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. 1a. **Appropriate record.** "Appropriate record" is a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury.

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

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

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

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

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

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

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

Subp. 9. **Injury.** "Injury" is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a "personal injury."

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

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

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609; 15 SR 124*

5221.0200 AUTHORITY.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0300 PURPOSE.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0400 SCOPE.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0500 EXCESSIVE CHARGES.

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

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

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

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0550 EXCESSIVE SERVICES.

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

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

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0600 PAYER RESPONSIBILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

D. a request for an appropriate record and/or the specific information requested to allow for proper determination of the bill under this part.

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

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0700 PROVIDER RESPONSIBILITIES.

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

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

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

A. Approved billing codes. Billing codes must be found in the most recent edition of the following: Physician's Current Procedural Terminology; Blue Cross/Blue Shield specialty procedure codes; HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS); Code on Dental Procedures and Nomenclature maintained by the Council on Dental Care Programs; and for audiology and speech therapy, the "home-grown" codes specified by the Department of Human Services or any other code listed in the medical fee schedule.

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

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

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

25105	Arthrotomy, wrist joint; for synovectomy	

C. 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 subitems (1) to (20).

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

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

(3) Modifier number 23 denotes unusual anesthesia. This modifier is appropriate to services which usually require no anesthesia or local anesthesia only, where unusual circumstances require that surgery be done under general anesthesia. Services with this modifier are not subject to the medical fee schedule.

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

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

(6) Modifier number 50 denotes bilateral procedures. Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session shall be identified by the appropriate five-digit code describing the first procedure. The second bilateral procedure shall be identified by adding modifier 50 to the procedure number.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section

176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0800 DISPUTE RESOLUTION.

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

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0900 [Repealed, 13 SR 2609]

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

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

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

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

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

D. to accommodate improvements or correct data base deficiencies. The Medical Services Review Board shall advise the commissioner regarding these revisions.

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

Subp. 4. **Applicability of the fee schedule.** The payer shall undertake reasonable investigations to ascertain whether a service and its corresponding charge is subject to the medical fee schedule. A charge is subject to the medical fee schedule if it conforms to a code under part 5221.0700, subpart 3, item A, and is included in the medical fee schedule for the appropriate provider group. If a ser-

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

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

Subp. 6. **Ambiguity.** If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service and its corresponding charge is subject to the medical fee schedule or what the correct code for a particular service is, the payer shall contact the provider and attempt to resolve the ambiguity. The provider shall cooperate in resolving this ambiguity. If the parties are unable to come to an agreement, either party may file a request for a determination with the commissioner under part 5221.0800.

Subp. 7. [Renumbered 5221.0700, subpart 3, item C, subitems (1) to (20)]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.1100 PHYSICIAN SERVICES; MEDICINE.

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

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

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

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

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

D. 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 sys-

tems 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.

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

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

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

Code	Service	Maximum Fee
90000-00	Office services; new patient; brief service	$ 38.25
90010-00	limited service	44.50
90015-00	intermediate service	55.00
90017-00	extended service	77.25
90020-00	comprehensive service	140.00
90030-00	Office services; established patient; minimal service	19.00
90040-00	brief service	26.25
90050-00	limited service	31.00
90060-00	intermediate service	41.50
90070-00	extended service	66.00
90080-00	comprehensive service	102.00

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

Code	Service	Maximum Fee
90110-00	Home medical service, new patient; limited service	$ 69.40
90130-00	Home medical service, established patient; minimal service	35.50
90140-00	brief service	44.00
90150-00	limited service	50.00
90160-00	intermediate service	55.00
90170-00	extended service	57.50

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 90292.

Code	Service	Maximum Fee
	Initial Hospital Care	
90200-00	Initial hospital care; brief	$ 75.00
90215-00	intermediate	96.50
90220-00	comprehensive	140.00
	Subsequent Hospital Care	
90240-00	Subsequent hospital care; brief service	$ 32.00
90250-00	limited service	40.00
90260-00	intermediate services	59.75
90270-00	extended service	90.00
90280-00	comprehensive service	105.00
	Hospital Discharge Services	
90292-00	Hospital discharge day management	$ 56.50

Subp. 5. **Skilled nursing, intermediate care, and long-term care facilities.** The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long-term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 52.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	72.00
90320-00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	90.00
90340-00	Subsequent care, skilled nursing, intermediate care, or long-term care facility; brief service	25.76
90350-00	limited service	33.00
90360-00	intermediate service	40.00
90370-00	extended service	57.00

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

Code	Service	Maximum Fee
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	$ 60.00
90410-00	limited service	46.00
90415-00	intermediate service	65.00
90420-00	comprehensive service	75.00
90430-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; minimal service	21.13
90440-00	brief service	25.76
90450-00	limited service	32.30
90460-00	intermediate service	55.00
90470-00	extended service	65.00

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

Code	Service	Maximum Fee
90500-00	Emergency department service new patient; minimal service	$ 32.00
90505-00	brief service	40.00
90510-00	limited service	55.00
90515-00	intermediate service	75.00
90517-00	extended service	100.00
90520-00	comprehensive service	135.00
90530-00	Emergency department service, established patient; minimal service	25.00
90540-00	brief service	40.00
90550-00	limited service	45.00
90560-00	intermediate service	57.50
90570-00	extended service	80.50
90580-00	comprehensive service	111.25

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

Code	Service	Maximum Fee
90590-00	Physician direction of Emergency Medical Systems (EMS), emergency care advanced life support	$ 50.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1200 CONSULTATIONS.

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

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

A. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient and the preparation of an appropriate record. When as a result of the consultation the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician cannot be billed as a consultation.

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

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

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

(4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to a consultation for a young person with fever, arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a record with recommendations.

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

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

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

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

Code	Service	Maximum Fee
	Initial Consultation	
90600-00	Initial consultation; limited	$ 66.00
90605-00	intermediate consultation	87.00
90610-00	extensive consultation	115.00
90620-00	comprehensive consultation	155.00
90630-00	complex consultation	200.00
	Follow-up Consultation	
90640-00	Follow-up consultation; brief visit	$ 39.30
90641-00	limited	49.00
90642-00	intermediate	75.25
90643-00	complex	122.00
	Confirmatory (Additional Opinion) Consultation	
90650-00	Confirmatory consultation; limited	$ 67.50
90651-00	intermediate	86.00
90652-00	extensive	100.00
90653-00	comprehensive	150.00
90654-00	complex	250.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1210 IMMUNIZATION INJECTIONS.

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

Code	Service	Maximum Fee
90701-00	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	$ 24.00
90702-00	diphtheria and tetanus toxoids (DT)	12.75
90703-00	tetanus toxoid	12.00
90704-00	mumps virus vaccine, live	26.00
90705-00	measles virus vaccine, live, attenuated	26.00
90706-00	rubella virus vaccine, live	26.00
90707-00	measles, mumps, and rubella virus vaccine, live	38.00
90708-00	measles and rubella virus vaccine, live	30.00

90712-00	polio virus vaccine, live, oral; any type(s)	19.00
90713-00	poliomyelitis vaccine	26.00
90714-00	typhoid vaccine	12.00
90717-00	yellow fever vaccine	39.50
90718-00	tetanus and diphtheria toxoids absorbed, for adult use (TD)	12.00
90719-00	diphtheria toxoid	2.00
90724-00	influenza virus vaccine	13.00
90725-00	cholera vaccine	12.60
90726-00	rabies vaccine	97.50
90731-00	hepatitis B vaccine	68.50
90732-00	pneumococcal vaccine, polyvalent	20.00
90733-00	meningococcal polysaccharide vaccine; any group(s)	26.25
90737-00	hemophilus influenza B measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicella-zoster	26.75
90741-00	Immunization, passive; immune serum globulin, human (ISG)	17.00
90742-00	specific hyperimmune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicella-zoster)	46.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.1215 INFUSION THERAPY.

The following procedures encompass prolonged intravenous injections. These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous, or intramuscular or routine intravenous (IV) drug injections.

Code	Service	Maximum Fee
90780-00	IV infusion therapy, administered by physician or under direct supervision of physician; up to one hour	$ 49.00
90781-00	each additional hour, up to eight hours	82.00

Statutory Authority: *MS s 176.136*

History: *14 SR 722; 15 SR 738*

5221.1220 THERAPEUTIC INJECTIONS.

Code	Service	Maximum Fee
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	$ 13.00
90788-00	Intramuscular injection of antibiotic (specify)	16.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.1300 PSYCHIATRY AND PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medi-

cine or a doctor of osteopathy. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

Code	Service	Maximum Fee
	General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures	
90801-00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the patient).	$ 130.00
90825-00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	75.00
90830-00	Psychological testing by physician, with written report, per hour	85.00
90831-00	Telephone consultation with or about patient for psychiatric therapeutic or diagnostic purposes	65.00
90841-00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis, insight-oriented, behavior-modifying, or supportive psychotherapy; time unspecified	120.00
90843-00	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	70.00
90844-00	approximately 45 or 50 minutes	106.25
90847-00	Family medical psychotherapy (conjoint psychotherapy)	107.50
90849-00	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated	77.00
90853-00	Group medical psychotherapy (other than of a multiple-family group)	50.00
90862-00	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	60.00

90870-00	Electroconvulsive therapy (includes necessary monitoring); single seizure	125.00
90871-00	multiple seizures, per day	215.00
	Other Psychiatric Therapy	
90880-00	Medical hypnotherapy	$ 76.00
90887-00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	100.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1400 [Repealed, 13 SR 2609]

5221.1410 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
90900-00	Biofeedback training; by electromyogram application (e.g., in tension headache muscle spasm)	$ 75.00
90904-00	regulation of blood pressure (e.g., in essential hypertension)	84.00
90906-00	regulation of skin temperature of peripheral blood flow	45.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.1450 DIALYSIS.

The following codes, service descriptions, and maximum fees apply to dialysis procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Office and hospital services are not to be reported in addition to the dialysis procedures.

Code	Service	Maximum Fee
90935-00	Hemodialysis procedure with single physician evaluation	$ 206.50
90937-00	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	325.00
90945-00	Dialysis procedure other than hemodialysis (e.g., peritoneal, hemofiltration), with single physician evaluation	150.00

90947-00	Dialysis procedure other than hemodialysis (e.g., peritoneal, hemofiltration) requiring repeated evaluations, with or without substantial revision of dialysis prescription	400.00
90990-00	Hemodialysis training and/or counseling	237.93

Statutory Authority: *MS s 176.136*

History: *15 SR 738*

5221.1500 OPHTHALMOLOGICAL SERVICES.

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

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

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

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

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

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

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

D. Comprehensive ophthalmological service. "Comprehensive ophthalmological service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological examination, gross visual fields, and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and 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 neces-

sary 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 92002-00 to 92020-00, 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 92225-00 to 92260-00, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

Code	Service	Maximum Fee
	General Services	
92002-00	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient	$ 55.50
92004-00	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program; new patient, one or more visits	63.00
92012-00	Ophthalmological services: medical examination and evaluation, with initiation or continuation or diagnostic and treatment program; intermediate, established patient	47.50
92014-00	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient, one or more visits	60.00
92018-00	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	159.00
92019-00	limited	392.00
92020-00	Gonioscopy with medical diagnostic evaluation (separate procedure)	32.00
	Special Services	
92060-00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 38.00

92065-00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	50.00
92070-00	Fitting of contact lens for treatment of disease, including supply of lens	120.00
92082-00	Visual field examination with medical diagnostic evaluation; intermediate examination (e.g., multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel, full field automated test, such as Octopus program 33 or 34 equivalent)	55.00
92083-00	extended examination; quantitative perimetry (e.g., manual static and kinetic perimetry or Goldmann or Tubingen perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41)	75.00
92100-00	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	25.00
92120-00	Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method	25.00
92140-00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00

Ophthalmoscopy

92225-00	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial	$ 40.00
92226-00	subsequent	37.00
92230-00	Ophthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	37.00
92235-00	with fluorescein angiography (includes multiframe photography)	169.00
92250-00	with fundus photography	37.90
92260-00	with ophthalmodynamometry	53.00

Other Specialized Services

92275-00	Electroretinography, with medical diagnostic evaluation	$ 189.00
92285-00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereophotography)	35.00

92286-00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	150.00

Contact Lenses

92311-00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaption; corneal lens for aphakia, one eye	$ 90.00
92325-00	Modification of contact lens (separate procedure), with medical supervision of adaptation	22.00
92326-00	Replacement of contact lens	72.00

Spectacle Services

92340-00	Fitting of spectacles, except for aphakia; monofocal	$ 34.00
92341-00	bifocal	48.00
92358-00	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	20.00
92390-00	Supply of spectacles, except prosthesis for aphakia and low vision aids	116.00
92391-00	Supply of contact lenses, except prosthesis for aphakia	80.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1600 MR 1987 [Repealed, 12 SR 662]

5221.1600 OTORHINOLARYNGOLOGIC SERVICES.

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

Code	Service	Maximum Fee
92504-00	Binocular microscopy (separate diagnostic procedure)	$ 11.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	44.00
92508-00	group	32.40
92511-00	Nasopharyngoscopy with endoscope (separate procedure)	64.00

92512-00	Nasal function studies (e.g., rhinomanometry)	53.50
92516-00	Facial nerve function studies	47.00
92532-00	Positional nystagmus	24.60
92533-00	Caloric vestibular test, each irrigation (binaural), bithermal stimulation constitutes four tests	34.00
92541-00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	45.00
92542-00	Positional nystagmus test, minimum of four positions, with recording	45.00
92543-00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	79.00
92544-00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	33.00
92545-00	Oscillating tracking test, with recording	30.00
92547-00	Use of vertical electrodes in any or all of above tests counts as one additional test	41.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.1700 [Repealed, 13 SR 2609]

5221.1800 CARDIOVASCULAR.

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

Code	Service	Maximum Fee
	Cardiovascular Services	
92950-00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 225.50
92960-00	Cardioversion, elective, electrical conversion of arrhythmia, external	272.00
92982-00	Percutaneous transluminal coronary angioplasty; single vessel	2,200.00
93000-00	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	46.00
93005-00	tracing only, without interpretation and/or report	46.55
93010-00	interpretation and report only	17.50
93012-00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	55.00
93015-00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	217.00
93017-00	tracing only, without interpretation and report	125.00
93018-00	interpretation and report only	100.00

93040-00	Rhythm ECG, one to three leads; with interpretation	24.00
93041-00	tracing only, without interpretation and report	25.00
93042-00	Rhythm ECG, tracing with interpretation and report only	16.00
93210-00	Phonocardiogram, intracardiac	46.87
93220-00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	75.00
93258-00	Electrocardiographic monitoring for up to 12 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; with superimposition scanning	125.00
93263-00	Electrocardiographic monitoring, 12-24 hours of continuous analog recording, with physician review, interpretation, and report, with or without full disclosure printout; without superimposition scanning	237.50
93266-00	Electrocardiographic monitoring, 24 hours noncontinuous computerized monitoring and intermittent cardiac event recording (Real-Time Data Analysis)	223.00
93269-00	Patient demand single event ECG recording; presymptom memory loop and transmission and postsymptom memory loop and transmission	80.50
93300-00	Echocardiography, M-mode; complete	85.00
93305-00	limited (e.g., follow-up or limited study)	125.00
93307-00	Echocardiography, real-time with image documentation (2D); complete	155.00
93308-00	limited	132.00
93309-00	Echocardiography, M-mode and real-time with image documentation (2D)	268.00
93312-00	Echocardiography, real-time with image documentation (2D) (with or without M-mode recording), transesophageal	320.00
	Cardiac Catheterization	
93501-00	Right heart catheterization only	$ 680.00
93503-00	Placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purposes, collection of blood, and/or angiography	375.00
93505-00	Endomyocardial biopsy	695.00
93510-00	Left heart catheterization, retrograde, from the brachial artery, axillary artery, or femoral artery; percutaneous	930.50
93536-00	Percutaneous insertion of intra-aortic balloon catheter	534.00
93545-00	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	700.00

93547-00	Combined left heart catheterization, selective coronary angiography and selective left ventricular angiography	875.00
93549-00	Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography	1,300.00
93550-00	with selective visualization of bypass graft	1,525.00
93552-00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, selective left ventricular cineangiography and visualization of bypass grafts	1,200.00
93561-00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement	100.00
93562-00	subsequent measurement of cardiac output	100.00
93612-00	Intraventricular pacing	325.00
	Other Vascular Studies	
93720-00	Plethysmography, total body; with interpretation and report	$ 50.00
93731-00	Electronic analysis of dual-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	50.00
93732-00	with reprogramming	66.40
93733-00	telephone analysis	70.70
93734-00	Electronic analysis of single-chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker); without reprogramming	59.50
93735-00	with reprogramming	57.25
93736-00	telephonic analysis	59.50
93770-00	Determination of venous pressure	5.00
93784-00	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours; including recording, scanning analysis, interpretation, and report	210.00
93788-00	scanning analysis with report	170.00
93790-00	physician review with interpretation and report	37.00

	Noninvasive Peripheral Vascular Diagnostic Studies Cerebrovascular Arterial Studies	
93850-00	Noninvasive studies of cerebral arteries other than carotid (e.g., periorbital flow direction with arterial compression, periorbital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing)	$ 91.00
93860-00	Noninvasive studies of carotid arteries, nonimaging (e.g., photoangiography with or without spectrum analysis, flow velocity pattern evaluation, analog velocity wave form analysis, diastolic flow evaluation, vertebral arteries flow direction measurement)	200.00
93870-00	Noninvasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	157.50
93890-00	Noninvasive studies of extremity arteries (e.g., segmental blood pressure measurements, continuous wave Doppler analog wave form analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmographic or pulse volume digit wave form analysis, flow velocity signals); upper extremity	80.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1900 PULMONARY.

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

Code	Service	Maximum Fee
94010-00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements, and/or maximal voluntary ventilation	$ 35.00
94060-00	Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	62.70
94070-00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010-00	88.20
94150-00	Vital capacity, total	21.00

94160-00	Vital capacity screening tests; total capacity, with timed force expiratory volume (state duration), and peak flow rate	18.00
94200-00	Maximum breathing capacity, maximal voluntary ventilation	31.90
94250-00	Expired gas collection, quantitative, single procedure (separate procedure)	84.00
94350-00	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equalibration time	63.00
94375-00	Respiratory flow volume loop	26.40
94640-00	Nonpressurized inhalation treatment for acute airway obstruction	25.50
94650-00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation	30.00
94651-00	subsequent	40.00
94656-00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	152.48
94657-00	subsequent days	55.00
94660-00	Continuous positive airway pressure ventilation (CPAP), initiation and management	120.00
94664-00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	38.00
94665-00	subsequent	35.00
94681-00	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	109.40
94700-00	Analysis of arterial blood gas (oxygen saturation, pO2, pCO2, CO2, pH); rest only	30.00
94705-00	rest and exercise (including cannulization of artery)	153.70
94710-00	three or more (O2 administration, IPPB, exercise)	30.00
94715-00	Hemoglobin-oxygen affinity (pO2 for 50 percent hemoglobin saturation with oxygen)	88.00
94725-00	Membrane diffusion capacity	13.00
94750-00	Pulmonary compliance study, any method	17.00
94760-00	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	37.70
94761-00	multiple determinations (e.g., during exercise)	48.80
94770-00	Carbon dioxide, expired gas determination by infrared analyzer	39.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

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

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

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

Code	Service	Maximum Fee
95001-00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; 31-60 tests	$ 2.50
95002-00	61-90 tests	2.25
95005-00	Percutaneous tests (scratch, puncture, prick) with antibiotics, biologicals, stinging insects; one to five tests	3.00
95018-00	Intracutaneous (intradermal) tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; more than 15 tests	11.00
95021-00	Intracutaneous (intradermal) tests with allergenic extracts, immediate reaction 15-20 minutes; 11-20 tests	4.25
95022-00	21-30 tests	4.50
95023-00	more than 30 tests	2.75
95040-00	Patch or application tests; up to ten tests	3.50
95041-00	11-20 tests	5.00
95042-00	21-30 tests	4.00
95043-00	more than 30 tests	5.00
95050-00	Photo patch tests; up to ten tests	8.35
95078-00	Provocative testing	15.00
95115-00	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	9.00
95117-00	multiple injections	10.00
95120-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen	11.00
95125-00	Multiple antigens (specify number of injections)	11.25
95130-00	Single stinging insect venom	23.50

95131-00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two stinging insect venoms	16.00
95132-00	three stinging insect venoms	20.50

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

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
95822-00	Electroencephalogram (EEG); sleep only	$ 170.00
95823-00	physical or pharmacological activation only	153.00
95831-00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	30.00
95851-00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	30.00
95852-00	hand, with or without comparison with normal side	20.00
95857-00	Tensilon test for myasthenia gravis	90.00
95860-00	Electromyography; one extremity and related paraspinal areas	190.00
95861-00	two extremities and related paraspinal areas	242.00
95863-00	three extremities and related paraspinal areas	230.10
95864-00	four extremities and related paraspinal areas	337.10
95869-00	Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	91.40
95881-00	Assessment of higher cerebral function with medical interpretation; developmental testing	100.00
95882-00	cognitive testing and others	45.00
95900-00	Nerve conduction, velocity, or latency study, motor, each nerve	58.90
95904-00	Nerve conduction, velocity and/or latency study; sensory, each nerve	67.10
95935-00	"H" reflex, by electrodiagnostic testing	55.00
95937-00	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	53.50

95951-00	Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; combined EEG and videorecording and interpretation, initial 24 hours	800.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2050 CHEMOTHERAPY INJECTIONS.

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

Code	Service	Maximum Fee
96501-00	Chemotherapy injection, intravenous, single premixed agent, administered by qualified assistant under supervision of physician or by physician; by infusion technique	$ 84.00
96504-00	Chemotherapy injection, intravenous, multiple premixed agents, administered by qualified assistant under supervision of physician or by physician; by push technique	60.50
96505-00	by infusion technique	80.00
96508-00	Chemotherapy injection, intravenous, complex, using one or more agents, requiring mixing, administered by qualified assistant under supervision of physician or by physician; by push technique	45.00
96509-00	by infusion technique	88.20
96510-00	by infusion technique, prolonged, requiring attendance up to one hour	90.00
96511-00	by infusion technique, prolonged, each additional hour up to a total of eight hours	66.00
96512-00	by infusion technique, prolonged, up to a total of several days, involving the use of portable pumps	100.00
96520-00	Portable pump refilling and maintenance	30.00
96530-00	Implantable pump filling and maintenance	60.00
96538-00	Chemotherapy injection, requiring lumbar puncture, administered by physician	133.80

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.2070 DERMATOLOGICAL PROCEDURES.

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

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

Code	Service	Maximum Fee
96900-00	Actinotherapy (ultraviolet light)	$ 10.00
96910-00	Photochemotherapy; tar and ultraviolet B (Geockerman treatment) or petrolatum and ultraviolet B	18.00
96912-00	psoralens and ultraviolet A (PUVA)	35.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.2100 PHYSICAL MEDICINE.

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

Code	Service	Maximum Fee
	Modalities	
97260-00	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	$ 33.20
97261-00	each additional area	9.40

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2200 SPECIAL SERVICES AND REPORTS.

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

Code	Service	Maximum Fee
	Miscellaneous Services	
99000-00	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$ 10.00
99001-00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)	21.80

99002-00	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivery, or mailing) when devices such as orthotics, protectives, and prosthetics are fabricated by an outside laboratory or shop but which items have been designed and are to be fitted and adjusted by the attending physician	5.00
99013-00	Telephone calls for consultation or medical management; simple or brief	8.00
99014-00	intermediate	16.00
99025-00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit	28.00
99052-00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	28.00
99054-00	Services requested on Sundays and holidays in addition to basic services	33.12
99058-00	Office services provided on an emergency basis	25.00
99062-00	Emergency care facility services; when the nonhospital-based physician is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	48.00
99064-00	Emergency care facility services; when the nonhospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	70.00
99065-00	during regular office hours	68.00
99075-00	Medical testimony	Reasonableness of charges reviewable by commissioner
99080-00	Special reports like insurance forms, or the review of medical data to clarify a patient's status; more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner	Reasonableness of charges reviewable by commissioner
99090-00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00

Prolonged Services

99150-00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gasses during surgery); 30 minutes to one hour	$ 141.40

Medical Conferences

99155-00	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes	$ 75.00
99156-00	approximately 50 minutes	127.00

Critical Care Services

Critical care services (codes 99160-00 to 99173-00) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
	Critical Care	
99160-00	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$ 200.00
99162-00	additional 30 minutes	92.00
99170-00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	100.00
99171-00	Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness	67.00
99172-00	limited examination, evaluation, or treatment for same or new illness	65.00
99173-00	intermediate examination, evaluation, or treatment, same or new illness	83.00

99174-00	extended reexamination, reevaluation, and/or treatment, same or new illness	150.00

Other Services

99175-00	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	$ 73.00
99190-00	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour	150.00
99195-00	Phlebotomy, therapeutic (separate procedure)	40.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

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 F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in-hospital follow-up care, provided by the surgeon both pre- and postoperative. This concept is referred to as a "package" for surgical procedures. 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 asterisked procedure is carried out at the time of an initial visit (new patient) and this procedure constitutes the major service at that visit, procedure number 99025 is listed in lieu of the initial visit as an additional service;

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

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

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

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

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

F. Special situations.

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

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

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

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

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

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

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

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

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

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

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

Subp. 3. **Integumentary system.**

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200-00 to 11444-00) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions.

(2) Treatment of burns (codes 16000-00 to 16030-00) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001-00 to 12020-00) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit.

(b) Intermediate repair (codes 12031-00 to 12053-00) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure.

(c) Complex repair (codes 13101-00 to 13152-00) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

(4) The instructions in units (a) to (c) also apply to coding of repair services (codes 12001-00 to 13152-00):

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

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

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

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

Code	Service	Maximum Fee
	Incision	
10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 60.00

10003*00	Incision and drainage of infected or noninfected epithelial inclusion cyst (sebaceous cyst) with complete removal of sac and treatment of cavity	75.00
10020*00	Incision and drainage of furuncle	49.40
10040*00	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	27.00
10060*00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	70.40
10061-00	complicated	130.00
10080*00	Incision and drainage of pilonidal cyst; simple	68.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	56.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple	60.00
10121*00	complicated	134.80
10140*00	Incision and drainage of hematoma; simple	59.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst	49.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	50.00
11040-00	Debridement; skin, partial thickness	50.00
11041-00	full thickness	40.00
11043-00	skin, subcutaneous tissue and muscle	331.00
11044-00	skin, subcutaneous tissue, muscle, and bone	505.00

Paring or Curettement

11050*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 32.00
11051-00	two to four lesions	44.50
11052-00	more than four lesions	71.00

Biopsy

11100-00	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 72.00
11101-00	each additional lesion	45.00

Excision — Benign Lesions

11200*00	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 62.20

11400-00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	77.00
11401-00	lesion diameter 0.5 to 1.0 centimeter	93.00
11402-00	lesion diameter 1.0 to 2.0 centimeters	121.00
11403-00	lesion diameter 2.0 to 3.0 centimeters	135.00
11404-00	lesion diameter 3.0 to 4.0 centimeters	158.00
11406-00	lesion diameter over 4.0 centimeters	234.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter (MD/DO)	90.00
11421-00	lesion diameter 0.5 to 1.0 centimeter	111.00
11422-00	lesion diameter 1.0 to 2.0 centimeters	135.00
11423-00	lesion diameter 2.0 to 3.0 centimeters	161.75
11424-00	lesion diameter 3.1 to 4.0 centimeters	200.00
11426-00	lesion diameter over 4.0 centimeters	250.00
11440-00	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	103.00
11441-00	lesion diameter 0.5 to 1.0 centimeter	131.00
11442-00	lesion diameter 1.1 to 2.0 centimeters	160.00
11443-00	lesion diameter 2.1 to 3.0 centimeters	205.00
11444-00	lesion diameter 3.1 to 4.0 centimeters	300.00

Excision — Malignant Lesions

11600-00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	$ 127.50
11601-00	lesion diameter 0.6 to 1.0 centimeter	190.00
11602-00	lesion diameter 1.1 to 2.0 centimeters	234.00
11603-00	lesion diameter 2.1 to 3.0 centimeters	280.00
11604-00	lesion diameter 3.1 to 4.0 centimeters	360.00
11620-00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less	170.00
11621-00	lesion diameter 0.6 to 1.0 centimeter	257.50

11622-00	lesion diameter 1.1 to 2.0 centimeters	335.00
11623-00	lesion diameter 2.1 to 3.0 centimeters	350.30
11640-00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less	307.00
11641-00	lesion diameter 0.6 to 1.0 centimeter	350.00
11642-00	lesion diameter 1.1 to 2.0 centimeters	443.03
11643-00	lesion diameter 2.1 to 3.0 centimeters	405.10

Nails

11700*00	Debridement of nails, manual; five or less	$ 32.00
11710*00	Debridement of nails, electric grinder; five or less	27.50
11730*00	Avulsion of nail plate, partial or complete, simple; single	71.00
11740-00	Evacuation of subungual hematoma	45.00
11750-00	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal	175.00
11760-00	Reconstruction of nail bed; simple	210.00
11765-00	Wedge excision of skin of nail fold (e.g., for ingrown toenail)	75.00

Miscellaneous

11770-00	Excision of pilonidal cyst or sinus; simple	$ 618.00
11771-00	extensive	670.00
11900*00	Injection, intralesional, up to and including seven lesions	37.00

Introduction

11901*00	Injection, intralesional; up to and including seven lesions	$ 52.00
11954-00	Subcutaneous injection of "filling" material (e.g., silicone); over ten centimeters	50.00
11960-00	Insertion of tissue expander(s)	1,925.00

Repair — Simple

12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	$ 64.00
12002*00	2.5 to 7.5 centimeters	97.00
12004*00	7.5 to 12.5 centimeters	130.50
12005*00	12.5 to 20.0 centimeters	183.00

12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	91.60
12013*00	2.5 to 5.0 centimeters	127.00
12014-00	5.1 to 7.5 centimeters	139.00
12015-00	7.6 to 12.5 centimeters	191.85
	Repair — Intermediate	
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 94.00
12032*00	2.5 to 7.5 centimeters	136.00
12034-00	7.6 to 12.5 centimeters	170.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	113.00
12042-00	2.5 to 7.5 centimeters	150.00
12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	133.00
12052-00	2.5 to 5.0 centimeters	180.00
12053-00	5.1 to 7.5 centimeters	238.00
	Repair — Complex	
13120-00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters	$ 250.00
13121-00	2.6 to 7.5 centimeters	300.00
13131-00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters	350.00
13132-00	2.6 to 7.5 centimeters	490.00
13150-00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less	276.00
13151-00	1.0 to 2.5 centimeters	420.00
13152-00	2.5 to 7.5 centimeters	690.00
	Adjacent Tissue Transfer or Rearrangement	
14040-00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect ten square centimeters or less	$ 855.00
14060-00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to ten square centimeters	1,058.00
	Free Skin Grafts	
15120-00	Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; 100 square centimeters or less	$ 707.00

	Miscellaneous Procedures	
15823-00	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	$ 1,000.00
15851-00	Removal of sutures under anesthesia (other than local), other surgeon	27.25
	Burns, Local Treatment	
16000-00	Initial treatment, first degree burn, when no more than local treatment is required	$ 55.65
16020*00	without anesthesia, office or hospital, small	48.00
16025*00	without anesthesia, medium (e.g., whole face or whole extremity)	89.00
	Destruction	
17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 51.00
17001-00	second and third lesions, each	33.80
17002-00	over three lesions, each additional lesion	25.00
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	53.00
17101-00	second lesion	30.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or *molluscum contagiosum*, *milia*, up to 15 lesions	50.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	51.75
17250*00	Chemical cauterization of a wound	46.00
17304-00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to five horizontal, microscopic specimens	525.00
17305-00	second stage, fixed or fresh tissue, up to five specimens	160.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)	35.95

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 modifier number 76 to the usual procedure number to indicate "repeat procedure by same physician."

Code	Service	Maximum Fee
	Excision — General	
20205-00	Biopsy, muscle; deep	$ 328.00
20220-00	Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	200.00
	Introduction or Removal — General	
20525-00	Removal of foreign body in muscle or tendon sheath; deep or complicated	$ 274.92
20550*00	Injection, tendon sheath, ligament, or trigger points	51.00
20600*00	Arthrocentesis, aspiration, or injection; small joint or bursa (e.g., fingers, toes)	52.00
20605*00	intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)	67.00
20610*00	major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)	68.00
20670*00	Removal of implant; superficial (e.g., buried wire, pin, or rod)	95.00
20680-00	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod, or plate)	375.00
	Head — Repair, Revision, or Reconstruction	
21310-00	Treatment of closed or open nasal fracture without manipulation	$ 62.00
21315-00	mandible (includes obtaining graft)	222.35
21320-00	Manipulative treatment, nasal bone fracture; with stabilization	395.00
21335-00	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	1,800.00
	Neck (Soft Tissues) and Thorax — Fracture or Dislocation	
21800-00	Treatment of rib fracture; closed, uncomplicated, each	$ 75.00
	Shoulders — Fracture or Dislocation	
23420-00	Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy)	$ 1,635.00
23472-00	Arthroplasty with glenoid and proximal humeral replacement (e.g., total shoulder)	3,406.00
23500-00	Treatment of closed clavicular fracture; without manipulation	114.00

23600-00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	195.69
23650-00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	176.00
23655-00	requiring anesthesia	295.00
23700*00	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	235.00

Humerus (Upper Arm) and Elbow — Fracture or Dislocation

24105-00	Excision, olecranon bursa	$ 455.00
24500-00	Treatment of closed humeral shaft fracture; without manipulation	245.00
24530-00	Treatment of closed humeral supracondylar or transcondylar fracture, without manipulation	286.85
24600-00	Treatment of closed humeral epicondylar fracture, medial or lateral; without manipulation	232.50
24650-00	Treatment of closed radial head or neck fracture without manipulation	187.25

Forearm and Wrist — Incision and Excision

25000-00	Tendon sheath incision; at radial styloid for de Quervain's disease	$ 465.00
25111-00	Excision of ganglion, wrist (dorsal or volar); primary	449.00

Forearm and Wrist — Fracture or Dislocation

25500-00	Treatment of closed radial shaft fracture; without manipulation	$ 206.00
25505-00	with manipulation	375.00
25530-00	Treatment of closed ulnar shaft fracture; without manipulation	200.00
25560-00	Treatment of closed radial and ulnar shaft fractures; without manipulation	256.00
25565-00	with manipulation	572.30
25600-00	Treatment of closed distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	219.80
25605-00	with manipulation	390.00
25610-00	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning	540.00

25622-00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	251.00
	Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction	
26010*00	Drainage of finger abscess; simple	$ 62.00
26055-00	Tendon sheath incision for trigger finger	440.00
26115-00	Excision, tumor, hand or finger; subcutaneous	312.00
26116-00	deep, subfascial, intramuscular	460.00
26120-00	Fasciectomy, palmar, simple, for Dupuytren's contracture; partial excision	675.00
26122-00	up to one-half palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	1,520.00
26160-00	Excision of lesion of tendon sheath or capsule	295.00
26418-00	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	485.00
	Hands and Fingers — Fractures or Dislocations	
26600-00	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 143.00
26605-00	with manipulation, each bone	240.00
26615-00	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone	615.00
26720-00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	100.00
26725-00	with manipulation, each	191.50
26727-00	Treatment of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, requiring traction or fixation, each	595.00
26735-00	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each	570.00
26750-00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	60.75
26760-00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	137.00

26770-00	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	79.00
	Hand and Fingers — Amputation	
26951-00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 300.00
	Pelvis and Hip Joint	
27125-00	Hemiarthroplasty of hip; prostheses (e.g., Austin-Moore, bipolar arthroplasty)	$ 2,300.00
27130-00	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple	3,293.00
27134-00	Revision of total hip arthroplasty; both components	4,785.00
27235-00	Treatment of closed or open femoral fracture, proximal end, neck, in situ pinning of undisplaced or impacted fracture	1,523.80
27236-00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	1,796.00
27244-00	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,556.00
27252-00	Treatment of closed hip dislocation; requiring anesthesia	432.00
	Femur (Thigh Region) and Knee Joint — Introduction or Removal	
27370-00	Injection procedure for knee arthrography	$ 70.00
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27446-00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	$ 2,709.00
27447-00	medial and lateral compartments with or without patella resurfacing (total knee replacement)	3,280.00
27487-00	Revision of total knee arthroplasty; all components	5,155.00

27506-00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,640.00
27520-00	Treatment of closed patellar fracture, without manipulation	207.00
27524-00	Open treatment of closed or open patellar fracture, with repair and/or excision	1,039.00
	Amputation	
27590-00	Amputation, thigh, through femur, any level	$ 1,155.00
	Leg (Tibula and Fibula) and Ankle Joint — Fractures or Dislocations	
27750-00	Treatment of closed tibial shaft fracture; without manipulation	$ 300.00
27760-00	Treatment of closed distal tibial fracture (medial malleolus) without manipulation	216.00
27766-00	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation	855.00
27780-00	Treatment of closed proximal fibula or shaft fracture; without manipulation	180.00
27786-00	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	189.00
27792-00	Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation	831.00
27802-00	with manipulation	595.00
27806-00	Open treatment of closed or open tibia and fibula fractures, shafts, with or without internal or external skeletal fixation	1,376.00
27808-00	Treatment of closed bimalleolar ankle fracture, (including Potts); without manipulation	264.00
27814-00	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	1,085.00
27822-00	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	1,225.00
27880-00	Amputation leg, through tibia and fibula	1,000.00

	Foot	
28080-00	Excision of Morton neuroma; single each	$ 420.00
28090-00	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot	414.00
28190*00	Removal of foreign body, foot; subcutaneous	100.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy)	441.50
28290-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)	545.00
28292-00	Keller, McBride, or Mayo type procedure	750.00
28296-00	with metatarsal osteotomy (Mitchell, Chevron, or concentric type procedure)	927.50
28400-00	Treatment of closed calcaneal fracture; without manipulation	228.00
28450-00	Treatment of closed tarsal bone fracture (except talus and calcaneus); without manipulation, each	164.00
28470-00	Treatment of closed metatarsal fracture; without manipulation, each	140.00
28490-00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	67.25
28510-00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	50.00
28820-00	Amputation, toe; metatarsophalangeal joint	306.03

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.

Code	Service	Maximum Fee
	Body and Upper Extremity Casts	
29065-00	Application; shoulder to hand (long arm)	$ 92.00
29075-00	elbow to finger (short arm)	75.00
29085-00	hand and lower forearm (gauntlet)	80.00
	Splints	
29105-00	Application of long arm splint (shoulder to hand)	$ 54.00

29125-00	Application of short arm splint (forearm to hand); static	48.00
29130-00	Application of finger splint; static	31.00
	Strapping — Any Age	
29260-00	Strapping; elbow or wrist	$ 22.00
29345-00	Application of long leg cast (thigh to toes)	123.00
29355-00	walker or ambulatory type	134.00
29358-00	Application of long leg cast brace	241.00
29365-00	Application of cylinder cast (thigh to ankle)	97.00
29405-00	Application of short leg cast (below knee to toes)	95.00
29425-00	walking or ambulatory type	102.00
29435-00	Application of patellar tendon bearing (PTB) cast	133.00
29440-00	Adding walker to previously applied cast	37.50
29450-00	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	62.50
29455-00	bilateral	121.00
	Splints	
29505-00	Application of long leg splint (thigh to ankle or toes)	$ 75.60
29515-00	Application of short leg splint (calf to foot)	53.00
	Strapping — Any Age	
29530-00	Strapping; knee	$ 52.00
29540-00	ankle	41.00
29550-00	toes	28.00
29580-00	Unna boot	37.00
	Removal or Repair	
29700-00	Removal or bivalving; gauntlet, boot or body cast	$ 36.00
29705-00	full arm or full leg cast	40.00
29720-00	Repair of spica, body cast, or jacket	23.00
	Arthroscopy	
29870-00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$ 705.00

29874-00	Arthroscopy, knee, surgical; for infection, lavage and drainage; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)	1,390.00
29875-00	synovectomy, limited (e.g., plica or shelf resection)	1,378.00
29877-00	debridement/shaving of articular cartilage (chrondroplasty)	1,550.00
29879-00	abrasion arthroplasty (includes chrondroplasty where necessary) or multiple drilling	1,657.00
29880-00	with meniscectomy (medial AND lateral, including any meniscal shaving)	1,893.00
29881-00	with meniscectomy (medial or lateral including any meniscal shaving)	1,620.00
29888-00	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	3,120.00

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

Code	Service	Maximum Fee
	Nose	
30100-00	Biopsy, intranasal	$ 71.00
30110-00	Excision, nasal polyp(s), simple; unilateral	150.00
30111-00	bilateral	260.00
30116-00	Excision, nasal polyp(s), extensive; bilateral	610.00
30200*00	Injection into turbinate(s), therapeutic	50.50
30300*00	Removal foreign body, intranasal; office type procedure	42.00
	Nose — Repair	
30420-00	Rhinoplasty, primary; including major septal repair	$ 2,500.00
30520-00	Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft	1,146.00
30800*00	Cauterization turbinates, unilateral or bilateral (separate procedure); superficial	56.00
	Other Procedures	
30901*00	Control nasal hemorrhage, anterior, simple (cauterization); unilateral	$ 59.00
30902*00	bilateral	78.00
30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral	109.00

30905*00	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cauterization; initial	168.00
31000*00	Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium)	60.00
31020-00	Sinusotomy, maxillary (antrotomy); intranasal, unilateral	450.00
31021-00	intranasal, bilateral	661.00
31250-00	Nasal endoscopy, diagnostic (includes examination of the medial meatus, infundibulum and sinus ostia)	63.00
	Larynx	
31500-00	Intubation, endotracheal, emergency procedure	$ 147.00
31505-00	Laryngoscopy, indirect; diagnostic	40.00
31535-00	Laryngoscopy, direct, operative, with biopsy;	560.70
31536-00	with operating microscope	657.00
31541-00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis	775.00
31575-00	Laryngoscopy, flexible fiberscopic; diagnostic	128.00
	Trachea and Bronchi	
31600-00	Tracheostomy, planned (separate procedure)	$ 515.15
31622-00	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing	481.00
31625-00	with biopsy	500.00
31628-00	with transbronchial lung biopsy, with or without fluoroscopic guidance	567.00
	Lungs	
32000*00	Thoracocentesis, puncture of pleural cavity for aspiration, initial or subsequent	$ 121.60
32005-00	Chemical pleurodesis (e.g., for recurrent or persistent pneumothorax)	90.00
32020-00	Tube thoracotomy with water seal (e.g., pneumothorax, hemothorax, empyema)(separate procedure)	446.00
32100-00	Thoracotomy, major; with exploration and biopsy	1,730.00
32405-00	Biopsy, lung, percutaneous needle	345.00
32480-00	Lobectomy, total or segmental	2,159.00
32500-00	Wedge resection of lung, single or multiple	1,720.00

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

Code	Service	Maximum Fee
	Heart	
33206-00	Insertion of permanent pacemaker with transvenous electrode(s); atrial	$ 1,456.00
33207-00	ventricular	1,558.00
33208-00	AV sequential	1,950.00
33210-00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter	545.00
33212-00	Insertion or replacement of pulse generator only	875.00
33405-00	Replacement, aortic valve, with cardiopulmonary bypass	4,800.00
	Coronary Artery Procedures	
33511-00	Two coronary grafts	$ 5,280.00
33512-00	three coronary grafts	5,875.00
33513-00	four coronary grafts	6,575.00
33514-00	five coronary grafts	6,630.00
	Arteries and Veins	
34201-00	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	$ 1,120.00
35081-00	Direct repair of aneurysm or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm or occlusive disease, abdominal aorta	3,322.72
35102-00	for aneurysm or occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	3,585.00
35301-00	Thromboendarterectomy, with or without patch graft, carotid, vertebral, subclavian, by neck incision	2,244.00
35556-00	Bypass graft, with vein; femoral-popliteal	2,140.00
35585-00	In situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in situ)	3,040.00
35656-00	Bypass graft, with other than vein; femoral-popliteal	2,020.00

Vascular Injection Procedures

36000*00	Introduction of needle or intracatheter, vein; unilateral	$ 44.00
36010-00	Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery	380.00
36410*00	Venipuncture, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	69.50
36415*00	Routine venipuncture for collection of specimen(s)	8.00
36470*00	Injection of sclerosing solution; single vein	48.00
36471*00	multiple veins, same leg	75.00
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age two	140.00
36491*00	cutdown, over age two	525.00
36495-00	Insertion of implantable intravenous infusion pump or venous access port	890.00
36520-00	Therapeutic apheresis (plasma and/or cell exchange)	130.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	24.87
36620-00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	112.50
36625-00	cutdown	210.00
36800-00	Insertion of cannula for hemodialysis, other purpose; vein to vein	292.70
36830-00	Creation of arteriovenous fistula; nonautogenous graft	1,277.00
37609-00	Ligation or biopsy, temporal artery	265.00
37720-00	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, slip, extravascular, intravascular (umbrella device)	853.00
37721-00	Ligation and division and complete stripping of long or short saphenous veins; bilateral	1,380.00
37730-00	Ligation and division and complete stripping of long and short saphenous veins; unilateral	870.00
37731-00	bilateral	1,417.60
37785-00	Ligation division, and/or excision of secondary varicose veins (clusters) of leg; unilateral	290.00

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

Code	Service	Maximum Fee
	Hemic and Lymphatic Systems	
38100-00	Splenectomy (separate procedure); total	$ 1,365.00
38500-00	Biopsy or excision of lymph node superficial (separate procedure)	190.00
38525-00	deep axillary node(s)	385.50
	Mediastinum and Diaphragm	
39400-00	Mediastinoscopy, with or without biopsy	$ 783.00

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

Code	Service	Maximum Fee
	Mouth	
40490-00	Biopsy of lip	$ 110.00
40808-00	Biopsy, vestibule of mouth	80.10
40812-00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	173.00
41100-00	Biopsy of tongue; anterior two-thirds	108.00
42330-00	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	117.00
42415-00	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	1,820.00
42700*00	Incision and drainage abscess; peritonsillar	115.00
42821-00	Tonsillectomy and adenoidectomy; age 12 or over	552.00
42826-00	Tonsillectomy, primary or secondary; age 12 or over	545.00
	Esophagus	
43200-00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 375.00
43202-00	for biopsy and/or collection of specimen by brushing or washing	404.00
43204-00	for injection sclerosis of esophageal varices	700.00
43215-00	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of a foreign body	532.50
43220-00	for dilation, direct	680.00
43234-00	Upper gastrointestinal endoscopy, simple primary examination (e.g., gastrointestinal endoscopy, with small diameter flexible fiberscope)	420.00

43235-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	393.75
43239-00	For biopsy and/or collection or specimen by brushing or washing	458.00
43245-00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for dilation of gastric outlet for obstruction	538.00
43246-00	for directed placement of percutaneous gastrostomy tube	730.00
43247-00	for removal of foreign body	616.00
43255-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	505.00
43260-00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection	588.00
43262-00	for sphincterotomy/papillotomy	1,074.00
43264-00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without biopsy and/or collection of specimen	1,035.00
43324-00	Esophagogastric fundoplasty (e.g., Nissen, Belsey IV, Hill procedures)	1,940.00
43450*00	Dilation esophagus, by unguided sound(s) or bougie(s), single or multiple passes; initial session	93.00
43451*00	subsequent session	85.00
	Stomach	
43520-00	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	$ 1,100.00
43635-00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type	2,102.00
43640-00	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	1,557.00
43760*00	Change of gastrostomy tube (MD/DO)	76.00
43830-00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure) (MD/DO)	862.50
43840-00	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	1,250.00
	Intestines	
44005-00	Enterolysis (freeing of intestinal adhesion) for acute bowel obstruction	$ 1,314.00
44100-00	Biopsy of intestine by capsule, tube, peroral (one or more specimens)	227.00

44120-00	Enterectomy, resection of small intestine; with anastomosis	1,635.00
44130-00	Enteroenterostomy, anastomosis of intestine; (separate procedure)	1,543.00
44140-00	Colectomy, partial; with anastomosis	1,663.41
44143-00	with end colostomy and closure of distal segment (Hartmann type procedure)	1,890.00
44145-00	with coloproctostomy (low pelvic anastomosis)	2,310.00
44160-00	Colectomy with removal of terminal ileum and ileocolostomy	2,300.00
44320-00	Colostomy or skin level cecostomy; (separate procedure)	1,020.00
44625-00	Closure of enterostomy, large or small intestine; with resection and anastomosis	1,615.00

Appendix

44950-00	Appendectomy	$ 845.00
44960-00	for ruptured appendix with abscesses or generalized peritonitis	1,069.00

Rectum

45300-00	Proctosigmoidoscopy; diagnostic	$ 79.00
45305-00	for biopsy	113.40
45310-00	Proctosigmoidoscopy; for removal of polyp or papilloma	160.00
45330-00	Sigmoidoscopy, flexible fiberoptic; diagnostic	120.75
45331-00	for biopsy and/or collection of specimen by brushing or washing	181.00
45333-00	Sigmoidoscopy, flexible fiberoptic; for removal of polypoid lesion(s)	263.00
45355-00	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple	125.00
45378-00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure	581.00
45380-00	for biopsy and/or collection of specimen by brushing or washing	684.00
45382-00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	825.00
45383-00	for ablation of tumor or mucosal lesion (e.g., electrocoagulation, laser photocoagulation, hot biopsy/fulguration)	610.00
45385-00	for removal of polypoid lesion(s)	750.50
45505-00	Proctoplasty; for prolapse of mucous membrane	850.00

	Anus	
46040-00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	$ 250.00
46050*00	Incision and drainage, perianal abscess, superficial	115.00
46083-00	Incision of thrombosed hemorrhoid, external	80.00
46200-00	Fissurectomy, with or without sphincterotomy	499.00
46221-00	Hemorrhoidectomy, by simple ligature (e.g., rubber band)	114.43
46230-00	Excision of external hemorrhoid tags and/or multiple papillae	112.50
46255-00	Hemorrhoidectomy, internal and external, simple	750.00
46260-00	Hemorrhoidectomy, internal and external, complex or extensive	910.00
46275-00	Fistulectomy; submuscular	825.00
46320*00	Enucleation or excision of external thrombotic hemorrhoid	90.00
46600-00	Anoscopy; diagnostic (separate procedure)	35.00
46900*00	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	42.00
46916-00	cyrosurgery	30.00
46945-00	Ligation of internal hemorrhoids; single procedure	143.00
46946-00	multiple procedures	75.75
	Liver	
47000*00	Biopsy of liver; percutaneous needle	$ 203.00
47600-00	Cholecystectomy	1,322.00
47605-00	with cholangiography	1,505.00
47610-00	Cholecystectomy with exploration of common duct	1,676.00
	Abdomen	
49000-00	Exploratory laparotomy, exploratory celiotomy	$ 929.50
49080*00	Peritoneocentesis, abdominal paracentesis; initial	100.00
49505-00	Repair inguinal hernia, age five or over	809.00
49515-00	with excision of hydrocele or spermatocele	888.00
49520-00	Repair inguinal hernia; recurrent	929.50
49530-00	incarcerated	910.00
49560-00	Repair ventral (incisional) hernia (separate procedure)	903.00
49581-00	Repair umbilical hernia; age five or over	740.00

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

Code	Service	Maximum Fee
	Kidney	
50200*00	Renal biopsy, percutaneous trocar or needle	$ 360.60
50220-00	Nephrectomy, including partial ureterectomy, any approach including rib resection	1,805.50
50230-00	Nephrectomy, including partial ureterectomy, any approach including resection; radical, with regional lymphadenectomy	2,099.00
50394-00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	40.00
50590-00	Lithotripsy, extracorporeal shock wave	2,000.00
50690-00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure)	36.75
	Bladder	
51010-00	Aspiration of bladder; with insertion of suprapubic catheter	$ 150.00
51700*00	Bladder irrigation, simple, lavage and/or instillation	32.95
51705*00	Change of cystostomy tube; simple	57.10
51720-00	Bladder instillation of anticarcinogenic agent (including detention time)	80.50
51726-00	Complex cystometrogram (e.g., calibrated electronic equipment)	123.75
51736-00	Simple uroflowmetry (UFR) (e.g., stopwatch flow rate, mechanical uroflowmeter)	52.00
51741-00	Complex uroflowmetry	68.00
51785-00	Electromyography studies (EMG) of anal or urethral sphincter, any technique	135.00
51840-00	Anterior vesicourethropexy, or urethropexy; simple	1,284.00
51841-00	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); complicated (e.g., secondary repair)	1,365.00
51845-00	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,500.00
	Endoscopy	
52000-00	Cystourethroscopy (separate procedure)	$ 159.50

52005-00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or or ureteropyelography, exclusive of radiologic service	176.00
52204-00	Cystourethroscopy with biopsy	143.00
52214-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery of trigone bladder neck, prostatic fossa, urethra, or periurethral glands)	312.00
52224-00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 centimeter) lesion(s) with or without biopsy	290.00
52240-00	LARGE bladder tumor(s)	1,207.50
52260-00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	260.00
52276-00	Cystourethroscopy with direct vision internal urethrotomy	499.00
52281-00	Cystourethroscopy, with calibration and/or dilation or urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; office	250.00
52285-00	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	404.00
52310-00	Cystourethroscopy, with removal of foreign body, calculus, or urethral stent from urethra or bladder (separate procedure); simple	312.00
52320-00	Cystourethroscopy; with removal of ureteral calculus	624.00
52332-00	Cystourethroscopy, with insertion of indwelling ureteral stent	396.00
52336-00	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method; with removal or manipulation of calculus) (ureteral catheterization is included)	1,430.00
52500-00	Transurethral resection of bladder neck (separate procedure)	709.00
52601-00	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	1,444.00

Urethra

53600*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	$ 40.00
53601*00	male; subsequent	34.00
53620*00	Dilation of urethral stricture by passage of filiform and follower, male; initial	67.00
53621*00	subsequent	45.33
53660*00	Dilation of female urethra including suppository and/or instillation; initial	33.00
53661*00	subsequent	34.00
53670*00	Catheterization; urethral; simple	29.00
53675*00	complicated (may include difficult removal of balloon catheter)	62.64

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

Code	Service	Maximum Fee
	Male Reproductive System	
54050*00	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	$ 38.15
54055*00	electrodesiccation	72.00
54060-00	surgical excision	160.00
54235-00	Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine, etc.)	50.00
54405-00	Insertion of inflatable (multicomponent) penile prosthesis, including placement of pump, cylinders, and/or reservoir	2,881.25
54521-00	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral	624.00
54640-00	Orchiopexy, any type, with or without hernia repair; unilateral	1,010.00
54840-00	Excision of spermatocele, with or without epididymectomy	681.00
55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	47.75
55040-00	Excision of hydrocele; unilateral	631.00
55700-00	Biopsy, prostate; needle or punch, single or multiple, any approach	139.00
55845-00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	2,650.00
	Female Reproductive System	
56400*00	Incision and drainage, abscess of vulva, extensive	$ 125.00
56420*00	Incision and drainage of Bartholin's gland	95.00

56501-00	Destruction of lesion(s), vulva; simple, any method	60.00
56515-00	extensive, any method	200.00
56600*00	Biopsy of vulva (separate procedure)	94.00
57061-00	Destruction of vaginal lesion(s); simple, any method	62.00
57100*00	Biopsy of vaginal mucosa; simple, (separate procedure)	78.00
57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	20.00
57240-00	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele (separate procedure)	850.00
57260-00	Combined anteroposterior colporrhaphy	1,100.00
57265-00	with enterocele repair	1,180.00
57410*00	Pelvic examination under anesthesia	52.30
57452*00	Colposcopy (vaginoscopy); (separate procedure)	145.00
57454*00	with biopsies, or biopsy of the cervix	170.50
57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	79.00
57505-00	Endocervical curettage (not done as part of a dilation and curettage)	85.00
57510-00	Cauterization of cervix; electro or thermal	92.00
57511*00	cryocautery, initial or repeat	110.00
57520-00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair	550.00
58100*00	Endometrial biopsy, suction type (separate procedure)	90.00
58102-00	Office endometrial curettage	141.00
58120-00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	375.00
58150-00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	1,475.00
58152-00	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type)	2,100.00
58260-00	Vaginal hysterectomy	1,461.00
58265-00	with plastic repair of vagina, anterior and/or posterior colporrhaphy	1,669.50
58340*00	Injection procedure for hysterosalpingography	125.00
58720-00	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	1,055.00
58925-00	Ovarian cystectomy, unilateral or bilateral	1,102.00
58940-00	Oophorectomy, partial or total, unilateral or bilateral	989.00
58980-00	Laparoscopy for visualization of pelvic viscera	667.00

58982-00	with fulguration of oviducts (with or without transection)	755.00
58983-00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	829.50
58984-00	with fulguration of ovarian or peritoneal lesions by any method	831.00
58985-00	with lysis of adhesions	800.00
58986-00	with biopsy (single or multiple)	810.00
58990-00	Hysteroscopy; diagnostic	625.00

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

Code	Service	Maximum Fee
60100*00	Biopsy thyroid, percutaneous needle	$ 138.50
60220-00	Total thyroid lobectomy, unilateral	1,220.00
60245-00	Thyroidectomy, subtotal or partial	1,452.10
60500-00	Parathyroidectomy or exploration of parathyroid(s)	1,562.00

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

Code	Service	Maximum Fee
61154-00	Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural; unilateral	$ 2,020.00
61312-00	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	2,978.80
61510-00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	3,575.00
62223-00	Creation of shunt; ventriculo-peritoneal, -pleural, -other terminus	1,960.00
	Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic	$ 110.90
62273*00	Injection lumbar epidural, of blood or clot patch	260.00
62279*00	epidural or caudal, continuous	300.00
62282*00	Injection of neurolytic substance (e.g., alcohol, phenol, iced saline solutions); lumbar or caudal epidural	432.00
62284*00	Injection procedure for myelography and/or computerized axial tomography, spinal, or posterior fossa	295.00
62288*00	Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure)	75.00
62289*00	lumbar or caudal epidural	275.00

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

63005-00	Laminectomy for exploration/decompression of spinal cord and/or cauda, equina, one or two segments; lumbar, except for spondylolisthesis	$ 2,650.00
63017-00	Laminectomy for exploration/ decompression of spinal cord and/or cauda equina, more than two segments; lumbar	3,400.00
63020-00	Laminotomy (hemilaminectomy), for decompression of nerve root, including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical, unilateral	2,870.00
63030-00	one interspace, lumbar, unilateral	2,351.90
63031-00	one interspace, lumbar, bilateral	2,700.00
63042-00	reexploration; lumbar	2,950.00
63047-00	Laminectomy, including unilateral or bilateral complete facetectomy or foraminotomy for decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single segment; lumbar	3,350.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

64405*00	Injection, anesthetic agent; greater occipital nerve	$ 146.00
64440*00	paravertebral nerve (thoracic, lumbar, sacral, coccygeal), single vertebral level	50.00
64442*00	paravertebral facet joint nerve, lumbar, single level	100.00
64450*00	other peripheral nerve or branch	90.00
64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	224.00
64520*00	lumbar or thoracic (paravertebral sympathetic)	255.00
64550-00	Application of surface (transcutaneous) neurostimulator	55.00
64640-00	Destruction by neurolytic agent; other peripheral nerve or branch	267.00
64721-00	median nerve at carpal tunnel	770.00

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

Code	Service	Maximum Fee
65205*00	Removal foreign body, external eye; conjunctival superficial	$ 46.00

65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	50.00
65220*00	corneal, without slit lamp	61.00
65222*00	corneal, with slit lamp	72.00
65420-00	Excision or transposition of pterygium; without graft	553.50
65435*00	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	75.00
65730-00	Keratoplasty (corneal transplant), penetrating (except in aphakia), includes autografts, and fresh or preserved homografts	2,945.00
65855-00	Trabeculoplasty by laser surgery (one or more sessions) (defined treatment series)	757.00
66170-00	Fistulization of sclera for glaucoma; trabeculectomy ab externo	1,250.00
66761-00	Iridotomy by photocoagulation (one or more sessions) (e.g., for glaucoma)	750.00
66802-00	Discission of lens capsule; laser surgery (one or more stages)	570.00
66820-00	Discission of secondary membranous cataract ("after cataract"), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)	525.00
66821-00	laser surgery (one or more stages)	712.20
66940-00	Extraction of lens with or without iridectomy; extracapsular	1,821.00
66983-00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,700.00
66984-00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure)	1,900.00
66985-00	Insertion of intraocular lens subsequent to cataract removal (separate procedure)	1,360.00
67036-00	Vitrectomy, mechanical, pars plana approach	2,592.28
67038-00	with epiretinal membrane stripping	3,800.00
67105-00	Repair of retinal detachment, one or more sessions, same hospitalization; photocoagulation (laser or xenon arc, one or more sessions) with drainage of subretinal fluid	875.00
67107-00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,288.00
67141-00	Prophylaxis of retinal detachment (e.g., retinal break, lattice, degeneration) without drainage, one or more sessions; cryotherapy, diathermy	845.00
67145-00	photocoagulation (laser or xenon arc)	770.00

67210-00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), one or more sessions; photocoagulation (laser or xenon arc)	1,020.63
67227-00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; cryotherapy, diathermy	930.00
67228-00	photocoagulation (laser or xenon arc)	900.00
67312-00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); two muscles, one or both eyes	1,193.00
67500*00	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	75.00
67515*00	Injection of therapeutic agent into Tenon's capsule	60.00
67800-00	Excision of chalazion; single	91.00
67801-00	multiple, same lid	135.00
67810*00	Biopsy of eyelid	75.00
67820*00	Correction of trichiasis; epilation, by forceps only	38.00
67825*00	epilation, (e.g., by electrosurgery or cryotherapy)	100.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	95.00
67880-00	Construction of intermarginal adhesions, medial tarsorrhaphy, or canthorrhaphy	450.00
67904-00	Repair of blepharoptosis; (tarso) levator resection, external approach	1,650.00
67923-00	Repair of entropion; blepharoplasty, excision tarsal wedge	675.00
67924-00	blepharoplasty, extensive (e.g., Wheeler operation)	675.00
67938-00	Removal of embedded foreign body; eyelid	49.00
68110-00	Excision of lesion, conjunctiva; up to one centimeter	125.00
68200*00	Subconjunctival injection	75.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	40.00
68820*00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral	92.00
68825-00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring general anesthesia	275.00
68840*00	Probing of lacrimal canaliculi, with or without irrigation	75.00

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

Code	Service	Maximum Fee
69210-00	Removal impacted cerumen (separate procedure), one or both ears	$ 25.00
69220-00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning); unilateral	42.00
69301-00	Otoplasty, protruding ear, with or without size reduction; bilateral	1,675.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	100.00
69425-00	Ventilating tube removal when originally inserted by another physician; bilateral	210.00
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral	233.00
69434*00	bilateral	350.00
69436-00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral	300.00
69437-00	bilateral	405.00
69440-00	Middle ear exploration through postauricular or ear canal incision	1,070.00
69610-00	Tympanic membrane repair, with or without site preparation or perforation preparation for closure without patch	83.00
69620-00	Myringoplasty	1,487.50
69631-00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	2,056.00
69632-00	with ossicular chain reconstruction (e.g., postfenestration)	2,546.00
69660-00	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material	2,270.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 10 SR 1548; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 124; 15 SR 738*

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

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

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

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation

and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

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

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

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

Code	Service	Maximum Fee
	Head and Neck	
70100-00	Radiologic examination, mandible; partial, less than four views	$ 59.25
70110-00	complete, minimum of four views	76.70
70120-00	Radiologic examination, mastoids; less than three views per side	81.00
70130-00	complete, minimum of three views per side	103.00
70140-00	Radiologic examination, facial bones; less than three views	54.00
70150-00	complete, minimum of three views	77.00
70160-00	Radiologic examination, nasal bones; complete, minimum of three views	56.00
70200-00	Radiologic examination; orbits, complete, minimum of four views	78.00
70210-00	Radiologic examination, sinuses, paranasal, less than three views	40.00
70220-00	Radiologic examination, sinuses, paranasal, complete, minimum of three views	77.00
70250-00	Radiologic examination, skull; less than four views, with or without stereo	60.00
70260-00	complete, minimum of four views, with or without stereo	96.50
70300-00	Radiologic examination, teeth; single view	16.70
70310-00	partial examination, less than full mouth	21.60
70328-00	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	72.00
70333-00	Temporomandibular joint arthrography; complete procedure	250.00
70336-00	Magnetic resonance (e.g., proton) imaging, temporomandibular joint	930.00
70355-00	Orthopantogram	55.00

70360-00	Radiologic examination, neck, soft tissue	42.00
70450-00	Computerized axial tomography, head or brain; without contrast material	371.00
70460-00	with contrast material	460.00
70470-00	without contrast material, followed by contrast material(s) and further sections	486.00
70480-00	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	454.00
70481-00	with contrast material(s)	437.80
70482-00	without contrast material, followed by contrast material(s) and further sections	559.00
70490-00	Computerized axial tomography, soft tissue neck; without contrast material	405.00
70491-00	with contrast material(s)	440.00
70551-00	Magnetic resonance (e.g., proton) imaging brain (including brain stem)	885.00

Chest

71010-00	Radiologic examination, chest; single view, frontal	$ 40.00
71015-00	stereo, posteroanterior	41.20
71020-00	Radiologic examination, chest, two views, frontal and lateral	56.00
71021-00	with apical lordotic procedure	47.75
71022-00	with oblique projections	85.50
71030-00	Radiological examination, chest, complete, minimum of four views	46.20
71035-00	Radiologic examination, chest, special views (e.g., lateral decubitus, Bucky studies)	28.40
71100-00	Radiologic examination, ribs, unilateral; two views	61.00
71101-00	including posteroanterior chest, minimum of three views	66.00
71110-00	Radiologic examination, ribs, bilateral; three views	73.00
71111-00	including posteroanterior chest, minimum of four views	93.00
71120-00	Radiologic examination; sternum, minimum of two views	58.00
71250-00	Computerized axial tomography, thorax, without contrast materials	468.00
71260-00	with contrast materials	520.00
71270-00	without contrast material, followed by contrast material(s) and further sections	580.00
71550-00	Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy)	875.00

Spine and Pelvis

72010-00	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral	$ 107.00
72020-00	Radiologic examination, spine, single view, specify level	50.00
72040-00	Radiologic examination, spine, cervical; anteroposterior and lateral	61.00
72050-00	minimum of four views	90.00
72052-00	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies	104.00
72070-00	Radiologic examination, spine; thoracic, anteroposterior and lateral	66.50
72072-00	thoracic anteroposterior and lateral, including swimmer's view of the cervicothoracic junction	78.00
72080-00	Radiologic examination, spine; thoracolumbar, anteroposterior and lateral	68.00
72090-00	scoliosis study, including supine and erect studies	69.00
72100-00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	72.00
72110-00	complete, with oblique views	99.75
72114-00	complete, including bending views	101.00
72120-00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	95.00
72125-00	Computerized axial tomography, cervical spine; without contrast material	540.00
72128-00	Computerized axial tomography, thoracic spine;	498.00
72131-00	Computerized axial tomography, lumbar spine; without contrast material	498.00
72132-00	with contrast material	505.00
72141-00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents	955.00
72143-00	thoracic	905.00
72144-00	lumbar	930.00
72170-00	Radiologic examination, pelvis anteroposterior only	47.00
72180-00	stereo	47.00
72190-00	complete, minimum of three views	67.00
72192-00	Computerized axial tomography, pelvis, without contrast material	234.00
72193-00	with contrast material(s)	509.00
72196-00	Magnetic resonance (e.g., proton) imaging, pelvis	865.00
72200-00	Radiologic examination, sacroiliac joints; less than three views	59.00
72202-00	three or more views	70.00
72220-00	Radiologic examination, sacrum and coccyx, minimum of two views	60.50

72266-00	Myelography, lumbosacral; complete procedure	608.00

Upper Extremities

73000-00	Radiologic examination; clavicle, complete	$ 43.00
73010-00	scapula, complete	56.00
73020-00	Radiologic examination, shoulder; one view	42.00
73030-00	complete, minimum of two views	55.00
73041-00	Radiologic examination, shoulder, arthrography; complete procedure	235.00
73050-00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	60.45
73060-00	humerus, minimum of two views	49.00
73070-00	Radiologic examination, elbow; anteroposterior and lateral views	45.00
73080-00	complete, minimum of three views	51.00
73090-00	Radiologic examination; forearm, anteroposterior and lateral views	46.00
73100-00	Radiologic examination, wrist; anteroposterior and lateral views	45.00
73110-00	complete, minimum of three views	50.00
73120-00	Radiologic examination, hand; two views	45.00
73130-00	minimum of three views	50.00
73140-00	Radiologic examination, finger or fingers, minimum of two views	40.00
73200-00	Computerized axial tomography, upper extremity; without contrast material	470.00
73220-00	Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint	981.00
73221-00	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity	865.00

Lower Extremities

73500-00	Radiologic examination, hip; unilateral, one view	$ 40.00
73510-00	complete, minimum of two views	63.00
73520-00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	65.00
73550-00	Radiologic examination, femur, anteroposterior and lateral views	54.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	47.00
73562-00	anteroposterior and lateral, with oblique, minimum of three views	59.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	66.70
73581-00	Radiologic examination, knee, arthrography; complete procedure	234.30

73590-00	Radiologic examination, tibia and fibula, anteroposterior and lateral views	49.00
73600-00	Radiologic examination, ankle; anteroposterior and lateral views	43.00
73610-00	complete, minimum of three views	51.50
73620-00	Radiologic examination, foot; anteroposterior and lateral views	44.00
73630-00	complete, minimum of three views	52.00
73650-00	Radiologic examination; calcaneus, minimum of two views	43.00
73660-00	toe or toes, minimum of two views	40.50
73700-00	Computerized axial tomography, lower extremity; without contrast material	470.00
73720-00	Magnetic resonance (e.g., proton) imaging, lower extremity	795.00
73721-00	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity	865.00

Abdomen

74000-00	Radiologic examination, abdomen, single anteroposterior view	$ 47.00
74010-00	anteroposterior and additional oblique and cone views	61.00
74020-00	complete, including decubitus and/or erect views	65.50
74022-00	Complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest	100.00
74150-00	Computerized axial tomography, abdomen; without contrast material	468.00
74160-00	with contrast material(s)	524.00
74170-00	without contrast material, followed by contrast material(s) and further sections	569.20
74181-00	Magnetic resonance (e.g., proton) imaging, abdomen	955.00

Gastrointestinal Tract

74210-00	Radiologic examination; pharynx and/or cervical esophagus	$ 81.00
74220-00	esophagus	118.00
74230-00	Swallowing function, pharynx and/or esophagus, with cineradiography and/or video	42.42
74240-00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	132.90
74241-00	with or without delayed films, with KUB	140.00
74245-00	with small bowel, includes multiple serial films	191.86

74246-00	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without delayed films; without KUB	141.00
74247-00	with or without delayed films, with KUB	180.50
74250-00	Radiologic examination, small bowel, includes multiple serial films	156.00
74270-00	Radiologic examination, colon; barium enema	132.90
74280-00	air contrast with specific high density barium, with or without glucagon	183.00
74290-00	Cholecystography, oral contrast	84.00
74291-00	additional or repeat examination or multiple day examination	50.00
74305-00	Cholangiography and/or pancreatography; postoperative	121.50
74330-00	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography	87.00

Urinary Tract

74400-00	Urography, (pyelography) intravenous, with or without KUB	$ 163.25
74405-00	with special hypertensive contrast concentration and/or clearance studies	171.91
74410-00	Urography, infusion, drip technique	160.00
74415-00	Urography, infusion, drip technique and/or bolus technique; with nephrotomography	195.00
74420-00	Urography, retrograde, with or without KUB	114.60
74426-00	Urography, antegrade, (pyelostogram, nephrostogram, loopogram); complete procedure	142.60
74431-00	Cystography, minimum of three views; complete procedure	125.00
74451-00	Urethrocystography, retrograde; complete procedure	159.00
74456-00	Urethrocystography, voiding; complete procedure	165.20

Gynecological and Obstetrical

74720-00	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view	$ 47.10
74741-00	Hysterosalpingography; complete procedure	161.50

	Veins and Lymphatics	
75821-00	Venography, extremity, unilateral; complete procedure	$ 255.00
	Miscellaneous	
76000-00	Fluoroscopy (separate procedure), up to one hour physician time	$ 83.00
76020-00	Bone age studies	50.00
76040-00	Bone length studies (orthoroentgenogram, scanogram)	73.00
76061-00	Radiologic examination, osseous survey: limited (e.g., for metastases)	157.25
76062-00	Radiologic examination, osseous survey; complete	207.00
76090-00	Mammography; unilateral	60.00
76091-00	bilateral	75.00
76096-00	Localization of breast nodule or calcification before operation, with marker and confirmation of its position with appropriate imaging (e.g., radiologic or ultrasound)	199.00
76098-00	Radiological examination, breast surgical specimen	27.34
76100-00	Radiologic examination, single plane body section	140.00
76101-00	Radiologic examination, complex motion (e.g., hypercycloidal) body section (e.g., mastoid polytomography), other than kidney; unilateral	110.20
76102-00	bilateral	132.50
76140-00	Consultation on x-ray examination made elsewhere, written report	28.50
76150-00	Xeroradiography	54.00
76361-00	Computerized tomography guidance for needle biopsy; complete procedure	579.25
76370-00	Computerized tomography guidance for placement of radiation therapy fields	187.50
76375-00	Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction	65.00

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

Code	Service	Maximum Fee
	Head and Neck	
76511-00	Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification	$ 151.50
76512-00	contact B-scan	163.00
76516-00	Ophthalmic, biometry; by ultrasound echography, A-mode	155.00
76519-00	intraocular lens power calculation	155.00
76536-00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B-scan and/or real-time with image documentation	218.00
	Chest	
76629-00	Echocardiography, M-mode and real-time with image documentation	$ 300.00
76632-00	Doppler echocardiography	103.00
	Abdomen and Retroperitoneum	
76700-00	Echography, abdominal, B-scan; and/or real-time with image documentation	$ 187.50
76705-00	limited	135.00
76770-00	Echography, retroperitoneal (e.g., renal, aorta, nodes), B-scan	181.90
76775-00	limited	110.00
	Pelvis	
76805-00	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete	$ 125.00
76815-00	limited (fetal growth rate, heart beat, anomalies, placental location)	95.00
76816-00	follow-up or repeat	80.00
76818-00	Fetal biophysical profile	126.00
76855-00	Echography, pelvic area (Doppler)	181.90
76856-00	Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; complete	136.00
76857-00	limited or follow-up (e.g., for follicles)	85.00
	Genitalia	
76870-00	Echography, scrotum and contents	$ 218.00
	Extremities	
76880-00	Echography, extremity, B-scan and/or real-time with image documentation	$ 200.30

	Vascular studies	
76926-00	Imaging, head and trunk (e.g., Duplex Doppler)	$ 128.40
	Ultrasonic Guidance Procedures	
76943-00	Ultrasonic guidance for needle biopsy; complete procedure	$ 306.80
	Miscellaneous	
76970-00	Ultrasound study follow-up (specify)	$ 67.50
76991-00	Intraluminal ultrasound study (e.g., transrectal, transvaginal)	200.00

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

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

Code	Service	Maximum Fee
77261-00	Therapeutic radiology treatment planning; simple	$ 110.00
77262-00	intermediate	325.00
77263-00	complex	519.00
77280-00	Therapeutic radiology simulation-aided field setting; simple	179.00
77285-00	intermediate	274.50
77290-00	complex	428.00
77300-00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment	88.00
77310-00	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)	214.30
77315-00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	329.00

77331-00	Special dosimetry (e.g., TLD, microdosimetry) (specify)	200.00
77332-00	Treatment devices, design and construction; simple (simple block, simple bolus)	150.00
77333-00	intermediate (multiple blocks, stents, bite blocks, special bolus)	127.04
77334-00	complex	251.00
77336-00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance	98.00
77400-00	Daily megavoltage treatment management; simple	98.00
77405-00	intermediate	195.00
77410-00	complex	149.00
77415-00	Therapeutic radiology treatment port film interpretation and verification, per treatment course	23.00
77465-00	Daily kilovoltage treatment management	50.00

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

Code	Service	Maximum Fee
	Diagnostic - Endocrine System	
78000-00	Thyroid uptake; single determination	$ 56.00
78001-00	multiple determinations	134.10
78010-00	Thyroid imaging; only	187.00
	Diagnostic - Gastrointestinal System	
78215-00	Liver and spleen imaging	$ 244.10
78223-00	Hepatobiliary ductal system imaging, including gallbladder	255.00
78270-00	Vitamin B-12 absorption study (e.g., Schilling test); without intrinsic factor	132.00
	Diagnostic - Musculoskeletal System	
78300-00	Bone imaging; limited area (e.g., skull, pelvis)	$ 195.00
78305-00	multiple areas	270.00
78306-00	whole body	296.20
78350-00	Bone density (bone mineral content) study; single photon absorptiometry	84.00
78351-00	dual photon absorptiometry	187.30
	Cardiovascular System	
78460-00	Myocardial imaging; resting only, quantitative or qualitative	$ 210.00

78461-00	exercise and redistribution, qualitative or quantitative, with or without pharmacological intervention	428.50
78464-00	tomographic (SPECT), at rest only, qualitative or quantitative	275.00
78465-00	tomographic (SPECT) with exercise and redistribution, qualitative or quantitative, with or without pharmacologic intervention	800.00
78471-00	Cardiac blood pool imaging, gated equilibrium, at rest, wall motion study plus ejection fraction	403.00
78477-00	Cardiac blood pool imaging, gated equilibrium, at rest; quantitative wall motion study, plus ejection fraction plus ventricular volume determination, with exercise and/or pharmacologic intervention	501.90
	Diagnostic - Respiratory System	
78580-00	Pulmonary perfusion imaging; particulate	$ 325.00
78585-00	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	559.20
	Diagnostic - Genitourinary System	
78707-00	Kidney imaging; with vascular flow and function study	$ 487.90
	Miscellaneous Studies	
78890-00	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	$ 74.69
78891-00	complex manipulations and interpretation, exceeding 30 minutes	88.70
78990-00	Provision of diagnostic radionuclide(s)	100.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

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 com-

bination of three or more tests among those listed below, the appropriate code from 80002-00 to 80090-00 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

A. Albumin
B. Albumin/globulin ratio
C. Bilirubin, direct
D. Bilirubin, total
E. Calcium
F. Carbon dioxide content
G. Chlorides
H. Cholesterol
I. Creatinine
J. Globulin
K. Glucose (sugar)
L. Lactic dehydrogenase (LDH)
M. Phosphatase, alkaline
N. Phosphorus (inorganic phosphate)
O. Potassium
P. Protein, total
Q. Sodium
R. Transaminase, glutamic oxaloacetic (SGOT)
S. Transaminase, glutamic pyruvic (SGPT)
T. Urea nitrogen (BUN)
U. Uric acid

Code	Service	Maximum Fee
	Automated Multichannel Tests	
80002-00	Automated multichannel test one or two clinical chemistry tests	$ 19.00
80003-00	three clinical chemistry tests	25.50
80004-00	four clinical chemistry tests	31.00
80005-00	five clinical chemistry tests	30.50
80006-00	six clinical chemistry tests	32.00
80007-00	seven clinical chemistry tests	33.10
80008-00	eight clinical chemistry tests	33.80
80009-00	nine clinical chemistry tests	36.00
80010-00	ten clinical chemistry tests	38.00
80011-00	11 clinical chemistry tests	38.10
80012-00	12 clinical chemistry tests	43.00
80016-00	13-16 clinical chemistry tests	42.50
80018-00	17-18 clinical chemistry tests	48.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	35.00
	Therapeutic Drug Monitoring	
80031-00	Therapeutic quantitative drug monitoring in body fluids and/or excreta; measurement one drug	$ 43.20
80032-00	two drugs measured	73.75

80034-00	four or more drugs measured	21.90
80040-00	Serum radioimmunoassay for circulating antibiotic levels	28.30

Organ or Disease Oriented Panels

80050-00	General health screen panel	$ 49.50
80053-00	Executive profile	78.00
80055-00	Obstetric profile	40.00
80058-00	Hepatic function panel	33.00
80059-00	Hepatitis panel	71.00
80060-00	Hypertension panel	35.00
80061-00	Lipid profile	32.55
80062-00	Cardiac evaluation (including coronary risk) panel	35.00
80063-00	Cardiac injury panel	35.00
80064-00	with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination	35.00
80065-00	Metabolic panel	57.50
80070-00	Thyroid panel	40.00
80071-00	with thyrotropin releasing hormone (TRH)	49.00
80072-00	Arthritis panel	45.00
80073-00	Renal panel	30.00
80085-00	Microcytic anemia panel	58.25
80086-00	Macrocytic anemia panel	43.40
80090-00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	89.00

Consultations (Clinical Pathology)

80500-00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 29.65
80502-00	comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	30.00

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

Code	Service	Maximum Fee
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$ 14.00
81002-00	routine, without microscopy	9.00
81004-00	components, single, not otherwise listed, specify	8.00
81005-00	chemical, qualitative, any number of constituents	8.75
81015-00	microscopic only	9.75
81020-00	two or three glass test	12.40

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
82010-00	Acetone; quantitative	$ 7.75
82011-00	Acetylsalicylic acid; quantitative	25.90
82024-00	Adrenocorticotropic hormone (ACTH), RIA	116.00
82040-00	Albumin; serum	11.10
82055-00	Alcohol (ethanol), blood; chemical	38.00
82085-00	Aldolase, blood; kinetic ultraviolet method	26.40
82086-00	colorimetric	37.50
82088-00	Aldosterone; RIA, blood	112.00
82130-00	Amino acids, urine or plasma, chromatographic fractionation and quantitation, one or more	178.00
82137-00	Aminophylline	40.50
82138-00	Amitryptyline	52.60
82140-00	Ammonia; blood	47.30
82150-00	Amylase, serum	25.00
82156-00	Amylase, urine	19.50
82157-00	Androstenedione, RIA	94.00
82164-00	Angiotensin-converting enzyme	41.00
82172-00	Apolipoprotein, immunoassay	25.00
82175-00	Arsenic, blood, urine, gastric contents, hair or nails, quantitative	69.85
82205-00	Barbiturates; quantitative	35.00
82210-00	quantitative and identification	38.00
82232-00	Beta-2 microglobulin, RIA; serum	60.00
82250-00	Bilirubin; blood, total OR direct	17.00
82251-00	blood, total AND direct	17.00
82270-00	Blood; occult, feces, screening	9.50
82306-00	Calcifediol (25-OH Vitamin D-3), chromatographic technique	140.30
82307-00	Calciferol (Vitamin D), RIA	65.40
82308-00	Calcitonin, RIA	77.90
82310-00	Calcium, blood; chemical	13.00
82325-00	atomic absorption flame photometry	13.80
82330-00	fractionated diffusible	35.00
82340-00	Calcium, urine; quantitative, timed specimen	19.90
82355-00	Calculus (stone); qualitative, chemical	38.00
82360-00	Calculus (stone); quantitative, chemical	39.90
82365-00	infrared spectroscopy	47.60
82372-00	Carbamazepine, serum	36.00
82374-00	Carbon dioxide, combining power or content	8.80
82375-00	Carbon monoxide, (carboxyhemoglobin); quantitative	46.00
82376-00	qualitative	12.00
82380-00	Carotene, blood	27.25
82382-00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine	59.50

82384-00	fractionated	81.05
82390-00	Ceruloplasmin, chemical (copper oxidase), blood	32.00
82435-00	Chlorides; blood (specify chemical or electrometric)	8.80
82465-00	Cholesterol, serum; total	15.00
82470-00	total and esters	16.00
82486-00	Chromatography; gas-liquid, compound and method not elsewhere specified	54.00
82495-00	Chromium, urine	15.00
82507-00	Citrate	79.90
82512-00	Clonazepam	49.83
82525-00	Copper; blood	40.00
82532-00	Cortisol; CPB, urine	53.10
82533-00	Cortisol; RIA, plasma	49.60
82534-00	RIA, urine	65.00
82540-00	Creatine; blood	21.00
82546-00	Creatine and creatinine	12.00
82550-00	Creatine phosphokinase (CPK), blood; timed kinetic ultraviolet method	24.20
82552-00	isoenzymes	42.50
82555-00	Colorimetric	37.00
82565-00	Creatinine; blood	15.00
82570-00	urine	15.00
82575-00	clearance	35.00
82595-00	Cryoglobulin, blood	42.10
82606-00	Cyanocobalamin (Vitamin B-12); bioassay	34.00
82607-00	RIA	39.83
82608-00	unsaturated binding capacity	59.00
82615-00	Cystine and homocystine, urine; qualitative	59.00
82620-00	quantitative	103.80
82626-00	Dehydroepiandrosterone (DHEA), RIA	89.25
82628-00	Desipramine	63.75
82640-00	Digitoxin (digitalis); blood, RIA	50.50
82643-00	Digoxin, RIA	39.60
82656-00	Doxepin	49.00
82660-00	Drug screen (amphetamines, barbiturates, alkaloids)	47.00
82662-00	Immunoassay technique for drugs	43.00
82670-00	Estradiol, RIA (placental)	71.70
82672-00	total	95.50
82692-00	Ethosuximide	40.00
82705-00	Fat or lipids, feces; screening	20.00
82710-00	quantitative, 24 or 72 hour specimen	75.60
82728-00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)	43.00
82745-00	Folic acid (folate), blood; bioassay	40.00
82746-00	RIA	44.92
82756-00	Free thyroxine index (T-7)	26.00
82784-00	Gamma globulin, E (e.g., RIA, EIA)	59.70
82785-00	Gamma globulin, E	36.00
82792-00	Gasses, blood, oxygen saturation; by calculation from pO2	30.00
82800-00	Gasses, blood; pH only	24.85
82803-00	pH, pCO2, pO2, simultaneous	60.00
82941-00	Gastrin, RIA	57.80

82946-00	Glucagon tolerance test	32.00
82947-00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid)	16.00
82948-00	blood, stick test	12.00
82949-00	fermentation	15.00
82950-00	post glucose dose (includes glucose)	19.00
82951-00	tolerance test (GTT), three specimens (includes glucose)	45.00
82952-00	tolerance test, each additional beyond three specimens	15.50
82954-00	Glucose, urine	7.00
82977-00	Glutamyl transpeptidase, gamma (GGT)	20.50
83000-00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	52.10
83001-00	RIA	56.00
83002-00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	54.50
83003-00	Growth hormone, human (HGH) (somatotropin); RIA	49.40
83010-00	Haptoglobin; chemical	31.00
83015-00	Heavy metal screen (arsenic, bismuth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)	95.00
83036-00	Hemoglobin; glycosylated	25.00
83052-00	sickle, turbidimetric	18.00
83150-00	Homovanillic acid (HVA), urine	60.10
83497-00	Hydroxyindolacetic acid, 5-(HIAA), urine	51.80
83498-00	Hydroxyprogesterone, 17-d, RIA	78.40
83523-00	Imipramine	60.00
83525-00	Insulin, RIA	36.00
83540-00	Iron, serum; chemical	15.30
83545-00	automated	10.86
83550-00	Iron binding capacity, serum; chemical	22.50
83555-00	automated	31.90
83565-00	radioactive uptake method	27.50
83582-00	Ketogenic steroids, urine; 17-(17-KGS)	43.70
83605-00	Lactate (lactic acid)	29.60
83610-00	Lactic dehydrogenase (LDH), RIA	15.00
83615-00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method	17.10
83620-00	Lactic dehydrogenase (LDH), blood colorimetric or fluorometric	17.50
83625-00	isoenzymes, electrophoretic separation and quantitation	38.27
83645-00	Lead, screening; blood	25.00
83655-00	Lead, quantitative; blood	34.50
83661-00	Lecithin-sphingomyelin ratio (L/S ratio), amniotic fluid	121.49
83690-00	Lipase, blood	24.90
83700-00	total	22.00
83705-00	fractionated	26.75
83715-00	Lipoprotein, blood; electrophoretic separation and quantitation (phenotyping)	32.00
83717-00	analytic ultracentrifugation separation and quantitation (atherogenic index)	22.00

83718-00	Lipoprotein high density cholesterol by precipitation method	21.70
83719-00	Lipoprotein very low density cholesterol (VLDL cholesterol) by ultracentrifugation	23.00
83720-00	Lipoprotein cholesterol fractionation calculation by formula	15.00
83725-00	Lithium, blood, quantitative	24.50
83735-00	Magnesium, blood; chemical	18.00
83750-00	atomic absorption	27.00
83765-00	Magnesium, urine; atomic absorption	27.00
83835-00	Metanephrines, urine	50.00
83872-00	Mucin, synovial fluid (Ropes test)	15.00
83915-00	Nucleotidase 5'-	31.10
83916-00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis	69.80
83930-00	Osmolality; blood	22.50
83945-00	Oxalate, urine	39.00
83970-00	Parathormone, RIA	122.00
84030-00	Phenylalanine (PKU); Guthrie	15.00
84035-00	Phenylketones; blood, qualitative	17.00
84037-00	Phenylketones; urine, qualitative	8.00
84045-00	Phenytoin	36.40
84060-00	Phosphatase, acid; blood	24.50
84065-00	prostatic fraction	23.15
84066-00	prostatic fraction, RIA	45.00
84075-00	Phosphatase, alkaline, blood	18.30
84080-00	isoenzymes, electrophoretic method	43.70
84100-00	Phosphorus (phosphate); blood	13.90
84105-00	urine	17.50
84126-00	Porphyrins, feces, quantitative	45.00
84132-00	Potassium; blood	15.00
84133-00	urine	17.90
84136-00	Pregnanediol; other method (specify)	15.00
84141-00	Primidone	42.00
84142-00	Procainamide	50.50
84144-00	Progesterone, any method	59.00
84146-00	Prolactin, RIA	55.90
84155-00	Protein, total, serum; chemical	15.10
84165-00	Protein, total, serum; electrophoretic fractionation and quantitation	31.20
84175-00	Protein, other sources, quantitative	17.50
84176-00	Protein, special studies (e.g., monoclonal protein analysis)	125.00
84180-00	Protein, urine; quantitative, 24-hour specimen	20.50
84190-00	electrophoretic fractionation and quantitation	39.00
84195-00	Protein, spinal fluid; semiquantitative (Pandy)	21.00
84203-00	Protoporphyrin, RBC; screen	9.00
84208-00	Pyrophosphate vs urate, crystals (polarization)	20.50
84220-00	Pyruvic kinase, RBC	1.80
84230-00	Quinidine, blood	39.00
84231-00	Radioimmunoassay (RIA) not elsewhere specified	72.00

84238-00	Receptor assay; nonendocrine (e.g., acetylcholine) (specify receptor)	134.00
84244-00	Renin (angiotensin I); (RIA)	78.00
84275-00	Sialic acid, blood	80.00
84295-00	Sodium; blood (MD/DO)	15.55
84300-00	urine	13.70
84403-00	Testosterone, blood, RIA	90.25
84408-00	Tetrahydrocannabinol THC (marijuana)	24.00
84420-00	Theophylline, blood, or saliva	36.75
84435-00	Thyroxine, CPB or resin uptake	17.00
84436-00	Thyroxine, true, RIA	20.80
84439-00	Thyroxine, free, RIA	28.50
84442-00	Thyroxine binding globulin (TBG)	40.70
84443-00	Thyroid stimulating hormone (TSH), RIA	47.50
84446-00	Tocopherol alpha (Vitamin E)	37.40
84447-00	Toxicology, screen; general	49.00
84448-00	sedative	50.00
84450-00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method (MD/DO)	19.10
84455-00	colorimetric or fluorometric	19.00
84460-00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	22.00
84478-00	Triglycerides, blood	15.90
84479-00	Triiodothyronine (t-3), resin uptake	22.00
84480-00	Triiodothyronine, true, RIA	53.60
84520-00	Urea nitrogen, blood (BUN); quantitative	14.00
84550-00	Uric acid; blood, chemical	17.00
84555-00	uricase, ultraviolet method	15.10
84560-00	Uric acid, urine	25.00
84585-00	Vanillylmandelic acid (VMA), urine	59.60
84590-00	Vitamin A, blood;	37.40
84595-00	including carotene	78.60
84630-00	Zinc, quantitative; blood	22.90
84695-00	Gentamicin	48.75
84702-00	Gonadotropin, chorionic; quantitative	40.40
84703-00	qualitative	22.50

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

Code	Service	Maximum Fee
85000-00	Bleeding time; Duke	$ 12.00
85002-00	Ivy or template	30.00
85007-00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)	14.00
85009-00	differential WBC count, buffy coat	21.30
85012-00	eosinophil count, direct	16.00
85014-00	hematocrit	10.00
85018-00	hemoglobin, colorimetric	11.00
85021-00	hemogram, automated (RBC, WBC, Hgb, Hct, and indexes only)	21.00
85022-00	hemogram, automated, and manual differential WBC count (CBC)	27.00

85023-00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	32.50
85024-00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	28.00
85025-00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	22.00
85027-00	hemogram, and platelet count, automated	22.00
85029-00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram); one to three indices	8.00
85030-00	four or more indices	12.00
85031-00	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes)	24.00
85041-00	red blood cell (RBC) only	10.00
85044-00	reticulocyte count	15.80
85048-00	White blood cell (WBC)	11.00
85060-00	Blood smear, peripheral, interpretation by physician with written report	58.50
85095-00	Bone marrow smear and/or cell block; aspiration only	95.95
85097-00	Bone marrow smear and/or cell block; smear interpretation only	97.00
85100-00	aspiration, staining, and interpretation	165.00
85102-00	Bone marrow needle biopsy	151.00
85103-00	staining and interpretation	155.00
85109-00	staining and preparation only	80.20
85240-00	factor VII (AHG), one stage factor VIII (AHG), one stage	89.20
85341-00	Clotting inhibitors or anticoagulants; PTT inhibition test	16.00
85362-00	Fibrin degradation (split) products (FDP) (FSP); agglutination, slide	39.50
85376-00	Fibrinogen; thrombin with plasma dilution	35.50
85530-00	Heparin-protamine tolerance test	16.00
85535-00	Iron stain (RBC or bone marrow smears)	42.90
85540-00	Leukocyte alkaline phosphatase with count	41.25
85544-00	Lupus erythematosus (LE) cell prep	27.50
85548-00	Morphology of red blood cells only	30.00
85575-00	Platelet; adhesiveness (in vivo)	19.00
85580-00	count (Rees-Ecker)	16.00
85585-00	estimation on smear only	9.00
85590-00	phase microscopy	22.50
85595-00	electronic technique	14.00
85610-00	Prothrombin time	15.00
85618-00	Prothrombin-Proconvertin, P&P (Owren)	20.15
85650-00	Sedimentation rate (ESR); Wintrobe type	12.00

85651-00	Westergren type	12.00
85660-00	Sickling of RBC, reduction, slide method	10.00
85670-00	Thrombin time; plasma	14.30
85730-00	Thromboplastin time, partial; plasma or whole blood	22.00
85732-00	substitution, plasma	17.50

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

Code	Service	Maximum Fee
86000-00	Agglutinins; febrile, each antigen	$ 32.40
86006-00	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	17.00
86008-00	Antibody, quantitative titer, not otherwise specified; first antigen	31.10
86009-00	each additional antigen	15.00
86012-00	Antibody absorption, cold auto absorption; per serum	20.00
86013-00	differential	10.00
86016-00	Antibodies, RBC, saline; high protein and antihuman globulin technique	30.60
86018-00	enzyme technique, including antihuman globulin	15.00
86024-00	Antibody identification; RBC antibodies (eight to ten cell panel); standard technique	26.50
86028-00	saline or high protein, each (Rh, AB, etc.)	43.25
86031-00	Antihuman globulin test; direct (Coombs) one to three dilutins	17.00
86032-00	indirect, qualitative	30.50
86033-00	indirect, titer (broad, gamma or nongamma each)	10.50
86034-00	enzyme technique, qualitative	5.00
86038-00	Antinuclear antibodies (ANA), RIA	34.00
86060-00	Antistreptolysin O; titer	26.00
86063-00	screen	15.00
86066-00	Antitrypsin, alpha-1; Pi (protest inhibitor) typing	69.80
86067-00	other method (specify)	46.50
86068-00	Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; first unit	69.50
86069-00	each additional unit	46.00
86080-00	Blood typing; ABO only	12.00
86082-00	ABO and Rho(D)	24.60
86095-00	Blood typing, RBC, antigens other than ABO or Rho(D); antiglobulin technique, each antigen	22.50
86096-00	direct, slide or tube, including Rh subtypes, each antigen	15.00
86100-00	Blood typing; Rho(D) only	12.00
86105-00	Rh genotyping, complete	10.50

86115-00	anti-Rh immunoglobulin testing (RhoGAM type)	70.00
86128-00	Collection, processing and storage of predeposited autologous whole blood or components	191.60
86140-00	C-reactive protein	22.70
86149-00	Carcinoembryonic antigen (CEA); gel diffusion	51.00
86151-00	Carcinoembryonic antigen (CEA); RIA or EIA	60.00
86158-00	Complement; $C^1$1 esterase	58.75
86162-00	total (CH 50)	61.30
86163-00	$C^1$3 esterase	30.00
86164-00	$C^1$4 esterase	35.25
86171-00	Complement fixation tests, each (e.g., cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis)	18.00
86215-00	Deoxyribonuclease, antibody	56.10
86225-00	Deoxyribonucleic acid (DNA) antibody	43.00
86229-00	Enzyme immunoassay for chemical constituent	48.00
86235-00	Antibody to specific nuclear antigen, any method, each	66.25
86244-00	Fetoprotein, alpha-1, RIA or EIA	54.00
86255-00	Fluorescent antibody; screen	35.90
86256-00	titer	43.00
86265-00	Frozen blood, preparation for freezing, each unit, including processing and collection	102.00
86280-00	Hemagglutination inhibition tests (HAI), each (e.g., rubella, viral)	22.00
86282-00	Hemolysins and agglutinins, auto, screen, each	23.00
86287-00	Hepatitis B surface antigen (HBsAg) Australian antigen, HAA, RIA, or EIA	25.00
86288-00	Hepatitis B core antigen (HBcAg), RIA	27.50
86289-00	Hepatitis B core antibody; RIA (HBcAg)	37.80
86290-00	IgM antibody (e.g., RIA, EIA, RPHA)	57.60
86291-00	Hepatitis B surface antibody	25.90
86293-00	Hepatitis Be antigen	24.65
86295-00	Hepatitis Be antibody (HBeAb) (e.g., RIA, EIA)	37.50
86296-00	Hepatitis A antibody	40.40
86299-00	IgM antibody	40.90
86300-00	Heterophile antibodies; screening (includes monotype test), slide or tube	17.00
86305-00	quantitative titer	25.00
86310-00	plus titers after absorption with beef cells and guinea pig kidney	35.50
86312-00	HIV (HTLV-III) antibody detection; immunoassay	27.40
86316-00	Immunoassay for tumor antigen (e.g., prostate specific antigen, cancer antigen)	62.00

86317-00	Immunoassay for infectious agent antigen or antibody, each	18.00
86320-00	Immunoelectrophoresis; serum, each	75.60
86325-00	other fluids (e.g., urine) with concentration, each specimen	75.60
86329-00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify)	40.60
86335-00	Immunoglobulin typing (Gc, Gm, Inv), each	18.00
86357-00	Insulin antibodies, RIA	143.00
86376-00	Microsomal antibody (thyroid); RIA	37.00
86377-00	other method (specify)	55.10
86382-00	Neutralization test, viral	22.30
86403-00	Particle agglutination, rapid test for infectious agent, each antigen	18.00
86405-00	Precipitin test for blood (species identification)	11.63
86421-00	Radioallergosorbent test, in vitro testing for allergen-specific IgE (e.g., RAST, MAST, FAST, IP, PRIST, etc.); up to five tests	33.00
86422-00	six or more tests	15.20
86423-00	Radioimmunosorbent test IgE, quantitative	37.00
86430-00	Rheumatoid factor, latex fixation	20.00
86455-00	Skin test; anergy testing, one or more antigens	15.90
86490-00	coccidioidomycosis	20.15
86510-00	histoplasmosis	16.00
86540-00	mumps	23.70
86580-00	Skin test; tuberculosis or intradermal	11.00
86585-00	tuberculosis, tine test	10.00
86590-00	Streptokinase, antibody	28.25
86592-00	Syphilis, test; qualitative	13.70
86593-00	quantitative	13.00
86594-00	Thyroid autoantibodies	65.00
86600-00	Toxoplasmosis, dye test	27.80
86650-00	Treponema antibodies, fluorescent, absorbed	44.00
86800-00	Thyroglobulin antibody, RIA	42.00
86812-00	Tissue typing; HLA typing, A, B, or C (e.g., A10, B7, B27), single antigen	74.20
86813-00	HLA typing, A, B, and/or C (e.g., A10, B7, B27), multiple antigens	296.00
86817-00	HLA typing, DR, multiple antigens	400.00

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

Code	Service	Maximum Fee
87015-00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	$ 21.00

87040-00	Culture, bacterial, definitive; blood (includes anaerobic screen)	39.60
87045-00	stool	35.00
87060-00	throat or nose	15.00
87070-00	any other source	30.00
87072-00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	15.00
87075-00	Culture, bacterial, any source; anaerobic (isolation)	33.00
87081-00	Culture, bacterial, screening only, for single organisms	16.00
87082-00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083-00	multiple organisms	9.00
87084-00	with colony estimation from density chart	17.75
87086-00	Culture, bacterial, urine; quantitative, colony count	20.00
87087-00	commercial kit	13.50
87088-00	identification, in addition to quantitative or commercial kit	25.00
87101-00	Culture, fungi, isolation; skin	21.00
87102-00	other source (except blood)	14.25
87103-00	blood	58.90
87106-00	Culture, fungi, definitive identification of each fungus	31.90
87109-00	Culture, mycoplasma, any source	47.00
87110-00	Culture, Chlamydia	32.50
87116-00	Culture, tubercle or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); source, isolation only	41.45
87117-00	concentration plus isolation	42.10
87118-00	Culture, mycobacteria, definitive identification of each organism	35.00
87140-00	Culture, typing; fluorescent method, each antiserum	15.50
87147-00	Serologic method, agglutination grouping, per antiserum	20.00
87158-00	other methods	27.00
87163-00	Culture, any source, additional identification methods required	32.50
87164-00	Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection	10.00
87174-00	Endotoxin, bacterial (pyrogens); chemical	30.00
87176-00	homogenization, tissue, for culture	42.10
87177-00	Ova and parasites, direct smears, concentration and identification	31.00
87181-00	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	18.00
87184-00	disc method, each plate (12 or less discs)	19.50

87186-00	microtiter, minimum inhibitory concentration (MIC), eight or less any number of antibiotics	26.50
87188-00	macrotube dilution method, each antibiotic	21.00
87205-00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	16.90
87206-00	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	30.00
87207-00	special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala-azar, herpes)	31.00
87208-00	direct or concentrated, dry, for ova and parasites	15.00
87210-00	wet mount with simple stain for bacteria, fungi, ova, and/or parasites	14.75
87211-00	wet and dry mount, for ova and parasites	18.40
87220-00	Tissue examination for fungi (e.g., KOH slide)	14.00
87230-00	Toxin or antitoxin assay, tissue culture (e.g., Clostridium difficile toxin)	59.30
87250-00	Virus identification; inoculation of embryonated eggs, or small animal, includes observation and dissection	51.00
87252-00	tissue culture inoculation and observation	54.60
87253-00	tissue culture, additional studies (e.g., hemadsorption, neutralization) each isolate	41.00

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

Code	Service	Maximum Fee
	Cytopathology	
88104-00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 33.00
88106-00	filter method only with interpretation	50.00
88107-00	smears and filter preparation with interpretation	34.70
88130-00	Sex chromatin identification; Barr bodies	18.50
88150-00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to three smears; screen by technical under physician supervision	18.00
88151-00	requiring interpretation by physician	21.25
88155-00	with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index)	21.00

88160-00	Cytopathology, any other source; screening and interpretation	29.75
88170-00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	93.30
88172-00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	56.00
88173-00	interpretation and report	85.50
88262-00	Chromosome analysis; count 15-20 cells, two karyotypes, with banding	546.90
88267-00	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotope, with banding	608.80

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 (88300-00 to 88307-00) should be used in reporting specimens (single or multiple) that are removed during a single surgical procedure.

Code	Service	Maximum Fee
88300-00	Surgical pathology, gross examination only	$ 30.65
88302-00	Surgical pathology, gross and microscopic; examination of presumptively normal tissue, for identification and record purposes	42.00
88304-00	Surgical pathology, gross and microscopic; diagnostic examination of presumptively abnormal tissue; uncomplicated specimen	48.50
88305-00	single complicated or multiple uncomplicated specimen(s), without complex dissection	89.00
88307-00	single complicated specimen requiring complex dissection or multiple complicated specimens	128.90
88311-00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	22.66
88312-00	Special stains; Group I stains for microorganisms	28.30
88313-00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	26.00
88321-00	Consultation and report on referred slides prepared elsewhere	36.00
88325-00	Consultation, comprehensive, with review of records and specimens, with report on referred material	69.40
88331-00	with frozen section(s); single specimen	103.00
88332-00	Consultation during surgery; each additional tissue block with frozen section(s)	45.00

88342-00	Immunocytochemistry (including tissue immunoperoxidase), each antibody	120.00
88348-00	Electron microscopy; diagnostic	355.00

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

Code	Service	Maximum Fee
89050-00	Cell count, miscellaneous body fluids (e.g., CSF, joint fluid), except blood	$ 23.00
89051-00	with differential count	16.30
89060-00	Crystal identification by compensated polarizing lens analysis, synovial fluid	16.00
89125-00	Fat stain, feces, urine, or sputum	28.00
89190-00	Nasal smear for eosinophils	14.00
89205-00	Occult blood, any source except feces	10.90
89300-00	Semen analysis; presence and/or motility of sperm, including Huhner test	34.00
89310-00	motility and count	33.85
89320-00	Semen analysis; complete (volume count, motility and differential)	45.00
89325-00	Sperm antibodies	192.60
89329-00	Sperm evaluation; hamster penetration test	343.60
89350-00	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	65.30

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2500 DENTISTS.

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

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

Code	Service	Maximum Fee
	Restorative	
02140-00	Amalgam; one surface, permanent	$ 33.00
02150-00	two surfaces, permanent	46.00
02160-00	three surfaces, permanent	59.00
02161-00	four or more surfaces, permanent	71.00
	Acrylic or Plastic Restorations	
02330-00	Resin; one surface, anterior	$ 45.00
02331-00	two surfaces, anterior	64.00
02332-00	three surfaces, anterior	84.00
02335-00	four or more surfaces or (involving incisal angle)	85.00
	Inlay Restorations	
02530-00	Inlay - metallic; three surfaces	$ 385.00

02540-00	Onlay - metallic; per tooth (in addition to inlay)	405.00
	Crowns - Single Restoration Only	
02740-00	Crown; porcelain/ceramic substrate	$ 425.00
02750-00	porcelain fused to high noble metal	420.00
02751-00	porcelain fused to predominantly base metal	395.00
02752-00	porcelain fused to noble metal	400.00
02790-00	full cast high noble metal	400.00
02791-00	full cast predominantly base metal	335.00
02792-00	full cast noble metal	366.00
02810-00	3/4 cast metallic	375.00
02824-00	Removal of tooth; bony impaction presenting unusual difficulties and circumstances	200.00
02825-00	Removal of tooth, soft tissue impaction	105.00
02826-00	partial bony impaction	135.00
02827-00	complete bony impaction	155.00
02829-00	Apicoectomy; performed as separate surgical procedure (per root)	275.00
02830-00	stainless steel	90.00
02832-00	Alveolectomy/alveoloplasty, per quadrant (in conjunction with extractions)	90.00
02848-00	Osseous surgery; per quadrant	405.00
	Other Restorative Services	
02910-00	Recement inlays	$ 36.00
02920-00	Recement crowns	30.00
02940-00	Sedative fillings	28.00
02950-00	Crown buildups, including any pins	90.00
	Endodontics	
03110-00	Pulp cap; direct (excluding final restoration)	$ 24.00
03120-00	indirect (excluding final restoration)	17.00
03220-00	Therapeutic pulpotomy	50.00
	Root Canal Therapy	
03310-00	One canal (excludes final restoration)	$ 220.00
03320-00	Two canals (excludes final restoration)	260.00
03330-00	Three canals (excludes final restoration)	375.00
	Periapical Services	
03410-00	Apicoectomy; (per tooth) first root	$ 250.00
03430-00	Retrograde filling; per root	95.00

	Other Endodontic Procedures	
03950-00	Canal preparation and fitting of preformed dowel or post	$ 70.00
	Prosthodontics, Removable Complete Dentures - Including Routine Postdelivery Care	
05110-00	Complete upper	$ 550.00
05120-00	Complete lower	525.00
05130-00	Immediate upper	605.00
05140-00	Immediate lower	605.00
	Partial Dentures - Including Routine Postdelivery Care	
05213-00	Upper partial, predominately base cast base with acrylic saddles (including any conventional clasps and rests)	$ 670.00
05214-00	Lower partial, predominately base cast base with acrylic saddles (including any conventional clasps and rests)	625.00
05215-00	Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests)	660.00
05216-00	Lower; high noble cast base with acrylic saddles (including any conventional clasps and rests)	650.00
	Adjustments to Dentures	
05410-00	Adjust complete denture; upper	$ 20.00
05422-00	lower	24.00
	Repairs to Dentures	
05610-00	Repair acrylic saddle or base	$ 54.00
05620-00	Repair cast framework	55.00
05640-00	Replace broken teeth; per tooth	40.00
05650-00	Add tooth to existing partial denture	65.00
05660-00	Add clasp to existing partial denture	120.00
	Denture Relining	
05750-00	Relining complete upper denture (laboratory)	$ 170.00
05760-00	Relining upper partial denture (laboratory)	175.00
	Other Removable Prosthetic Services	
05820-00	Temporary (partial stayplate), denture upper	$ 180.00

05850-00	Tissue conditioning; per denture unit	30.00
	Bridge Pontics	
06210-00	Pontic; cast high noble metal	$ 395.00
06212-00	Pontic; cast noble metal	350.00
06240-00	porcelain fused to high noble metal	415.00
06241-00	porcelain fused to predominantly base metal	380.00
06242-00	porcelain fused to noble metal	400.00
	Retainers	
06545-00	Cast metal retainer for acid etch bridge	$ 168.50
	Prosthodontics, Fixed	
06640-00	Replace broken facing with acrylic	$ 95.00
	Bridge Retainers — Crowns	
06750-00	Crown; porcelain fused to high noble metal	$ 425.00
06751-00	porcelain fused to predominantly base metal	390.00
06752-00	porcelain fused to noble metal	400.00
06790-00	full cast high noble metal	385.00
06792-00	full cast noble metal	395.00
06801-00	Diagnostic exam and DXL	25.00
06802-00	Prevention	30.00
06803-00	Restorative	58.00
06804-00	Endodontics	333.00
06808-00	Dental oral surgery	50.00
	Other Fixed Prosthetic Services	
06930-00	Recement bridge	$ 50.00
	Oral Surgery Extractions — Includes Local Anesthesia and Routine Postoperative Care	
07110-00	Single tooth	$ 41.00
07120-00	Each additional tooth	40.00
	Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care	
07210-00	Surgical removal of tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 90.00

07220-00	Removal of impacted tooth; soft tissue	110.00
07230-00	Removal of the impacted tooth; partially bony	141.00
07240-00	Removal of impacted tooth; completely bony	165.00
07241-00	Removal of impacted tooth; completely bony, with unusual surgical complications	200.00
07250-00	Surgical removal of residual tooth roots	87.00
	Other Surgical Procedures	
07280-00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	$ 170.00
07281-00	Surgical exposure of impacted or unerupted tooth to aid eruption	115.00
07286-00	Biopsy of oral tissue; soft	125.00
	Alveoloplasty - Surgical Preparation of Ridge For Dentures	
07310-00	Alveoloplasty (per quadrant) in conjunction with extractions	$ 75.00
	Surgical Incision	
07510-00	Incision and drainage of abscess; intraoral soft tissue	$ 55.00
07520-00	extraoral soft tissue	75.00
	Other Repair Procedures	
07960-00	Frenulectomy	$ 105.00
	Interceptive Orthodontic Treatment	
08360-00	Removable appliance therapy	$ 650.00
08370-00	Fixed appliance therapy	660.00
	Other Orthodontic Devices	
08750-00	Posttreatment stabilization	$ 100.00
	Adjunctive General Services Unclassified Treatment	
09110-00	Palliative (emergency) treatment of dental pain; minor procedures	$ 30.00

	Anesthesia	
09210-00	Local anesthesia not in conjunction with operative or surgical procedures	$ 12.00
09220-00	General; first 30 minutes	120.00
09230-00	Analgesia	15.00
	Professional Consultation	
09310-00	Consultation; per session	$ 35.00
09420-00	Hospital call	50.00
09430-00	Office visit during regularly scheduled office hours	20.00
	Drugs	
09610-00	Therapeutic drug injection, by report	$ 15.00
09630-00	Other drugs and/or medicaments	15.00
	Miscellaneous Services	
09910-00	Application of desensitizing medicaments	$ 18.00
	Surgery	
21110-00	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	$ 450.00
21200-00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	3,500.00
40808-00	Biopsy, vestibule of mouth	120.00
40819-00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	145.00
41825-00	Excision of lesion tumor, dentoalveolar structures; without repair	190.00

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; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2600 OPTOMETRISTS.

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

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 49.50
06502-00	Bifocal eyeglass lenses (one lens)	57.50
06503-00	Trifocal eyeglass lenses (one lens)	77.50
06506-00	Eyeglass frames	85.00
06510-00	Tinting for lenses	15.00
06587-00	Contact lenses, soft (one lens)	80.00
06588-00	Contact lenses, hard (one lens)	86.00
06589-00	Dispensing fee; single vision lenses	20.00
06590-00	bifocal lenses	25.80
06591-00	trifocal lenses	26.00
06636-00	Eyeglass lenses (prosthesis)	58.00
06654-00	Surgical dressings	100.00
09213-00	Eye refraction	32.00

Subp. 2. [Repealed by amendment, 13 SR 2609]

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2650 OPTICIANS.

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

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

Code	Service	Maximum Fee
06501-00	Single vision eyeglass lenses (one lens)	$ 52.50
06502-00	Bifocal eyeglass lenses (one lens)	65.00
06503-00	Trifocal eyeglass lenses (one lens)	68.50
06506-00	Eyeglass frames	96.00
06510-00	Tinting for lenses	13.50
06587-00	Contact lenses, soft (one lens)	64.50
06588-00	Contact lenses, hard (one lens)	84.00
06635-00	Contact lenses (prosthesis)	98.00
06636-00	Eyeglass lenses (prosthesis)	92.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.2700 [Repealed, 14 SR 722]

5221.2750 SPEECH PATHOLOGISTS.

The following codes, service descriptions, and maximum fees apply to speech pathologists holding a certificate of clinical competency (CCC-SP) or to

speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

Code	Service	Maximum Fee
92506-00	Medical evaluation speech, language, and/or hearing problems	$ 100.00
92507-00	Speech, language, or hearing therapy, with continuing medical supervision; individual	97.14
92508-00	group	40.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

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

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

A. "Therapeutic exercise" (code 97110-00) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular re-education" (code 97112-00) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident, and systemic neurological disease.

C. "Functional activities" (code 97114-00) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work-related activities.

D. "Gait training" (code 97116-00) means teaching individuals with neurological or musculoskeletal disorders to ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240-00) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540-00) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

G. "Testing for strength, dexterity, or stamina" (code 97720-00) means detailed testing of a patient with neuromusculoskeletal dysfunction.

H. "Kinetic activities" (code 97530-00) means services when there are neuromusculoskeletal dysfunction which limit the patient's performing the activities that are ordinarily prescribed under therepeutic exercise.

Subp. 3. MR 1985 [Repealed, 10 SR 765]

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

A. The physical and occupational therapy treatment plan must be in

writing and shall include objectives, modalities, and frequency of treatment and duration.

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

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

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

Code	Service	Maximum Fee
	Modalities	
97010-00	Physical medicine treatment to one area; hot or cold packs	$ 19.00
97012-00	traction, mechanical	19.75
97014-00	electrical stimulation (unattended)	17.00
97016-00	vasopneumatic devices	16.00
97018-00	paraffin bath	20.00
97020-00	microwave	17.00
97022-00	whirlpool	20.00
97024-00	diathermy	20.00
97026-00	infrared	29.50
97028-00	ultraviolet	22.00
	Procedures	
97110-00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	$ 29.00
97112-00	neuromuscular re-education	25.00
97114-00	functional activities	24.00
97116-00	gait training	24.00
97118-00	electrical stimulation (manual)	18.00
97120-00	iontophoresis	25.00
97122-00	traction, manual	20.00
97124-00	massage	21.50
97126-00	contrast baths	22.00
97128-00	ultrasound	20.00
97145-00	Physical medicine treatment to one area, each additional 15 minutes	15.00
97220-00	Hubbard tank; initial 30 minutes, each visit	50.00
97240-00	Pool therapy or Hubbard tank with therapeutic exercises: initial 30 minutes, each visit	38.00
97500-00	Orthotics training (dynamic bracing, splinting), upper/lower extremities; initial 30 minutes, each visit	34.00
97501-00	each additional 15 minutes	18.00

97530-00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit	31.00
97531-00	each additional 15 minutes	16.00
97540-00	Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit	30.00
97541-00	each additional 15 minutes	23.00
	Tests and Measurements	
97700-00	Office visit, including one of the following tests, measurements, or evaluation with report: initial 30 minutes a. Orthotic check-out; b. Prosthetic check-out; c. Activities of daily living check-out; d. Follow-up evaluation for testing for strength, dexterity, or stamina	$ 30.00
97701-00	each additional 15 minutes	33.00
97720-00	Initial evaluation for testing for strength, dexterity, or stamina; initial 30 minutes, each visit	34.00
97721-00	each additional 15 minutes	22.00
97752-00	Muscle testing with torque curves during isometric and isokinetic exercise mechanized or computerized evaluations with printout	62.50
97753-00	for trunk/back	139.80

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2900 CHIROPRACTORS.

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

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

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

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

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

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

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

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

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

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

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

A. Use code 09542-00 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation.

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

Code	Service	Maximum Fee
	Examinations - Includes History and Diagnosis, Office	
09520-00	New patient; brief examination	$ 30.00
09521-00	intermediate examination	40.00
09522-00	extensive examination	60.00
09530-00	Established patient; brief examination	25.00
09531-00	intermediate examination	40.00
09532-00	extensive examination	65.00
	Chiropractic Visit With Manipulation/Adjustment	
09540-00	Visit with manipulation/adjustment, initial; office	$ 22.00
09541-00	subsequent; office	23.00
09542-00	Each additional manipulation/adjustment on same day; office, home, or nursing home	14.50
	Home/Nursing Home Visits	
09550-00	Chiropractic visit with manipulation/adjustment	$ 50.00
09556-00	Visit with cast application to one area; (e.g., long leg, thoracolumbar lumbosacral, or full-body corset type)	12.00
09557-00	Medical conference by chiropractor regarding medical management with patient or relative, guardian, or other; up to 25 minutes	65.00
	Conjunctive Therapy/Modality - Office, Home, or Nursing Home	
09560-00	Application of hot pack	$ 12.00
09561-00	Application of cold pack	12.00
09562-00	Diathermy	12.00

09563-00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic	12.00
09564-00	Intersegmental motorized mobilization	14.00
09565-00	Muscle stimulation, manual	13.00
09566-00	Ultrasound therapy	12.00
09567-00	Traction	13.00
09568-00	Acupressure, manual or mechanical	14.00
09569-00	Acupuncture	15.00
09570-00	Whirlpool	21.00
09572-00	Infrared - heat lamp	8.00
09573-00	Ultraviolet	20.00
09574-00	Trigger point therapy	14.00
09591-00	Nutritional supplement	17.97

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

Code	Service	Maximum Fee
	Chest	
71010-00	Radiologic examination, chest; single view, frontal	$ 30.00
71100-00	Radiologic examination, ribs, unilateral; two views	50.00
	Spine and Pelvis	
72010-00	Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral)	$ 65.00
72020-00	Radiologic examination, spine; single view, (specify level)	35.00
72040-00	Radiologic examination, spine, cervical; limited	48.00
72070-00	Radiologic examination, spine; thoracic	56.00
72072-00	thoracic, anteroposterior and lateral, including swimmer's view of the cervicothoracic junction	50.00
72074-00	thoracic, complete, including obliques, minimum of four views	45.00
72080-00	thoracic, limited (anteroposterior and lateral)	60.00
72090-00	scoliosis study, comprehensive	40.00
72100-00	Radiologic examination, spine; lumbosacral; limited (anteroposterior and lateral)	60.00
72114-00	complete, including bending views	108.00
72120-00	bending views only, minimum of four views	80.00
72170-00	Radiologic examination, pelvis; limited (minimum two views)	50.00

	Upper Extremities	
73020-00	Radiologic examination, shoulder; limited (one projection)	$ 30.00
73030-00	complete, minimum of two views	50.00
73070-00	Radiologic examination, elbow; limited (anteroposterior and lateral)	40.00
73100-00	Radiologic examination, wrist; limited (anteroposterior and lateral)	40.00
73120-00	Radiologic examination, hand	39.00
73140-00	Radiologic examination, finger or fingers, minimum of two views	35.00
	Lower Extremities	
73500-00	Radiologic examination, hip; limited (one view)	$ 30.00
73560-00	Radiologic examination, knee; anteroposterior and lateral views	48.00
73562-00	anteroposterior and lateral, with oblique(s), minimum of three views	50.00
73564-00	complete, including oblique(s), and/or tunnel, and/or patellar, and/or standing views	70.00
73600-00	Radiologic examination, ankle; limited (two views)	40.00
73610-00	Radiologic examination, ankle; comprehensive (minimum of three views)	45.00
73620-00	Radiologic examination; foot; anteroposterior and lateral views	32.00
73630-00	complete, minimum of three views	50.00
	Miscellaneous	
76140-00	Consultation on x-ray examination made elsewhere, written report	$ 25.00

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

Code	Service	Maximum Fee
	Laboratory Codes	
81002-00	Urinalysis; routine, without microscopy	$ 12.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 9 SR 1619; 10 SR 765; 10 SR 974; 11 SR 491; 11 SR 711; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.3000 PODIATRISTS.

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

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

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

Code	Service	Maximum Fee
	Surgery	
10060-00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	$ 40.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	53.00
10101*00	multiple or complicated	65.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst	45.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	28.00
11040-00	Debridement; skin, partial thickness	54.00
11041-00	skin, full thickness	25.00
11050*00	Paring or curettement of benign lesion with or without chemical cauterization; single lesion	26.00
11051*00	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions	23.00
11052-00	more than four lesions	43.00
11420-00	Excision, benign lesion, except skin tag (unless listed elsewhere), hands, feet; lesion diameter up to 0.5 centimeter	80.00
11421-00	lesion diameter 0.6 - 1.0 centimeters	125.00
11422-00	lesion diameter 1.1 - 2.0 centimeters	136.00
	Nails	
11700*00	Debridement of nails, manual; five or less	$ 24.00
11701-00	each additional, five or less	12.00
11710*00	Debridement of nails, electric grinder; five or less	26.00
11711-00	each additional, five or less	10.30
11730*00	Avulsion of nail plate, partial or complete simple; single	72.00
11750-00	Excision of nail and nail matrix, partial or complete, for permanent removal	220.00
11900*00	Injection, intralesional; up to and including seven lesions	37.00
	Other Procedures	
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	$ 30.00

17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	50.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)	31.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	40.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)	46.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., wrist, ankle)	60.00
28080-00	Excision of Morton neuroma, single, each	515.00
28124-00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), phalanx of toe	400.00
28153-00	Resection, head of phalanx, toe	400.00
28285-00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	450.00
28292-00	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	900.00
28296-00	with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)	1,050.00
28308-00	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; other than first metatarsal	605.00
29405-00	Application of short leg cast (below knee to toes)	150.00
28425-00	walking or ambulatory type	150.00
29540-00	Strapping; ankle	24.00
29550-00	toes	23.00
29580-00	Unna boot	45.00
36415*00	Routine venipuncture for collection of specimens	10.00
64450-00	Injection, anesthetic agent; other peripheral nerve or branch	36.49

Radiology

73600-00	Radiologic examination, ankle; anteroposterior and lateral views	$ 40.00
73610-00	complete, minimum of three views	64.00
73620-00	Radiologic examination, foot; anteroposterior and lateral views	40.00
73630-00	complete, minimum of three views	55.00
73650-00	Radiologic examination; calcaneus, minimum of two views	36.00
73660-00	toe or toes, minimum of two views	34.60
76000-00	Fluoroscopy (separate procedure), up to one hour physician time	40.00

Pathology and Laboratory

80002-00	Automated multichannel test; one or two clinical chemistry test(s)	$ 10.00
80012-00	12 clinical chemistry tests	40.00
80019-00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	15.00
81000-00	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances such as glucose), with microscopy	13.00
81002-00	routine, without microscopy	15.00
82947-00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid)	15.00
82948-00	blood, stick test	15.00
85000-00	Bleeding time; Duke	8.00
85007-00	Blood count; manual differential WBC (includes RBC morphology and platelet estimation)	12.00
85018-00	hemoglobin, colorimetric	8.00
85345-00	Coagulation time; Lee and White	7.50
85610-00	Prothrombin time	15.00
87070-00	Culture, bacterial, definitive; any other source	25.00
87101-00	Culture, fungi, isolation; skin	20.00
87184-00	Sensitivity studies, antibiotic; disk method, per plate (12 or less disks)	22.00
88302-00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes	40.00
88304-00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	50.00

Patient Visits

90000-00	New patient; brief service	$ 30.00
90010-00	limited service	36.00
90015-00	intermediate service	40.00
90017-00	extended service	44.50
90020-00	comprehensive service	38.00
90030-00	Established patient; minimal service	18.00
90040-00	brief service	24.00
90050-00	limited service	25.00
90060-00	intermediate services	29.00
90070-00	extended service	40.00
90080-00	comprehensive service	45.00

Home Medical Services

90115-00	Home medical service, new patient; intermediate service	$ 27.00

90140-00	Home medical service, established patient; brief service	40.00
90150-00	Home medical service, established patient; limited service	45.00
90160-00	intermediate service	33.00
	Hospital Medical Services	
90200-00	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	$ 70.00
90215-00	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	50.00
	Skilled Nursing, Intermediate Care, and Long-Term Care Facilities	
90300-00	Initial care, skilled nursing, intermediate care, or long-term care facility; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 17.00
90315-00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	37.00
90340-00	Subsequent care, skilled nursing, intermediate care or long-term care facility; brief service	17.00
90350-00	limited service	17.00
90360-00	intermediate service	25.00
	Nursing Home, Boarding Home, Domiciliary, or Custodial Care Medical Services	
90400-00	Nursing home, boarding home, domiciliary, or custodial care medical service, new patient; brief service	$ 17.44
90410-00	limited service	21.00
90450-00	Nursing home, boarding home, domiciliary, or custodial care medical service, established patient; limited service	18.56
90460-00	intermediate service	40.00
	Consultations	
90600-00	Initial consultation; limited	$ 52.00
	Therapeutic Injections	
90782-00	Therapeutic injection of medication (specify); subcutaneous or intramuscular	$ 25.00

	Noninvasive Vascular Diagnostic Studies	
93910-00	Noninvasive studies of lower extremity arteries (e.g., segmental blood pressure measurements, continuous Wave Doppler analog wave form analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmography or pulse volume digit wave form analysis, flow velocity signals)	$ 90.00
	Neurology and Neuromuscular Procedures	
95851-00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	$ 45.00
	Physical Medicine	
97022-00	Physical medicine treatment to one area; whirlpool	$ 22.00
97116-00	Physical medicine treatment to one area, initial 30 minutes, each visit; gait training	6.00
97118-00	electrical stimulation (manual)	26.50
97120-00	iontophoresis	24.00
97128-00	ultrasound	17.00
97700-00	Office visit, including one of the following tests or measurements, with report: a. Orthotic "check-out"; b. Prosthetic "check-out"; c. Activities of daily living "check-out"; initial 30 minutes, each visit	25.37
	Special Services and Reports	
99000-00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	$ 10.00
99025-00	Initial (new patient) visit when starred (*) surgical procedure constitutes major service at that visit	25.00

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.3100 [Repealed, 14 SR 722]

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS AND RULE 29 FACILITIES.

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

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

Code	Service	Maximum Fee
06046-00	Independent social worker services	$ 80.00
09046-00	Initial office visit with evaluation and history; one hour	85.00
09048-00	Initial inpatient hospital visit, including history and evaluation; per hour	105.00
09050-00	Initial consultation; one hour	90.00
09051-00	Consultation; follow-up, per 15 minutes	27.50
09061-00	Psychological testing; one hour	75.00
09062-00	Follow-up office visit; 15 minutes	30.00
09064-00	Biofeedback; per hour	80.00
09065-00	per one-half hour	30.00
09066-00	Psychotherapy (inpatient, outpatient, office or home)	85.00
09067-00	Psychotherapy, group (maximum ten persons per group); per session	45.00
09068-00	Psychotherapy, individual (one-half hour inpatient, outpatient, office, or home)	45.00
09070-00	Family members psychotherapy, conjoint (two or more members, family group, evaluation and therapy per hour)	84.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.3160 SOCIAL WORKERS.

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

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

Code	Service	Maximum Fee
06046-00	Independent social worker services	$ 80.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 R 722; 15 SR 738*

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. Mount Sinai Hospital, Minneapolis
R. North Memorial Medical Center, Robbinsdale
S. Saint Cloud Hospital, Saint Cloud
T. St. John's Hospital Northeast, Saint Paul
U. Saint Joseph's Hospital, Saint Paul
V. Saint Luke's Hospital, Duluth
W. Saint Mary's Hospital, Duluth
X. Saint Mary's Hospital, Minneapolis
Y. The Samaritan Hospital, Saint Paul
Z. United Hospital, Saint Paul
AA. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ 410.00

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
ZZZZ. Saint Gabriel's Hospital, Little Falls
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
ZZZZZ. Warren Community Hospital, Warren
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	$ 290.71

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	$ 340.05

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	$ 285.15

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738*

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*

5221.3310 [Repealed, 14 SR 722]

5221.3400 [Repealed, 13 SR 2609]

5221.3500 EFFECTIVE DATE.

This chapter is effective October 1, 1990, and applies to all health care services or supplies governed by this chapter provided on and after October 1, 1990.

Statutory Authority: *MS s 176.136*

History: *14 SR 722; 15 SR 738*