

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include laboratory procedures, interpretation, and physician services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010-00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements, and/or maximal voluntary ventilation	$ 30.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after broncodilator (aerosol or parenteral) or exercise	50.00
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	65.70
94150-00	Vital capacity, total	~~$ 15.00~~ 18.00
94160-00	Vital capacity screening tests; total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity, maximal voluntary ventilation	20.00
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	79.00
94260-00	Thoric gas volume	11.00
94350-00	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including a alveolar nitrogen or helium equilibration time	46.45
94360-00	Determination of resistance to airflow, oscillatory or plethysmographic methods	10.00
94375-00	Respiratory flow volume loop	24.00
94640-00	Nonpressurized inhalation treatment for acute airway obstruction (MD/DO)	~~21.00~~ 22.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (MD/DO)	20.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	128.50
94657-00	subsequent days	56.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	~~19.30~~ 20.50
	~~Allergy and Clinical Immunology~~	
~~95120~~	~~Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen~~	~~$ 7.50~~
~~95125~~	~~Multiple antigens (specify number of injections)~~	~~9.25~~
94665-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent	21.50
94680-00	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	35.00
94681-00	including CO_2 output, percentage oxygen extracted	94.60
94700-00	Analysis of arterial blood gas (oxygen saturation, pO_2, pCO_2, CO_2, pH); rest only	33.30

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

Subpart 1. **Allergy sensitivity tests.** Allergy sensitivity

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tests are the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests.

Subp. 2. **Immunotherapy (desensitization, hyposensitization).** Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

Subp. 3. **Other therapy.** Other therapy for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see 95105-00. (For definitions of Levels of Service see the Introduction.) (For Medical Service Procedures, see 90000-90699.)

Code	Service	Maximum Fee
95000-00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; up to 30 tests	$ 2.50
95001-00	31-60 tests	2.05
95002-00	61-90 tests	2.00
95007-00	Percutaneous tests (scratch, puncture, prick) with antibiotics, biologicals, stinging insects; 11-15 tests	22.50
95011-00	more than 15 tests	50.00
95014-00	Intracutaneous (intradermal) tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 1-5 tests	15.00
95017-00	Intracutaneous (intradermal tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 11-15 tests	45.00
95021-00	Intracutaneous (intradermal tests with allergenic extracts, immediate reaction 15-20 minutes; 11-20 tests	4.00
95022-00	21-30 tests	3.30
95023-00	more than 30 tests	2.25
95027-00	Skin and point titration	6.00
95030-00	Intracutaneous (intradermal) tests with allergenic extracts, delayed reaction 24-72 hours, including reading; 2 tests	11.00
95031-00	3-4 tests	10.00
95042-00	Patch or application tests; 21-30 tests	3.33

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95043-00	more than 30 tests	4.00
95070-00	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds	110.00
95078-00	Provocative testing (MD/DO)	14.00
95105-00	Medical conference services (e.g., use of mechanical and electric devices, climatotherapy, breathing exercises and/or postural drainage)	35.00
95120-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen (MD/DO)	8.00
95125-00	Multiple antigens (specify number of injections) (MD/DO)	9.00
95130-00	Single stinging insect venom (MD/DO)	23.50
95131-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 2 stinging insect venoms	22.00
95132-00	3 stinging insect venoms	27.50
95180-00	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, horse serum)	6.70

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

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

Code	Service	Maximum Fee
~~95819-26~~	~~Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation, standard or portable, same facility, professional component only~~	~~$ 55.00~~
~~95819-TC~~	~~technical component only~~	~~110.00~~
~~95833~~	~~Muscle testing, manual, total evaluation of body, excluding hand~~	~~10.00~~
95821-00	Electroencephalogram (EEG); sleep only	$ 145.00
95823-00	physical or pharmacological activation only	100.00
95827-00	all night sleep recording only	300.00
95831-00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	25.00
95851-00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	50.00
95852-00	hand, with or without comparison with normal side	16.00
95857-00	Tensilon test for myasthenia gravis	57.00
95860-00	Electromyography; one extremity and related paraspinal areas (MD/DO)	~~170.00~~ 175.00
~~95860-26~~	~~professional component only~~	~~120.00~~
95861-00	two extremities and related paraspinal	

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		areas (MD/DO)	~~235.00~~ 250.00
95863-00		three extremities and related paraspinal areas (MD/DO)	~~155.70~~ 165.00
95864-00		four extremities and related paraspinal areas (MD/DO)	~~215.20~~ 226.00
~~95864-26~~		~~professional component only~~	~~152.00~~
95869-00		Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	77.80
95882-00		Assessment of higher cerebral function with medical interpretation; cognitive testing and others (MD/DO)	~~150.00~~ 45.00
95900-00		Nerve conduction, velocity, or latency study, motor, each nerve (MD/DO)	50.00
95904-00		Nerve conduction, velocity and/or latency study; sensory, each nerve	59.50
95935-00		"H" reflex, by electrodiagnostic testing	45.00
95950-00		Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; electroencephalographic (EEG) recording and interpretation, initial 24 hours	380.00
95951-00		combined electroencephalographic (EEG) and video recording and interpretation, initial 24 hours	1,000.00

5221.2050 CHEMOTHERAPY INJECTIONS.

The codes, service descriptions, and maximum fees of this part apply to chemotherapy injections, and to a provider licensed as a doctor of medicine, a doctor of osteopathy, or by a qualified assistant under supervision of the physician.

Code	Service	Maximum Fee
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 60.00
96505-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by infusion technique	55.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	37.00
96509-00	by infusion technique	90.00
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	81.50
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	321.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	48.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	217.30
96540-00	Chemotherapy injection, intrathecal via reservoir, single or multiple agents, administered by physician	107.00

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5221.2070 DERMATOLOGICAL PROCEDURES.

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

Subp. 2. **Services.** Dermatologic services are typically consultative, and any of the levels of consultation described in part 5221.1200 may be appropriate. In addition, physician services for dermatological procedures are the same as the definitions described in part 5221.1100.

Code	Service	Maximum Fee
96900-00	Actinotherapy (ultraviolet light)	$ 7.50
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	25.00
96912-00	psoralens and ultraviolet A (PUVA)	30.00

5221.2100 PHYSICAL MEDICINE.

The following codes, service descriptions, and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. ~~Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities and procedures require supervision by the physician, and constant attendance by the physician or therapist.~~

Code	Service	Maximum Fee
	Modalities	
~~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~~	~~$ 18.00~~
~~97010~~	~~Physical medicine treatment to one area, hot or cold packs~~	~~24.50~~
~~97012~~	~~Physical medicine treatment to one area, traction mechanical~~	~~15.50~~
~~97014~~	~~Physical medicine treatment to one ea, electrical stimulation (unattended)~~	~~17.00~~
~~97020~~	~~Microwave~~	~~12.75~~
~~97024~~	~~Diathermy~~	~~14.75~~

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97026	Infrared		7.50
97039	Unlisted modality (specify)		27.10
	Procedures		
97110	Physical medicine treatment to one area, initial 30 minutes, each visit, therapeutic exercises		$ 26.50
97116	Gait training		20.00
97118	Electrical stimulation (manual)		16.00
97124	Massage		17.00
97128	Ultrasound		17.00
97145	Physical medicine treatment to one area, each additional 15 minutes		12.50
97240	Pool therapy or Hubbard tank with therapeutic exercises, initial 30 minutes, each visit		32.00
97260-00	Manipulation (cervical, thoracic, lumbosacral, socroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system		30.00
97261-00	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; each additional area (MD/DO)	8.00	8.40
97700	Office visit, including one of the following tests or measurements, with report:		
	a. Orthotic checkout		
	b. Prosthetic checkout		
	c. Activities of daily living checkout, initial 30 minutes, each visit		45.00
97701	each additional 15 minutes		33.00

5221.2200 CRITICAL CARE SPECIAL SERVICES AND REPORTS.

Critical care services (codes 99162 to 99173) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion

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~~of-arrhythmia,-are-not-permitted-when-critical-care-services-are billed-on-a-per-hour-basis.~~ Special services and reports apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include a means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. (See part 5221.1100 for definitions on levels of services.

Code	Service	Maximum Fee
	Miscellaneous Services	
99000-00	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory (MD/DO)	$ ~~8.00~~ 9.25
99001-00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated) (MD/DO)	~~11.90~~ 11.00
99014-00	Telephone calls for consultation or medical management; intermediate	15.00
	~~Surgical Procedures~~	
99025-00	Initial, new patient visit; when ~~asterisk~~ asterisked (*) surgical procedure constitutes major service at that visit (MD/DO)	~~20.00~~ 25.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	27.10
99054-00	Services requested on Sundays and holidays in addition to basic services	25.00
99056-00	Services provided at request of patient in a location other than physician's office which are normally provided in the office	55.00
99058-00	Office services provided on an emergency basis (MD/DO)	~~35.00~~ 40.00
99062-00	Emergency care facility services; when the nonhospital-based physician is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	52.00
99064-00	Emergency care facility services; when the nonhospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	50.00
99065-00	during regular office hours	50.50
99075-00	Medical testimony (MD/DO)	Reasonableness of charges reviewable by commissioner
99080-00	Special reports like insurance forms, or the review of medical data to clarify a patient's status; more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner (MD/DO)	Reasonableness of charges

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		reviewable by commissioner	
99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)		25.00
	Prolonged Services		
99150-00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour (MD/DO)	$ ~~100.00~~	114.00
99151-00	more than one hour		191.00
	Medical Conferences		
99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes (MD/DO)	~~65.00~~	73.70
99156-00	approximately 50 minutes	~~115.00~~	100.00

Critical Care Services

. Critical care services (codes 99162-00 to 99173-00) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99160-00	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the	

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		physician; each hour (MD/DO)	$ ~~140.00~~ 151.50
	99162-00	additional 30 minutes (MD/DO)	~~75.00~~ 76.50
	99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	75.00
	99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness (MD/DO)	~~55.00~~ 60.00
	99172-00	~~Critical care, subsequent follow-up visit;~~ limited examination, evaluation, or treatment for same or new illness (MD/DO)	53.00
	99173-00	intermediate examination, evaluation, or treatment, same or new illness (MD/DO)	~~75.00~~ 78.00
	99174-00	Extended reexamination, reevaluation and/or treatment, same or new illness (MD/DO)	~~131.00~~ 150.00
	~~99175~~	~~Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison~~	~~62.00~~
		Other Services	
	99195-00	Phlebotomy, therapeutic (separate procedure)	35.00

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. [Unchanged.]

Subp. 2. **Instructions.** The instructions in items A to ~~E~~ F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in-hospital follow-up care, provided by the surgeon both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. The surgical package includes the assistant surgeons if any are used. Reimbursement for the assistant surgeon is made from the fee collected for the surgical package and is the responsibility of the primary physician. For the purposes of this definition, preoperative care does not include any care administered before the provider determines that surgery is required.

B. to D. [Unchanged.]

E. Certain minor surgical services involve a readily identifiable surgical procedure but include variable

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

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

(2) Preoperative services shall be listed when:

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

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

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

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

(3) All postoperative care is added on a service-by-service basis.

(4) Complications are added on a service-by-service basis as with surgical procedures.

F. Special situations.

(1) Multiple procedures (more than one procedure

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is performed at a single operative session through the same incision.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 50 percent of the Medical Fee Schedule, whichever is less.

(2) Multiple procedures (more than one procedure is performed at a single operative session through different incisions.)

(a) The major or primary procedures must be billed with the applicable 5-digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 65 percent of the Medical Fee Schedule, whichever is less.

(3) Bilateral procedures (pertaining to two sides and requiring separate incisions.)

(a) When bilateral procedures are performed at the same operative session and the descriptor for the procedure code specifies bilateral procedures, the procedures must be reported using the applicable procedure code listed in the Medical Fee Schedule. Reimbursement must be at the provider's usual charge or the Medical Fee Schedule, whichever is less.

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(b) When the descriptor of the procedure code does not specify that it is bilateral, the primary procedure must be reported twice using the applicable procedure codes.

For the first procedure, the applicable 5-digit procedure code must be billed without a modifier. Reimbursement will be at the provider's usual rate or the rate set in the Medical Fee Schedule, whichever is less.

For the second procedure, the applicable 5-digit code must be billed with modifier 50. Reimbursement must be at the provider's usual rate or 75 percent of the rate set in the Medical Fee Schedule, whichever is less.

Subp. 3. **Integumentary system.** ~~**The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.**~~

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200 to 11441) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions.

(2) Treatment of burns (codes 16000 to 16030) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001 to 12014) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit.

(b) Intermediate repair (codes 12031 to 12052) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure.

(c) Complex repair (codes 13120 to 13152)

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

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

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

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

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

B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

Incision

Code	Service	Maximum Fee

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10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion (MD/DO)	$ ~~50.00~~	53.00
10003*00	Incision and drainage of infected or noninfected epithelial inclusion cyst (sebaceous cyst) with complete removal of sac and treatment of cavity (MD/DO)	~~59.00~~	60.00
10020*00	Incision and drainage of furuncle (MD/DO)	~~35.00~~	40.00
10040*00	Acne surgery (e.g. marsupialization, opening or removal of multiple milia, comedones, cysts, pustules		23.00
10060*00	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple (MD/DO)	~~51.50~~	54.00
10061-00	complicated		130.00
10080*00	Incision and drainage of piloridial cyst; simple (MD/DO)	~~59.25~~	60.00
10100*00	Incision and drainage of onychia or paronychia single or simple (MD/DO)	~~45.00~~	47.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple (MD/DO)	~~50.00~~	52.50
10121*00	complicated		112.20
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst (MD/DO)		45.00
10180-00	Incision and drainage, complex, postoperative wound infection		100.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface		35.00
11041-00	Debridement; skin, full thickness		35.00
11042-00	skin, and subcutaneous tissue		80.00
	Paring or Curettement		
11050*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ ~~27.00~~	28.00
11051-00	two to four lesions		40.00
11052-00	more than four lesions		52.00
	Biopsy		
11100-00	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion (MD/DO)	$ ~~60.00~~	63.00
~~11101~~	~~each additional lesion~~		~~31.50~~
	Excision -- Benign Lesions		
11200*00	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions (MD/DO)	$ ~~54.00~~	55.00
11400-00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter (MD/DO)	~~68.00~~	70.40
11401-00	lesion diameter 0.5 to 1.0 centimeter	~~78.00~~	82.00
11402-00	lesion diameter 1.0 to 2.0 centimeters	~~96.50~~	100.00
11403-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)		115.00
11404-00	lesion diameter 3.0 to 4.0 centimeters (MD/DO)	~~130.00~~	150.00
11406-00	lesion diameter over 4.0 centimeters		200.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion		

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		diameter up to 0.5 centimeter (MD/DO)	~~72.50~~	77.00
	11421-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	~~91.25~~	96.60
	11422-00	lesion diameter 1.0 to 2.0 centimeters (MD/DO)	~~110.00~~	120.00
	11423-00	lesion diameter 2.0 to 3.0 centimeters (MD/DO)	~~140.00~~	144.00
	11424-00	lesion diameter 3.1 to 4.0 centimeters		160.00
	11426-00	lesion diameter over 4.0 centimeters		300.00
	11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter (MD-DO)	~~87.00~~	90.00
	11441-00	lesion diameter 0.5 to 1.0 centimeter (MD/DO)	~~100.00~~	113.00
	11442-00	lesion diameter 1.1 to 2.0 centimeters		135.00
	11443-00	lesion diameter 2.1 to 3.0 centimeters		89.00
		Excision -- Malignant Lesions		
	16000-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less		$ 111.00
	11601-00	lesion diameter 0.6 to 1.0 centimeter		145.00
	11602-00	lesion diameter 1.1 to 2.0 centimeters		204.00
	11603-00	lesion diameter 2.1 to 3.0 centimeters		260.00
	11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less		171.00
	11621-00	lesion diameter 0.6 to 1.0 centimeter		220.00
	11622-00	lesion diameter 1.1 to 2.0 centimeters		280.43
	11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less		243.00
	11641-00	lesion diameter 0.6 to 1.0 centimeter		292.90
		Nails		
	11700*00	Debridement of nails, manual; 5 or less		$ 29.00
	11710*00	Debridement of nails, electric grinder, 5 or less		25.00
	11730*00	Avulsion of nail plate, partial or complete, simple; single (MD/DO)	~~$ 60.00~~	64.00
	11740-00	Evacuation of subungual hematoma (MD/DO)	~~35.00~~	36.50
	11750-00	Excision of nail and nail matrix, partial or complete, (e.g. ingrown or deformed nail) for permanent removal		125.00
	11760-00	Reconstruction of nail bed; simple		77.00
		Miscellaneous		
	11770-00	Excision of piloridial cyst or sinus; simple		$ 550.00
	11771-00	extensive		600.00
	11900*00	Injection, intralesional, up to and including seven lesions (MD/DO)		$ 35.00
		Introduction		
	11901*00	Injection, intralesional; up to and including 7 lesions		$ 71.00
	11954-00	Subcutaneous injection of "filling" material (e.g. silicone); over 10 cc		50.00
		Repair -- Simple		
	12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters (MD/DO)	$ ~~53.00~~	55.50

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12002*00	2.5 to 7.5 centimeters (MD/DO)	~~77.00~~	82.00
12004*00	7.5 to 12.5 centimeters (MD/DO)	~~112.00~~	120.00
12005*00	12.5 to 20.0 centimeters (MD/DO)	~~134.00~~	175.00
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters (MD/DO)	~~78.00~~	83.00
12013*00	2.5 to 5.0 centimeters	~~107.00~~	115.00
12014-00	5.1 to 7.5 centimeters		75.00
	Repair -- Intermediate		
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters (MD/DO)	~~$ 80.00~~	84.00
12032*00	2.5 to 7.5 centimeters (MD/DO)	~~100.00~~	118.00
12034-00	7.6 to 12.5 centimeters (MD/DO)	~~143.10~~	168.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters (MD/DO)		98.00
12042-00	2.5 to 7.5 centimeters (MD/DO)	~~130.00~~	140.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters (MD/DO)	~~110.00~~	112.00
12052-00	2.5 to 5.0 centimeters (MD/DO)	~~139.00~~	160.00
	Repair -- Complex		
13100-00	Repair, complex, trunk; 1.1 to 2.5 centimeters		$ 140.00
13101-00	2.6 to 7.5 centimeters		275.00
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters		280.00
13121-00	2.6 to 7.5 centimeters		234.00
13131-00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters		350.00
13132-00	2.6 to 7.5 centimeters		490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less		210.00
13151-00	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters (MD/DO)	$	420.00
13152-00	2.5 to 7.5 centimeters (MD/DO)	~~697.00~~	630.00
	Adjacent Tissue Transfer or Rearrangement		
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters (MD/DO)	$ ~~726.25~~	725.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters (MD/DO)	~~850.00~~	1,000.00
	Free Skin Grafts		
15100-00	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters or less, or each one percent of body area of infants and children (MD/DO)	$ ~~583.00~~	635.00
	Burns, Local Treatment		
16000-00	Initial treatment, first degree burn, when no more than local treatment is required (MD/DO)	$ ~~50.00~~	47.50
16020*00	Dressings or debridement, initial or		

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	subsequent; without anesthesia, office or hospital, small (MD/DO)	~~40.00~~	42.50
16025*00	without anesthesia, medium, for example, whole face or whole extremity (MD/DO)	~~66.00~~	71.00

Destruction

17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion (MD/DO)	$ ~~47.50~~	46.50
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (MD/DO)	~~36.50~~	43.00
17101-00	second lesion (MD/DO)	~~20.25~~	22.25
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions		40.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions (MD/DO)	~~51.00~~	50.00
~~17250*~~	~~Chemical cauterization of a wound~~		~~30.00~~
17304-00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to 5 horizontal, microscopic specimens		460.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2) (MD/DO)	~~28.00~~	30.00
17360*00	Chemical exfoliation for acne (e.g. acne paste, acid)		31.00

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

Excision -- General

Code	Service	Maximum Fee
20220-00	Biopsy, bone, trocar, or needle; superficial, for example ilium, sternum, spinous process, ribs	$ ~~150.00~~ 175.00

Introduction or Removal -- General

~~20501*~~	~~Injection of sinus tract, diagnostic (sinogram) (separate procedure)~~		~~$ 48.00~~
20550*00	Injection, tendon sheath, ligament, or trigger points (MD/DO)	~~41.00~~	46.00
20600*00	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes (MD/DO)	~~42.00~~	50.00
20605*00	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa (MD/DO)	~~58.55~~	60.25

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20610*00	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa (MD/DO)	~~57.00~~	61.00
20670*00	Removal of implant; superficial, (e.g. buried wire, pin, or rod)		86.50
20680-00	Removal of implant; deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate (MD/DO)	~~320.00~~	344.00
	Head -- ~~Fracture or Dislocation~~ Repair, Revision, or Reconstruction		
~~21240~~	~~Arthroplasty, temporomandibular joint~~	~~$ 2,226.00~~	
21116-00	Injection procedure for temporomandibular joint arthrography		$162.00
21310-00	Treatment of closed or open nasal fracture without manipulation (MD/DO)	~~45.00~~	55.00
21315-00	mandible (includes obtaining graft)		120.00
21320-00	Manipulative treatment, nasal bone fracture; with stabilization (MD/DO)	~~270.00~~	300.00
~~21455~~	~~Closed manipulative treatment by interdental fixation of closed or open mandibular fracture~~		~~718.43~~
	Neck (Soft Tissues) and Thorax -- Fracture or Dislocation		
21800-00	Treatment of rib fracture; closed, uncomplicated, each		65.00
	Spine		
Code	Service		Maximum Fee
22555-00	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) (MD/DO)	$ ~~2,261.00~~	2,300.00
	Shoulders -- Fracture or Dislocation		
23350-00	Injection procedure for shoulder arthrography (MD/DO)		$ 58.00
23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) (MD/DO)	~~1,563.50~~	1,515.00
23450-00	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation (MD/DO)	~~1,355.00~~	1,359.00
23500-00	Treatment of closed clavicular fracture; without manipulation (MD/DO)		100.00
~~23550~~	~~Open treatment of closed or open acromioclavicular dislocation, acute or chronic~~		~~852.00~~
23540-00	Treatment of closed acromioclavicular dislocation; without manipulation		75.00
23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation		202.25
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia (MD/DO)	~~146.00~~	138.00
23655-00	requiring anesthesia (MD/DO)	~~197.00~~	213.00
	~~Shoulder----Manipulation~~		
~~23700*~~	~~Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)~~		~~$ 188.00~~

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		Humerus (Upper Arm) and Elbow -- Fracture or Dislocation	
~~24105~~		~~Excision, olecranon bursa~~	~~$ 375.00~~
24500-00		Treatment of closed humeral shaft fracture; without manipulation	$233.70
24600-00		Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	168.00
24650-00		Treatment of closed radial head or neck fracture without manipulation (MD/DO)	~~135.00~~ 160.00
		Forearm and Wrist -- Incision and Excision	
25000-00		Tendon sheath incision; at radial styloid for de Quervain's disease	$395.00
25111-00		Excision of ganglion, wrist (dorsal or volar); primary (MD/DO)	~~$ 380.00~~ 400.00
~~25500~~		~~Treatment of closed radial shaft fracture; without manipulation~~	~~150.50~~
		Forearm and Wrist -- Fracture or Dislocation	
25505-00		Treatment of closed radial shaft fracture; with manipulation (MD/DO)	~~$ 341.00~~ 345.00
25560-00		Treatment of closed radial and ulnar shaft fractures; without manipulation	211.50
25565-00		Treatment of closed radial and ulnar shaft fractures; with manipulation (MD/DO)	~~406.00~~ 435.00
25600-00		Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation (MD/DO)	~~189.00~~ 176.00
25605-00		with manipulation (MD/DO)	~~318.00~~ 322.00
25610-00		Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning (MD/DO)	~~443.00~~ 460.00
25611-00		with external skeletal fixation or percutaneous pinning (MD/DO)	~~600.00~~ 643.00
25622-00		Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	185.00
		Hand and Fingers -- Incision, Excision, Repair, Revision, or Reconstruction	
26010*00		Draining of finger abscess; simple	$55.00
26055-00		Tendon sheath incision for trigger finger (MD/DO)	~~$383.00~~ 400.00
26115-00		Excision, tumor, hand or finger; subcutaneous	315.00
26116-00		deep, subfascial, intramuscular	537.50
26122-00		Fasciectomy, palmar, simple for Dupuytren's contracture; up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,309.00
26160-00		Excision of lesion of tendon sheath or capsule (MD/DO)	~~248.00~~ 231.00
26418-00		Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon (MD/DO)	~~255.00~~ 333.00
		Hands and Fingers -- Fractures or Dislocations	

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26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone (MD/DO)	$ ~~126.00~~	116.00
26605-00	with manipulation, each bone (MD/DO)	~~195.00~~	196.00
~~26615~~	~~Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone~~		~~490.00~~
26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each (MD/DO)	~~80.00~~	77.00
26725-00	with manipulation, each (MD/DO)	~~137.00~~	150.00
26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each		400.00
26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each (MD/DO)	~~56.00~~	55.50
26755-00	with manipulation, each		112.00
26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each		100.00
26770-00	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia (MD/DO)	~~62.00~~	65.00

Hand and Fingers -- Amputation

26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (MD/DO)	$ ~~275.00~~	295.50

Pelvis and Hip Joint

27125-00	Hemiarthroplasty of hip; prostheses (e.g. Austin-Moore, bipolar arthroplasty)		$2,098.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple (MD/DO)		3,050.00
~~27131~~	~~complex~~		~~3,620.00~~
27134-00	Revision of total hip arthroplasty; both components		4,100.00
27235-00	Treatment of closed or open femoral fracture, in situ pinning of undisplaced or impacted fracture		1,493.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (MD/DO)	~~1,629.00~~	1,700.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation (MD/DO)	~~1,491.00~~	1,496.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia		381.00

Femur (Thigh Region) and Knee Joint -- Introduction or Removal

27370-00	Injection procedure for knee arthrography (MD/DO)		$ 55.64
~~27374~~	~~Arthroscopy, knee, surgical, debridement with cartilage shaving or drilling or resection of reactive synovium~~		~~1,450.00~~
~~27378~~	~~with partial meniscectomy~~		~~1,380.00~~
~~27379~~	~~with plica resection or shelf resection~~		~~1,225.00~~

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		Femur (Thigh Region) and Knee Joint -- Repair, Revision, or Reconstruction	
27422-00		Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	~~$ 1,156.00~~ 1,203.00
27425-00		Lateral retinacular release, any method	1,235.00
27446-00		Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,400.00
27447-00		Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement) (MD/DO)	3,000.00
27506-00		Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation (MD/DO)	~~1,580.00~~ 1,482.00
		Amputation	
27590-00		Amputation, thigh, through femur, any level	$1,050.40
		Leg (Tibula and Fibula) and Ankle Joint --Fractures or Dislocations	
~~27752~~		~~Treatment of closed tibial shaft fracture, with manipulation~~	~~$ 425.00~~
27750-00		Treatment of closed tibial shaft fracture; without manipulation	$275.00
27760-00		Treatment of closed distal tibial fracture (medial malleolus) without manipulation	190.00
27780-00		Treatment of closed proximal fibula or shaft fracture; without manipulation (MD/DO)	~~150.00~~ 141.00
27786-00		Treatment of closed distal fibular fracture (lateral malleolus); without manipulation (MD/DO)	~~152.50~~ 176.00
~~27792~~		~~Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation~~	~~730.00~~
27800-00		Treatment of closed tibia and fibula fractures, shafts; without manipulation	315.00
27802-00		~~Treatment of closed tibia and fibula fractures, shafts;~~ with manipulation (MD/DO)	~~511.00~~ 540.00
27814-00		Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation (MD/DO)	~~920.00~~ 950.00
27822-00		Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only (MD/DO)	~~1,112.00~~ 1,153.00
27880-00		Amputation leg, through tibia and fibulat (MD/DO)	~~893.00~~ 918.00
		Foot ~~---Fracture or Dislocation~~	
28080-00		Excision of Morton neuroma; single each (MD/DO)	$ ~~350.00~~ 381.00
28090-00		Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot (MD/DO)	~~303.00~~ 316.30
28114-00		Ostectomy, complete excision; all metatarsal	

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		heads, with proximal phalangectomy, excluding first metatarsal (Clayton type procedure)	40.00
	28190*00	Removal of foreign body, foot; subcutaneous	65.00
	28285-00	Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy) (MD/DO)	~~385.00~~ 394.00
	28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure) (MD/DO)	~~425.00~~ 478.50
	28292-00	Keller, McBride or Mayo type procedure	675.00
	28296-00	with metatarsal osteotomy (Mitchell ~~or~~ ~~Lapidus~~, Chevron, or concentric type procedure)	~~760.00~~ 840.00
	28470-00	Treatment of closed metatarsal fracture; without manipulation, each (MD/DO)	~~133.13~~ 128.25
	28490-00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation (MD/DO)	~~50.00~~ 66.00
	28510-00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each (MD/DO)	~~51.25~~ 55.90
		~~Amputation~~	
	28820-00	Amputation, toe; metatarso phalangeal joint	$ ~~300.00~~ 247.00

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

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29065-00	Application; shoulder to hand (long arm) (MD/DO)	$ ~~82.50~~ 84.00
29075-00	elbow to finger (short arm) (MD/DO)	~~66.00~~ 70.00
29085-00	hand and lower forearm (gauntlet) (MD/DO)	~~67.00~~ 70.00

Splints

29105-00	Application of long arm splint (shoulder to hand) (MD/DO)	$ ~~47.00~~ 49.00
29125-00	Application of short arm splint (forearm to hand); static (MD/DO)	42.00
29130-00	Application of finger splint; static	26.00

Strapping -- Any Age

29220-00	Strapping; low back (MD/DO)	$ ~~21.00~~ 30.00
29240-00	shoulder (e.g. Velpeau)	50.00
29260-00	elbow or wrist (MD/DO)	20.00
~~29325~~	~~Application of hip spica cast; bilateral, or one and one half spica~~	~~282.00~~
29345-00	Application of long leg cast (thigh	

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		to toes) (MD/DO)	~~109.00~~ 111.00
	29355-00	walker or ambulatory type (MD/DO)	~~124.00~~ 127.00
	29365-00	Application of cylinder cast (thigh to ankle) (MD/DO)	~~85.00~~ 87.50
	29405-00	Application of short leg cast (below knee to toes) (MD/DO)	~~82.00~~ 85.00
	29425-00	walking or ambulatory type (MD/DO)	~~90.50~~ 96.00
	29435-00	Application of patellar tendon bearing (PTB) cast (MD/DO)	~~119.00~~ 124.00
	29440-00	Adding walker to previously applied cast (MD/DO)	~~32.25~~ 34.00
	29450-00	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral (MD/DO)	~~52.00~~ 56.00
	29455-00	bilateral	~~100.00~~ 103.00

Splints

	29505-00	Application of long leg splint (thigh to ankle or toes) (MD/DO)	$ ~~74.00~~ 62.00
	29515-00	Application of short leg splint (calf to foot) (MD/DO)	~~45.00~~ 50.00

Strapping -- Any Age

	29530-00	Strapping; knee	$ 48.00
	29540-00	ankle (MD/DO)	25.00
	29550-00	toes	20.00
	29580-00	Unna boot (MD/DO)	34.00

Removal or Repair

	29700-00	Removal or bivalving; gauntlet, boot or body cast	$33.20
	29705-00	full arm or full leg cast	30.00
	29720-00	Repair of spica, body cast, or jacket (MD/DO)	$ ~~20.00~~ 21.00

Arthroscopy

	29870-00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$500.00
	29874-00	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body (for example, osteochondritis dissecans fragmentation, chondral fragmentation) (MD/DO)	$ 1,310.00
	29875-00	synovectomy, limited (for example, plica or shelf resection) (MD/DO)	~~1,210.00~~ 1,225.00
	29877-00	debridement/shaving of articular cartilage (chondroplasty) (MD/DO)	~~1,400.00~~ 1,416.00
	29879-00	abrasion arthroplasty (includes chrondroplastywhere necessary) or multiple drilling	15.25
	29881-00	with meniscectomy (medial or lateral including any meniscal shaving) (MD/DO)	1,450.00

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

Code	Service	Maximum Fee
30100-00	Biopsy, intranasal	88.50
30110-00	Excision, nasal polyp(s), simple; unilateral	120.00
30116-00	Excision, nasal polyp(s), extensive; bilateral	505.00
30200*00	Injection into turbinate(s), therapeutic	40.50
30300*00	Removal foreign body, intranasal;	

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		office type procedure(MD/DO)	$ ~~35.00~~	39.00
		Nose -- Repair		
	30420-00	Rhinoplasty, primary; ~~complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip,~~ including major septal repair (MD/DO)	$ ~~2,045.00~~	2,250.00
	30520-00	Septoplasty or submucous resection, with or without cartilage		
		with or without cartilage ~~implant (separate procedure)~~ scoring, contouring, or replacement with graft (MD/DO)	~~921.00~~	970.00
	30800*00	Cauterization turbinates, unilateral or bilateral (separate procedure); superficial		30.00
		Other Procedures		
	30901*00	Control nasal hemorrhage, anterior, simple (cauterization);		
		unilateral (MD/DO)	$ ~~49.00~~	50.00
	30902*00	bilateral		70.00
	30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing);		
		unilateral (MD/DO)	~~95.00~~	90.00
	31000*00	Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium)		47.00
	31021-00	Sinusotomy, maxillary (antrotomy); intranasal, bilateral		550.00
		Larynx		
	31500-00	Intubation, endotracheal, emergency procedure (MD/DO)	$ ~~95.00~~	119.00
	31505-00	Laryngoscopy, indirect; diagnostic (MD/DO)	~~35.00~~	37.00
	31525-00	Laryngoscopy, direct; diagnostic, except newborn (MD/DO)	~~291.00~~	106.00
	~~31535~~	~~Laryngoscopy, direct, operative, with biopsy~~		~~470.00~~
	31536-00	Laryngoscopy, direct, operative, with biopsy; with operating microscope		560.50
	31541-00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis		660.00
	31575-00	Laryngoscopy, flexible fiberscopic; diagnostic (MD/DO)	~~74.00~~	75.00
		Trachea and Bronchi		
	31600-00	Tracheostomy, planned (separate procedure) (MD/DO)	$ ~~425.00~~	505.00
	~~31620~~			
	31622-00	Bronchoscopy; diagnostic, (flexible or rigid), ~~bronchoscope~~ with or without cell washing or brushing (MD/DO)	~~450.00~~	465.00
	~~31621~~	~~diagnostic, fiberoptic bronchoscope (flexible)~~		~~449.50~~
	31625-00	with biopsy (MD/DO)		470.00
	~~31626~~	~~with biopsy, fiberoptic bronchoscope (flexible)~~		~~470.00~~
	~~31627~~	~~with brushing, fiberoptic bronchoscope (flexible)~~		~~450.00~~
	31628-00	with transbronchial lung biopsy, ~~fiberoptic bronchoscope (flexible)~~ under with or without fluoroscopic guidance	~~493.75~~	555.00

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Lungs

32000*00	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (MD/DO)	$ ~~115.50~~ 120.00
32020-00	Tube thoracotomy with water seal (for example, pneumothorax, hemothorax, empyema)(separate procedure) (MD/DO)	~~420.00~~ 399.00
32100-00	Thoracotomy, major; with exploration and biopsy	1,600.00
32405-00	Biopsy, lung, percutaneous needle	313.00
32480-00	Lobectomy, total or segmental (MD/DO)	1,840.00
32500-00	Wedge resection of lung, single or multiple	1,480.00

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

Heart

Code	Service	Maximum Fee
33206-00	Insertion of permanent pacemaker with transvenous electrode(s); atrial	$1,480.00
33207-00	ventricular	1,552.00
33210-00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter (MD/DO)	~~$429.00~~ 506.00
33212-00	Insertion or replacement of pulse generator only	770.00
33405-00	Replacement, aortic valve, with cardiopulmonary bypass	4,259.00

Coronary Artery Procedures

33511-00	Coronary artery bypass, autogenous graft (e.g. saphenous vein or internal mammary artery); two coronary grafts (MD/DO)	$4,900.00
33512-00	~~Coronary artery bypass, autogenous graft (for example, saphenous vein or internal mammary artery);~~ three coronary ~~arteries~~ grafts (MD/DO)	~~$4,970.00~~ 4,900.00
33513-00	four coronary grafts	5,570.00
33514-00	five coronary grafts	6,224.00

Vascular Injection Procedures ---~~Venous~~

36000*00	Introduction of needle or intracatheter, vein; unilateral (MD/DO)	$ ~~23.00~~ 63.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery (MD/DO)	331.00
36140-00	Introduction of needle or intracatheter; extremity artery	274.61
36200-00	Introduction of catheter, aorta (arch,	

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		abdominal, midstream renal, aortioliac run-off) or selective; initial placement	330.50
	36215-00	each additional selective thoracic and/or cerebral artery catheter placement (e.g. vertebral or carotid)	448.00
	36230-00	coronary artery, selective, unilateral or bilateral	449.28
	36245-00	each additional selective abdominal artery catheter placement (e.g. celiac artery, gastroduodenal artery, inferior mesenteric artery, renal artery)	441.00
	36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	44.10
	36415*00	Routine venipuncture for collection of specimen(s) (MD/DO)	~~8.00~~ 7.60
	36430-00	Transfusion, blood or blood (MD/DO) components;	70.50
	~~36431~~	~~Transfusion, blood or blood components; direct~~	~~27.30~~
	36470*00	Injection of sclerosing solution; single vein	42.00
	36471*00	Injection of sclerosing solution; multiple veins, same leg (MD/DO)	~~36.50~~ 50.00
	~~36480*~~	~~Catheterization, subclavian, external jugular or other vein, for central venous pressure determination, percutaneous~~	~~105.00~~
	36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	~~125.00~~ 133.20
	~~36510~~	~~Catheterization of umbilical vein for diagnosis or therapy, newborn~~	~~100.00~~
	36520-00	Therapeutic apheresis (plasma and/or cell exchange) (MD/DO)	~~150.00~~ 156.00
		~~Vascular Injection Procedures---Arterial~~	
	36600*00	Arterial puncture, withdrawal of blood for diagnosis	47.00
	36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	$~~125.00~~ 117.00
	~~36660~~	~~Arterial catheterization, umbilical artery, newborn, for diagnosis or therapy~~	~~150.00~~
	36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	410.00
	36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,255.00
	37609-00	Ligation or biopsy, temporal artery	280.00
	37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	650.00
	37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	921.00
	37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	830.00
	37731-00	bilateral	1,256.00

Subp. 8. **Hemic and lymphatic systems.** The following codes, service descriptions, and maximum fees apply to surgical

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procedures of the hemic (blood) and lymphatic systems.

Code	Service	Maximum Fee
38100-00	Splenectomy; total	$ 1,500.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	180.00
38510-00	deep cervical nodes	366.00
	Mediastinum and Diaphragm	
39400-00	Mediastinoscopy, with or without biopsy	540.00

Subp. ~~8.~~ 9. **Digestive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the digestive system.

~~Abdomen, Peritoneum, and Omentum---Repair, Herniaplasty, Herniorrhaphy, Herniotomy~~

Code	Service	Maximum Fee
	Spleen	
~~38100~~	~~Splenectomy; total~~	~~$ 1,015.00~~
40490-00	Biopsy of lip	$102.00
40808-00	Biopsy, vestibule of mouth	70.00
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	151.50
41010-00	Incision of lingual frenum (frenotomy)	41.50
42330-00	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	120.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,795.00
42700*00	Incision and drainage abscess; peritonsillar	103.75
42809-00	Removal of foreign body from pharynx	72.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	462.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	475.00
	Esophagus	
43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ ~~350.00~~ 304.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	490.00
43220-00	for dilation, direct	585.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	439.16
43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	~~343.00~~ 350.00
43239-00	For biopsy and/or collection or specimen by brushing or washing	~~374.00~~ 406.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	508.00

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43246-00	for directed placement of percutaneous gastrostomy tube		695.00
43247-00	for removal of foreign body		500.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)		473.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection		536.00
43262-00	for sphincterotomy/papillotomy		1,023.00
43450*00	Dilation esophagus, by unguided sounds(s) or bougie(s), single or multiple passes; ~~indirect;~~ initial session		84.00
43451*00	subsequent session	~~64.00~~	70.00
43520-00	Pyloromyotomy, cutting of pyloric muscle (Fredet-Tamstedt type operation)		965.00
43635-00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type		1,750.00
	Stomach		
43760*00	Change of gastrostomy tube~~;-simple~~ (MD/DO)	$ ~~47.50~~	50.00
43830-00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure)~~;-neonatal;~~ ~~for feeding~~ (MD/DO)	~~632.00~~	700.00
43846-00	Gastric bypass with Roux-en-Y gastroenterostomy for morbid obesity (MD/DO)	~~2,625.00~~	2,593.00
	Intestines		
~~44000~~	~~Enterolysis;-freeing-of-intestinal adhesion~~		~~$--840.00~~
44005-00	Enterolysis (freeing of intestinal adhesion) ~~with~~ for acute bowel obstruction	~~1,094.25~~	1,056.00
44100-00	Biopsy of intestine by capsule, tube, peroral (1 or more specimens)		208.00
44120-00	Enterectomy, resection of small intestine; with anastomosis		1,480.00
44140-00	Colectomy, partial; with anastomosis (MD/DO)	~~1,401.25~~	1,550.00
44143-00	with end colostomy and closure of distal segment (Hartmann type procedure		1,544.00
44145-00	with coloproctostomy (low pelvic anastomosis)		1,901.00
44160-00	Colectomy with removal of terminal ileum and ileocolostomy		1,992.00
44950-00	Appendectomy (MD/DO)	~~700.00~~	741.00
44960-00	for ruptured appendix with abscesses or generalized peritonitis (MD/DO)	~~850.00~~	890.00
45110-00	Proctectomy; complete, combined abdominoperineal, with colostomy, 1 or 2 stages		2,179.40
45300-00	Proctosigmoidoscopy; diagnostic (MD/DO)	~~63.00~~	60.00
45305-00	for biopsy		100.00
45310-00	Proctosigmoidoscopy; for removal of polyp or papilloma		130.00
45315-00	for removal of multiple excrescences, papillomata or polyps		150.00
45330-00	Sigmoidoscopy, flexible fiberoptic; diagnostic (MD/DO)	~~100.00~~	103.00
45331-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	~~147.00~~	159.00
45333-00	Sigmoidoscopy, flexible fiberoptic; for removal of polypoid lesions(s)		193.50
45355-00	Colonoscopy, with standard sigmoidoscope,		

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		transabdominal via colotomy, single or multiple		120.00
	45378-00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure (MD/DO)	~~475.00~~	500.00
	45380-00	for biopsy and/or collection of specimen by brushing or washing (MD/DO)	~~555.00~~	601.00
	45383-00	Colonoscopy, fiberoptic, beyond splenic flexure; for ablation of tumor or musocal lesion (e.g., electrocoagulation, laser photocoagulation, hop biopsy/fulguration)		572.00
	45385-00	for removal of polypoid lesion(s) (MD/DO)	~~620.00~~	657.00
	45505-00	Proctoplasty; for prolapse of mucous membrane (MD/DO)	~~770.00~~	750.00
	46040-00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)		280.00
	46050*00	Incision and drainage, perianal abscess, superficial		105.00
	46083-00	Incision of thrombosed hemorrhoid, external		66.00
	46220-00	Papillectomy or excision of single tag, anus (separate procedure)		90.00
	46221-00	Hemorrhoidectomy, by simple ligature (e.g. rubber band)		97.00
	46230-00	Excision of external hemorrhoid tags and/or multiple papillae		96.00
	46255-00	Hemorrhoidectomy, internal and external, simple (MD/DO)	~~625.00~~	609.50
	46260-00	Hemorrhoidectomy, internal and external, complex or extensive		700.00
	46275-00	Fistulectomy; submuscular (MD/DO)		760.00
	46320*00	Enucleation or excision of external thrombotic hemorrhoid	~~70.43~~	81.00
	46500*00	Injection of sclerosing solution, hemorrhoids		55.00
	46600-00	Anoscopy; diagnostic (separate procedure)		29.00
	46910*00	Destruction of lesion(s), anus (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation		85.00
	46945-00	Ligation of internal hemorrhoids; single procedure		91.00
	46946-00	multiple procedures		73.00
		~~Liver~~		
	47000*00	Biopsy of Liver; percutaneous needle (MD/DO)		182.00
	47600-00	Cholecystectomy	~~$1,071.75~~	1,185.00
	47605-00	with cholangiography (MD/DO)	~~1,250.00~~	1,296.00
	47610-00	Cholecystectomy with exploration of common duct (MD/DO)	~~1,330.00~~	1,400.00
	49000-00	Exploratory laparotomy, exploratory celiotomy (MD/DO)	~~719.75~~	790.00
	49080*00	Peritoneocentesis, abdominal paracentesis; initial		100.00
	~~49420*~~	~~Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary~~		~~250.00~~
	~~49500~~	~~Repair inguinal hernia, under age 5 years, with or without hydrocelectomy~~		~~600.00~~
	49505-00	Repair inguinal hernia, age 5 or over; ~~unilateral~~ (MD/DO)	~~695.00~~	728.00
	~~49515~~	~~with excision of hydrocele or spermatocele~~		~~900.00~~
	49520-00	Repair inguinal hernia; recurrent (MD/DO)	~~805.00~~	895.00
	49525-00	sliding		920.50
	49530-00	incarcerated	~~900.00~~	870.00
	49550-00	Repair femoral hernial groin incision (MD/DO)	~~672.00~~	700.00
	49560-00	Repair ventral (incisional) hernia (separate procedure) (MD/DO)	~~780.00~~	805.00
	49565-00	Repair ventral (incisional) hernia (separate		

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		procedure); recurrent (MD/DO)	~~931.00~~ 1,020.00
	49580-00	Repair umbilical hernia; under age 5 years	510.00
	49581-00	Repair umbilical hernia; age 5 or over	~~595.00~~ 640.00

Subp. 10. **Urinary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the urinary system.

Kidney

	50200*00	Renal biopsy, percutaneous trocar or needle (MD/DO)	$ ~~350.00~~ 353.50
	50230-00	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy	1,821.00
	50360-00	Renal homotransplantation, implantation of graft; excluding donor and recipient nephrectomy	3,094.00
	50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	50.00
	50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
	50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure	30.50
	51600*00	Injection procedure for cystography or voiding urethrocystography (MD/DO)	~~17.00~~ 18.56
	51605-00	Injection procedure and placement of chain for contrast and/or chain urethrocystrography	49.51
	51610-00	Injection procedure for retrograde urethrocystography	29.00
	51700*00	Bladder irrigation, simple, lavage and/or instillation	34.00
	51705*00	Change of cystostomy tube; simple (MD/DO)	~~39.00~~ 39.40
	51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	81.20
	~~51725~~	~~Simple cystometrogram (CMG) (for example, spinal manometer)~~	~~70.00~~
	51726-00	Complex cystometrogram (for example, calibrated electronic equipment) (MD/DO)	~~75.00~~ 104.00
	~~51736~~	~~Simple uroflowmetry~~	~~70.00~~
	51741-00	Complex uroflowmetry	60.00
	51840-00	Anterior vesicourethropexy, or urethropexy; simple	~~1,098.00~~ 1,113.00
	51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,250.00
	51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,400.00
	52000-00	Cystourethroscopy, ~~office~~ (separate procedure) (MD/DO)	~~140.00~~ 131.00
	~~52204~~	~~Cystourethroscopy with biopsy, office~~	~~163.63~~
	52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	250.00
	52204-00	Cystourethroscopy with biopsy	186.00
	52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands)	297.00
	52224-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of	

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		MINOR (less than 0.5 cm) lesion(s) with or without biopsy	290.00
52234-00		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)	530.00
52235-00		MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	820.00
52240-00		LARGE bladder tumor(s)	1,200.00
52260-00		Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	216.00
52281-00		Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office (MD/DO)	~~230.00~~ 227.00
52310-00		Cystourethroscopy, with removal of foreign body, calculus, or uretheral stent from urethra or bladder (separate procedure); simple	322.00
52320-00		Cystourethroscopy; with removal of ureteral calculus (MD/DO)	~~518.75~~ 517.00
52332-00		Cystourethroscopy, with insertion of indwelling ureteral stent (MD/DO)	~~319.00~~ 360.00
52336-00		Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method; with removal or manipulation of calculus) (ureteral catheterization is included)	1,300.00
52340-00		Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic musocal folds)	500.00
52500-00		Transurethral resection of bladder neck (separate procedure)	785.00
52601-00		Transurethral resection of prostate, including control of post-operative bleeding, complete (vasectomy, meatotomy, cysto-urethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	1,325.50
53600*00		Dilation of urethral stricture by passage of sound or urethral dilator, male; initial (MD/DO)	~~37.00~~ 36.00
53601*00		Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent	27.80
53620*00		Dilation of urethral stricture by passage of filiform and follower, male; initial	57.60
53621*00		subsequent	35.35
53660*00		Dilation of female urethra including suppository and/or instillation; initial (MD/DO)	~~29.00~~ 28.00
53661-00		subsequent (MD/DO)	~~28.00~~ 30.00
53670*00		Catheterization; urethral; simple	~~35.00~~ 25.00

Subp. 10. **Reproductive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the reproductive system.

Male Reproductive System

Code	Service	Maximum Fee
54055*00	Destruction of lesions(s), penis (e.g., condyloma, papilloma molluscum contagiosum, herpetic vesical), simple; electrodesiccation	$65.00
54240-00	Penile plethysmography	80.00
54521-00	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral	550.00
54640-00	Orchiopexy, any type, with or	

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		without hernia repair; unilateral (MD/DO)	~~855.00~~	890.00
	54840-00	Excision of spermatocele, with or without epididymectomy		600.00
	55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication		39.00
	55040-00	Excision of hydrocele; unilateral (MD/DO)	~~560.00~~	550.00
	55700-00	Biopsy, prostate; needle or punch, single or multiple, any approach		134.00
	58980	Laparoscopy for visualization of pelvic viscera		550.00
	55845-00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes		2,500.00
		Female Reproductive System		
	56420*00	Incision and drainage of Bartholin's gland abscess, unilateral	$	104.00
	56440-00	Marsupialization of Bartholin's gland cyst		347.00
	56501-00	Destruction of lesion(s), vulva; simple, any method		40.00
	56600*00	Biopsy of vulva (separate procedure)		77.00
	57061-00	Destruction of vaginal lesion(s); simple, any method		48.00
	57100*00	Biopsy of vaginal mucosa; simple, (separate procedure)		70.00
	57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease		18.00
	57160*00	Insertion of pessary		25.00
	57260-00	Combined anteroposterior colporrhaphy		1,030.00
	57265-00	with enterocele repair		1,065.00
	57452*00	Colposcopy (vaginoscopy); (separate procedure)		118.00
	57454*00	with biopsies, or biopsy of the cervix		140.00
	57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)		72.00
	57510-00	Cauterization of cervix; electro or thermal		72.00
	57511*00	cryocautery, initial or repeat		81.00
	57513-00	laser surgery		450.00
	57520-00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair		466.00
	57700-00	Cerclage of uterine cervix (tracheloplasty)		499.00
	58100*00	Endometrial biopsy, suction type (separate procedure)		76.00
	58102-00	Office endometrial curettage		103.00
	58120-00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)		320.00
	58150-00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) (MD/DO)	~~1,199.25~~	1,280.00
	58152-00	with clopo-urethrocystopexy (Marshall-Marchetti-Krantz type)		1,875.00
	58260-00	Vaginal hysterectomy (MD/DO)	~~1,116.00~~	1,250.00
	58265-00	with plastic repair of vagina, anterior and/or posterior colporrhaphy (MD/DO)	~~1,375.00~~	1,450.00
	58340-00	Injection procedure for hysterosalpinography		85.30
	58720-00	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (MD/DO)	~~860.00~~	905.00
	58925-00	Ovarian cystectomy, unilateral or bilateral		931.00
	58940-00	Oophorectomy, partial or total, unilateral or bilateral		950.00
	58980-00	Laparoscopy for visualization of pelvic viscera (MD/DO)	~~550.00~~	585.00

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58982-00	with fulguration of oviducts (with or without transection)	675.00
58983-00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	773.00
58984-00	with fulguration of ovarian or peritoneal lesions by any method	750.00
58985-00	with lysis of adhesions	686.00
58987-00	with aspiration (single or multiple)	926.00

Subp. 12. **Endocrine system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the endocrine (glandular) system.

Code	Service	Maximum Fee
60100-00	Biopsy thyroid, percutaneous needle	$ 123.50
60220-00	Total thyroid lobectomy, unilateral	1,100.00
60245-00	Thyroidectomy, subtotal or partial	1,223.00
60500-00	Parathyroidectomy or exploration of parathyroid(s)	1,602.00

Subp. ~~9.~~ 13. **Nervous system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the nervous system.

Code	Service	Maximum Fee
61310-00	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial (MD/DO)	$ 2,625.00
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	2,845.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,690.00
	Spine and Spinal Cord -- Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic (MD/DO)	$ ~~90.00~~ 100.00
62273*00	Injection lumbar epidural, of blood or clot patch (MD/DO)	~~200.00~~ 240.00
62279*00	epidural or caudal, continuous	275.00
62284*00	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa (MD/DO)	135.20
62289*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal (MD/DO)	~~240.00~~ 256.00
~~62292~~	~~Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar~~	~~1,775.00~~
	Spine and Spinal Cord -- Laminectomy or Laminotomy, for Exploration or Decompression	
63005-00	Laminectomy for exploration/decompression of spinal cord and/or ~~cavda~~ cauda, equina, one or two segments; lumbar, except for spondylolisthesis (MD/DO)	~~$2,060.00~~ 2,420.00
63020-00	Laminotomy (hemilaminectomy), for ~~excision of herniated intervertebral disk, and/or~~ decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of	

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		herniated intervertebral disk; one interspace, cervical, unilateral (MD/DO)	~~2,025.00~~	2,075.00
	63030-00	~~Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, lumbar, unilateral (MD/DO)~~	~~1,936.00~~	2,005.00
	63042-00	~~Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or~~ reexploration; lumbar (MD/DO)	~~2,150.00~~	2,586.00
		Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System ~~---Exploration, Neurolysis, or Nerve Decompression (Neuroplasty)~~		
	64405*00	Injection, anesthetic agent; greater occipital nerve		114.00
	64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block		$ 130.00
	64442-00	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level		120.00
	64450*00	Injection, anesthetic agent; other peripheral nerve or branch (MD/DO)	~~110.00~~	84.00
	64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)		255.00
	64520*00	lumbar or thoracic (paravertebral sympathetic)		169.70
	64550-00	Application of surface (transcutaneous) neurostimulator (MD/DO)		45.00
	64640-00	Destruction by neurolytic agent; other peripheral nerve or branch		324.00
	64718-00	Neurolysis or transposition; ulnar nerve at elbow (MD/DO)	~~884.00~~	1,015.00
	64721-00	median nerve at carpal tunnel (MD/DO)	~~645.00~~	728.00
	~~64831~~	~~Suture of digital nerve, hand or foot, one nerve~~		~~450.00~~
		~~Eye and Ocular Adnexa---Removal of Ocular Foreign Body~~		
		Subp. 14. **Eye and ocular adnexa.** The following codes, service descriptions and maximum fees apply to surgical procedures involving the eye and ocular adnexa.		
	65205*00	Removal foreign body, external eye; conjunctival superficial (MD/DO)	$ ~~40.00~~	45.00
	65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating (MD/DO)		50.00
	65220*00	corneal, without slit lamp (MD/DO)	~~50.00~~	52.00
	65222*00	corneal, with slit lamp (MD/DO)	~~60.00~~	61.80
	65420-00	Excision or transposition of pterygium; without graft (MD/DO)	~~437.50~~	545.00
	65435*00	Removal of corneal epithelium; with or without chemo-cauterization (abrasion, curettage)		51.90
	65855-00	Trabeculoplasty by laser surgery, (1 or more sessions) (defined treatment series)		693.00
	66761-00	Iridotomy by photocoagulation (1 or more sessions) (e.g., for glaucoma)		650.00
	66762-00	Coreoplasty by photocoagulation (1 or more sessions) (e.g., for improvement of vision)		600.00
	66802-00	Discission of lens capsule; laser surgery (one or more stages)		600.00
	66820-00	Discission of secondary membranous cataract		

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		("after cataract"), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)	547.00
	66821-00	laser surgery (one or more stages)	700.00
	66940-00	Extraction of lens with or without iridectomy; extracapsular	1,682.00
	66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,770.00
	66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) (MD/DO) ~~1,850.00~~	1,763.50
	66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,287.50
	67036-00	Vitrectomy, mechanical, pars plana approach	3,025.00
	67105-00	Repair of retinal detachment, 1 or more sessions, same hospitalization; photocoagulation (laser or xenon arc, 1 or more sessions) with drainage of subretinal fluid	556.00
	67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,080.00
	67145-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	700.00
	67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), 1 or more sessions; photocoagulation (laser or xenon arc)	975.00
	~~67226~~	~~Destruction of progressive retinopathy, one or more stages; photocoagulation, laser~~	~~650.00~~
	67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), 1 or more sessions; cryotherapy, diathermy	818.00
	67228-00	photocoagulation (laser or xenon arc)	778.00
	67311-00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); 1 muscle	900.00
	67312-00	2 muscles, 1 or both eyes	968.00
	67515*00	Injection of therapeutic agent into Tenon's capsule	49.00
	67700*00	Blepharotomy, drainage of abscess, eyelid	57.00
	67800-00	Excision of chalazion; single	75.00
	67801-00	multiple, same lid	110.00
	67805-00	multiple, different lids	135.00
	67810*00	Biopsy of eyelid	106.00
	67820*00	Correction of trichiasis; epilation, by forceps only	31.00
	67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	87.00
	67921-00	Repair of entropion; suture	700.00
	67938-00	Removal of embedded foreign body; eyelid	40.00
	68200*00	Subconjunctival injection	48.00
	68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral (MD/DO) ~~35.00~~	37.00
	68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring ~~hospitalization~~ general anesthesia ~~237.00~~	260.00

~~Auditory System~~

Subp. 15. **Auditory system.** The following codes, services

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descriptions, and maximum fees apply to surgical procedures involving the auditory system.

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 55.00
69200-00	Removal foreign body from external auditory canal; without general anesthesia	27.24
69210-00	Removal impacted cerumen (separate procedure), 1 or both ears	20.75
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	38.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	84.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral (MD/DO)	~~$ 152.50~~ 150.00
69434*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral	240.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral (MD/DO)	~~210.00~~ 252.00
69437-00	bilateral (MD/DO)	350.00
69440-00	Middle ear exploration through postauricular or ear canal incision (MD/DO)	~~785.00~~ 897.00
69610-00	Tympanic membrane repair, with or without site preparation or perforation preparation for closure without patch	90.00
69620-00	Myringoplasty (MD/DO)	~~1,186.00~~ 1,305.00
69631-00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction (MD/DO)	~~1,785.75~~ 1,950.00
69632-00	with ossicular chain reconstruction (for example, postfenestration) (MD/DO)	~~2,006.00~~ 2,115.00
69641-00	Tympanoplasty with ~~antrotomy or~~ mastoidotomy; without ossicular chain reconstruction (MD/DO)	2,100.00

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 1. **General.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine ~~or~~, a doctor of osteopathy, or a technician under the supervision of a doctor of medicine or 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.~~

A. Single charge including both professional and technical component. The maximum fee represents the appropriate charges for professional services plus expenses of nonradiologist personnel, materials, facilities, and space used

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and for diagnostic or therapeutic services rendered, but excludes the cost of radio-isotopes. This value is applicable in any situation in which a single charge is made to include both professional services and the cost involved in providing that service.

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

When the physician component is billed separately, the procedure may be identified by adding the modifier "-26" to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 40 percent of the fee maximum.

(2) Technical component: certain procedures (e.g., laboratory, radiology, electrocardiogram, specific diagnostic, and therapeutic services) are a combination of a physician component and a technical component. When the technical component is billed separately, the procedure may be identified by adding the modifier "T.C." to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 60 percent of the fee maximum.

Subp. 2. **Diagnostic radiology.** The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Head and Neck

Code	Service	Maximum Fee

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70050	Radiologic examination, eye, for detection and localization of foreign body			$ 22.40
70100-00	Radiologic examination, mandible; partial, less than four views (MD/DO)		45.00	47.25
70100-26	professional component only			20.75
70110-26	professional component only			21.20
70120-00	Radiologic examination, mastoids; less than three views per side (MD/DO)		53.00	72.00
70130-00	Radiologic examination, mastoids, complete, minimum of three views per side (MD/DO)		87.00	90.00
70134	Radiologic examination, internal auditory meati, complete			78.00
70140-00	Radiologic examination, facial bones; less than three views (MD/DO)		56.91	41.70
70140-26	professional component only			18.80
70150-2600	professional component only			24.50
	complete, minimum of three views (MD/DO)			55.00
70160-00	Radiologic examination, nasal bones; complete, minimum of three views (MD/DO)		48.38	47.00
70160-26	professional component only			15.00
70200-2600	professional component only			23.20
	Radiologic examination; orbits, complete, minimum of four views (MD/DO)			46.30
70210	Radiologic examination, sinuses, paranasal, less than three views (MD/DO)		35.00	37.00
70210-26	professional component only			16.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views, without contrast studies (MD/DO)		66.00	69.50
70220-26	Radiologic examination, sinuses, paranasal, complete, minimum of three views, without contrast studies, professional component only			23.25
70240-00	Radiologic examination, sella turcia (MD/DO)			48.25
70260-26				
70250-00	Radiologic examination, skull, less than four views, with or without stereo, (MD/DO)			48.00
70260-00	complete, minimum of four views, with or without stereo (MD/DO)			74.00
	professional component only			33.00
70260-TC	technical component only			57.50
70320	Radiologic examination, teeth, complete, full mouth			51.00
70328	Radiologic examination, temporomandibular joint, open and closed mouth, unilateral			67.50
70300-00	Radiologic examination, teeth; single view			14.20
70310-00	partial examination, less than full mouth			18.90
70320-00	complete, full mouth			55.00
70330-00	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral			81.00
70332-00	Temporomandibular joint arthrography; supervision and interpretation only			250.00
70333-00	complete procedure			180.00
70355-2600	Orthopantogram, professional component only		19.00	35.00
70360-00	Radiologic examination, neck, soft tissue (MD/DO)		28.00	33.75
70360-26	professional component only			13.50
70450-26	professional component only			77.00
70460-26	professional component only			86.25
70470-26	professional component only			105.50
70380-00	Radiologic examination, salivary gland for calculus			48.50
70390-00	Sialography; supervision and interpretation only			99.00
70450-00	Computerized axial tomography, head or brain (MD/DO)			120.90
70480-00	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material			150.00

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70481-00	with contrast material			139.00
70486-00	Computerized axial tomography, maxillofacial area; without contrast material			91.40
70491-00	Computerized axial tomography, soft tissue neck; with contrast material(s)			132.00
70540-00	Magnetic resonance (e.g., proton) imaging; orbit, face, and neck			600.00
	Chest			
71010-00	Radiologic examination, chest; single view, ~~posteroanterior~~ frontal (MD/DO)	~~$-31.50~~		$34.00
~~71010-26~~	~~professional component only~~			~~13.50~~
~~71010-TC~~	~~technical component only~~			~~30.00~~
71015-00	stereo, posteroanterior (MD/DO)	~~33.30~~		35.00
71020-00	Radiologic examination, chest, two views, ~~posteroanterior~~ frontal and lateral (MD/DO)	~~45.00~~		47.25
~~71020-TC~~	~~technical component only~~			~~36.25~~
~~71020-26~~	~~professional component only~~			~~10.75~~
71021-00	~~Radiological examination, frontal and lateral;~~ with apical lordotic procedure (MD/DO)	~~41.50~~		44.00
71022-00	~~Radiologic examination, chest;~~ with oblique projections (MD/DO)	~~21.00~~		22.50
~~71022-26~~	~~professional component only~~			~~21.00~~
~~71030-26~~	~~professional component only~~			~~27.38~~
71030-00	Radiological examination, chest, complete, minimum of four views (MD/DO)			45.00
71034-00	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy			56.00
71035-00	Radiologic examination, chest, special views, e.g., lateral decubitus, Bucky studies			23.50
71100-2600	Radiologic examination, ribs, unilateral; two views; ~~professional component only~~ (MD/DO)	~~19.50~~		53.00
~~71100-TC~~	~~technical component only~~			~~40.00~~
71101-00	Radiologic examination, ribs, unilateral; including postero-anterior chest, minimum of three views			60.00
71110-00	Radiologic examination, ribs, bilateral; three views (MD/DO)	~~60.00~~		62.00
~~71110-26~~	~~professional component only~~			~~28.13~~
71111-00	Radiologic examination, ribs, bilateral; including postero-anterior chest, minimum of four views			73.00
71120-00	Radiologic examination; sternum, minimum of two views (MD/DO)			38.00
~~71120-26~~	~~professional component only~~			~~17.70~~
71130-00	Radiologic examination; sternoclavicular joint or joints, minimum of three views			60.00
~~71250-26~~	~~Computerized axial tomography, thorax; without contrast material; professional component only~~			~~126.00~~
71260-2600	~~professional component only~~ with contrast material			~~105.50~~ 142.20
	Spine and Pelvis			
72010-2600	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral; ~~professional component only~~ (MD/DO)	~~$-42.25~~		$ 86.00
72020-2600	Radiologic examination, spine, single view, specify level; ~~professional component only~~ (MD/DO)	~~15.00~~		37.00
72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral (MD/DO)	~~47.00~~		50.50
~~72040-26~~	~~professional component only~~			~~20.00~~
72050-00	minimum of four views (MD/DO)	~~75.00~~		80.40
~~72050-26~~	~~professional component only~~			~~27.00~~

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72050-TC	technical component only			55.50
72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies			89.00
72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral (MD/DO)		53.00	57.50
72070-26	professional component only			22.00
72070-TC	technical component only			47.00
72072-2600	professional component only			22.10
	Thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction (MD/DO)			58.50
72074-00	Radiologic examination, spine; thoracic, complete, including obliques, minimum of four views			65.00
72080-00	thoracolumbar, anteroposterior and lateral (MD/DO)		62.00	58.00
72090-00	scoliosis study, including supine and erect studies (MD/DO)		50.00	50.75
72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral (MD/DO)		57.95	62.00
72100-26	professional component only			24.50
72110	complete, with oblique views			80.00
72110-26	professional component only			30.00
72110-TC	technical component only			62.00
72114-00	complete, including bending views (MD/DO)			95.00
72120-00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views			61.20
72125-26	Computerized axial tomography, cervical spine, without contrast material, professional component only			114.00
72126-2600	professional component only			135.00
	Computerized axial tomography, cervical spine; with contrast material (MD/DO)			174.40
72128-26	Computerized axial tomography, thoracic spine, without contrast material, professional component only			111.75
72129	Computerized axial tomography, thoracic spine, with contrast material			120.00
72131	Computerized axial tomography, lumbar spine, without contrast material			465.00
72131-26	professional component only			100.00
72132-26	professional component only			104.00
72132-00	with contrast material (MD/DO)			163.00
72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents			790.00
72170-2600	Radiologic examination, pelvis anteroposterior only, professional component only (MD/DO)		16.00	41.00
72180-00	stereo (MD/DO)			42.00
72180-26	professional component only			22.25
72190-00	complete, minimum of three views (MD/DO)		61.00	65.00
72190-26	professional component only			21.50
72192-2600	Computerized axial tomography, pelvis; without contrast material, professional component only (MD/DO)		114.00	212.50
72193-2600	with contrast material(s), professional component only (MD/DO)		97.00	106.00
72200-00	Radiologic examination, sacroiliac joints; less than three views (MD/DO)		45.00	52.40
72202-00	three or more views (MD/DO)		49.00	58.75
72202-26	professional component only			19.90
72220-00	Radiologic examination, sacrum and coccyx, minimum of two views (MD/DO)		48.00	50.00
72220-26	professional component only			17.70
72240-00	Myelography, cervical; supervision and interpretation only			213.90
72241-2600	Myelography, cervical, complete procedure, professional component only (MD/DO)			

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			~~245.00~~	590.00
	~~72265-26~~	~~Myelography, lumbosacral, supervision and interpretation only, professional component only~~		~~67.00~~
	72266-~~26~~00	complete procedure, ~~professional component only~~ (MD/DO)	~~198.69~~	216.00
	72270-00	Myelography, entire spinal canal; supervision and interpretation only (MD/DO)	~~194.40~~	205.44
	72271-00	complete procedure (MD/DO)	~~305.00~~	340.30
	~~72271-26~~	~~professional component only~~		~~303.50~~
		Upper Extremities		
	73000-00	Radiologic examination; clavicle, complete (MD/DO)	$ ~~33.00~~	37.50
	~~73000-26~~	~~professional component only~~		~~12.75~~
	~~73000-TC~~	~~technical component only~~		~~42.00~~
	73010-00	scapula, complete (MD/DO)		42.75
	~~73010-26~~	~~professional component only~~		~~15.00~~
	73020-00	Radiologic examination, shoulder; one view (MD/DO)	~~35.00~~	37.00
	~~73020-26~~	~~professional component only~~		~~13.25~~
	73030-00	complete, minimum of two views (MD/DO)		48.00
	~~73030-26~~	~~professional component only~~		~~15.00~~
	~~73040-26~~	~~Radiologic examination, shoulder, arthrography, supervision and interpretation only, professional component only~~		~~14.00~~
	73041-~~26~~00	complete procedure, ~~professional component only~~ (MD/DO)	~~167.00~~	154.00
	73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (MD/DO)	~~48.50~~	54.00
	~~73050-26~~	~~professional component only~~		~~15.88~~
	73060-00	humerus, minimum of two views (MD/DO)	~~39.00~~	42.75
	~~73060-26~~	~~professional component only~~		~~14.00~~
	73070-00	Radiologic examination, elbow; anteroposterior and lateral views (MD/DO)	~~38.00~~	41.00
	~~73070-26~~	~~professional component only~~		~~13.50~~
	~~73070-TC~~	~~technical component only~~		~~34.00~~
	73080-00	complete, minimum of three views (MD/DO)	~~39.00~~	44.00
	~~73080-26~~	~~professional component only~~		~~15.75~~
	~~73080-TC~~	~~technical component only~~		~~36.00~~
	73090-00	Radiologic examination; forearm, anteroposterior and lateral views (MD/DO)	~~37.00~~	41.00
	~~73090-26~~	~~professional component only~~		~~14.00~~
	~~73090-TC~~	~~technical component only~~		~~34.00~~
	73100-00	Radiologic examination, wrist; anteroposterior and lateral views (MD/DO)	~~37.00~~	40.00
	~~73100-26~~	~~professional component only~~		~~13.50~~
	~~73100-TC~~	~~technical component only~~		~~34.00~~
	73110-00	complete, minimum of three views (MD/DO)	~~41.00~~	44.00
	~~73110-26~~	~~professional component only~~		~~15.75~~
	~~73110-TC~~	~~technical component only~~		~~42.50~~
	73115-00	Radiologic examination, wrist, arthography; supervision and interpretation only		49.00
	73120-00	Radiologic examination, hand; two views (MD/DO)	~~36.50~~	40.00
	~~73120-26~~	~~professional component only~~		~~13.25~~
	~~73120-TC~~	~~technical component only~~		~~23.75~~
	73130-00	minimum of three views (MD/DO)	~~40.50~~	44.24
	~~73130-26~~	~~professional component only~~		~~14.00~~
	~~73130-TC~~	~~technical component only~~		~~41.50~~
	73140-00	Radiologic examination, finger or fingers, minimum of two views (MD/DO)	~~32.00~~	35.00
	~~73140-26~~	~~professional component only~~		~~12.00~~
	~~73140-TC~~	~~technical component only~~		~~30.00~~

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73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity			700.00
	Lower Extremities			
73500-00	Radiologic examination, hip; unilateral, one view (MD/DO)	$	36.56	34.00
~~73500-26~~	~~professional component only~~			~~14.10~~
73510-00	complete, minimum of two views (MD/DO)		48.00	51.00
~~73510-26~~	~~professional component only~~			~~20.00~~
~~73510-TC~~	~~technical component only~~			~~41.00~~
73520-00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis (MD/DO)		56.00	50.00
~~73520-26~~	~~professional component only~~			~~24.21~~
73530-2600	Radiologic examination, hip, during operative procedure, ~~professional component only~~ (MD/DO)		28.50	26.30
~~73540~~	~~Radiologic examination, pelvis and hips, infant or child, minimum of two views~~			~~48.00~~
~~73550~~	~~Radiologic examination, femur, anteroposterior, and lateral views~~			~~42.00~~
~~73550-26~~	~~professional component only~~			~~14.50~~
73560-00	Radiologic examination, knee; anteroposterior and lateral views (MD/DO)		40.00	42.00
~~73560-26~~	~~professional component only~~			~~14.00~~
~~73560-TC~~	~~technical component only~~			~~33.00~~
73562-00	anteroposterior and lateral, with oblique, minimum of three views (MD/DO)		50.00	54.00
~~73562-26~~	~~professional component only~~			~~14.50~~
~~73562-TC~~	~~technical component only~~			~~39.00~~
~~73564~~	~~complete, including oblique, or tunnel, or patellar, or standing views~~			~~55.75~~
~~73564-26~~	~~professional component only~~			~~18.00~~
~~73564-TC~~	~~technical component only~~			~~65.00~~
73580-00	Radiologic examination, knee, arthography; supervision and interpretation only (MD/DO)		120.00	130.00
73581-2600	~~Radiologic examination, knee, arthography,~~ complete procedure, ~~professional component only~~ (MD/DO)		144.50	154.00
73590-00	Radiologic examination, tibia and fibula, anteroposterior and lateral views (MD/DO)		40.00	43.70
~~73590-26~~	~~professional component only~~			~~14.00~~
~~73590-TC~~	~~technical component only~~			~~36.50~~
73600-00	Radiologic examination, ankle; anteroposterior and lateral views (MD/DO)		35.20	38.00
~~73600-26~~	~~professional component only~~			~~13.50~~
~~73600-TC~~	~~technical component only~~			~~30.10~~
73610-00	complete, minimum of three views (MD/DO)		41.00	45.60
~~73610-26~~	~~professional component only~~			~~15.00~~
~~73610-TC~~	~~technical component only~~			~~40.00~~
73620-00	Radiologic examination, foot; anteroposterior and lateral views (MD/DO)		35.00	39.00
~~73620-26~~	~~professional component only~~			~~14.00~~
~~73620-TC~~	~~technical component only~~			~~28.70~~
73630-00	complete, minimum of three views (MD/DO)		43.00	45.00
~~73630-26~~	~~professional component only~~			~~14.25~~
~~73630-TC~~	~~technical component only~~			~~41.00~~
73650-00	Radiologic examination; calcaneus, minimum of two views (MD/DO)		36.00	38.00
~~73650-26~~	~~professional component only~~			~~13.00~~
73660-00	toe or toes, minimum of two views (MD/DO)		32.00	35.00
~~73660-26~~	~~professional component only~~			~~11.70~~
~~73660-TC~~	~~technical component only~~			~~30.00~~
73700-00	Computerized axial tomography, lower			

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		extremity; without contrast material		130.00
	73720-00	Magnetic resonance (e.g., proton) imaging, lower extremity		665.00
		Abdomen		
	74000-2600	Radiologic examination, abdomen, single anteroposterior view; professional component only (MD/DO)	$ 16.00	37.00
	74000-TC	technical component only		32.00
	74010-2600	anteroposterior and additional oblique and cone views; professional component only (MD/DO)	20.25	40.00
	74020-2600	complete, including decubitus or erect views; professional component only (MD/DO)	22.50	41.00
	74022-00	Complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest (MD/DO)	32.00	34.00
	74022-26	professional component only		32.00
	74150-2600	Computerized axial tomography, abdomen; without contrast material; professional component only (MD/DO)	100.50	212.50
	74160-2600	with contrast materials; professional component only (MD/DO)	114.00	129.50
	74170-26	without contrast material followed by contrast material and further sections; professional component only		136.00
		Gastrointestinal Tract		
	74220-2600	Radiologic examination; esophagus; professional component only (MD/DO)	$ 49.50	78.00
	74230-00	Swallowing function, paraynx and/or esophagus, with cineradiography and/or video		56.00
	74240-00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB (MD/DO)	90.00	103.00
	74240-26	professional component only		52.00
	74241-00	with or without delayed films, with KUB (MD/DO)	58.00	68.40
	74241-26	professional component only		46.50
	74241-TC	technical component only		58.00
	74245-2600	with small bowel, includes multiple serial films; professional component only (MD/DO)	73.75	142.50
	74246-00	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without delayed films; without KUB		103.00
	74247-00	with or without delayed films, with KUB (MD/DO)	57.00	125.00
	74250-2600	Radiologic examination, small bowel, includes multiple serial films; professional component only (MD/DO)	48.00	97.50
	74270-00	Radiologic examination, colon; barium enema (MD/DO)	90.00	101.00
	74270-26	professional component only		52.00
	74270-TC	technical component only		72.00
	74280-2600	air contrast with specific high density barium, with or without glucagon; professional component only (MD/DO)	69.00	152.00
	74290-00	Cholecystography, oral contrast (MD/DO)	64.90	73.00
	74290-26	professional component only		24.75
	74290-TC	technical component only		57.00
	74300-2600	Cholangiography and/or pancreatography; during surgery; professional component only (MD/DO)	39.00	41.50
	74305-00	Cholangiography and/or pancreatography; postoperative		59.50

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74328-00	Endoscopic catheterization of the biliary ductal system, fluoroscopic monitoring and radiography		43.75
74329-00	Endoscopic catheterization of the pancreatic ductal system, fluoroscopic monitoring and radiography		53.00
74330-00	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography (MD/DO)	~~59.00~~	62.00
~~74330-26~~	~~professional component only~~		~~53.00~~
74340-00	Introduction of long gastrointestinal tube (e.g., Miller-Abbott) with multiple fluoroscopies and films		49.25

Urinary Tract

74400-2600	Urography, (pyelography) intravenous, with or without KUB (MD/DO) ~~including kidneys, ureters, and bladder; professional component only~~	$ ~~52.50~~	112.00
74405-2600	~~Urography (pyelography), intravenous, including kidneys, ureters, and bladder~~ with special hypertensive contrast concentration and/or or clearance studies; ~~professional component only~~ (MD/DO)	~~48.00~~	161.70
74410-2600	Urography, infusion, drip technique; ~~professional component only~~ (MD/DO)	~~39.13~~	90.00
74415-00	Urography, infusion, drip technique and/or bolus technique; with nephrotomography		161.70
74420-2600	Urography, retrograde, with or without kidneys, ureters, and bladder; ~~professional component only~~ (MD/DO)	~~23.63~~	55.00
74425-2600	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); supervision and interpretation only (MD/DO) ~~professional component only~~	~~43.00~~	43.75
74426-00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); complete procedure		145.60
74430-2600	Cystography, minimum of three views; supervision and interpretation only; ~~professional component only~~ (MD/DO)	~~27.00~~	46.00
74431-00	Cystography, minimum of three views; complete procedure		91.00
74451-00	Urethrocystography, retrograde; complete procedure		97.40
74455-2600	Urethrocystography, voiding; supervision and interpretation only (MD/DO) ~~professional component only~~	~~37.50~~	69.50
74456-2600	complete procedure (MD/DO) ~~professional component only~~	~~56.25~~	87.50
74475-00	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, with fluoroscopic monitoring and radiography; supervision and interpretation only		155.00

Gynecological and Obstetrical

74710-00	Pelvimetry, with or without placental localization		$ 83.10
74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view		42.00
74740-00	Hysterosalpingography; supervision and interpretation only		101.00
74741-00	complete procedure		137.20

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		Vascular System		
75550-00		Angiocardiography by cineradiography; supervision and interpretation only		$144.50
75605-00		Aortography, thoracic, by serialography; supervision and interpretation only		106.00
75627-00		Aortography, abdominal catheter, by serialography; supervision and interpretation only		84.50
75628-2600		Aortography, abdominal, catheter by serialography;-professional component-only (MD/DO)	361.31	288.00
75630-00		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; supervision and interpretation only		168.00
75631-2600		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; professional-component-only (MD/DO)	416.00	436.25
75650-00		Angiography, cervicocerebral, catheter, including vessel origin; supervision and interpretation only		284.50
75655-2600		Angiography, cerviocerebral, selective catheter, including vessel origin; two vessels, complete procedure; professional-component-only (MD/DO)	474.50	503.00
75656-00		Angiography, cervicocerebral, selective catheter, including vessel origin, three or four vessels, supervision and interpretation only		250.00
75657-2600		three or four vessels, complete procedure;-professional-component only (MD/DO)	551.25	603.80
75671-00		Angiography, carotid, cerebral, bilateral; supervision and interpretation only		238.00
75673-00		Angiography, carotid cerebral, bilateral; catheter, complete procedure (MD/DO)		498.00
75710-00		Angiography, extremity, unilateral, supervision and interpretation only		77.50
75712-2600		Angiography, extremity, unilateral; by serialography, complete procedure; professional-component-only (MD/DO)	229.00	334.80
75716-00		Angiography, extremity, bilateral; supervision and intrepretation only		95.50
75718-00		by serialography, complete procedure		267.00
75750-2600		Angiography, coronary, root injection;-professional-component only (MD/DO)	76.50	83.80
75752-00		Angiography, coronary, unilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only		50.00
75754-2600		Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording;-professional component-only (MD/DO)	131.25	171.00
75762-00		Angiography, coronary bypass, unilateral selective injection; supervision and interpretation only		50.50
75766-00		Angiography, coronary bypass, multiple selective injection; supervision and interpretation only		74.00
		Veins and Lymphatics		
75820-00		Venography, extremity, unilateral;		

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		supervision and interpretation only	$ 98.50
75821-~~26~~00		Venography, extremity, unilateral; complete procedure~~, professional component only~~ (MD/DO)	~~$ 120.50~~ 130.15
75897-00		Transcatheter therapy, infusion (e.g., thrombolysis other than coronary), including angiography; complete procedure	375.00
75962-00		Percutaneous transluminal angioplasty, peripheral artery; supervision and interpretation only	68.00
75985-00		Change of percutaneous drainage catheter with contrast monitoring (i.e., biliary tract, urinary tract); complete procedure	199.00
		Miscellaneous	
76000-00		Fluoroscopy (separate procedure), up to one hour physician time	$ 40.00
76020-00		Bone age studies	36.00
76040-00		Bone length studies (orthoroentgenogram, scanogram)	69.00
76061-00		Radiologic examination, osseous survey: limited (e.g., for metastases)	139.00
76062-00		Radiologic examination, osseous survey; complete (MD/DO)	~~$ 160.00~~ 195.50
76066-00		Joint survey, single view, one or more joints (specify)	23.00
76080-00		Radiologic examination, fistula or sinus tract study; supervision and interpretation only	61.00
76081-~~26~~00		Radiologic examination, fistula or sinus tract study; complete procedure~~, professional component only~~ (MD/DO)	~~63.00~~ 76.70
76100-00		Radiologic examination, single plane body section (MD/DO)	~~96.50~~ 101.30
76101-00		Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	93.60
76102-00		bilateral	100.00
76150-00		Xeroradiography	50.00
76361-00		Computerized tomography guidance for needle biopsy; complete procedure	436.00
76370-00		Computerized tomography guidance for placement of radiation therapy fields	74.25
76375-00		Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction	45.00

Subp. 3. **Diagnostic ultrasound.** The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

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Head and Neck

Code	Service	Maximum Fee
76506-00	Echoencephalography, B-scan and/or real-time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	$ 140.00
76511-00	Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification (MD/DO)	$ 150.00
76516-00	~~Echography, ultrasonic biometry~~ Ophthalmic, biometry; by ultrasound echography, A-mode (MD/DO)	~~150.00~~ 153.90
76519-00	~~Ophthalmic biometry by ultra-sound echography, A-mode~~ intraocular lens power calculation (MD/DO)	~~168.00~~ 175.00
76536-00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B-scan and/or real-time with image documentation	118.00

Chest

76604-00	Echography, chest B-scan (includes Mediastinum) and/or real time with image documentation (MD/DO)	$ ~~63.75~~ 68.00
76620-~~26~~00	Echocardiography, M-mode; ~~professional component only~~ (MD/DO)	~~96.65~~ 120.00
76627-00	Echocardiography, real-time with image documentation (2D); complete	163.00
76629-00	Echocardiography, M-mode and real time with image documentation (MD/DO)	~~186.00~~ 225.00
76632-00	Doppler echocardiography	70.50
76700-~~26~~00	Echography, abdominal, B-scan; and/or real-time with image documentation (MD/DO) ~~professional component only~~	~~67.50~~ 110.00
76705-~~26~~00	limited, ~~professional component only~~ (MD/DO)	~~46.25~~ 98.00
76770-~~26~~00	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan, ~~professional component only~~ (MD/DO)	~~63.75~~ 123.50
76775-~~26~~00	~~Echography, retroperitoneal, B-scan and/or real time with image documentation, complete, professional component only~~ limited (MD/DO)	~~68.25~~ 67.50

Pelvis

76805-~~26~~00	Echography, ~~pelvic~~ pregnant uterus, B-scan ~~(for example,~~ and/or real time~~)~~, ~~in obstetrics, gynecology, or transplants,~~ with image documentation; complete, ~~professional component only~~ (MD/DO)	$ ~~61.50~~ 98.80
76815-00	Echography, pregnant uterus, B-scan and/or real-time with image documentation; limited (fetal growth rate, heart beat, anomalies, placental location)	73.00
76816-00	follow-up or repeat	65.00
76818-00	Fetal biophysical profile	106.00
76855-00	Echography, pelvic area (Doppler)	90.00
76856-00	Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; complete	90.00
76857-00	limited or follow-up (e.g., for follicles)	65.00
76870-00	Echography, scrotum and contents	137.40
76880-00	Echography, extremity, B-scan and/or	

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	real-time with image documentation	88.00
76925-00	Imaging, peripheral (e.g., B-scan, Doppler or real-time scan	110.00
76943-00	Ultrasonic guidance for needle biopsy; complete procedure	249.25
76970-00	Ultrasound study follow-up (specify)	50.00
76986-00	Echography, intraoperative	62.00
76991-00	Intraluminal ultrasound study (e.g., transrectal, transvaginal)	200.00

Subp. 4. **Therapeutic radiology.** The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

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

Code	Service	Maximum Fee
77262-00	Therapeutic radiology treatment planning; intermediate	$ 295.00
77263-00	complex	345.00
77280-00	Therapeutic radiology simulation-aided field setting; simple (MD/DO)	100.04
77285-00	intermediate	125.00
77290-00	complex	175.00
77300-~~2~~600	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment; ~~professional component only~~ (MD/DO)	~~$ 50.00~~ 60.00
77305-00	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	125.00
77310-00	intermediate (three or more	

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		treatment ports directed to a single area of interest)		150.00
77315-00		complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)		280.00
77334-00		Treatment devices, design and construction; complex (MD/DO)	92.00	150.00
77336-00		Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance (MD/DO)	90.00	61.50
77400-26		professional component only Daily megavoltage treatment management; simple (MD/DO)	34.75	42.40
77405-00		intermediate		50.00
77410-2600		professional component only complex (MD/DO)	48.00	70.00
77420-2600		Weekly megavoltage treatment management; simple, professional component only (MD/DO)	48.00	25.00
77425-00		intermediate		95.83
77465-2600		Daily kilovoltage treatment management, professional component only (MD/DO)	40.00	31.50
77465-TC		technical component only		33.75

Subp. 5. **Nuclear medicine.** The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

Code	Service	Maximum Fee	
78000-2600	Thyroid uptake; single determination, professional component only (MD/DO)	$ 19.75	21.00
78001-00	Thyroid uptake; multiple determinations		113.90
78003-00	stimulation, suppression or discharge (not including initial uptake studies)		65.25
78006-2600	Thyroid imaging, with uptake; single determination, professional component only (MD/DO)	59.00	63.00
78007-00	Thyroid imaging, with uptake; multiple determinations		88.00
78010-2600	Thyroid imaging; only, professional component only (MD/DO)	49.60	81.40
	Diagnostic - Gastrointestinal System		
78201-00	Liver imaging; static only (MD/DO)	$ 69.00	69.75
78215-2600	Liver and spleen imaging, professional component only (MD/DO)	72.50	207.40
78216-00	with vascular flow (MD/DO)	86.00	90.00
78220-26	professional component only		63.00
78220-00	Liver function study with hepatobiliary agents, with serial images (MD/DO)		86.50
78223-2600	Hepatobiliary ductal system imaging, including gallbladder (MD/DO) professional component only	85.00	90.00
78264-00	Gastric emptying study		65.25
78278-00	Acute gastrointestinal blood loss imaging		118.50
78280	Gastrointestinal blood loss study		74.90
78290-00	Bowel imaging (for example, ectopic gastric mucosa, Meckel's localization, volvulus (MD/DO)	72.50	78.00

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		Diagnostic - Musculoskeletal System	
78300-2600		Bone imaging; limited area (for, example, skull, pelvis), professional component only (MD/DO)	52.00 $ 80.00
		Diagnostic - Musculoskeletal System	
78305-2600		professional component only multiple areas	$ 82.00 87.50
78306-26		whole body, professional component only	79.30
78310		Bone imaging, vascular flow only	70.00
78350-00		Bone density (bone mineral content) study; single photon absorptiometry	78.00
		Diagnostic - Cardiovascular System	
78402		Cardiac blood pool imaging, with vascular flow assessment (sequential imaging with or without time activity curve evaluation)	$ 78.60
78403-26		Cardiac blood pool imaging, with determination of regional ventricular function including ejection fraction and wall motion, professional component only	87.00
78411		Cardiac blood pool imaging by first pass technique, with determination of global or regional ventricular function (specify right, left, or both) including but not necessarily limited to ejection fraction and wall motion, at rest	107.50
78422		Myocardium imaging, regional Myocardial perfusion at rest for evaluation of infarction (infarct avid imaging)	75.00
78424		Myocardium imaging, with quantitive evaluation (for example, pharmacokinetic temporal assessment) regional myocardial perfusion (redistribution resting or postexercise study)	76.00
		Respiratory System	
78580-2600		Pulmonary perfusion imaging; particulate professional component only (MD/DO)	76.00 $ 81.50
		Diagnostic - Respiratory System	
78581-00		Pulmonary perfusion imaging, gaseous (MD/DO)	$ 76.00 80.00
78582-00		gaseous, with ventilation, rebreathing and washout (MD/DO)	70.10 68.50
78585-00		rebreathing and washout, with or without single breath	114.75
78587-00		Pulmonary ventilation imaging; multiple projections (MD/DO)	73.50 100.00
78587-26		professional component only	58.75
78591-26		Pulmonary ventilation imaging, gaseous single breath, single projection; professional component only	62.00
78593-00		Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection (MD/DO)	65.00 98.00
78594-00		Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views)	81.50
		Nervous System	

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~~78605~~	~~Brain imaging, complete study; static~~		~~$ 77.00~~
78660-00	Dacryocystography (lacrimal flow study		$ 15.00
	Genitourinary System		
78700-00	Kidney imaging; static only		$ 68.00
78704-00	Kidney imaging; with function study (e.g., imaging renogram) (MD/DO)	~~$ 76.00~~	81.00
78715-00	Kidney vascular flow only	~~51.00~~	54.60
~~78715-26~~	~~professional component only~~		~~45.00~~
~~78720-26~~	~~professional component only~~		~~69.00~~
78725-00	Kidney function study only		152.00
78727-00	Kidney transplant evaluation		95.00
78740-00	Ureteral reflux study (radionuclide voiding cystogram)		80.00
78805-00	Radionuclide localization of abscess; limited area		483.80
78890-00	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes		121.50

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

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

Subp. 2. **Automated, multichannel tests.** The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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

Automated Multichannel Tests

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Code	Service	Maximum Fee
80002-00	Automated multichannel tests; 1 or 2 clinical chemistry tests (MD/DO)	~~$ 14.75~~ 15.50
80003-00	~~Automated multichannel tests;~~ 3 clinical chemistry tests (MD/DO)	30.00
80004-00	4 clinical chemistry tests (MD/DO)	~~24.00~~ 25.70
80005-00	5 clinical chemistry tests (MD/DO)	~~31.50~~ 45.00
80006-00	6 clinical chemistry tests (MD/DO)	26.50
80007-00	7 clinical chemistry tests (MD/DO)	~~27.50~~ 29.25
80008-00	8 clinical chemistry tests (MD/DO)	30.00
80009-00	9 clinical chemistry tests (MD/DO)	33.50
80010-00	10 clinical chemistry tests (MD/DO)	~~32.00~~ 33.50
80011-00	11 clinical chemistry tests (MD/DO)	~~38.90~~ 35.50
80012-00	12 clinical chemistry tests (MD/DO)	~~35.00~~ 36.80
80016-00	13-16 clinical chemistry tests (MD/DO)	~~38.00~~ 40.00
80018-00	17-18 clinical chemistry tests (MD/DO)	44.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed) (MD/DO)	~~35.00~~ 32.00
	Therapeutic Drug Monitoring	
80031-00	Therapeutic quantitative drug monitoring in ~~blood and/or urine;~~ body fluids and or excreta; measurement one drug (MD/DO)	~~37.00~~ $ 33.00
80032-00	two drugs measured	39.00
	Organ or Disease Oriented Panels	
80050-00	General health screen panel	$ 42.75
80053-00	Executive profile (MD/DO)	60.00
80055-00	Obstetric profile (MD/DO)	~~32.00~~ 35.00
~~80056~~	~~Amenorrhea profile~~	~~130.00~~
80058-00	Hepatic function panel (MD/DO)	~~28.00~~ 29.50
80059-00	Hepatitis panel (MD/DO)	~~57.25~~ 76.00
80060-00	Hypertension panel (MD/DO)	30.00
80061-00	Lipid profile (MD/DO)	30.00
80062-00	Cardiac evaluation (including coronary risk) panel (MD/DO)	~~32.00~~ 30.00
80063-00	Cardiac injury panel	51.00
80064-00	Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination (MD/DO)	25.00
80065-00	Metabolic panel (MD/DO)	~~48.75~~ 50.25
80070-00	Thyroid panel (MD/DO)	~~29.50~~ 30.50
80071-00	with thyrotropin releasing hormone (TRH) (MD/DO)	49.50
80072-00	Arthritis panel (MD/DO)	~~41.00~~ 43.00
80073-00	Renal panel	28.00
80085-00	Microcytic anemia panel	62.00
80086-00	Macrocytic anemia panel (MD/DO)	~~42.00~~ 37.60
80090-00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	74.00
	Consultations (Clinical Pathology)	
80500-00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 18.00

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

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing	

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	substances as glucose), with microscopy (MD/DO)	~~$ 11.00~~	12.00
81002-00	routine, without microscopy (MD/DO)		7.00
81004-00	components, single, not otherwise listed, specify (MD/DO)	~~6.50~~	6.00
81005-00	chemical, qualitative, any number of constituents (MD/DO)	~~5.50~~	6.50
81010-00	concentration and dilution test (MD/DO)		5.00
81015-00	microscopic only (MD/DO)		8.00
81020-00	two or three glass test		10.00

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

Code	Service		Maximum Fee
82009-00	Acetone, qualitative		7.25
82010-00	quantitative		6.00
82011-00	Acetylsalicylic acid; quantitative (MD/DO)	~~$ 19.00~~	20.50
82024-00	Adrenocorticotropic hormone (ACTH), RIA		101.20
82042-00	Albumin; urine, quantitative (specify method, e.g., Esbach)		2.90
~~82060~~	~~Alcohol, blood; by gas-liquid chromatography~~		~~36.10~~
82070-00	Alcohol (ethanol), urine; by gas-liquid chromatography		46.50
82085-00	Aldolase, blood; kinetic ultraviolet method		27.00
82088-00	Aldosterone; RIA, blood		132.30
82130-00	Amino acids, urine or plasma, chromatographic fractionation and quantitation; one or more		176.90
82137-00	Aminophylline (MD/DO)	~~32.50~~	35.00
82138-00	Amitriptyline		51.40
82140-00	Ammonia; blood		31.50
82143-00	Amniotic fluic scan (spectrophotometric)		58.00
82150-00	Amylase, serum (MD/DO)	~~19.00~~	20.30
82156-00	Amylase, urine (MD/DO)	~~20.30~~	21.30
82157-00	Androstenedione, RIA		90.00
82164-00	Angiotensin-converting enzyme		35.50
82172-00	Apolipoprotein, immunoassay		25.00
82205-00	Barbiturates; quantitative (MD/DO)	~~32.75~~	28.00
82210-00	quantitative and identification (MD/DO)		31.00
~~82245~~	~~Bile pigments, urine~~		~~6.00~~
82250-00	Bilirubin; blood, total OR direct (MD/DO)		15.00
82251-00	blood, total AND direct		22.00
82270-00	Blood; occult, feces, screening		8.00
82273-00	duodenal, gastric contents, qualitative		6.00
82306-00	Calcifediol (25-OH Vitamin D-3), chromatographic technique		133.50
82310-00	Calcium, blood; chemical (MD/DO)	~~13.75~~	14.95
82330-00	fractionated diffusible		24.00
82340-00	Calcium, urine; quantitative, timed specimen (MD/DO)	~~17.10~~	17.50
82355-00	Calculus (stone), qualitative, chemical		30.50
82360-00	Calculus (stone, quantitative; chemical		31.50
82372-00	Carbamazepine, serum (MD/DO)	~~30.00~~	32.00
82374-00	Carbon dioxide, combining power or content		19.15
82375-00	Carbon monoxide, (carboxyhemoglobin); quantitative		42.10
82376-00	qualitative		10.00

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82380-00	Carotene, blood			28.00
82382-00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine			66.00
82384-00	fractionated			77.00
82390-00	Ceruloplasmin, chemical (copper oxidase), blood			29.00
82435-00	Chlorides; blood (specify chemical or electrometric) (MD/DO)		~~17.00~~	18.00
82465-00	Cholesterol, serum; total (MD/DO)		~~14.40~~	15.00
82470-00	total and esters			15.35
82480-00	Cholinesterase; serum (MD/DO)		~~35.00~~	39.00
82486-00	Chromatography; gas-liquid, compound and method not elsewhere specified			61.50
82507-00	Citrate			69.20
82512-00	Clonazepam (MD/DO)		~~39.40~~	49.00
82525-00	Copper; blood			33.00
82529-00	Cortisol; fluorometric, plasma			39.85
82533-00	Cortisol; RIA, plasma (MD/DO)		~~41.00~~	40.00
82534-00	RIA, urine			47.00
82540-00	Creatine; blood (MD/DO)		~~12.00~~	15.00
82546-00	Creatine and creatinine			12.00
82550-00	Creatine phosphokinase (CPK), blood; timed kinet ultraviolet method			20.90
82552-00	isoenzymes			34.00
82555-00	Colorimetric (MD/DO)		~~18.00~~	16.00
82565-00	Creatinine; blood (MD/DO)		~~13.75~~	14.00
82570-00	urine			15.00
82575-00	clearance (MD/DO)		~~29.00~~	30.50
82595-00	Cryoglobulin, blood			25.70
82607-00	~~Cyanocobalamin (Vitamin B-12);~~ RIA (MD/DO)		~~33.00~~	34.50
82615-00	Cystine and homocystine, urine; qualitative			51.00
82626-00	Dehydroepiandrosterone (DHEA), RIA			75.00
82628-00	Desipramine			50.00
82640-00	Digitoxin (digitalis); blood, RIA			33.00
82643-00	Digoxin, RIA			37.10
82660-00	Drug screen (amphetamines, barbiturates, alkaloids) (MD/DO)			40.00
82662-00	Immunoassay technique for drugs			31.50
82664-00	Electrophoretic technique, not elsewhere specified			110.00
82670-00	Estradiol, RIA (placental)			62.00
82671-00	Estrogens; fractionated			15.00
82672-00	total			70.50
82677-00	Estriol; RIA			49.00
82692-00	Ethosuximide			37.75
82705-00	Fat orllipids, feces; screening			19.50
82728-00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)			37.25
82730-00	Fibrinogen, quantitative			28.50
82745-00	Folic acid (folate), blood; bioassay			44.50
82746-00	RIA			40.00
82756-00	Free thyroxine index (T-7) (MD/DO)		~~25.00~~	28.50
82784-00	Gammaglobulin, E (e.g., RIA, EIA)			44.00
82785-00	Gammaglobulin, E (MD/DO)		~~28.50~~	32.50
82792-00	Gases, blood, oxygen saturation; by ~~oximetry~~ calculation from pO2 (MD/DO)		~~35.00~~	35.90
82801-00	Gasses, blood; pCO2			10.50
82941-00	Gastrin, RIA			35.00
82946-00	Glucagon tolerance test			20.00
82947-00	Glucose; except urine (for example, blood, spinal fluid, joint fluid) (MD/DO)			14.00
82948-00	blood, stick test			10.50
82949-00	~~Glucose;~~ fermentation (MD/DO)		~~9.00~~	10.25
82950-00	post glucose dose (includes glucose)		~~15.00~~	16.00
82951-00	tolerance test (GTT), three specimens (includes glucose) (MD/DO)		~~42.00~~	40.50

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82952-00	tolerance test, each additional beyond three specimens			23.25
82954-00	Glucose, urine			7.00
82977-00	Glutamyl transpeptidase, gamma (GGT)			16.30
~~82996~~	~~Gonadotropin, chorionic, bioassay; qualitative~~			~~17.00~~
~~82997~~	~~quantitative~~			~~22.00~~
~~82998~~	~~Gonadotropin, chorionic, RIA~~			~~28.50~~
83000-00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay			45.00
83001-00	RIA (MD/DO)		~~44.00~~	45.90
83002-00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA			50.00
83003-00	Growth hormone, human (HGH) (somatotropin); RIA			48.00
83010-00	Haptoglobin; chemical			37.00
83015-00	Heavy metal screen (arsenic, bismurth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)			90.00
83020-00	Hemoglobin; electrophoresis (includes A2, S, C, etc.)			10.00
83036-00	Hemoglobin; glycosylated		~~19.00~~	22.50
83050-00	Methemoglobin, quantitative		~~8.00~~	12.50
83051-00	plasma			14.55
83150-00	Homovanillic acid (HVA), urine			16.00
83497-00	Hydroxyindolacetic acid, 5-(HIAA), urine			44.80
83498-00	Hydroxyprogesterone, 17-d, RIA			68.95
83523-00	Imipramine (MD/DO)		~~52.40~~	50.00
83540-00	Iron, serum; chemical (MD/DO)		~~15.00~~	16.40
~~83545~~	~~automated~~			~~13.00~~
83550-00	Iron binding capacity, serum; chemical			21.25
83555-00	automated		~~26.30~~	27.60
83565-00	~~Iron-binding-capacity, serum;~~ radioactive uptake method		~~26.50~~	27.50
83582-00	Ketogenic steroids, urine; 17-(17-KGS)			43.90
83589-00	Ketosteroids, 17-(17-KS), urine; total			42.00
83615-00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method			20.50
83620-00	Lactic dehydrogenase (LDH), blood colorimetric or fluorometric (MD/DO)		~~14.55~~	16.50
83625-00	isoenzymes, electrophoretic separation and quantitation			28.00
83631-00	Lactic dehydrogenase (LDH), CSF			11.00
83645-00	Lead, screening; blood			11.00
83655-00	Lead, quantitative; blood			35.00
83690-00	Lipase, blood (MD/DO)		~~19.90~~	22.00
83700-00	total			20.00
83705-00	~~lipids, blood;~~ fractionated		~~19.20~~	23.00
83715-00	Lipoprotein, blood; electrophoretic separation and quantitation (phenotyping)			30.00
83718-00	Lipoprotein high density cholesterol by precipitation method		~~17.90~~	18.80
83719-00	Lipoprotein very low density cholesterol VLDL cholesterol) by ultracentrifugation			24.00
83720-00	Lipoprotein cholesterol fractionation calculation by formula			19.00
83725-00	Lithium, blood, quantitative (MD/DO)		~~18.75~~	20.85
83735-00	Magnesium, blood; chemical (MD/DO)		~~17.10~~	17.55
83750-00	atomic absorption			20.00
83835-00	Metanephrines, urine (MD/DO)		~~29.45~~	49.00
83916-00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis			61.75
83930-00	Osmolality; blood (MD/DO)		~~9.80~~	10.30
83945-00	Oxalate, urine			35.00
83947-00	Oxybutyric acid, beta			15.20
83970-00	Parathormone, RIA (MD/DO)		~~92.90~~	108.50
~~84030~~	~~Phenylalanine (PKU), blood, Guthrie~~			~~13.00~~
84035-00	Phenylketones; blood, qualitative			15.00
84045-00	Phenytoin (MD/DO)		~~29.50~~	31.00
84060-00	Phosphatase, acid; blood (MD/DO)		~~21.50~~	22.00
84065-00	prostatic fraction (MD/DO)		~~24.00~~	25.00

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84066-00	prostatic fraction, RIA			48.00
84075-00	Phosphatase, alkaline, blood (MD/DO)	~~15.00~~		15.80
84078-00	heat stable (total not included)			16.80
84080-00	isoenzymes, electrophoretic method (MD/DO)	~~39.00~~		41.00
84100-00	Phosphorus (phosphate); blood (MD/DO)	~~11.40~~		14.00
84105-00	urine (MD/DO)	~~14.50~~		15.50
84126-00	Porphyrins, feces, quantitative			33.50
84132-00	Potassium; blood (MD/DO)	~~15.00~~		14.25
84133-00	urine			11.00
84136-00	Pregnanediol; other method (specify)			15.00
84141-00	Primidone (MD/DO)	~~40.70~~		40.50
84142-00	Procainamide			43.00
84144-00	Progesterone, any method (MD/DO)	~~45.00~~		50.00
84146-00	Prolactin, RIA (MD/DO)	~~46.00~~		50.00
84155-00	Protein, total, serum; chemical			14.10
84165-00	Protein, total, serum; electrophoretic fractionation and quantitation (MD/DO)	~~25.70~~		27.00
84175-00	Protein, other sources, quantitative (MD/DO)	~~16.50~~		19.50
84180-00	Protein, urine; quantitative, 24-hour specimen (MD/DO)	~~16.70~~		18.00
84185-00	Bence-Jones			12.20
84190-00	electrophoretic fractionation and quantitation (MD/DO)	~~32.20~~		27.35
84195-00	Protein, spinal fluid; semi-quantitative (Pandy)			19.00
84202-00	Protoporphyrin, RBC; quantitative (MD/DO)			13.00
84203-00	screen (MD/DO)			9.00
84207-00	Pyridoxine (Vitamin B-6)			6.00
84208-00	Pyrophosphate vs urate, crystals (polarization)			15.50
84220-00	Pyruvic Kinase, RBC			41.90
84230-00	Quinidine, blood			31.00
84231-00	Radioimmunoassay (RIA) not elsewhere specified			52.00
84233-00	Receptor assay; estrogen (estradiol)			58.00
84238-00	non-endocrine (e.g., acetylcholine) (specify receptor)			103.10
84244-00	Renin (angiotensin I); (RIA)			65.70
84275-00	Sialic acid, blood			78.00
84295-00	Sodium; blood (MD/DO)	~~12.00~~		14.75
84300-00	urine			15.50
84403-00	Testosterone, blood, RIA (MD/DO)	~~84.00~~		79.30
84408-00	Tetrahydrocannabinol THC (marijuana)			30.00
84420-00	Theophylline, blood, or saliva (MD/DO)	~~30.00~~		32.00
84435-00	Thyroxine, CPB or resin uptake (MD/DO)	~~18.00~~		16.00
84436-00	Thyroxine, true, RIA (MD/DO)	~~18.50~~		19.25
84439-00	Thyroxine, free, RIA (MD/DO)	~~22.00~~		20.00
84442-00	Thyroxine binding globulin (TBG) (MD/DO)	~~33.50~~		35.20
84443-00	Thyroid stimulating hormone (TSH), RIA (MD/DO)	~~37.95~~		40.00
84447-00	Toxicology, screen; general (MD/DO)	~~87.00~~		68.30
84448-00	sedative (MD/DO)			40.00
84450-00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method (MD/DO)	~~15.00~~		16.00
84455-00	coloraimetric or fluorometric (MD/DO)			14.00
84460-00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method (MD/DO)	~~14.00~~		16.00
84465-00	colorimetric or fluorometric			15.50
84478-00	Triglycerides, blood (MD/DO)			15.00
84479-00	Triiodothyronine (t-3), resin uptake			19.80
84480-00	Triiodothyronine, true, RIA (MD/DO)			50.00
84520-00	Urea nitrogen, blood (BUN); quantitative (MD/DO)	~~14.00~~		14.50

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84550-00	Uric acid; blood, chemical (MD/DO)	~~14.00~~	15.00
84555-00	uricase, ultraviolet method (MD/DO)	~~13.20~~	17.40
84560-00	Uric acid, urine (MD/DO)	~~17.50~~	20.00
84580-00	Urobilinogen, urine; quantitative, timed specimen		12.00
84585-00	Vanillymandelic acid (VMA), urine		53.60
84630-00	Zinc, quantitative; blood		28.10
84702-00	Gonadotropin, chorionic; quantitative		28.30
84703-00	qualitative		20.00
84999-00	Unlisted chemistry or toxicology procedure		34.00

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

Code	Service	Maximum Fee	
85000-00	Bleeding time; Duke (MD/DO)		$ 8.00
85002-00	Ivy or template (MD/DO)	~~20.40~~	21.40
85007-00	Blood count; ~~basophil count,~~ manual differential WBC count (includes RBC morphology and platelet estimation) (MD/DO)	~~11.00~~	11.25
85009-00	differential WBC count, buffy coat		19.00
85012-00	eosinophil count, direct (MD/DO)		14.00
85014-00	hematocrit (MD/DO)	~~7.00~~	9.00
85018-00	hemoglobin, colorimetric (MD/DO)	~~9.00~~	9.50
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only) (MD/DO)		19.00
85022-00	hemogram, automated, ~~with platelet count~~ and manual differential WBC count (CBC) (MD/DO)	~~25.00~~	24.25
85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)		31.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)		23.00
85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)		27.20
85027-00	hemogram, and platelet count, automated, ~~and differential WBC count (CBC)~~ (MD/DO)	~~14.50~~	15.25
~~85028~~	~~Hemogram, automated, and differential WBC count (CBC) with platelet count~~		~~26.00~~
85029-00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram; 1-3 indices		10.50
85030-00	4 or more indices		15.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes) (MD/DO)	~~21.00~~	22.00
85041-00	red blood cell (RBC) only		8.00
85044-00	reticulocyte count (MD/DO)	~~13.25~~	13.50
85048-00	White blood cell (WBC) (MD/DO)	~~9.00~~	10.00
85060-00	Blood smear, peripheral, interpretation by physician with written report		50.50
85095-00	Bone marrow smear and/or cell block; aspiration only		87.00
85097-00	Bone marrow smear and/or cell block; smear interpretation only MD/DO)	~~80.00~~	75.00
~~85097-26~~	~~professional component only~~		~~70.00~~
85100-00	aspiration, staining, and interpretation (MD/DO)	~~105.00~~	114.00
85102-00	Bone marrow needle biopsy (MD/DO)	~~80.00~~	94.00
85103-~~26~~00	~~Bone marrow needle biopsy;~~ staining and interpretation, ~~professional component only~~ (MD/DO)	~~43.00~~	115.00
85105-~~26~~00	~~professional component only~~		

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		interpretation only (MD/DO)	~~70.00~~	81.50
85210-00		Clotting; factor II, prothrombin, specific		14.00
85240-00		factor VIII (AHG), 1 stage		77.20
85341-00		Clotting inhibitors or anticoagulants; PTT inhibition test		14.00
85368-00		Fibrin degradation (split) products (FDP) (FSP); protamine paracoagulation (PPP)		11.00
85540-00		Leukocyte alkaline phosphatase with count		27.00
85544-00		Lupus erythematosus (LE) cell prep (MD/DO)	~~24.00~~	20.00
85548-00		Morphology of red blood cells only (MD/DO)		27.00
85575-00		Platelet; adhesiveness (in vivo)		11.00
85580-00		~~Platelet,~~ count (Rees-Ecker) (MD/DO)		14.00
85585-00		~~Platelet,~~ estimation on smear only (MD/DO)		9.00
85590-00		phase microscopy (MD/DO)		15.00
85595-00		electronic technique (MD/DO)		14.00
85610-00		Prothrombin time; (MD/DO)	~~12.00~~	13.00
85618-00		Prothrombin-Proconvertin, P&P (Owren)		9.80
85630-00		Red blood cell size (Price-Jones)		12.00
85650-00		Sedimentation rate (ESR); Wintrobe type (MD/DO)	~~10.00~~	11.00
85651-00		Westergren type (MD/DO)	9.50	10.00
85660-00		Sickling of RBC, reduction, slide method (MD/DO)	~~14.00~~	12.00
85670-00		Thrombin time; plasma		25.00
85730-00		Thromboplastin time, partial; plasma or whole blood (MD/DO)	~~17.30~~	19.00

Subp. 6. **Immunology.** The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee	
86000-00	Agglutinins; febrile, each antigen (MD/DO)	$ ~~16.20~~	19.00
86004-00	warm		15.50
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube (MD/OD)	~~15.50~~	16.00
86007-00	~~Antibody, qualitative, not otherwise specified,~~ each additional antigen (MD/DO)		25.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen		20.00
86009-00	each additional antigen		37.00
86012-00	Antibody absorption, cold auto absorption; per serum		15.50
86013-00	Antibody absorption, cold auto absorption; differential (MD/DO)	~~7.50~~	8.00
86-16-00	Antibodies, RBC, saline; high protein and antihuman globulin technique		27.00
86017-00	with ABO+Rh(D) typing (for blood instead of complete crossmatch		15.00
86018-00	enzyme technique, including antihuman globulin		10.00
86024-00	Antibody identification; RBC antibodies (8-10 cell panel); standard technique (MD/DO)	~~24.00~~	26.00
86028-00	Saline or high protein, each (MD/DO)	~~34.50~~	27.50
86031-00	Antihuman globulin test; direct, 1-3 dilutins (MD/DO)	~~14.13~~	15.25
86032-00	indirect, qualitative (MD/DO)	~~20.00~~	17.50
86033-00	indirect, titer (broad, gamma or nongamma each)		10.00
86038-00	Antinuclear antibodies (ANA), RIA		30.00
86060-00	Antistreptolysin O; titer (MD/DO)	~~19.25~~	23.00
86063-00	screen (MD/DO)	~~14.00~~	15.00

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86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing			21.00
86067-00	other method (specify)			54.50
86069-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; each additional unit			35.50
~~86072~~	~~Blood crossmatch, enzyme technique~~			~~20.40~~
86075-00	Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening first unit			18.25
86080-00	Blood typing; ABO only (MD/DO)		~~8.00~~	11.75
86082-00	ABO and Rho(D) (MD/DO)		~~20.30~~	21.30
86095-00	Blood typing, RBC, antigens other than ABO or Rho(D); antiglobulin technique, each antigen (MD/DO)			20.00
86096-00	direct, slide or tube, including Rh subtypes, each antigen			13.50
86100-00	Blood typing; Rho(D) only			12.50
86105-00	Blood typing; Rh genotyping, complete (MD/DO)		~~8.00~~	8.50
86115-00	anti-Rh immunoglobulin testing (RhoGAM type)			45.00
86128-00	Blood autotransfusion, including collection, processing, and storage			19.05
86140-00	C-reactive protein (MD/DO)		~~13.50~~	14.00
86149-00	Carcinoembryonic antigen (CEA); gel diffusion			51.00
86151-00	Carcinoembryonic antigen (CEA); RIA or EIA (MD/DO)			60.00
86158-00	Complement; $C^1$1 esterase			44.00
86162-00	total (CH 50)			56.60
86163-00	Complement; $C^1$3 esterase (MD/DO)		~~28.56~~	30.00
86164-00	$C^1$4 esterase			28.00
86171-00	Complement fixation tests, each (for example, cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis) (MD/DO)		~~15.50~~	16.50
~~86185~~	~~Counterelectrophonesis, each antigen~~			~~81.50~~
86225-00	Deoxyribonucleic acid (DNA) antibody (MD/DO)		~~33.45~~	40.00
86229-00	Enzyme immunoassay for chemical constituent			15.80
86235-00	Antibody to specific nuclear antigen, any method, each			65.50
86244-00	Feto-protein, alpha-1, RIA or EIA			49.70
86255-00	Fluorescent antibody; screen (MD/DO)		~~30.00~~	28.00
86256-00	titer (MD/DO)		~~30.70~~	34.00
86265-00	Frozen blood, preparation for freezing, each unit, including processing and collection			50.10
86277-00	Growth hormone, human (HGH), antibody, RIA			17.00
86280-00	Hemagglutination inhibition tests (HAI), each (for example, ~~amebiasis~~, rubella, viral) (MD/DO)		~~16.00~~	19.00
86282-00	Hemolysins and agglutinins, auto, screen, each			21.25
~~86286~~	~~Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA), counterelectrophoresis with concentration of serum~~			~~25.00~~
86287-00	Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA, RIA or EIA			26.70
86288-00	Hepatitis B core antigen (HBcAg), RIA			27.00
86289-00	Hepatitis B core antibody; RIA ~~or EIA~~ (HBcAg) (MD/DO)		~~15.00~~	35.00
86291-00	Hepatitis B surface antibody (MD/DO)		~~25.40~~	26.70
86293-00	Hepatitis Be antigen (MD/DO)		~~52.00~~	33.00

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86296-00	Hepatitis A antibody (MD/DO)	~~33.30~~	33.74
86298-00	IgG antibody		40.00
86299-00	IgM antibody		35.40
86300-00	Heterophile antibodies; screening (includes monotype test), slide or tube (MD/DO)	~~14.50~~	15.00
86305-00	~~Heterophile antibodies,~~ quantitive titer (MD/DO)	~~18.00~~	20.00
86312-00	HIV (HTLV-III) antibody detection; immunoassay		22.00
86314-00	confirmatory test (e.g., Western blot)		47.00
86320-00	Immunoelectrophoresis; serum, each		65.50
86325-00	other fluids (e.g., urine) with concentration, each specimen		65.50
86329-00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify) (MD/DO)	~~40.00~~	50.00
86335-00	Immunoglobulin typing (Gc, Gm, Inv), each		15.00
86357-00	Insulin antibodies, RIA		123.70
86376-00	Microsomal antibody (thyroid); RIA		29.40
86377-00	other method (specify)		47.70
86382-00	Neutralization test, viral		9.50
86403-00	Particle agglutination, rapid test for infectious agent, each antigen		14.00
86422-00	Radioallergosorbent test, in vitro testing for allergen-specific IgE (for example, RAST, MAST, FAST, IP, PRIST, etc.); 6 or more tests		15.50
86423-00	Radioimmunosorbent test IgE, quantitative (MD/DO)		35.00
86430-00	Rheumatoid factor, latex fixation	~~16.50~~	18.40
86455-00	Skin test; anergy testing, 1 or more antigens		25.00
86490-00	coccidioidomycosis		14.00
86510-00	histoplasmosis		16.00
86580-00	Skin test; tuberculosis, ~~patch,~~ or intradermal (MD/DO)	~~9.00~~	9.50
86585-00	tuberculosis, tine test (MD/DO)	~~7.50~~	8.00
86590-00	Streptokinase, antibody	~~10.00~~	16.00
86592-00	Syphilis, ~~precipitation or flocculation tests,~~ test; qualitative ~~VDRL, RPR, ART~~	~~10.00~~	12.75
86593-00	quantitative		12.00
86594-00	Thyroid autoantibodies		48.00
86595-00	Tissue culture		62.55
86600-00	Toxoplasmosis, dye test		16.00
86650	Treponema antibodies, fluorescent, absorbed (MD/DO)	~~37.50~~	39.40
86800-00	Thyroglobulin antibody, RIA		42.40
86812-00	Tissue typing; HLA typing, A, B, or C (for example, A10, B7, B27), single antigen		65.00

Subp. 7. **Microbiology.** The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
~~87040~~	~~Culture, bacterial, definitive, aerobic, blood (may include anaerobic screen)~~	~~$ 23.00~~
87015-00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	27.00
87045-00	stool	~~27.50~~ 28.40
87060-00	~~Culture, bacterial, definitive, aerobic,~~ throat or nose	~~12.00~~ 12.50
87070-00	any other source	~~21.00~~ 23.00

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87072-00	Culture, ~~presumptive, pathogenic organisms~~ or direct bacterial identification method, each organism, by commercial kit, any source except urine		~~13.50~~	16.20
87075-00	Culture, bacterial, any source; anaerobic (isolation)			29.00
87081-00	Culture, bacterial, screening only, for single organisms		~~12.70~~	14.50
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms		~~12.00~~	15.00
87083-00	multiple organisms			17.25
87084-00	with colony estimation from density chart			10.00
87085-00	with colony count			29.00
87086-00	Culture, bacterial, urine; quantitative, colony count (MD/DO)		~~17.60~~	19.00
87087-00	commercial kit			11.25
87088-00	identification, in addition to quantitative or commercial kit		~~22.00~~	23.00
87101-00	Culture, fungi, isolation; skin			18.00
87102-00	other source (except blood)			13.50
87106-00	Culture, fungi, ~~isolation, skin, definitive identification, by culture, per organism, in addition to skin or other source~~ of each fungus		~~26.30~~	27.60
87109-00	Culture, mycoplasma, any source			43.50
87116-00	Culture, tubercle or other acid-fast bacilli (for example, TB, AFB, mycobacteria); source, isolation only			31.00
87117-00	concentration plus isolation			36.40
87118-00	Culture, mycobacteria, definitive identification of each organism			25.00
87140-00	Culture, typing; fluorescent method, each antiserum			14.50
87147-00	Serologic method, agglutination grouping, per antiserum (MD/DO)		~~15.00~~	20.00
87151-00	serologic method, speciation			19.00
87158-00	other methods			52.40
87163-00	Culture, ~~special extensive definitive diagnostic studies, beyond usual definitive studies~~ any source, additional identification methods required (MD/DO)		~~22.50~~	25.00
87164-00	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection (MD/DO)		~~7.50~~	8.00
87174-00	Endotoxin, bacterial (pyrogens); chemical			40.00
87177-00	Ova and parasites, direct smears, concentration and identification (MD/DO)		~~24.00~~	25.30
87181-00	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic (MD/DO)			15.00
87184-00	disc method, each plate (12 or less discs)		~~17.50~~	18.75
87186-00	microtiter, minimum inhibitory concentration (MIC), 8 or less any number of antibiotics (MD/DO)		~~21.05~~	22.50
87188-00	macrotube dilution method, each antibiotic			16.50
87205-00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types (MD/DO)		~~13.00~~	14.60
87206-00	fluorescent and/or acid fast stain for bacteria, fungi, or cell types			30.00
87207-00	special stain for inclusion bodies or intracellular parasites (for example, malaria, kala azar, herpes)			31.00
87208-00	direct or concentrated, dry,			

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		for ova and parasites (MD/DO)	~~12.50~~ 13.00
87210-00		wet mount with simple stain ~~and interpretation,~~ for bacteria, fungi, ova, ~~or~~ and/or parasites (MD/DO)	~~12.00~~ 12.25
87211-00		wet and dry mount, ~~with interpretation,~~ for ova and parasites (MD/DO)	~~11.50~~ 12.00
87220-00		Tissue examination for fungi (for example, KOH slide) (MD/DO)	12.50
87250-00		Virus identification; inoculation of embryonated eggs, or small animal, includes observation and dissection	39.00

Subp. 8. **Anatomic pathology.** The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

Cytopathology

Code	Service	Maximum Fee
88104-00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation (MD/DO)	$ ~~32.25~~ 30.00
~~88109~~	~~smears and cell block with interpretation~~	~~53.50~~
88106-00	filter method only with interpretation	31.70
88107-00	smears and filter preparation with interpretation	30.00
88108-00	concentration technique, smears and interpretation (e.g., Saccomanno technique)	37.00
88130-00	Sex chromatin identification; Barr bodies	15.50
88150-00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to 3 smears; screening by technical under physician supervision	16.75
88151-00	requiring interpretation by physician	19.25
88155-00	with definitive hormonal evaluation (e.g., maturation index, karyopknotic index, estrogenic index)	
88160	Cytopathology, any other source; screening and interpretation (MD/DO	~~35.00~~ 28.50
88161-2600	preparation, screening, and ~~interpretation, professional component only~~ (MD/DO)	~~28.50~~ 40.90
88162-00	extended study involving over 5 slides and/or multiple stains	55.00
88170-00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	90.00
88172-00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	27.50
88173-00	interpretation and report	88.00
88260-00	Chromosome analysis; count 5 cells, screening. with banding	400.00
88262-00	count 15-20 cells, 2 karyotypes, with banding	363.40
88267-00	Chromosone analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotope, with banding	453.00

Subp. 9. **Surgical pathology.** The following codes, service descriptions, and maximum fees apply to surgical pathology procedures. The services listed include accession, handling, and reporting. Only one of the codes listed (88302 to 88307)

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should be used in reporting specimens (single or multiple) that are removed during a single surgical procedure.

Code	Service	Maximum Fee
88300-00	Surgical pathology, gross examination only	25.00
88302-00	Surgical pathology, gross and microscopic; examination ~~for~~ of presumptively normal tissue, for identification and record purposes ~~(for example, uterine tubes, vas deferens, sympathetic ganglion)~~ (MD/DO) ~~$ 35.00~~	36.00
~~88302-26~~	~~professional component only~~	~~31.00~~
88304-00	Surgical pathology, gross and microscopic; diagnostic ~~exam, small or~~ examination of presumptively abnormal tissue; uncomplicated specimen ~~(for example, skin lesion, needle biopsy)~~ (MD/DO)	45.00
88305-00	single complicated or multiple uncomplicated specimen(s), without complex dissection	73.90
88307-00	~~complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides~~ single complicated specimen requiring complex dissection or multiple complicated specimens	~~90.00~~ 128.90
88309-00	Complex diagnostic problem with or without extensive dissection (MD/DO) ~~150.00~~	185.60
88311-00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	20.90
88312-00	Special stains; Group I stains for microorganisms (MD/DO)	25.00
88313-00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	18.50
88314-00	histochemical staining with frozen section(s)	10.00
88321-00	Consultation and report on referred slides prepared elsewhere	67.95
88323-00	Consultation and report on referred material requiring preparation of slides	52.50
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	48.00
~~88329-26~~	~~Consultation during surgery, professional component only~~	~~40.00~~
88331-00	with frozen section(s); single specimen	100.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	42.00

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

Code	Service	Maximum Fee
~~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)~~	~~$ 25.00~~
89050-00	Cell count, miscellaneous body fluids (e.g., CSFm joint fluid), except blood	20.40
89051-00	Cell count, miscellaneous body fluids (e.g. CSF, joint fluid), except blood, with differential count ~~13.40~~	15.50
89060-00	Crystal identification by compensated	

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		polarizing lens analysis, synovial fluid		16.00
	89125-00	Fat stain, feces, urine, or sputum		24.30
	89130-00	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology (MD/DO)	~~42.10~~	61.00
	~~89180~~	~~Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify)~~		~~11.60~~
	89190-00	Nasal smear for eosinophils (MD/DO)	~~11.25~~	12.00
	89205-00	Occult blood, any source except feces		11.00
	89300-00	Semen analysis; presence and/or motility of sperm, including Huhner test		32.00
	89310-00	motility and count		19.00
	89320-00	Semen analysis; complete(volume count, motility and differential) (MD/DO)	~~39.75~~	39.00
	89325-00	Sperm antibodies		109.00
	89330-00	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkheit test		32.00
	89350-00	Sputum, obtaining specimen, aerosol induced technique (MD/DO)	~~54.00~~	17.10

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Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

Subp. 2. **Diagnostic.** The following codes, service descriptions, and maximum fees apply to diagnostic services.

~~Clinical Oral Examination~~

Code	Service	Maximum Fee
~~00110~~	~~Initial oral examination~~	~~$15.00~~
~~00120~~	~~Periodic oral examination~~	~~12.00~~
~~00130~~	~~Emergency oral examination~~	~~15.00~~
	~~Radiographs~~	
~~00210~~	~~Intraoral complete series~~	~~$38.00~~
~~00220~~	~~Intraoral, periapical, single, first film~~	~~6.00~~
~~00272~~	~~Bitewing, two films~~	~~10.00~~
~~00274~~	~~four films~~	~~16.00~~
~~00330~~	~~Panoramic, maxilla and mandible, film~~	~~35.00~~
~~00335~~	~~maxilla and mandible, film, with bitewings~~	~~43.00~~
~~00340~~	~~Cephalometric film~~	~~38.00~~
	~~Tests and Laboratory Examinations~~	
~~00450~~	~~Histopathologic examination~~	~~$40.00~~
	~~Restorative~~	
~~02110~~	~~Amalgam, one surface, deciduous~~	~~$25.00~~
~~02120~~	~~Amalgam, two surfaces, deciduous~~	~~35.00~~
~~02130~~	~~Amalgam, three surfaces, deciduous~~	~~45.00~~
~~02131~~	~~Amalgam, four surfaces, deciduous~~	~~54.00~~
02140-00	Amalgam; one surface, permanent (DDS)	~~25.00~~ 28.00
02150-00	~~Amalgam,~~ two surfaces, permanent (DDS)	~~36.00~~ 40.00
02160-00	~~Amalgam,~~ three surfaces, permanent (DDS)	~~48.00~~ 53.00
02161-00	~~Amalgam,~~ four or more surfaces, permanent (DDS)	~~58.00~~ 64.00
	Acrylic or Plastic Restorations	
02330-00	~~Composite~~ resin; one	

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		surface, anterior (DDS)	$ ~~34.00~~	38.00
	02331-00	~~Composite resin;~~ two surfaces, anterior (DDS)	~~46.00~~	54.00
	02332-00	~~Composite resin;~~ three surfaces, anterior (DDS)	~~61.00~~	70.00
	02335-00	~~Composite resin~~ four or more surfaces or (involving incisal angle (DDS)	~~60.00~~	70.00
		Inlay Restorations		
	02530-00	Inlay - metallic; three surfaces		310.00
	02540-00	Onlay - metallic; per tooth (in addition to inlay)		395.00
		Crowns - Single Restoration Only		
	02711-00	Plastic, prefabricated	$ ~~90.00~~	135.00
	02740-00	Crown; porcelain/ceramic substrate		420.00
	02750-00	porcelain fused to high noble metal		375.00
	02751-00	porcelain fused to predominantly base metal		360.00
	02752-00	porcelain fused to noble metal		360.00
	02790-00	full cast high noble metal		355.00
	02791-00	full cast predominantly base metal		310.00
	02792-00	full cast noble metal		305.00
	02810-00	3/4 cast metallic		380.00
	02815-00	Incision and drainage of abscess; intraoral		90.00
	02824-00	Removal of tooth; bony impaction presenting unusual difficulties and circumstances		160.00
	02825-00	Removal of tooth, soft tissue impaction (DDS)	~~80.00~~	90.00
	02826-00	~~Removal of tooth,~~ partial bony impaction (DDS)	88.00	115.00
	02827-00	~~Removal of tooth,~~ complete bony impaction (DDS)	~~90.00~~	140.00
	02828-00	Dental root resection		96.00
	02829-00	Apicoectomy; performed as separate surgical procedure (per root)		200.00
	02830-00	stainless steel (DDS)	~~75.00~~	85.00
	02848-00	Osseous surgery; per quadrant		350.00
		Other Restorative Services		
	02910-00	Recement inlays (DDS)	~~25.00~~	28.00
	02920-00	Recement crowns (DDS)	~~22.00~~	25.00
	02940-00	Sedative fillings (DDS)	~~21.00~~	25.00
	02950-00	Crown buildups, including any pins (DDS)	~~75.00~~	80.00
	02960-00	Labial veneer (laminate); chairside		165.00
		Endodontics		
	03110-00	Pulp cap; direct		20.00
		(excluding final restoration)		20.00
	03120-00	indirect (excluding final restoration)		12.00
	03220-00	~~Vital~~ Therapeutic pulpotomy	$ ~~40.00~~	40.00
		Root Canal Therapy		
	03310-00	~~Anterior~~ One canal (excludes final restoration) (DDS)	$ ~~171.75~~	195.00
	03320-00	~~Bicuspid~~ Two canals (excludes final restoration) (DDS)	~~200.00~~	238.00
	03330-00	~~Molar~~ Three canals (excludes final restoration) (DDS)	~~260.00~~	325.00
		Periapical Services		
	03410-00	Apicoectomy - (per tooth) first root ~~performed as separate~~		

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		~~surgical procedure (per root)~~ (DDS)	~~130.00~~	200.00
		Other Endodontic Procedures		
	03950-00	Canal preparation and fitting of preformed dowel or post	~~60.00~~	85.00
	03960-00	Bleaching of discolored tooth		40.00
		Prosthodontics, Removable		
		Complete Dentures - including ~~six-months~~ routine post-delivery care		
	05110-00	Complete upper (DDS)	~~$ 453.00~~	495.00
	05120-00	Complete lower (DDS)	~~455.00~~	500.00
	05130-00	Immediate upper (DDS)	~~450.00~~	537.00
	05140-00	Immediate lower (DDS)	~~450.00~~	550.00
		Partial Dentures - including routine ~~six-months~~ post-delivery care		
	05212-00	Lower ~~--without clasps~~, partial; acrylic base (including any conventional clasps and rests	~~$ 490.75~~	537.00
	05213-00	Upper partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests		565.00
	05214-00	Lower partial; predominantly base cast base with acrylic saddles (including any conventional clasps and rests)		575.00
	05215-00	Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests		565.00
	05216-00	~~Upper---with two chrome clasps with rests,~~ Lower; high noble cast base with acrylic ~~base~~ saddles (including any conventional clasps and rests (DDS)	~~485.00~~	595.00
	~~05218~~	~~Lower---with chrome clasps with rests, acrylic base~~		~~500.00~~
	~~05231~~	~~Lower---with chrome lingual bar and two clasps, acrylic base~~		~~500.00~~
	~~05241~~	~~Lower---with chrome lingual bar and two clasps, cast base~~		~~525.00~~
	~~05251~~	~~Upper---with chrome palatal bar and two clasps, acrylic base~~		~~500.00~~
	~~05261~~	~~Upper---with chrome palatal bar and two clasps, cast base~~		~~550.00~~
	~~05292~~	~~Full cast partial---with two chrome clasps (upper)~~		~~520.00~~
	~~05294~~	~~Full cast partial---with two chrome clasps (lower)~~		~~520.00~~
		Adjustments to Dentures		
	05410-00	Adjust complete denture; upper		25.00
	05421-00	Adjust partial denture; upper		30.00
	05422-00	lower		25.00
		Repairs to Dentures		
	~~05610~~	~~Repair broken or complete or partial denture---no teeth damaged~~	~~$ 51.00~~	
	~~05620~~	~~Repair broken complete or partial denture---replace one broken tooth~~		~~59.00~~
	05610-00	Repair acrylic saddle or base		48.00
	05620-00	Repair (DDS)		50.00
	05630-00	Repair or replace broken clasp (DDS)		45.00
	05640-00	Replace broken ~~tooth or denture---not other repairs~~ teeth; per tooth (DDS)	~~45.00~~	48.00
	05650-00	~~Adding~~ Add tooth to existing partial denture ~~to replace extracted tooth---each tooth~~		

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		~~(not involving clasp or abutment tooth)~~ (DDS)	65.00
	05660-00	~~Adding tooth~~ Add clasp to existing partial denture ~~to replace extracted tooth - each tooth (involving clasp or abutment tooth)~~ (DDS) ~~92.25~~	90.00
	~~05670~~	~~Reattaching damaged clasp on denture~~	~~65.00~~
	~~05680~~	~~Replacing broken clasp with new clasp on denture~~	~~75.00~~
	~~05690~~	~~Each additional clasp with rest~~	~~64.00~~
		~~Denture Duplication~~	
	~~05710~~	~~Duplicate upper or lower complete denture~~	~~$ 202.50~~
	~~05720~~	~~Duplicate upper or lower partial denture~~	~~207.50~~
		Denture Relining	
	~~05740~~	~~Relining upper or lower partial denture (office reline)~~	~~$ 95.00~~
	05730-00	Relining complete upper denture (chairside) (DDS)	$ 135.00
	05750-00	Relining complete upper ~~or lower complete~~ denture (laboratory) (DDS) ~~150.00~~	158.00
	05760-00	Relining upper ~~or lower~~ partial denture (laboratory) (DDS) ~~144.50~~	160.00
		Other Removable Prosthetic Services	
	05820-00	~~Denture~~ Temporary (partial stayplate), denture upper (DDS) $ ~~160.00~~	200.00
	05850-00	Tissue Conditioning; per denture unit (DDS) ~~28.00~~	39.00
		Bridge Pontics	
	06210-00	Pontic; cast high noble metal	$ 135.00
	06240-00	porcelain fused to high noble metal	363.00
	06241-00	porcelain fused to predominantly base metal	355.00
	06242-00	porcelain fused to noble metal	350.00
		Retainers	
	06545-00	Cast metal retainer for acid etch bridge	132.00
		Prosthodontics, ~~Fixes~~ Fixed	
	06640-00	Replace broken facing with acrylic (DDS) $ ~~54.00~~	70.00
		Bridge Retainers -- Crowns	
	06750-00	Crown; porcelain fused to high noble metal	377.00
	06751-00	porcelain fused to predominantly base metal	360.00
	06752-00	porcelain fused to noble metal	355.00
	06790-00	full cast high noble metal	355.00
	06791-00	full cast predominantly base metal	295.00
	06792-00	full cast noble metal	300.00
	06801-00	Diagnostic exam and DXL	20.00
	06802-00	Prevention	25.00
	06803-00	Restorative	52.50
	06804-00	Endodontics	285.00
	06808-00	Dental oral surgery	45.00
	06809-00	Unlisted dental procedures	24.00
		Other Fixed Prosthetic Services	
	06930-00	Recement bridge (DDS)	40.00
		Oral Surgery	
		Extractions - includes local anesthesia	
		and routine postoperative care	

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07110-00	Single tooth (DDS)	$ ~~30.00~~	35.00
07120-00	Each additional tooth (DDS)	~~20.00~~	35.00
	Surgical Extractions - includes local anesthesia and routine postoperative care		
07210-00	~~Extraction~~ Surgical removal of tooth --~~erupted~~ requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth (DDS)	~~70.00~~	75.00
07220-00	~~Impaction that requires incision of overlying soft tissue and the~~ Removal of ~~the~~ impacted tooth; soft tissue (DDS)	~~80.00~~	86.00
07230-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the~~ Removal of the impacted tooth; partially bony (DDS)	~~100.00~~	119.00
07240-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, Removal of bone and sectioning of the tooth for~~ Removal of impacted tooth; completely bony (DDS)	~~120.00~~	140.00
07241-00	~~Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the~~ Removal of impacted tooth ~~for removal, and presents~~ ; completely bony, with unusual ~~difficulties and circumstances~~ surgical complications (DDS)	~~135.00~~	150.00
07250-00	~~Root recovery (~~Surgical removal of residual ~~roots~~ tooth roots (DDS)	~~60.00~~	75.00
	Other Surgical Procedures		
07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons - including ~~wire attachment~~ orthodontic attachments (DDS)	~~80.00~~	125.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption		140.00
07286-00	Biopsy of oral tissue; soft		90.00
	Alveoplasty - Surgical Preparation of Ridge For Dentures		
07310-00	Alveoloplasty (per quadrant) in conjunction with extractions (DDS)	~~60.00~~	75.00
~~07320~~	~~per quadrant, not in conjunction with extractions~~		~~75.00~~
	~~Surgical Excision~~		
07425-00	~~Excision periocoronal gingiva~~		~~$ 30.60~~
	Surgical Incision		
07510-00	Incision and drainage of abscess, intraoral soft tissue (DDS)	~~44.50~~	45.00
	Other ~~Oral Surgery~~ Repair Procedures		
07960-00	Frenulectomy	$ ~~80.00~~	90.00
	Adjunctive General Services		
	Unclassified treatment		
09110-00	Palliative (emergency) treatment of dental pain; minor procedures		25.00

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	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 8.00
09211-00	Regional block anesthesia	10.00
09220-00	General; first 30 minutes (DDS)	$ 90.00
09230-00	Analgesia (DDS)	12.00
	Professional Consultation	
09310-00	Consultation; per session	35.00
09420-00	Hospital call	14.00
09430-00	Office visit during regularly scheduled office hours	15.00
	Drugs	
09610-00	Therapeutic drug injection, by report	15.00
09630-00	Other drugs and/or medicaments	15.00
	Miscellaneous Services	
09910-00	Application of desensitizing medicaments (DDS)	$ 15.00
09991-00		25.00
09993-00		30.00
	Surgery	
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	2,960.00
21203-00	mandibular ramus (osteotomy)	2,950.00
21240-00	Arthroplasty, temporomandibular joint, with or without autograft	2,400.00
40808-00	Biopsy, vestibule of mouth	107.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frebectomy)	100.00
4215-00	Removal of exostosis, bony palate	280.00
	Radiology -- Dental	
70320-00	Radiologic examination, teeth; complete, full mouth	45.00
70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	35.00
70330-00	bilateral	90.00
70350-00	Caphalogram, orthodontic	40.00
70355-00	Orthopantogram	35.00
76100-00	Radiologic examination, single plane body section (e.g., tomography)	73.00
	Surgical Pathology -- Dental	
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	40.00
	Office Dental Services	
90000-00	Office dental service, new patient; brief service	25.00
90010-00	limited service	33.00
90020-00	comprehensive service	75.20
90030-00	Office dental service, established patient; minimal service	24.00
90040-00	brief service	25.00
90050-00	limited service	34.00
90060-00	intermediate service	44.00
90070-00	extended service	55.00

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	Hospital Dental Services	
90240-00	Subsequent hospital care, each day; brief services	35.00
90250-00	limited services	41.75
90260-00	intermediate services	60.00
90600-00	Initial consultation; limited	35.00
90605-00	intermediate	62.00
90620-00	comprehensive	95.00
	Dental Injections	
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	15.00
	Cardiovascular - - Dental	
93000-00	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	15.00
97010-00	Physical-dental medicine treatment to one area; hot or cold packs	25.00
97110-00	Physical-dental medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	28.50
97128-00	Ultrasound	25.00

5221.2600 OPTOMETRISTS~~,-OPTICIANS~~.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed ~~optometrists-and-opticians~~ as a doctor of optometry.

Subp. 2. ~~**Basic-optometric-services**~~ **Definitions.** The ~~following-codes,-service-descriptions,-and-maximum-fees-apply-to basic-optometric-services~~ terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. "New patient" and "established patient" have the meanings given them in part 5221.1100.

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

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

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

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hemmorrhage or evaluation and replacement of a lost contact lens.

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

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

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

(6) "Comprehensive service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity, but need not be performed in one session. When indicated in the doctor's professional judgment, this service may include, but is not limited to history, general health observation, external examination of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination, biomicroscopy, tonometry, gross visual fields, and blood pressure screening. It may include initiation of diagnostic and treatment programs,

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or referral, as indicated. The treatment services include the prescription of lenses, other therapy, or arranging for special optometric diagnostic or treatment services, consultation, or laboratory procedures, as may be indicated.

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$48.00
06502-00	Bifocal eyeglass lenses (one lens)	70.20
06503-00	Trifocal eyeglass ~~lens~~ lenses (one lens)	~~$108.00~~ 90.00
06504-00	Lenticular eyeglass lenses (one lens)	21.00
06506-00	Eyeglass frames	~~69.00~~ 67.00
06510-00	Tinting for lenses	15.00
06587-00	Contact ~~lens~~ lenses, soft (one lens)	~~161.00~~ 80.00
06588-00	Contact lenses, hard (one lens)	70.00
06589-00	Dispensing fee; single vision ~~lens~~ lenses	~~36.10~~ 25.00
06590-00	bifocal lenses	30.00
06591-00	trifocal lenses	32.00
~~06592~~	~~Dispensing fee, special lenses (e.g. prisms, tints, or lenticular)~~	~~10.00~~
~~06593~~	~~Dispensing fee, frames~~	~~45.20~~
09201-00	Eye examination with complete visual fields included	~~40.00~~ 44.00
~~09203~~	~~Eye examination with slit lamp angle testing~~	~~49.00~~
~~09206~~	~~Orthoptic evaluation~~	~~35.00~~
09213-00	Eye refraction	~~38.00~~ 29.00

Office Services

Code	Service	Maximum Fee
90000-00	New patient; brief service	$ 22.00
90010-00	limited service	28.00
90015-00	intermediate service	38.00
90017-00	extended service	50.00
90020-00	comprehensive service	50.00
90030-00	Established patient; minimal service	15.00
90040-00	brief service	19.00
90050-00	limited service	25.00
90060-00	intermediate service (does not include determination of the refractive state)	31.00
90070-00	extended service	45.00
90080-00	comprehensive service	49.00
92002-00	New patient; intermediate service	39.00
92004-00	comprehensive service, one or more visits	50.00
92012-00	Established patient; intermediate service (includes determination of the refractive state	38.00
92014-00	comprehensive service, one or more visits	44.00
92060-00	Sensorimotor examination with diagnostic evaluation	50.00
92065-00	Orthoptic and/or pleoptic training, with continuing direction and evaluation	40.00
92081-00	Visual field examination with medical diagnostic evaluation; tangent screen, autoplot or equivalent	20.00
92082-00	quantitative perimetry (for example, several isopters on Goldmann perimeter or equivalent	42.50
92083-00	static and kinetic perimetry, or equivalent	60.00
92100-00	Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day	10.00
92140-00	Provocative tests for glaucoma, with	

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	medical diagnostic evaluation	15.00
92225-00	Opthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomocroscopy), with medical diagnostic evaluation; initial	22.20
92250-00	Ophthalmoscopy, with medical diagnostic evaluation; with fundus photography	15.00
92285-00	Extended ocular photography for documentation of progress	10.00
92287-00	Specular endothelial microscopy with photographic documentation, evaluation and report; with flouroscein antiography	38.00
92310-00	Prescription and management of corneal contact lens, both eyes, except for aphakia	50.00
92312-00	corneal lens for aphakia, two eyes	130.00
92325-00	Modification of contact lens	20.00
92326-00	Replacement of contact lens	58.00
92340-00	Treatment with spectacles, except for aphakia; monofocal	49.00
92341-00	bifocal	64.00
92342-00	multifocal, other than bifocal	84.00
92370-00	Repair and adjusting spectacles; except for aphakia	68.95
92390-00	Supply of all spectacle lenses, except for aphakia and low vision aids (all combinations, nonspecific); one lens only (enter two units for a pair)	79.00
92391-00	Supply of contact lenses, except prosthesis for aphakia; one lens only (enter two units for a pair)	108.00
99056-00	Services provided at request of patient in a location other than optometrist's office that are normally provided in the office	6.00

5221.2650 OPTICIANS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to certified opticians.

Subp. 2. **Basic optician services.** The following codes, service descriptions, and maximum fees apply to basic optician services and supplies:

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 53.00
06502-00	Bifocal eyeglass lenses (one lens)	69.95
06503-00	Trifocal eyeglass lenses (one lens)	85.00
06504-00	Lenticular eyeglass lenses (one lens)	24.00
06506-00	Eyeglass frames	80.00
06510-00	Tinting for lenses	12.00
06587-00	Contact lenses, soft (one lens)	109.00
06588-00	Contact lenses, hard (one lens)	61.00
06593-00	Dispensing fee, frames for lenses	70.20
	Office Services	
92004-00	New patient; comprehensive service	$ 34.00
92012-00	Established patient; intermediate service	40.00
92340-00	Treatment with spectacles, except for aphakia; monofocal	50.00

5221.2700 AUDIOLOGISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to audiologists ~~and-to-speech~~

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~~pathologists~~ holding a certificate of clinical competency (CCC-A) or to audiologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

Code	Service	Maximum Fee
06665-00	Monaural dispensing fee (CCC-A/CFY)	190.00
21010-00	Basic hearing evaluation (CCC-A/CFY)	40.00
21020-00	Basic hearing evaluation (CCC-A/CFY)	45.00
21021-00	Limited hearing evaluation (CCC-A/CFY)	32.00
21022-00	Extended hearing evaluation (CCC-A/CFY)	64.00
21031-00	Limited site of auditory lesion evaluation (CCC-A/CFY)	16.00
21032-00	Extended site of auditory lesion evaluation (CCC-A/CFY)	32.00
21050-00	Basic prescription hearing aid evaluation (CCC-A/CFY)	40.00
21052-00	Extended prescription hearing aid evaluation (CCC-A/CFY)	45.00
21053-00	Performance evaluation of specific hearing aid (CCC-A/CFY)	20.00
21081-00	Hearing screening group (CCC-A/CFY)	9.50
22010-00	Basic speech, language, or voice evaluation (CCC-A/CFY)	80.00
~~92506~~	~~Medical evaluation, speech, language and/or hearing problems~~	~~$51.00~~
~~92532~~	~~Positional nystagmus~~	~~20.00~~
~~92545~~	~~Oscillating tracking test, with recording~~	~~31.00~~
92551-00	Screening test, pure tone, air only (CCC-A/CFY)	~~12.50~~ 18.50
~~92552~~	~~Pure tone audiometry (threshold), air only~~	~~21.00~~
92553-00	air and bone (CCC-A/CFY)	~~35.00~~ 33.00
~~92555~~	~~Speech audiometry, threshold only~~	~~16.00~~
92556-00	threshold and discrimination (CCC-A/CFY)	~~32.00~~ 44.25
92557-00	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination) (CCC-A/CFY)	~~54.00~~ 60.00
~~92562~~	~~Loudness balance test, alternate binaural or monaural~~	~~18.00~~
~~92563~~	~~Tone decay test~~	~~15.00~~
92566-00	Impedance testing (CCC-A/CFY)	~~20.00~~ 18.00
92567-00	Tympanometry (CCC-A/CFY)	~~18.00~~ 22.00
~~92568~~	~~Acoustic reflex testing~~	~~16.00~~
~~92575~~	~~Sensorineural acuity level test~~	~~10.00~~
~~92581~~	~~Evoked response (EEG) audiometry~~	~~185.00~~
92582-00	Conditioning play audiomety (CCC-A/CFY)	30.00
92585-00	Brainstem evoked response recording (CCC-A/CFY)	~~182.00~~ .....
92590-00	Hearing and examination and selection; monaural (CCC-A/CFY)	~~53.50~~ 50.00
92591	binaural (CCC-A/CFY)	~~65.00~~ .....
92592-00	Hearing aid check; monaural (CCC-A//CFY)	53.50
92593	~~Hearing aid check;~~ binaural	30.00 .....

5221.2750 SPEECH PATHOLOGISTS.

The following codes, service description, and maximum fees

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apply to speech pathologists holding a certificate of clinical competency (CCC-SP) or to speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

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

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

Subp. 2. ~~**Physical therapy.** The following codes, service descriptions, and maximum fees apply to physical therapy procedures.~~ **Definitions.** The terms defined in this subpart have the meanings given to them when used in subpart 4 unless the context clearly indicates a different meaning.

A. "Therapeutic exercise" (code 97110) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular re-education" (code 97112) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident and systemic neurological disease.

C. "Functional activities" (code 97114) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work-related activities.

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D. "Gait training" (code 97116) means teaching individuals with neurological or musculoskeletal disorders to ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how to prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

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

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

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

Subp. 3. **Physical and occupational therapy instructions.**

A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration. The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for therapy service and do not command a separate fee.

B. Physical therapy services must be provided by a Minnesota licensed registered physical therapist or physical therapy assistant under the direct supervision of a licensed

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registered physical therapist. Upon request, the provider must supply a Minnesota license number.

C. Occupational therapy services must be provided by a nationally registered occupational therapist or certified occupational therapy assistant under the direction of a nationally registered occupational therapist.

Subp. 4. **Scope.** The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed in an independent clinic, a doctor's office, a hospital satellite clinic, or hospital out-patient setting.

~~**Evaluations**~~

Code	Service	Maximum Fee
~~95831~~	~~Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report~~	~~$ 14.00~~
~~95851~~	~~Range of motion measurements and report (separate procedure); each extremity, excluding hand~~	~~9.25~~

Modalities

97010-00	Physical medicine treatment to one area; hot or cold packs (RPT/OTR)	~~$ 16.00~~	17.00
97012-00	~~Physical medicine treatment to one area;~~ traction, mechanical (RPT/OTR)	~~15.50~~	16.00
97014-00	electrical stimulation (unattended) (RPT/OTR)		15.00
97016-00	vasopneumatic devices (RPT/OTR)	~~15.00~~	16.00
97018-00	paraffin bath (RPT/OTR)	~~15.00~~	20.00
97022-00	whirlpool (RPT/OTR)		17.00
97024-00	diathermy (RPT/OTR)	~~15.00~~	16.00
~~97026~~	~~infrared~~		~~11.50~~
97028-00	ultraviolet (RPT/OTR)		25.00

Procedures

97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises (RPT/OTR)	$ ~~20.00~~	22.00
97112-00	neuromuscular reeducation (RPT/OTR)	~~20.00~~	25.00
97114-00	functional activities (RPT/OTR)	~~26.00~~	19.00
97116-00	gait training (RPT/OTR)	~~24.86~~	23.00
97118-00	electrical stimulation (manual) (RPT/OTR)		16.25
97120-00	iontophoresis (RPT/OTR)	~~25.00~~	20.00
97122-00	traction, manual (RPT/OTR)	~~15.50~~	18.00
97124-00	massage (RPT/OTR)	~~15.50~~	17.25
97126-00	contrast baths	~~16.00~~	18.00
97128-00	ultrasound (RPT/OTR)	~~16.00~~	16.25
97145-00	Physical medicine treatment to one area, each additional 15 minutes	~~12.50~~	13.00
97220-00	Hubbard tank; initial 30 minutes each visit (RPT/OTR)		45.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit (RPT/OTR)		30.00

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~~97260~~	~~Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician, one area~~		~~18.00~~
97500-00	Orthotics training (dynamic bracing, splinting), upper extremities; initial 30 minutes, each visit (RPT/OTR)	~~26.00~~	21.00
97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit (RPT/OTR)		25.00
97531-00	each additional 15 minutes (RPT/OTR)	~~12.00~~	18.50
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit (RPT/OTR)	~~33.00~~	20.00
97541-00	each additional 15 minutes (RPT/OTR)		18.50
	Tests and Measurements		
97700-00	Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes (RPT/OTR) a. Orthotic check-out; b. Prosthetic check-out; c. Activities of daily living check-out; d. Follow-up evaluation for extremity testing for strength, dexterity, or stamina		$ 21.00
97701-00	each additional 15 minutes		21.00
97720-00	Initial evaluation for extremity testing for strength, dexterity, or stamina; initial 30 minutes, each visit (RPT/OTR)	$ ~~45.00~~	32.00
97721-00	each additional 15 minutes (RPT/OTR)		25.00
97752-00	Muscle testing with torque curves during isometric and isokinetic exercise mechanized or computerized evalators with printout (e.g., by use of cybex or similar type machine); for extremities (RPT/OTR)		55.00
97753-00	for trunk/back		134.40

5221.2900 CHIROPRACTORS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of chiropractic medicine.

Subp. 1a. **Definitions.** For purposes of this part, the following terms have the meaning given them unless the content clearly indicates a different meaning.

A. "Examination/consultation" means inspection of the patient, review of diagnostic tests to diagnose disease or evaluate progress and preparation of an appropriate record.

(1) "Brief examination" means a condition requiring only a routine history and examination.

(2) "Intermediate examination" means a condition involving a diagnostic or management problem and a history and examination.

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(3) "Extensive examination" means an unusual amount of effort or judgment and a detailed history and examination of multiple body systems.

B. "Initial office visit with manipulation/adjustment" means the first time a patient is seen for a brief evaluation to determine the appropriate treatment on that date and all necessary spinal manipulative/adjustment procedures rendered.

C. "Subsequent office visit with manipulation/adjustment" means all office visits, except the first one, where a brief evaluation is done to determine appropriate treatment on that day and all necessary spinal manipulation/adjustment procedures rendered.

D. "New patient" means a patient new to the chiropractor or a known patient with a new industrial injury or condition, whose medical and administrative record needs to be established.

E. "Established patient" means a patient whose medical and administrative records are available to the chiropractor.

Subp. 1b. **Chiropractor instructions.**

A. Use code 09542 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation on the same day.

Subp. 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Examinations - Includes History and Diagnosis, Office	
~~09509~~	~~Home or nursing home visit with routine chiropractic examination and/or treatment which includes adjustment, manipulation, and/or one unit of conjunctive therapy for the same or new condition~~	~~$ 50.00~~
09520-00	New patient; brief examination (CHIRO/DC)	$ 30.00
09521-00	intermediate examination (CHIRO/DC)	40.00

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09522-00	extensive examination (CHIRO/DC)	~~65.00~~ 60.00
09530-00	Established patient; brief examination (CHIRO/DC)	25.00
09531-00	intermediate examination (CHIRO/DC)	~~36.00~~ 40.00
09532-00	extensive examination (CHIRO/DC)	~~65.00~~ 60.00

Chiropractic Visit With Manipulation/Adjustment

09540-00	Visit with manipulation/adjustment, initial; office (CHIRO/DC)	$ 20.00
09541-00	~~Visit with manipulation/adjustment,~~ subsequent; office (CHIRO/DC)	22.00
09542-00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00

Home/Nursing Home Visits

09550-00	Chiropractic visit with manipulation/adjustment (CHIRO/DC)	40.00
09555-00	Visit with cast application to one area; (e.g., short arm, short leg, knee, or elbow)	25.00

Conjunctive Therapy/Modality - Office, Home, or Nursing Home

09560-00	Application of hot pack (CHIRO/DC)	$ 10.00
09561-00	Application of cold pack (CHIRO/DC)	~~10.00~~ 11.00
09562-00	Diathermy (CHIRO/DC)	~~20.00~~ 12.00
09563-00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic (CHIRO/DC)	12.00
09564-00	Intersegmental motorized mobilization (CHIRO/DC)	~~14.00~~ 12.00
09565-00	Muscle stimulation, manual (CHIRO/DC)	12.00
09566-00	Ultrasound therapy (CHIRO/DC)	~~12.00~~ 11.00
09567-00	Traction (CHIRO/DC)	~~13.00~~ 12.00
09568-00	Acupressure, manual or mechanical (CHIRO/DC)	~~10.00~~ 12.00
09569-00	Acupuncture (CHIRO/DC)	15.00
09570-00	Whirlpool	10.00
09572-00	Infrared - heat lamp (CHIRO/DC)	~~9.00~~ 7.00
09573-00	Ultraviolet (CHIRO/DC)	~~11.67~~ 10.00
09574-00	Trigger point therapy (CHIRO/DC)	~~12.00~~ 13.00
09591-00	Nutritional supplement	15.00
09592-00	Exercise consultation or instruction	25.00
09593-00	Diet consultation/instruction (CHIRO/DC)	25.00

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

Chest

Code	Service	Maximum Fee
71010CHR	Radiologic examination, chest; (single view, posteroanterior) (CHIRO/DC)	$ 30.00

Spine and Pelvis

72010CHR	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral) (CHIRO/DC)	$ 60.00
72020CHR	Radiologic examination, spine;	

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		single view, (specify level) (CHIRO/DC)	~~40.00~~	38.00
	72040CHR	Radiologic examination, spine, cervical; limited (CHIRO/DC)	~~42.00~~	44.00
	~~72050~~	~~--comprehensive-(minimum-four-views)~~		~~80.00~~
	72070CHR	Radiologic examination, spine; thoracic (CHIRO/DC)	~~50.00~~	55.00
	72080CHR	thoracic, limited (anteroposterior and lateral) (CHIRO/DC)	~~47.50~~	52.00
	72090CHR	scoliosis study, comprehensive (CHIRO/DC)	~~40.00~~	52.00
	72100CHR	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral) (CHIRO/DC)	~~51.00~~	55.00
	~~72114~~	~~Radiologic-examination,-spine,-lumbosacral,-complete,-including bending-views~~		~~170.00~~
	72170CHR	Radiologic examination, pelvis; limited (minimum two views) (CHIRO/DC)	~~42.00~~	44.00
	~~72180~~	~~Radiologic-examination,-pelvis,-stereo~~		~~35.00~~
	72190CHR	complete; (minimum of three views (CHIRO/DC)		90.00
		Upper Extremities		
	73020CHR	Radiologic examination, shoulder; limited (one projection) (CHIRO/DC)		$ 30.00
	73030-00	complete, minimum of two views	~~47.00~~	54.00
	73070CHR	Radiologic examination, elbow; limited (anteroposterior and lateral) (CHIRO/DC)	~~40.00~~	35.00
	73100CHR	Radiologic examination, wrist; limited (anteroposterior and lateral) (CHIRO/DC)		35.00
	73110-00	complete, minimum of three views		50.00
	73120CHR	Radiologic examination, hand (CHIRO/DC)		36.00
	~~73140~~	~~Radiologic-examination,-finger-or-fingers,-minimum-of-two-views~~		~~30.00~~
		Lower Extremities		
	73500CHR	Radiologic examination, hip; limited (one view) (CHIRO/DC)	$ ~~30.00~~	35.00
	73510CHR	Radiologic examination, hip; complete, minimum of two views (CHIRO/DC)		53.00
	73560-00	Radiologic examination, knee; anteroposterior and lateral views		40.00
	73562CHR	anteroposterior and lateral, with oblique(s), minimum of three views (CHIRO/DC)		55.00
	73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views		70.00
	73600CHR	Radiologic examination, ankle; limited (two views) (CHIRO/DC)		35.00
	73610CHR	Radiologic examination, ankle; comprehensive (minimum of three views (CHIRO/DC)		50.00
	73620-00	Radiologic examination; foot; anteroposterior and lateral views		32.00
		Miscellaneous		
	76140-00	Consultation on x-ray examination made elsewhere, written report		25.00

Subp. 4. **Laboratory.** The following codes, service descriptions, and maximum fees apply to laboratory procedures.

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Automated, standard chemistry profiles include the following tests.

Code	Service	Maximum Fee
~~80016~~	~~Automated multichannel test; 13-16 clinical chemistry tests~~	~~$ 115.00~~
	Automated Multichannel Test	
80019CHR	Automated multichannel tests; 19 or more clinical chemistry tests (indicate instrument use and number of tests performed) (CHIRO/DC)	$ 60.00
	Urinalysis	
81000-00	Urinalysis; routine (pH, specific gravity, protein tests for reducing substances such as glucose), with microscopy	12.00
81002-00	routine, without microscopy	12.00
81015CHR	Urinalysis; microscopic only (CHIRO/DC)	12.00
	Hematology	
85022CHR	Blood count; hemogram, automated, and differential WBC count (CBC)	29.00
85031CHR	hemogram, manual, complete CBC (RBC, WBC, Hgb, HcT, differential and indices) (CHIRO/DC)	15.00
85548-00	Morphology of red blood cells, only	42.00
~~87164~~	~~Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection~~	~~35.00~~

5221.3000 PODIATRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. **Ancillary services.** Services performed by podiatric assistants must be by order of and under the direct on-site supervision of a licensed doctor of podiatric medicine.

Subp. ~~2.~~ 3. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Surgery

Code	Service	Maximum Fee
02229-00	.....	200.00
10060-00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	50.00
10100*00	Incision and drainage of onychia or paronychia; single or simple (POD/DP$ ~~40.00~~	55.00
10101*00	multiple or complicated	75.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	20.00
11040-00	Debridement; skin, partial thickness	50.00

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11050*00	Paring or curettement of benign lesion with or without chemical cauterization; single lesion (POD/DPM)	~~23.00~~	25.00
11051*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions		21.00
11052-00	more than four lesions (POD/DPM)	~~25.45~~	28.85
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), hands, feet; lesion diameter up to 0.5 centimeter (POD/DPM)		85.00
11421-00	lesion diameter 0.6 - 1.0 centimeters		99.00
11422-00	lesion diameter 1.1 - 2.0 centimeters		125.00
	Nails		
11700*00	Debridement of nails, manual; five or less (POD/DPM)	$ ~~10.00~~	20.00
11701-00	each additional, five or less (POD/DPM)	~~10.00~~	15.00
11710*00	Debridement of nails, electric grinder; five or less (POD/DPM)	~~15.00~~	26.00
11711-00	each additional, five or less (POD/DPM)		9.00
11730*00	Avulsion of nail plate, partial or complete simple; single		68.00
11750-00	Excision of nail and nail matrix, partial or complete, for permanent removal (POD/DPM)	~~175.00~~	200.00
11900*00	Injection, intralesional; up to and including seven lesions		35.00
	Other procedures		
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion (POD/DPM)	~~35.00~~	28.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions (POD/DPM)	~~24.00~~	30.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)		22.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst		42.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)		50.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)		45.00
28080-00	Excision of Morton neuroma, single, each		465.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe		325.00
28126-00	Concylectomy, phalangeal base, single toe, each		350.00
28153-00	Resection, head of phalanx, toe		375.00
28285	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)		400.00
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostechtomy Silver type procedure)		593.00
28292-00	Keller, McBride, or Mayo type procedure		930.00
28308-00	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal		614.00
29405-00	Application of short leg cast (below knee to toes) (POD/DPM)		100.00

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29425-00	Application of short leg case (below knee to toes); walking or ambulatory type			125.00
29540-00	Strapping; ankle (POD/DPM)	~~15.00~~		22.00
29550-00	toes (POD/DPM)	~~18.00~~		23.00
29580-00	Unna boot (POD/DPM)	~~22.00~~		35.00
29590-00	Dennis Browne splint strapping			25.00
36415*00	Routine venipuncture for collection of specimens			10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch (POD/DPM)			30.00
	Radiology			
73600-00	Radiologic examination, ankle; anteroposterior and lateral views (POD/DPM)	~~36.96~~		40.00
73610-00	complete, minimum of three views			45.00
73620-00	Radiologic examination, foot; anteroposterior and lateral views (POD/DPM)			35.00
73630-00	complete, minimum of three views (POD/DPM)	~~50.00~~		51.00
73650-00	Radiologic examination; calcaneus, minimum of two views			30.00
73660-00	toe or toes, minimum of two views (POD/DPM)	~~30.00~~		30.00
80012-00	Automated multichannel test; 12 clinical chemistry tests			40.00
81000-00	Urinalysis; routine (pH, specify gravity, protein, tests for reducing substances such as glucose), with microscopy			11.00
81002-00	routine, without microscopy			13.00
82947-00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid) (POD/DPM)			13.00
82948-00	blood stick test			12.00
85000-00	Bleeding time; Duke			6.00
85014-00	Blood count; hematocrit			9.00
85018-00	Blood count; hemoglobin, colorimetric (POD/DPM)	~~6.50~~		8.00
85022-00	hemogram, automated, and manual differential WBC count			40.00
85345-00	Coagulation time; Lee and White			7.50
87075-00	Culture, bacterial, any source; anaerobic (isolation)			14.00
87101-00	Culture, fungi, isolation; skin			18.00
88302-00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes			35.00
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen			40.00
	Patient Visits			
90000POD	New patient; brief service (POD/DPM)			27.00
90010POD	~~New patient;~~ limited service (POD/DPM)			35.00
90015POD	~~New patient;~~ intermediate service (POD/DPM)			38.00
90017POD	extended service (POD/DPM)			45.00
90020POD	~~New patient;~~ comprehensive service (POD/DPM)			35.00
90030POD	Established patient; minimal service (POD/DPM)	~~16.00~~		17.00
90040POD	~~Established patient;~~ brief service (POD/DPM)			22.00
90050POD	~~Established patient;~~ limited service (POD/DPM)	~~24.00~~		25.00

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90060POD	~~Established patient;~~ intermediate service (POD/DPM)	~~28.00~~	29.00
90070POD	~~Established patient;~~ extended service (POD/DPM)	~~36.00~~	27.00
90080POD	comprehensive service (POD/DPM)		40.00
	Hospital Medical Services		
90115-00	Home medical service, new patient; intermediate service		25.00
90140POD	Home medical service, established patient; brief service (POD/DPM)		15.00
90200POD	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)	$ 65.00	70.00
90215POD	Intermediate ~~examination~~ history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records (POD/DPM)		40.00
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records		17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records		35.00
90350-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; limited service		15.00
90360-00	intermediate service		25.00
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service		16.00
90410-00	limited service		15.00
90440-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient, brief service		13.00
90450-00	limited service		12.00
90600-00	Initial consultation; limited		55.00
90610-00	extensive		35.00
	Therapeutic Injections		
90782POD	Therapeutic injection of medication (specify); subcutaneous or intramuscular		$ 30.00
	(POD/DPM)	$ ~~30.00~~	20.00
90784-00	intravenous		20.00
90788POD	Intramuscular injection of antibiotic (specify) (POD/DPM)		15.00
	Physical Medicine		
95851POD	Range of motion measurements and report (separate procedure); each extremity (POD/DPM)	$ ~~37.50~~	40.00
97022POD	whirlpool (POD/DPM)	~~17.44~~	20.00
97128POD	ultrasound (POD/DPM)	~~14.00~~	16.00
~~L1940~~	~~Ankle-foot-arthoses, molded to patient model, plastic~~		~~79.00~~
~~L3000~~	~~Foot, insert, removable, molded to patient model (UCB) type Berkeley Shell, each~~		~~82.50~~
L3010POD	Foot, insert, removable, molded to patient model, longitudinal arch		

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	support, each (POD/DPM)	~~105.00~~	.....
	Other Procedures		
X1229POD	Radical excision of nail (POD/DPM)	$ ~~200.00~~	.....
97700-00	Office visit, including one of the following tests or measurements, with report: a. Orthotic "check-out" b. Prosthetic "check-out" c. Activities of daily living "check-out"; initial 30 minutes, each visit		25.00
99000-00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		10.00
99025-00	Initial (new patient) visit when asterisked (*) surgical procedure constitutes major service at that visit		20.00

5221.3100 PSYCHOLOGISTS AND RULE 29 FACILITIES.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to licensed psychologists and ~~social workers with the master of social work degree or a comparable degree~~ Rule 29 facilities (mental health centers and clinics).

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

Code	Service	Maximum Fee
09046-00	Initial office visit with evaluation and history, one hour (PSYCH)	$ 80.00
09048-00	Initial inpatient hospital visit, including history and evaluation, per hour (POD/DPM)	90.00
09050-00	Initial consultation, one hour (POD/DPM)	85.00
09064-00	Biofeedback, per hour (PSYCH)	~~75.00~~ 80.00
09065-00	Biofeedback, per half hour (PSYCH)	~~45.00~~ 47.00
09066-00	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed ~~consulting~~ psychologist, one hour (PSYCH)	~~75.00~~ 80.00
09067-00	Psychotherapy, group (maximum ten persons per group), 1-1/2 hours per person (PSYCH)	40.00
09068-00	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour (PSYCH)	45.00
09070-00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge) (PSYCH)	~~70.00~~ 75.00

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

Subpart 1. **Scope.** The codes, service descriptions, and

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maximum fees of this part apply to licensed consulting psychologists (LCP).

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

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

5221.3160 SOCIAL WORKERS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to social workers with a master of social work (MSW) degree or a comparable degree.

Subp. 2. **Social worker services.** The following codes, service descriptions, and maximum fees apply to social worker services performed by persons meeting the requirements of the board of social work.

Code	Service	Maximum Fee
06043-00	Independent behavior and/or other analysts, counselors, and other therapists (MSW)	$ 45.00
06046-00	Independent social worker services (MSW)	70.00

5221.3170 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees

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apply to biofeedback procedures, and to a provider certified by the Biofeedback Certification Institute of America (BCIA). Anyone doing biofeedback without certification should be under the supervision of a doctor of medicine (M.D.) or a licensed consulting psychologist (LCP).

Code	Service	Maximum Fee
90900-00	Biofeedback training; by electromyogram application (e.g., in tension headache muscle spasm) (BCIA/LCP)	$ 70.00
90906-00	regulation of skin temperature of peripheral blood flow (BCIA/LCP)	45.00

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. [Unchanged.]

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

A. to P. [Unchanged.]

Q. ~~Mounds Park Hospital, Saint Paul~~

~~R.~~ Mount Sinai Hospital, Minneapolis

~~S.~~ R. North Memorial Medical Center, Robbinsdale

~~T.~~ S. Saint Cloud Hospital, Saint Cloud

~~U. Saint John's Hospital, Saint Paul~~

~~V.~~ T. St. John's Hospital Northeast, Saint Paul

~~W.~~ U. Saint Joseph's Hospital, Saint Paul

~~X.~~ V. Saint Luke's Hospital, Duluth

~~Y.~~ W. Saint Mary's Hospital, Duluth

~~Z.~~ X. Saint Mary's Hospital, Minneapolis

~~AA.~~ Y. The Samaritan Hospital, Saint Paul

~~BB.~~ Z. United Hospital, Saint Paul

~~CC.~~ AA. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ ~~276.45~~ 293.10

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

A. to JJJJJJ. [Unchanged.]

Service	Maximum Fee
Group 2 semiprivate room charge for one day	$ ~~202.57~~ 216.00

Subp. 4. **Group 3.** The following hospitals make up group 3:

A. Hennepin County Medical Center, Minneapolis

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B. Saint Paul Ramsey Medical Center, Saint Paul

C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	$ ~~332.56~~ 400.18

Subp. 5. **Group 4.** The following hospitals make up group 4:

A. Rochester Methodist Hospital, Rochester

B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	$ ~~172.80~~ 180.80

5221.3310 EFFECTIVE DATE.

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

REPEALER. Minnesota Rules, parts 5221.0900 and 5221.1400, are repealed.

RENUMBER. Minnesota Rules, part 5221.1000, subpart 7, is renumbered as part 5221.0700, subpart 3, item C, subitems (1) to (20).

Approved by Revisor _____

Minnesota
Department of Labor and Industry

Labor and Industry Building
443 Lafayette Road
St. Paul, Minnesota 55101
(612) 296-6107

Telecommunication Device
for the Deaf (612) 297-4198

March 20, 1989

ATTORNEY GENERAL'S OFFICE
515 TRANSPORTATION BLDG
ST PAUL, MN 55155

MAR 21 89

RECEIVED

The Office of the Attorney General
Public Finance Division
515 Transportation Building
John Ireland Boulevard
St. Paul, Minnesota 55155

RE: In the Matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

Dear Sir or Madam:

Enclosed please find the following rulemaking documents in the above-captioned matter for your review and submission for final approval:

1. The Notice of Solicitation of Outside Information or Opinion as published in the State Register on July 25, 1988 and a copy of the original Notice of Solicitation of Information or Opinion.

2. A copy of the rule as proposed (Revisor's draft dated December 16, 1988).

3. The Notice of Intent to Adopt Amendments to Rules Without a Public Hearing as mailed.

4. The Statement of Need and Reasonableness.

5. The Affidavit of Mailing the Notice of Intent to Adopt a Rule Without a Public Hearing and Certificate of Mailing List.

6. A copy of the Notice of Intent to adopt Rules Without a Public Hearing as published in the State Register on December 27, 1988.

7. Four copies of the Rules as Adopted (Revisor's draft dated February 27, 1989).

8. The Findings of Fact, Conclusions, and Order Adopting Rule without Public Hearing.

9. The written requests for hearing and public comments

10. The Declaration of Counsel.

RECEIVED
MAR 20 89
ATTORNEY GENERAL'S OFFICE
515 TRANSPORTATION BLDG
ST. PAUL, MN 55155

2 folders = 1 Rule

If you need anything else, please do not hesitate to contact me at 297-3313.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/kh

Enclosures

cc: Gloria Gebhard

Minnesota
Department of Labor and Industry

Labor and Industry Building
443 Lafayette Road
St. Paul, Minnesota 55101
(612) 296-6107
TDD (612) 297-4198

6r2193
7-3313

April 3, 1989

The Office of the Attorney General
Public Finance Division
515 Transportation Building
John Ireland Boulevard
St. Paul, Minnesota 55155

RE: In the Matter of the Proposed Adoption of Amendments to Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

Dear Sir or Madam:

It has been determined that an additional modification is necessary to Part 5221.2800, subpart 4 of the above rules, which were submitted for your review on March 20, 1989. Therefore, enclosed please find the following documents:

1. An Order for withdrawal and resubmission of rules for review by the Attorney General

2. Four copies of the Rules as adopted, Revisor's draft dated March 29, 1989 to be substituted for the Revisor's draft dated February 27, 1989

3. Supplemental Findings of Fact and Order

Our goal is a publication date of April 24, 1989 so that the rules can become effective on May 1, 1989, for ease in application. If this date does not appear realistic or if you have any questions please call me at 297-3313.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/kh

Enclosures

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

ORDER FOR WITHDRAWAL AND RESUBMISSION OF RULES FOR REVIEW BY THE ATTORNEY GENERAL

IT IS ORDERED this 31st day of March, 1989 that the above rules as adopted, revisor's draft dated February 27, 1989, be withdrawn from review by the Attorney General.

IT IS FURTHER ORDERED that the rules as adopted, revisor's draft dated March 29, 1989 be submitted for review by the Attorney General with Supplemental Findings of Fact and Order dated March 31, 1989.

Ken Peterson
Commissioner

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

SUPPLEMENTAL FINDINGS OF FACT AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

Based on the comments and evidence in the record before the agency, the following additional nonsubstantial modification is added to Finding #15 of the Findings of Fact, Conclusions and Order dated March 13, 1989.

Part 5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS
Subpart 4. ~~Scope~~ Physical Therapy and occupational therapy services.

The following codes, service descriptions and maximum fees apply to physical and occupational therapy procedures when performed within the physical or occupational therapist's scope of practice in an independent clinic~~,~~ or a doctor's office~~, a hospital satellite clinic, or hospital outpatient setting~~.

Modification of the heading of subpart 4 and the new language regarding scope of practice are nonsubstantial changes identified and discussed in the March 13, 1989 Finding #15.

This supplemental Finding concerns the deleted language. Language is deleted which included physical therapy or occupational therapy services provided in hospital satellite or outpatient clinics. It has recently been determined that the data base from Blue Cross/Blue Shield consists of significantly fewer hospital billings for these services than previously understood. Due to this limited data, the inclusion of hospital physical and occupational therapy services in the fee schedule is omitted pending further analysis and review. This is not a substantial change because the modification does not affect a new class of persons or introduces a new subject matter. Further, this modification addresses the primary area of concern expressed by the 24 persons who requested a hearing.

NOW, THEREFORE, IT IS ORDERED that the rule identified as part 5221.0100-5221.3310 as modified is adopted this 31st day of March, 1989 pursuant to authority vested in me by Minnesota Statutes, sections 176.136 (1988) and 176.83 (1988).

Ken Peterson
Commissioner