CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

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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 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 provider charges.

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

Subp. 6. **Compensable or compensability.** "Compensable" or "compensability," in reference to a service, means an employer is liable for the service pursuant to Minnesota Statutes, chapter 176.

Subp. 7. **Excessive.** "Excessive," in reference to a charge, means a charge which meets any of the standards of excessiveness described in part 5221.0500.

Subp. 8. **Injury.** "Injury" is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 9. **Maximum fee schedule.** "Maximum fee schedule" means the list of codes, service descriptions, and corresponding 75th percentile dollar amounts established pursuant to part 5221.0900.

Subp. 10. **Payer.** "Payer" refers to all entities responsible for payment and administration of workers' compensation medical claims, including all insurer, self-insurer, and group self-insurer members of the workers' compensation reinsurance association, pursuant to Minnesota Statutes, section 79.34, subdivision 1, service companies licensed to provide claim administration services to self-insurers and group self-insurers pursuant to Minnesota Statutes, section 60A.23, subdivision 8, the reopened case fund, established by Minnesota Statutes,

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section 176.134, the special compensation fund established by Minnesota Statutes, section 176.129, and the assigned risk plan, established by Minnesota Statutes, sections 79.251 and 79.252.

Subp. 11. **Provider.** "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 12. **Reasonable.** "Reasonable," in reference to a charge, means a charge or portion of a charge which is not excessive.

Subp. 13. **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 relieving an injured worker from the effects of an injury or occupational disease, pursuant to Minnesota Statutes, section 176.135, subdivision 1.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0200 AUTHORITY.

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

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0300 PURPOSE.

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

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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 injuries or diseases pursuant to Minnesota Statutes, section 176.135, subdivision 1.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0500 EXCESSIVENESS.

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 in the maximum fee schedule of this chapter;

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

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

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

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

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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.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0600 PAYER RESPONSIBILITIES.

Subpart 1. **Compensability.** This chapter does not require a payer to pay a charge which is not compensable or a charge which is the primary obligation of another payer.

Subp. 2. **Payment of charges.** 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.

Subp. 3. **Determination of excessiveness.** 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.

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.

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C. If a service is not included in the maximum fee schedule, the payer shall pay the reasonable value of that service as defined in Minnesota Statutes, section 176.135, subdivision 3, if not otherwise excessive.

Subp. 4. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the standards prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment within one year of the payment.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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 services provided and all injuries or conditions treated, the date upon which each service was provided, and the providers' social security 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.

Subp. 3. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply promptly with payers' reasonable requests for 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.

Subp. 4. **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.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0800 APPEALS PROCEDURE.

Pursuant to Minnesota Statutes, sections 176.103 and 176.271 and related statutes and rules, providers may request that the commissioner determine whether a charge is excessive. This determination may be appealed first to the medical services review board, and then to the workers' compensation court of appeals.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.0900 MAXIMUM FEE SCHEDULE.

Subpart 1. **Contents.** This chapter is the maximum fee schedule. The maximum fee schedule shall contain codes and descriptions of services compensable under Minnesota Statutes, section 176.135 and dollar amounts which fairly represent the 75th percentile of usual and customary charges for those services in Minnesota during the preceding calendar year.

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

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.1000 MAXIMUM FEE SCHEDULE FOR REIMBURSEMENT OF WORKERS' COMPENSATION MEDICAL SERVICES.

Subpart 1. **Maximum fee schedule instructions.** The instructions in this part and this chapter govern the use and application of fees in this chapter.

Subp. 2. **Applicability of the fee schedule.** The payer shall undertake reasonable investigations to ascertain whether a service is subject to the maximum fee schedule. A service is subject to the maximum fee schedule if it conforms to a description contained in the maximum fee schedule in the section for the appropriate kind of medical provider. The standards of excessiveness contained in part 5221.0500 apply whether or not a service is subject to the maximum fee schedule.

Subp. 3. **Coding.** For services which are or which may be subject to the maximum fee schedule, the payer shall undertake reasonable investigations to ascertain whether or not the code assigned to a service by the provider is correct. If no code has been assigned the payer shall determine the appropriate code, and shall evaluate the service on the basis of that code. A broad, inclusive service description may be divided into its component services, charges, and codes, if the inclusive service is not subject to the maximum fee schedule but some of the component services are.

Subp. 4. **Ambiguity.** If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service is subject to the maximum fee schedule or what the correct code for a particular service is, the payer shall decide the issue in favor of the provider or refer the issue to the commissioner for determination. 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.

Subp. 5. **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.

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

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

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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 fee schedule.

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

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.

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

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

L. 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.

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M. 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. 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. 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. 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. 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. 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 fee schedule.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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.

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 need to be established.

B. Established patient. "Established patient" means a patient whose medical and administrative records 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. 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. Minimal service. "Minimal service" means a level of service supervised by the physician but not necessarily requiring the physician's presence, including but not limited to services similar to the following in level:

(1) routine immunization for tetanus;

(2) removal of sutures from laceration; or

(3) blood pressure determination for adequacy of control.

E. Brief service. "Brief service" means a level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history

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and examination, including but not limited to services similar to the following in level:

(1) examination of a patient with subconjunctival hemorrhage;

(2) examination of minor trauma;

(3) review of recent x-ray report and abbreviated discussion with patient under study;

(4) concurrent hospital care for a minor secondary diagnosis;

(5) examination for acute tonsillitis; or

(6) abbreviated evaluation of a hospitalized patient in stage of recovery from an uncomplicated renal colic.

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

(1) treatment of acute respiratory infection;

(2) review of interval history, physical status, and control of a diabetic patient;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 3. **Office services.** The following codes, service descriptions and maximum fees apply to services provided at the physician's office.

Code	Service	Maximum Fee
90000	New patient - brief service	$ 25.00
90010	New patient - limited service	34.00
90015	New patient - intermediate service	50.00
90017	New patient - extended service	78.00
90020	New patient - comprehensive service	129.00
90030	Established patient - minimal service	15.00
90040	Established patient - brief service	19.00
90050	Established patient - limited service	21.00
90060	Established patient - intermediate service	28.00
90070	Established patient - extended service	42.00
90080	Established patient - comprehensive service	67.00

Subp. 4. **Hospital services.** The following codes, service descriptions and maximum fees apply to services provided at a hospital. Initial hospital care shall be categorized under codes 90200 to 90220. Subsequent hospital care shall be categorized under codes 90240 to 90280.

Code	Service	Maximum Fee
90200	Brief initial hospital care	53.00
90215	Intermediate initial hospital care	72.00
90220	Comprehensive initial hospital care	102.00
90240	Subsequent hospital care - brief service	23.50
90250	Subsequent hospital care - limited service	30.00
90270	Subsequent hospital care - extended service	60.00
90280	Subsequent hospital care - comprehensive service	88.00

Subp. 5. **Emergency department services.** The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department.

Code	Service	Maximum Fee
90500	New patient - minimal service	26.00
90505	New patient - brief service	30.00
90510	New patient - limited service	38.00
90515	New patient - intermediate service	45.00
90517	New patient - extended service	65.00
90530	Established patient - minimal service	20.10
90540	Established patient - brief service	30.00
90550	Established patient - limited service	33.00
90560	Established patient - intermediate service	37.00

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90570	Established patient - extended service	55.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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. 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 be a consultation. A referral does not constitute a consultation if the effect of the referral is to transfer the total or specific care of the patient from one physician to another.

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

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

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

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

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

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psychotic adult unresponsive to extensive treatment efforts under consideration for residential care.

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

Code	Service	Maximum Fee
90605	Intermediate consultation	64.00
90610	Extensive consultation	77.00
90620	Comprehensive consultation	115.00
90630	Complex consultation	132.50

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.1300 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.

Code	Service	Maximum Fee
	General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures	
90801	Psychiatric diagnostic interview examination including history, mental status, or disposition	$100.00
90843	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	50.00
90844	approximately 45 or 50 minutes	85.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.1400 BIOFEEDBACK.

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

Code	Service	Maximum Fee
90900	Biofeedback training; by electromyogram application, as with tension headache or muscle spasm	$ 70.00
90906	Regulation of skin temperature or peripheral blood flow	70.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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.

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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 5221.1100.

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

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

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

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

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

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92014, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92250, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

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General Services

Code	Service	Maximum Fee
92002	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program--new patient	$ 43.00
92004	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program--new patient, one or more visits	46.00
92014	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program--established patient, one or more visits	46.00
	Special Services	
92065	Orthoptic or pleoptic training, with continuing medical direction and evaluation	$ 20.00
92082	Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent	45.00
92100	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	20.00
92140	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00
	Opthalmoscopy	
92225	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial	$ 24.00
92235	Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation	112.00
92250	with fundus photography	28.00
	Other Specialized Services	
92265	Oculoelectromyography, one more extraocular muscles, one or both eyes, with medical diagnostic evaluation	$ 66.00
92280	Visually evoked potential or response study, with medical diagnostic evaluation	125.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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

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otoscopy, rhinoscopy, or tuning fork test, should not be itemized separately. All of the following services include medical diagnostic evaluation. Technical procedures, which may or may not be performed by the physician personally, are often part of the service, but do not constitute the service itself.

Code	Service	Maximum Fee
92506	Medical evaluation of speech, language, or hearing problems	$ 51.00
92508	Speech, language, or hearing therapy, with continuing medical supervision group	23.75
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	47.00
92544	Optokinetic nystagmus test, biodirectional, foveal, or peripheral stimulation, with recording	33.00
92545	Oscillating tracking test, with recording	27.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.1700 AUDIOLOGIC TESTS.

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

Basic Audiometry

Code	Service	Maximum Fee
92551	Screening test, pure tone, air only	$ 12.00
92552	Pure tone audiometry (threshold); air only	17.00
92555	Speech audiometry; threshold only	12.00
92556	threshold and discrimination	30.00
92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	48.50
	Audiologic Tests	
92562	Loudness balance test, alternate binaural or monaural	$ 16.00
92563	Tone decay test	14.00
92564	Short increment sensitivity index	17.00
92566	Impedance testing	17.75
92567	Tympanometry	13.00
92568	Acoustic reflex testing	25.00
92569	Acoustic reflex decay test	14.00
92575	Sensorineural acuity level test	8.25
92581	Evoked response audiometry	150.00
92582	Conditioning play audiometry	24.00
92583	Select picture audiometry	24.00

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92591	Hearing aid examination and selection binaural	66.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.1800 CARDIOGRAPHY.

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
93000	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	$ 36.00
93005	tracing only, without interpretation and report	25.00
93010	interpretation and report only	16.50
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	145.00
93017	tracing only without interpretation and report	107.00
93018	interpretation and report only	90.00
93040	Rhythm ECG, one to three leads; with interpretation	20.00
93220	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	36.10
93270	Electrocardiographic monitoring utilizing a system such as magnetic tape for up through 12 hours; includes recording, scanning anlysis, interpretation, and report	155.00
93274	Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis,interpretation, and report	183.00
93277	physician review and interpretation, with report	85.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement or	

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	maximal voluntary ventilation	$ 28.00
94060	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	36.00
94150	Vital capacity, total (separate procedure)	15.00
94160	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	15.00
94200	Maximum breathing capacity, maximal voluntary ventilation	21.50
94375	Respiratory flow volume loop	22.00
94656	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	96.50
94640	Nonpressurized inhalation treatment for acute airway obstruction	19.00
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	17.10

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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	Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation; standard or portable, same facility	$ 112.00
95822	Electroencephalogram (EEG); sleep only	128.25
95823	physical or pharmacological activation only	112.00
95851	Range of motion measurements and report (separate procedure); each extremity, excluding hand	30.00
95860	Electromyography; one extremity and related paraspinal areas	145.00
95861	two extremities and related paraspinal areas	170.00
95863	three extremities and related paraspinal areas	133.30
95864	four extremities and related paraspinal areas	184.10
95900	Nerve conduction, velocity, or latency study; motor, each nerve	48.00
95904	sensory, each nerve	48.00

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95925	Somatosensory testing, for example, cerebral evoked potentials, one or more nerves	162.00
95935	"H" reflex, by electrodiagnostic testing	35.00
95950	Ambulatory 24-hour EEG monitoring	400.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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 physican, and constant attendance by the physician or therapist.

Special Dermatological Procedures

Code	Service	Maximum Fee
96900	Actinotherapy (ultraviolet light)	$ 7.00
96912	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment)	20.00
	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	15.00
97012	Physical medicine treatment to one area; traction mechanical	13.50
97050	Office visit with two or more modalities to same area	25.35
	Procedures	
97100	Office visit with one of the following procedures to one area: 1. Therapeutic exercises 2. Neuromuscular reeducation 3. Functional activities 4. Gait training 5. Electrical stimulation (manual) 6. Iontophoresis 7. Traction, manual 8. Massage 9. Contrast baths 10. Ultrasound; initial 30 minutes	18.00
97101	each additional 15 minutes	10.00
97200	Office visit, including combination of	

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	any modality and procedure; initial 30 minutes	31.00
97201	each additional 15 minutes	10.00
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area	21.00
97261	each additional area	5.00
	Tests and Measurements	
97740	Kinetic activities to increase coordination, strength, and/or range of motion, one area, any two extremities, initial 30 minutes	28.50

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.2200 CRITICAL CARE SERVICES.

Critical care services (codes 99160 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 of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99000	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$ 7.50
99075	Medical testimony	Reasonableness of charges reviewable by commissioner
99080	Special reports like insurance forms, or the review of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner	Reasonableness of charges reviewable by commissioner
	Surgical Procedures	
99025	Initial, new patient visit when asterisk (*) surgical procedure constitutes major service at that visit	$ 15.00

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	Prolonged Services	
99155	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physican); approximately 25 minutes	$ 40.00
99156	approximately 50 minutes	112.50
	Critical Care	
99160	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$100.00
99170	Gastric intubation, and aspiration or lavage for treatment (i.e., ingested poisons)	40.00
99172	Critical care, subsequent follow-up visit; limited examination, evaluation, or treatment for same or new illness	47.00
99173	intermediate examination, evaluation, or treatment, same or new illness	79.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.2250 PHYSICIAN SERVICES--SURGERY.

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

Subp. 2. **Instructions.** The instructions in items A to E 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 follow-up care, both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. For the purposes of this definition, preoperative care does not include any care administered before the provider determines that surgery is required.

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

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

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

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

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

(d) the asterisk procedure requires hospitalization, an appropriate hospital visit is listed in addition to the asterisk 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.

Subp. 3. **Integumentary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system. Excision of benign lesions (codes 11200 to 11442) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions. Treatment of burns (codes 16000 to 16020) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12013) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12031 to 12051) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13121 to 13132) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in items A to C also apply to coding of repair services (codes 12001 to 13132):

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 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.

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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.

Incision

Code	Service	Maximum Fee
10000*	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 42.50
10003*	Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity	50.00
10020*	Incision and drainage of furuncle	30.00
10060*	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	43.50
10080	Incision and drainage of piloridial cyst; simple	45.50
10100*	Incision and drainage of onychia or paronychia single or simple	42.00
10120*	Incision and removal of foreign body, subcutaneous tissues; simple	44.00
10140	Incision and drainage of hematoma; simple	43.50
10160*	Puncture aspiration of abscess, hematoma, bulla, or cyst	35.00

Excision-Debridement

Code	Service	Maximum Fee
11000	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	30.00

Paring or Curettement

Code	Service	Maximum Fee
11050*	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 24.50
11051	two to four lesions	30.80
11052	more than four lesions	50.00

Biopsy

Code	Service	Maximum Fee
11100	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 52.50

Excision--Benign Lesions

Code	Service	Maximum Fee
11200*	Excision, skin tags, multiple fibrocutaneous tags, any area; up to	

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Code	Description	Fee
	15 lesions	$ 47.00
11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	56.50
11401	lesion diameter 0.5 to 1.0 centimeter	66.00
11402	lesion diameter 1.0 to 2.0 centimeters	78.00
11403	lesion diameter 2.0 to 3.0 centimeters	96.00
11404	lesion diameter 3.0 to 4.0 centimeters	120.00
11420	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	65.00
11421	lesion diameter 0.5 to 1.0 centimeter	75.00
11422	lesion diameter 1.0 to 2.0 centimeters	99.00
11423	lesion diameter 2.0 to 3.0 centimeters	71.00
11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	70.00
11441	lesion diameter 0.5 to 1.0 centimeter	90.00
11442	lesion diameter 1.0 to 2.0 centimeters	108.00
	Nails	
11700*	Debridement of nails, manual; five or less	$ 25.00
11730*	Avulsion of nail plate, partial or complete, simple; single	55.00
11740	Evacuation of subungual hematoma	29.00
11760	Reconstruction of nail bed; simple	68.50
	Repair--Simple	
12001*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	$ 45.00
12002*	2.5 to 7.5 centimeters	65.00
12004*	7.5 to 12.5 centimeters	90.00
12011*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	65.00
12013*	2.5 to 5.0 centimeters	84.00
12014	5.0 to 7.5 centimeters	82.00
	Repair--Intermediate	
12031*	Layer closure of wounds of scalp,	

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	axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 60.00
12034	7.5 to 12.5 centimeters	145.00
12041*	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	90.00
12042	2.5 to 7.5 centimeters	105.00
12051*	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	100.00
12052	2.5 to 5.0 centimeters	127.20
	Repair--Complex	
13150	Repair, complex, eyelids, nose, ears, or lips; up to 1.0 centimeter	$180.00
13151	1.0 to 2.5 centimeters	360.00
13152	2.5 to 7.5 centimeters	575.00
	Adjacent Tissue Transfer or Rearrangement	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters	552.00
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	720.00
	Free Skin Grafts	
15050*	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area except on face, up to defect size 2 centimeters diameter	$120.00
15100	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters, or each one percent of body area of infants and children (except 15050)	450.00
	Burns, Local Treatment	
16000	Initial treatment, first degree burn, when no more than local treatment is required	$ 44.00
16010	Dressings or debridement, initial or subsequent; under anesthesia, small	30.00
16020*	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small	30.00
16025*	without anesthesia, medium, for example, whole face or whole extremity	42.00
	Destruction	
17000*	Destruction by any method, with or without surgical curettement, all	

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Code	Service	Maximum Fee
	facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 35.00
17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	31.50
17200*	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	35.00
17250*	Chemical cauterization of a wound	25.05
17340*	Cryotherapy (CO_2 slush, liquid N_2)	22.00

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
20205	Biopsy, muscle; deep	$ 200.00
20220	Biopsy, bone, trocar, or needle; superficial for example ilium, sternum, spinous process, ribs	137.00
20225	Biopsy, bone, trocar, or needle; superficial, deep, (vertebral body, Femur)	375.00
	Introduction or Removal--General	
20501*	Injection of sinus tract; diagnostic (sinogram) (separate procedure)	$ 47.00
20550*	Injection, tendon sheath, ligament, or trigger points	37.00
20600*	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	40.00
20605*	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa	44.00
20610*	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa	45.00
20670*	Removal of implant; superficial, for example, buried wire, pin or rod (separate procedure)	70.00
20680	deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate	268.00
	Head--Fracture or Dislocation	
21315*	Manipulative treatment, nasal bone fracture; without stabilization	$ 95.00
21320	with stabilization	240.00

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

Code	Service	Maximum Fee
21800	Treatment of rib fracture; closed, uncomplicated, each	$ 55.00
	Spine (Vertebral Column)--Manipulation	
22500*	Manipulation of spine, any region	17.00
	Shoulders--Fracture or Dislocation	
23350	Injection procedure for shoulder Arthrography	58.30
23500	Treatment of closed clavicular fracture; without manipulation	79.00
23505	Treatment of closed clavicular fracture; with manipulation	175.00
23550	Open treatment of closed or open acromioclavicular dislocation, acute or chronic	785.00
23650	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	105.00
23655	requiring anesthesia	120.00
	Shoulder--Manipulation	
23700*	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	$125.00
	Humerus (Upper Arm) and Elbow--Fracture or Dislocation	
24505	Treatment of closed humeral shaft fracture; with manipulation	315.00
24650	Treatment of closed radial head or neck fracture without manipulation	100.00
	Forearm and Wrist--Incision and Excision	
25000	Tendon sheath incision; at radial styloid for DeQuervain's Disease	314.00
25111	Excision of ganglion, wrist (dorsal or volar); primary	322.00
	Forearm and Wrist--Fracture or Dislocation	
25505	Treatment of closed radial shaft fracture; with manipulation	264.00
25560	Treatment of closed radial and ulnar shaft fractures; without manipulation	163.00
25565	Treatment of closed radial and ulnar shaft fractures; with manipulation	350.00
25600	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	150.00
25605	with manipulation	265.00
25610	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletalfixation or percutaneous	

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	pinning	360.00
25611	with external skeletal fixation or percutaneous pinning	475.00

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

26055	Tendon sheath incision for trigger finger	$315.00
26160	Excision of lesion of tendon sheath or capsule	176.00
26418	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	250.00

Hands and Fingers--Fractures or Dislocations

26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 75.00
26605	with manipulation, each bone	162.00
26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone	420.00
26720	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	54.00
26725	with manipulation, each	116.00
26735	Open treatment of closed or open phalangeal shaft fracture, finger or thumb, with or without internal or external skeletal fixation, each	300.00
26750	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	45.00
26770	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	45.00

Hand and Fingers--Amputation

26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 209.50
27130	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple	2,700.00
27236	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	1,450.00
27244	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,325.00
27252	Treatment of closed hip dislocation, traumatic; with anesthesia	350.00

Femur (Thigh Region) and Knee Joint--Excision

27331	Arthrotomy, knee; with joint	

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	exploration, with or without biopsy, with or without removal of loose bodies	857.00
27332	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial or lateral	898.00
27345	Excision of synovial cyst of popliteal space (Baker's cyst)	505.00
	Femur (Thigh Region) and Knee Joint--Introduction or Removal	
27370	Injection procedure for knee arthrography	$ 53.50
27373	Arthroscopy, knee, diagnostic (separate procedure)	350.00
27374	Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium	1,220.00
27376	with synovial biopsy	650.00
27377	with removal of loose body	1,136.00
27378	with partial meniscectomy	1,270.00
27379	with plica resection or shelf resection	998.00
	Femur (Thigh Region) and Knee Joint-- Repair, Revision, or Reconstruction	
27422	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	900.00
27444	Arthroplasty, knee, total; fascial	2,810.00
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement)	2,582.00
	Femur (Thigh Region) and Knee Joint--Manipulation Fractures and Dislocations	
27506	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,350.00
27524	Open treatment of closed or open patellar fracture, with repair and/or excision	850.00
	Leg (Tibula and Fibula) and Ankle Joint-- Fractures or Dislocations	
27650	Suture, primary, ruptured achilles tendon	737.00
27752	Treatment of closed tibial shaft fracture; with manipulation	$316.00
27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	150.00
27792	Open treatment of closed or open distal fibular fracture (lateral malleolus) with fixation	600.00
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation	427.00

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27814	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	800.00
27822	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	953.00
27880	Amputation leg, through tibia and fibula	800.00
	Foot--Fracture or Dislocation	
28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot	$260.00
28285	Hammertoe operation; one toe (e.g. interphalangeal fusion, filleting, phalangectomy) (separate procedure)	310.00
28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure)	335.00
28292	Keller, McBride or Mayo type procedure	520.00
28296	with metatarsal osteotomy (Mitchell or Lapidus type procedure)	635.00
28470	Treatment of closed metatarsal fracture; without manipulation, each	100.00
28475	with manipulation, each	127.60
28490	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	47.00
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	39.00
28515	with manipulation, each	70.00
28820	Amputation, metatarsal, with toe, single	275.00

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
29035	Application of body cast, shoulder to hips	$159.00
29065	shoulder to hand (long arm)	70.00
29075	elbow to finger (short arm)	60.00
29085	hand and lower forearm (gauntlet)	60.00
	Splints	
29105	Application of long arm splint (shoulder to hand)	$ 39.00

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29125	Application of short arm splint (forearm to hand); static	33.00
29130	Application of finger splint; static	23.00
	Strapping--Any Age	
29200	Strapping; thorax	$ 20.00
29220	low back	20.00
29260	elbow or wrist	20.00
29345	Application of long leg cast (thigh to toes)	100.00
29355	walker or ambulatory type	105.00
29358	Application of long leg cast brace	$234.00
29365	Application of cylinder cast (thigh to ankle)	78.00
29405	Application of short leg cast (below knee to toes)	71.00
29425	walking or ambulatory type	79.00
29435	Application of patellar tendon bearing (PTB) cast	102.00
29440	Adding walker to previously applied cast	29.00
29450	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	44.00
29455	bilateral	87.50
	Splints	
29505	Application of long leg splint (thigh to ankle or toes)	$ 51.00
29515	Application of short leg splint (calf to foot)	40.00
	Strapping--Any Age	
29540	Strapping; ankle	23.00
29580	Unna boot	25.00
	Removal or Repair	
29700	Removal or bivalving; gauntlet, boot, or body cast	$ 21.00
29720	Repair of spica, body cast, or jacket	17.00

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

	Nose--Removal Foreign Body	
Code	Service	Maximum Fee
30300*	Removal foreign body, intranasal; office type procedure	$ 35.00
	Nose--Repair	
30420	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip, including major septal repair	$ 1,695.00
30520	Septoplasty with or without cartilage implant (separate procedure)	800.00

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Other Procedures

Code	Service	Maximum Fee
30901	Control nasal hemmorrhage, anterior, simple (cauterization); unilateral	$40.00
30903	Control nasal hemmorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral	55.00

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.

Vascular Injection Procedures--Venous

Code	Service	Maximum Fee
36410*	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	$ 40.50
36425	Venipuncture, cutdown, age 1 or over	18.00
36471	multiple veins, same leg	32.50
36480*	Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous	103.00

Vascular Injection Procedures--Arterial

Code	Service	Maximum Fee
36600	Arterial puncture, withdrawal of blood for diagnosis	$126.00
36620	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	110.00

Subp. 8. **Digestive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the digestive system.

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

Code	Service	Maximum Fee
49505	Repair inguinal hernia, age 5 or over; unilateral	$ 600.00
49506	bilateral	1,000.00
49515	with excision of hydrocele or spermatocele	709.50
49520	recurrent	710.00
49550	Repair Femoral hernial groin incision	495.00
49560	Repair ventral (incisional) hernia (separate procedure)	726.00
49581	Repair umbilical hernia; age 5 or over	495.00

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

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

Code	Service	Maximum Fee
62270*	Spinal puncture lumbar diagnostic	$ 74.00
62273*	Injection lumbar epidural, of blood or clot patch	164.00
62274*	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural simple	75.00
62278*	epidural or caudal single	125.00
62284*	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa	130.00
62289	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal	176.00
62292	Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar	1,530.00

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

Code	Service	Maximum Fee
63020	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, cervical, unilateral	$1,800.00
63030	one interspace, lumbar, unilateral	1,675.00
63042	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or re-exploration; lumbar	2,108.00

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

Code	Service	Maximum Fee
64510*	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	$126.00

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

Code	Service	Maximum Fee
64718	Neurolysis or transposition; ulnar nerve at elbow	$798.00
64721	median nerve at carpal tunnel	609.00

Eye and Ocular Adnexa--Removal of Ocular Foreign Body

Code	Service	Maximum Fee
65205*	Removal foreign body, external eye; conjunctival superficial	$ 33.00
65210*	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	42.00
65220*	corneal, without slit lamp	40.00
65222*	corneal, with slit lamp	54.00

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

External Ear--Removal Foreign Material

Code	Service	Maximum Fee
69200	Removal foreign body from external auditory canal; without general anesthesia	$ 23.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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. 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.

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

Head and Neck

Code	Service	Maximum Fee
70110	Radiologic examination, mandible; complete, minimum of four views	$ 60.00
70110-26	professional component only	19.20
70130	Radiologic examination, mastoids; complete, minimum of three views per side	70.00
70130-26	professional component only	21.25
70140	Radiologic examination, facial bones; less than three views	40.50
70140-26	professional component only	16.75
70150	complete, minimum of three views	56.50
70150-26	professional component only	20.50
70160	Radiologic examination, nasal bones, complete, minimum of three views	39.00
70160-26	professional component only	12.00
70200	Radiologic examination; orbits, complete, minimum of four views	53.00
70200-26	professional component only	19.20
70210	Radiologic examination, sinuses, paranasal, less than three views	32.00
70210-26	professional component only	13.00
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies	55.70
70220-26	professional component only	18.00
70250	Radiologic examination, skull; less than four views, with or without stereo	42.00
70250-26	professional component only	20.75
70260	complete, minimum of four views, with or without stereo	73.00
70260-26	professional component only	24.75

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70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	56.00
70330-26	professional component only	21.25
70355-26	Orthopantogram; professional component only	15.25
70360	Radiologic examination; neck, soft tissue	27.00
70360-26	professional component only	12.00
70450	Computerized axial tomography, head; without contrast material	268.00
70450-26	professional component only	70.00
70460	with contrast material	318.00
70460-26	professional component only	75.00
70470	without intravenous contrast material, followed by contrast material and further sections	353.00
70470-26	professional component only	95.00

Chest

71000	Radiologic examination, chest, minifilm	$ 25.25
71010	Radiologic examination, chest; single view, posteroanterior	30.00
71010-26	professional component only	11.00
71015	stereo, posteroanterior	29.20
71015-26	professional component only	29.20
71020	two views, posteroanterior and lateral	42.00
71020-26	professional component only	16.50
71021	apical lordotic procedure	38.30
71100	Radiologic examination, ribs, unilateral; two views	47.00
71100-26	professional component only	16.50
71101-26	including posteroanterior chest, minimum of three views, professional component only	20.20
71110	Radiologic examination, ribs, bilateral; three views	57.00
71250-26	Computerized axial tomography, thorax; without contrast material, professional component only	87.25

Spine and Pelvis

72010	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral	$116.10
72010-26	professional component only	25.00
72020	Radiologic examination, spine, single view, specify level	34.50
72020-26	professional component only	15.00
72040	Radiologic examination, spine, cervical; anteroposterior and lateral	45.00
72040-26	professional component only	17.00
72050	minimum of four views	64.20
72050-26	professional component only	21.50
72052	complete, including oblique and flexion or extension studies	78.00

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72052-26	professional component only	27.00
72070	Radiologic examination, spine; thoracic, anteroposterior and lateral	50.00
72070-26	professional component only	19.10
72080	thoracolumbar, anteroposterior and lateral	48.00
72080-26	professional component only	12.50
72090	scoliosis study, including supine and erect studies	42.00
72090-26	professional component only	35.00
72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	53.50
72100-26	professional component only	19.75
72110	complete, with oblique views	72.00
72110-26	professional component only	25.75
72114	complete, including bending views	87.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	52.00
72120-26	professional component only	17.25
72145	Computerized axial tomography, spine; with or without contrast material	380.00
72145-26	professional component only	100.00
72170	Radiologic examination, pelvis; anteroposterior only	35.00
72170-26	professional component only	13.60
72180	stereo	38.70
72180-26	professional component only	17.80
72190	complete, minimum of three views	48.50
72190-26	professional component only	21.50
72220	Radiologic examination, sacrum and coccyx, minimum of two views	41.00
72220-26	professional component only	14.75
72241-26	Myelography, cervical; complete procedure professional component only	204.25
72265-26	Myelography, lumbosacral; supervision and interpretation only, professional component only	59.75
72266-26	complete procedure, professional component only	192.50

Upper Extremities

73000	Radiologic examination; clavicle, complete	$ 30.00
73000-26	professional component only	10.50
73010	scapula, complete	35.00
73010-26	professional component only	13.00
73020	Radiologic examination, shoulder; one view	30.00
73020-26	professional component only	10.50
73030	complete, minimum of two views	41.30
73030-26	professional component only	13.00
73040-26	Radiologic examination, shoulder, arthrography; supervision and interpretation only, professional	

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	component only	12.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	40.00
73050-26	professional component only	14.25
73060	humerus, minimum of two views	35.00
73060-26	professional component only	12.00
73070	Radiologic examination, elbow; anteroposterior and lateral views	33.00
73070-26	professional component only	12.00
73080	complete, minimum of three views	36.00
73080-26	professional component only	14.25
73090	Radiologic examination; forearm, anteroposterior and lateral views	35.00
73090-26	professional component only	12.00
73100	Radiologic examination, wrist; anteroposterior and lateral views	30.50
73100-26	professional component only	12.00
73110	complete, minimum of three views	39.00
73110-26	professional component only	13.25
73120	Radiologic examination, hand; two views	32.00
73120-26	professional component only	12.00
73130	minimum of three views	36.00
73130-26	professional component only	13.00
73140	Radiologic examination, finger or fingers, minimum of two views	29.50
73140-26	professional component only	10.00

Lower Extremities

73500	Radiologic examination, hip; unilateral, one view	$ 31.30
73500-26	professional component only	12.00
73510	complete, minimum of two views	47.00
73510-26	professional component only	17.00
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	54.50
73520-26	professional component only	21.00
73550	Radiologic examination, femur, anteroposterior, and lateral views	39.00
73550-26	professional component only	12.00
73560	Radiologic examination, knee; anteroposterior and lateral views	35.00
73560-26	professional component only	12.00
73562	anteroposterior and lateral, with oblique, minimum of three views	44.50
73562-26	professional component only	13.00
73564	complete, including oblique, or tunnel, or patellar, or standing views	47.20
73564-26	professional component only	15.00
73580	Radiologic examination, knee, arthography; supervision and interpretation only	99.00
73581	complete procedure	182.00

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73581-26	professional component only	122.70
73590	Radiologic examination; tibia and fibula, anteroposterior and lateral views	36.50
73590-26	professional component only	12.00
73600	Radiologic examination, ankle; anteroposterior and lateral views	30.00
73600-26	professional component only	12.00
73610	complete, minimum of three views	38.00
73610-26	professional component only	13.50
73620	Radiologic examination, foot; anteroposterior and lateral views	32.00
73620-26	professional component only	12.00
73630	complete, minimum of three views	36.00
73630-26	professional component only	12.50
73650	Radiologic examination; calcaneus, minimum of two views	33.00
73650-26	professional component only	10.50
73660	toe or toes, minimum of two views	29.50
73660-26	professional component only	10.25

Abdomen

Code	Service	Maximum Fee
74000	Radiologic examination, abdomen; single anteroposterior view	$ 34.50
74000-26	professional component only	14.00
74010	anteroposterior and additional oblique and cone views	44.00
74010-26	professional component only	17.50
74020	complete, including decubitus or erect views	45.00
74020-26	professional component only	20.00
74150-26	Computerized axial tomography, abdomen; without contrast material, professional component only	90.00
74170	without contrast material followed by contrast material and further sections	403.00
74170-26	professional component only	115.50

Gastrointestinal Tract

74220	Radiologic examination; esophagus	$ 77.75
74220-26	professional component only	43.25
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	93.00
74240-26	professional component only	44.00
74241	with or without delayed films, with KUB	57.00
74241-26	professional component only	37.75
74245	with small bowel, includes multiple serial films	130.60
74245-26	professional component only	64.60
74250	Radiologic examination, small bowel, includes multiple serial films	117.70
74250-26	professional component only	38.50
74270	Radiologic examination, colon; barium	

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	enema	94.20
74270-26	professional component only	42.95
74280	air contrast with specific high density barium, with or without glucagon	125.00
74280-26	professional component only	66.80
74290	Cholecystography, oral contrast	64.00
74290-26	professional component only	22.00
74291	additional, repeat examination or, multiple day examination	38.50
74291-26	professional component only	13.75
74300-26	Cholangiography; during surgery, professional component only	28.40
74305-26	postoperative, professional component only	34.50

Urinary Tract

74400	Urography (pyelography), intravenous, including kidneys, ureters, and bladder	$109.00
74400-26	professional component only	43.00
74405	with special hypertensive contrast concentration or clearance studies	135.00
74405-26	professional component only	44.00
74410	Urography, infusion, drip technique	86.50
74410-26	professional component only	32.50
74415	with nephrotomography	124.60
74415-26	professional component only	47.25
74429-26	Urography, retrograde, with or without kidneys, ureters, and bladder, professional component only	16.50
74430-26	Cystography, minimum of three views; supervision and interpretation only, professional component only	17.75
74431	complete procedure	107.20
74431-26	professional component only	56.55
74450-26	Urethrocystography, retrograde; supervision and interpretation only, professional component only	15.50
74455	Urethrocystography, voiding; supervision and interpretation only	66.00
74455-26	professional component only	22.70
74456	complete procedure	117.10
74456-26	professional component only	50.50

Aorta and Arteries

75754-26	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only, professional component only	$161.50

Veins and Lymphatics

75821-26	Venography, extremity, unilateral; complete procedure professional component only	$108.25

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Miscellaneous

76000-26	Fluoroscopy (separate procedure), other than 71034 professional component only	$ 36.95
76020	Bone age studies	37.50
76020-26	professional component only	21.00
76040	Bone length studies (orthoroentgenogram, scanogram)	50.00
76040-26	professional component only	21.25
76090	Mammography; unilateral	60.00
76090-26	professional component only	30.00
76091	bilateral	93.90
76091-26	professional component only	39.50
76100	Radiologic examination, single plane body section (for example, tomography), other than kidney	100.00
76100-26	professional component only	54.00
76300	Thermography	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
76505-26	Echoencephalography, A-mode; complete (diencephalic midline and ventricular size), professional component only	$ 62.50
76506-26	Echoencephalography, B-mode (gray scale) complete (for determination of ventricular size, delineation of cerebral contents and detection of fluid, masses, or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated, professional component only	130.00
76516	Echography, opthalmic, ultrasonic biometry;	150.00
76535-26	Echography, thyroid; B-scan, professional component only	54.50

Chest

76620	Echocardiography, M-mode; complete	$206.80
76620-26	professional component only	60.00

Abdomen and Retroperitoneum

76700	Echography, abdominal, B-scan; complete	$135.00
76700-26	professional component only	65.00
76705	limited (for example, follow-up or limited study)	115.00
76705-26	professional component only	46.00

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76770	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; complete	148.00
76770-26	professional component only	57.25
	Pelvis	
76805	Echography, pelvic, B-scan (for example, real-time), in obstetrics, gynecology, or transplants; complete	$ 90.00
76805-26	professional component only	58.00
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	65.00
76815-26	professional component only	40.00
76855	Echography, pelvic area (Doppler)	117.20
76855-26	professional component only	60.50
76856	Echography, pelvic, real-time	72.00
76856-26	professional component only	57.25

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
77400-26	Daily megavoltage treatment management; simple professional component only	$ 18.50
77405	intermediate	85.00
77405-26	professional component only	54.00
77410	complex	29.50
77410-26	professional component only	45.00
77415-26	Therapeutic radiology treatment port film interpretation and verification, per treatment course, professional component only	36.00
77420	Weekly megavoltage treatment management; simple	20.00
77465	Daily kilovoltage treatment management	45.00

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

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Diagnostic--Endocrine System

Code	Service	Maximum Fee
78000	Thyroid uptake; single determination	$ 14.00
78000-26	professional component only	19.00
78006-26	Thyroid imaging, with uptake; single determination, professional component only	51.20
78010-26	Thyroid imaging; only, professional component only	42.05
	Diagnostic--Gastrointestinal System	
78201-26	Liver imaging only; professional component only	$ 65.00
78215-26	Liver and spleen imaging; professional component only	61.00
	Diagnostic--Musculoskeletal System	
78300-26	Bone imaging; limited area (for example, skull, pelvis), professional component only	70.00
78305-26	multiple areas, professional component only	70.00
78306	whole body	238.00
78306-26	professional component only	70.00
	Diagnostic--Cardiovascular System	
78403-26	Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion (for example, gated blood pool images), professional component only	75.50
	Diagnostic--Respiratory System	
78580-26	Pulmonary perfusion imaging; particulate, professional component only	$ 70.00
	Diagnostic--Nervous System	
78601-26	Brain imaging, limited procedure; with vascular flow professional component only	$ 56.00
	Diagnostic--Genitourinary System	
78704-26	Kidney imaging; with function study (imaging renogram), professional component only	$ 70.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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 80019 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

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Albumin
Albumin/globulin ratio
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Chloride
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
80003	Automated multichannel tests; 3 clinical chemistry tests	$ 30.00
80004	4 clinical chemistry tests	24.50
80005	5 clinical chemistry tests	31.00
80006	6 clinical chemistry tests	28.00
80007	7 clinical chemistry tests	24.00
80008	8 clinical chemistry tests	30.00
80009	9 clinical chemistry tests	31.00
80010	10 clinical chemistry tests	33.00
80011	11 clinical chemistry tests	29.10
80012	12 clinical chemistry tests	28.00
80016	13-16 clinical chemistry tests	31.90
80018	17-18 clinical chemistry tests	34.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	30.65

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

Code	Service	Maximum Fee
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$ 9.20
81002	routine, without microscopy	6.00
81004	components, single, not otherwise listed, specify	5.50
81005	chemical, qualitative, any number of constituents	5.00
81010	concentration and dilution test	6.50
81015	microscopic only	7.00

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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
82011	Acetylsalicylic acid; quantitative	$ 19.00
82012	qualitative	15.25
82150	Amylase, serum;	16.00
82250	Bilirubin; blood, total OR direct	12.00
82270	Blood; occult, feces, screening	5.75
82310	Calcium, blood; chemical	12.50
82372	Carbamazepine, serum	27.85
82375	Carbon monoxide, (carboxyhemoglobin); quantitative	20.00
82435	Chlorides; blood (specify chemical or electrometric)	14.00
82465	Cholesterol, serum; total	11.50
82480	Cholinesterase; serum	18.00
82565	Creatinine; blood	11.50
82570	urine	13.00
82575	clearance	25.50
82607	Cyanocobalamin (Vitamin B-12); RIA	30.00
82643	Digoxin, RIA	30.00
82660	Drug screen (amphetamines, barbiturates, alkaloids	31.00
82756	Free thyroxine index (T-7)	27.40
82947	Glucose; except urine (for example, blood, spinal fluid, joint fluid)	12.00
82948	blood, stick test	9.00
82950	post glucose dose (includes glucose)	12.00
82951	tolerance test (GTT), three specimens (includes glucose)	38.00
82977	Glutamyl transpeptidase, gamma (GGT)	12.00
82996	Gonadotropin, chorionic, bioassay; qualitative	14.50
82997	quantitative	17.00
82998	Gonadotropin, chorionic, RIA	26.00
83000	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	40.00
83001	RIA	37.00
83002	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	39.00
83020	Hemoglobin; electrophoresis	6.00
83540	Iron, serum; chemical	16.00
83545	automated	13.75
83550	Iron binding capacity, serum; chemical	23.75
83555	automated	21.90
83725	Lithium, blood, quantitative	15.75
84030	Phenylalanine (PKU), blood; Guthrie	9.00
84035	Phenylketones; blood, qualitative	10.00
84037	urine, qualitative	4.50
84045	Phenytoin	26.50
84060	Phosphatase, acid; blood	19.00
84065	prostatic fraction	22.00

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84075	Phosphatase, alkaline, blood;	13.50
84078	heat stable (total not included)	18.00
84080	isoenzymes, electrophoretic method	35.00
84100	Phosphorus (phosphate); blood	12.00
84105	urine	12.50
84132	Potassium; blood	11.75
84133	urine	10.00
84136	Pregnanediol; other method (specify)	16.00
84139	Pregnanetriol; other method (specify)	12.00
84165	Protein, total, serum; electrophoretic fractionation and quantitation	25.00
84180	Protein, urine; quantitative, 24-hour specimen	13.00
84190	electrophoretic fractionation and quantitation	21.30
84295	Sodium; blood	10.25
84300	urine	10.00
84420	Theophylline, blood, or saliva	31.00
84442	Thyroxine binding globulin (TBG)	21.50
84443	Thyroid stimulating hormone (TSH), RIA	35.00
84450	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method	12.90
84455	colorimetric or fluorometric	11.50
84460	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	16.50
84478	Triglycerides, blood	14.50
84520	Urea nitrogen, blood (BUN); quantitative	11.75
84550	Uric acid; blood, chemical	12.00
84555	uricase, ultraviolet method	13.00
84560	Uric acid, urine	13.50

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

Code	Service	Maximum Fee
85005	Blood count; basophil count, direct	$ 16.00
85007	differential WBC count (includes RBC morphology and platelet estimation)	9.00
85009	differential WBC count, buffy coat	12.25
85012	eosinophil count, direct	12.00
85014	hematocrit	7.00
85018	hemoglobin, colorimetric	7.00
85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)	14.00
85022	hemogram, automated, with platelet count	20.00
85027	hemogram, automated, and differential WBC count (CBC)	20.25
85031	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	19.00
85041	red blood cell (RBC)	6.50
85044	reticulocyte count	11.00
85095	Bone marrow; aspiration only	54.00

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85102	biopsy core (needle)	72.00
85210	Clotting; factor 11, prothrombin, specific	10.00
85580	Platelet; count (Rees-Ecker)	11.70
85585	estimation on smear, only	9.00
85590	phase microscopy	12.00
85595	electronic technique	10.40
85610	Prothrombin time;	10.00
85650	Sedimentation rate (ESR); Wintrobe type	8.25
85651	Westergren type	8.50
85660	Sickling of RBC, reduction, slide method	8.00

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

Code	Service	Maximum Fee
86006	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	$ 15.30
86008	Antibody, quantitative titer, not otherwise specified; first antigen	17.50
86016	Antibodies, RBC, saline; high protein and antihuman globulin technique	14.00
86017	with ABO + Rh(D) typing (for holding blood instead of complete crossmatch)	16.00
86060	Antistreptolysin O; titer	19.00
86063	screen	10.00
86080	Blood typing; ABO only	9.50
86096	Blood typing, RBC antigens other than ABO or Rho(D); direct, slide or tube, including Rh subtypes, each antigen	10.00
86100	Blood typing; Rho(D) only	14.00
86105	Rh genotyping, complete	10.35
86140	C-reactive protein	11.25
86255	Fluorescent antibody; screen	27.55
86256	titer	26.50
86280	Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral)	17.00
86287	Hepatitis B surface antigen (HB_xAg) (Australian antigen, HAA); RIA method	20.00
86300	Heterophile antibodies; screening (includes monotype test), slide or tube	11.00
86305	quantitative titer	16.00
86430	Rheumatoid factor, latex fixation	14.00
86580	Skin test; tuberculosis, patch, or intradermal	7.50
86585	tuberculosis, tine test	6.25

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)	$ 15.00
87045	stool	21.35
87060	throat or nose	10.00

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Code	Description	Fee
87072	Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine	20.00
87076	Culture, bacterial, any source; definitive identification, including gas chromatography in addition to anaerobic culture	17.75
87081	Culture, bacterial, screening only, for single organisms	11.50
87082	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	10.00
87083	multiple organisms	17.50
87084	with colony estimation from density chart (includes throat cultures)	19.25
87086	Culture, bacterial, urine; quantitative, colony count	15.00
87087	commercial kit	8.75
87088	identification, in addition to quantitative or commercial kit	18.00
87101	Culture, fungi, isolation; skin	15.00
87102	other source	8.00
87106	definitive identification, by culture, per organism, in addition to skin or other source	21.90
87140	Culture, typing; fluorescent method, each antiserum	12.65
87163	Culture, special extensive definitive diagnostic studies, beyond usual definitive studies	29.00
87164	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection	6.00
87181	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	15.50
87184	disc method, each plate (12 or less discs)	15.00
87186	microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics	20.00
87188	tube dilution method, each antibiotic	19.00
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	10.00
87206	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	11.80
87210	wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites	9.30
87211	wet and dry mount, with interpretation, for ova and parasites	9.80
87220	Tissue examination for fungi (for example, KOH slide)	10.30

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

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Cytopathology

Code	Service	Maximum Fee
88104	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 26.90
88109	smears and cell block with interpretation	45.00

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	Surgical pathology, gross examination only	$ 25.00
88302	Surgical pathology, gross and microscopic; examination for identification and record purposes (for example, uterine tubes, vas deferens, sympathetic ganglion)	30.00
88304	diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy)	35.00
88305	diagnostic exam, larger specimen or multiple small specimens (for example, prostate clippings, uterine curetings segment of stomach)	70.00
88307	complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides	80.00
88312	Special stains; Group I stains for microorganisms (for example, Gridley, acid fast, methenamine silver, Levaditi)	16.40
88313	Group II, all other special stains, except immunoperoxidase stains	15.00

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)	$ 38.50
89050	Cell count, miscellaneous body fluids (for example, CSF, joint fluid, except blood)	$ 15.00
89180	Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of	

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stools, others (specify) 10.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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 Examinations

Code	Service	Maximum Fee
00110	Initial oral examination	$ 11.00
00120	Periodic oral examination	10.00
00130	Emergency oral examination	12.00
	Radiographs	
00210	Intraoral complete series (including bitewings)	$ 34.00
00220	Intraoral; periapical, single, first film	5.00
00230	periapical, each additional film	4.00
00240	occlusal, film	7.00
00250	Extraoral; single, first film	5.00
00260	each additional film	4.00
00270	Bitewing; single film	6.00
00272	two films	9.00
00274	four films	13.00
00330	Panoramic; maxilla and mandible, film	30.00
00335	maxilla and mandible, film, with bitewings	37.00
00340	Cephalometric film	34.00
	Tests and Laboratory Examinations	
00460	Pulp vitality tests	$ 10.00
00470	Diagnostic casts, with report	25.00
00471	Diagnostic photographs	17.00

Subp. 3. **Restorative.** The following codes, service descriptions, and maximum fees apply to restorative procedures. Amalgam restorations include polishing.

Amalgam Restorations

Code	Service	Maximum Fee
02110	Amalgam; one surface, deciduous	$ 20.00
02120	two surfaces, deciduous	31.00
02130	three surfaces, deciduous	40.00
02131	four surfaces, deciduous	48.00
02140	one surface, permanent	20.00
02150	two surfaces, permanent	32.00
02160	three surfaces, permanent	42.00
02161	four or more surfaces, permanent	50.00
02190	Pin retention, exclusive of amalgam	10.00
	Silicate Restorations	
02210	Silicate cement per restoration	$ 20.00

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	Acrylic or Plastic Restorations	
02310	Acrylic or plastic	$ 24.00
02330	Composite resin; one surface	26.00
02331	two surfaces	40.00
02332	three surfaces	51.00
02334	Pin retention, exclusive of composite resin	10.00
02335	Composite resin (involving incisal angel)	50.00
	Crowns--Single Restorations Only	
02711	Plastic, prefabricated	$ 80.00
02830	Stainless steel	60.00
02840	Temporary (fractured tooth)	52.00
02892	Steel post and composite or amalgam in addition to crown	65.00
	Other Restorative Services	
02910	Recement inlays	$ 17.00
02920	Recement crowns	20.00
02940	Fillings (sedative)	20.00
02950	Crown buildups, pin retained	60.00

Subp. 4. **Endodontics.** The following codes, service descriptions, and maximum fees apply to endodontic procedures. Pulpotomy procedures exclude final restoration. Root canal therapy includes treatment plan, clinical procedures, and follow-up care.

	Pulpotomy	
Code	Service	Maximum Fee
03220	Vital pulpotomy	$ 34.00
	Root Canal Therapy	
03310	Anterior (excludes final restoration)	$ 150.00
03320	Bicuspid (excludes final restoration)	175.00
03330	Molar (excludes final restoration)	220.00
	Periapical Services	
03410	Apicoectomy; performed as separate surgical procedure (per root)	$ 97.50
03420	performed in conjunction with endodontic procedure (per root)	85.00
03430	Retrograde filling	90.00
03440	Apical curettage	75.00

Subp. 5. **Periodontics.** The following codes, service descriptions, and maximum fees apply to periodontic procedures. Surgical services include usual post-operative services.

	Surgical Services	
Code	Service	Maximum Fee
04210	Gingivectomy or gingivoplasty, per quadrant	$ 100.00
04220	Gingival curettage and root planing	70.00
04260	Osseous surgery (including flap entry and closure), per quadrant	200.00
	Adjunctive Periodontal Services	
04330	Occlusal adjustment; limited	$ 35.00
04331	complete	100.00

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Subp. 6. **Prosthodontics, removable.** The following codes, service descriptions, and maximum fees apply to removable prosthodontics. Complete and partial denture procedures include six months post-delivery care.

Code	Service	Maximum Fee
	Complete Dentures	
05110	Complete upper	$ 400.00
05120	Complete lower	400.00
05130	Immediate upper	400.00
05140	Immediate lower	400.00
05151	Identification, upper prosthesis	10.00
05161	Identification, lower prosthesis	10.00
	Partial Dentures	
05211	Upper, without clasps, acrylic base	$ 200.00
05216	Upper, with two chrome clasps with rests, acrylic base	420.00
05218	Lower, with chrome clasps with rests, acrylic base	450.00
05231	Lower, with chrome lingual bar and two clasps, acrylic base	450.00
05241	Lower, with chrome lingual bar and two clasps, cast base	475.00
05251	Upper, with chrome palatal bar and two clasps, acrylic base	450.00
05261	Upper, with chrome palatal bar and two clasps, cast base	475.00
05292	Full cast partial, with two chrome clasps (upper)	475.00
05294	Full cast partial, with two chrome clasps (lower)	475.00
	Adjustments to Dentures	
05410	Complete denture	$ 15.00
05421	Partial denture (upper)	15.00
05422	Partial denture (lower)	15.00
	Repairs to Dentures	
05610	Repair broken complete or partial denture, no teeth damaged	$ 45.00
05620	Repair broken complete or partial denture, replace one broken tooth	47.00
05630	Replace additional teeth, each tooth	20.00
05640	Replace broken tooth or denture, no other repairs	40.00
05650	Adding tooth to partial denture to replace extracted tooth; each tooth (not involving clasp or abutment tooth)	50.00
05660	each tooth (involving clasp or abutment tooth)	75.00
05670	Reattaching damaged clasp on denture	50.00
05680	Replacing broken clasp with new clasp on denture	61.00
05690	Each additional clasp with rest	50.00
	Denture Duplication	
05710	Duplicate upper or lower complete denture	$ 185.00

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05720	Duplicate upper or lower partial denture	175.00
	Denture Relining	
05730	Relining upper or lower complete denture (office recline)	$ 110.00
05740	Relining upper or lower partial denture (office recline)	80.00
05750	Relining upper or lower complete denture (laboratory)	125.00
05760	Relining upper or lower partial denture (laboratory)	125.00
	Other Prosthetic Services	
05820	Denture, temporary (partial-stayplate), upper	$ 130.00
05850	Tissue conditioning	24.00

Subp. 7. **Prosthodontics, fixed.** The following codes, service descriptions, and maximum fees apply to fixed prosthodontics.

Repairs

Code	Service	Maximum Fee
06620	Replace broken facing where post is intact	$ 40.00
06640	Replace broken facing with acrylic	50.00
	Other Prosthetic Services	
06930	Recement bridge	$ 30.00

Subp. 8. **Oral surgery.** The following codes, service descriptions, and maximum fees apply to oral surgery procedures. Surgical extractions include local anesthesia and routine post-operative care. Surgical excisions apply to excision of reactive inflammatory lesions (scar tissue or localized congenital lesions).

Extractions

Code	Service	Maximum Fee
07110	Single tooth	$ 25.00
07120	Each additional tooth	25.00
	Surgical Extractions	
07210	Extraction of tooth, erupted	$ 55.00
07220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	70.00
07230	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the removal of the tooth	89.00
07240	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal	100.00
07241	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and presents unusual difficulties and circumstances	110.00

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07250	Root recovery (surgical removal of residual root)	50.00

Other Surgical Procedures

07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including wire attachment where indicated	$ 95.00
07285	Biopsy of oral tissue (hard)	50.00
07286	Biopsy of oral tissue (soft)	70.00

Alveoloplasty

(surgical preparation of ridge for dentures)

07310	Per quadrant, in conjunction with extractions	$ 50.00
07320	Per quadrant, not in conjunction with extractions	60.00

Surgical Excision

07410	Radical excision; lesion diameter up to 1.25 centimeters	$ 50.00
07425	Excision pericoronal gingiva	30.00

Removal of Cysts and Neoplasms

07450	Removal of odontogenic cyst or tumor, up to 1.25 centimeters diameter	$ 85.00

Surgical Incision

07510	Incision and drainage of abscesses, intraoral	$ 35.00

Other Repair Procedures

07960	Frenulectomy, separate procedure (frenectomy or frenotomy)	$ 70.00

Subp. 9. **Orthodontics.** The following codes, service descriptions, and maximum fees apply to orthodontic procedures.

Diagnostic Procedures

Code	Service	Maximum Fee
08010	Examination, OIS sheet, photos	$ 25.00
08020	Full ortho case study	80.00

Subp. 10. **Miscellaneous.** The following codes, service descriptions, and maximum fees apply to miscellaneous dental procedures not listed elsewhere.

Code	Service	Maximum Fee
09110	Palliative (emergency) treatment of dental pain, minor procedures	18.00

Anesthesia

09220	General	$ 50.00
09230	Analgesia	10.00

Professional Consultation

09310	Consultation, per session	$ 20.00

Professional Visits

09410	House calls	$ 15.00
09420	Hospital calls	12.00
09430	Office visit, during regularly scheduled office hours (no operative services	

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	performed)	12.00
09440	Office visit, after regularly scheduled office hours (no operative services performed and no other services rendered)	25.00
	Drugs	
09610	Therapeutic drug injection (excluding drug cost)	$ 10.00
	Miscellaneous Other Services	
09910	Application of desensitizing medicaments (where not included or implied in associated procedure)	$ 10.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.2600 OPTOMETRISTS, OPTICIANS.

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

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

Code	Service	Maximum Fee
80101	Basic vision examination and diagnosis, to include the following minimum procedures: case history; visual acuity, distance and near; internal and external eye health examination; subjective refraction for distance and near; phorometric tests of accommodation, convergence, and binocular coordination at far and near point; visual skills; and case analysis and presentation	$ 32.00
80102	Basic vision examination and diagnosis, presbyopic (over 30) to include the following procedures: all included in 80101, except visual skills may be deleted; and tonometry and field screening	36.00
80103	Single vision prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	25.00
80104	Single vision dispensing services (includes frame selection, fitting, and servicing)	23.00
80113	Multifocal prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	27.00
80114	Multifocal dispensing services (includes frame selection, fitting, and servicing)	24.00
80105	Office call: visual screening or evaluation of patient's complaint to determine need for further examination	15.00

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80106	Out of office call	10.00

Subp. 3. **Low vision prescription device.** The following codes, service descriptions, and maximum fees apply to low vision prescription devices. The services and codes listed are to be employed in place of 80103 and 80104.

Code	Service	Maximum Fee
80403	Prescription services, including: frame measurement, vertex distance measurement; computation of lens specifications; and verification of completed prescription	$ 40.00
80404	Dispensing services, including: frame selection; and fitting and servicing	25.00

Subp. 4. **Miscellaneous services.** The following codes, service descriptions, and maximum fees apply to miscellaneous services not listed elsewhere. The services listed shall not be employed for follow-up services included in prior charges to established patients. The services listed do not include laboratory or materials charges.

Code	Service	Maximum Fee
80801	Minor refitting	$ 5.00
80811	Complete refitting	4.60
80802	Frame replacements with necessary adjustments	17.00
80803	Front replacements with necessary adjustments	12.00
80804	One or both temple replacements with necessary adjustments	8.00
80805	Hinge repair	5.50
80807	Minor frame repair and readjustment of frame, including: replacement of screws; supply of new nose pads; supply of temple covers; supply of pad covers; soldering; and other miscellaneous minor repairs	5.00
80808	Neutralization of lenses for copy of prescription	4.00
80809	Lens replacement; one lens, single vision	12.00
80810	both lenses, single vision	27.00
80819	one lens, multifocal vision	19.00
80820	both lenses, multifocal vision	42.40

Subp. 5. **Materials, supplies.** The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services.

Code	Service	Maximum Fee
80107	Frames	$ 12.00
80108	Single vision lenses	17.50
80111	Multifocal lenses	30.00
80118	Lenses for aphakia	58.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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5221.2700 AUDIOLOGISTS AND SPEECH PATHOLOGISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to audiologists and to speech pathologists certified by the American Speech and Hearing Association.

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

Code	Service	Maximum Fee
21020	Basic hearing evaluation	$ 45.00
21021	Limited hearing evaluation	32.00
21022	Extended hearing evaluation	64.00
21031	Limited site of auditory lesion evaluation	16.00
21032	Extended site of auditory lesion evaluation	32.00
21050	Basic prescription hearing aid evaluation	40.00
21052	Extended prescription hearing aid evaluation	45.00
21053	Performance evaluation of specific hearing aid	15.00
21081	Hearing screening, group	9.50

Subp. 3. **Speech pathology.** The following codes, service descriptions, and maximum fees apply to speech pathology services.

Code	Service	Maximum Fee
22010	Basic speech, language, or voice evaluation	$ 80.00
22012	Extended speech, language, or voice evaluation	43.50
22060	Basic consultation	30.00
22070	Rehabilitation one-fourth hour, individual	16.50
22071	Rehabilitation one-half hour, individual	30.00
22072	Rehabilitation one hour, individual	58.00
22073	Rehabilitation one-half hour, group	20.00
22074	Rehabilitation one hour, group	30.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to registered physical therapists and occupational therapists.

Subp. 2. **Physical therapy.** The following codes, service descriptions, and maximum fees apply to physical therapy procedures.

Evaluations

Code	Service	Maximum Fee
24001	Physical function evaluation; initial 15-minute unit	$ 16.00
24010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	15.50
24011	additional 15-minute units	15.50
24015	Activities of daily living evaluation; initial 15-minute unit	25.00

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24016	additional 15-minute units	25.00
	Physical Restoration Procedures	
97000	Office visit with one of the following modalities to one area; 1. Hot or cold packs 2. Traction, mechanical 3. Electrical stimulation 4. Ultrasound 5. Vasopneumatic devices 6. Paraffin bath 7. Microwave 8. Whirlpool 9. Diathermy 10. Infrared 11. Ultraviolet	$ 27.50
97050	Office visit with two or more modalities to the same area	34.00
97100	Office visit with one of the following procedures to one area; initial 30 minutes 1. Therapeutic exercises 2. Neuromuscular reeducation 3. Functional activities 4. Gait training 5. Orthotics training 6. Prosthetics training 7. Electrical stimulation (manual) 8. Iontophoresis 9. Traction, manual 10. Massage 11. Contract baths 12. Muscle testing (manual) 13. Range of motion measurements 14. TENS	22.00
97101	each additional 15 minutes	10.00
97200	Office visit including combination of any modality and procedure; initial 30 minutes	29.50
97201	each additional 15 minutes	11.50
	Maintenance Therapy Procedures	
24201	Maintenance therapy procedures; initial 15-minute unit	$ 7.75
24202	additional 15-minute units	7.75
24301	Consultation with report--for specific individual patient; initial 15-minute unit	8.25
24302	additional 15-minute units	14.00

Subp. 3. **Occupational therapy.** The following codes, service descriptions, and maximum fees apply to occupational therapy procedures.

Evaluations

Code	Service	Maximum Fee
23010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	$ 17.00

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23011	additional 15-minute units	17.00
23015	Activities of daily living evaluation; initial 15-minute unit	12.50
23016	additional 15-minute units	12.50
	Physical Restoration Procedures	
23100	Activities of daily living training; initial 15-minute unit	$ 12.50
23101	additional 15-minute units	12.50
23115	Dexterity or coordination training; initial 15-minute unit	12.50
23116	additional 15-minute units	12.50
23135	Neurodevelopmental training; initial 15-minute unit	14.00
23136	additional 15-minute units	13.50
23150	Perceptual, sensory, or motor training: one hour group session	25.00
23151	initial 15-minute unit, individual	14.60
23152	additional 15-minute units, individual	13.50
	Consultation Services	
23300	Consultation with report, for specific individual patient; initial 15-minute unit	$ 14.60
23301	additional 15-minute units	13.50

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.2900 CHIROPRACTORS.

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

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

Code	Service	Maximum Fee
09510	Routine initial examination, history and diagnosis	$ 30.00
09501	Intermediate examination, history and diagnosis	30.00
09502	Extensive examination with history and diagnosis, complete history and physical examination of one or more systems, with report	60.00
09506	Intermediate examination or evaluation, same illness, established patient, progress examination, with report	27.00
09509	Home or nursing home visit with routine chiropractic examination and/or treatment which includes adjustment, manipulation, and/or one unit of conjunctive therapy for the same or new condition	50.00
09503	Office visit with cast application to one area, for example, short arm, short leg, knee, or elbow, excluding materials	21.00
09508	Office visit with cast application to one area, for example, long leg,	

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	thoracolumbar, lumbosacral, or full body corset type, excluding materials	27.00
09009	Same visit, each additional conjunctive or manipulative therapy per anatomical area of diagnosis, for example, neck, back, extremities --anatomical areas include associated soft tissues and nerves. Includes office visit	10.00
09504	Treatment, one unit of manipulative or conjunctive therapy (specify). Includes office visit	18.00
09505	Treatment, one unit of manipulative and one unit of conjunctive therapy (specify). Includes office visit	27.00
09194	Thermography, initial or subsequent, used for evaluative purposes	30.00
09507	Ambulation traction application	10.00

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

Chest

Code	Service	Maximum Fee
71010	Radiologic examination, chest; (single view, posteroanterior)	$ 25.00
	Spine and Pelvis	
72010	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral)	$ 90.00
72040	Radiologic examination, spine, cervical; limited (anteroposterior and lateral)	44.00
72050	comprehensive (minimum of four views)	90.00
72052	comprehensive (minimum of seven views including flexion and extension)	125.00
72070	Radiologic examination, spine; thoracic, (anteroposterior and lateral)	39.00
72080	thoracic, limited (anteroposterior and lateral)	35.00
72090	scoliosis study, comprehensive	34.00
72100	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral)	56.00
72110	lumbosacral, comprehensive (minimum of five views)	100.00
72120	Radiologic examination, spine, lumbosacral, bending views only (minimum of four views)	40.00
72170	Radiologic examination, pelvis; limited (minimum of two views)	40.00
	Upper Extremities	
73020	Radiologic examination, shoulder; limited (one projection)	$ 25.00
73030	comprehensive, complete study	30.00
73070	Radiologic examination, elbow; limited (anteroposterior and lateral)	25.00

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73100	Radiologic examination, wrist; limited (anteroposterior and lateral)	30.00
73120	Radiologic examination, hand	25.00
	Lower Extremities	
73500	Radiologic examination, hip; limited (one view)	$ 25.00
73560	Radiologic examination, knee; limited (two views)	30.00
73570	Radiologic examination, knee; comprehensive (minimum of three views)	35.00
73600	Radiologic examination, ankle; limited (two views)	30.00
73610	comprehensive (minimum of three views)	55.00
73620	Radiologic examination, foot; limited (two views)	25.00
73630	complete routine study (minimum of three views)	35.00
	Miscellaneous	
76140	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 (codes 8003 to 80019) include the following tests:

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

Code	Service	Maximum Fee
80003	Standard profile (up to and including 12	

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	tests) for arthritic, bone, lipid and thyroid	$ 74.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	71.00
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	10.00
81002	routine, without microscopy	15.00
85022	Blood count; hemogram, automated (CBC) with differential WBC count	22.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 9 SR 1619*

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

Patient Visits

Code	Service	Maximum Fee
09000	Initial office visit, routine, new patient or new illness, history and examination	$ 28.00
09003	Follow-up office visit, brief, for example, routine injection, minimal dressing	15.00
09004	Follow-up office visit, routine	18.00
09005	Follow-up office visit necessitating professional care over and above routine visit	24.00
09006	Follow-up office visit, prolonged, over and above 09005	23.00
09001	Initial hospital visit, limited	35.00
09002	Comprehensive hospital visit	24.00
09010	Initial home or convalescent home visit, routine, new patient or new illness, history and examination	18.00

Physical Medicine

09440	Office visit with one or more of the following modalities to one area: Hot or cold packs Traction, mechanical Electrical stimulation Ultrasound Vasopneumatic devices Ultraviolet Paraffin bath Microwave Whirlpool Diathermy Infrared	$ 18.00

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Subp. 3. **Surgery.** The following codes, service descriptions, and maximum fees apply to surgical services. An asterisk (*) indicates that the service includes the surgical procedure only. All other services include the operation per se, and normal uncomplicated pre- and postoperative follow-up care.

Integumentary System

Code	Service	Maximum Fee
00125*	Drainage of onychia or paronychia	$ 20.00
00160*	Debridement of extensively eczematized or infected skin up to ten percent of the body surface	18.00
00162*	Debridement of nails, any method; five or less	18.00
00163*	each additional five nails or major portion thereof	9.00
00164	Debridement of abrasions	20.00
00171	Biopsy, excision of skin, subcutaneous tissue or mucus membrane for biopsy including simple closure as an independent procedure	25.00
00225*	Avulsion, nail, partial or complete, simple	17.00
00228	Excision of nail or nail matrix, partial or complete, for example, ingrown or deformed nail for permanent removal	159.00
00403*	Electro-surgical destruction or cemocantery or cryocautery of benign or pre-malignant lesion with or without curettement, one lesion	27.00

Subp. 4. **Radiology.** The following codes, service descriptions, and maximum fees apply to radiology services.

Code	Service	Maximum Fee
07308	Radiologic examination, ankle; complete minimum of three views	$ 30.00
07309	Radiologic examination, foot; two views	30.00
07310	complete routine study, minimum of three views	45.00

Subp. 5. **Material, supplies.** The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services, unless explicitly stated.

Code	Service	Maximum Fee
01209	Fitted orthotic balanced appliance: metal, thermoplastic, or other; unilateral	$ 66.00
01259	bilateral	150.00
01509	Negative impression for fitted orthotic, unilateral	25.50
01809	Post-surgical splint (Reece surgical shoe)	16.50
01909	Strappings for partial immobilization of foot or ankle	15.00
02009	Foot, ankle, leg measurements (bio-mechanical evaluation) for orthotics, prosthetics for foot	

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	deformities	25.00
06600	Sterile surgical tray set-up (supplies)	40.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.3100 PSYCHOLOGISTS AND SOCIAL WORKERS.

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.

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

Code	Service	Maximum Fee
09046	Initial office visit with evaluation and history, one hour	$ 70.00
09048	Initial inpatient hospital visit, including history and evaluation, per hour	70.00
09066	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour	70.00
09067	Psychotherapy, group (maximum ten persons per group) 1-1/2 hours per person	35.00
09068	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour	45.00
09070	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge)	65.00

Subp. 3. **Social workers counseling.** The following codes, service descriptions, and maximum fees apply to counseling by social workers.

Code	Service	Maximum Fee
25210	Individual client counseling; initial 30-minute unit	$ 30.00
25211	additional 30-minute units	30.00
25215	Family counseling; initial 30-minute unit	23.10
25216	additional 30-minute units	23.10

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.3200 HOSPITAL--SEMI-PRIVATE ROOM CHARGES.

Subpart 1. **Scope.** The following service descriptions and maximum fees apply to daily charges for semi-private rooms at the hospitals listed below. The maximum fees do not apply to semi-private rooms for which a rate higher than the hospital's normal rate applies and which require an unusually high level of service, such as emergency or intensive care rooms. The maximum fees apply to daily semi-private room charges only. The maximum fees do not apply to private or ward rooms, and do not apply to hospital charges for services not customarily included in the daily room charge.

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

A. Abbott Northwestern Hospital, Minneapolis
B. Bethesda Lutheran Medical Center, Saint Paul
C. The Children's Hospital, Saint Paul
D. Divine Redeemer Memorial Hospital, South Saint Paul
E. Eitel Hospital, Minneapolis
F. Fairview Hospital, Minneapolis
G. Fairview-Deaconess Hospital, Minneapolis
H. Fairview-Southdale Hospital, Minneapolis
I. Gillette Children's Hospital, Saint Paul
J. Golden Valley Health Center, Golden Valley
K. Mercy Medical Center, Coon Rapids
L. Methodist Hospital, Saint Louis Park
M. Metropolitan Medical Center, Minneapolis
N. Midway Hospital, Saint Paul
O. Miller-Dwan Medical Center, Duluth
P. Minneapolis Children's Hospital, Minneapolis
Q. Mounds Park Hospital, Saint Paul
R. Mount Sinai Hospital, Minneapolis
S. North Memorial Medical Center, Robbinsdale
T. Saint Cloud Hospital, Saint Cloud
U. Saint John's Hospital, Saint Paul
V. Saint Joseph's Hospital, Saint Paul
W. Saint Luke's Hospital, Duluth
X. Saint Mary's Hospital, Duluth
Y. Saint Mary's Hospital, Minneapolis
Z. The Samaritan Hospital, Saint Paul
AA. United Hospital, Saint Paul
BB. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semi-private room charge for one day	$ 200.86

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

A. A. L. Vadheim Memorial Hospital, Tyler
B. Ada Municipal Hospital, Greenbush
C. Aitkin Community Hospital, Aitkin
D. Albany Community Hospital, Albany
E. Appleton Municipal Hospital, Appleton
F. Arlington Municipal Hospital, Arlington
G. Arnold Memorial Hospital, Adrian
H. Buffalo Memorial Hospital, Buffalo
I. Caledonia Community Hospital, Caledonia
J. Canby Community Hospital, Canby
K. Central Mesabi Medical Center, Hibbing
L. Chippewa County-Montevideo Hospital, Montevideo
M. Chisago Lakes Hospital, Chisago City
N. Clarkfield Memorial Hospital, Clarkfield
O. Clearwater County Memorial Hospital, Bagley
P. Cloquet Community Memorial Hospital, Cloquet
Q. Comfrey Hospital, Comfrey
R. Community Hospital--Cannon Falls, Cannon Falls

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S. Community Hospital--Saint Peter, Saint Peter
T. Community Memorial Hospital--Deer River, Deer River
U. Community Memorial Hospital--Spring Valley, Spring Valley
V. Community Memorial Hospital--Winona, Winona
W. Community Mercy Hospital--Onamia, Onamia
X. Cook Community Hospital, Cook
Y. Cook County Northshore Hospital, Grand Marais
Z. Cuyuna Range District Hospital, Crosby
AA. Dr. Henry Schmidt Memorial Hospital, Westbrook
BB. District Memorial Hospital--Forest Lake, Forest Lake
CC. Divine Providence Hospital, Ivanhoe
DD. Douglas County Hospital, Alexandria
EE. Ely-Bloomenson Community Hospital, Ely
FF. Eveleth Fitzgerald Community Hospital, Eveleth
GG. Fairmont Community Hospital, Fairmont
HH. Fairview Princeton Hospital, Princeton
II. Fosston Municipal Hospital, Fosston
JJ. Gaylord Community Hospital, Gaylord
KK. Glacial Ridge Hospital, Glennwood
LL. Glencoe Municipal Hospital, Glencoe
MM. Granite Falls Municipal Hospital, Granite Falls
NN. Grant County Hospital, Elbow Lake
OO. Greenbush Community Hospital, Greenbush
PP. Harmony Community Hospital, Harmony
QQ. Hendricks Community Hospital, Hendricks
RR. Heron Lake Municipal Hospital, Heron Lake
SS. Holy Trinity Hospital, Graceville
TT. Hutchinson Community Hospital, Hutchinson
UU. Immanuel-Saint Joseph's Hospital, Mankato
VV. International Falls Memorial Hospital, International Falls
WW. Itasca Memorial Hospital, Grand Rapids
XX. Jackson Municipal Hospital, Jackson
YY. Johnson Memorial Hospital, Dawson
ZZ. Kanabec Hospital, Mora
AAA. Karlstad Health Facilities, Karlstad
BBB. Kittson Memorial Hospital, Hallock
CCC. Lake City Hospital, Lake City
DDD. Lake Region Hospital, Fergus Falls
EEE. Lake View Memorial Hospital, Two Harbors
FFF. Lakefield Municipal Hospital, Lakefield
GGG. Lakeview Memorial Hospital, Stillwater
HHH. Littlefork Municipal Hospital, Littlefork
III. Long Prairie Memorial Hospital, Long Prairie
JJJ. Luverne Community Hospital, Luverne
KKK. Madelia Community Hospital, Madelia
LLL. Madison Hospital, Madison
MMM. Mahnomen County-Village Hospital, Mahnomen
NNN. Meeker County Memorial Hospital, Litchfield
OOO. Melrose Hospital, Melrose
PPP. Memorial Hospital--Cambridge, Cambridge
QQQ. Memorial Hospital--Perham, Perham

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RRR. Memorial Community Hospital--Bertha, Bertha
SSS. Mercy Hospital, Moose Lake
TTT. Milaca Area Hospital, Milaca
UUU. Minnesota Valley Memorial Hospital, Le Sueur
VVV. Minnewaska District Hospital, Starbuck
WWW. Monticello-Big Lake Community Hospital, Monticello
XXX. Mountain Lake Community Hospital, Mountain Lake
YYY. Murray County Memorial Hospital, Slayton
ZZZ. Naeve Hospital, Albert Lea
AAAA. North Country Hospital, Bemidji
BBBB. Northern Itasca Hospital, Big Fork
CCCC. Northfield City Hospital, Northfield
DDDD. Northwestern Hospital, Thief River Falls
EEEE. Olmsted Community Hospital, Rochester
FFFF. Ortonville Hospital, Ortonville
GGGG. Owatonna City Hospital, Owatonna
HHHH. Parkers Prairie District Hospital, Parkers Prairie
IIII. Paynesville Community Hospital, Paynesville
JJJJ. Pelican Valley Health Center, Pelican Valley
KKKK. Pipestone County Hospital, Pipestone
LLLL. Queen of Peace Hospital, New Prague
MMMM. Redwood Falls Municipal Hospital, Redwood Falls
NNNN. Renville County Hospital, Olivia
OOOO. Rice County District One Hospital, Faribault
PPPP. Rice Memorial Hospital, Willmar
QQQQ. Riverview Hospital, Crookston
RRRR. Roseau Area Hospital, Roseau
SSSS. Rush City Hospital, Rush City
TTTT. Saint Ansgar Hospital, Moorhead
UUUU. Saint Elizabeth Hospital, Wabasha
VVVV. Saint Francis Hospital, Breckenridge
WWWW. Saint Francis Regional Medical Center, Shakopee
XXXX. Saint Gabriel's Hospital, Little Falls
YYYY. Saint John's Hospital, Browerville
ZZZZ. Saint John's Hospital, Red Lake Falls
AAAAA. Saint John's Hospital, Red Wing
BBBBB. Saint Joseph's Hospital, Brainerd
CCCCC. Saint Joseph's Hospital, Park Rapids
DDDDD. Saint Mary's Hospital, Detroit Lakes
EEEEE. Saint Mary's Hospital, Winstead
FFFFF. Saint Michael's Hospital, Sauk Centre
GGGGG. Saint Olaf Hospital, Austin
HHHHH. Sandstone Area Hospital, Sandstone
IIIII. Sanford Memorial Hospital, Farmington
JJJJJ. Sioux Valley Hospital, New Ulm
KKKKK. Sleepy Eye Municipal Hospital, Sleepy Eye
LLLLL. Springfield Community Hospital, Springfield
MMMMM. Stevens County Memorial Hospital, Morris
NNNNN. Swift County-Benson Hospital, Benson
OOOOO. Tracy Municipal Hospital, Tracy
PPPPP. Tri-County Hospital, Wadena

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QQQQQ. Trimont Community Hospital, Trimont
RRRRR. Trinity Hospital, Baudette
SSSSS. Tweeten Memorial Hospital, Spring Grove
TTTTT. United District Hospital, Staples
UUUUU. United Hospital, Blue Earth
VVVVV. Virginia Regional Medical Center, Virginia
WWWWW. Waconia Ridgeview Hospital, Waconia
XXXXX. Warren Community Hospital, Warren
YYYYY. Waseca Area Memorial Hospital, Waseca
ZZZZZ. Weiner Memorial Medical Center, Marshall
AAAAAA. Wells Municipal Hospital, Wells
BBBBBB. White Community Hospital, Aurora
CCCCCC. Windom Area Hospital, Windom
DDDDDD. Winona General Hospital, Winona
EEEEEE. Worthington Regional Hospital, Worthington
FFFFFF. Zumbrota Community Hospital, Zumbrota

Service	Maximum Fee
Group 2 semi-private room charge for one day	$ 155.00

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 semi-private room charge for one day	$ 266.30

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 semi-private room charge for one day	$ 151.86

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.3300 EFFECTIVE DATE.

This chapter is effective October 1, 1984, and applies to all health care services or supplies governed by this chapter provided after October 1, 1984.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

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