CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

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, section 176.134, the special compensation fund established by Minnesota Statutes, sec-

tion 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*

NOTE: Minnesota Statutes, section 176.134, was repealed by Laws of Minnesota 1985, chapter 234, section 22.

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;

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.

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.

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 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 management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

K. Modifier number 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.

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 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;

(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 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	$ 30.00
90010	New patient - limited service	36.00
90015	New patient - intermediate service	46.00
90017	New patient - extended service	70.00
90030	Established patient - minimal service	16.00
90040	Established patient - brief service	22.00
90050	Established patient - limited service	25.00
90060	Established patient - intermediate service	34.00
90070	Established patient - extended service	55.00
90080	Established patient - comprehensive service	82.25

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

Code	Service	Maximum Fee
90200	Brief initial hospital care	$ 62.50
90215	Intermediate initial hospital care	85.00
90220	Comprehensive initial hospital care	123.00
90240	Subsequent hospital care - brief service	26.50
90250	Subsequent hospital care - limited service	37.00
90260	Intermediate services	50.00
90270	Subsequent hospital care - extended service	75.00
90280	Subsequent hospital care - comprehensive service	75.00
	Hospital Discharge Services	
90292	Hospital discharge day management	$ 52.00

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	35.00
90510	New patient - limited service	44.00
90515	New patient - intermediate service	60.00
90517	New patient - extended service	82.00
90540	Established patient - brief service	35.00
90550	Established patient - limited service	39.00
90560	Established patient - intermediate service	46.00
90570	Established patient - extended service	52.50

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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 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
90600	Initial consultation; limited	$ 55.00
90605	Intermediate consultation	73.00
90610	Extensive consultation	89.00
90620	Comprehensive consultation	135.00
90630	Complex consultation	155.00

Follow-up Consultation

90640	Follow-up consultation; brief visit	$ 65.00
90641	limited	53.00

Confirmatory (Additional Opinion) Consultation

90650	Confirmatory consultation; limited	$ 55.00
90651	intermediate	75.00
90652	extensive	80.00
90654	complex	175.00

Immunization Injections

90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	$ 15.00
90702	diphtheria and tetanus toxoids (DT)	10.00
90703	tetanus toxoid	9.00
90704	mumps virus vaccine, live	14.50
90705	measles virus vaccine, live, attenuated	14.50
90706	rubella virus vaccine, live	14.19
90707	measles, mumps, and rubella virus vaccine, live	23.50
90712	polio virus vaccine, live, oral; any type(s)	12.65
90713	poliomyelitis vaccine	10.00
90718	tetanus and diphtheria toxoids absorbed, for adult use (Td)	9.50
90719	diphtheria toxoid	9.00
90724	influenza virus vaccine	11.00
90732	pneumococcal vaccine, polyvalent	16.00
90733	meningococcal polysaccharide vaccine; any group(s)	15.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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.

General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures

Code	Service	Maximum Fee
90801	Psychiatric diagnostic interview examination including history, mental status, or disposition	$ 113.00
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	55.00
90844	approximately 45 or 50 minutes	95.00
90847	Family medical psychotherapy (conjoint psychotherapy)	90.00

90853	Group medical psychotherapy (other than of a multiple-family group)	45.00
	Other Psychiatric Therapy	
90880	Medical hypnotherapy	$ 55.00
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	90.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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 (for example, in tension headache, muscle spasm)	$ 70.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 12 SR 662*

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

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

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

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

General Services

Code	Service	Maximum Fee
92002	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient	$ 48.50
92004	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient, one or more visits	54.00
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient	38.40
92014	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program - established patient, one or more visits	53.00

92020	Gonioscopy with medical diagnostic evaluation (separate procedure)	27.00
	Special Services	
92083	Visual field examination with medical diagnostic evaluation; extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41)	$ 54.00
92100	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	23.50
92140	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00
	Ophthalmoscopy	
92225	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial	$ 32.00
92226	subsequent	30.00
92235	Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation	143.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.1600 [Repealed, 12 SR 662]

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	$ 12.50
92552	Pure tone audiometry (threshold); air only	21.00
92553	Pure tone audiometry (threshold); air and bone	35.00
92555	Speech audiometry; threshold only	16.00
92556	Speech audiometry; threshold and discrimination	32.00
92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	54.00

Audiologic Tests

92562	Loudness balance test, alternate binaural or monaural	$ 18.00
92563	Tone decay test	15.00
92566	Impedance testing	20.00
92567	Tympanometry	18.00
92568	Acoustic reflex testing	16.00
92575	Sensorineural acuity level test	10.00
92581	Evoked response audiometry	185.00
92582	Conditioning play audiometry	32.00
92585	Brainstem evoked response recording	182.00
92591	Hearing aid examination and selection binaural	65.00
92593	Hearing aid check; binaural	30.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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
92960	Cardioversion, elective, electrical conversion of arrhythmia, external	$ 202.50
93000	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	42.20
93005	tracing only, without interpretation and report	29.50
93010	interpretation and report only	18.00
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, tracing only without interpretation and report	94.00
93018	interpretation and report only	104.00
93040	Rhythm ECG, one to three leads; with interpretation	22.00
93042	Rhythm ECG, tracing with interpretation and report only	15.00
93220	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	95.00
93276	Scanning analysis with report	100.00
93300-26	Echocardiography, M-mode; professional component only	63.00

Cardiac Catheterization

93501	Right heart catheterization only	$ 560.00
93503	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography	360.00
93543	Injection procedure during cardiac catheterization; for pulmonary angiography	

	for selective left ventricular or left atrial angiography	300.00
93544	for aortography	300.00
93547	Combined left heart catheterization, selective coronary angiography and selective left ventricular angiography	750.00
93549	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography	994.50
	Noninvasive Peripheral Vascular Diagnostic Studies	
	Cerebrovascular Arterial Studies	
93870	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	$ 245.00
	Venous Studies	
93950-26	Noninvasive studies of extremity veins; professional component only	$ 36.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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
94150	Vital capacity, total	$ 15.00
94640	Nonpressurized inhalation treatment for acute airway obstruction	21.00
94650	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation	20.00
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	19.30
	Allergy and Clinical Immunology	
95120	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen	$ 7.50
95125	Multiple antigens (specify number of injections)	9.25

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

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

Code	Service	Maximum Fee
95819-26	Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation, standard or portable, same facility; professional component only	$ 55.00
95819-TC	technical component only	110.00
95833	Muscle testing, manual; total evaluation of body, excluding hand	10.00
95860	Electromyography; one extremity and related paraspinal areas	170.00
95860-26	professional component only	120.00
95861	two extremities and related paraspinal areas	235.00
95863	three extremities and related paraspinal areas	155.70
95864	four extremities and related paraspinal areas	215.20
95864-26	professional component only	152.00
95882	Assessment of higher cerebral function with medical interpretation; cognitive testing and others	150.00
95900	Nerve conduction, velocity, or latency study, motor, each nerve	50.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2100 PHYSICAL MEDICINE.

The following codes, service descriptions, and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities and procedures require supervision by the physician, and constant attendance by the physician or therapist.

Modalities

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

	10. Ultraviolet	$ 18.00
97010	Physical medicine treatment to one area; hot or cold packs	24.50
97012	Physical medicine treatment to one area; traction mechanical	15.50
97014	Physical medicine treatment to one area; electrical stimulation (unattended)	17.00
97020	Microwave	12.75
97024	Diathermy	14.75
97026	Infrared	7.50
97039	Unlisted modality (specify)	27.10
	Procedures	
97110	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	$ 26.50
97116	Gait training	20.00
97118	Electrical stimulation (manual)	16.00
97124	Massage	17.00
97128	Ultrasound	17.00
97145	Physical medicine treatment to one area, each additional 15 minutes	12.50
97240	Pool therapy or Hubbard tank with therapeutic exercises; initial 30 minutes, each visit	32.00
97261	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; each additional area	8.00
97700	Office visit, including one of the following tests or measurements, with report:	
	a. Orthotic checkout	
	b. Prosthetic checkout	
	c. Activities of daily living checkout; initial 30 minutes, each visit	45.00
97701	each additional 15 minutes	33.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2200 CRITICAL CARE SERVICES.

Critical care services (codes 99162 to 99173) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion 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	$ 8.00
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)	11.90
	Surgical Procedures	
99025	Initial, new patient visit when asterisk (*) surgical procedure constitutes major service at that visit	20.00
99058	Office services provided on an emergency basis	35.00
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
	Prolonged Services	
99150	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour	$ 100.00
99155	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes	65.00
99156	approximately 50 minutes	115.00
	Critical Care	
99160	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$ 140.00
99162	additional 30 minutes	75.00
99171	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness	55.00
99172	Critical care, subsequent follow-up	

	visit; limited examination, evaluation, or treatment for same or new illness	53.00
99173	intermediate examination, evaluation, or treatment, same or new illness	75.00
99174	Extended reexamination, reevaluation and/or treatment, same or new illness	131.00
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	62.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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.

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 11441) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions. Treatment of burns (codes 16000 to 16030) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12014) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12031 to 12052) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13120 to 13152) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in items A to C also apply to coding of repair services (codes 12001 to 13152):

A. When multiple wounds are repaired, the lengths of those of the same classification shall be added together and reported as a single item. When more than one classification of wounds 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. 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	$ 50.00

10003*	Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity	59.00
10020*	Incision and drainage of furuncle	35.00
10060*	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	51.50
10080	Incision and drainage of piloridial cyst; simple	59.25
10100*	Incision and drainage of onychia or paronychia single or simple	45.00
10120*	Incision and removal of foreign body, subcutaneous tissues; simple	50.00
10160*	Puncture aspiration of abscess, hematoma, bulla, or cyst	45.00
	Paring or Curettement	
11050*	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 27.00
11051	two to four lesions	40.00
11052	more than four lesions	52.00
	Biopsy	
11100	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 60.00
11101	each additional lesion	31.50
	Excision — Benign Lesions	
11200*	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 54.00
11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	68.00
11401	lesion diameter 0.5 to 1.0 centimeter	78.00
11402	lesion diameter 1.0 to 2.0 centimeters	96.50
11403	lesion diameter 2.0 to 3.0 centimeters	115.00
11404	lesion diameter 3.0 to 4.0 centimeters	130.00
11420	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	72.50
11421	lesion diameter 0.5 to 1.0 centimeter	91.25
11422	lesion diameter 1.0 to 2.0 centimeters	110.00
11423	lesion diameter 2.0 to 3.0 centimeters	140.00
11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	87.00

11441	lesion diameter 0.5 to 1.0 centimeter	108.80
	Nails	
11730*	Avulsion of nail plate, partial or complete, simple; single	$ 60.00
11740	Evacuation of subungual hematoma	35.00
	Miscellaneous	
11900	Injection, intralesional, up to and including seven lesions	$ 35.00
	Repair — Simple	
12001*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	$ 53.00
12002*	2.5 to 7.5 centimeters	77.00
12004*	7.5 to 12.5 centimeters	112.00
12005*	12.5 to 20.0 centimeters	134.00
12011*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	78.00
12013*	2.5 to 5.0 centimeters	107.00
	Repair — Intermediate	
12031*	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 80.00
12032	2.5 to 7.5 centimeters	100.00
12034	7.6 to 12.5 centimeters	143.10
12041*	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	98.00
12042	2.5 to 7.5 centimeters	130.00
12051*	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	110.00
12052	2.5 to 5.0 centimeters	139.00
	Repair — Complex	
13151	Repair, complex, eyelids, nose, ears, or lips; 1.0 to 2.5 centimeters	$ 420.00
13152	2.5 to 7.5 centimeters	697.00
	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	$ 726.25
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	850.00

	Free Skin Grafts	
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	$ 583.00
	Burns, Local Treatment	
16000	Initial treatment, first degree burn, when no more than local treatment is required	$ 50.00
16020*	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small	40.00
16025*	without anesthesia, medium, for example, whole face or whole extremity	66.00
	Destruction	
17000*	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 47.50
17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	36.50
17101	second lesion	20.25
17200*	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	51.00
17250*	Chemical cauterization of a wound	30.00
17340*	Cryotherapy (CO_2 slush, liquid N_2)	28.00

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

Excision — General

Code	Service	Maximum Fee
20220	Biopsy, bone, trocar, or needle; superficial, for example ilium, sternum, spinous process, ribs	$ 150.00
	Introduction or Removal — General	
20501*	Injection of sinus tract; diagnostic (sinogram) (separate procedure)	$ 48.88
20550*	Injection, tendon sheath, ligament, or trigger points	41.00
20600*	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	42.00
20605*	intermediate joint or bursa, for example, temporomandibular,	

	acromioclavicular, wrist, elbow, or ankle, olecranon bursa	58.55
20610*	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa	57.00
20680	Removal of implant; deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate	320.00

Head — Fracture or Dislocation

21240	Arthroplasty, temporomandibular joint	$ 2,226.00
21310	Treatment of closed or open nasal fracture without manipulation	45.00
21320	Manipulative treatment, nasal bone fracture; with stabilization	278.00
21455	Closed manipulative treatment by interdental fixation of closed or open mandibular fracture	718.43

Neck (Soft Tissues) and Thorax — Fracture or Dislocation

Spine

Code	Service	Maximum Fee
22555	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft)	$ 2,261.00

Shoulders — Fracture or Dislocation

23350	Injection procedure for shoulder arthrography	$ 58.00
23420	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy)	1,563.50
23450	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation	1,355.00
23500	Treatment of closed clavicular fracture; without manipulation	100.00
23550	Open treatment of closed or open acromioclavicular dislocation, acute or chronic	852.00
23650	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	146.00
23655	requiring anesthesia	197.00

Shoulder — Manipulation

23700*	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	$ 188.00

Humerus (Upper Arm) and Elbow — Fracture or Dislocation

24105	Excision, olecranon bursa	$ 375.00

24650	Treatment of closed radial head or neck fracture without manipulation	135.00
	Forearm and Wrist — Incision and Excision	
25111	Excision of ganglion, wrist (dorsal or volar); primary	$ 380.00
25500	Treatment of closed radial shaft fracture; without manipulation	150.50
	Forearm and Wrist — Fracture or Dislocation	
25505	Treatment of closed radial shaft fracture; with manipulation	$ 341.00
25565	Treatment of closed radial and ulnar shaft fractures; with manipulation	406.00
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	189.00
25605	with manipulation	318.00
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 skeletal fixation or percutaneous pinning	443.00
25611	with external skeletal fixation or percutaneous pinning	600.00
	Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction	
26055	Tendon sheath incision for trigger finger	$ 383.00
26160	Excision of lesion of tendon sheath or capsule	248.00
26418	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	255.00
	Hands and Fingers — Fractures or Dislocations	
26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 126.00
26605	with manipulation, each bone	195.00
26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone	490.00
26720	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	80.00
26725	with manipulation, each	137.00
26750	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	56.00
26770	Treatment of closed interphalangeal	

	joint dislocation, single, with manipulation; without anesthesia	62.00
	Hand and Fingers — Amputation	
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 275.00
27130	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple	3,050.00
27131	complex	3,628.00
27236	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	1,629.00
27244	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,491.00
	Femur (Thigh Region) and Knee Joint — Introduction or Removal	
27370	Injection procedure for knee arthrography	$ 55.64
27374	Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium	1,450.00
27378	with partial meniscectomy	1,380.00
27379	with plica resection or shelf resection	1,225.00
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27422	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	$ 1,156.00
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement)	3,000.00
27506	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,580.88
	Leg (Tibula and Fibula) and Ankle Joint —Fractures or Dislocations	
27752	Treatment of closed tibial shaft fracture; with manipulation	$ 425.00
27780	Treatment of closed proximal fibula or shaft fracture; without manipulation	150.00
27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	152.50
27792	Open treatment of closed or open	

	distal fibular fracture (lateral malleolus); with fixation	730.00
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation	511.00
27814	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	920.00
27822	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	1,112.00
27880	Amputation leg, through tibia and fibulat	893.00
	Foot — Fracture or Dislocation	
28080	Excision of Morton neuroma; single each	$ 350.00
28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot	303.80
28285	Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy)	385.00
28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure)	425.00
28292	Keller, McBride or Mayo type procedure	675.00
28296	with metatarsal osteotomy (Mitchell or Lapidus type procedure)	760.00
28470	Treatment of closed metatarsal fracture; without manipulation, each	133.13
28490	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	50.00
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	51.25
	Amputation	
28820	Amputation, toe; metatarso phalangeal joint	$ 300.00

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

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29065	shoulder to hand (long arm)	$ 82.50
29075	elbow to finger (short arm)	66.00
29085	hand and lower forearm (gauntlet)	67.00
	Splints	

29105	Application of long arm splint (shoulder to hand)	$ 47.00
29125	Application of short arm splint (forearm to hand); static	42.00
	Strapping — Any Age	
29220	Strapping; low back	$ 21.00
29260	elbow or wrist	20.00
29325	Application of hip spica cast; bilateral, or one and one-half spica	282.00
29345	Application of long leg cast (thigh to toes)	109.00
29355	walker or ambulatory type	124.00
29365	Application of cylinder cast (thigh to ankle)	85.00
29405	Application of short leg cast (below knee to toes)	82.00
29425	walking or ambulatory type	90.50
29435	Application of patellar tendon bearing (PTB) cast	119.00
29440	Adding walker to previously applied cast	32.25
29450	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	52.00
29455	bilateral	100.00
	Splints	
29505	Application of long leg splint (thigh to ankle or toes)	$ 74.00
29515	Application of short leg splint (calf to foot)	45.00
	Strapping — Any Age	
29530	Strapping; knee	$ 48.00
	Removal or Repair	
29720	Repair of spica, body cast, or jacket	$ 20.00
	Arthroscopy	
29874	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body (for example, osteochondritis dissecans fragmentation, chondral fragmentation)	$ 1,310.00
29875	synovectomy, limited (for example, plica or shelf resection)	1,210.00
29877	debridement/shaving of articular cartilage (chondroplasty)	1,400.00
29881	with meniscectomy (medial or lateral including any meniscal shaving)	1,450.00

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

Code	Service	Maximum Fee
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	$ 2,045.00
30520	Septoplasty with or without cartilage implant (separate procedure)	921.00
	Other Procedures	
30901	Control nasal hemorrhage, anterior, simple (cauterization); unilateral	$ 49.00
30903	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral	95.00
	Larynx	
31500	Intubation, endotracheal, emergency procedure	$ 95.00
31505	Laryngoscopy, indirect; diagnostic	35.00
31525	Laryngoscopy, direct; diagnostic, except newborn	291.00
31535	Laryngoscopy, direct; operative, with biopsy	470.00
31575	Laryngoscopy, flexible fiberscopic; diagnostic	74.00
	Trachea and Bronchi	
31600	Tracheostomy, planned (separate procedure)	$ 425.00
31620	Bronchoscopy; diagnostic, rigid bronchoscope	450.00
31621	diagnostic, fiberoptic bronchoscope (flexible)	449.50
31626	with biopsy, fiberoptic bronchoscope (flexible)	470.00
31627	with brushing, fiberoptic bronchoscope (flexible)	450.00
31628	with transbronchial lung biopsy, fiberoptic bronchoscope (flexible) under fluoroscopic guidance	493.75
	Lungs	
32000*	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	$ 115.50
32020	Tube thoracotomy with water seal (for example, pneumothorax, hemothorax, empyema)(separate procedure)	420.00

Subp. 7. **Cardiovascular system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the cardiovascular system. Injection procedures include necessary local anesthesia, introduction of needles or catheter, injection of contrast medium with or without automatic power injection, or necessary pre- and postinjection care specifically related to the

injection procedure. Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.

Heart

Code	Service	Maximum Fee
33210	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter	$ 429.00
	Coronary Artery Procedures	
33512	Coronary artery bypass, autogenous graft (for example, saphenous vein or internal mammary artery); three coronary arteries	$ 4,970.00
	Vascular Injection Procedures — Venous	
36000*	Introduction of needle or intracatheter, vein; unilateral	$ 23.00
36010	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery	331.00
36415*	Routine venipuncture for collection of specimen(s)	8.00
36431	Transfusion, blood or blood components; direct	27.30
36471*	Injection of sclerosing solution; multiple veins, same	36.50
36480*	Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous	105.00
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (for example, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	125.00
36510	Catheterization of umbilical vein for diagnosis or therapy, newborn	100.00
36520	Therapeutic apheresis (plasma and/or cell exchange)	150.00
	Vascular Injection Procedures — Arterial	
36620	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	$ 125.00
36660	Arterial catheterization, umbilical artery, newborn, for diagnosis or therapy	150.00

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
	Spleen	
38100	Splenectomy; total	$ 1,015.00

	Esophagus	
43200	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 350.00
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	343.00
43239	For biopsy and/or collection or specimen by brushing or washing	374.00
43450*	Dilation esophagus, by unguided sounds(s) or bougie(s), indirect; initial session	84.00
43451*	subsequent session	64.00
	Stomach	
43760*	Change of gastrostomy tube; simple	$ 47.50
43830	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure); neonatal, for feeding	632.00
43846	Gastric bypass with Roux-en-Y gastroenterostomy for morbid obesity	2,625.00
	Intestines	
44000	Enterolysis, freeing of intestinal adhesion	$ 840.00
44005	with acute bowel obstruction	1,094.25
44140	Colectomy, partial; with anastomosis	1,401.25
44950	Appendectomy	700.00
44960	for ruptured appendix with abscesses or generalized peritonitis	850.00
45300	Proctosigmoidoscopy; diagnostic	63.00
45330	Sigmoidoscopy, flexible fiberoptic; diagnostic	100.00
45331	for biopsy and/or collection of specimen by brushing or washing	147.00
45378	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure	475.00
45380	for biopsy and/or collection of specimen by brushing or washing	555.00
45385	for removal of polypoid lesion(s)	620.00
45505	Proctoplasty; for prolapse of mucous membrane	770.00
46255	Hemorrhoidectomy, internal and external, simple	625.00
46320*	Enucleation or excision of external thrombotic hemorrhoid	70.43
	Liver	
47600	Cholecystectomy	$ 1,071.75
47605	with cholangiography	1,250.00
47610	Cholecystectomy with exploration of common duct	1,330.00
49000	Exploratory laparotomy, exploratory celiotomy	719.75

49420*	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary	250.00
49500	Repair inguinal hernia, under age 5 years, with or without hydrocelectomy	608.00
49505	Repair inguinal hernia, age 5 or over; unilateral	695.00
49515	with excision of hydrocele or spermatocele	900.00
49520	recurrent	805.00
49530	incarcerated	900.00
49550	Repair femoral hernial groin incision	672.00
49560	Repair ventral (incisional) hernia (separate procedure)	780.00
49565	Repair ventral (incisional) hernia (separate procedure); recurrent	931.00
49580	Repair umbilical hernia; under age 5 years	510.00
49581	Repair umbilical hernia; age 5 or over	595.00
	Kidney	
50200*	Renal biopsy, percutaneous trocar or needle	$ 350.00
51600*	Injection procedure for cystography or voiding urethrocystography	17.00
51705*	Change of cystostomy tube; simple	39.00
51725	Simple cystometrogram (CMG) (for example, spinal manometer)	70.00
51726	Complex cystometrogram (for example, calibrated electronic equipment)	75.00
51736	Simple uroflowmetry	70.00
51840	Anterior vesicourethropexy, or urethropexy; simple	1,098.00
52000	Cystourethroscopy, office	140.00
52204	Cystourethroscopy with biopsy; office	163.63
52281	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office	230.00
52320	Cystourethroscopy; with removal of ureteral calculus	518.75
52332	Cystourethroscopy, with insertion of indwelling ureteral stent	319.00
53600*	Dilation of urethral stricture by passage of sound, male; initial	37.00
53660*	Dilation of female urethra including suppository and/or instillation; initial	29.00
53661	subsequent	28.00
53670*	Catheterization; simple	35.00
54640	Orchiopexy, any type, with or without hernia repair; unilateral	855.00
55040	Excision of hydrocele; unilateral	560.00
58150	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	1,199.25
58260	Vaginal hysterectomy	1,175.00
58265	with plastic repair of vagina, anterior and/or posterior colporrhaphy	1,375.00

58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	860.00
58980	Laparoscopy for visualization of pelvic viscera	550.00

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

Code	Service	Maximum Fee
61310	Craniectomy or craniotomy, evacuation of hematoma, extradural, subdural, or intracerebral; supratentorial	$ 2,625.00
	Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration	
62270*	Spinal puncture lumbar diagnostic	$ 90.00
62273*	Injection lumbar epidural, of blood or clot patch	200.00
62284*	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa	135.20
62289	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal	240.00
62292	Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar	1,775.00
	Spine and Spinal Cord — Laminectomy or Laminotomy, for Exploration or Decompression	
63005	Laminectomy for decompression of spinal cord and/or cavda equina, one or two segments; lumbar, except for spondylolisthesis	$ 2,060.00
63020	Laminotomy (hemilaminectomy), for excision of herniated intervertebral disk, and/or decompression of nerve root; one interspace, cervical, unilateral	2,025.00
63030	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, lumbar, unilateral	1,936.00
63042	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or reexploration; lumbar	2,150.00
	Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System — Exploration, Neurolysis, or Nerve Decompression (Neuroplasty)	
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	$ 130.00
64450*	Injection, anesthetic agent; other peripheral nerve or branch	110.00
64718	Neurolysis or transposition; ulnar nerve at elbow	891.00
64721	median nerve at carpal tunnel	698.00
64831	Suture of digital nerve, hand or foot; one nerve	450.00

Eye and Ocular Adnexa — Removal of Ocular Foreign Body

65205*	Removal foreign body, external eye; conjunctival superficial	$ 40.80
65210*	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	50.00
65220*	corneal, without slit lamp	50.00
65222*	corneal, with slit lamp	60.00
65420	Excision or transposition of pterygium; without graft	437.50
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure)	1,893.00
67226	Destruction of progressive retinopathy, one or more stages; photocoagulation, laser	650.00
68800*	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	35.00
68825	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring hospitalization	237.00

Auditory System

69433*	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral	$ 152.50
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral	210.00
69437	bilateral	350.00
69440	Middle ear exploration through postauricular or ear canal incision	865.00
69620	Myringoplasty	1,186.00
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	1,785.75
69632	with ossicular chain reconstruction (for example, postfenestration)	2,006.00
69641	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	2,100.00

Subp. 10. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 10 SR 1548; 11 SR 491; 12 SR 662*

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
70050	Radiologic examination, eye; for detection and localization of foreign body	$ 22.40
70100	Radiologic examination, mandible; partial, less than four views	45.00
70100-26	professional component only	20.75
70110-26	professional component only	21.20
70120	Radiologic examination, mastoids; less than three views per side	53.00
70130	Radiologic examination, mastoids; complete, minimum of three views per side	87.00
70134	Radiologic examination, internal auditory meati, complete	78.00
70140	Radiologic examination, facial bones; less than three views	56.91
70140-26	professional component only	18.88
70150-26	professional component only	24.50
70160	Radiologic examination, nasal bones; complete, minimum of three views	48.38
70160-26	professional component only	15.00
70200-26	professional component only	23.20
70210	Radiologic examination, sinuses, paranasal, less than three views	35.00
70210-26	professional component only	16.00
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies	66.00
70220-26	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies; professional component only	23.25
70260-26	Radiologic examination, skull, less than four views, with or without stereo, complete, minimum of four views; professional component only	33.00
70260-TC	technical component only	57.50
70320	Radiologic examination, teeth; complete, full mouth	51.00
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	67.50
70355-26	Orthopantogram; professional component only	19.00
70360	Radiologic examination, neck, soft tissue	28.00
70360-26	professional component only	13.50
70450-26	professional component only	77.00
70460-26	professional component only	86.25
70470-26	professional component only	105.50

Chest

71010	Radiologic examination, chest; single view, posteroanterior	$ 31.50
71010-26	professional component only	13.50
71010-TC	technical component only	30.00
71015	stereo, posteroanterior	33.30

71020	two views, posteroanterior and lateral	45.00
71020-TC	technical component only	38.25
71020-26	professional component only	18.75
71021	Radiological examination, frontal and lateral; with apical lordotic procedure	41.50
71022	Radiologic examination, chest; with oblique projections	21.00
71022-26	professional component only	21.00
71030-26	professional component only	27.38
71100-26	Radiologic examination, ribs, unilateral; two views; professional component only	19.50
71100-TC	technical component only	40.00
71110	Radiologic examination, ribs, bilateral; three views	60.00
71110-26	professional component only	28.13
71120	Radiologic examination; sternum, minimum of two views	38.00
71120-26	professional component only	17.70
71250-26	Computerized axial tomography, thorax; without contrast material; professional component only	126.00
71260-26	professional component only	105.50
	Spine and Pelvis	
72010-26	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral; professional component only	$ 42.25
72020-26	Radiologic examination, spine, single view, specify level; professional component only	15.00
72040	Radiologic examination, spine, cervical; anteroposterior and lateral	47.00
72040-26	professional component only	20.00
72050	minimum of four views	75.00
72050-26	professional component only	27.00
72050-TC	technical component only	55.50
72070	Radiologic examination, spine; thoracic, anteroposterior and lateral	53.00
72070-26	professional component only	22.00
72070-TC	technical component only	47.00
72072-26	professional component only	22.10
72080	thoracolumbar, anteroposterior and lateral	62.00
72090	scoliosis study, including supine and erect studies	50.00
72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	57.95
72100-26	professional component only	24.50
72110	complete, with oblique views	80.00
72110-26	professional component only	30.00
72110-TC	technical component only	62.00
72114	complete, including bending views	95.00
72125-26	Computerized axial tomography, cervical spine; without contrast material; professional component only	114.00
72126-26	professional component only	135.00
72128-26	Computerized axial tomography,	

	thoracic spine; without contrast material; professional component only	111.75
72129	Computerized axial tomography, thoracic spine; with contrast material	120.00
72131	Computerized axial tomography, lumbar spine; without contrast material	465.00
72131-26	professional component only	100.00
72132-26	professional component only	104.00
72170-26	Radiologic examination, pelvis; anteroposterior only; professional component only	16.00
72180-26	professional component only	22.25
72190	complete, minimum of three views	61.00
72190-26	professional component only	21.50
72192-26	Computerized axial tomography, pelvis; without contrast material; professional component only	114.00
72193-26	with contrast material(s); professional component only	97.00
72200	Radiologic examination, sacroiliac joints; less than three views	45.00
72202	three or more views	49.00
72202-26	professional component only	19.90
72220	Radiologic examination, sacrum and coccyx, minimum of two views	48.00
72220-26	professional component only	17.70
72241-26	Myelography, cervical, complete procedure; professional component only	245.06
72265-26	Myelography, lumbosacral; supervision and interpretation only; professional component only	67.00
72266-26	complete procedure; professional component only	198.69
72270	Myelography, entire spinal canal; supervision and interpretation only	194.40
72271	complete procedure	305.00
72271-26	professional component only	303.50
	Upper Extremities	
73000	Radiologic examination; clavicle, complete	$ 33.00
73000-26	professional component only	12.75
73000-TC	technical component only	42.00
73010-26	professional component only	15.00
73020	Radiologic examination, shoulder; one view	35.00
73020-26	professional component only	13.25
73030-26	professional component only	15.00
73040-26	Radiologic examination, shoulder, arthrography; supervision and interpretation only; professional component only	14.00
73041-26	complete procedure; professional component only	167.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	48.50

73050-26	professional component only	15.88
73060	humerus, minimum of two views	39.00
73060-26	professional component only	14.00
73070	Radiologic examination, elbow; anteroposterior and lateral views	38.00
73070-26	professional component only	13.50
73070-TC	technical component only	34.00
73080	complete, minimum of three views	39.00
73080-26	professional component only	15.75
73080-TC	technical component only	36.00
73090	Radiologic examination; forearm, anteroposterior and lateral views	37.00
73090-26	professional component only	14.00
73090-TC	technical component only	34.00
73100	Radiologic examination, wrist; anteroposterior and lateral views	37.00
73100-26	professional component only	13.50
73100-TC	technical component only	34.00
73110	complete, minimum of three views	41.00
73110-26	professional component only	15.75
73110-TC	technical component only	42.50
73120	Radiologic examination, hand; two views	36.50
73120-26	professional component only	13.25
73120-TC	technical component only	23.75
73130	minimum of three views	40.50
73130-26	professional component only	14.00
73130-TC	technical component only	41.50
73140	Radiologic examination, finger or fingers, minimum of two views	32.00
73140-26	professional component only	12.00
73140-TC	technical component only	30.00
	Lower Extremities	
73500	Radiologic examination, hip; unilateral, one view	$ 36.56
73500-26	professional component only	14.10
73510	complete, minimum of two views	48.00
73510-26	professional component only	20.00
73510-TC	technical component only	41.00
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	56.00
73520-26	professional component only	24.21
73530-26	Radiologic examination, hip, during operative procedure; professional component only	28.50
73540	Radiologic examination, pelvis and hips, infant or child, minimum of two views	48.00
73550	Radiologic examination, femur, anteroposterior, and lateral views	42.00
73550-26	professional component only	14.50
73560	Radiologic examination, knee; anteroposterior and lateral views	40.00
73560-26	professional component only	14.00
73560-TC	technical component only	33.00
73562	anteroposterior and lateral; with	

	oblique, minimum of three views	50.00
73562-26	professional component only	14.50
73562-TC	technical component only	39.00
73564	complete, including oblique, or tunnel, or patellar, or standing views	55.75
73564-26	professional component only	18.00
73564-TC	technical component only	65.00
73580	Radiologic examination, knee, arthography; supervision and interpretation only	120.00
73581-26	Radiologic examination, knee, arthography; complete procedure; professional component only	144.50
73590	Radiologic examination, tibia and fibula, anteroposterior and lateral views	40.00
73590-26	professional component only	14.00
73590-TC	technical component only	36.50
73600	Radiologic examination, ankle; anteroposterior and lateral views	35.20
73600-26	professional component only	13.50
73600-TC	technical component only	30.10
73610	complete, minimum of three views	41.00
73610-26	professional component only	15.00
73610-TC	technical component only	40.00
73620	Radiologic examination, foot; anteroposterior and lateral views	35.00
73620-26	professional component only	14.00
73620-TC	technical component only	28.70
73630	complete, minimum of three views	43.00
73630-26	professional component only	14.25
73630-TC	technical component only	41.00
73650	Radiologic examination; calcaneus, minimum of two views	36.00
73650-26	professional component only	13.00
73660	toe or toes, minimum of two views	32.00
73660-26	professional component only	11.70
73660-TC	technical component only	30.00

Abdomen

74000-26	Radiologic examination, abdomen, single anteroposterior view; professional component only	$ 16.00
74000-TC	technical component only	32.00
74010-26	anteroposterior and additional oblique and cone views, professional component only	20.25
74020-26	complete, including decubitus or erect views, professional component only	22.50
74022	Complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest	32.00
74022-26	professional component only	32.00
74150-26	Computerized axial tomography, abdomen; without contrast material, professional component only	108.50
74160-26	with contrast materials;	

	professional component only	114.00
74170-26	without contrast material followed by contrast material and further sections; professional component only	136.00
	Gastrointestinal Tract	
74220-26	Radiologic examination; esophagus; professional component only	$ 49.50
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	90.00
74240-26	professional component only	52.00
74241	with or without delayed films, with KUB	58.00
74241-26	professional component only	46.50
74241-TC	technical component only	58.00
74245-26	with small bowel, includes multiple serial films; professional component only	73.75
74247	with or without delayed films, with KUB	57.00
74250-26	Radiologic examination, small bowel, includes multiple serial films; professional component only	48.00
74270	Radiologic examination, colon; barium enema	90.00
74270-26	professional component only	52.00
74270-TC	technical component only	72.00
74280-26	air contrast with specific high density barium, with or without glucagon; professional component only	69.00
74290	Cholecystography, oral contrast	64.90
74290-26	professional component only	24.75
74290-TC	technical component only	57.00
74300-26	Cholangiography; during surgery, professional component only	39.00
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography	59.00
74330-26	professional component only	53.00
	Urinary Tract	
74400-26	Urography, intravenous, including kidneys, ureters, and bladder; professional component only	$ 52.50
74405-26	Urography (pyelography), intravenous, including kidneys, ureters, and bladder with special hypertensive contrast concentration or clearance studies; professional component only	48.00
74410-26	Urography, infusion, drip technique; professional component only	39.13
74420-26	Urography, retrograde, with or without kidneys, ureters, and bladder; professional component only	23.63
74425-26	professional component only	43.00

74430-26	Cystography, minimum of three views; supervision and interpretation only, professional component only	27.00
74455-26	Urethrocystography, voiding; professional component only	37.50
74456-26	professional component only	56.25
75628-26	Aortography, abdominal, catheter by serialography; professional component only	361.31
75631-26	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography; professional component only	416.00
75655-26	Angiography, cerviocerebral, selective catheter, including vessel origin; two vessels, complete procedure; professional component only	474.50
75657-26	three or four vessels, complete procedure; professional component only	551.25
75712-26	Angiography, by serialography, complete procedure; professional component only	229.00
75750-26	Angiography, coronary, root injection; professional component only	76.50
75754-26	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; professional component only	131.25
	Veins and Lymphatics	
75821-26	Venography, extremity, unilateral; complete procedure; professional component only	$ 120.50
	Miscellaneous	
76062	Radiologic examination, osseous survey; complete	$ 160.00
76081-26	Radiologic examination, fistula or sinus tract study; complete procedure; professional component only	63.00
76100	Radiologic examination, single plane body section	96.50

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
76511	Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification	$ 150.00
76516	Echography, ophthalmic, ultrasonic biometry;	150.00
76519	Ophthalmic biometry by ultra sound echography, A-mode	168.00

Chest

76604	B-scan (includes Mediastinum) and/or real time with image documentation	$ 63.75
76620-26	Echocardiography, M-mode; professional component only	96.65
76629	Echocardiography, M-mode and real time with image documentation	186.00
76700-26	Echography, abdominal, B-scan; professional component only	67.50
76705-26	limited; professional component only	46.25
76770-26	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; professional component only	63.75
76775-26	Echography, retroperitoneal, B-scan and/or real time with image documentation; complete; professional component only	68.25

Pelvis

76805-26	Echography, pelvic, B-scan (for example, real time), in obstetrics, gynecology, or transplants; complete; professional component only	$ 61.50

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
77300-26	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation off axis factor, tissue inhomogeneity factors, as required during course of treatment; professional component only	$ 50.00
77334	Treatment devices, design and construction; complex	92.00

77336	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance	90.00
77400-26	professional component only	34.75
77410-26	professional component only	48.00
77420-26	Weekly megavoltage treatment management; simple; professional component only	48.00
77465-26	Daily kilovoltage treatment management; professional component only	40.00
77465-TC	technical component only	33.75

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

Code	Service	Maximum Fee
78000-26	Thyroid uptake; single determination; professional component only	$ 19.75
78006-26	Thyroid imaging, with uptake; single determination, professional component only	59.00
78010-26	Thyroid imaging; only, professional component only	49.60
	Diagnostic - Gastrointestinal System	
78201	Liver imaging only	$ 69.00
78215-26	Liver and spleen imaging; professional component only	72.50
78216	with vascular flow	86.00
78220-26	professional component only	63.00
78223-26	professional component only	85.00
78280	Gastrointestinal blood loss study	74.90
78290	Bowel imaging (for example, ectopic gastric mucosa, Meckel's localization, volvulus	72.50
78300-26	Bone imaging; limited area (for, example, skull, pelvis), professional component only	52.00
	Diagnostic - Musculoskeletal System	
78305-26	professional component only	$ 82.00
78306-26	whole body; professional component only	79.38
78310	Bone imaging; vascular flow only	70.00
	Diagnostic - Cardiovascular System	
78402	Cardiac blood pool imaging, with vascular flow assessment (sequential imaging with or without time activity curve evaluation)	$ 78.60
78403-26	Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion; professional component only	87.00
78411	Cardiac blood pool imaging by first pass technique, with determination of global or regional ventricular function (specify right, left, or both) including but not	

	necessarily limited to ejection fraction and wall motion, at rest	107.50
78422	Myocardium imaging; regional Myocardial perfusion at rest for evaluation of infarction (infarct avid imaging)	75.00
78424	Myocardium imaging; with quantitive evaluation (for example, pharmacokinetic temporal assessment) regional myocardial perfusion (redistribution resting or postexercise study)	76.80
78580-26	professional component only	76.80
	Diagnostic - Respiratory System	
78581	Pulmonary perfusion imaging; gaseous	$ 76.00
78582	gaseous, with ventilation, rebreathing and washout	78.10
78587	multiple projections	73.50
78587-26	professional component only	58.75
78591-26	Pulmonary ventilation imaging, gaseous single breath, single projection; professional component only	62.00
78593	Pulmonary ventilation imaging, gaseous, with rebreathing and washout, with or without single breath; single projection	65.00
	Nervous System	
78605	Brain imaging, complete study; static	$ 77.00
	Genitourinary System	
78704	Kidney imaging; with function study (imaging renogram)	$ 76.00
78715	Kidney vascular flow only	51.00
78715-26	professional component only	45.00
78720-26	professional component only	69.88

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

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

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

Albumin
Albumin/globulin ratio
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content

Chloride
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase (LDH)
Phosphatase, alkaline
Phosphorus (inorganic phosphate)
Potassium
Protein, total
Sodium
Transaminase, glutamic oxaloacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen (BUN)
Uric acid

Automated Multichannel Tests

Code	Service	Maximum Fee
80002	Automated multichannel tests; 1 or 2 clinical chemistry tests	$ 14.75
80003	Automated multichannel tests; 3 clinical chemistry tests	30.00
80004	4 clinical chemistry tests	24.00
80005	5 clinical chemistry tests	31.50
80006	6 clinical chemistry tests	26.50
80007	7 clinical chemistry tests	27.50
80008	8 clinical chemistry tests	30.00
80010	10 clinical chemistry tests	32.00
80011	11 clinical chemistry tests	38.90
80012	12 clinical chemistry tests	35.00
80016	13-16 clinical chemistry tests	38.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of test performed)	35.00
80031	Therapeutic quantitative drug monitoring in blood and/or urine; measurement one drug	37.80
80053	Executive profile	60.00
80055	Obstetric profile	32.00
80056	Amenorrhea profile	130.00
80058	Hepatic function panel	28.00
80059	Hepatitis panel	57.25
80060	Hypertension panel	30.00
80061	Lipid profile	30.00
80062	Cardiac evaluation (including coronary risk) panel	32.00
80064	Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination	25.00
80065	Metabolic panel	48.75
80070	Thyroid panel	29.50
80072	Arthritis panel	41.00
80086	Macrocytic anemia panel	42.00

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	$ 11.00
81002	routine, without microscopy	7.00
81004	components, single, not otherwise listed, specify	6.50
81005	chemical, qualitative, any number of constituents	5.50
81015	microscopic only	8.00

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

Code	Service	Maximum Fee
82011	Acetylsalicylic acid; quantitative	$ 19.00
82060	Alcohol, blood; by gas-liquid chromatography	36.10
82137	Aminophylline	32.50
82150	Amylase, serum	19.00
82156	Amylase, urine	20.30
82205	Barbiturates; quantitative	32.75
82210	quantitative and identification	31.00
82245	Bile pigments, urine	6.00
82250	Bilirubin; blood, total OR direct	15.00
82310	Calcium, blood; chemical	13.75
82340	Calcium, urine; quantitative, timed specimen	17.10
82372	Carbamazepine, serum	30.00
82435	Chlorides; blood (specify chemical or electrometric)	17.00
82465	Cholesterol, serum; total	14.40
82480	Cholinesterase; serum	35.00
82512	Clonazepam	39.40
82533	Cortisol; RIA, plasma	41.00
82540	Creatine; blood	12.00
82555	Colorimetric	18.00
82565	Creatinine; blood	13.75
82575	clearance	29.00
82607	Cyanocobalamin (Vitamin B-12); RIA	33.00
82660	Drug screen (amphetamines, barbiturates, alkaloids)	40.00
82756	Free thyroxine index (T-7)	25.00
82785	Gammaglobulin, E	28.50
82792	Gases, blood, oxygen saturation; by oximetry	35.00
82947	Glucose; except urine (for example, blood, spinal fluid, joint fluid)	14.00
82949	Glucose; fermentation	9.00
82950	post glucose dose (includes glucose)	15.00
82951	tolerance test (GTT), three specimens (includes glucose)	42.00
82996	Gonadotropin, chorionic, bioassay; qualitative	17.00
82997	quantitative	22.00
82998	Gonadotropin, chorionic, RIA	28.50
83001	RIA	44.00
83002	Gonadotropin, pituitary, luteinizing	

	hormone (LH) (ICSH), RIA	50.00
83036	Hemoglobin; glycosylated	19.00
83050	Methemoglobin	8.00
83523	Imipramine	52.40
83540	Iron, serum; chemical	15.00
83545	automated	13.00
83555	automated	26.30
83565	Iron binding capacity, serum; radioactive uptake method	26.50
83620	colorimetric or fluorometric	14.55
83690	Lipase, blood	19.90
83705	Lipids, blood; fractionated	19.20
83718	Lipoprotein high density cholesterol by precipitation method	17.90
83725	Lithium, blood, quantitative	18.75
83735	Magnesium, blood; chemical	17.10
83835	Metanephrines, urine	29.45
83930	Osmolality; blood	9.80
83970	Parathormone, RIA	92.90
84030	Phenylalanine (PKU), blood; Guthrie	13.00
84045	Phenytoin	29.50
84060	Phosphatase, acid; blood	21.50
84065	prostatic fraction	24.00
84075	Phosphatase, alkaline, blood;	15.00
84080	isoenzymes, electrophoretic method	39.00
84100	Phosphorus (phosphate); blood	11.40
84105	urine	14.50
84132	Potassium; blood	15.00
84141	Primidone	40.70
84144	Progesterone, any method	45.00
84146	Prolactin, RIA	46.00
84165	Protein, total, serum; electrophoretic fractionation and quantitation	25.70
84175	Protein, other sources, quantitative	16.50
84180	Protein, urine; quantitative, 24-hour specimen	16.70
84190	electrophoretic fractionation and quantitation	32.20
84202	Protoporphyrin, RBC; quantitative	13.00
84203	screen	9.00
84295	Sodium; blood	12.00
84403	Testosterone, blood, RIA	84.00
84420	Theophylline, blood, or saliva	30.00
84435	Thyroxine, CPB or resin uptake	18.00
84436	Thyroxine, true, RIA	18.50
84439	Thyroxine, free, RIA	22.00
84442	Thyroxine binding globulin (TBG)	33.50
84443	Thyroid stimulating hormone (TSH), RIA	37.95
84447	Toxicology, screen; general	87.00
84450	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method	15.00
84460	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	14.00
84478	Triglycerides, blood	15.00
84480	Triiodothyronine, true, RIA	50.00
84520	Urea nitrogen, blood (BUN); quantitative	14.00

84550	Uric acid; blood, chemical	14.00
84555	uricase, ultraviolet method	13.20
84560	Uric acid, urine	17.50

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

Code	Service	Maximum Fee
85000	Bleeding time; Duke	$ 8.00
85002	Ivy or template	20.40
85007	Blood count; basophil count, differential WBC count (includes RBC morphology and platelet estimation)	11.00
85012	eosinophil count, direct	14.00
85014	hematocrit	7.00
85018	hemoglobin, colorimetric	9.00
85021	hemogram, automated (RBC, WBC, Hgb, Hct and indexes only)	19.00
85022	hemogram, automated, with platelet count	25.00
85027	hemogram, automated, and differential WBC count (CBC)	14.50
85028	Hemogram, automated, and differential WBC count (CBC) with platelet count	26.00
85031	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes)	21.00
85044	reticulocyte count	13.25
85048	White blood cell (WBC)	9.00
85097	Bone marrow smear and/or cell block; smear interpretation only	80.00
85097-26	professional component only	70.00
85100	aspiration, staining, and interpretation	105.00
85102	Bone marrow needle biopsy	80.00
85103-26	Bone marrow needle biopsy; staining and interpretation; professional component only	43.00
85105-26	professional component only	70.00
85544	Lupus erythematosus (LE) cell prep	24.00
85548	Morphology of red blood cells only	27.00
85580	Platelet; count (Rees-Ecker)	14.00
85585	Platelet; estimation on smear only	9.00
85590	phase microscopy	15.00
85595	electronic technique	14.00
85610	Prothrombin time;	12.00
85650	Sedimentation rate (ESR); Wintrobe type	10.00
85651	Westergren type	9.50
85660	Sickling of RBC, reduction, slide method	14.00
85730	Thromboplastin time, partial; plasma or whole blood	17.30

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

Code	Service	Maximum Fee
86000	Agglutinins; febrile, each	$ 16.20
86006	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	15.50
86007	Antibody, qualitative, not otherwise	

	specified; each additional antigen	25.00
86013	Antibody absorption, cold auto absorption; differential	7.50
86024	Antibody identification; RBC antibodies (8-10 cell panel); standard technique	24.00
86028	Saline or high protein, each	34.50
86031	Antihuman globulin test; direct, 1-3 dilutins	14.13
86032	indirect, qualitative	20.00
86060	Antistreptolysin O; titer	19.25
86063	screen	14.00
86072	Blood crossmatch; enzyme technique	20.40
86080	Blood typing; ABO only	8.00
86082	ABO and Rho(D)	20.30
86095	Blood typing, RBC, antigens other than ABO or Rho(D); antiglobulin technique, each antigen	20.00
86105	Blood typing; Rh genotyping, complete	8.00
86140	C-reactive protein	13.50
86151	Carcinoembryonic antigen (CEA); RIA	60.00
86163	Complement; C'3 esterase	28.56
86171	Complement fixation tests, each (for example, cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis)	15.50
86185	Counterelectrophonesis, each antigen	81.50
86225	Deoxyribonucleic acid (DNA) antibody	33.45
86255	Fluorescent antibody; screen	30.00
86256	titer	30.70
86280	Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral)	16.00
86286	Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA); counterelectrophoresis with concentration of serum	25.00
86289	Hepatitis B core antibody; RIA or EIA	15.00
86291	Hepatitis B surface antibody	25.40
86293	Hepatitis Be antigen	52.00
86296	Hepatitis A antibody	33.30
86300	Heterophile antibodies; screening (includes monotype test), slide or tube	14.50
86305	Heterophile antibodies; quantitive titer	18.00
86329	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify)	40.00
86430	Rheumatoid factor, latex fixation	16.50
86580	Skin test; tuberculosis, patch, or intradermal	9.00
86585	tuberculosis, tine test	7.50
86590	Streptokinase, antibody	10.00
86592	Syphilis, precipitation or flocculation tests, qualitative VDRL, RPR, ART	10.00
86650	Treponema antibodies, fluorescent, absorbed	37.50

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

Code	Service	Maximum Fee
87040	Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen)	$ 23.00
87045	stool	27.50
87060	Culture, bacterial, definitive, aerobic, throat or nose	12.00
87070	any other source	21.00
87072	Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine	13.50
87081	Culture, bacterial, screening only, for single organisms	12.70
87082	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	12.00
87086	Culture, bacterial, urine; quantitative, colony count	17.60
87088	identification, in addition to quantitative or commercial kit	22.00
87106	Culture, fungi, isolation; skin; definitive identification, by culture, per organism, in addition to skin or other source	26.30
87147	Serologic method, agglutination grouping, per antiserum	15.00
87163	Culture, special extensive definitive diagnostic studies, beyond usual definitive studies	22.50
87164	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection	7.50
87177	Ova and parasites, direct smears, concentration and identification	24.00
87181	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	15.00
87184	disc method, each plate (12 or less discs)	17.50
87186	microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics	21.05
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	13.00
87208	direct or concentrated, dry, for ova and parasites	12.50
87210	wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites	12.00
87211	wet and dry mount, with interpretation, for ova and parasites	11.50
87220	Tissue examination for fungi (for example, KOH slide)	12.50

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

Cytopathology

Code	Service	Maximum Fee
88104	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 32.25
88109	smears and cell block with interpretation	53.50
88160	Cytopathology, any other source; screening and interpretation	35.00
88161-26	preparation, screening, and interpretation; professional component only	28.50

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
88302	Surgical pathology, gross and microscopic; examination for identification and record purposes (for example, uterine tubes, vas deferens, sympathetic ganglion)	$ 35.00
88302-26	professional component only	31.00
88304	diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy)	45.00
88307	complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides	90.00
88309	Complex diagnostic problem with or without dissection	150.00
88312	Special stains; Group I stains for microorganisms	25.00
88329-26	Consultation during surgery; professional component only	40.00
88331	with frozen section(s); single specimen	100.00

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

Code	Service	Maximum Fee
89007	Test combinations assigned individual procedure numbers for secretarial convenience only; CBC, urinalysis, serology, blood typing, and Rh grouping (includes codes 85022 or 85031, 81000, 86592, 86082, and 86100)	$ 25.00
89051	with differential count	13.40
89130	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology	42.10
89180	Microscopic examination for eosinophils, nasal secretions, sputum,	

	bronchoscopic aspiration, mucus of stools, others (specify)	11.60
89190	Nasal smear for eosinophils	11.25
89320	complete	39.75
89350	Sputum, obtaining specimen, aerosol induced technique	54.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2500 DENTISTS.

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

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

Clinical Oral Examination

Code	Service	Maximum Fee
00110	Initial oral examination	$ 15.00
00120	Periodic oral examination	12.00
00130	Emergency oral examination	15.00
	Radiographs	
00210	Intraoral complete series	$ 38.00
00220	Intraoral; periapical, single, first film	6.00
00272	Bitewing; two films	10.00
00274	four films	16.00
00330	Panoramic; maxilla and mandible, film	35.00
00335	maxilla and mandible, film, with bitewings	43.00
00340	Cephalometric film	38.00
	Tests and Laboratory Examinations	
00450	Histopathologic examination	$ 40.00
	Restorative	
02110	Amalgam; one surface, deciduous	$ 25.00
02120	Amalgam; two surfaces, deciduous	35.00
02130	Amalgam; three surfaces, deciduous	45.00
02131	Amalgam; four surfaces, deciduous	54.00
02140	Amalgam; one surface, permanent	25.00
02150	Amalgam; two surfaces, permanent	36.00
02160	Amalgam; three surfaces, permanent	48.00
02161	Amalgam; four or more surfaces, permanent	58.00
	Acrylic or Plastic Restorations	
02330	Composite resin; one surface	$ 34.00
02331	Composite resin; two surfaces	46.00
02332	Composite resin; three surfaces	61.00
02335	Composite resin (involving incisal angle	60.00
	Crowns - Single Restoration Only	
02711	Plastic, prefabricated	$ 90.00
02825	Removal of tooth, soft tissue impaction	80.00

02826	Removal of tooth, partial bony impaction	88.00
02827	Removal of tooth, complete bony impaction	90.00
02830	stainless steel	75.00
02910	Recement inlays	25.00
02920	Recement crowns	22.00
02940	Fillings	21.00
02950	Crown buildups	75.00

Endodontics

03220	Vital pulpotomy	$ 40.00

Root Canal Therapy

03310	Anterior (excludes final restoration)	$ 171.75
03320	Bicuspid (excludes final restoration)	200.00
03330	Molar (excludes final restoration)	260.00
03410	Apicoectomy - performed as separate surgical procedure (per root)	130.00
03950	Canal preparation and fitting of preformed dowel or post	60.00

Prosthodontics, Removable

Complete Dentures - including six months postdelivery care

05110	Complete upper	$ 453.00
05120	Complete lower	455.00
05130	Immediate upper	450.00
05140	Immediate lower	450.00

Partial Dentures - including six months postdelivery care

05212	Lower - without clasps, acrylic base	$ 498.75
05216	Upper - with two chrome clasps with rests, acrylic base	485.00
05218	Lower - with chrome clasps with rests, acrylic base	500.00
05231	Lower - with chrome lingual bar and two clasps, acrylic base	500.00
05241	Lower - with chrome lingual bar and two clasps, cast base	525.00
05251	Upper - with chrome palatal bar and two clasps, acrylic base	500.00
05261	Upper - with chrome palatal bar and two clasps, cast base	550.00
05292	Full cast partial - with two chrome clasps (upper)	520.00
05294	Full cast partial - with two chrome clasps (lower)	520.00

Repairs to Dentures

05610	Repair broken or complete or partial denture - no teeth damaged	$ 51.00
05620	Repair broken complete or partial denture - replace one broken tooth	59.00
05640	Replace broken tooth or denture - no other repairs	45.00
05650	Adding tooth to partial denture to	

	replace extracted tooth - each tooth (not involving clasp or abutment tooth)	65.00
05660	Adding tooth to partial denture to replace extracted tooth - each tooth (involving clasp or abutment tooth)	92.25
05670	Reattaching damaged clasp on denture	65.00
05680	Replacing broken clasp with new clasp on denture	75.00
05690	Each additional clasp with rest	64.80
	Denture Duplication	
05710	Duplicate upper or lower complete denture	$ 202.50
05720	Duplicate upper or lower partial denture	207.50
	Denture Relining	
05740	Relining upper or lower partial denture (office reline)	$ 95.00
05750	Relining upper or lower complete denture (laboratory)	150.00
05760	Relining upper or lower partial denture (laboratory)	144.50
	Other Prosthetic Services	
05820	Denture temporary (partial stayplate), upper	$ 160.00
05850	Tissue Conditioning	28.00
	Prosthodontics, Fixes	
06640	Replace broken facing with acrylic	$ 54.00
06930	Recement bridge	40.00
	Oral Surgery	
	Extractions - includes local anesthesia and routine postoperative care	
07110	Single tooth	$ 30.00
07120	Each additional tooth	28.00
	Surgical Extractions - includes local anesthesia and routine postoperative care	
07210	Extraction of tooth - erupted	$ 70.00
07220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	80.00
07230	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the removal of the tooth	100.00
07240	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal	120.00
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	135.00

07250	Root recovery (surgical removal of residual root)	60.00
07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons - including wire attachment	80.00
07310	Alveoloplasty (per quadrant) in conjunction with extractions	60.00
07320	per quadrant; not in conjunction with extractions	75.00
	Surgical Excision	
07425	Excision periocoronial gingiva	$ 30.60
07510	Incision and drainage of abscess, intraoral	44.50
	Other Oral Surgery	
07960	Frenulectomy	$ 80.00
	Adjunctive General Services	
	Unclassified treatment	
09220	General	$ 70.00
	Miscellaneous Services	
09910	Application of desensitizing medicaments	$ 15.00

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Subp. 6. [Repealed, 10 SR 765]

Subp. 7. [Repealed, 10 SR 765]

Subp. 8. [Repealed, 10 SR 765]

Subp. 9. [Repealed, 10 SR 765]

Subp. 10. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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
06503	Trifocal lens	$108.00
06506	Frames	69.00
06587	Contact lens, soft	161.00
06589	Dispensing fee, single vision lens	36.10
06592	Dispensing fee, special lenses (e.g. prisms, tints, or lenticular)	10.00
06593	Dispensing fee, frames	45.20
09201	Eye examination with complete visual fields included	40.00
09203	Eye examination with slit lamp	

	angle testing	49.00
09206	Orthoptic evaluation	35.00
09213	Eye refraction	38.00

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765*

5221.2700 AUDIOLOGISTS.

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
92506	Medical evaluation, speech, language and/or hearing problems	$ 51.00
92532	Positional nystagmus	20.00
92545	Oscillating tracking test, with recording	31.00
92551	Screening test, pure tone, air only	12.50
92552	Pure tone audiometry (threshold); air only	21.00
92553	air and bone	35.00
92555	Speech audiometry; threshold only	16.00
92556	threshold and discrimination	32.00
92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	54.00
92562	Loudness balance test, alternate binaural or monaural	18.00
92563	Tone decay test	15.00
92566	Impedance testing	20.00
92567	Tympanometry	18.00
92568	Acoustic reflex testing	16.00
92575	Sensorineural acuity level test	10.00
92581	Evoked response (EEG) audiometry	185.00
92585	Brainstem evoked response recording	182.00
92590	Hearing and examination and selection; monaural	53.50
92591	binaural	65.00
92593	Hearing aid check; binaural	30.00

Subp. 3. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.2800 PHYSICAL 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.

Code	Service	Maximum Fee
	Evaluations	
95831	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	$ 14.00
95851	Range of motion measurements and report (separate procedure); each extremity, excluding hand	9.25
	Modalities	
97010	Physical medicine treatment to one area; hot or cold packs	$ 16.00
97012	Physical medicine treatment to one area; traction, mechanical	15.50
97014	electrical stimulation (unattended)	15.00
97016	vasopneumatic devices	15.00
97018	paraffin bath	15.00
97022	whirlpool	17.00
97024	diathermy	15.00
97026	infrared	11.50
	Procedures	
97110	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	$ 20.00
97112	neuromuscular reeducation	20.00
97114	functional activities	26.00
97116	gait training	24.86
97120	iontophoresis	25.00
97122	traction, manual	15.50
97124	massage	15.50
97126	contrast baths	16.00
97128	ultrasound	16.00
97145	Physical medicine treatment to one area, each additional 15 minutes	12.50
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist)(separate procedure), performed by physician; one area	18.00
97500	Orthotics training (dynamic bracing, splinting), upper extremities; initial 30 minutes, each visit	26.00
97530	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit	25.00
97531	each additional 15 minutes	12.00
97540	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit	33.00
	Tests and Measurements	
97720	Extremity testing for strength, dexterity, or stamina; initial 30 minutes, each visit	$ 45.00

Subp. 3. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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
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
	Examinations - Includes History and Diagnosis, Office	
09520	New patient; brief examination	$ 30.00
09521	intermediate	40.00
09522	extensive	65.00
09530	Established patient; brief examination	25.00
09531	intermediate	36.00
09532	extensive	65.00
	Chiropractic visit with manipulation/adjustment	
09540	Visit with manipulation/adjustment, initial; office	$ 20.00
09541	Visit with manipulation/adjustment, subsequent; office	22.00
09542	Each additional manipulation/ adjustment on same day; office, home, or nursing home	12.00
	Conjunctive therapy/modality - office, home, or nursing home	
09560	Application of hot pack	$ 10.00
09561	Application of cold pack	10.00
09562	Diathermy	20.00
09563	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic	12.00
09564	Intersegmental motorized mobilization	14.00
09565	Muscle stimulation, manual	12.00
09566	Ultrasound therapy	12.00
09567	Traction	13.00
09568	Acupressure, manual or mechanical	10.00
09572	Infrared - heat lamp	9.00
09573	Ultraviolet	11.67
09574	Trigger point therapy	12.00

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)	$ 30.00

Spine and Pelvis

72010	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral)	$ 60.00
72020	Radiologic examination, spine; single view, (specify level)	40.00
72040	Radiologic examination, spine, cervical; limited	42.00
72050	comprehensive (minimum four views)	80.00
72070	Radiologic examination, spine; thoracic	50.00
72080	thoracic, limited (anteroposterior and lateral)	47.50
72090	scoliosis study, comprehensive	40.00
72100	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral)	51.00
72114	Radiologic examination, spine, lumbosacral; complete, including bending views	170.00
72170	Radiologic examination, pelvis; limited (minimum two views)	42.00
72180	Radiologic examination, pelvis; stereo	35.00

Upper Extremities

73020	Radiologic examination, shoulder; limited (one projection)	$ 30.00
73030	complete, minimum of two views	47.00
73070	Radiologic examination, elbow; limited (anteroposterior and lateral)	40.00
73100	Radiologic examination, wrist; limited (anteroposterior and lateral)	35.00
73140	Radiologic examination, finger or fingers, minimum of two views	30.00

Lower Extremities

73500	Radiologic examination, hip; limited (one view)	$ 30.00
73510	Radiologic examination, hip; complete, minimum of two views	53.00
73600	Radiologic examination, ankle; limited (two views)	35.00

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

Code	Service	Maximum Fee
80016	Automated multichannel test; 13-16 clinical chemistry tests	$ 115.00
81015	Urinalysis; microscopic only	12.00
85022	Blood count; hemogram, automated, and differential WBC count (CBC)	29.00
87164	Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection	35.00

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 9 SR 1619; 10 SR 765; 10 SR 974; 11 SR 491; 11 SR 711; 12 SR 662*

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.

Surgery

Code	Service	Maximum Fee
10100*	Incision and drainage of onychia or paronychia; single or simple	$ 48.00
11050*	Paring or curettement of benign lesion with or without chemical cauterization; single lesion	23.00
11052	more than four lesions	25.45

Nails

11700*	Debridement of nails, manual; five or less	$ 18.00
11701	each additional, five or less	10.00
11710*	Debridement of nails, electric grinder; five or less	15.00
11711	each additional, five or less	9.00
11750	Excision of nail and nail matrix, partial or complete, for permanent removal	175.00
17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	35.00
17110*	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	24.00
29540	Strapping; ankle	15.00
29550	toes	18.00
29580	Unna boot	22.00
64450	Injection, anesthetic agent; other peripheral nerve or branch	30.00
73600	Radiologic examination, ankle; anteroposterior and lateral views	36.96
73620	Radiologic examination, foot; anteroposterior and lateral views	35.00
73630	complete, minimum of three views	50.00
73660	toe or toes, minimum of two views	38.00
85018	Blood count; hemoglobin, colorimetric	6.50
90000	New patient; brief service	27.00
90010	New patient; limited service	35.00
90015	New patient; intermediate service	38.00
90020	New patient; comprehensive service	35.00
90030	Established patient; minimal service	16.00
90040	Established patient; brief service	22.00
90050	Established patient; limited service	24.00
90060	Established patient; intermediate service	28.00
90070	Established patient; extended service	36.00

	Hospital Medical Services	
90200	Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	$ 65.00
90215	Intermediate examination	40.00
	Therapeutic Injections	
90782	Therapeutic injection of medication (specify); subcutaneous or intramuscular	$ 30.00
	Physical Medicine	
95851	Range of motion measurements and report (separate procedure); each extremity	$ 37.50
97022	Whirlpool	17.44
97128	Ultrasound	14.00
L1940	Ankle-foot arthoses, molded to patient model, plastic	79.00
L3000	Foot, insert, removable, molded to patient model (UCB) type Berkeley Shell, each	82.50
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each	105.00
	Other Procedures	
X1229	Radical excision of nail	$ 200.00

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.3100 PSYCHOLOGISTS.

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	$ 80.00
09064	Biofeedback, per hour	75.00
09065	Biofeedback, per half hour	45.00
09066	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour	75.00
09067	Psychotherapy, group (maximum ten persons per group), 1-1/2 hours per person	40.00
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)	70.00

Subp. 3. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. **Scope.** The following service descriptions and maximum fees apply to daily charges for semiprivate rooms at the hospitals listed below. The maximum fees do not apply to semiprivate 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 semiprivate 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.

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-Ridges Hospital, Burnsville
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. St. John's Hospital Northeast, Saint Paul
W. Saint Joseph's Hospital, Saint Paul
X. Saint Luke's Hospital, Duluth
Y. Saint Mary's Hospital, Duluth
Z. Saint Mary's Hospital, Minneapolis
AA. The Samaritan Hospital, Saint Paul
BB. United Hospital, Saint Paul
CC. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ 276.45

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
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. Constance Bultman Wilson Center
Y. Cook Community Hospital, Cook
Z. Cook County Northshore Hospital, Grand Marais
AA. Cuyuna Range District Hospital, Crosby
BB. Dr. Henry Schmidt Memorial Hospital, Westbrook
CC. District Memorial Hospital—Forest Lake, Forest Lake
DD. Divine Providence Hospital, Ivanhoe
EE. Douglas County Hospital, Alexandria
FF. Ely-Bloomenson Community Hospital, Ely
GG. Eveleth Fitzgerald Community Hospital, Eveleth
HH. Fairmont Community Hospital, Fairmont
II. Fairview Princeton Hospital, Princeton
JJ. Fosston Municipal Hospital, Fosston
KK. Gaylord Community Hospital, Gaylord
LL. Glacial Ridge Hospital, Glennwood
MM. Glencoe Municipal Hospital, Glencoe
NN. Granite Falls Municipal Hospital, Granite Falls
OO. Grant County Hospital, Elbow Lake
PP. Greenbush Community Hospital, Greenbush
QQ. Harmony Community Hospital, Harmony
RR. Hendricks Community Hospital, Hendricks
SS. Heron Lake Municipal Hospital, Heron Lake
TT. Holy Trinity Hospital, Graceville
UU. Hutchinson Community Hospital, Hutchinson
VV. Immanuel-Saint Joseph's Hospital, Mankato

WW. International Falls Memorial Hospital, International Falls
XX. Itasca Memorial Hospital, Grand Rapids
YY. Jackson Municipal Hospital, Jackson
ZZ. Johnson Memorial Hospital, Dawson
AAA. Kanabec Hospital, Mora
BBB. Karlstad Health Facilities, Karlstad
CCC. Kittson Memorial Hospital, Hallock
DDD. Lake City Hospital, Lake City
EEE. Lake Region Hospital, Fergus Falls
FFF. Lake View Memorial Hospital, Two Harbors
GGG. Lakefield Municipal Hospital, Lakefield
HHH. Lakeview Memorial Hospital, Stillwater
III. Littlefork Municipal Hospital, Littlefork
JJJ. Long Prairie Memorial Hospital, Long Prairie
KKK. Luverne Community Hospital, Luverne
LLL. Madelia Community Hospital, Madelia
MMM. Madison Hospital, Madison
NNN. Mahnomen County-Village Hospital, Mahnomen
OOO. Meeker County Memorial Hospital, Litchfield
PPP. Melrose Hospital, Melrose
QQQ. Memorial Hospital—Cambridge, Cambridge
RRR. Memorial Hospital—Perham, Perham
SSS. Memorial Community Hospital—Bertha, Bertha
TTT. Mercy Hospital, Moose Lake
UUU. Milaca Area Hospital, Milaca
VVV. Minnesota Valley Memorial Hospital, Le Sueur
WWW. Minnewaska District Hospital, Starbuck
XXX. Monticello-Big Lake Community Hospital, Monticello
YYY. Mountain Lake Community Hospital, Mountain Lake
ZZZ. Murray County Memorial Hospital, Slayton
AAAA. Naeve Hospital, Albert Lea
BBBB. North Country Hospital, Bemidji
CCCC. Northern Itasca Hospital, Big Fork
DDDD. Northfield City Hospital, Northfield
EEEE. Northwestern Hospital, Thief River Falls
FFFF. Olmsted Community Hospital, Rochester
GGGG. Ortonville Hospital, Ortonville
HHHH. Owatonna City Hospital, Owatonna
IIII. Parkers Prairie District Hospital, Parkers Prairie
JJJJ. Paynesville Community Hospital, Paynesville
KKKK. Pelican Valley Health Center, Pelican Valley
LLLL. Pipestone County Hospital, Pipestone
MMMM. Queen of Peace Hospital, New Prague
NNNN. Redwood Falls Municipal Hospital, Redwood Falls
OOOO. Regina Memorial Hospital, Hastings
PPPP. Renville County Hospital, Olivia
QQQQ. Rice County District One Hospital, Faribault
RRRR. Rice Memorial Hospital, Willmar

SSSS. Riverview Hospital, Crookston
TTTT. Roseau Area Hospital, Roseau
UUUU. Rush City Hospital, Rush City
VVVV. Saint Ansgar Hospital, Moorhead
WWWW. Saint Elizabeth Hospital, Wabasha
XXXX. Saint Francis Hospital, Breckenridge
YYYY. Saint Francis Regional Medical Center, Shakopee
AAAAA. Saint John's Hospital, Browerville
BBBBB. Saint John's Hospital, Red Lake Falls
CCCCC. Saint John's Hospital, Red Wing
DDDDD. Saint Joseph's Hospital, Brainerd
EEEEE. Saint Joseph's Hospital, Park Rapids
FFFFF. Saint Mary's Hospital, Detroit Lakes
GGGGG. Saint Mary's Hospital, Winsted
HHHHH. Saint Michael's Hospital, Sauk Centre
IIIII. Saint Olaf Hospital, Austin
JJJJJ. Sandstone Area Hospital, Sandstone
KKKKK. Sanford Memorial Hospital, Farmington
LLLLL. Sioux Valley Hospital, New Ulm
MMMMM. Sleepy Eye Municipal Hospital, Sleepy Eye
NNNNN. Springfield Community Hospital, Springfield
OOOOO. Stevens County Memorial Hospital, Morris
PPPPP. Swift County-Benson Hospital, Benson
QQQQQ. Tracy Municipal Hospital, Tracy
RRRRR. Tri-County Hospital, Wadena
SSSSS. Trimont Community Hospital, Trimont
TTTTT. Trinity Hospital, Baudette
UUUUU. Tweeten Memorial Hospital, Spring Grove
VVVVV. United District Hospital, Staples
WWWWW. United Hospital, Blue Earth
XXXXX. Virginia Regional Medical Center, Virginia
YYYYY. Waconia Ridgeview Hospital, Waconia
AAAAAA. Waseca Area Memorial Hospital, Waseca
BBBBBB. Watonwan Memorial Hospital, St. James
CCCCCC. Weiner Memorial Medical Center, Marshall
DDDDDD. Wells Municipal Hospital, Wells
EEEEEE. Wheaton Community Hospital, Wheaton
FFFFFF. White Community Hospital, Aurora
GGGGGG. Windom Area Hospital, Windom
HHHHHH. Winona General Hospital, Winona
IIIIII. Worthington Regional Hospital, Worthington
JJJJJJ. Zumbrota Community Hospital, Zumbrota

Service	Maximum Fee
Group 2 semiprivate room charge for one day	$ 202.57

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

A. Hennepin County Medical Center, Minneapolis
B. Saint Paul Ramsey Medical Center, Saint Paul

C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	$ 332.56

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

A. Rochester Methodist Hospital, Rochester

B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	$ 172.80

Statutory Authority: *MS s 176.136*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662*

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*

5221.3400 EFFECTIVE DATE.

The amendments to the rules in this chapter adopted at 12 State Register, page 662, on October 5, 1987 are effective October 1, 1987, and apply to all health care services or supplies governed by parts 5221.0100 to 5221.3200 provided after October 1, 1987.

Statutory Authority: *MS s 176.136*

History: *11 SR 491; 12 SR 662*