Title 20: Labor

Part 2: Mississippi Workers' Compensation Medical Fee Schedule

Introduction

Pursuant to Mississippi Code Annotated (MCA), §71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of ~~July~~ November 1, ~~2010~~2013, and, in the case of inpatient treatment, to services where the discharge date is on or after ~~July~~ November 1, ~~2010~~2013. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

This Fee Schedule shall be used by the Workers' Compensation Commission, insurance payers, and self-insurers for approving and paying medical charges of physicians, surgeons, and other qualified health care ~~providers~~ professionals for services rendered under the Mississippi Workers' Compensation Law. This Fee Schedule applies to all medical services provided to injured workers by physicians, and also covers other medical services arranged for by a physician. In practical terms, this means professional services provided by hospital-employed physicians and other qualified health care professionals, as well as those ~~physicians~~ practicing independently, are reimbursed under this Fee Schedule.

The Commission will require the use of the most current ~~version of the~~ CPT®, CDT, ~~book~~ and HCPCS codes and modifiers in effect at the time services are rendered. All coding, billing and other issues, including disputes, associated with a claim, shall be determined in accordance with the CPT rules and guidelines in effect at the time service is rendered, unless otherwise provided in this Fee Schedule or by the Commission. As used in this Fee Schedule, CPT refers to the American Medical Association's *Current Procedural Terminology* codes and nomenclature. CPT is a registered trademark of the American Medical Association. *Current Dental Terminology* (CDT) codes are developed and maintained by the American Dental Association (ADA). HCPCS is an acronym for the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book. However, the inclusion of a service, product or supply ~~in the CPT book or HCPCS book~~ identified by a CPT, HCPCS, or CDT code does not necessarily imply coverage, reimbursement or endorsement.

I. FORMAT

This Fee Schedule is comprised of the following sections: Introduction; General Rules; Billing and Reimbursement Rules; Medical Records Rules; Dispute Resolution Rules; Utilization Review Rules; Rules for Modifiers and Code Exceptions; Pharmacy Rules; ~~Nurse Practitioner and Physician Assistant~~Other Qualified Health Care Professional Rules; ~~Pharmacy Rules;~~ Home Health Rules; Skilled Nursing Facility Rules; Evaluation and Management; Anesthesia; Pain Management; Surgery; Radiology; Pathology and Laboratory; Medicine Services; ~~Physical Medicine~~Therapeutic Services; Dental; Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes; Inpatient Hospital and Outpatient Facility Payment Schedule and Rules; and Forms. Each section listed above has specific instructions (rules/guidelines). The Fee Schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the

service(s) they render. **In the event a rule/guideline contained in one of the specific service sections conflicts with a general rule/guideline, the specific section rule/guideline will supersede, unless otherwise provided elsewhere in this Fee Schedule.**

~~This Fee Schedule utilizes *Current Procedural Terminology* (CPT) codes and guidelines under copyright agreement with the American Medical Association. The descriptions included are full procedure descriptions. Beginning in 2010, CPT instituted a practice of resequencing code numbers. The CPT codes will appear in this fee schedule in numeric order with their full CPT description. The resequenced codes will include the # symbol.~~

This Fee Schedule utilizes procedure codes under copyright agreement. The descriptions included are full procedure descriptions. A complete list of modifiers is included in a separate section for easy reference.

II. SCOPE

The *Mississippi Workers' Compensation Medical Fee Schedule* does the following:

A. Establishes rules/guidelines by which the employer shall furnish, or cause to be furnished, to an employee who suffers a bodily injury or occupational disease covered by the Mississippi Workers' Compensation Law, reasonable and necessary medical, surgical, and hospital services and medicines, supplies or other attendance or treatment as necessary. The employer shall provide to the injured employee such medical or dental surgery, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances which are reasonable and necessary to treat, cure, and/or relieve the employee from the effects of the injury/illness, in accordance with MCA §71-3-15 (Rev. 2000), as amended.

B. Establishes a schedule of maximum reimbursement allowances (MRA) for such treatment, attendance, service, device, apparatus, or medicine.

C. Establishes rules/guidelines by which a health care provider shall be paid the lesser of (a) the provider's total billed charge, or (b) the maximum reimbursement allowance (MRA) established under this Fee Schedule.

D. Establishes rules for cost containment to include utilization review of health care and health care services, and provides for the acquisition by an employer/payer, other interested parties, and the Mississippi Workers' Compensation Commission, of the necessary records, medical bills, and other information concerning any health care or health care service under review.

E. Establishes rules for the evaluation of the appropriateness of both the level and quality of health care and health care services provided to injured employees, based upon medically accepted standards.

F. Authorizes employers/payers to withhold payment from, or recover payment from, health facilities or health care providers that have made excessive charges or which have provided unjustified and/or unnecessary treatment, hospitalization, or visits.

G. Provides for the review by the employer/payer or Commission any health facility or health care provider records and/or medical bills that have been determined not to be in compliance with the schedule of charges established herein.

H. Establishes that a health care provider or facility may be required by the employer/payer to explain in writing the medical necessity of health care or health care service that is not usually associated with, is longer and/or more frequent than, the health care or health care service usually accompanying the diagnosis or condition for which the patient is being treated.

I. Provides for medical cost containment review and decision responsibility. The rules and definitions hereunder are not intended to supersede or modify the Workers' Compensation Act, the

administrative rules of the Commission, or court decisions interpreting the Act or the Commission's administrative rules.

J. Provides for the monitoring of employers/payers to determine their compliance with the criteria and standards established by this Fee Schedule.

K. Establishes deposition/witness fees.

L. Establishes fees for medical reports.

M. Provides for uniformity in billing of provider services.

N. Establishes rules/guidelines for billing.

O. Establishes rules/guidelines for reporting medical claims for service.

P. Establishes rules/guidelines for obtaining medical services by out-of-state providers.

Q. Establishes rules/guidelines for Utilization Review to include pre-certification, concurrent review, discharge planning and retrospective review.

R. Establishes rules for dispute resolution which includes an appeal process for determining disputes which arise under this Fee Schedule.

S. Establishes a ~~P~~peer ~~R~~review system for determining medical necessity. Peer review is conducted by professional practitioners of the same specialty as the treating medical provider on a particular case.

T. Establishes the list of health care professionals who are considered authorized providers to treat employees under the Mississippi Workers' Compensation Law; and who, by reference in this rule, will be subject to the rules, guidelines and maximum reimbursement limits in this Fee Schedule.

U. Establishes financial and other administrative penalties to be levied against payers or providers who fail to comply with the provisions of the Fee Schedule, including but not limited to interest charges for late billing or payment, percentage penalties for late billing or payment, and additional civil penalties for practices deemed unreasonable by the Commission.

III. MEDICAL NECESSITY

The concept of medical necessity is the foundation of all treatment and reimbursement made under the provision of §71-3-15, Mississippi Code of 1972, as amended. For reimbursement to be made, services and supplies must meet the definition of "medically necessary." ~~Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.~~The sole use of extraneous guidelines, including but not limited to the Official Disability Guidelines ("ODG"), to determine the appropriateness or extent of treatment or reimbursement is prohibited. Continuation of treatment shall be based on the concept of medical necessity and predicated on objective or appropriate subjective improvements in the patient's clinical status. Arbitrary limits on treatment or reimbursement based solely on diagnosis or guidelines outside this Fee Schedule are not permitted.

A. For the purpose of the Workers' Compensation Program, any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries, is considered "medically necessary." The service must be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be experimental, investigational, or research in nature

except in those instances in which prior approval of the payer has been obtained. For purposes of this provision, "peer group" is defined as similarly situated physicians of the same specialty, licensed in the State of Mississippi, and qualified to provide the services in question.

B. Services for which reimbursement is due under this Fee Schedule are those services meeting the definition of "medically necessary" above and includes such testing or other procedures reasonably necessary and required to determine or diagnose whether a work-related injury or illness has been sustained, or which are required for the remedial treatment or diagnosis of an on-the-job injury, a work-related illness, a pre-existing condition affected by the injury or illness, or a complication resulting from the injury or illness, and which are provided for such period as the nature of the injury or process of recovery may require.

C. Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition or if the treatment is not deemed medically necessary for the patient's rehabilitation from the industrial injury.

IV. DEFINITIONS

Act means Mississippi Workers' Compensation Law, Mississippi Code Annotated (MCA), §71-3-1 et seq (Rev. 2000 as amended).

Adjust means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

APC means ambulatory payment classification and guidelines as developed by the Centers for Medicare and Medicaid Services (CMS) and adopted in this Fee Schedule.

Appropriate care means health care that is suitable for a particular patient, condition, occasion, or place.

AWP means Average Wholesale Price; a price generally twenty percent (20%) greater than a manufacturer sells to distributors and large customers and is based on data obtained from manufacturers, distributors, and other suppliers.

Bill means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

Carrier means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation Insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer.

Case means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

CCI (See National Correct Coding Initiative.)

CMS-1500 means the CMS-1500 form and instructions that are used by non-institutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required.

Commission means the Mississippi Workers' Compensation Commission (MWCC).

~~**Case** means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.~~

Consultation means a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. *A second opinion is considered a consultation.*

~~Consultation services are reported with designated CPT consultation codes even though they are not recognized by CMS and some other payers.~~

Controverted claim is a workers' compensation claim which is pending before the Commission and in which the patient or patient's legal representative has filed a Petition to Controvert.

Covered injury or illness means an injury or illness for which treatment is mandated under the Act.

Critical care means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

CPT (Current Procedural Terminology) means a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. The CPT code set is also used by other entities to report outpatient services. Each procedure or service is identified with a five-digit code.

Day means a continuous 24-hour period.

Diagnostic procedure means a service that helps determine the nature and causes of a disease or injury.

Durable medical equipment (DME) means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

Employer Medical Evaluation (EME) means a second opinion evaluation available to the Employer or Carrier pursuant to MCA §71-3-15(1) (Rev. 2000) for the purpose of evaluating temporary or permanent disability, or the medical treatment being rendered to the injured worker.

Expendable medical supply means a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

Follow-up days (FUD) are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

Health care review means the review of a health care case, bill, or both by the payer or the payer's agent.

Incident-to means that ~~the~~ services and supplies ~~used by non-physician practioners~~ are commonly furnished as an integral part of the primary service or procedure ~~under the direction of the provider~~and not reimbursed separately.

Incidental surgery means surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

Incorrect payment means the provider was not reimbursed according to the rules/guidelines of the Fee Schedule and the payer has failed to provide any reasonable basis for the adjusted payment.

Independent medical examination (IME) means a consultation provided by a physician to evaluate a patient at the request of the Commission. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

Independent procedure means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Inpatient services means services rendered to a person who is admitted as an inpatient to a hospital.

Maximum reimbursement allowance (MRA) means the maximum fee allowed for medical services as set forth in this Fee Schedule.

Medical only case means a case that does not involve more than five (5) days of disability or lost work time and for which only medical treatment is required.

Medically accepted standard means a measure set by a competent authority as the rule for evaluating quality or quantity of health care or health care services and which may be defined in relation to any of the following:

- Professional performance
- Professional credentials
- The actual or predicted effects of care
- The range of variation from the norm

Medically necessary means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries. Utilization management or review decisions shall not be based ~~solely~~ on application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

Medical record means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

Medical supply means either a piece of durable medical equipment or an expendable medical supply.

National Correct Coding Initiative means the official list of codes from the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Policy Manual that identifies services considered an integral part of a comprehensive code.

NCCI (See National Correct Coding Initiative.)

Observation services means services rendered to a person who is designated or admitted to a hospital or facility as observation status.

Operative report means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

Optometrist means an individual licensed to practice optometry.

Orthotic equipment means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

Orthotist means a person skilled in the construction and application of orthotic equipment.

Outpatient service means services provided to patients at a time when they are not hospitalized as inpatients.

Payer means the employer or self-insured ~~employed~~ group, carrier, or third-party administrator (TPA) who pays the provider billings.

Pharmacy means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Practitioner means a person licensed, registered, or certified as an acupuncturist, audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, massage therapist, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional or provider.

Primary procedure means the therapeutic procedure most closely related to the principal diagnosis, and in billing, the ~~CPT~~ code with the highest relative value unit (RVU) ~~or highest dollar amount in this Fee Schedule~~ that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure. Reimbursement for the primary procedure is not dependent on the ordering or re-ordering of codes.

Procedure means a unit of health service.

Procedure code means a five–digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

Properly submitted bill means a request by a provider for payment of health care services submitted to a payer on the appropriate forms with appropriate documentation and within the time frame established under the guidelines of the ~~Medical~~ Fee Schedule.

Prosthesis means an artificial substitute for a missing body part.

Prosthetist means a person skilled in the construction and application of prostheses.

Provider means a facility, health care organization, or a practitioner who provides medical care or services.

Resequenced code means a code that is printed in the CPT book out of numeric sequence but is printed in this Fee Schedule in the numeric order.

Secondary procedure means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

Special report means a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

Specialist means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.

~~Usual and customary rate/fee, as defined by the State, is a reimbursement allowance equal to the amount displayed by the Ingenix MDR Payment System (Mississippi State Version) for the procedure at the 40th percentile. The Ingenix MDR Payment System is a national database of Relative and Actual Charge Data (RACD) which includes charge information for the State of Mississippi.~~**Usual and customary** means that when a payment is designated herein as "usual and customary," the amount of the payment equates to the charge value reported by FAIR Health, Inc. in its FH RV Benchmarks products at the 40th percentile for the applicable geographic area in Mississippi.

V. How to Interpret the Fee Schedule

For each procedure, the Fee Schedule table includes the following columns and details (if applicable):

~~CPT Code~~

~~The first column lists the American Medical Association's (AMA) CPT code. *CPT 2010* codes are used by arrangement with the AMA.~~

Code Icons

Add-on Codes

+ denotes procedure codes that are considered "add-on" codes as defined in the CPT book.

Modifier 51 Exempt

⃠ denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book. Modifier 51 exempt services and procedures can be found in Appendix E of *CPT 2013*. Additional codes that should not be subject to modifier 51 have been

identified by Optum based upon CPT guidelines and are included in this Fee Schedule using the same CPT icon.

Moderate (Conscious) Sedation

⊙ denotes procedure codes that include conscious sedation as an inherent part of providing the procedure.

Resequenced Codes

# denotes procedure codes that are in numeric order but are considered resequenced and display in a different order within the ~~2010~~ 2013 CPT book.

Code

This Fee Schedule uses 2013 CPT, CDT, and HCPCS codes.

Description

This Fee Schedule uses ~~actual 2010~~ 2013 ~~CPT~~ full descriptions.

Relative Value

This column lists the relative value unit (RVU) assigned to each procedure. There are, however, procedures ~~that are~~ too variable to accept a set value—these are "by report" procedures and are noted ~~as~~ BR in the Amount column. Procedures with a 0.00 in the Relative Value column and a $0.00 in the Amount column are not covered or are not reimbursed.

Amount

This column lists the total reimbursable as a monetary amount.

PC Amount

Where there is an identifiable professional and technical component to a procedure, the portion considered to be the professional component is listed. The professional component gives the total reimbursable as a monetary amount. The technical component can be identified as the Amount minus the PC Amount. See Rules for Modifiers and Code Exceptions for additional information.

FUD

Follow-up days included in a surgical procedure's global charge are listed in this column.

Assist Surg

The assistant surgeon column identifies procedures that are approved for an assistant to the primary surgeon whether a physician, physician assistant (PA), registered nurse first assistant (RNFA, RA), or other individual qualified for reimbursement as an assistant under the Fee Schedule.

APC ~~Fee~~Amount

~~The facility amounts that were previously in the Fee Schedule have been replaced with Ambulatory Payment Classification (APC) amounts. It is important to note that the~~ Ambulatory Payment Classification (APC) is a payment method for facility outpatient services. The APC system as developed by the Centers for Medicare and Medicaid Services (CMS) includes many of the supplies that have previously been separately billed. These supplies will now be bundled into the APC Amount consistent with CMS guidelines. The APC Amount shall constitute the reimbursement amount for both hospital based and freestanding outpatient facilities.

VI. AUTHORIZED PROVIDERS

The following health care providers are recognized by the Mississippi Workers' Compensation Commission as acceptable to provide treatment to injured workers under the terms of the Act, and must comply with the rules, guidelines, billing and reimbursement policies and maximum reimbursement allowance (MRA) contained in this Fee Schedule when providing treatment or service under the terms of the Act:

Acupuncturist (L.A.C.)

Audiologist

Certified Registered Nurse Anesthetist (C.R.N.A.)

Doctor of Chiropractic (D.C.)

Doctor of Dental Surgery (D.D.S.)/Doctor of Dental Medicine (D.D.M.)

Doctor of Osteopathy (D.O.)

Licensed Clinical Social Worker (L.C.S.W.)

Licensed Nursing Assistant

Licensed Practical Nurse (L.P.N.)

Massage Therapist

Medical Doctor (M.D.)

Nurse Practitioner (N.P.)

Occupational Therapist (O.T.)

Optometrist (O.D.)

Oral Surgeon (M.D., D.O., D.M.D., D.D.S.)

Pharmacist (R.Ph.)

Physical Therapist (P.T.)

Physical or Occupational Therapist Assistant (P.T.A., O.T.A.)

Physician Assistant (P.A.)

Podiatrist (D.P.M.)

Prosthetist or Orthotist

Psychologist (Ph.D.)

Registered Nurse (R.N.)

Registered Nurse First Assistant (R.N.F.A., R.A.)

Speech Therapist

All health care providers, as listed herein, are subject to the rules, limitations, exclusions, and maximum reimbursement allowances of this Fee Schedule. Medical treatment under the terms of the Act may be provided by any other person licensed, registered, or certified as a health care professional if approved by the payer or Commission, and in such case, said provider and payer shall be subject to the rules and guidelines, including maximum reimbursement amounts, provided herein.

VII. INFORMATION PROGRAM

The Workers' Compensation Commission shall provide ongoing information regarding this Fee Schedule for providers, payers, their representatives and any other interested persons or parties. This information shall be provided primarily through informational sessions and seminar presentations at our Annual Education Conference as well as the distribution of appropriate information materials via the Commission's website (www.mwcc.ms.gov), and by other means as needed.

General Rules

I. CONFIRMATORY CONSULTATION

As provided in §71-3-15(1) of the Act, and in M.W.C.C. General Rule 9, a payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered. This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation code with modifier 32 appended to indicate a mandated service and paid in accordance with the Fee Schedule.

II. CODING STANDARD

A. The most current version of the American Medical Association's *Current Procedural Terminology* (CPT®) ~~book~~ or the *ADA Practical Guide to Dental Procedure Codes* (CDT)~~, and, where appropriate, the codes and descriptors of the American Society of Anesthesiologists' *Relative Value Guide*™,~~ in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Fee Schedule.

B. The most current version of HCPCS Level II codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Fee Schedule.

C. Services will be coded according to the appropriate code edits. For the purpose of this Fee Schedule, the National Correct Coding Initiative (NCCI) edits are used, and apply to all sections.

III. DEPOSITION/WITNESS FEES; MEDICAL RECORDS AFFIDAVIT

A. Any health care provider who gives a deposition or is otherwise subpoenaed to appear in proceedings pending before the Commission shall be paid a witness fee as provided by M.W.C.C. Procedural Rule 18(h) in the amount of $25.00 per day plus mileage reimbursement at the rate authorized by MWCC General Rule 14. Procedure code 99075 must be used to bill for a deposition.

B. In addition to the above fee and mileage reimbursement, any health care provider who gives testimony by deposition or who appears in person to testify at a hearing before the Commission shall be paid $500.00 for the first hour and $125.00 per quarter hour thereafter. This fee includes necessary preparation time. In the event a deposition is cancelled through no fault of the provider, the provider shall be entitled to a payment of $250.00 unless notice of said cancellation is given to the provider at least 72 hours in advance. In the event a deposition is cancelled through no fault of the provider within 24 hours of the scheduled time, then, in that event, the provider shall be paid the rate due for the first hour of a deposition. Nothing stated herein shall prohibit a medical provider and a

party seeking to take the medical provider's deposition from entering into a separate contract which provides for reimbursement other than as above provided.

C. Pursuant to Mississippi Workers' Compensation Commission Procedural Rule 9, an examining or treating physician may execute an affidavit in lieu of direct testimony. The Physician's Medical Record Custodian is allowed to sign the affidavit in lieu of the physician's signature. Such charge for execution of the affidavit is limited to a maximum reimbursement of $25.00. Reimbursement for copies of medical records that are attached to affidavits shall be made as outlined elsewhere in the Fee Schedule.

IV. IMPAIRMENT RATING

A. In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the *Guides to the Evaluation of Permanent Impairment,* as published and copyrighted by the American Medical Association which is in effect at the time the service is rendered. Only a medical doctor is entitled under these rules to reimbursement for conducting an impairment rating evaluation.

B. A provider is entitled to reimbursement for conducting an impairment rating evaluation and determining the extent of permanent impairment, and should bill for such services using CPT code 99455. The maximum reimbursement for CPT code 99455 shall be $250.00.

V. INDEPENDENT MEDICAL EXAMINATION (IME)

A. An independent medical examination (IME) may be ordered by the Mississippi Workers' Compensation Commission or its Administrative Judges. A practitioner other than the treating practitioner must do the medical examination, and the Commission or Judge shall designate the examiner.

B. An independent medical examination (IME) shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. An IME can only be ordered by the Workers' Compensation Commission or one of its Administrative Judges. A copy of the report must be sent to the patient, or his attorney if represented, the payer, and the Mississippi Workers' Compensation Commission.

C. The fee for the IME may be set by the Commission or Judge, or negotiated by the payer and provider prior to setting the appointment, and in such cases, reimbursement shall be made according to the order of the Commission or Judge, or according to the mutual agreement of the parties. In the absence of an agreement or order regarding reimbursement for an IME, the provider shall bill for the IME using the appropriate level and site-specific consultation code appended with modifier 32 to indicate a mandated service, and shall be reimbursed according to the Fee Schedule.

VI. MAXIMUM MEDICAL IMPROVEMENT

A. When an employee has reached maximum medical improvement (MMI) for the work related injury and/or illness, the physician should promptly, and at least within fourteen (14) days, submit a report to the payer showing the date of maximum medical improvement (MWCC Form B9,27).

B. Maximum medical improvement is reached at such time as the patient reaches the maximum benefit from medical treatment or is as far restored as the permanent character of his injuries will permit and/or the current limits of medical science will permit. Maximum medical improvement may be found even though the employee will require further treatment or care.

VII. OUT-OF-STATE MEDICAL TREATMENT

A. Each employer shall furnish all reasonable and necessary drugs, supplies, hospital care and services, and medical and surgical treatment for the work-related injury or illness. All such care, services, and treatment shall be performed at facilities within the state when available.

B. When billing for out-of-state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, the same quality of care cannot be provided within the state, or more cost-effective care can be provided out-of-state. In determining whether out-of-state treatment is more cost effective, this question must be viewed from both the payer and patient's perspective. ~~As stated in General Rule 9, t~~Treatment should be provided in an area reasonably convenient to the place of the injury or the residence of the injured employee, in addition to being reasonably suited to the nature of the injury.

C. Reimbursement for out-of-state services shall be based on one of the following, in order of preference: (1) the workers' compensation fee schedule for the state in which services are rendered; or (2) in cases where there is no applicable fee schedule for the state in which services are rendered, or the fee schedule in said state excludes or otherwise does not provide reimbursement allowances for the services rendered, reimbursement should be paid at the usual and customary rate for the geographical area in which the services are rendered; or (3) reimbursement for out-of-state services may be based on the mutual agreement of the parties. The *Mississippi Workers' Compensation Medical Fee Schedule* coding and billing rules must be followed in order for out of state providers to obtain reimbursement.

D. Prior authorization must be obtained from the payer for referral to out-of-state providers. The documentation must include the following:

   1. Name and location of the out-of-state provider,
   2. Justification for an out-of-state provider, including qualifications of the provider and description of services being requested.

VIII. AUTHORIZATION FOR TREATMENT

A. **Prior Authorization.** Providers must request authorization from the payer before service is rendered for the services and supplies listed below:

   1. Non-emergency elective inpatient hospitalization
   2. Non-emergency elective inpatient surgery
   3. Non-emergency elective outpatient surgery
   4. Physical medicine treatments after 15 visits or 30 days, whichever comes first
   5. Rental or purchase of supplies or equipment over the amount of ~~$50.00~~$100.00 per item
   6. Rental or purchase of TENS
   7. Home health services
   8. Pain clinic/therapy programs, including interdisciplinary pain rehabilitation programs
   9. External spinal stimulators
   10. Pain control programs
   11. Work hardening programs, ~~back schools~~functional capacity testing, ISO kinetic testing
   12. Referral for orthotics or prosthetics
   13. Referral for acupuncture

14. Referral for biofeedback
15. Referral to psychological testing/counseling
16. Referral to substance abuse program
17. Referral to weight reduction program
18. Referral to any non-emergency medical service outside the State of Mississippi
19. Repeat MRI (more than one per injury)
20. Repeat CT Scan (more than one per injury)
21. ~~Inter~~Intraoperative neurophysiologic monitoring (e.g., SSEP, VEP, DEP, BAEP, MEP)

B. **Response Time.** The payer must respond within two (2) business days to a request of prior authorization for non-emergency services.

C. **Federal Facilities.** Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in this manual.

D. **Pre-certification for Non-emergency Surgery.** Providers must pre-certify all non-emergency surgery. However, certain catastrophic cases require frequent returns to the operating room (O.R.) (e.g., burns may require daily surgical debridement). In such cases, it is appropriate for the provider to obtain certification of the treatment plan to include multiple surgical procedures. The provider's treatment plan must be specific and agreement must be mutual between the provider and the payer regarding the number and frequency of procedures certified.

E. **Retrospective Review.** Failure to obtain pre-certification as required by this Fee Schedule shall not, in and of itself, result in a denial of payment for the services provided. Instead, the payer, if requested to do so by the provider within one (1) year of the date of service or discharge, shall conduct a retrospective review of the services, and if the payer determines that the services provided would have been pre-certified, in whole or in part, if pre-certification had been timely sought by the provider, then the payer shall reimburse the provider for the approved services according to the Fee Schedule, or, if applicable, according to the separate fee agreement between the payer and provider, less a ten percent (10%) penalty for the provider's failure to obtain pre-certification as required by this Fee Schedule. This penalty shall be computed as ten percent (10%) of the total allowed reimbursement. If, upon retrospective review, the payer determines that pre-certification would not have been given, or would not have been given as to part of the requested services, then the payer shall dispute the bill and proceed in accordance with the Billing and ~~Payment~~ Reimbursement Rules as hereafter provided.

F. **Authorization Provided by Employer or Payer.** When authorization for treatment is sought and obtained from the employer, or payer, whether verbally or in writing, and medical treatment is rendered in good faith reliance on this authorization, the provider is entitled to payment from the employer or payer for the initial visit or evaluation, or in emergency cases, for treatment which is medically necessary to stabilize the patient. Reimbursement is not dependent on, and payment is due regardless of, the outcome of medically necessary services which are provided in good faith reliance upon authorization given by the employer or payer.

IX. RETURN TO WORK

If an employee is capable of some form of gainful employment, it is advisable for the physician to release the employee to light work and make a specific report to the payer as to the date of such release and setting out any restrictions on such light work. It can be to the employee's economic advantage to be released to light or alternative work, since he/she can receive compensation based on sixty-six and two-thirds percent (66 2/3%) of the difference between the employee's earnings in such work and the

employee's pre-injury average weekly wage. The physician's judgment in such matters is extremely important, particularly as to whether the patient is medically capable of returning to work in some capacity. Return to work decisions should be based on objective findings, and the physician's return to work assessment should identify, if possible, any alternative duty employment to which the patient may return if return to full duty is not medically advisable.

X. SELECTION OF PROVIDERS

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to surgical/procedure facilities, CAT scans, MRI, x-ray, and laboratory, ~~for~~ physical or occupational therapy, including work hardening, functional capacity evaluations, ~~back schools,~~ chronic pain programs, or massage therapy shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

~~Physical or occupational therapy, including work hardening, functional capacity evaluations, back schools, chronic pain programs, or massage therapy shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician, the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.~~

Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA §71-3-15 (Rev. 2000).

XI. DRUG SCREENING

Only one (1) drug screen or drug test result shall be eligible for reimbursement for each drug test conducted on the same patient on the same day, except and unless the initial screening results are deemed by the prescribing provider to be inconsistent or inherently unreliable. In that event, a confirmation screening may be ordered by the prescribing provider and paid for by the payer. In addition, treatment may not be discontinued based on the results of a drug test absent a confirmation test, which shall be reimbursed in addition to the initial screening test. Merely duplicate screenings or tests which are rerun to confirm initial results are not otherwise eligible for reimbursement.

XII. MILEAGE REIMBURSEMENT

The payer shall reimburse each claimant for all travel to obtain medical treatment which is being obtained under the provisions of the Mississippi Workers' Compensation Law, including travel to a pharmacy to obtain medication or supplies necessary for treatment of a compensable injury, regardless of the number of miles traveled. There is no minimum distance of travel required for reimbursement, and reimbursement

shall be made for each mile of round trip travel necessitated by the compensable injury, at the rate adopted by the Commission and in effect at the time of the travel. Only reasonable and necessary miles traveled are subject to reimbursement.

Billing and Reimbursement Rules

I. GENERAL PROVISIONS

A. **Maximum Reimbursement Allowance (MRA).** Unless the payer and provider have a separate fee contract which provides for a different level of reimbursement, the maximum reimbursement allowance for health care services shall be the lesser of (a) the provider's total billed charge, or (b) the maximum specific fee established by the Fee Schedule. Items or services or procedures which do not have a maximum specific fee established by this Fee Schedule shall be reimbursed at the usual and customary fee as defined in this Fee Schedule, and in such cases, the maximum reimbursement allowance shall be the lesser of (1) the provider's total billed charge, or (2) the usual and customary fee as defined by this Fee Schedule.

If this Fee Schedule does not establish a maximum specific fee for a particular service or procedure, and a usual and customary rate cannot be determined because the ~~Ingenix MDR Payment System database~~ FH RV Benchmarks products ~~does~~do not contain a fee for same, then the maximum reimbursement allowance shall be equal to the national Medicare allowance plus thirty percent (30%). In the absence of an established Medicare value, and assuming none of the above provisions apply, the maximum reimbursement allowance shall be the provider's total billed charge. Any new codes will be assigned values and posted on the MWCC website annually, or as needed.

B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.

1. **Repricing Agreements.** Payers and providers may voluntarily enter into repricing agreements designed to contain the cost of workers' compensation health care after the medical care or service has been provided, and in such case, the reimbursement voluntarily agreed to by the parties shall control to the exclusion of the Fee Schedule. However, the time spent by the payer and provider attempting to negotiate a post-care repricing agreement does not extend the time elsewhere provided in this Fee Schedule for billing claims, paying claims, requesting correction of an incorrect payment, requesting reconsideration, seeking dispute resolution, or reviewing and responding to requests for correction or reconsideration or dispute resolution. In addition, applicable interest and penalties related to late billing and/or late payment shall continue to accrue as otherwise provided. Efforts to negotiate a post-care repricing agreement do not justify

late billing or payment, and either party may seek further relief in accordance with the rules provided herein should billing or payment not be made within the time otherwise due under these rules. No party shall be obligated to negotiate or enter into a repricing agreement of any kind whatsoever.

No party, in attempting to negotiate a repricing or other post treatment price reduction agreement, shall state or imply that consent to such an agreement is mandatory, or that the failure to enter into any such agreement may result in audit, delay of payment, or other adverse consequence. If the Commission determines that any party, or other person in privity therewith, has made such false or misleading statements in an effort to coerce another party's consent to a repricing or other price reduction agreement outside the Fee Schedule, the Commission may refer the matter to the appropriate authorities to consider whether such conduct warrants criminal prosecution under §71-3-69 of the Law. This statute declares that any false or misleading statement or representation made for the purpose of wrongfully withholding any benefit or payment otherwise due under the terms of the Workers' Compensation Law shall be considered a felony. In addition, the Commission may levy a civil penalty in an amount not to exceed ten thousand dollars ($10,000.00) if it finds that payment of a just claim has been delayed without reasonable grounds, as provided in §71-3-59(2) of the Law.

C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms: Providers must bill outpatient professional services on the most recently authorized paper or electronic version, 837p, or the CMS-1500 form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform billing form. The electronic version, 837i, or the UB-04 (CMS-1450) ~~has been~~ is required ~~since May 23, 2007~~. Billing must be submitted using the most current paper or electronic forms which are authorized by CMS.

D. **Identification Number.** All professional reimbursement submissions by Covered Healthcare Providers as defined under CMS rules for the implementation of the National Provider Identifier (NPI) must include the National Provider Identifier (NPI) field so as to enable the specific identification of individual providers without the need for other unique provider identification numbers. Providers who do not yet have an NPI should ~~continue to use their legacy identifiers~~ use the CMS default identifier until such time as an NPI is obtained. Providers are required to obtain an NPI within the dates specified by CMS in its implementation rules.

E. **Physician Specialty.** The rules and reimbursement allowances in the *Mississippi Workers' Compensation Medical Fee Schedule* do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.

F. **"No Show" Appointments.** When an appointment is made for a physician visit by the employer or payer, and the claimant/patient does not show, the provider is entitled to payment at the rate allowed for a minimal office visit.

G. **"After Hours" and Other Adjunct Service Codes.** When an office service occurs after a provider's normal business hours, procedure code 99050 may be billed. Other adjunct service codes (99051–99060) may be billed as appropriate. Typically, only a single adjunct service code is reported per encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.

H. **Portable Services.** When procedures are performed using portable equipment, bill the appropriate procedure code. The charge for the procedure includes the cost of the portable equipment.

I. **Injections.**

1. Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.

2. The description must include the name of the medication, strength, and dose injected.
3. When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.
4. Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.
5. Reimbursement for intra-articular and intra-bursal injections medications (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.

J. **Supplies.** Use CPT® code 99070 or specific HCPCS Level II codes to report supplies over and above those usually included with the office visit or service rendered. Do not bill for supplies that are currently included in surgical packages, such as gauze, sponges, and Steri-Strips®. Supplies and materials provided by the physician over and above those usually included with the office visit (drugs, splints, sutures, etc.) may be charged separately and reimbursed at a reasonable rate.

II. INSTRUCTIONS TO PROVIDERS

A. All bills for service must be coded with the appropriate CPT, ASA, DentalCDT, or HCPCS Level II code.

B. The medical provider must file the appropriate billing form and necessary documentation within thirty (30) days of rendering services on a newly diagnosed work-related injury or illness. Subsequent billings must be submitted at least every thirty (30) days, or within thirty (30) days of each treatment or visit, whichever last occurs, with the appropriate medical records to substantiate the medical necessity for continued services. Late billings will be subject to discounts, not to exceed one and one-half percent (1.5%) per month of the bill or part thereof which was not timely billed, from the date the billing or part thereof is first due until received by the payer. Any bill or part thereof not submitted to the payer within sixty (60) days after the due date under this rule shall be subject to an additional discount penalty equal to ten percent (10%) of the total bill or part thereof. Any bill for services rendered which is not submitted to the payer within one (1) year after the date of service, or date of discharge for inpatient care, will not be eligible or considered for reimbursement under this Fee Schedule, unless otherwise ordered by the Commission or its Cost Containment Division.

C. Fees in excess of the maximum reimbursement allowance (MRA) must not be billed to the employee, employer, or payer. The provider cannot collect any non-allowed amount (MCA §71-3-15(3) (Rev. 2000)).

D. If it is medically necessary to exceed the Fee Schedule limitations and/or exclusions, substantiating documentation must be submitted by the provider to the payer with the claim form.

E. If a provider believes an incorrect payment was made for services rendered, or disagrees for any reason with the payment and explanation of review tendered by the payer, then the provider may request reconsideration pursuant to the rules set forth herein.

F. If, after the resolution of a reconsideration request or a formal dispute resolution request, or otherwise, the provider is determined to owe a refund to the payer, the amount refunded shall bear interest at the rate of one and one-half percent (1.5%) per month from the date the refunded amount was first received by the provider, until refunded to the payer.

III. INSTRUCTIONS TO PAYERS

A. An employer's/payer's payment shall reflect any adjustments in the bill made through the employer's/payer's bill review program. The employer/payer must provide an explanation of review (EOR) to a health care provider whenever reimbursement differs from the amount billed by the provider. This must be done individually for each bill.

B. In a case where documentation does not indicate the service was performed, the charge for the service may be denied. The ~~explanation of review (~~EOR~~)~~ must clearly and specifically indicate the reason for the denial.

C. (1) When a billed service is documented, but the code selected by the provider is not, in the payer's/reviewer's estimation, the most accurate code available to describe the service, the reviewer must not deny payment, but shall reimburse based on the revised code. The ~~explanation of review (~~EOR~~)~~ must clearly and specifically detail the reason(s) for recoding the service or otherwise altering the claim. No claim shall be recoded or otherwise revised or altered without the payer having actually reviewed the medical records associated with the claim which document the service(s) provided.

(2) As an alternative to recoding or altering a claim, the payer may treat the matter under rule E(1) and (2) below by paying any undisputed portion of the bill, and notifying the provider by ~~explanation of review (~~EOR~~)~~ that the remaining parts of the bill are denied or disputed.

(3) Recoding cannot be used solely for cost containment. Recoding may only be used for the correction of miscoded services. Whenever there is any dispute concerning coding, the provider must be notified immediately and given the opportunity to furnish additional information, although nothing herein suspends the time periods for making payment or giving notice of dispute. Any recoding or so-called "down coding," which is found by the Commission or its Cost Containment Division to be solely for the purpose of cost containment, will subject the party engaging in such conduct to additional penalties as allowed by law.

D. Properly submitted bills must be paid within thirty (30) days of receipt by the payer. Properly submitted bills not fully paid within thirty (30) days of receipt by the payer shall automatically include interest on the unpaid balance at the rate of one and one-half percent (1.5%) per month from the due date of any unpaid remaining balance until such time as the claim is fully paid and satisfied. Properly submitted bills not fully paid within sixty (60) days of receipt will be subject to an additional penalty equal to ten percent (10%) of the unpaid remaining balance, including interest as herein provided.

E. (1) When an employer/payer disputes or otherwise adjusts a bill or portion thereof, the employer/payer shall pay the undisputed or unadjusted portion of the bill within thirty (30) days of receipt of the bill. Failure to pay the undisputed portion when due shall subject the payer to interest and penalty as above provided on the undisputed portion of the bill. If the dispute is ultimately resolved in the provider's favor, interest and penalty on the disputed amounts will apply from the original due date of the bill <u>until paid</u>.

(2) When a payer disputes a bill or portion thereof, the payer shall notify the provider within thirty (30) days of the receipt of the bill of the reasons for disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the payer's action. The payer shall set forth the clear and specific reasons for disputing a bill or portion thereof on the ~~explanation of review (~~EOR~~)~~, and shall provide additional documentation if necessary to provide an adequate explanation of the dispute.

F. Reimbursement determinations shall be based on medical necessity of services to either establish a diagnosis or treat an injury/illness. Thus, where service is provided in good faith reliance on authorization given by the employer or payer, reimbursement shall not be dependent on the outcome of medically necessary diagnostic services or treatment.

IV. FACILITY FEE RULES

Please refer to the Pain Management section for the ~~S~~state-specific facility reimbursement rules to be used for outpatient pain management procedures.

Please refer to the ~~Surgery~~ Inpatient Hospital and Outpatient Facility Payment Schedule and Rules section for the ~~S~~state-specific facility reimbursement rules to be used for ambulatory surgery center (ASC) procedures and hospital based outpatient departments.

A. **Prepayment Review for Facilities.** The payer must perform a prepayment review on inpatient hospital bills and outpatient surgery bills in order to verify the charges submitted.

1. At a minimum, the pre-payment review should:
    a. Validate that prior authorization was approved according to Fee Schedule guidelines;
    b. Validate that the length of stay and the level of service was appropriate for the diagnosis;
    c. Review the bill for possible overcharges or billing errors;
    d. Determine if an on-site audit is appropriate;
    e. Identify over utilization of services;
    f. Identify those bills and case records that shall be subject to professional review by a physician or appropriate peer.
2. The payer must reimburse the hospital within thirty (30) days of receipt of a valid claim form if prepayment review criteria are met. An exception to the thirty (30) day payment time will be made if additional documentation is requested for prepayment review, and in such cases, payment should be made within thirty (30) days following receipt of this additional documentation if prepayment review criteria are met. If a full audit is scheduled, fifty percent (50%) of the total bill must be paid prior to the audit, and in such event, the payer shall not be liable for interest and penalty as above provided on any additional sums which may be due following completion of the audit. Failure to pay fifty percent (50%) of the total bill prior to the audit shall result in interest and penalty as above provided being added to the total amount determined to be due, from the original due date until paid.
3. If the hospital does not forward copies of requested medical records to the payer after two (2) consecutive written requests following the initial request, or if it fails to submit necessary or adequate documentation to support the hospital services rendered, the payer should perform a charge audit.

B. **Charge Audit.** All charge audits must be performed on-site unless otherwise agreed to by the provider and payer.

1. The following information must be provided to the hospital by the payer/auditor when scheduling an audit:
    a. Patient name
    b. Account number
    c. Date(s) of service
    d. Diagnosis(es)
    e. Total amount of bill
    f. Insurance company
    g. Name of audit requester
    h. Telephone number and address of requester

2. A hospital must schedule a charge audit within thirty (30) days of a request by a payer/auditor.
3. Hospitals shall be reimbursed an audit fee of $50.00 for associated audit costs.
4. When a charge audit is necessary, the auditor must identify additional charges for medically necessary hospital services that were ordered by the authorized physician and were provided, but were not included, on the initial bill.
5. The auditor must review and verify the audit findings with a hospital representative at the conclusion of the audit. The hospital may waive its right to the exit conference.
6. The auditor must provide written explanation of the final reimbursement determination based on the audit findings, whether or not an exit conference is held with the hospital. This written explanation must be provided within thirty (30) days following the conclusion of the audit.

C. When any hospital bill that has been prescreened and found to be correct, or when corrections have been made to the bill as required, or when a hospital bill has been audited and verified as correct, it must be paid within thirty (30) days thereafter.

D. Any hospital bill not paid when due under these rules shall automatically include interest at the rate of one and one-half percent (1.5%) per month from the due date of such bill until paid. Any such bill not paid within sixty (60) days after it is due under these rules will be subject to an additional penalty equal to ten percent (10%) of the total amount due, including interest as herein provided.

E. **Implantables.** An implantable is an item that is implanted into the body for the purpose of permanent placement, and remains in the body as a fixture. Absorbable items, temporary items, or other items used to help place the implant, are not within the definition of "implantable" and are not reimbursed as such.

Implantables are included in the applicable MS-DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement is likewise included in the APC Amount paid to the facility. No separate billing or payment for implants shall be made in either the inpatient or outpatient setting. ~~shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at cost plus ten percent (10%).~~

~~A "suitable invoice" is an acquisition invoice from the manufacturer that contains pricing information showing the actual cost of the implant(s) being billed, or, as in situations such as a bulk purchase, containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead from the implant supplier or manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to one hundred ten percent (110%) of the original manufacturer's invoice price.~~

V. EXPLANATION OF REVIEW (EOR)

A. Payers must provide an explanation of review (EOR) to health care providers for each bill whenever the payer's reimbursement differs from the amount billed by the provider, or when an original claim is altered or adjusted by the payer. The EOR must be provided within thirty (30) days of receipt of the bill, and must accompany any payment that is being made.

B. A payer may use the listed EOR codes and descriptors or may develop codes of their own to explain why a provider's charge has been reduced or disallowed, or why a claim has been altered or adjusted in some other way. In all cases, the payer must clearly and specifically detail the reasons for adjusting or altering a bill, including references to the applicable provisions of the Fee Schedule or CPT book,

or other source(s) used as the basis for the EOR. Should the EOR include an alteration in the codes submitted on the original claim, it must be based on a review of the medical records documenting the service.

C. The EOR must contain appropriate identifying information to enable the provider to relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.

D. Acceptable EORs may include manually produced or computerized forms that contain the EOR codes, written explanations, and the appropriate identifying information.

E. The following EOR codes may be used by the payer to explain to the provider why a procedure or service is not reimbursed as billed, provided clear and specific detail is included, along with references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR:

001 These services are not reimbursable under the Workers' Compensation Law for the following reason(s): [Provide specific reason(s) why services are not reimbursable under the Workers' Compensation Law]

002 Charges exceed maximum reimbursement allowance [Specify]

003 Charge is included in the basic surgical allowance [Specify]

004 Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required [Specify]

005 This procedure is included in the basic allowance of another procedure [Specify the other procedure]

006 This procedure is not appropriate to the diagnosis [Specify]

007 This procedure is not within the scope of the license of the billing provider [Specify]

008 Equipment or services are not prescribed by a physician [Specify]

009 This service exceeds reimbursement limitations [Specify]

010 This service is not reimbursable unless billed by a physician [Specify]

011 Incorrect billing form [Specify]

012 Incorrect or incomplete identification number of billing provider [Specify]

013 Medical report required for payment [Specify]

014 Documentation does not justify level of service billed [Specify]

015 Place of service is inconsistent with procedure billed [Specify]

016 Invalid procedure code [Specify]

017 Prior authorization was not obtained [Specify]

VI. REQUEST FOR RECONSIDERATION

A. When, after examination of the explanation of review (EOR) and other documentation, a health care provider is dissatisfied with a payer's payment or dispute of a bill for medical services, reconsideration may be requested by the provider. Any other matter in dispute between the provider and payer may be subject to reconsideration as herein provided at the request of either party, including, but not limited to, a request by the payer for refund of an alleged over-payment. Alleged over-payments should be addressed through the dispute resolution process, if necessary, and not by way of unilateral recoupment initiated by the payer on subsequent billings.

B. A provider or payer must make a written request for reconsideration within thirty (30) days from the receipt of the explanation of review (EOR) or other written documentation evidencing the basis for the dispute. A request for reconsideration must be accompanied by a copy of the bill in question, the payers' explanation of review (EOR), and/or any additional documentation to support the request for reconsideration.

C. The payer or provider, upon receipt of a request for reconsideration, must review and re-evaluate the original bill and accompanying documentation, and, must notify the requesting party ~~within twenty (20)~~ thirty (30) days thereafter of the results of the reconsideration. The response must adequately explain the reason(s) for the decision, and cite the specific basis upon which the final determination was made. If the payer finds the provider's request for reconsideration is meritorious, and that additional payment(s) should be made, or if the provider finds the payer's request for refund or other payment is meritorious, the additional payment should be made within the above ~~twenty (20)~~thirty (30) day period. Any additional payment(s) made in response to a provider's or payer's request for reconsideration shall include interest from the original due date of the bill or payment, and an additional ten percent (10%) penalty if applicable.

D. If the dispute is not resolved within the above time after a proper request for reconsideration has been served by the provider or payer, then either party may request further review by the Commission pursuant to the Dispute Resolution Rules set forth hereafter.

E. Failure to seek reconsideration within the time above provided shall bar and prohibit any further reconsideration or review of the bill or other issue in question unless, for good cause shown, the Commission or its representative extends the time for seeking reconsideration or review under these rules. In no event shall the time for seeking reconsideration hereunder be extended by more than an additional thirty (30) days, and any such request for additional time in which to seek reconsideration or further review must be made in writing to the Commission within the initial thirty (30) day period set forth in paragraph B. above.

F. Requests by either provider or payer for refunds, or for additional payment, or other requests related to the billing or payment of a claim, must be sought in accordance with the specific rules set forth herein. No retrospective audits or dispute requests shall be allowed beyond the time otherwise provided herein for seeking reconsideration and/or review.

Medical Records Rules

I. MEDICAL RECORDS

A. The medical record, which documents the patient's course of treatment, is the responsibility of the provider and is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, failure to submit necessary or adequate documentation to support the services rendered may result in the services being disallowed.

B. A medical provider may not charge any fee for completing a medical report or form required by the Workers' Compensation Commission which is part of the required supporting documentation which accompanies a request for payment. The supporting documentation that is required to substantiate the medical treatment is included in the fee for service and does not warrant a separate fee as it is incidental to providing medical care. CPT® code 99080 is appropriate for billing special reports beyond those required by this Fee Schedule and requested by the payer or their representatives.

C. Medical records must be legible and include, as applicable:

1. Initial office visit notes which document a history and physical examination appropriate to the level of service indicated by the presenting injury/illness or treatment of the ongoing injury/illness;
2. Progress notes which reflect patient complaints, objective findings, assessment of the problem, and plan of care or treatment;
3. Copies of lab, x-ray, or other diagnostic tests that reflect current progress of the patient and/or response to therapy or treatment;
4. Physical medicine/occupational therapy progress notes that reflect the patient's response to treatment/therapy;
5. Operative reports, consultation notes with report, and/or dictated report; and
6. Impairment rating (projected and actual) and anticipated maximum medical improvement (MMI) date.

D. A plan of care should be included in the medical record and should address, as applicable, the following:

1. The disability;
2. Degree of restoration anticipated;
3. Measurable goals;
4. Specific therapies to be used;
5. Frequency and duration of treatments to be provided;
6. Anticipated return to work date;
7. Projected impairment.

E. Health care providers must submit copies of records and reports to payers upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate

documentation to the payer when requested. Only those records for a specific date of injury are considered non-privileged as it relates to a workers' compensation injury. The employer/payer is not privileged to non-work related medical information.

F. Providers must submit documentation for the following:

1. The initial office visit;
2. A progress report if still treating after thirty (30) days;
3. Evaluation for ~~physical medicine~~ therapy services/treatment (P.T., O.T., C.M.T., O.M.T.);
4. A progress report every thirty (30) days for ~~physical medicine services~~therapy services/treatment (P.T., O.T., C.M.T., O.M.T.);
5. An operative report or office note (if done in the office) for a surgical procedure;
6. A consultation;
7. The anesthesia record for anesthesia services;
8. A functional capacity or work hardening evaluation;
9. When billing ~~a by report~~ "By Report" (BR) ~~service~~, a description of the service is required; this description should include 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;
10. Whenever a modifier is used to describe an unusual circumstance;
11. Whenever the procedure code descriptors include a written report.

G. Hospitals and other inpatient facilities must submit required documentation with the appropriate billing forms as follows:

1. Admission history and physical;
2. Discharge summary;
3. Operative reports;
4. Pathology reports;
5. Radiology reports;
6. Consultations;
7. Other dictated reports;
8. Emergency room records.

H. The Health Insurance Portability & Accountability Act (HIPAA) makes important exceptions concerning the disclosure of protected health information for workers' compensation purposes. For additional information, refer to the MWCC website (mwcc.ms.gov), or consult an attorney and/or the HIPAA resource site maintained by the U. S. Department of Health and Human Services (http://www.hhs.gov/ocr/privacy/).

II. COPIES OF RECORDS

A. **Outpatient Records.** The payer may request additional records or reports from the provider concerning service or treatment provided to a patient other than on an inpatient basis. These additional records and reports will be reimbursed as follows:

1-5 pages — $15.00

6+ pages — $.50 per page in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

As provided by MCA §11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

B. **Inpatient Records.** The payer may request additional records or reports from a facility concerning inpatient service or treatment provided to a patient. Such reports or records requested by the payer will be reimbursed as follows:

1-5 pages — $15.00/per admission

6+ pages — $.50 per page/per admission in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

There is a maximum reimbursement allowance of fifty dollars ($50.00) for a particular inpatient medical record, exclusive of postage, handling and retrieval charges as set forth below. This is per admission.

As provided by MCA §11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

C. Copies of records requested by the patient and/or the patient's attorney or legal representative will be reimbursed by the requesting party according to the provisions of this section on additional reports and records.

D. Documentation submitted by the provider which has not been specifically requested will not be subject to reimbursement.

E. Health care providers may charge up to ten dollars ($10.00) per film for copying x-rays or for providing copies of x-rays via electronic or other magnetic media. (Copies of film do not have to be returned to the provider.)

F. Payers, their representatives, and other parties requesting records and reports must be specific in their requests so as not to place undue demands on provider time for copying records.

G. Providers should respond promptly (within fourteen (14) working days) to requests for additional records and reports.

H. Records requested by the Mississippi Workers' Compensation Commission will be furnished by the provider without charge to the Commission.

I. Any additional reimbursement, including copy service vendors, other than is specifically set forth above, is not required, and providers or their vendors will not be paid any additional amounts.

III. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) AND WORKERS' COMPENSATION

HIPAA makes important exceptions concerning the disclosure of protected health information (PHI) for workers' compensation purposes. The United States Department of Health and Human Services, through its Office for Civil Rights, enforces the HIPAA Law and maintains an informative website with information on HIPAA and its application to workers' compensation claims. See, for example: http://www.hhs.gov/ocr/privacy/.

Dispute Resolution Rules

I. General Provisions

A. Unresolved disputes may be appealed to and resolved by the Mississippi Workers' Compensation Commission.

B. Reconsideration must be sought by the provider or payer prior to a request for resolution of a dispute being sent to the Commission. This provides the payer and provider an opportunity to resolve most concerns in a timely manner.

C. All communication between parties in dispute will be handled by the Mississippi Workers' Compensation Commission, Cost Containment Division. In addition, there will be no communication between the parties in dispute and any Peer Reviewer who might be called upon to assist the Commission in the resolution of a dispute.

II. Forms and Documentation

A. Valid requests for resolution of a dispute must be submitted on the "Request for Resolution of Dispute" form (~~in~~ see the Forms section or http://www.mwcc.state.ms.us/services/feeschedule.asp) along with the following:

1. Copies of the original and resubmitted bills in dispute that include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of any unusual services or circumstances;
2. EOR including the specific reimbursement;
3. Supporting documentation and correspondence;
4. Specific information regarding contact with the payer; and
5. Any other information deemed relevant by the applicant for dispute resolution.

B. A request for Resolution of Dispute must be submitted to:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P.O. Box 5300
Jackson, MS 39296-5300

C. A party, whether payer, provider, patient, or any representative of such parties, shall certify that a copy of the Request for Resolution of Dispute, and any supporting documentation, being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission. This requirement shall also apply when a party files a request seeking review of a dispute by the Commission, or when enforcement of a final decision of the Cost Containment Director is sought.

III. TIME FOR FILING

A Request for Resolution of Dispute must be filed with the Commission within ~~twenty (20)~~thirty (30) days following the payer's or provider's response to a request for reconsideration of any matter in dispute, or, in cases where the payer or provider fails to respond to a request for reconsideration, within ~~twenty (20)~~thirty (30) days of the expiration of the time in which said response should have been provided. Failure to file a Request for Resolution of Dispute within this time shall bar any further action on the disputed issue(s) unless, for good cause shown, the Commission or its Cost Containment Director extends the time for filing said request. In no event will the time for filing a Request for Resolution of Dispute be extended more than once or more than an additional twenty (20) days from the time said request was first due to be filed, provided the request for additional time in which to file a Request for Resolution of Dispute is filed within the initial ~~twenty (20)~~thirty (30) day period provided herein; and, absent compelling circumstances, a dispute resolution request will not be considered by the Cost Containment Division if submitted more than one (1) year after the date of service. The decision to extend the time for filing a Request for Resolution of Dispute based on "good cause" shall be entirely at the discretion of the Commission or its Cost Containment Director. Mere neglect will not constitute "good cause."

IV. PROCEDURE BY COST CONTAINMENT DIVISION

A. Requests for dispute resolution will be reviewed and decided by the Cost Containment Division of the Commission ~~within thirty (30) days of receipt of the request,~~ after all required and requested information has been received. ~~unless a~~Additional time ~~is~~ may be required to accommodate a Peer Review. The payer and/or provider may be contacted by telephone or other means for additional information if necessary; however, both parties to a dispute may submit in writing any information or argument they deem relevant to the issue in dispute, if not already submitted with the request for dispute resolution, and this information shall be considered by the Cost Containment Division when rendering a decision. Any written information or argument submitted for consideration by a party to a dispute, without a request from the Commission, must be received by the Cost Containment Division within ~~ten (10)~~fourteen (14) days after filing the request for dispute resolution in order to merit consideration.

B. Every effort will be made to resolve disputes by telephone or in writing. The payer and provider may be requested to attend an informal hearing conducted by a Commission representative. Failure to appear at an informal hearing may result in dismissal of the request for dispute resolution.

C. Following review of all documentation submitted for dispute resolution and/or following contact with the payer and/or provider for additional information and/or negotiation, the Cost Containment Division shall render an administrative decision on the request for dispute resolution, and forward it to the involved parties.

D. Cases involving medical care determination may be referred for peer review, but only on request of the Commission. The peer review consultant will render an opinion and submit same to the Commission representative within the time set by the Cost Containment Division. The Commission representative will notify the parties in dispute if a Peer Review has been requested, and of the peer review consultant's determination.

V. COMMISSION REVIEW OF A DISPUTE

A. Any party aggrieved by the decision of the Cost Containment Division shall have twenty (20) days from the date of said decision to request review by the Commission. Failure to file a written request for review with the Commission within this twenty (20) day period shall bar any further review or action with regard to the issue(s) presented. No extension of time within which to file for Commission review of a dispute under these Rules shall be allowed. In the event a request for review is not filed with the Commission within twenty (20) days or within the time allowed by any extension which has been granted, the parties to the dispute shall have fourteen (14) days thereafter in which to comply with the final decision of the Cost Containment Division.

1. A party to a dispute may, when a written request for review has not been timely filed with the Commission, file with the Commission a written request to compel compliance with the final administrative decision of the Cost Containment Division. The Commission may consider such a request with or without a hearing. A request to compel compliance with the final decision of the Cost Containment Division may be filed at any time following fourteen (14) days after the decision of the Cost Containment Division becomes final, and must be submitted on the form approved by the Commission for this purpose. No such request to compel or enforce compliance with a final decision of the Cost Containment Director shall be considered if filed more than one (1) year after the date of the Cost Containment Director's decision.

   The party seeking relief hereunder shall certify that a copy of the request for relief and any supporting documentation being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission.

B. The request for review by the Commission shall be filed with the Cost Containment Division of the Mississippi Workers' Compensation Commission, and shall be in writing and shall state the grounds on which the requesting party relies. All documentation submitted to and considered by the Cost Containment Division, including the Request for Resolution of Dispute form, along with a copy of the decision of the Cost Containment Division, shall be attached to the request for review which is filed with the Commission. The party seeking relief hereunder shall certify that a copy of the request for review and any supporting documentation being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission.

C. The Commission shall review the issue(s) solely on the basis of the documentation submitted to the Cost Containment Division. No additional documentation not presented to and considered by the Cost Containment Division shall be considered by the Commission on review, unless specifically requested by the Commission, and no hearing or oral argument shall be allowed.

D. The Commission shall consider the request for review and issue a decision ~~thereon within thirty (30) days after said request is filed, unless otherwise provided by the Commission~~.

E. Following the decision of the Commission, or following the conclusion of the dispute resolution process at any stage without an appeal to the Commission, no further audit, adjustment, refund, review, consideration, reconsideration or appeal with respect to the claim in question may be sought by either party.

F. The costs incurred in seeking Commission review, or in seeking compliance with an Administrative Decision rendered by the Cost Containment Director, including reasonable attorney fees, if any, shall be assessed to the party who requested review if that party's position is not sustained by the Commission and to the party who has failed to comply with a prior decision if compliance therewith is ordered by the Commission. Otherwise, each party shall bear their own costs, including attorney's fees.

G. If the Commission determines that a dispute is based on or arises from a billing error, a payment adjustment or error, including but not limited to improper bundling of service codes, unbundling, downcoding, code shifting, or other action by either party to the dispute, or if the Commission determines that a provider or payer has unreasonably refused to comply with the Law, the Rules of the Commission, including this Fee Schedule, or with any decision of the Commission or its representatives, and that this causes proceedings with respect to the billing and/or payment for covered medical services to be instituted or continued or delayed without reasonable grounds, then the Commission may require the responsible party or parties to pay the reasonable expenses, including attorney's fees, if any, to the opposing party; and, in addition, the Commission may levy against the responsible party or parties a civil penalty not to exceed the sum of ten thousand dollars ($10,000.00), payable to the Commission, as provided in §71-3-59(2) of the Law. The award of costs and penalties as herein provided shall be in addition to interest and penalty charges which may apply under other provisions of this Fee Schedule.

Utilization Review Rules

The Mississippi Workers' Compensation Commission requires mandatory utilization review of certain medical services ~~and charges~~ associated with the provision of medical treatment covered under the Act and subject to the Fee Schedule. "Utilization review" refers to a system for reviewing proposed medical services to make sure that such procedures are medically necessary and represent the most efficient and appropriate use of medical resources given the nature of the injury to the patient and the process of his or her recovery, and that such services are properly and timely reimbursed. These rules are set forth to encourage ~~consistency in the procedures for interaction between workers' compensation utilization review agents, representatives or organizations, providers, and payers~~ efficient and timely communication between payers and providers (including agents of either) in order to make sure that medically necessary services are provided and timely reimbursed, and to curtail the use of unnecessary or unreasonable treatment. The provisions herein set forth regarding utilization review are in addition to the requirements of MCA §41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure~~, and~~ ~~i~~In the event of conflict between this Fee Schedule~~,~~ and the ~~requirements of the~~ above statutes, and any implementing regulations adopted by the Health Department or Board of Medical Licensure, the provisions ~~of~~ in this Fee Schedule or other applicable rules of the Mississippi Workers' Compensation Commission shall ~~govern~~control.

A payer may provide for utilization review by using personnel or units in-house, by contracting with a third party utilization review agent properly licensed by the MS Department of Health, or by contracting with a Nurse Case Manager or similar person to monitor the care being provided in person working with the patient and provider. An injured worker and/or his or her attorney and any case manager assigned by the payer shall strive to cooperate with one another for the purpose of ensuring the injured worker receives all of the medically necessary care needed for the treatment of the injury and the process of recovery. A payer also may exercise their statutory right to an Employer Medical Evaluation (EME) as provided for in MCA §71-3-15(1) (Rev. 2000) in conjunction with, or in lieu of, ongoing utilization review.

AS STATED IN MCA §41-83-31(a), (b) (Rev. 2009), NO DECISION OR DETERMINATION ADVERSE TO A PATIENT OR HEALTH CARE PROVIDER WHICH MAY RESULT IN THE DENIAL OF PAYMENT, OR IN THE DENIAL OF PRE-CERTIFICATION FOR TREATMENT IN THIS STATE, SHALL BE MADE WITHOUT THE PRIOR EVALUATION AND CONCURRENCE IN THE ADVERSE DETERMINATION BY A PHYSICIAN CURRENTLY LICENSED TO PRACTICE MEDICINE IN THE STATE OF MISSISSIPPI, AND PROPERLY TRAINED IN THE SAME SPECIALTY OR SUB-SPECIALTY AS THE REQUESTING PROVIDER WHO IS SEEKING APPROVAL FOR TREATMENT OR SERVICES.

THIS ADVERSE DETERMINATION MUST BE PROVIDED WITHIN TWO (2) BUSINESS DAYS EITHER BY TELEPHONE OR FACSIMILE OR EMAIL, AND IN WRITING WITHIN ONE (1) BUSINESS DAY THEREAFTER, TO THE REQUESTING PROVIDER. ANY SUCH ADVERSE DETERMINATION MUST INCLUDE WRITTEN DOCUMENTATION CONTAINING THE SPECIFIC EVALUATION, FINDINGS AND CONCURRENCE OF THE MISSISSIPPI LICENSED PHYSICIAN TRAINED IN THE RELEVANT SPECIALTY OR SUB-SPECIALTY, AND MUST REFERENCE ANY SPECIFIC PROVISIONS OF THE MIS-

SISSIPPI WORKERS' COMPENSATION MEDICAL FEE SCHEDULE WHICH ALLEGEDLY JUSTIFIES THE ADVERSE DETERMINATION.

ANY ADVERSE DETERMINATION WHICH DOES NOT COMPLY WITH THIS PROVISION SHALL HAVE NO FORCE OR EFFECT AND SHALL NOT PREVENT THE PROVIDER FROM PROCEEDING WITH THE PROPOSED TREATMENT AND ULTIMATELY BEING REIMBURSED AS THOUGH THE PROPOSED TREATMENT OR SERVICE HAD BEEN TIMELY APPROVED IN ADVANCE.

IF A PAYER ELECTS TO SEEK AN EME IN LIEU OF A UTILIZATION REVIEW, THE INJURED WORKER AND THE PROVIDER MUST BE NOTIFIED OF THIS ELECTION WITHIN THE SAME TWO (2) DAY PERIOD APPLICABLE TO ADVERSE DETERMINATIONS STATED ABOVE.

I. SERVICES REQUIRING UTILIZATION REVIEW

Mandatory utilization review is required for the following:

A. All admissions to inpatient facilities of any type.

B. All surgical procedures, inpatient and outpatient. (All surgical or other invasive procedures which are administered in the context of pain management treatment shall be regulated by the specific guidelines set forth in the Pain Management section of the Fee Schedule. Only in the event a surgically invasive pain management procedure is not specifically addressed in the Pain Management guidelines shall the provisions in this section control.)

C. Repeat MRI ~~(more than one per injury)~~ scans, repeat CT Scans, repeat EMG/NCS studies, and repeat myelograms (meaning more than one such diagnostic procedure which is being prescribed for the same injury) are subject to mandatory utilization review, except that where surgery has been performed following proper approval, the treating physician is entitled to obtain one repeat of the aforementioned diagnostic procedures post-surgery without having to obtain separate approval for each such procedure. In other words, surgical cases merit two diagnostic procedures of the kind listed herein without the necessity of pre-certification provided one procedure occurs prior to surgical treatment and one procedure occurs post-surgical treatment. The two diagnostic procedures selected by the treating provider hereunder may be the same two diagnostic procedures, or any two of the aforementioned procedures.

~~D. Repeat CT Scan (more than one per injury).~~

~~E~~D. Work hardening programs, pain management programs, ~~back schools,~~ massage therapy, acupuncture, and biofeedback. Biofeedback therapy shall not exceed ten (10) visits or sessions, unless otherwise agreed to by the payer and provider. Back schools are no longer covered under this Fee Schedule. Pain management programs include but are not limited to a "chronic pain inter-disciplinary pain rehabilitation program" for which specific guidelines are set forth in the Therapeutic Services section.

1. Work Hardening Program Guidelines

a. Work hardening is an interdisciplinary, individualized, job or goal-specific program of activity with the goal of returning an injured patient to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the bio-mechanical, neuromuscular, and cardiovascular functioning of the worker. Approval or certification must be based on whether the proposed work hardening program appears reasonably tailored to accomplish the stated goals.

(1) A work hardening program must, at a minimum, have the following components:

- Development of strength and endurance of the individual in relation to the return to work goal;
- Equipment and methods that quantify and measure strength and conditioning levels, i.e., ergometers, dynamometers, treadmills, measured walking tolerances;
- Commercial strength and exercise devices, free weights, circuit training. Goals for each worker are dependent on the demands of their respective jobs;
- Simulation of the critical work demands, the tasks and the environment of the job to which the worker will return. Job simulation tasks that provide for progression in frequency, load, and duration are essential. They must be related to the work goal and include a variety of work stations that offer opportunities to practice work related positions and motions, i.e., clerical, plumbing, electrical;
- Education that stresses body mechanics, work pacing, safety and injury prevention and that promotes worker responsibility and self-management. The education component requires direct therapist and worker interaction;
- Assessment of the need for job modifications. Focus on whether the worker can return to the stated job goal but only with changes, i.e., added equipment, changes in work position or ergonomics, changes at the work site;
- An individualized written plan that identifies observable and measurable goals, the methodology being used to reach these goals, the projected time necessary to accomplish the goal, and the expected outcomes. This plan must be signed by both the provider and the patient;
- This plan needs to be based on a functional capacity (baseline) evaluation and must be completed within the first two (2) days of the program and compared to the critical demands as stated on the job analysis. A comparative analysis (re-evaluation) is done prior to discharge to determine job readiness;
- A reporting system that includes:
  - Documentation of the initial plan;
  - Documentation of progress or lack of progress and future goals;
  - A discharge summary that includes an assessment of the functional capacity level and the achievement of the individual's program goals;
  - A record of the worker's daily attendance including number of days and number of hours per day in the program.

b. Criteria for admission:

(1) The worker must have reached a point in his or her recovery where no further active or invasive treatment intervention is being anticipated;

(2) Physical recovery sufficient to allow participation for a minimum of 4 hours a day for three to five days a week;

(3) Worker's current levels of functioning interfere with his/her ability to carry out specific tasks required in the work place;

(4) A defined return to work goal which includes:

- A documented specific job to which the patient can return, along with a specific job analysis; and
- A return to work goal agreed to by the employer and the patient/employee;
- The facts must show how the worker must be able to benefit from the program;
- The facts must show the worker is motivated to return to work. A worker whose primary limitation is psychological or clouded by significant illness behavior (i.e., significant self-imitation on F.C.E.) is typically not going to be motivated and will not likely benefit.

c. Criteria for discharge from a work hardening program:

- The worker has reached the goal stated in the plan;
- The worker has not progressed according to the program plan;
- The worker has not reached interim goals and is not benefitting from the program, or;
- Number of absences exceeds those allowed by the program (a maximum of two (2) absences is recommended);
- Worker does not adhere to the schedule;
- Completion of the program (the program should take 2 to 4 weeks to complete);
- The previously identified job is no longer available.

2. Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

~~F~~E. External spinal stimulators.

~~G~~F. ~~Physical medicine~~ Therapeutic treatments, exclusive of chiropractic treatments, after fifteen (15) visits or thirty (30) days, whichever comes first. If, however, the patient undergoes properly approved surgical intervention, he or she shall be entitled to one round of pre-surgical therapeutic treatment up to fifteen (15) treatments or thirty (30) days, whichever first occurs, as provided immediately above; and, in the discretion of the treating physician, to one additional round of therapeutic treatment following surgery for an additional period of fifteen (15) visits or thirty (30) days, whichever first occurs, both of which treatment rounds may be administered without the necessity for seeking pre-certification or pre-approval. The authorization contained herein for a first and second round of limited therapy treatment following surgery shall apply to all reasonable physical and/or occupational therapy treatments, but does not include chiropractic manipulative treatment which is addressed separately below.

G. Chiropractic manipulative treatments are allowed for up to fifteen (15) visits or thirty (30) days, whichever first occurs, without any need to seek pre-certification or authorization. However, chiropractic manipulative treatments which are proposed beyond the first fifteen (15) visits or thirty (30) days, under any circumstances, must be pre-certified or pre-approved.

Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated

or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medical necessary.

~~H. Home health.~~

~~I~~H. Psychiatric treatment, whether inpatient or outpatient treatment.

I. Retrospective review of services after they have been provided when properly requested by the patient, patient representative, or provider.

J. Any proposed treatment, procedure or service which is more specifically addressed in another section of this Fee Schedule, such as certain pain management procedures, shall be regulated first by the specific guidelines in place in those sections. These utilization review rules apply only where no other, more specific guidelines are set forth in the individual treatment sections of the Fee Schedule; or, where possible, to supplement more specific treatment guidelines spelled out elsewhere in the Fee Schedule.

II. DEFINITIONS

Case Management. The clinical and administrative process in which timely, individualized, and cost effective medical rehabilitation services are implemented, coordinated, and evaluated, by a nurse, ~~or~~ other case manager, or other utilization reviewer employed by the payer, on an ongoing basis for patients who have sustained an injury or illness. Use of case management is optional in Mississippi. Use Mississippi-specific code 9936M for a conference with workers' compensation medical case manager/claims manager.

Certification. A determination by a payer and/or its utilization review organization or agent that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the standard of medical necessity as defined elsewhere in this Fee Schedule.~~clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the requirements of the workers' compensation program.~~

Clinical Peer. A health professional that holds an unrestricted medical or equivalent license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

Clinical Rationale. A statement or other documentation that taken together provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the worker's condition or treatment plan, and ~~should supply~~ must include a detailed basis for denial or non-certification of the proposed treatment so as to give the provider or patient a sufficient basis for a decision to pursue an appeal. Clinical rationale must include specific reference to any applicable provisions of the *Mississippi Workers' Compensation Medical Fee Schedule* which allegedly support the determination of the reviewer, or a statement attesting to the fact that no such provision(s) exists in the Fee Schedule.

~~Clinical Review Criteria. The written screens, decision rules, medical protocols, or guidelines used by the payer's Utilization Management Program as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services.~~

Concurrent Review. Utilization management or review which is conducted during a worker's hospital stay or course of treatment, sometimes called continued stay review.

Discharge Planning. The process of assessing a patient's need for medically appropriate treatment after hospitalization ~~and affecting an~~ including plans for an appropriate and timely discharge.

Expedited Appeal. An expedited appeal is a request ~~for additional review of~~ to reconsider a prior determination not to certify imminent or ongoing services, an admission, an extension of stay, or other medical services of an emergency, imminent, or ongoing nature. Also sometimes referred to as a reconsideration request.

First Level Clinical Review. Review conducted by a registered nurse~~s~~, nurse case manager, or ~~and~~ other appropriate licensed or certified health professional~~s~~. First level clinical review staff may approve requests for admissions, procedures, and services that meet the standard of medical necessity as defined elsewhere in the Fee Schedule~~clinical review criteria~~, but must refer requests that do not meet this medical necessity standard, in their opinion, ~~clinical review criteria~~ to second level clinical peer reviewers for approval or denial.

Notification. Correspondence transmitted by mail, telephone, facsimile, email, and/or ~~electronic data interchange (EDI)~~other reliable electronic means.

Pre-certification. The review and assessment ~~of medical necessity and appropriateness~~ of proposed medical treatment or services before they occur to determine if such treatment or services meet the definition of medical necessity as set forth elsewhere in this Fee Schedule. The appropriateness of the site or level of care is assessed along with the duration and timing of the proposed services.

Provider. A licensed health care facility, program, agency, or health professional that delivers health care services.

Retrospective Review. Utilization review conducted after services have been provided to the worker.

Second Level Clinical Review. ~~Clinical~~ Peer review conducted by appropriate clinical peers when the First Level Clinical Reviewer is unable to determine whether a request for an admission, procedure, or service ~~does not meet clinical review criteria.~~satisfies the standard of medical necessity as defined elsewhere in this Fee Schedule. A decision to deny, or not certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty or sub-specialty as the requesting provider.

Standard Appeal. A request ~~to review~~ by or on behalf of the patient or provider to reconsider a prior decision by the payer or its utilization review agent to deny proposed medical treatment or service, including but not limited to, a determination not to certify an admission, extension of stay, or other health care service.

Third Level Clinical Review. ~~Clinical~~ Medical necessity review conducted by appropriate clinical peers who were not involved in the first or second level review when a decision not to certify a requested admission, procedure, or service has been appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider. A decision to deny, or not certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty or sub-specialty as the requesting provider.

Utilization Review. Evaluation of the medical necessity~~,~~ and appropriateness~~, and efficiency for the use~~ of proposed health care services. It includes both prospective and concurrent review, and ~~may~~ shall include retrospective review under certain circumstances.

Utilization Reviewer. An entity, organization, or representative thereof, or other person performing utilization review activities or services on behalf of an employer, payer or third-party claims administrator.

Variance. A deviation from a specific standard.

III. STANDARDS

Payers and their ~~U~~utilization review organizations or programs or agents are required to meet the following standards:

A. The payer's utilization reviewer or agent must comply with the licensing and certification requirements of MCA §41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and shall have utilization review personnel, agents or representatives who are properly qualified, trained, supervised, and supported by explicit clinical review criteria and review procedures. In no event shall proposed treatment or services be denied except in accordance with the express provisions stated elsewhere in these Rules and in accordance with MCA §41-83-31 (Rev. 2009).

B. The first level review is performed if the claims adjuster or manager has not already approved the treatment in question, and is performed by individuals who are health care professionals, who possess a current and valid professional license, and who have been trained in the principles and procedures of utilization review.

C. The first level reviewers are required to be supported by a doctor of medicine who has an unrestricted license to practice medicine, and in cases where treatment is being denied or withheld by a utilization reviewer, this determination must be supported in writing by a physician licensed in Mississippi and trained in the relevant specialty or sub-specialty, as previously set forth in these Rules.

D. The second and third level review is performed by clinical peers who hold a current, unrestricted Mississippi license to practice in the same or like specialty as the treating physician whose recommendation is under review, and are oriented in the principles and procedures of utilization review. The second level review shall be conducted for all cases where a clinical determination to certify has not already been made by the payer or payer's agent, and the determination of medical necessity cannot be made by first level clinical reviewers. Second and third level clinical reviewers shall be available within one (1) business day by telephone or other electronic means to discuss the determination with the attending physicians or other ordering providers. In the event more information is required before a determination can be rendered by a second or third level reviewer, the attending/ordering provider must be notified immediately of the delay and given a specific time frame for determination, and a specific explanation of the additional information needed. A requesting provider shall not be required to participate in further discussions where the payer or its agents have unilaterally scheduled such a conference. Further, a request for treatment or service may not be denied solely on grounds the requesting provider fails to participate in a conference which has been unilaterally scheduled by the payer or their agent. Follow-up conferences must be arranged by joint agreement.

E. The payer's utilization reviewer shall ~~conduct third level reviews by requiring peers who serve in this capacity to hold a current, unrestricted license and be board certified in a specialty board approved by the American Board of Medical Specialties. Board certification requirement is not applicable to reviewers who are not doctors of medicine. Third level clinical reviewers shall be in the same profession or similar specialty as typically manages the medical condition, procedure, or treatment under review.~~maintain all licensing applications, certificates, and other supporting information, including any and all reports, data, studies, etc., along with written policies and procedures for the effective management of its utilization review activities, which shall be made available to the provider, or the Commission, upon request.

~~F. The payer's utilization reviewer shall maintain written policies and procedures for the effective management of its utilization review activities, which shall be made available to the provider, or the Commission, upon request.~~

~~G~~F. The payer maintains the responsibility for the oversight of the delegated functions if the payer delegates utilization review responsibility to a vendor. The vendor or organization to which the function is being delegated must be currently certified by the Mississippi Board of Health, Division of Licensure and Certification to perform utilization management in the State of Mississippi. A copy of the license or certification held by the utilization review agent shall be furnished to the provider, or to the Commission, upon request. The payer who has another entity perform utilization review functions or activities on its behalf maintains full responsibility for compliance with the rules.

~~H~~G. The payer's utilization reviewer shall maintain a telephone review service that provides access to its review staff at a toll free number from at least 9:00 a.m. to 5:00 p.m. CST each normal business day. There should be an established procedure for receiving or redirecting calls after hours or receiving faxed requests. Reviews should be conducted during hospitals' and health professionals' reasonable and normal business hours.

~~I~~H. The payer's utilization reviewer shall collect only the information necessary to certify the admission procedure or treatment, length of stay, frequency, and duration of services. The utilization reviewer should have a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments to avoid duplicate requests to providers. (Providers may use the Mississippi Workers' Compensation Commission Utilization Review Request Form.)

IV. PROCEDURES FOR REVIEW DETERMINATIONS

The following procedures are required for effective review determination.

A. Initial ~~R~~review determinations must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. The Mississippi Workers' Compensation Utilization Review Request Form may be used to request pre-certification.

B. When an initial determination is made to certify, notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written or electronic notification to the provider or facility rendering the service. If an initial determination to certify is provided by telephone, a written notification of the determination shall be provided within two (2) business days thereafter. The written notification shall include the number of days approved, the new total number of days or services approved, and the date of admission or onset of services.

C. When a determination is made not to certify, ~~notify~~ notification to the attending or ordering provider or facility must be provided by telephone or electronic means within one (1) business day followed by ~~and send~~ a written notification within one (1) business day thereafter. The written notification must include the principal reason/clinical rationale for the determination not to certify, including specific reference to any provision of this Fee Schedule relied upon by the reviewer, and instructions for initiating an appeal and/or reconsideration request. ~~Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.~~

D. The payer~~'s utilization reviewer~~ or its review agent shall inform the attending physician and/or other ordering provider of their right to initiate an expedited appeal in cases involving emergency or imminent care or admission, or a standard appeal, as the case may permit, of a determination not to certify, and the procedure to do so.

1. Expedited appeal—When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring imminent or expedited review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone or by electronic mail or facsimile on an expedited basis within one (1) business day.

    a. Each private review agent shall provide for prompt and expeditious ~~reasonable~~ access to its consulting physician(s) for such appeals.

    b. Both providers of care and private review agents should attempt to share the maximum information by phone, fax, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.

    c. Expedited appeals, which do not resolve a difference of opinion, may be resubmitted through the standard appeal process, or submitted directly to the Commission's Medical Cost Containment Division as a Request for Resolution of Dispute. A disagreement warranting expedited review or reconsideration does not have to be resubmitted to the payer or utilization review agent through the standard appeal process unless the requesting provider so wishes.

2. Standard appeal—A standard appeal will be considered as a request for reconsideration, and notification of the appeal decision given to the provider, not later than twenty (20) calendar days after receiving the required documentation for the appeal.

    a. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify treatment or services must ~~should~~ be provided the clinical rationale for the determination along with the notification of the appeal decision.~~upon request.~~

3. Retrospective review—~~F~~For retrospective review, the review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided. Retrospective review is not optional or conducted solely at the discretion of the review agent. A request for review and approval of services already provided must be handled by the payer or its utilization reviewer in the same manner any other request for approval of services is handled.

    a. When there is retrospective determination not to certify an admission, stay, or other service, the attending physician or other ordering provider and hospital or facility shall receive written notification, or notification by facsimile or electronic mail, within twenty (20) calendar days after receiving the request for retrospective review and all necessary and supporting documentation.

    b. Notification should include the principal reasons for the determination and a statement of the procedure ~~method~~ for standard appeal if the determination is adverse to the patient.

4. Emergency admissions or surgical procedures—Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review ~~will~~ may be initiated.

    a. If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.

b. To overcome a prima facie case for emergency admission as established above, the utilization reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.

E. Failure of the health care provider to provide necessary information for review, after being specifically requested to do so by the payer or its review agent in detail, may result in denial of certification and/or reimbursement.

F. When a payer and provider have completed the utilization review appeals process and cannot agree on a resolution to a dispute, either party, or the patient, can appeal to the Cost Containment Division of the Mississippi Workers' Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a utilization review dispute should be filed with the Commission within twenty (20) calendar days following the conclusion of the underlying appeal process provided by the payer or its utilization reviewer. The Commission shall consider and decide a request for resolution of a utilization review dispute in accordance with the Dispute Resolution Rules provided elsewhere in this Fee Schedule.

G. Failure ~~by the utilization reviewer~~ of a payer or its utilization review agent to timely notify the provider of a decision whether to certify or approve an admission, procedure, service or other treatment shall be deemed to constitute approval by the payer of the requested treatment, and shall obligate the payer to reimburse the provider in accordance with other applicable provisions of this Fee Schedule should the provider elect to proceed with the proposed treatment or service. Timely notification means notification by mail, facsimile, electronic mail, or telephone, followed by written notification, to the provider, within the applicable time periods set forth in these Utilization Review Rules.

H. Upon request of the provider, or the Commission, a payer and/or the review agent~~utilization reviewer~~ must furnish a copy of the license or certification obtained from the State Department of Health, along with all supporting documentation, reports, data, studies, etc., which authorizes the reviewer to engage in utilization review activities in the State of Mississippi. The Commission may, likewise, obtain this information unilaterally from the Mississippi Department of Health pursuant to an agreement with that Agency.

I. Upon a finding by the Commission or an Administrative Judge that a payer ~~or the payer's utilization reviewer~~, and/or their review agent, has ~~failed without reasonable grounds to comply with the time requirements of these rules~~unreasonably delayed a claim without reasonable grounds within the meaning of §71-3-59 of the Law, penalties pursuant to MCA §71-3-59 (Rev. 2000) may be assessed against the payer.

Any payer electing to obtain an Employer Medical Evaluation (EME) pursuant to MCA §71-3-15(1) must do so without unreasonable delay. With respect to an EME sought after the filing of a motion to compel medical treatment by a claimant, failure by the payer to obtain and submit the EME report to the claimant and the Commission within 45 days of the claimant's filing of a motion to compel may be deemed an unreasonable delay. Counsel for both parties may agree to extend the forty-five-day (45-day) limitation, or the Administrative Judge may extend the forty-five-day (45-day) limitation at his or her discretion. The forty-five-day (45-day) limitation does not apply to experts selected by the agreement of both parties to render a second opinion. If an Administrative Judge or the Commission finds that a payer has demonstrated unreasonable delay in seeking or obtaining an EME, regardless of whether a motion to compel medical treatment has been filed, such a finding may result in the imposition of penalties and/or attorney's fees or expenses pursuant to MCA §71-3-59 and/or waiver of the payer's right to an EME.

J. Regardless of the outcome of a dispute arising hereunder regarding certification or approval of a proposed treatment or service, in no event shall the injured worker/patient be held liable for the payment of any portion of a bill related thereto. As provided in §71-3-15(1) of the Law, any dispute over the amount due a medical provider for any reason shall be resolved between the payer and provider, with

each holding the claimant harmless from payment of same, regardless of whether the treatment has been provided inside or outside the State of Mississippi.

K. Nothing provided herein shall estop or prevent the patient from obtaining legal counsel and/or seeking relief in the form of a request to compel medical treatment before an Administrative Judge.

Rules for Modifiers and Code Exceptions

Please see the modifier rules in each section of the *Mississippi Workers' Compensation Medical Fee Schedule* for a complete listing of appropriate modifiers for each area.

A. Modifiers ~~codes~~ must be used by providers to identify procedures or services that are modified due to specific circumstances.

B. When modifier 22 is used to report an increased service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing. When appropriate, the *Mississippi Workers' Compensation Medical Fee Schedule* reimbursement for modifier 22 is one hundred twenty percent (120%) of the maximum reimbursement allowance.

C. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for a modified service or procedure is based on documentation of medical necessity and determined on a case-by-case basis.

D. Modifiers allow health care providers to indicate that a service was altered in some way from the stated description without actually changing the definition of the service.

I. MODIFIERS FOR CPT® (HCPCS LEVEL I) CODES

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow.

This section contains a list of modifiers used with CPT codes. Also consult each practice-area section of the Fee Schedule for additional modifiers.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a ~~physician~~ professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

~~Mississippi's note~~Mississippi guideline: The technical component is calculated by subtracting the ~~professional component~~ PC ~~a~~Amount from the ~~total a~~Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures ~~00100-01999~~.

Mississippi guideline~~Mississippi's note~~: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same ~~operative~~ session, should be identified by adding modifier 50 to the appropriate 5 ~~five-~~digit code.

51 Multiple Procedures

When multiple procedures, other than E/M Services, ~~p~~Physical ~~m~~Medicine and ~~r~~Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same ~~provider~~individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see ~~the applicable CPT book a~~Appendix D).

~~Mississippi's note~~Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the ~~applicable CPT book~~Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When ~~one~~ 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When ~~one~~1 physician or other qualified health care professional performed the postoperative management and another ~~physician~~ performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When ~~one~~1 physician or other qualified health care professional performed the preoperative care and evaluation and another ~~physician~~ performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated ~~prospectively at the time of the original procedure~~ (staged); b) more extensive than the original procedure; or c) for therapy following a ~~diagnostic~~ surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating~~/ or~~ procedure room, (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures~~/ or~~ services other than E/M services that are not normally reported together, but are appropriate under the circumstances. ~~This may represent~~ Documentation must support a different session~~ or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same ~~physician~~individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) ~~is~~are performed during the same surgical session, ~~a~~ separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those service~~s(s)~~ may be reported using ~~a~~ separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating ~~physician~~ individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure~~/~~ or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

~~The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.~~It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this ~~subsequent~~ procedure is related to the first, and requires the use of ~~the~~an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures ~~on the same day~~, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The ~~physician~~ individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

~~Mississippi's note~~Mississippi guideline: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

~~Mississippi's note~~Mississippi guideline: Physician reimbursement is ten percent (10%) of the maximum reimbursement allowance~~allowable~~.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe~~s~~ a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for ~~a~~ laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require permanent dedicated space; hence by its design ~~it~~ may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances ~~two~~2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA ~~Anesthesiologist~~ Anesthesia Services Performed Personally by ~~an~~ Anesthesiologist

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than ~~Four~~ 4 Concurrent Anesthesia Procedures

Report modifier AD when the anesthesiologist supervises more than ~~four~~4 concurrent anesthesia procedures.

AS Assistant at Surgery Services Provided by Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery

Assistant at surgery services provided by a another qualified individual (e.g., physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant) registered nurse first assistant or other qualified individual (excluding assistant at surgery services provided by a physician) and not another physician are identified by adding modifier AS to the listed applicable surgical procedures. The use of the Modifier AS modifier may be appended to is appropriate for any code identified that otherwise is reimbursable for a physician assisting a surgeon in the operating roomas appropriate for surgical assistance in this Fee Schedule.

Mississippi's noteMississippi guideline: AS reimbursement is ten percent (10%) of the allowablemaximum reimbursement allowance. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

NPM1 Nurse Practitioner (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a nurse practitioner.

PAM2 Physician Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a physician assistant.

PTM3 Physical or Occupational Therapist Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by either a physical therapist assistant or an occupational therapist assistant.

CAM4 CARF Accredited (Mississippi Modifier)

This modifier should be used in conjunction with CPT code 97799 Unlisted physical medicine/rehabilitation service or procedure, to indicate chronic pain treatment being administered by a CARF accredited provider as part of a pre-approved interdisciplinary pain rehabilitation program.

CPM5 Chronic Pain Treatment (Mississippi Modifier)

This modifier should be used only in conjunction with CPT code 97799 Unlisted physical medicine/rehabilitation service or procedure, to indicate chronic pain treatment being administered as part of a pre-approved interdisciplinary pain rehabilitation program.

QK Medical Direction of Two, Three, or Four 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals (CRNA) by an Anesthesiologist

Report modifier QK when the anesthesiologist supervises two, three, or four2, 3, or 4 concurrent anesthesia procedures involving qualified individuals (CRNA or AA).

QX Qualified Non-Physician Anesthetist CRNA Service: with Medical Direction by an Anesthesiologista Physician

Regional or general anesthesia provided by the CRNA or AA a qualified non-physician anesthetist with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) Qualified Non-Physician Anesthetist by an Anesthesiologist

Report modifier QY when the anesthesiologist supervises one CRNA or AAqualified non-physician anesthetist.

QZ CRNA Service without Medical Direction by ~~an Anesthesiologist~~a Physician

Regional or general anesthesia provided by the CRNA (certified registered nurse anesthetist) or AA (anesthesiologist assistant) without medical direction by a physician may be reported by adding modifier QZ.

II. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE

This section contains a list of modifiers used with ambulatory surgery center and hospital-based outpatient services. Also consult each practice-area section of the Fee Schedule for additional modifiers.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same ~~operative~~ session, should be identified by adding modifier 50 to the appropriate ~~five~~5 digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52,

signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated ~~prospectively at the time of the original procedure~~ (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/~~ or~~ procedure room~~,~~ (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/~~ or~~ services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session~~ or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated ~~subsequent to the original procedure or service.~~by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure~~/~~ or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

~~The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.~~It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this ~~subsequent~~ procedure is related to the first, and requires the use of ~~the~~ an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures ~~on the same day~~, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The ~~physician~~ individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

III. MODIFIERS FOR HCPCS LEVEL II CODES

This section contains a list of commonly used modifiers with HCPCS Level II DME codes. Other HCPCS Level II modifiers, including those which can be used with CPT codes, are acceptable modifiers.

AU Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply

AV Item Furnished in Conjunction with a Prosthetic Device, Prosthetic, or Orthotic

AW Item Furnished in Conjunction with a Surgical Dressing

KC Replacement of Special Power Wheelchair Interface

NU ~~Purchased n~~New Equipment

RR Rental ~~equipment (listed amount is the per-month allowance)~~(use the RR modifier when DME is to be rented)

Mississippi guideline: Listed amount is the per month allowance.

UE ~~Purchased u~~Used Durable Medical Equipment

Mississippi guideline: Used to report the purchase of used durable medical equipment.

IV. CODE EXCEPTIONS

A. **Unlisted Procedure Codes.** If a procedure is performed that is not listed in the ~~Medical~~ Fee Schedule, the provider must bill with the appropriate "Unlisted Procedure" code and submit a narrative report to the payer explaining why it was medically necessary to use an unlisted procedure code.

The CPT book contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed by report (see below).

B. **By Report (BR) Codes.** By report (BR) codes are used by payers to determine the reimbursement for a service or procedure performed by the provider that does not have an established maximum reimbursement allowance (MRA).

1. Reimbursement for procedure codes listed as "BR" must be determined by the payer based on documentation submitted by the provider in a special report attached to the claim form. The required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:
    a. A complete description of the actual procedure or service performed;
    b. The amount of time necessary to complete the procedure or service performed;
    c. Accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.
2. Reimbursement of "BR" procedures should be based on the usual and customary rate.

C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in the CPT book ~~*CPT 2010*~~. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory services. These codes do not have an associated relative value or fee.

D. **Category III Codes.** This Fee Schedule does not include Category III codes published in ~~*CPT 2010*~~the CPT book. If a provider bills a Category III code, payment may be denied.

E. **Add-On Codes.** ~~Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with a + symbol, and are listed in the applicable CPT book. Add-on codes can be readily identified by specific descriptor nomenclature which includes phrases such as "each additional" or "(List separately in addition to code for primary procedure)."~~

~~The "add-on" code concept in the CPT book applies only to add-on procedures/services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure (eg, additional digit(s), lesion(s) neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)).~~The CPT book identifies procedures that are always performed in addition to the primary procedure and designates them with a + symbol. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician or other qualified health care provider that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesions(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)).

Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Add-on codes are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's charge, whichever is less.

Refer to the most current version of the CPT book for a complete list of add-on codes.

F. **Codes Exempt From Modifier 51.** ~~Certain codes are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures/services. Please consult the most current CPT book for the list of codes that are exempt from modifier 51. Codes designated as exempt from modifier 51 are identified with a * symbol, and are listed in the most current CPT book.~~This symbol ⃠ denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book. Modifier 51 exempt services and procedures can be found in Appendix E of CPT 2013. Additional codes that should not be subject to modifier 51 have been identified by Optum based upon CPT guidelines and are included in this Fee Schedule using the same CPT icon.

~~All codes exempt from modifier 51 found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section).~~ Codes exempt from modifier 51 are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's ~~usual~~ charge, whichever is less.

G. **Moderate (Conscious) Sedation.** To report moderate (conscious) sedation provided by the physician also performing the diagnostic or therapeutic service for which conscious sedation is being provided, see codes 99143–99145. It is not appropriate for the physician performing the sedation and the service for which the conscious sedation is being provided to report the sedation separately when the code is listed with the conscious sedation symbol ⊙. The conscious sedation symbol identifies services that include moderate (conscious) sedation. A list of codes for services that include moderate (conscious) sedation is also included in the most current CPT book.

For procedures listed with ⊙, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service using codes

99148–99150. ~~Moderate (conscious) sedation services are not reported additionally when performed by the second physician in the non-facility setting (e.g., physician office, freestanding imaging center).~~

Moderate sedation codes are not used to report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.

Pharmacy Rules

I. SCOPE

This section provides specific rules for the dispensing of and payment for medications and other pharmacy services prescribed to treat work-related injury/illness under the terms of the Act.

II. DEFINITIONS

A. **Medications** are defined as drugs prescribed by a licensed health care provider and include name brand and generic drugs as well as patented or over-the-counter drugs, compound drugs and physician-dispensed or repackaged drugs.

B. **Average Wholesale Price** means the AWP based on the most current edition of the *Drug Topics Red Book* in effect at the time the medication is dispensed.

III. RULES

A. Generic Equivalent Drug Products. Unless otherwise specified by the ordering physician, all prescriptions will be filled under the generic name.

When the physician writes "brand medically necessary" on the prescription, the pharmacist will fill the order with the brand name. When taking telephone orders, the pharmacist will assume the generic brand is to be used unless "brand medically necessary" is specifically ordered by the treating physician. Without exception, the treating physician has the authority to order a brand name medication if he/she feels the trademark drug is substantially more effective.

B. A payer or provider may not prohibit or limit any person from selecting a pharmacy or pharmacist of his/her choice, and may not require any person to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or program, or to obtain medication dispensed by the physician or in the physician's office, provided the pharmacy or pharmacist selected by the claimant has agreed to be bound by the terms of the Workers' Compensation Law and this Fee Schedule with regard to the provision of services and the billing and payment therefor.

C. Dietary supplements, including but not limited to minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established as related to the work injury.

D. Not more than one dispensing fee shall be paid per drug within a ten (10) day period.

IV. REIMBURSEMENT

A. Reimbursement for pharmaceuticals ordered for the treatment of work-related injury/illness is as follows:

1. Brand/Trade Name Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
2. Generic Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
3. Over-the-counter medications are reimbursed at usual and customary rates.
4. Dispensing fees are payable only if the prescription is filled under the direct supervision of a registered pharmacist. If a physician dispenses medications from his/her office, a dispensing fee is not allowed.
5. Repackaged and/or Physician Dispensed Medication: If the National Drug Code (NDC) for the drug product as dispensed is a repackaged drug, the maximum allowable fee shall be the lesser of AWP using a) the NDC for the underlying drug product from the original labeler, or b) the therapeutic equivalent drug product from the original labeler NDC.

   For purposes of this provision, "therapeutically equivalent drugs" means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter "A" in the Food and Drug Administration's publication "Approved Drug Products with Therapeutic Equivalence Evaluations" (Orange Book). The Orange Book may be accessed through the Food and Drug Administration website at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm.

   National Drug Code "for the underlying drug product from the original labeler" means the NDC of the drug product actually utilized by the repackager in producing the repackaged product.
6. Compound Medications: Compound drugs or medications shall be billed by listing each drug and its NDC number included in the compound and calculating the charge for each drug separately. Payment shall be based on the sum of the fee for each ingredient, plus a single dispensing fee of five dollars ($5.00). If the NDC for any ingredient is a repackaged drug, reimbursement for the repackaged ingredient(s) shall be as above provided. Reimbursement for a compound cream medication is limited to a maximum total reimbursement of three hundred dollars ($300.00) for one hundred twenty (120) grams per month. Any additional quantity over and above this one hundred twenty (120) gram limit requires further documentation and prior authorization (pre-certification).
7. If information pertaining to the original labeler of the underlying drug product used in repackaged or compound medications is not provided or is otherwise unknown or unavailable, the payer shall reimburse using the lowest priced generic therapeutic equivalent drug product.

B. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule. Supplies and equipment not listed in the Fee Schedule will be reimbursed at the usual and customary rate.

C. Mail-order pharmaceutical services are subject to the rules and reimbursement limitations of this Fee Schedule when supplying medications to Mississippi Workers' Compensation claimants.

~~Nurse Practitioner, Physician Assistant, and Physical or Occupational Therapist Assistant~~Other Qualified Health Care Professional Rules

I. **Nurse Practitioner**

A. Modifier ~~NP~~M1 should be attached to the appropriate CPT® code when billing services rendered by the nurse practitioner. The nurse practitioner must use his/her unique identifier to bill for all services. Nurse practitioners must comply with the requirements for a National Provider Identifier (NPI) as specified in the Billing and Reimbursement Rules of this Fee Schedule.

~~II.~~ B. The nurse practitioner is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.

~~III.~~ C. There is only one fee allowed for each CPT code. It is the decision of the physician or the nurse practitioner as to who will bill for a service when both have shared in the provision of the service. Incorrect billing of the service may cause a delay or improper payment by the payer. ~~The payer will reimburse the bill which is received first.~~ The medical doctor (MD) must be on-site on the date of service in order for physician reimbursement to apply.

~~IV~~II **Physician Assistant**

A. Modifier M2 should be attached to the appropriate CPT code(s) when billing services rendered by the physician assistant.

B. The physician assistant ~~shall be~~ is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.~~at the same rate as for the nurse practitioner, and t~~

C. The same rules as apply to the nurse practitioners with regard to billing and reimbursement, shall apply to the physician assistant.

~~VIII~~.~~Modifier PA should be attached to the appropriate CPT code when billing services rendered by the physician assistant.~~**Physical Therapist Assistant or Occupational Therapist Assistant**

A. Modifier M3 should be attached to the appropriate CPT code(s) when billing services rendered by a physical therapist assistant or an occupational therapist assistant.

B. The physical therapist assistant or occupational therapist assistant ~~shall be~~ is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure. ~~Modifier PT should be attached to the appropriate CPT code(s) when billing services rendered by a physical therapist assistant or an occupational therapist assistant.~~

IV. **Psychology**

When a provider other than a psychiatrist provides psychology services, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, counselors, etc.

Home Health Rules

I. SCOPE

This section of the Fee Schedule pertains to home health services provided to patients who have a work-related injury/illness.

A. The determination that the injury/illness or condition is work related must be made by the payer and home health services shall be pre-certified as medically necessary by the payer's Utilization Management Program.

B. All nursing services and personal care services shall have prior authorization by the payer.

C. A description of needed nursing or other attendant care must accompany the request for authorization.

II. REIMBURSEMENT

A. If a payer and provider have a mutually agreed upon contractual arrangement governing the payment for home health services to injured/ill employees, the payer shall reimburse under the contractual agreement and not according to the Fee Schedule.

B. In the absence of a mutually agreed upon contractual arrangement governing payment for home health service, reimbursement shall be made as in other cases (see Billing and Reimbursement Rules) in an amount equal to billed charges, or the maximum reimbursement allowance (MRA), whichever is less. Billing for home health services is appropriate using the applicable billing form for other institutional providers or facilities.

C. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.

D. A visit is defined as time up to and including the first two hours.

E. The maximum reimbursement allowances (MRA) ~~rates~~ listed herein are inclusive of mileage and other incidental travel expenses, unless otherwise agreed to by the payer and provider.

F. The hourly rates set forth in this section of the Fee Schedule apply to all hours worked. No additional reimbursement is allowed for overtime hours, unless otherwise agreed to by the parties in a separate fee contract.

III. RATES

A. The following ~~rates~~ MRAs and codes apply to services provided by or through a home health agency:

Service	Fee Per Visit	Billing Code
Skilled Nursing Care	$110.00	G0154
Physical Therapy	$120.00	G0151
Speech Therapy	$125.00	G0153
Occupational Therapy	$125.00	G0152
Medical Social Services	$125.00	G0155
Home Health Aide	$60.00	G0156

For services that exceed two (2) hours, reimbursement for time in excess of the first two (2) hours shall be pro-rated and based on an hourly rate equal to fifty percent (50%) of the above visit fee. For home health services rendered in two (2) hours or less, reimbursement shall be made for a visit as above provided.

Note: In addition to the Skilled Nursing Care fees above, an additional sum of seven dollars and sixteen cents ($7.16) per visit shall be added to cover the cost of medical supplies, provided the billing form adequately specifies what supplies were utilized.

B. The following Private Duty Rates shall apply:

Skilled Nursing Care – R.N.	$44.00 per hour
Skilled Nursing Care – L.P.N.	$37.00 per hour
Certified Nurse Assistant	$20.00 per hour
Sitter/Attendant	~~$13~~15.00 per hour

C. Any reimbursement to persons not working under a professional license, such as a spouse or relative, will be at the rate of eight dollars ($8.00) per hour unless otherwise negotiated by the payer and caregiver or provider.

D. Professional providers not assigned a ~~maximum allowable rate~~ MRA for home health services and who have not negotiated their rates with the payer prior to provision of home health care, shall be reimbursed at the usual and customary rate, or the total billed charge, whichever is less.

IV. PARENTERAL/ENTERAL THERAPY IN THE HOME SETTING

A. The MRA for this therapy provided in the home setting is a per diem amount and includes necessary supplies for the safe and effective administration of the prescribed therapy. Supplies include set(s), needles, syringes, saline, tubing, dressing kits, saline, heparin, alcohol pads, start kits, catheters, adapters, tape, gauges, pump, poles, and other supplies.

B. Per diem amounts are as follows:

Parenteral therapy (with or without antibiotics)	Daily – $ 165.00
	Twice a day – $ 190.00
	Three times a day – $ 215.00
	Four times a day – $ 265.00
	5 or more times a day – $ 335.00
Total Parental Nutrition (TPN):	1-1.6 Liters per day – $280.00
	1.7-2.4 Liters per day – $350.00
	More than 2.4 liters per day – $385.00
LIPIDS:	10% – $75.00
	20% – $95.00
Enteral Therapy:	$24.00 per day

C. Medications for Parenteral/Enteral Therapy are reimbursed at AWP.

Skilled Nursing Facility Rules

I. **Reimbursement**

The maximum reimbursement ~~amount~~ allowance for medical care provided within the confines of a freestanding skilled nursing facility, a hospital based skilled nursing facility, or a swing bed facility, shall be ~~three~~four hundred dollars (~~$300.00~~$400.00) per day. This rate covers and includes all routine and ancillary health care services provided to a claimant during each day of a covered skilled nursing facility stay.

II. **Excluded Services**

The following services are excluded from the daily skilled nursing facility rate, and shall be reimbursed separately and in addition to the above daily rate:

~~cardiac catheterization; angiography; magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans; radiation therapy and chemotherapy; emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in~~

- Cardiac catheterization
- Angiography
- Magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans
- Radiation therapy and chemotherapy
- Emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in:
  - (a) serious impairment of bodily function(s)
  - (b) serious or permanent dysfunction of any bodily organ or part or system
  - (c) permanently placing the person's health in jeopardy, or
  - (d) other serious medical consequence
- Outpatient services when provided in a hospital or other free standing outpatient facility separate from the skilled nursing facility
- Customized prosthetic services
- Ambulance transportation related to any of the above services
- Services provided independent of the facility by physicians, and other ~~medical practitioners~~ qualified health care professionals (e.g., NP, PA, CRNA, psychologist).

III. **Exclusions**

As in other cases, the above provisions shall not apply to any mutual agreement or contract entered into by the payer and provider which sets forth the terms for the provision of skilled nursing facility services and reimbursement therefor.

Evaluation and Management

This section contains rules and codes used to report evaluation and management (E/M) services. Rules and Guidelines follow the current CPT® Guidelines as stated.

Note: Rules used by all physicians in reporting their services are presented in the General Rules section.

I. DEFINITIONS AND RULES

Definitions and rules pertaining to ~~evaluation and management~~E/M services are as follows:

A. **Consultations.** The CPT book defines a consultation as "a type of evaluation and management service provided ~~by a~~ at the request of another physician ~~whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician~~ or ~~other~~ appropriate source~~."~~ to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem." (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

In order to qualify as a consultation the following criteria must be met:

- The verbal or written request for a consult must be documented in the patient's medical record;
- The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record;
- The consulting physician must provide a written report to the requesting physician or other appropriate source.

A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation codes 99241–99245 for office or other outpatient consultations and 99251–99255 for inpatient consultations, with modifier 32 appended to indicate a mandated service.

Evaluation and management consultation services will continue to be reported with CPT codes 99241–99245 for outpatient consultation services and codes 99251–99255 for inpatient consultation services. The rules and guidelines regarding the definition, documentation, and reporting of consultation services as contained in the CPT book will apply unless superseded by these guidelines. Consultation services will be reimbursed at the lesser of the ~~*Mississippi Worker's Compensation Medical*~~ Fee Schedule amount or the billed amount.

B. **Referral.** Subject to the definition of "consultation" provided in this Fee Schedule, a referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in the ~~E/M~~Evaluation and Management ~~services~~section).

C. **New and Established Patient Service.** Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

- *New Patient.* A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, for this same injury or within the past three years.
- *Established Patient.* An established patient is a patient who has been treated for the same injury by any physician, of the same specialty, who belongs to the same group practice.

D. **E/M Service Components.** The first three components of history, examination, and medical decision making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation or consultation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.

1. The history component is categorized by four levels:
   a. *Problem Focused.* Chief complaint; brief history of present illness or problem.
   b. *Expanded Problem Focused.* Chief complaint; brief history of present illness; problem-pertinent system review.
   c. *Detailed.* Chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems.
   d. *Comprehensive.* Chief complaint; extended history of present illness; review of systems that ~~are~~is directly related to the problem(s) identified in the history of the present illness, plus a review of all additional body systems; **complete** past, family, and social history.
2. The physical exam component is similarly divided into four levels of complexity:
   a. *Problem Focused.* ~~An exam limited to~~ A limited examination of the affected body area or organ system.
   b. *Expanded Problem Focused.* A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
   c. *Detailed.* An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
   d. *Comprehensive.* A general multi-system examination or a complete examination of a single organ system.

   The CPT book identifies the following body areas:

   - Head, including the face
   - Neck
   - Chest, including breasts and axilla~~e~~
   - Abdomen
   - Genitalia, groin, buttocks

- Back
- Each extremity

The CPT book identifies the following organ systems:

- ~~Constitutional symptoms (fevers, weight loss, etc.)~~
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

3. Medical decision making is the final piece of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:
    a. The number of possible diagnoses and/or the number of management options ~~to~~ that must be considered.
    b. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be ~~retrieved~~obtained, reviewed, and analyzed.
    c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

E. **Contributory Components.**

1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than fifty percent (50%) of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:
    a. Diagnostic results, impressions, and/or recommended diagnostic studies;
    b. Prognosis;
    c. Risks and benefits of management (treatment) options;
    d. Instructions for management (treatment) and/or follow-up;
    e. Importance of compliance with chosen management (treatment) options;
    f. Risk factor reduction;
    g. Patient and family education.

2. E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient and/or family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.

F. **Interpretation of Diagnostic Studies in the Emergency Room**

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.
2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.
3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.
4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

   Example: In many emergency departments (EDs), an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiologist reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.
5. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

II. GENERAL GUIDELINES

The E/M ~~code~~ section is divided into ~~subsections by type and place of service~~broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.
- Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.

III. OFFICE OR OTHER OUTPATIENT SERVICES (99201–99215)

Use the Office or Other Outpatient Services codes to report ~~the~~ evaluation and management services ~~for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary and include documentation to support medical necessity.~~provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

IV. HOSPITAL OBSERVATION SERVICES (99217–9922~~0~~6)

CPT codes 99217 through 9922~~0~~6 report E/M services provided to patients designated/~~ or~~ admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital~~ to use these codes however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used~~.

~~The instructional notes for Initial Hospital Observation Care include the following:~~

~~A. Use these codes to report the encounters by the supervising physician when the patient is designated as "observation status."~~

~~B. These codes include initiation of "observation status," supervision of the health care plan for observation, and performance of periodic reassessments.~~

~~C. When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for post-recovery of a procedure that is considered a global surgical service.~~

~~D. Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is admitted to the hospital on the same date. The observation service is not reported separately.~~

~~E. Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.~~

~~F. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported separately with the appropriate Initial Hospital Care code 99221–99223.~~

~~G. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234–99236.~~

~~See Office and Other Outpatient Consultation codes to report observation encounters by other physicians.~~

V. OBSERVATION CARE DISCHARGE SERVICES (99217)

A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

B. If a patient is admitted to and subsequently discharged from observation status on the same date, see codes 99234–99236 as appropriate.

C. Do not report observation care discharge CPT code 99217 in conjunction with a hospital admission.

VI. HOSPITAL INPATIENT SERVICES (99221–99239)

Codes 99221–99239 are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a "partial hospital" setting. These codes are to be used to report these partial hospitalization services. ~~The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. For inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor.~~

~~This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other physicians, nursing staff, respiratory therapists, etc.~~

~~A. If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.~~

~~B. For initial hospital care of a patient admitted on one date and discharged a subsequent day, report 99221–99223 for the initial inpatient care, 99231–99233 for the subsequent hospital care excluding the discharge day.~~

~~C. For a patient admitted and discharged for inpatient services or observation status on the same date, report the service with CPT codes 99234–99236.~~

~~D. Code 99238 or 99239 reports hospital discharge day management, but excludes discharge of a patient from observation status and inpatients admitted and discharged on the same date. When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.~~

~~VII. MULTIPLE HOSPITAL VISITS~~

~~Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.~~

VIII. CONSULTATIONS (99241–99255)

Consultations in *CPT ~~2010~~ 2013* fall under two subcategories: Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When required by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241–99245 for office or other outpatient consultation or 99251–99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

~~I~~VIII. EMERGENCY DEPARTMENT SERVICES (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. ~~The notes in the CPT book clearly define a~~An emergency department is defined as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281–99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201–99215) and reimbursement will be made accordingly.

IX. CRITICAL CARE SERVICES (99291–~~9929~~99300)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

~~Critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care codes 99471 and 99472. Critical care services provided to neonates (28 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99468 and 99469. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of pediatric and neonatal critical care services is not based on time, the type of unit (e.g., pediatric or neonatal critical care unit) or the type of provider delivering the care. For additional instructions on reporting these services, see the Inpatient Neonatal and Pediatric Critical Care section of the CPT book and codes 99468–99480.~~

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physicianindividual.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94002–94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed which are not listed above should be reported separately when performed in conjunction with critical services reported with code 99291–99292. When reporting inpatient neonatal and pediatric critical care services 99468–99476, consult the CPT book for additional procedures that are bundled into codes 99468–99476.

Codes 99291–99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of the critically ill or injured pediatric patient (24 months of age or less) are separately reportable, see 99466, 99467.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing in provision of critical care services to a critically ill or critically injured patient, even if the time spent by the physician providing care on that date is not continuous. For any given period of time spent providing critical care services, the physician individual must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

XI. NURSING FACILITY SERVICES (99304–99318)

Nursing facility E/M services have been grouped into four subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), long-term care facilities (LTCFs), and psychiatric residential treatment centers. Psychiatric residential treatment centers must provide a "24-hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

Codes 99304–99318 are used to report evaluation and management services to patients in nursing facilities (skilled nursing facilities (SNFs)) intermediate care facilities (ICFs), or long-term care facilities (LTCFs).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as a medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.

XII. DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES (99324–99340)

The evaluation and management codes are used to report ~~care given to patients residing~~ evaluation and management services in a facility that provides room, ~~and~~ board, and other personal assistance services generally on a long-term basis. They also are used to report evaluation and management services in an assisted living facility. ~~The facility is generally a long-term facility. The facility's services do not include a medical component. Typical times have not been established for this code group.~~

XIII. HOME SERVICES (99341–99350)

Services and care provided in a private residence ~~at the patient's home~~ are coded from this subcategory. ~~Typical times have not been established for this code group.~~

XIIIV. PROLONGED SERVICES (99354–99359)

~~A. *Prolonged Physician Service with Direct Patient Contact (99354–99357).* Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.~~

~~Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.~~

~~Prolonged physician services should be reported only once per date of service, even if the time spent is not continuous. Please refer to the most current CPT book for a more complete explanation of prolonged physician care.~~

~~B. *Prolonged Physician Service without Direct Patient Contact.* Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.~~

~~Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441–99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.~~ Codes 99354–99357 are used when a physician or other qualified health care professional provides prolonged service involving direct patient contact that is provided beyond the usual service in either the inpatient or outpatient setting. Codes 99358–99359 are used when a physician or other qualified health care professional provides prolonged service for patient management where face-to-face services have or will occur on another date of service.

XIV. PHYSICIAN STANDBY SERVICES (99360)

Code 99360 is used to report physician or other qualified health care professional standby service that is requested by another ~~physician~~ individual and that involves prolonged ~~physician~~ attendance without direct (face-to-face) patient contact. ~~The physician~~ Care or services may not be provided ~~providing care or~~

~~services~~ to other patients during this period. This code is not used to report time spent proctoring another ~~physician~~individual. It is also not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the ~~physician~~ individual who was on standby.

~~Code 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.~~

~~Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.~~

XVI. CASE MANAGEMENT SERVICES (99363–99368)

~~Physician c~~Case management is a process in which a physician or other qualified health care professional is responsible for direct care of a patient, and, additionally, for coordinating, ~~and controlling~~ managing access to, ~~or~~ initiating, and/or supervising other health care services needed by the patient.

Mississippi guideline: Use Mississippi specific code 9936M for a conference with workers' compensation medical case manager/claims manager.

XVII. CARE PLAN OVERSIGHT SERVICES (99339–99340, 99374–99380)

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, ~~or~~ domiciliary, or non-face-to-face services. The complexity and the approximate ~~physician~~ time ~~spent in~~ of the care plan oversight services provided within a thirty (30) day period determine~~s the~~ code ~~to be billed~~selection.

Only one ~~physician~~ individual may report care plan oversight services ~~during~~ for a given period of time, ~~reflecting~~ to reflect the sole or predominant supervisory role with a particular ~~the physician's sole or predominant supervisory role with the~~ patient. These codes should not be used for supervision of ~~a~~ patients in ~~a~~ nursing ~~facility~~ facilities or under the care of ~~a~~ home health ~~agency~~ agencies unless they require recurrent supervision of therapy. ~~Care plan oversight services are considered part of the patient evaluation and management services when less than fifteen (15) minutes are provided during a thirty (30) day period.~~

XVIII. SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450–99456)

These codes are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. ~~This series of codes was introduced in *CPT 1995* to report physician evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability.~~

~~XIX~~XVIII. OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

This is an unlisted code to report E/M services not specifically defined in the CPT book.

XIX. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows:

~~***21 Prolonged Evaluation and Management Services***~~

~~When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.~~

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating

circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Anesthesia

I. INTRODUCTION

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The ~~2010~~ 2013 American Society of Anesthesiologists' (ASA) *Relative Value Guide*® is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT® codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at $~~45.00~~50.00 per unit.

Total anesthesia value is defined in the following formula:

(Base units + time units + modifying units) x conversion factor = reimbursement

II. BASE UNITS

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

III. TIME UNITS

Anesthesia time begins when the anesthesiologist starts the preparation of the patient for anesthesia in the preoperative area, the operating room or a similar area, and ends when the injured employee is placed under postoperative care, such as transfer to the recovery room.

~~Time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Time ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.~~ The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

IV. SPECIAL CIRCUMSTANCES

A. **Physical Status Modifiers**

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

Status	Description	Base Units
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A patient declared brain-dead whose organs are being removed for donor purposes	0

The above six levels are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

B. **Qualifying Circumstances**

1. ~~Qualifying circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. The unit value listed is added to the existing anesthesia base units.~~Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative condition, and/or unusual risk factors. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.

CPT	Description	Units
99100	Anesthesia for patient of extreme age, younger than ~~one~~ 1 year and older than ~~seventy~~ 70 (List separately in addition to code for primary anesthesia procedure)	1
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5

99140	Anesthesia complicated by emergency conditions (specify ~~conditions~~) (List separately in addition to code for primary anesthesia procedure) ~~(An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.)~~	2

2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

V. MONITORED ANESTHESIA CARE

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to ~~insure~~ ensure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

VI. REIMBURSEMENT FOR ANESTHESIA SERVICES

A. **Criteria for Reimbursement**

Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiology Assistant (AA).
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:
   a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
   b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

B. **Reimbursement**

1. The maximum reimbursement allowance (MRA) for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.
2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.

3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report (BR).
4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated ~~BR~~by report. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value).
5. Payment for covered anesthesia services is as follows:
    a. When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the Billing and Reimbursement Rules of this Fee Schedule.
    b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).
    c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the Fee Schedule for that procedure.
6. Anesthesiologists, CRNAs, and AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

    AA ~~Anesthesiologist~~ Anesthesia services performed personally by ~~an~~ anesthesiologist

    AD Medical supervision by a physician: more than ~~four~~4 concurrent anesthesia procedures

    QK Medical direction of ~~two, three, or four~~ 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals ~~(CRNA or AA) by an anesthesiologist~~

    QX Qualified non-physician anesthetist ~~CRNA or AA service:~~ with medical direction by ~~an anesthesiologist~~a physician

    QY Medical direction of one ~~certified registered nurse anesthetist (CRNA or AA)~~ qualified non-physician anesthetist by an anesthesiologist

    QZ CRNA service without medical direction by ~~an anesthesiologist~~a physician

~~C. Facility Fees~~
~~The facility fee for outpatient services is the APC amount. Additional information can be found in the Ambulatory Surgical Center section guidelines.~~

VII. ANESTHESIA MODIFIERS

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the ~~modifying~~ circumstances should be identified by ~~the addition of the appropriate~~ a modifier code: a two-digit number placed ~~(including the hyphen)~~ after the usual ~~anesthesia~~ procedure code separated by a hyphen. ~~Certain modifiers require a special report for clarification of services provided.~~ If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in anesthesia are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of

procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

~~Mississippi's note~~Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one hundred and twenty percent (120%) of the maximum reimbursement allowance.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

53 Discontinued Procedure

Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. ~~This may represent~~ Documentation must support a different session~~ or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same ~~physician~~individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA Anesthesia Services Performed Personally by ~~the~~ Anesthesiologist

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than ~~Four~~4 Concurrent Anesthesia Procedures

Report modifier AD when the anesthesiologist supervises more than ~~four~~4 concurrent anesthesia procedures.

QK Medical Direction of ~~Two, Three, or Four~~ 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals

Report modifier QK when the anesthesiologist supervises ~~two, three, or four~~ 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.

QX Qualified Non-Physician Anesthetist ~~CRNA or AA Service~~ with Medical Direction by a Physician

Regional or general anesthesia provided by a qualified non-physician anesthetist ~~the CRNA or AA~~ with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction ~~Supervision by Physician~~ of One Qualified Non-Physician Anesthetist ~~CRNA or AA~~by an Anesthesiologist

Report modifier QY when the anesthesiologist supervises one qualified non-physician anesthetist~~CRNA or AA~~.

QZ CRNA ~~or AA~~ Service without Medical Direction by a Physician

Regional or general anesthesia provided by the CRNA (certified registered nurse anesthetist) or AA (anesthesiologist assistant) without medical direction by a physician may be reported by adding modifier QZ.

Pain Management

I. INTRODUCTION

In addition to the General Rules, this section provides specific rules for Pain Management services.

Utilization review (UR) is expected and welcomed as part of the process in which Interventional Pain Management (IPM) procedures are performed. The objectives to this IPM portion of the Fee Schedule are to minimize or eliminate unnecessary, ineffective or inappropriate treatment, while at the same time facilitating the performance of appropriate, effective and necessary treatment. Rendering unnecessary treatment less costly via lowered reimbursement fails to meet these objectives, as the payer still reimburses for unnecessary treatment, and the patient is still subjected to the risks, however diminutive, inherent in all treatment. Delaying or even denying necessary treatment is equally undesirable. It is well documented that the chances of returning the injured worker with back-related pain to their initial level of work activity—or even any level of work—decrease significantly with increasing time off work. Therefore, expedience of appropriate care is as desirous as elimination of unnecessary—and potentially injurious—care.

To these ends, this portion of the Fee Schedule has been developed to give practitioners maximum flexibility in proceeding with demonstrably effective care, by decreasing or even eliminating some aspects of UR, while giving payers means to more objectively evaluate the effectiveness of care, project the cost of future IPM treatment, and avoid having to evaluate unnecessary and inappropriate care and unproven new technologies.

To be effective, these rules adopt the following strategies:

1. Providers must restrict treatment to indications recognized by established medical practice.
2. Providers must demonstrate more objectively the effectiveness of previously provided treatment in order to repeat or continue it.
3. Providers must give detailed descriptions of the specific treatment provided, and must archive images of that treatment that can be provided upon request of the payers.
4. Payers/URs must approve or deny treatment within the rules provided by the IPM portion of the Fee Schedule, and not involve extraneous outside guidelines.
5. Any UR personnel involved in the denial of care must cite the specific section of the IPM Fee Schedule used as a basis for that denial. Failure to do so will result in automatic adjudication in favor of the provider.

II. REIMBURSEMENT FOR PAIN MANAGEMENT SERVICES

~~A. Reimbursement for pain management services is based on the Resource Based Relative Value Scale (RBRVS).~~

~~B~~A. **Use of Fluoroscopy**

~~The r~~Reimbursement for the use of fluoroscopy (CPT® codes 77002 and 77003) is based on the ~~RBRVS~~Fee Schedule, regardless of the number of procedures performed, and may only be billed once per date of service.

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 Cervical (stellate ganglion) sympathetic block, or CPT code 64520 Thoracic or lumbar blocks.

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (i.e., cervical epidural~~, transforaminal epidural,~~ or sacroiliac joint), and including facet nerve neurolytic agent destruction.

All procedures performed fluoroscopically MUST have stored images (hard copy or digital) showing final needle placement in at least two (2) views (typically PA, lateral or oblique) demonstrating final needle placement AND disbursement of contrast (when not contraindicated). These images must be available upon request (with appropriate HIPAA compliance) by payers, or reimbursement may be denied.

~~C~~B. **Reimbursement for Injection/Destruction Procedures**

1. The current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (e.g., 64490 is for injection of cervical facet single or first level, and 64491 and 64492 are used for additional levels).
2. Facet injections~~,~~ and medial branch blocks ~~and nerve destruction procedures~~ are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional service levels (but not more) for facet or medial branch blocks in the cervical/thoracic (64491 and 64492) or lumbar (64494 and 64495) for a maximum of three (3) procedure levels reimbursed per treatment session or day. Additional injected site levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side. Nerve destructive procedures are only reimbursed for a maximum of two (2) anatomical levels. A higher number of diagnostic injections are allowed because some providers may want to block a larger anatomical level with the initial block to determine what, if any, response is noted to the initial diagnostic injection. This prevents adding further levels during additional diagnostic injections. The likelihood of true three (3) level involvement is exceedingly rare, such that further localization of the involved levels is expected prior to destructive lesioning.
3. Reimbursement for injection/destruction procedure codes is made on the basis of ~~nerves~~ joint levels, not nerves treated (e.g., destruction by neurolytic agent of the L4–L5 facets counts as ~~two (2)~~ one (1) level~~s~~/nerve~~s~~ and should be billed as 64622 (first level/nerve)~~ and 64623 (each additional level)~~). There are two nerves supplying each joint ~~and~~but reimbursement is based upon ~~nerve~~joint(s) treated, not the ~~joint levels~~ nerves treated. This applies to CPT codes 64622, 64623 (lumbar), and 64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. Additionally, bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical condition for which multiple injections would be appropriate. For bilateral injections, this includes

the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:

- Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4/5 disc herniation affecting the traversing L5 nerve root).
- Multiple dermatomal nerve root involvement.

A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.

Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.

5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.
6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This maximum applies to facet joint injections and nerve blocks, codes 64490–64495. Nerve destruction procedures, codes 64622–64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

~~D~~C. **Multiple Procedure Reimbursement**

Only one (1) type of pain management procedure is reimbursable on a given date of service, unless otherwise approved by the payer. This rule does not include multiple level injections or bilateral procedures of the same type, with appropriate modifiers. This also does not include separate procedures performed as part of a single primary service, such as implantation of a spinal cord stimulator.

"Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level or bilateral injections of a single procedure in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply. Diagnostic injections of more than one type in the same anatomic area on the same date of service are prohibited, and will not be reimbursed without prior authorization.

Example: A three-level lumbar facet injection would be billed as 64493 for the first level, 64494 for the second level, and 64495 for the third level.

III. REIMBURSEMENT FOR REFILL OF PAIN PUMPS

A. **Code 95990.** This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.

B. **Evaluation and Management Services.** Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional or other cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and payment will be allowed if supported by the documentation.

C. **Drugs.** Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.

D. **Compounding Fee.** If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at $157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

~~III~~IV. ~~"~~DIAGNOSTIC ~~ONLY"~~ INJECTIONS AND PROCEDURES

A. Valid ~~"~~diagnostic ~~only"~~ injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. ~~Clearly, a~~Analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.

B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to the procedure, and level of alertness during discography could result in denial of reimbursement.

C. Medial branch (facet nerve) or *diagnostic* intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient's response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.

D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed in the treatment facility after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. Subsequent pain scores must be documented at least hourly for two (2) hours after the procedure. The documentation available must also include the drugs used during the procedure, and comments on the patient's level of alertness in the treatment facility at each time period when the pain or response is evaluated. If the patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, ~~for example,~~ that which may be provided by lying in a recovery bed.

E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation, depending on the experience level of the practitioner ordering or administering the medication. Proper documentation of a lack of undue influence of sedation and analgesics must be provided to support a request for reimbursement for diagnostic procedures.

F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections ~~(see modifier T)~~, would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is ~~NOT~~ not a requirement for reimbursement.

~~IV.~~ ~~PHYSICAL THERAPY~~THERAPEUTIC SERVICES

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

VI. GENERAL RULES

A. This Fee Schedule does not recognize a "series" of epidural injections, regardless of number. A trial of epidural injections is permitted provided there is appropriate documentation of a recognized indication for this procedure. Only a single injection can be approved unless there is documentation of analgesic response consistent with response to the injection. Further injections require a positive analgesic response in order to be repeated~~for approval~~. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue epidural treatment. If there is no documented residual pain relief after two (2) injections, no further epidural injections will be considered medically necessary.

1. There is no recognized "series" of epidural injections, and repeat injections are contingent upon proper documentation of clinical responses as stated above. Repeat injections (up to two (2) additional injections, for a total of three (3) per twelve (12) month period), however, do NOT require prior approval as long as the appropriate responses are properly documented. Specifically, the first injection must provide at least a temporary analgesic response independent of any local anesthetic response or from sedatives or analgesics administered to the patient during the procedure. Typically, this means there should have been some benefit that occurred sometime after the first treatment day. Subsequent epidural injections must provide progressive and durable (persistent) relief of the targeted pain.
2. Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

B. Reimbursement will be limited to three (3) epidural pain injections in a twelve (12) month period unless the payer gives prior approval for more than three (3) such injections. Separate billing for the drug injected is not appropriate and will not be reimbursed.

C. Epidural Injections (Transforaminal and Interlaminar):

Transforaminal epidural injections are used for and are indicated for both diagnostic and therapeutic purposes.

Diagnostically, they may be used to:

- Determine whether a pain is somatic, visceral, sympathetic or functional.
- Determine which spinal nerve(s) (if any) are involved in the patient's pain process. This information may at times be used to determine the anatomical nerve root(s) involved for the purpose of surgical intervention.
- To determine if there is a component of pain related to involvement of a spinal nerve.
- To determine the source of pain when there is no clear pathology or conflicting pathology on imaging or EMG/NCV.

- To differentiate central from somatic pain following an injury to the central nervous system

1. **Diagnostic Epidural Injections**

Diagnostic transforaminal injections are often repeated due to the high incidence (up to forty percent (40%)) of false positive injections. Typically, local anesthetics of different durations of action (e.g., lidocaine and bupivacaine) are used for two consecutive injections to determine an appropriate duration of effect. Some practitioners may also use a placebo injection (typically saline) to further refine the patient's response. In order to be a "successful" ("positive") diagnostic procedure the patient must experience at least seventy-five percent (75%) relief of the index pain (pain suspected as being radicular). Pain levels should be measured during provocative testing pre- and postprocedure, if necessary, to insure that the patient is experiencing their usual discomfort prior to the procedure. The same provocative test should be repeated during each of the subsequent time intervals, and for at least two (2) hours. The provocative test(s) used should be one(s) that the patient is able to perform unassisted and that would not result in injury to the patient.

As with other diagnostic injections, excessive sedation and any narcotics should be avoided to evade impairing the patient's ability to determine a positive analgesic response to the injection. Diagnostic epidural injections are subject to the "diagnostic injection" rules specified in Section III, Subsection D.

Interlaminar epidural injections are seldom used for diagnostic purposes because the generalized regional spread of local anesthetic with spinal injection makes it impractical if not impossible to selectively block a specific nerve.

2. **Therapeutic Epidural Injections**

Therapeutically, epidural injections may be used (typically with steroids) for the treatment of radiating pain (upper/lower extremity, buttock and rarely dermatomal chest wall or abdominal pain from thoracic nerve root involvement), related to spinal nerve or dorsal root ganglion irritation, inflammation or compression. The pathology causing the radiating pain is often, but not exclusively, caused by pathology involving adjacent intervertebral discs, such as protrusions, herniations or bulges. Degenerative changes within the discs may also result in inflammatory processes that may cause radicular pain. Other causes may involve either central or lateral recess stenosis caused by facet joint pathology, ligamental hypertrophy and disc pathology.

Therapeutic injections for pain in the lumbar spine are typically transforaminal as these have been demonstrated by the available medical literature to be more effective than interlaminar injections for radicular pain. An exception would be the patient who is allergic to contrast media, as transforaminal epidural injections must be performed fluoroscopically with contrast. Cervical and thoracic therapeutic epidural injections are most often interlaminar, as this approach is inherently safer and less technically demanding, and the available medical literature does not suggest a clear therapeutic advantage to either a transforaminal or interlaminar technique. However, to be reimbursed, both cervical and interlaminar epidural steroid injections must be performed fluoroscopically, typically with contrast injection, unless there is a documented contrast allergy. The fluoroscopic guidance requirement for lumbar interlaminar epidural injections represents a change from previous Fee Schedules, and is now required to reflect a growing national trend of use of fluoroscopy with all epidural injections. The technical failure rate of non-fluoroscopic ("blind") epidural injections is documented to be as high as twenty-five percent (25%), and considering the benefit of interlaminar epidural injections for radicular pain is suspect at best, there is now the requirement for fluoroscopy with all epidural steroid injections.

Epidural blood patches do not require fluoroscopic guidance, though this is preferred.

The specific cause of radiating pain may not always be obvious on imaging, such as MRI, CT or x-rays. Normal imaging, or even abnormal imaging in which the pathology is on the side opposite

the pain, or at a level that would not be expected to cause the patient's particular anatomical pain pattern, can occur. However, the absence of such pathology does not rule out inflammation or irritation of a spinal nerve or dorsal root ganglion. Therefore, the indications for a trial of epidural steroid injections are based on the patient's clinical presentation, not imaging.

All nerve root pain or radiating pain is not caused by damage (nerve or axon loss) to the nerve or dorsal root ganglion. When there is only inflammation or irritation of the nerve, there may be radiating pain in the absence of physical exam findings of nerve damage such as altered or absent motor, sensory, or reflex function. In fact, actual nerve damage is not treated by steroid injections, as the latter does not accelerate the regeneration of new nerve (axon) regeneration. Therefore, EMG/NCV testing demonstrating nerve or axon loss is not necessary as an indication for a trial of epidural steroid injections. EMG testing can be superfluous when there is obvious nerve injury and imaging that demonstrate the etiology of the nerve injury (i.e., large disc herniation with appropriate nerve motor/sensory/reflex pathology). EMG/NCV testing is not capable of detecting coexisting nerve injury and inflammation so positive EMG/NCV is not a contraindication to a trial of epidural steroid injections.

A trial of epidural steroids injections may be indicated when there is radiating pain (extremity or buttock) with or without co-existing back pain. There is no acceptable "series" of epidural steroid injections as repeat injections are indicated based on the response to the preceding epidural injection. Repeat injections would typically occur two to four (2–4) weeks after the initial treatment, contingent upon some degree of continuing radiating pain. Repeat injections cannot be performed within two (2) weeks of the previous epidural injection.

In order to repeat an epidural injection, there must have been a positive analgesic response (pain improvement or functional improvement) to the previous injection. For the first injection, this relief may be temporary, but cannot be attributed solely to a local anesthetic effect or intra-procedural sedation (i.e., relief for the first few hours after injection). Additionally, in order to repeat an epidural injection, there must be continued radiating pain, and not only residual axial (back/neck) pain. After a second epidural injection, there must be some degree of *residual/durable* relief of the radiating component of pain that has persisted to the time of the patient's follow up visit.

Epidural injections (with or without steroids) may be used for the treatment of sympathetically mediated/maintained pain in the complex of conditions often referred to as "reflex sympathetic dystrophy" (RSD), "causalgia", complex regional pain syndrome type I and II (CRPS). This type of pain is typically distinctive, and does not typically radiate as does radicular pain related to nerve root inflammation or irritation. However, sympathetic pain may occur in the presence of nerve root injury (causalgia, CRPS II) where there is usually a component of radiating pain as well. The frequency of injection for these conditions may be (in rare cases) multiple times per week, and repeated as long as debilitating pain persists. However, as with other effective treatments, a trend towards improvement should be a necessary criterion for continued use of the treatment. It is, however, due to the complexity and variable presentation of these conditions, impractical to define a specific number of permissible injections, and providers and payers must rely on the demonstrable response and durability of relief provided by the treatment to determine the appropriateness of care.

3. **Initiation and Continuation of Epidural Injections**

It is necessary to obtain prior approval by the payer or appropriate utilization reviewer before initiating a trial of epidural injections. It is NOT necessary to obtain prior approval to repeat an injection as long as it is performed according to the rules outlined above. If the appropriate rules are followed, denial of reimbursement for repeated procedures will result in automatic adjudication favorable to the provider and may result in appropriate penalties and/or fines to the payer.

There will be a maximum of three (3) epidural injections per anatomical (cervical/thoracic/lumbar) area allowed within a given one (1) year time period. There may be times when additional injec-

tions are indicated (re-injury, intervening surgery, etc.,) but this is subject to prior approval by the payer, who has the sole authority to allow more than three (3) injections per one (1) year period.

Repeat trials of epidural injections may be considered after one (1) year if the preceding trial provided several months of demonstrable benefit. In order to be considered effective, this benefit must include greater than thirty percent (30%) improvement in pain scores, and documentation of either 1) significant reduction of daily narcotic consumption, defined as a sustained reduction (several months) of at least thirty percent (30%) of the daily narcotic use prior to initiation of the trial of epidural injections, or 2) ability to work for a sustained period of time (several months) at least at sedentary work level or the work level as determined by a valid Functional Capacity Rating (FCE). Also, no patient can be considered for a repeat trial of epidural steroid injections, if after the preceding trial (in a similar anatomical area) they are unable to reduce narcotic consumption to less than 100 mg morphine equivalent per day.

If, after an initial trial of epidural injections, it is suspected that there is a new nerve injury involving a different anatomical nerve, a trial of epidural injections may be indicated independent of the response to the initial trial of epidural injections. However, as this would represent a separate nerve injury, causation would have to be established prior to initiation of further treatment related to a work injury.

4. **Documentation Requirements for Epidural Injections (Adopted and Adapted from CMS MLN Matters #SE1102 rev)**

Documentation in the medical record must contain the initial evaluation including history and physical examination; diagnosis, pain, and disability of moderate to severe degree; site of injection with name and dosage of drug instilled; and the patient's response to the prior injections.

a. Documentation of conservative therapies that were tried and failed except in acute situations such as acute disc herniation with disabling and debilitating pain, reflex sympathetic dystrophy, postoperative and obstetric pain and intractable pain secondary to carcinoma.

b. All documentation must be maintained in the patient's medical record and available to the payer upon request.

c. The record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician responsible for and providing the care of the patient.

d. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

e. The patient's record should document an appropriate history and physical examination by the provider or provider's representative specifying the medical indications requiring his/her presence when applicable. The indications should be recorded by the provider performing the injection in their respective notes.

5. ICD-9 Codes for Epidural Injections

The following ICD-9-CM codes apply to the CPT/HCPCS codes 64479, 64480, 64483, and 64484:

337.21	REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB
337.22	REFLEX SYMPATHETIC DYSTROPHY OF THE LOWER LIMB
337.29	REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
353.0	BRACHIAL PLEXUS LESIONS

353.1 LUMBOSACRAL PLEXUS LESIONS
353.2 CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3 THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4 LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
354.4 CAUSALGIA OF UPPER LIMB
355.0 LESION OF SCIATIC NERVE
355.71 CAUSALGIA OF LOWER LIMB
722.0 DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11 DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2 DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.81 POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82 POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83 POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0 SPINAL STENOSIS IN CERVICAL REGION
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS
724.01 SPINAL STENOSIS OF THORACIC REGION
724.02 SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03 SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3 SCIATICA
724.4 THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
805.00–805.08 CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2 CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4 CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
953.0 INJURY TO CERVICAL NERVE ROOT
953.1 INJURY TO DORSAL NERVE ROOT
953.2 INJURY TO LUMBAR NERVE ROOT
953.3 INJURY TO SACRAL NERVE ROOT

~~C. Modifiers~~D. **Therapeutic and Diagnostic Services**

~~PM Pain Management~~

~~Modifier PM, which is a Mississippi-specific pain management code modifier, is no longer required, and will not be recognized for reimbursement for dates of service beginning August 1, 2007.~~

~~Modifiers T and D (Mississippi State Modifiers)~~

~~Facet joint/nerve injections can be used for diagnostic or therapeutic indications, or both. These injections should be used with modifier D to indicate a diagnostic intention of the injection, or with modifier T to indicate a therapeutic intention of the injection.~~

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic~~ and should be billed using modifier T~~.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region. For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet-related pain continues past twelve (12) months, further injections are limited to a total of two (2) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type~~, as determined by modifiers T or D, per twelve (12) month period. Failure to designate injections with the appropriate T or D modifier will limit reimbursement to no more than two (2) facet joint/nerve injections per twelve (12) month period~~. This rule applies to cervical, thoracic, and lumbar facet joint and facet joint nerve injections. Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above. Nerve-destructive procedures (e.g. radiofrequency facet nerve neurotomy, codes 64622, 64623, 64626, 64627) do ~~NOT~~not count as an additional therapeutic procedure for the purpose of this rule.

A “different anatomical area” refers to the lumbar, thoracic, and cervical areas. Injections within the lumbar spine, for example, are considered to be within the same anatomical area regardless of the actual lumbar joint/nerve level, or which side (right or left), is treated, and all limits would apply in this anatomical area. The same rule applies to the thoracic and cervical anatomical areas, regardless of the level or laterality treated within the same anatomical area.

In order to be a “successful” (“positive”) diagnostic facet procedure (either intra-articular or medial branch block(s)), the patient must experience at least seventy-five percent (75%) relief of the index pain (pain being treated by the procedure). Additionally, this index pain must be at least fifty percent (50%) of the patient’s total pain.

Pain levels should be measured during provocative testing pre- and postprocedure. The same provocative test should be repeated during each of the subsequent time intervals as described in these rules. The provocative test(s) used should be one(s) that the patient is able to perform unassisted and that would not result in injury to the patient.

Facet nerve (medial branch ablation) for cervical, thoracic or lumbar nerves will only be reimbursed once per ~~nine (9)~~seven (7) month period. Repeat (medial branch) ablation is contingent upon documentation of at least six (6) month’s measurable (greater than thirty percent (30%) improvement in pain scores, and documentation of either 1) reduction of daily narcotic consumption of at least thirty percent (30%) from the daily use noted prior to the procedure, or 2) ability to work at least at a sedentary work level or work level as determined by a valid Functional Capacity Evaluation (FCE). Also, no patient can be considered for a repeat neuroablative procedure (e.g., neurotomy) if after the preceding neuroablative procedure (at similar anatomical levels) they are unable to reduce narcotic consumption to less than 100 mg morphine equivalent per day.

In order to perform a repeat therapeutic facet joint injection (cervical, thoracic, or lumbar; codes 64490–64495), there must be documentation of a significant analgesic response that persists for at least four (4) weeks. This relief must be at least fifty percent (50%) of the pain in the specific anatomical area targeted by the injection, ~~or~~ and there must be documentation of a durable (also four (4) weeks) measurable improvement in the range of motion, or documentation of normal motion, of the involved joint area being treated.

~~D~~E. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee

Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Fee Schedule.

~~E~~F. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 OR 20553 is allowed per date of service.

1. Trigger Point Injections (Adopted and Adapted from CMS MLN Matters #SE1102 rev.)

- Trigger point injection refers to the injection of local anesthetics or anti-inflammatory medications into myofascial trigger points. Trigger points are self-sustaining irritative foci that occur in skeletal muscle in response to strain, as well as mechanical overload phenomena. These trigger points produce a referred pain pattern characteristic for the individual involved muscle.

- Trigger point injections are an integral part of comprehensive pain management, and may be used concurrently in support of other conservative modalities. Conservative therapy may include analgesics, physical therapy, ultrasound, range of motion, chiropractic intervention (within the defined limits of the Fee Schedule benefit) and active exercises. The diagnosis of trigger points requires a detailed history and thorough physical examination.

- The following clinical features are consistently present and are helpful in making the diagnosis:

  — History of onset of the painful condition and its presumed cause (e.g., injury or sprain)

  — Distribution pattern of pain consistent with the referral pattern of trigger points

  — Range of motion restriction

  — Muscular deconditioning in the affected area

  — Focal tenderness of a trigger point

  — Palpable taut band of muscle in which trigger point is located

  — Local taut response to snapping palpation

  — Reproduction of referred pain pattern upon stimulation of trigger point

- The goal is to treat the cause of pain, not just the symptoms. With this intent, it is expected that trigger point injections may be performed as frequently as weekly while in a physical therapy program. In order to be repeated in the same muscle group, there must be at least a fifty percent (50%) persistent benefit from the previous injection. For patients not in therapy, trigger point injections can be performed monthly, as long as there is a documented fifty percent (50%) residual benefit, and progressive relief (pain intensity and duration of relief) with the preceding injection. After six months, if similar pain persists, the patient should be re-evaluated regarding the etiology of the complaint, and the available treatment options reconsidered. The payer may consider payment for additional trigger point injections upon review.

2. **ICD-9 Codes for Trigger Point Injections**

The following ICD-9-CM codes apply to the CPT/HCPCS codes 20552 and 20553.

720.1	SPINAL ENTHESOPATHY
723.9	UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.32	LATERAL EPICONDYLITIS
726.39	OTHER ENTHESOPATHY OF ELBOW REGION
726.5	ENTHESOPATHY OF HIP REGION
726.71	ACHILLES BURSITIS OR TENDINITIS
726.72	TIBIALIS TENDINITIS
726.79	OTHER ENTHESOPATHY OF ANKLE AND TARSUS
726.90	ENTHESOPATHY OF UNSPECIFIED SITE
729.0–729.1	RHEUMATISM UNSPECIFIED AND FIBROSITIS - MYALGIA AND MYOSITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED

~~F~~G. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedures(s). Therefore, an additional fee for the fluoroscopy (CPT code 77002) is not warranted and will not be reimbursed. This code may only be used once per twelve (12) month period.

~~G~~H. Epidurography (CPT code 72275) is no longer reimbursable under this Fee Schedule.~~, a/k/a "epidural myelogram" or "epidural without dural puncture," is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the inherent use of a fluoroscope, and, therefore, an additional fluoroscopy fee for procedure code 77003 is not reimbursable. This code may only be used once per twelve (12) month period.~~

~~H~~I. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.

~~I~~J. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the *Mississippi Workers' Compensation Medical Fee Schedule:*

1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (22899);
2. Intraventricular administration of Morphine;
3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider;
4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies;
5. Percutaneous disc nucleoplasty;
6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.
7. X-STOP fusion devices.
8. MILD (minimally invasive lumbar decompression) procedures.
9. Non-Invasive Pain Procedure (NIP procedure or NIPP)
10. Alpha-Stim unit
11. ReBuilder and Low Laser treatment

~~J~~K. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:

1. Facet injections (64490–64495) (fluoroscopy is included in the procedure code)
2. Sacroiliac (SI) injections (27096)
3. Transforaminal epidural steroid injections (64479, 64480, 64483, 64484)
4. Cervical translaminar/interlaminar epidural injections (62310)
5. Additional information, adopted and adapted from CMS LCD L27512:

   a. Facet Joint Block (Adopted and Adapted from CMS MLN Matters #SE1102 rev.)

      Paravertebral facet joint nerve block (medial branch) and intraarticular facet joint injections are used to both diagnose and treat lumbar zygapophysial (facet joint) pain. Facet joint pain syndrome is a challenging diagnosis as there are no specific history, physical examination, or radiological imaging findings that point exclusively to the diagnosis. However, this diagnosis is considered if the patient describes nonspecific, usually mechanical low back pain that is located in the paravertebral area of the cervical, thoracic, and lumbar spine. Typically, though certainly not consistently, the pain is aggravated by loading the facets, typically with extension or rotation of the involved area of the spine. A detailed physical examination of the spine should be performed on all patients. Radiological imaging is often done as part of the workup of persistent chronic back pain to exclude other diagnoses.

      Facet joint or nerve block is one method used to diagnose a suspected component of pain related to the facet joints of the cervical, thoracic, and lumbar spine. Often the patient presents with chronic neck, thoracic, or back pain of a mechanical nature that lacks a strong radicular component, has no associated neurologic deficits, and is often aggravated by hyperextension, lateral bending or rotation of the spine.

      A local anesthetic is injected to temporarily denervate the facet joint. After a satisfactory block has been obtained, the patient is asked to repeat the maneuver or activities that produced their pain on exam. Temporary or prolonged abolition of the spinal pain suggests that facet joints were a source of the symptoms.

      A detailed pain history and appropriate exam is essential. Response to previous treatment should also be documented.

      Imaging guidance must be used for both diagnostic and therapeutic injections to assure that the needle is properly placed, and the injected substance reaches the intended target zone. Imaging also helps determine aberrant injection patterns such as intravascular injections.

      The following ICD-9-CM codes are considered indications for facet interventions and apply to the CPT/HCPCS codes 64490, 64491, 64492, 64493, 64494 and 64495:

Code	Description
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
723.1	CERVICALGIA

724.2 LUMBAGO

b. **Sacroiliac (SI) Joint Injections**

The following ICD-9-CM codes apply to the CPT/HCPCS codes 27096

Code	Description
720.0	ANKYLOSING SPONDYLITIS
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
724.6	DISORDERS OF SACRUM
846.0–846.9	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN - UNSPECIFIED SITE OF SACROILIAC REGION SPRAIN

Injections of the sacroiliac joint may be used to diagnose the cause of or to treat low back pain.

Pain arising from the SI joint may mimic pain originating from the lumbar disc, lumbar facet, or hip joint. Pain is typically a mechanical axial back pain below the L5 level, and is usually unilateral. There may be associated somatic referred leg pain involving the posterior thigh. The pain may also be experienced anteriorly, in the area of the anterior iliac spine. Except in the presence of clear pathology (tumor, fracture, infection), clinical diagnosis of SI joint pain is difficult and often one of exclusion.

The differential diagnosis of SI joint pain requires a detailed history and thorough physical exam. Imaging with radiographs, MRI, bone scans and CT scans do not consistently differentiate symptomatic from asymptomatic individuals.

SI joint injection can be done diagnostically or therapeutically. These are defined as follows:

- Diagnostic injections — either an anesthetic is injected for immediate pain relief or contrast media is injected into the joint for evaluation of the integrity (or lack thereof) of the articular cartilage and morphologic features of the joint space and capsule.
- Therapeutic injections — a steroid and/or anesthetic is injected into the SI joint for immediate and potentially lasting pain relief.

Both therapeutic and diagnostic sacroiliac joint injections require the use of image guidance. Injections performed without the use of image guidance, should be billed, and will be reimbursed, as a trigger point injection. CPT code 27096 requires the use of imaging confirmation of intra-articular needle positioning.

~~K~~L. Any analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, ~~DOES NOT~~does not allow for separate billing of analgesia/sedation.

~~L~~M. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Unless there is a contraindication to contrast media (e.g., documented allergy) it is expected that contrast injection AND a written description of the contrast spread pattern be included in the procedure report. Generic descriptions such as “the procedure was performed in the usual fashion,” “the needle was placed on (next to, by, etc.) the nerve/joint/target,” “the needle was placed in the correct anatomical location,” or similar wording, which was templated or otherwise lacking an actual detailed anatomical description

of needle placement or contrast pattern (where appropriate), is inadequate and subsequent cause for denial of payment. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.

~~M~~N. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). ~~A d~~Discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discogram is not considered medically necessary. Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.

When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should ~~NOT~~not be additionally reported.

Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).

~~N~~O. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.

~~O~~P. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly:

1. **Definitions**: For the purpose of this provision, the following terms have the meanings indicated:

    a. **~~"~~Chronic Pain~~".~~** ~~is a~~A pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain." For the purpose of this section, "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

    b. **~~"~~Acute Pain~~".~~** ~~is t~~The normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration. Title 21 CFR Part 1301 Food and Drugs.

c. ~~"~~**Addiction**~~".~~ ~~is a~~A neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

d. ~~"~~**Physical Dependence**~~".~~ ~~is a~~A physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.

e. ~~"~~**Substance Abuse**~~".~~ ~~is t~~The use of any substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

f. ~~"~~**Tolerance**~~".~~ ~~is a~~A physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.

2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.

3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

   a Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.

   b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.

   c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.

d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.

4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of "detoxification treatment," or "maintenance treatment," and no physician shall administer or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless they are properly registered in accordance with MCA §303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient's chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this Fee Schedule, as follows: not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

~~P~~Q. Radiographic Codes in Pain Management. Fluoroscopic imaging is reported with codes 77002 and 77003.~~In the 2007 CPT book, code 76003 was replaced by code 77002, and code 76005 (fluoroscopy for injection) is replaced by code 77003. Description of service and reimbursement will remain the same.~~

Codes 72010–72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

~~Q~~R. Soft Tissue Injections. “Myofascial, myoneural, and trigger point injections” are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are ~~NOT~~not to be used for “myofascial, myoneural or trigger point” injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and ~~NOT~~not for “myofascial, myoneural, or trigger point” injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

~~R~~S. Implantation of spinal cord stimulators.

1. The following conditions must be met for consideration of spinal cord stimulators.

- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
- There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
- During the trial stimulation, the patient must report functional improvement, decreased use of medications, and at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
- Psychological screening must be used to determine if the patient is free from:
  - Substance abuse issues
  - Untreated psychiatric conditions
  - Major psychiatric illness that could impair the patient’s ability to respond appropriately to the trial stimulation

2. Reimbursement for implantation is limited to a maximum of two (2) leads and a maximum of sixteen (16) electrodes, regardless of the number used.

~~S~~T. Sacroiliac joint injections (code 27096) require documentation of at least a four (4) week durable analgesic benefit of at least fifty (50%) pain relief in the anatomical area being targeted by the injection. A maximum of two (2) therapeutic sacroiliac joint injections is allowed per twelve (12) month period. This rule is limited only to the joint injected, and not the contralateral joint (i.e., right or left sided joint).

U. All Interventional Pain Management (IPM) procedures must be billed with the appropriate CPT codes and modifiers (where applicable) using accepted ICD-9 codes as the indications for the procedures. Providers MUST use acceptable codes in order to initiate or maintain treatment. Failure to do so is cause for denial of treatment until the proper appropriate codes are submitted.

Payers/URs must use the rules of this Fee Schedule to deny requested treatment. Failure to cite the specific section of the IPM portion of the *Mississippi Workers’ Compensation Medical Fee Schedule*

will result in automatic adjudication for the provider without appeal. “Specific” refers to citing the actual section, and appropriate subsections directly from the guidelines. Failure to have the Fee Schedule available during the review would obviously make such citation unachievable, resulting in automatic adjudication for the provider. ***No outside guidelines can be used to deny IPM care requested in accordance with the Fee Schedule.***

Any analgesia/sedation used in the performance of the IPM procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, does not allow for separate billing of analgesia/sedation.

VII. MODIFIERS

Please see the appropriate section (e.g., Surgery, Radiology) for applicable modifiers.

Surgery

I. GENERAL GUIDELINES

A. **Global Reimbursement**

The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery. The State of Mississippi follows the surgical package definition from *CPT® 2013.*

~~Global reimbursement includes:~~

~~1. The operation per se~~

~~2. Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia~~

~~3. Subsequent to the decision and/or authorization for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical), but does not include the initial consultation~~

~~4. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians~~

~~5. Writing orders~~

~~6. Evaluating the patient in the postanesthesia recovery area~~

~~7~~B. **Normal, Uncomplicated Follow-Up (FU) Care**

Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow-up days (FUD) column ~~to the right of~~ for each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.

~~8.~~ The maximum reimbursement allowance~~s~~ cover~~s~~ all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure ~~billed in conjunction with the ZZZ procedure~~ (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

~~B~~C. **Follow-up ~~Care~~ for Diagnostic Procedures**

~~Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the 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 charged for in accordance with the services rendered.When a procedure is done for diagnostic purposes, the follow-up does not include care of the condition itself, only recovery/recovery care for the procedure itself.

C**D**. **Follow-up Care for Therapeutic Surgical Procedures**

Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges.When a procedure is therapeutic in nature, the follow-up care includes routine post-op care and recovery. Any care needed for complications, care needed that is not part of routine post-op recovery, or any care that is not due to the procedure itself, may warrant additional charges.

D**E**. **Separate Procedures**

Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific "separate procedure" code.

E**F**. **Additional Surgical Procedure(s)**

When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

F**G**. **Microsurgery, Operating Microscope, and Use of Code 69990**

The surgical microscope is employed when the surgical services are performed using the technique of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for reporting visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where the use of the operating microscope is considered an inclusive component. When an The operating microscope is considered inclusive in the used during an operative procedure, it should be billed with code 69990. Modifier 51 is not reported with this code. This code is not reimbursed for use of corrective vision apparatus or magnifying devices. CPT code 69990 should not be billed with the following codes that include the use of the operating microscopeonly: 15756–15758; 15842; 19364; 19368; 20955–20962; 20969–20973; 22551, 22552, 22856–22861, 26551–26554; 26556; 31526; 31531; 31536; 31541; 31545; 31546; 31561; 31571; 43116; 43496; 49906; 61548; 63075, –63078; 64727; 64820–64823; 65091–68850; 0184T. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services. (For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique.) Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.

G**H**. **Unique Techniques**

A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.

H**I**. **Surgical Destruction**

Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

~~I~~J. **Incidental Procedure(s)**
An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

~~J~~K. **Endoscopic Procedures**
When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

~~K~~L. **Biopsy Procedures**
A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

~~L~~M. **Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs**
The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. Normal wound repair is considered part of the nerve, blood vessel and/or tendon repair. Additional reimbursement for wound repair is only warranted if it is a complex wound, and modifier 59 should be used to identify such.~~The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.~~

~~M~~N. **Suture Removal**
Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

~~N~~O. **Joint Manipulation Under Anesthesia**
There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the MRA for manipulation may be allowed.

~~O~~P. **Supplies and Materials**
Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

~~P~~Q. **Plastic and Metallic Implants**
Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

~~Q~~R. **Aspirations and Injections**
1. Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

2. When joint injections/trigger point injections are performed, ultrasound guidance is considered integral to the procedure and will not be separately reimbursed.

~~R~~S. **Surgical Assistant**

1. Physician Surgical Assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).
2. Registered Nurse Surgical Assistant or Physician Assistant
    a. A physician assistant, or registered nurse~~s~~ who ~~have~~ has completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).
    b. The maximum reimbursement allowance for the physician assistant or the registered nurse first assistant (RNFA) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.
    c. Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or RNFA at the same surgical encounter.
    d. Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA.
    e. CPT codes with modifier AS should be used to bill for physician assistant or RNFA services on a CMS-1500 form or electronic claim and should be submitted with the charge for the surgeon's services.
3. The Fee Schedule includes a column indicating which procedures are approved for assistant services with Y (yes) or N (no). If a surgical procedure is approved/precertified for a code with a Y in the "Assist Surg" column, the assistant is implied and does not require separate approval/precertification for reimbursement.

~~S~~T. **Operative Reports**

An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services, and should document the use of assistant services.

~~T~~U. **Needle Procedures**

Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

~~U~~V. **Therapeutic Procedures**

Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526–20610, 64400–64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

~~V~~W. **Anesthesia by Surgeon**

In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

~~W~~X. **Therapeutic/Diagnostic Injections**

Injections are considered incidental to the procedure when performed with a related invasive procedure.

~~X~~Y. **Intervertebral Biomechanical Device(s) and Use of Code 22851**

Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training, experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependent on a specific manufacturer, shape, or material of which it is constructed. Qualifying devices are machine cut to specific dimensions for precise application to an intervertebral defect. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a machine cut hexahedron cortical, cancellous, or corticocancellous allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

~~Y~~Z. **Intra-operative neurophysiologic monitoring (e.g., SSEP, MEP, BAEP, TES, DEP, VEP).**

All intra-operative neurophysiologic monitoring requires pre-authorization. Reimbursement for intra-operative neurophysiologic monitoring will not be allowed in the following cases, unless mutually agreed to by the payer and the provider:

1. Neuromuscular junction testing of each nerve during intraoperative monitoring;
2. Intraoperative monitoring during peripheral nerve entrapment releases, such as carpal release, ulnar nerve transposition at the elbow, and tarsal tunnel release;
3. During decompression of cervical nerve roots without myelopathy;
4. During placement of cervical instrumentation absent evidence of myelopathy;
5. During lumbar discectomy for ~~radiculopaty~~radiculopathy; or
6. During lumbar decompression for treatment of stenosis without the need for instrumentation.

~~II. AMBULATORY SURGERY CENTERS~~

~~A. Definition~~

~~For purposes of this section of the Fee Schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgery center may be a freestanding facility or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.~~

B. Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee based upon APC values. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the APC MRA, the lesser of the charges is paid to the facility.
5. The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
    - Nursing and technician services
    - Use of the facility
    - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
    - Materials for anesthesia
    - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery:
    - Pharmacy
    - Medical/surgical supplies
    - Sterile supplies
    - Operating room services
    - Anesthesia
    - Ambulatory surgical care
    - Recovery room
    - Treatment or Observation room
7. APC fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, CRNA or anesthesia physician services, prosthetic devices, ambulance services, braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to Fee Schedule MRA or HCPCS MRA, whichever is appropriate.

C. Facility Fee Reimbursement for ASCs

1. The Mississippi Worker's Compensation Commission has adopted the Medicare Ambulatory Payment Classification (APC) for classifying payment of facility fees for ambulatory surgery. The specific rates and groupings are more fully explained in the section on Inpatient and Outpatient Care Rules.
2. The APC payment rate has been added to the CPT code listing of fees in the Anesthesia, Surgery, Pathology and Laboratory, Radiology, and Medicine sections of the Fee Schedule. The column lists the total approved APC or facility fee for that particular CPT code.
3. The facility fees will be paid using APC values for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.

~~4. Procedures not assigned an APC fee will be reimbursed according to the lesser of total billed charges or usual and customary rates.~~

III. MULTIPLE PROCEDURES

A. **Multiple Procedure Reimbursement Rule**
Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second and subsequent procedures

B. **Bilateral Procedure Reimbursement Rule**
Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below:

69300 50 Otoplasty, protruding ear<u>, with or without size reduction</u>

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is one hundred dollars ($100.00) and it is performed bilaterally, reimbursement shall be one hundred fifty dollars ($150.00). However, if the procedure description states "bilateral," reimbursement shall be as listed in the Fee Schedule since the fee was calculated for provision of the procedure bilaterally.

C. **Multiple Procedures—Different Areas Rule**
When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

D. **Multiple Procedure Billing Rules**
1. The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

~~IV~~III. REPAIR OF WOUNDS

A. ~~Definitions~~Wound classifications of simple, intermediate, or complex are expected to be consistent with current CPT descriptions/definitions/guidelines.

~~Wound repairs are classified as simple, intermediate, or complex.~~

~~1. Simple repair. Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one layer closure/suturing. This includes local anesthesia and chemical or electrocauterization of wounds not closed.~~

~~2. Intermediate repair. Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.~~

~~3. Complex repair. Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.~~

B. Reporting

~~The following instructions are for reporting services at the time of the wound repair:~~

1. The use of appropriate codes should be consistent with the current CPT guidelines.~~The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.~~

~~2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.~~

~~3. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure (extensive debridement of soft tissue and/or bone).~~

~~4. Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.~~

~~5. Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.~~

~~6. Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W-plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered "bundled" into the tissue transfer procedure and is not reimbursed separately.~~

~~7~~2. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

IV. MUSCULOSKELETAL SYSTEM

A. **Casting and Strapping**
This applies to severe muscle sprains or strains that require casting or strapping.

1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.
3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

B. **Fracture Care**

1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.
2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
3. The phrase “with manipulation” describes reduction of a fracture.
4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate “repeat procedure” by the same physician.
5. The term “complicated” appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the “complicated” descriptor to justify reimbursement.

C. **Bone, Cartilage, and Fascia Grafts**

1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.

D. **Arthroscopy**
Note: ~~Surgical arthroscopy always includes a d~~Diagnostic arthroscopy is considered to be included in a surgical arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.

3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

E. **Arthrodesis Procedures**

Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.

To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement "including minimal discectomy" to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.

F. **External Spinal Stimulators Post Fusion**

1. The following criteria ~~is~~are established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
    a. Patient has had a previously failed spinal fusion, and/or
    b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
    c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion
2. The external spinal stimulator is not approved by the Mississippi Workers' Compensation Commission for use in primary spinal fusions.
3. The external spinal stimulator will be reimbursed by report (BR).
4. Precertification is required for use of the external spinal stimulator.

G. **Carpal Tunnel Release**

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

VI. BURNS, LOCAL TREATMENT

A. **Degree of Burns**

1. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
2. Codes 16020–16030 must be used when billing for treatment of partial-thickness burns only.
3. The claim form must be accompanied by a report substantiating the services performed.
4. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000–11001. Modifier 51 does not apply.

B. **Percentage of Total Body Surface (TBS) Area**

The following definitions apply to codes 16020–16030:

1. "Small" means ~~less than five percent (5%) of the total body surface area~~a burn that encompasses five percent (5%) of TBS area or less.
2. "Medium" means ~~whole face or whole extremity or five to ten percent (5%–10%) of the total body surface area~~a burn that encompasses five percent to ten percent (5%–10%) of TBS or that involves the whole face, or a whole extremity.
3. "Large" means ~~more than one extremity or greater than ten percent (10%) of the total body surface area~~a burn that encompasses greater than ten percent (10%) TBS area.

C. **Reimbursement**

1. To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
2. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

VII. NERVE BLOCKS

A. **Diagnostic or Therapeutic**

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.
    a. The name of the medication(s), dosage, and volume must be identified.
    b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

B. **Anesthetic**

When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

VIII. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. ~~Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes follow.~~

Modifiers commonly used in surgery are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi guideline ~~Mississippi's note~~: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures ~~00100-01999~~.

Mississippi guideline~~Mississippi's note~~: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate ~~five~~ 5 digit code.

51 Multiple Procedures

When multiple procedures, other than E/M services, ~~p~~Physical ~~m~~Medicine and ~~r~~Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual~~provider~~, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see ~~the applicable CPT book a~~Appendix D).

Mississippi guideline~~Mississippi's note~~: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the ~~most current CPT book~~Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When ~~one~~1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When ~~one~~1 physician or other qualified health care professional performed the postoperative management and another ~~physician~~ performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When ~~one~~1 physician or other qualified health care professional performed the preoperative care and evaluation and another ~~physician~~ performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned ~~prospectively at the time of the original procedure~~ or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a ~~diagnostic~~ surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the ~~operation~~ operating/~~or~~ procedure room (eg, an unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. ~~This may represent a~~ Documentation must support a different session ~~or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) ~~is~~are performed during the same surgical session, ~~a~~ separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of an additional procedure(s), other than those reported with the modifier 62, during the same surgical session, ~~the~~ those service~~s~~~~(s)~~ may be reported using ~~a~~ separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professional, often of different specialties, plus other highly skilled, specially trained personnel, ~~and~~ various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating ~~physician~~ individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure~~/~~ or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

~~The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.~~It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this ~~subsequent~~ procedure is related to the first and requires the use of ~~the~~an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures ~~on the same day~~, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The ~~physician~~ individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi guideline~~Mississippi's note~~: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi guideline~~Mississippi's note~~: Physician reimbursement is ten percent (10%) of the maximum reimbursement allowance~~allowable~~.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances ~~two~~2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AS ~~Assistant At Surgery Services Provided By Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist~~ Services for Assistant at Surgery

Assistant at surgery services provided by ~~a~~another qualified individual (e.g., physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant) ~~Registered Nurse First Assistant (RNFA), Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist~~ and not another physician are identified by adding modifier AS to the listed applicable surgical procedures. ~~The use of the~~ Modifier AS ~~modifier~~ may be appended to ~~is appropriate for~~ any code identified ~~that otherwise is reimbursable for a physician assisting a surgeon in the operating room~~as appropriate for surgical assistance in this Fee Schedule.

Mississippi guideline~~Mississippi's note~~: Modifier AS reimbursement is ten percent (10%) of the ~~allowable~~maximum reimbursement allowance. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

~~IX. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE~~

~~*25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*~~

~~It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M~~

service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an

E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

~~***91 Repeat Clinical Diagnostic Laboratory Test***~~

~~In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.~~

Radiology

I. SCOPE

The following guidelines apply to radiology services provided in offices, clinics, and under some circumstances in hospital x-ray departments. This section also contains guidelines that include nuclear medicine and diagnostic ultrasound.

II. GUIDELINES

A. **Total ~~Component~~Fee**

A total fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the Amount column represent the total reimbursement.

B. **Professional Component**

The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. Values in the PC Amount column are intended for the services of a radiologist for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

C. **Technical Component**

The technical component includes charges made by the institution or clinic to cover the services of technologists and other staff members, the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by HCPCS Level II modifier TC. The technical component amount is calculated by subtracting the PC Amount from the Amount for the total reimbursement.

D. **Review of X-rays**

Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is inherent to the evaluation and management code:

- The physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere.

- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.
- CPT® code 76140 Consultation on x-ray examination made elsewhere, written report, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services.
- This provision is for payment of a second interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation requests the expertise of another physician (i.e., expertise of a radiologist). CPT code 76140 is to be used when a second opinion is required for a radiological procedure. Reimbursement is limited to the ~~professional component~~ PC Amount listed in the Fee Schedule for that procedure.

E. **Additional X-rays**

No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic or digital media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

F. **Contrast Material**

1. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).
2. Low osmolar contrast material and paramagnetic contrast materials shall only be billed when not included in the descriptor of the procedure. When appropriately billed, the contrast media is reimbursed according to the maximum reimbursement allowance ~~rate~~ (MRA) listed in the HCPCS section of the Fee Schedule. Supplies are considered incidental to the administration of the contrast and are not separately reimbursable~~should be billed with the appropriate HCPCS Level II code and will be reimbursed according to the Fee Schedule~~.
3. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration is included as part of the procedure.
4. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and does not command a separate fee.

G. **Urologic Procedures**

In the case of urologic procedures (e.g., CPT codes 74400–74485), insertion of a urethral catheter is part of the procedure and is not separately billed.

H. **Separate or Multiple Procedures**

1. When multiple procedures are performed on the same day or at the same session, it is appropriate to designate them by separate entries. Surgical procedures performed in conjunction with a radiology procedure will be subject to the rules and regulations of the Surgery section.
2. When x-rays of multiple sections of a body area are billed separately, the total reimbursement must not exceed the maximum reimbursement allowance of the complete body area.

I. **Outpatient CT Scans and MRIs**

CT scans and MRIs, when performed on an outpatient basis, are subject to the limitations of the Fee Schedule, regardless of site of service.

J. **Unlisted Service or Procedure**

A service or procedure may be provided that is not listed in the most recent edition of the CPT book. When reporting such a service, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report. ~~The u~~Unlisted procedure~~s~~ codes ~~and accompanying codes are as follows:~~are listed in the CPT book.

~~76496 Unlisted fluoroscopic procedure (eg, diagnostic, interventional)~~

~~76497 Unlisted computed tomography procedure (eg, diagnostic, interventional)~~

~~76498 Unlisted magnetic resonance procedure (eg, diagnostic, interventional)~~

~~76499 Unlisted diagnostic radiographic procedure~~

~~76999 Unlisted diagnostic ultrasound procedure~~

~~77299 Unlisted procedure, therapeutic radiology, clinical treatment planning~~

~~77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services~~

~~77499 Unlisted procedure, therapeutic radiology treatment management~~

~~77799 Unlisted procedure, clinical brachytherapy~~

~~78099 Unlisted endocrine procedure, diagnostic nuclear medicine~~

~~78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine~~

~~78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine~~

~~78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine~~

~~78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine~~

~~78599 Unlisted respiratory procedure, diagnostic nuclear medicine~~

~~78699 Unlisted nervous system procedure, diagnostic nuclear medicine~~

~~78799 Unlisted genitourinary procedure, diagnostic nuclear medicine~~

~~78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine~~

~~79999 Unlisted radiopharmaceutical therapeutic procedure~~

K. **Special Report**

~~A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service.~~ Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used, and a full report of the findings. ~~Pertinent~~ Additional information provided should include an ~~adequate~~ acceptable definition or description of the extent and nature of the procedure, as well as information regarding the ~~nature, extent, and~~ need for the procedure~~, and the time, effort, and equipment necessary to provide the service~~. Also essential is data regarding the equipment necessary to perform the service, as well as the time and effort required. Special reports to justify the necessity of a service do not warrant a separate fee.

L. **By Report (BR)**

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

M. **Radiology Supervision and Interpretation Procedures**
There are times when a single physician may perform the procedure and supervise the imaging and interpretation. On other occasions, one physician may perform the procedure, and the imaging supervision with interpretation may be performed by another physician. The appropriate radiology codes are to be used for supervision and interpretation of the imaging. The appropriate surgical codes are to be used for the procedure, including necessary local anesthesia, placement of needle or catheters, injection of contrast media, etc. The surgical codes are subject to the rules and regulations of the Surgery section, and the radiology codes are subject to this section of radiology rules and regulations.

N. **Written Report(s)**
A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

O. **Facility Fee**
The Facility Fee for outpatient services is the APC Amount.~~The Facility Fee for outpatient services is the APC amount.~~

III. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow.~~Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number, separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow.~~ Modifiers commonly used in radiology (including nuclear medicine and diagnostic ultrasound) are as follows:

~~***22 Increased Procedural Services***~~
~~When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.~~

~~*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*~~

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a ~~physician~~ professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: ~~Mississippi's note:~~ The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Service

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures

When multiple procedures, other than E/M services, ~~p~~Physical ~~m~~Medicine and ~~r~~Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same ~~provider~~individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see ~~the applicable CPT book~~Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure~~/~~ or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

~~The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.~~ It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers

Under certain circumstances ~~two~~ 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Pathology and Laboratory

I. GUIDELINES

A. **Pathology Services**
~~Services in p~~Pathology and ~~l~~Laboratory services are provided for evaluating the nature of disease or a change in body tissue and organs due to injury and/or caused by a disease.~~by the pathologist, or by the technologist, under responsible supervision of a physician.~~

B. **Separate or Multiple Procedures**
~~It is appropriate to designate~~When multiple procedures are performed ~~rendered~~ on the same date or at the same session, it is appropriate to designate them by separate entries.

C. **Unlisted Service or Procedures**
Unlisted codes are used for laboratory/pathology services which do not currently have a CPT® code. All unlisted codes require an explanation and report. A list of unlisted codes may be found in the CPT book.~~A service or procedure may be provided that is not listed in this fee schedule. When reporting such a service or procedure, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report as discussed below. The unlisted procedures and accompanying codes for Pathology and Laboratory are as follows:~~

~~81099 *Unlisted urinalysis procedure*~~

~~84999 *Unlisted chemistry procedure*~~

~~85999 *Unlisted hematology and coagulation procedure*~~

~~86849 *Unlisted immunology procedure*~~

~~86999 *Unlisted transfusion medicine procedure*~~

~~87999 *Unlisted microbiology procedure*~~

~~88099 *Unlisted necropsy (autopsy) procedure*~~

~~88199 *Unlisted cytopathology procedure*~~

~~88299 *Unlisted cytogenetic study*~~

~~88399 *Unlisted surgical pathology procedure*~~

~~89240 *Unlisted miscellaneous pathology test*~~

D. **Special Report**

Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used and a full report of the findings. Special reports to justify the necessity of a service do not warrant a separate fee.~~A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include 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. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. This report does not command a separate fee for completion.~~

E. **By Report (BR)**

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

F. **Facility Fee**

The Facility Fee for outpatient services is the APC Amount.

II. GENERAL INFORMATION AND INSTRUCTIONS

A. **Panel Tests**

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (8004~~7~~8–80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

B. **Handling and Collection Process**

1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

C. **Global, Professional, and Technical Components**

Some procedures in the Pathology and Laboratory section are considered global fees (Amount) and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC ~~fee~~ Amount in addition to the ~~global fee~~Amount. For procedures listed with a PC ~~fee~~ Amount, the TC reimbursement rate is calculated by subtracting the PC ~~a~~Amount from the ~~total a~~Amount. The professional component should be billed with modifier 26.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results
- A written report, not a computer generated report, is submitted with the request for payment\

D. **Occupational Blood Exposure Testing/Treatment**

1. Work related Blood Exposures should minimally meet the appropriate CDC Guidelines for Management of Occupational Blood Exposures.
2. The CDC Guidelines are updated at intervals and the most current guidelines should be used.
3. Current information can be obtained at www.cdc.gov.

E. **Drug Screens**

1. Post-Accident Drug Screens should comply with MCA §71-7-1 and other state and federal regulations with which the employer must comply. Reimbursement will either be made by the payer/carrier or the employer.
2. Other drug screens: The only codes reimbursed by workers' compensation for drug screens other than Post-Accident are G0431 thru G0435.

III. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow.~~Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow.~~ Modifiers commonly used in pathology and laboratory are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi~~'s note~~ guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a ~~physician~~ professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi~~'s note~~ guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/~~ or~~ services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session~~ or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when ~~an~~other code(s) describe~~s~~ a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for ~~a~~ laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require permanent dedicated space; hence by its design ~~it~~ may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances ~~two~~2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Medicine Services

In addition to the general rules, this section applies ~~to~~ unique guidelines for medicine specialties. ~~Physical medicine~~ Therapeutic services and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

I. GUIDELINES

A. **Unlisted Services or Procedures**
Unlisted codes are used for medical services which do not currently have a CPT® code. All unlisted codes require an explanation and report. Unlisted codes are listed in the CPT book.~~When a service or procedure is provided that is not specifically listed in the Fee Schedule, documentation must be submitted to substantiate the charge.~~

B. **Multiple Procedures**
It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. **Separate Procedures**
Separate procedures are commonly carried out as an integral component of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific "separate procedure" code.~~Some of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.~~

D. **By Report (BR) Procedures**
By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.~~"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.~~

E. **Special Report**
Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used, and a full report of the findings. Special reports to justify the necessity

of a service do not warrant a separate fee.~~A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include 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. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.~~

F. **Materials Supplied by Physician**

Supplies and materials usually included in an office visit are included in the reimbursement for the office visit.~~provided by the physician over and above those usually included with the office visit~~ Other unusual supplies and materials should be identified with CPT code 99070 or specific HCPCS Level II code. Reimbursement shall be limited to the Fee Schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this Fee Schedule.

G. **Audiological Function Tests**

The audiometric tests (9255~~1~~0–9259~~7~~6) are reimbursed based on the AMA CPT Guidelines.~~require use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the examination and not paid separately.~~ All descriptors refer to testing of both ears.

H. **Psychological Services**

~~Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.~~

~~Psychotherapy codes (90804–90857) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).~~

~~A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors.~~

1. Payment for a psychiatric diagnostic interview/evaluation includes history and mental status determination, development of a treatment plan when necessary and the preparation of a written report that must be submitted with the required billing form. Use of an E/M code with a diagnostic interview/evaluation is not appropriate.
2. Psychotherapy codes from the current CPT manual are used regardless of place of service. The CPT code most closely matching the length of the session must be billed.
3. Use of an E/M code with a psychotherapy code should follow the guidelines from the CPT book and the American Psychiatric Association.
4. A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors, etc.

I. **Electromyography (EMG)**

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG

performed on the same day, with supporting documentation required as outlined in the Evaluation and Management section. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

J. **Manipulative Services**

Chiropractic and Osteopathic manipulative services, which are medicine services, will be discussed in the ~~Physical Medicine~~Therapeutic Services section.

II. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. ~~Listed services and procedures may be modified under certain circumstances. When applicable, identify the modifying circumstance by the addition of the appropriate modifier code, which may be reported by a two-digit number placed after the usual procedure number separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow.~~ Modifiers commonly used in Medicine Services are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi guideline~~'s note~~: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a ~~physician~~ professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline~~'s note~~: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M services, ~~p~~Physical ~~m~~Medicine and ~~r~~Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same ~~provider~~individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see ~~the applicable CPT book~~Appendix D).

Mississippi guideline~~'s note~~: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the ~~applicable CPT book~~Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the ~~physician's~~ discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the ~~physician~~ individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When ~~one~~ 1 physician or other qualified health care professional performed the postoperative management and another ~~physician~~ performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When ~~one~~ 1 physician or other qualified health care professional performed the preoperative care and evaluation and another ~~physician~~ performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

~~*57 Decision for Surgery*~~

~~An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.~~

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned ~~prospectively at the time of the original procedure~~or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a ~~diagnostic~~ surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For the treatment of a problem that requires a return to the operating~~/ or~~ procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures~~/ or~~ services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session ~~or patient encounter~~, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or ~~/~~service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.~~The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.~~

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this ~~subsequent~~ procedure is related to the first, and requires the use of ~~the~~an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures ~~on the same day~~, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The ~~physician~~ individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

~~*90 Reference (Outside) Laboratory*~~

~~When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.~~

99 Multiple Modifiers

Under certain circumstances ~~two~~ 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Therapeutic Services ~~Physical Medicine~~

I. SCOPE

A. **Therapeutic Services**~~Physical Medicine~~
Therapeutic services are ~~Physical medicine is~~ an integral part of the healing process for a variety of injured workers. Recognizing this, the Fee Schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Therapeutic Services ~~Physical Medicine~~ section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, ~~and~~ licensed occupational therapists, and speech pathologists.

B. **Selection of Providers**
Physical or occupational therapy, including work hardening, functional capacity evaluations, chronic pain programs, or massage therapy shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician, the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.

~~B~~C. **Physical Medical Assessment**

1. An assessment must be performed to determine if a patient will benefit from therapeutic services.~~physical medicine therapy.~~
2. When a physician examines a patient and an assessment for therapeutic services ~~physical medicine~~ is performed, the billing for the office visit includes the therapeutic assessment.~~physical medicine assessment.~~
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists. Procedure code 92506 is to be used for initial assessment by a speech pathologist.

~~C~~D. **Plan of Care**

1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain:
    a. The specific therapies to be provided, including the frequency and duration of each
    b. The estimated duration of the therapeutic regimen
    c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)

2. The initial plan of care must be signed by the treating physician and submitted to the payer within fourteen (14) days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.
3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.
4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.
5. Preparation of a care plan does not warrant a separate fee.

~~D~~E. **Qualifications for Reimbursement**

1. The patient's condition must have the potential for restoration of function.
2. The treatment must be prescribed by the authorized attending or treating physician.
3. The treatment must be specific to the injury and have the potential to improve the patient's condition.
4. The physician or therapist must be on-site during the provision of services.

II. REIMBURSEMENT

A. **Guidelines**

1. Visits for therapy may not exceed one visit per day without prior approval from the payer.
2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:
    a. The treatment must be medically necessary.
    b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of the payer representative giving authorization for the continued therapy.
3. Reimbursement is limited to no more than four (4) therapies concurrently at the same visit. In the event of multiple treatment areas, an additional four (4) therapies per treatment day may be allowed at the payer's discretion and with pre-authorization. In the event of multiple treatment areas, the second and subsequent areas are subject to the multiple procedure rule.

~~***[In the pain management setting, no more than two (2) modalities and/or procedures may be used on a given day (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). No more than one (1) modality may be used concurrently.]***~~

4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will not be allowed in the treatment of work-related injury/illness.
5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.
6. Only one (1) work hardening or work conditioning program is reimbursed per injury.
7. The Physical Therapist Assistant or Occupational Therapist Assistant shall be reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure. Mississippi modifier "M3"

should be attached to the appropriate CPT® code(s) when billing services rendered by a Physical Therapist Assistant or an Occupational Therapist Assistant.

8. NCCI edits or other bundle/unbundle edits do not apply to the CPT codes in the Therapeutic Services section, other than the stated rules provided in this section.

B. **Treatment Areas**

1. Spinal areas are recognized as the following five distinct regions:
   - Cranial
   - Cervical
   - Thoracic
   - Lumbar
   - Sacral

   Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral).
2. Pelvis
3. Upper extremity (either left or right) is recognized as the following six distinct regions:
   - Shoulder
   - Upper arm
   - Elbow
   - Forearm
   - Wrist
   - Hand
4. Lower extremity (either left or right) is recognized as the following eight distinct regions:
   - Hip
   - Thigh
   - Knee
   - Calf
   - Ankle
   - Foot
   - ~~Rib cage~~
   - ~~Anterior trunk~~
5. Rib cage
6. Anterior trunk

C. **Tests and Measurements**

1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 Total evaluation of body, including hands.
2. Functional capacity evaluation (FCE) must have pre-authorization from the payer before scheduling the tests.

3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a thirty (30) day period for the same body area. ~~If a physician's order specifically indicates testing in more than one plane of motion, (e.g., flexion/extension and internal/external rotation), then each plane of motion test is reimbursable, but not more than once in a thirty (30) day period for that same body area. The multiple procedure rule would apply.~~

D. **Fabrication of Orthotics**

1. Procedure code 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.
2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes ~~and Other HCPCS Codes~~ section of the Fee Schedule. For orthotics and supplies not listed in the DME ~~and Other HCPCS Codes~~ section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider's cost and an invoice may be required by the payer before reimbursement is made.

E. **~~Follow-up Examination~~Re-evaluation of an Established Patient**

A physician, physical therapist, ~~or~~ occupational therapist, or speech therapist may charge and be reimbursed for a ~~follow-up examination~~ re-evaluation for ~~physical therapy~~therapeutic services only if new symptoms present the need for re-examination and evaluation as follows:

1. There is a definitive change in the patient's condition
2. The patient fails to respond to treatment and there is a need to change the treatment plan
3. The patient has completed the therapy regimen and is ready to receive discharge instructions

III. WORK HARDENING RULES

Refer to the Utilization Review Rules section for specific requirements related to work hardening.

~~A. Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.~~

~~B. Not all claimants require these programs to reach a level of function that will allow successful return to work.~~

~~C. Only those programs that meet all of the specific guidelines will be defined as work hardening programs.~~

~~D. Programs will be reimbursed per the Fee Schedule after meeting all other requirements.~~

~~E. Work hardening will be reimbursed for a maximum of four weeks with prior authorization from the payer. The payer may approve additional two-week increments if the patient demonstrates substantial improvement.~~

~~F. For pre-admission criteria, all claimants must complete a preprogram assessment, including a functional capacity evaluation (FCE). The goal of the program is return to work; therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:~~

~~1. Specific written critical job demands and/or job site analysis~~

~~2. Verified written employment opportunities~~

G. For the evaluation process, initial screening evaluation is performed to determine if the injured worker will benefit from a work hardening program. The outcome of this evaluation will be:

1. Recommendation of release to return to work

2. Acceptance into the program with an individual written rehabilitation plan stating specific goals and recommended services

3. Rejection from program for specific reasons

4. Referral back to the provider for medical evaluation

H. The individualized work hardening plan must be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a one-to-one basis, more than fifty percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than five-to-one (5 patients to 1 therapist).

I. Progress should be documented and reviewed to ensure continued progress.

J. Simultaneous utilization of work conditioning and work hardening is not allowed. Prior authorization is required for either one of these services and requires documentation of specific goals and outcomes.

K. Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

L. Voluntary discharge is achieved by:

1. Meeting program goals

2. Early return to work

3. Acute or worsening medical condition

4. The claimant declining further treatment

M. Non-voluntary discharge may be necessary in cases of:

1. Failure to comply with program policies

2. Absenteeism

3. Lack of demonstrable benefit from treatment

N. Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and treating and attending (if different) provider.

O. Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the attending provider for release from the program.

P. The attending provider must sign a release to return to work when the program goals are achieved.

Q. The exit/discharge summary should delineate the person's:

1. Present functional status and potential

2. Functional status related to the targeted job, alternative occupations, or competitive labor market

R. For program evaluation, programs must provide insurers and referring providers with:

1. Initial interdisciplinary team evaluation report

2. Proposed treatment plan

3. Progress reports at weekly intervals

4. The opportunity to attend team meetings

~~5. Final discharge summary report~~

~~S. Fees for work hardening programs will be paid in accordance with the Fee Schedule, with written prior approval by the payer, utilizing the following guidelines:~~

~~1. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.~~

~~2. Non-~~multi~~ disciplinary work conditioning programs will be reimbursed utilizing existing physical therapy, occupational therapy, and physical medicine codes. CPT code 97545 (initial two hours) and code 97546 (each additional hour) are to be used to bill work hardening. CPT code 97545 is to be billed for the initial two hours of the work hardening program. This is a one-time charge. CPT code 97546 is to be used for billing each additional hour of the work hardening program after the initial two hours (indicated by code 97545).~~

IV. FUNCTIONAL CAPACITY EVALUATIONS

A. **The functional capacity evaluation (FCE) is utilized for the following purposes:**
   1. To determine the highest level of safe functionality and of maximal medical improvement.
   2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
   3. To objectively set restrictions and guidelines for return to work.
   4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
   5. To determine whether additional treatment or referral to a work hardening program is indicated.
   6. To assess outcome at the conclusion of a work hardening program.

B. **General Requirements**
   1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated.
   2. The FCE requires prior authorization by the payer.
   ~~3. The FCE should be billed using code 97750 Functional capacity evaluation.~~

C. The FCE should be billed using code 97750 Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Reimbursement of an FCE is limited to a maximum of 20 units. Documentation must include start and stop times for testing.

V. TENS UNITS

A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.

B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

VI. SUPPLIES, EQUIPMENT, ORTHOTICS, AND PROSTHETICS

A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than one hundred dollars ($100.00) ~~fifty dollars ($50.00)~~ per item for workers' compensation patients. When submitting bills, include the appropriate HCPCS Level II code. ~~. O~~or, if there is not an appropriate HCPCS code, use CPT code 99070.

B. The payer has sole right of selection of vendors.

VII. OTHER INSTRUCTIONS

A. Charges will not be reimbursed for publications, books, or digital media~~videocassettes~~ unless prior approval of the payer is obtained.

B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.

C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.

D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.

E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.

F. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.

G. Non-surgical debridement should be billed as CPT code 97597, 97598, or 97602.

VIII. BACK SCHOOLS

Back schools are no longer covered services under this Fee Schedule.

~~All back school programs shall require prior authorization from the payer. The payer and the back school program may agree upon the daily, weekly, or other time-based payment to be made for services provided to the injured/ill worker. This agreement shall supersede the use of this Physical Medicine section when calculating reimbursement, but it shall not exceed the usual and customary fee.~~

IX. MASSAGE THERAPY

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

X. CHIROPRACTIC MANIPULATIVE TREATMENT

Chiropractic manipulative treatments are allowed for up to fifteen (15) visits or thirty (30) days, whichever first occurs, without any need to seek pre-certification or authorization. However, chiropractic manipulative

treatments which are proposed beyond the first fifteen (15) visits or thirty (30) days, under any circumstances, must be pre-certified or pre-approved.

~~Codes 98940 through 98943 are used to code chiropractic manipulative treatment.~~ Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

XI. ELECTROMYOGRAM (EMG) AND NERVE CONDUCTION STUDY (NCS)

A. Only a licensed physical medicine doctor or a neurologist is entitled to reimbursement for performing an electromyogram (EMG) and/or a nerve conduction study (NCS).

B. Reimbursement is not allowed under this Fee Schedule for automated nerve conduction studies.

C. Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

XII. CHRONIC PAIN—INTER-~~DISCLIPLINARY~~DISCIPLINARY PAIN REHABILITATION PROGRAM

A. The Inter-Disciplinary Pain Rehabilitation (IDPR) program is based on the bio-psychosocial approach to managing chronic pain, and uses both ~~physicial~~physical medicine treatments as well as psychological treatments and therapy to manage the chronic pain patient. A goal oriented, team approach is used in an effort to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain. This is an outpatient program.

B. Pre-authorization is required in order to utilize an inter-~~disciliplinary~~disciplinary pain rehabilitation program to treat the chronic pain patient. A specific IDPR program plan must be submitted to the payer as part of the pre-authorization process.

C. The following guidelines shall be used to assist in pre-authorization, and concurrent review:

1. Persons considered suitable candidates for an inter-~~discliplinary~~disciplinary pain rehabilitation program are those:
    a. who are likely to benefit from the program design~~.~~;
    b. whose ~~symtoms~~symptoms are deemed by a pain management provider to constitute chronic pain syndrome; and
    c. whose medical, psychological, or other conditions do not prohibit participation in this program.
2. Mental Health Evaluation: an initial evaluation to determine the injured worker's readiness or suitability for this type of treatment may be performed prior to initiation of treatment. This evaluation is not considered part of the IDPR program and shall be billed separately.
3. Due to the nature of intensity of the program, both group and individual therapy may be part of the IDPR program. If the program plan for a particular patient includes individual psychotherapy, it

shall be billed as part of the program, and not separately. If the program does not include psychotherapy services, such services may be billed separately, if used, subject to applicable pre-authorization requirements.

4. Psychological treatments which are part of the IDPR program may be rendered by a psychiatrist, psychologist, licensed ~~counsler~~counselor, or licensed social worker.
5. The IDPR program shall always include a component designed to reduce the patient's dependence on and/or addiction to pain medications.
6. An individual plan of treatment shall be supervised by a doctor within a therapeutic environment. Although some time is spent with a doctor on a one-to-one basis, more than fifty percent (50%) of the time may be spent in direct care under the supervision of the physical therapist, occupational therapist, mental health provider, or other licensed member of the IDPR team.
7. Program supervision shall be provided by a doctor who is trained and experienced in the treatment of patients with chronic pain syndrome. The program supervisor shall:
    a. provide direct, on-site supervision of the daily pain management activities;
    b. participate in the initial and final evaluation of the patient;
    c. write the treatment plan for the patient, and write changes to the plan based on the patient's documented response to the treatment and/or based on documented changes in the patient's condition;
    d. direct the members of the IDPR team and review the patient's progress on a regular and consistent basis.
8. Participation in an IDPR program requires a minimum attendance of four (4) hours per day during the first week. The program shall not exceed eight (8) hours per day, except that workers who actually have experience working in a job for more than eight (8) hours per day may be allowed to participate for up to ten (10) hours per day, at the discretion of the program supervisor
9. Daily treatment and patient response shall be documented and provided to the payer at least every two (2) weeks.
10. Discharged/exit criteria shall include but not be limited to:
    a. the appropriate use of medications;
    b. decreased intensity of subjective pain;
    c. increased ability of the injured worker to manage pain;
    d. reduced health care use related to the chronic pain;
    e. return to work; and/or
    f. non-compliance with the program, or failure to obtain meaningful benefit after a reasonable period of time.

D. Billing. The IDPR program shall be billed using CPT 97799 Unlisted physical medicine/rehabilitation service or procedure, and appended with modifier ~~CP~~ M5 to indicate chronic pain treatment. The total number of hours shall be indicated in the units column of the bill, or in some other conspicuous place on the bill. CARF accredited providers shall also add ~~CA~~M4 as an additional modifier.

E. Reimbursement. Reimbursement shall be as agreed to by the parties, or a maximum of one hundred twenty-five dollars ($125.00) per hour for CARF accredited providers. Providers without CARF accreditation shall be paid eighty percent (80%) of the maximum reimbursement allowance for CARF accredited providers. Units of less than one hour shall be prorated in fifteen (15) minute increments. A single fifteen (15) minute increment shall be reimbursed if the time is equal to or greater than eight (8) minutes and less than twenty-three (23) minutes.

XIII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Certain procedures or treatments, such as VAX-D therapy, are considered investigational or experimental for purposes of this Fee Schedule, and are not approved for reimbursement. ~~These procedures or treatments include.~~ :

~~A. VAX-D therapy~~

XIV. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with therapeutic services are as follows.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M Services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Dental

Current Dental Terminology (CDT), codes D0120–D999, are developed, maintained, and copyrighted by the American Dental Association (ADA). ~~Dental codes (D0120–D9999), also referred to as D codes, are a separate category of HCPCS Level II national codes that contain the complete *Current Dental Terminology* (CDT) code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).~~

CDT is updated ~~every two years~~annually. The current edition is *CDT ~~2009/2010~~2013,* which is ~~the edition that has been~~ used in this Fee Schedule.

Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and its Code Maintenance Committee. ~~and not the national panel responsible for the administration of HCPCS Level II codes. The Department of Health and Human Services has an agreement with the ADA to include *CDT 2009/2010* as a set of HCPCS Level II codes used to report dental services.~~

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

I. DEFINITION

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes~~, with the exception of the dental codes (D0120–D9999),~~ are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the Fee Schedule contains HCPCS Level II codes. (See the Dental section for dental codes.) HCPCS Level II codes that are excluded from the Fee Schedule are ~~Physician Voluntary Reporting Program Codes (G8006–G9139),~~ Alcohol/Drug Abuse Treatment Services (H0001–H2037), and National Codes for State Medicaid Agencies (T1000–T5999). ~~These three sections are not included because there is no fee associated with the code (G8006–G9139) or the code was created for State Medicaid agencies (H0001–H2307, T1000–T5999) and no fee data is available.~~ Code categories included in this section are as follows:

Transportation Services Including Ambulance	A0021–A0999
Medical/Surgical Supplies	A4206–A8004
Administrative, Misc., and Investigational	A9150–A9999
Enteral and ~~/~~Parenteral Therapy	B400034 ~~–~~B9999
Outpatient PPS	C1300–C9899~~728~~
Durable Medical Equipment (DME)	E0100–E9999~~8002~~
Procedures/Professional Services (Temporary)	G0008–G~~3001~~9186

Drugs and Biologicals	J0120–J9999
K Codes (Temporary)	K0001–K9999~~0899~~
Orthotic Procedures	L0000~~112~~ – L4999~~398~~
Prosthetic Procedures	L5000–L9999~~00~~
Medical Services	M0000~~64~~ – M0301
Pathology and Laboratory Services	P0000~~2028~~ – P9999~~9615~~
Q Codes (Temporary)	Q0035–Q9968~~9~~
Diagnostic Radiology Services	R0000~~70~~ – R5999~~0076~~
Temporary National Codes (Non-Medicare)	S0000~~12~~ – S9999
Vision Services	V0000~~2020~~ – V2999~~799~~
Hearing Services	V5000~~8~~ – V5999~~364~~

II. GUIDELINES

A. **Transportation Services Including Ambulance (A0021–A0999)**

1. Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.
2. Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:

   D Diagnostic or therapeutic site other than ~~those identified in~~ "P" or "H" when these are used as origin codes

   E Residential, domiciliary, custodial facility (other than 1819 facility~~nursing home, not skilled nursing facility~~)

   G Hospital-based ~~dialysis~~ ESRD facility ~~(hospital or hospital-related)~~

   H Hospital

   I Site of transfer (e.g.~~for example~~, airport or helicopter pad) between ~~types~~ modes of ambulance transport

   J ~~Non-hospital-based dialysis~~Free-standing ESRD facility

   N Skilled nursing facility (SNF)

   P Physician's office ~~(includes HMO non-hospital facility, clinic, etc.)~~

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office ~~enroute~~ on way to ~~the~~ hospital (includes HMO non-hospital facility, clinic, etc. destination code only).

Note: Modifier X can only be used as a destination code in the second position of a modifier.

3. Transportation codes can also be found in the S codes. See S0207, S0208, S0209, and S0215.

~~4. Outpatient facility fees are reported and reimbursed according to the Ambulatory Payment Classification (APC) amounts. See the Ambulatory Surgery section of this Schedule for additional guidelines.~~

B. **Medical and Surgical Supplies (A4206–A8004)**

1. These A codes include ~~A~~a wide variety of medical, surgical, and some DME related supplies and services ~~are represented in this section~~.
2. For rules related to DME supplies, accessories, maintenance, and repair, see F. Durable Medical Equipment below.

C. **Administrative, Miscellaneous, and Investigational (A9150–A9999)**

1. These A codes ~~cover~~ include nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

D. **Enteral and Parenteral Therapy (~~B4034~~B4000–B9999)**

1. B codes ~~This section covers~~ include ~~enteral formulae, enteral medical~~ supplies, ~~parenteral~~ formulae, nutrition solutions and ~~supplies, and enteral and parenteral~~ infusion pumps.

E. **Outpatient PPS (C1300–~~C9728~~C9899)**

1. ~~These~~ C codes ~~report~~ include drugs, biologicals, and devices used by hospitals.

   Non-OPPS hospitals, Critical Access Hospitals (CAHs), Indian Health Services ospitals (HIS), hospitals located in American Samoa, Guam, Saipan, or the Virgin Islands, and Maryland waiver hospitals may report these codes at their discretion.

2. These codes are only used for facility (technical) services.

F. **Durable Medical Equipment (DME) (E0100–E8002)**

1. E codes include durable medical equipment such as canes, crutches, walkers, commodes, decubitus care, bath and toilet aids, hospital beds, oxygen and related respiratory equipment, monitoring equipment, pacemakers, patient lifts, safety equipment, restraints, traction equipment, fracture frames, wheelchairs, and artificial kidney machines.~~All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.~~

2. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.

~~2.~~3. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.

~~3.~~4. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.

4.5. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

G. **Procedures/Professional Services (Temporary) (G0008–G3001<u>9186</u>)**

1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.
2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.
3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

H. **Drugs and Biologicals (J0120–J9999)**

1. <u>J codes include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressive drugs, inhalation solutions, and other miscellaneous drugs and solutions.</u>~~These codes report drugs and biologicals that cannot be self-administered and are typically administered by injection, infusion, or inhalation. Exceptions include oral immunosuppressive and oral chemotherapy drugs.~~
2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).
3. ~~For oral anti-emetic drugs provided in conjunction with chemotherapy treatment, see Q0163–Q0181.~~
4<u>3</u>. Additional codes for drugs and biologicals may be found in the Q codes and S codes.

I. **Temporary Codes (K0001–K<u>9999</u>0899)**

1. ~~These~~ <u>K</u> codes are temporary codes used to report durable medical equipment that do not yet have a permanent national code.
2. For rules related to DME supplies, accessories, maintenance, and repair, see F. Durable Medical Equipment above.

J. **Orthotic Procedures and Devices (L0<u>000</u>112–L4<u>999</u>398) and Prosthetic Procedures (L5000–L9900)**

1. <u>L codes include orthotic and prosthetic procedures and devices as well as scoliosis equipment, orthopedic shoes, and prosthetic implants.</u>

2. <u>The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.</u>

K. **Medical Services (M00<u>0</u>064–M0301)**

1. ~~These~~ <u>M</u> codes ~~are used to report~~ <u>include</u> office services, cellular therapy, prolotherapy, intragastric hypothermia, IV chelation therapy, and fabric wrapping of an abdominal aneurysm.
2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

L. **Pathology and Laboratory Services (P~~2028~~0000–P~~9615~~999)**

1. P codes include chemistry, toxicology, and microbiology tests, screening Papanicolaou procedures, and various blood products.~~Included in this section are codes for chemistry and toxicology tests, pathology screening tests, microbiology tests, blood, and blood products.~~
2. Blood and blood product codes report the supply of the blood or blood product only.
3. The administration of blood or blood product is reported separately.
4. Code 36430 for transfusion of blood or blood components is reported only once per encounter regardless of the number of units provided.

~~M~~L. **Temporary Codes (Q0035–Q996~~98~~)**

1. ~~These temporary~~ Q codes ~~were~~ include temporary codes developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for:
   a. Oral anti-emetic drugs
   b. Casting supplies
   c. Splint supplies
   d. Low osmolar contrast
   e. High osmolar contrast
   f. Other supplies/services
2. Cast supplies and splints should be reported with the appropriate code from Q4001–Q4051. These codes report the cost of the supply only.
3. Cast supplies and splints are reported in addition to the CPT code for fracture management.
4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.
5. Refer to the CPT guidelines for rules related to reporting fracture management and cast application.

N. **Diagnostic Radiology Services (~~R0070~~R0000–R~~5999~~0076~~)**

1. ~~These~~ R codes are used for the transportation of portable x-ray and/or EKG equipment.
2. Only a single reasonable transportation charge is allowed for each trip to a single location.
3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.

O. **Temporary National Codes (Non-Medicare) (~~S0012~~S0000–S9999)**

1. ~~These~~ The S codes ~~were developed~~ are used by the ~~Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA)~~ private sector to report drugs, services, and supplies for which there are no ~~CPT or HCPCS Level II~~ national codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.
2. See J codes for reporting rules related to drugs and biologicals.
3. ~~For the purposes of pain management, if the drugs used in the refill of the pain pump must be compounded, report the compounding service with code S9430 Pharmacy compounding and dispensing services. The compounding service shall be reimbursed at $157.44 per individual refill. For purposes other than pain management, S9430 shall be reimbursed by report (BR).~~

P. **Vision~~, Hearing, and Speech-Language Pathology~~ Services (~~V2020~~V0000~~–V2799~~V2999~~, V5008–V5364~~)**

1. ~~Vision services~~These V codes include~~s codes for reporting~~ vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.

Q. **Hearing Services (V5000-V5999)**

~~2~~1. ~~Hearing services~~ These V codes include~~s codes for~~ hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative systems.

R. The Facility Fee for outpatient services is the APC Amount.

III. MODIFIERS

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

AU Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply

AV Item Furnished in Conjunction with a Prosthetic Device, Prosthetic, or Orthotic

AW Item Furnished in Conjunction with a Surgical Dressing

KC Replacement of Special Power Wheelchair Interface

NU ~~Purchased n~~New Equipment

RR Rental ~~equipment (~~use the RR modifier when DME is to be rented)

Mississippi guideline: ~~(~~Listed amount is the per-month allowance~~)~~

UE Used durable medical ~~Purchased used~~ equipment

Mississippi guideline: Used to report the purchase of used durable medical equipment.

Inpatient Hospital and Outpatient Facility Payment Schedule and Rules

I. INPATIENT AND OUTPATIENT CARE RULES

A. **Definition:**
For purposes of this schedule, “inpatient” means being admitted to a hospital setting for twenty-four (24) hours or more. An inpatient admission does not require official admission to the hospital.

B. **Billing and Reimbursement Rules for Inpatient Care:**

1. Facilities must submit the bill for inpatient services within thirty (30) days after discharge. For those cases involving extended hospitalization, interim bills must be submitted every thirty (30) days.
2. Reimbursement for acute inpatient hospital services shall be the maximum reimbursement allowance fixed by the rules set forth in this section of the Fee Schedule, regardless of the total charge.
3. Non-covered charges include but are not necessarily limited to:
    a. Convenience items;
    b. Charges for services not related to the work injury/illness;
    c. Services that were not certified by the payer or their representative as medically necessary.
4. When reviewing surgical claims, including for outlier consideration, the following apply:
    a. Most operative procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesiologist/anesthetist. Because these services are integral to the operating room environment, they are considered as part of the OR fee and are not separately reimbursed, nor are they included separately in the total charge for outlier consideration:
        1. Cardiac monitors
        2. Oximetry
        3. Blood pressure monitor

4. Lasers
5. Microscopes
6. Video equipment
7. Set up fees
8. Additional OR staff
9. Gowns
10. Gloves
11. Drapes
12. Towels
13. Mayo stand covers
14. On-call or call-back fees
15. After-hours fees

b. Billing for surgery packs as well as individual items in the packs is not allowed and shall not be included in the total charge for outlier consideration.

c. A majority of invasive procedures requires availability of vascular and/or airway access; therefore, the work associated with obtaining this access is included in the cost of the service, i.e., anesthesia—airway access is associated with general anesthesia and is included in the anesthesia charges.

d. Recovery room and ICU rates include the charge for cardiac monitoring and oximeter. It is assumed the patient is placed in these special areas for monitoring and specialized care which is bundled into the special care rate. Call-back fees are not reimbursed for recovery room.

e. Separate reimbursement is not allowed for setting up portable equipment at the patient's bedside.

f. The following items do not qualify for separate reimbursement regardless of inpatient or outpatient status, and are not included in the total charge for outlier consideration:

1. Applicators, cotton balls, band-aides
2. Syringes
3. Aspirin
4. Thermometers, blood pressure apparatus
5. Water pitchers
6. Alcohol preps
7. Ice bags

g. Separate reimbursement is not allowed for equipment such as compressive devices, or other equipment used during the operative or immediate postoperative period.

5. Maximum reimbursement is set for the following line item charges.

a. IV pump/daily – $50.00

b. Venipuncture reimbursement is limited to $4.25 per collection. A collection fee is not appropriate for finger stick, throat culture, or stool specimen collection

c. Pharmacy add-mixture/dispensing fee is limited to $4.50 per mixture

C. **Implants, Durable Medical Equipment, and Supplies**

Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Unless otherwise specifically provided herein, implantables used in the inpatient setting are included in the applicable MS-DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables.

~~For i~~Implantables used in the outpatient setting, are included in the applicable APC payment for outpatient services, and therefore, the provider of outpatient services is not required to furnish the payer with an invoice for implantables. ~~reimbursement shall be made separately from the facility fee and all other charges; and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.~~

~~Only the actual invoiced cost of the item(s), plus ten percent (10%), will be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.~~

D. **Reimbursement Methodology**

The inpatient maximum reimbursement allowable (MRA) totals are provided by MS-DRG in this Fee Schedule. As of the effective date of this publication, the MS-DRG ~~maximum reimbursement allowable~~MRA is based upon the ~~2010~~ 2013 CMS relative weights multiplied by the base rate as determined herein. (This methodology includes inpatient psych admissions.) Any MS-DRGs outside of this Fee Schedule shall be reimbursed at seventy-five percent (75%) of charges. MS-DRG MRAs represent payment in full, unless the outlier payment is applicable, or unless a contract between the payer and provider governs reimbursement, or unless otherwise specifically stated in this Fee Schedule.

1. MS-DRG Payment is calculated by multiplying the Base Rate times the Relative Weight for the MS-DRG.
2. The Base Rate for Mississippi is the current National Medicare Base Rate in effect as of the date of discharge, multiplied by two (2). This is posted annually on the Mississippi Workers' Compensation Commission (MWCC) website, Fee Schedule section.
3. Common Medicare add-ons, such as for teaching hospitals (GME), DSH and Capital PPS, will not be allowed, and shall be considered as already included in the enhanced MS-DRG Payment under this Fee Schedule.
4. All implantables shall be included in the applicable MS-DRG reimbursement for inpatient treatment, and shall not be reimbursed separately in addition to the MS-DRG payment.
5. Outlier Payments. To provide additional reimbursement for cases where the MS-DRG payment is deemed inadequate by the Commission to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

   The amount eligible for outlier reimbursement is equal to Total Charges minus MS-DRG Payment minus Implantable Charges minus Non-Covered or Non-Qualified charges (as provided in Part I.B. above) minus the Outlier Threshold. The Outlier Threshold amount shall be specific to each facility and shall be equal to one-half (1/2) of the Medicare MS-DRG outlier threshold in effect for each facility at the time of discharge.
6. Any amount determined to be eligible for additional outlier reimbursement shall be reimbursed at fifteen percent (15%) above the facility's cost for the outlier eligible charges. Cost is determined using the facility's cost-to-charge ratio, as determined by Medicare (CMS), which is in effect at the time of discharge. These cost-to-charge ratios are posted annually on the MWCC website, Fee Schedule section. Outlier payment is figured by multiplying the eligible outlier amount by the cost-to-charge ratio, and then adding fifteen percent (15%) to compute the additional outlier payment due.

~~E. Instructions~~

~~The current CMS base rate payment and related files may be found by:~~

~~1. Going to www.cms.gov~~

~~2. Select the Medicare link (currently, upper left in the list)~~

~~3. Select Acute Inpatient PPS (currently under Medicare Fee-for-Service Payment heading in the right-hand side column)~~

~~4. From this page, you can get either the rules or the data files~~

~~5. The current base rate will be in the rules. To find it:~~

~~a. Select IPPS Regulations and Notices in left-hand column;~~

~~b. Click on the year column so the most recent years are at the top;~~

~~c. Find "Hospital Inpatient Prospective Payment Systems and FY 2010 Rates" (The year will change annually. Remember, CMS inpatient is on the federal fiscal year, so the new year begins October 1 each year);~~

~~d. Click on the link for the year. Usually, there will be a Published/Draft option. The published option is as the rule appeared in the *Federal Register*;~~

~~e. Look for a table headlined: NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR. (The headline may be slightly different. Typically, this is one of the first tables in the document);~~

~~f. The wage index for Mississippi hospitals is less than 1.0. The full update amount should be used. Therefore, find the line reading: Final Rate for FY 2010 (after multiplying FY 2010 base rate by above factors) where the wage index is less than or equal to 1.0000. Labor: $3,593.52, Nonlabor: $1,629.62~~

~~g. Adding those two amounts together produces $3,593.52, which is the 2010 National Base Rate.~~

~~6. The hospital cost-to-charge ratio, used for reducing outliers to cost as well as the DRG relative weights, is found in the Inpatient Prospective Payment System data files from the page in Step 4 above:~~

~~a. Click on Acute Inpatient Files for Download~~

~~b. Sort by year so the most recent years are at the top.~~

~~c. The MS-DRG relative weight file will be Table 5. Note: Make sure you select the correct fiscal year as proposed files for next year may be in this list.~~

~~d. The cost to charge ratio will be in Impact file for IPPS FY 2010 Final Rule November 2009.~~

~~e. After downloading, the Impact File will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called OPCCR (Column Q in the 2010 version).~~

~~F~~E. **Emergency Room Services**

Emergency room facility fees, supplies, and treatment are reimbursed according to the Ambulatory Payment Classification system, as set forth herein under the heading "Ambulatory Surgery Center/Outpatient Facility Reimbursement." ~~Radiology, lab, and physician services are reimbursed according to the Rules contained elsewhere in this Fee Schedule.~~Laboratory and radiology services are reimbursed at the technical amount calculated from the data listed in the corresponding section of this Fee Schedule. The technical amount is calculated by subtracting the PC Amount from the Amount. Physician services are to be billed on an appropriate CMS claim form and paid according to the proper section.

~~G~~F. **Observation Services**

1. **Definition**
   Observation services are those services furnished by a hospital on the hospital's premises, and include use of a bed and periodic monitoring by a hospital's staff. The service must be reasonable and necessary to evaluate a patient's condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.

2. **General Guidelines**

   a. Observation begins when the patient monitoring begins and ends when the order for discharge is written or given verbally by the physician.

   b. On rare occasions, an observation stay may be extended to forty-eight (48) hours. In such cases, medical necessity must be established and pre-authorization must be given for payment by the payer.

   c. Services which are NOT considered necessary for observation are as follows:

      1. Services that are not reasonable and necessary for the diagnosis and treatment of the work related injury, but are provided for convenience of the patient, family, or physician

      2. Any substitution of an outpatient observation for a medically appropriate inpatient admission

      3. Services ordered as inpatient by the physician but billed as outpatient by the facility

      4. Standing orders for observation following outpatient surgery

      5. Test preparation for a surgical procedure

      6. Continued care of a patient who has had a significant procedure as identified with OPPS indicator S or T

   d. Observation is not reimbursable for routine preparation furnished prior to an outpatient service or recovery after an outpatient service. Please refer to the criteria for observation services.

3. **Billing and Reimbursement**

   a. Observation status is billed at an hourly monitoring rate. The hourly rate is all inclusive with the exception of *non-significant ancillary services*.

   b. Observation is billed at the rate of $300.00 for the first three (3) hours and $80.00 per hour thereafter. Laboratory and radiology are reimbursed according to the Fee Schedule payment limits.

   c. Revenue code 762 is used to bill observation charges.

   d. Observation services provided to a patient who is subsequently admitted as an inpatient should be included on the inpatient claim.

G. **Stand-alone Services**

When services are provided as an outpatient service, and are not performed as a surgical procedure, medical procedure, or emergency room service, then reimbursement equals the technical amount calculated from the data listed in the corresponding section of this Fee Schedule. The technical amount is calculated by subtracting the PC Amount from the Amount.

H. **Disputed Medical Charges; Abusive or Unfair Billing**

1. Disputes over charges, fees, services, or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Fee Schedule.

2. If the Commission determines that the charge amount for items substantially and consistently exceeds the facility's mark-up ratio, or if a facility's charges for other services or MS-DRGs is substantially and consistently higher than the average charges made for the same services or MS-DRGs by other facilitiesy's in the State, then the Commission may consider this to be an indication of abusive or unfair billing practices, and may order the facility in question to appear and show cause why penalties and other sanctions as allowed by Law should not be imposed on said facility for such abusive billing practices.

   For purposes of this provision, the mark-up ratio shall be the inverse of the facility's cost-to-charge ratio. The average charges by facilities for service or MS-DRGs may be determined by reference to the publicly available Medpar MedPAR file for Medicare inpatient admissions, with due consideration being given to the differences between the Medicare inpatient population and the workers' compensation inpatient population.

II. INPATIENT REHABILITATION FACILITIES (IRFS)

A. Inpatient Rehabilitation Facility Reimbursement Methodology
MWCC reimbursement for inpatient rehabilitation facilities (IRFs) will be based upon the CMS prospective payment system (PPS).

1. The MWCC Fee Schedule maximum reimbursement allowanceMRA for IRFs will be twice two (2) times the IRF CMS pricer calculation, unless the payer and provider have a separate contract governing the reimbursement of services provided by an IRF, or unless total billed charges are less.
2. The IRF reimbursement due under this Fee Schedule will be calculated using the CMS IRF pricer calculation in effect on the date of discharge.
3. The CMS IRF pricer is used only for facilities that have met the CMS qualifications for IRF.
4. Reimbursement for IRFs is not calculated using the MS-DRG methodology.
5. The CMS IRF pricer is available at: http://www.cms.hhs.gov/PCPricer/06_IRF.asp

B. **CMS Inpatient Rehabilitation Facility Reimbursement**
Medicare regulations define inpatient rehabilitation facilities (IRFs) in the Code of Federal Regulations, Part 412, and subpart B. Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412. The IRF must be currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), licensed by the State, and certified by Medicare as an IRF at the time the patient is treated.

The IRF must possess a Medicare/Medicaid provider number, or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025–3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g., 25TXXX. (http://www.cms.hhs.gov/transmittals/downloads/R29SOMA.pdf)

Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Fee Schedule shall be the IRF PPS calculated rate multiplied by two (2). Other inpatient MS-DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the *Federal Register*, prior to October 1 of each year., or at http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f.pdf.

IRF reimbursement is based upon the case mix group (CMG) to which the patient is assigned. MWCC will accept the CMG assigned by the Medicare CMG grouper. The CMG must be reported on

the claim with revenue code 0024. This code indicates that this claim is being paid under the PPS and the revenue code can appear on a claim only once.

The *Federal Register* explains the formula for calculating the IRF PPS rate. The rates are calculated on case mix group (CMG) assignment from the combinations of ICD-9-CM codes with additional factors of labor share, wage index, rural adjustment (if applicable) and low income percentage (LIP) for a final adjusted IRF PPS reimbursement.

This calculated IRF PPS reimbursement is multiplied by two (2) for the MWCC reimbursement rate.

	Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)
x	Labor Share (FY ~~2009~~2014 *Federal Register* Table ~~5~~4)
=	Labor portion of federal payment
x	CBSA Based Wage Index (See *Federal Register* Table I) Jackson, MS
=	Wage-Adjusted Amount
+	Non-labor amount (Unadjusted federal PPS less labor portion of federal payment)
=	Wage-adjusted federal payment
x	Rural Adjustment (See *Federal Register*)
=	Wage and rural adjusted federal payment
x	LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)
=	Wage, rural and LIP adjusted federal PPS payment rate
x	2 (MWCC reimbursement adjustment)
=	MWCC IRF PPS adjusted payment

MWCC will use the Medicare Pricer for the appropriate year and based on the date of discharge which is available as a free download from: http://www.cms.hhs.gov/PCPricer~~/06_IRF.asp#TopOfPage~~. The Medicare pricer returns the payment rate specific to the facility.

~~Pricer returns the following information:~~

- ~~PS Return Code~~
- ~~MSA /CBSA (effective October 1, 2005)~~
- ~~Wage Index~~
- ~~Average LOS~~
- ~~Relative Weight~~
- ~~Total Payment Amount~~
- ~~PPS Federal Payment Amount~~
- ~~Facility Specific Payment Amount~~
- ~~Outlier Payment Amount~~
- ~~Low-Income Payment (LIP) Amount~~
- ~~Teaching Amount (effective October 1, 2005)~~
- ~~LOS~~
- ~~Regular Days Used~~
- ~~LTR Days Used~~
- ~~Transfer Percentage~~
- ~~Facility Specific Rate pre-blend~~
- ~~Standard Payment Amount~~

- ~~PPS federal amount pre-blend~~
- ~~Facility costs~~
- ~~Outlier threshold~~
- ~~Submitted HIPPS/CMG code~~
- ~~PPS Pricer CMG code~~
- ~~Calculation version code~~

III. AMBULATORY SURGERY CENTER/OUTPATIENT FACILITY REIMBURSEMENT

A. Reimbursement for all hospital-based outpatient and freestanding ambulatory surgery center services shall be based on the Ambulatory Payment Classification (APC) system as developed by the Centers for Medicare and Medicaid Services (CMS) using relative weights effective ~~beginning January~~ April 1, ~~2008~~2013 and a ~~. The~~ Base Rate of $92.00~~effective from and after July 1, 2010 for payments made under this Schedule is $91.19~~.

B. For implantables used in the outpatient setting, reimbursement is included in the Fee Schedule APC Amount as listed. ~~shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at the payer cost plus ten percent (10%). A "suitable invoice" is an acquisition invoice from the manufacturer that contains pricing information showing the actual cost of the implant(s) being billed, or, as in situations such as a bulk purchase, containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead or other identifiable documentation from the implant manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to one hundred ten percent (110%) of the original manufacturer's invoice price.~~

C. ~~All "C" status and "E" status codes shall be paid using a relative weight of twenty-three (23).~~Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT®/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the ~~maximum reimbursable allowance (~~MRA~~)~~, the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the APC MRA, the lesser of the charge is paid to the facility.
5. The payment rate for an APC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
   - Nursing and technician services
   - Use of the facility
   - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
   - Implantables
   - Materials for anesthesia
   - Administration, record keeping and housekeeping items and services

6. Separate payment is not made for the following services that are directly related to the surgery:
    - Pharmacy
    - Medical/surgical supplies
    - Sterile supplies
    - Laboratory and radiology services with no APC Amount
    - Operating room services
    - Anesthesia
    - Ambulatory surgical care
    - Recovery room
    - Treatment or observation room
7. Pre-op workup services are included in the APC Amount and do not warrant separate reimbursement regardless of the date of service.
8. The ASC payment rate (APC Amount) has been added to the CPT code listing of fees in the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
9. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
10. Procedures not assigned an APC Amount will be reimbursed according to the lesser of total billed charges or usual and customary rate.

D. Status code "N" items and services are packaged into APC rates, and are paid under OPPS; payment is packaged into payment for other services including outliers. Therefore, there is no separate APC payment. Status code "P" (partial hospitalization) is also paid under OPPS.

Status code "Q" is paid at 100 percent of the APC MRA. Status code "T" is subject to the OPPS multiple procedure reduction.

~~Status indicators not cited above can be found at http://www.cms.gov/HospitalOutpatientPPS/.~~

~~E. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%).~~

~~F~~E. Outlier Payments: In an effort to target outliers to high cost and complex cases where a very costly service could cause a facility to incur a significant financial loss, the following outlier payment formula is to be used to calculate the appropriate, additional reimbursement:

Step 1: Reduce charges to cost using the default cost to charge ratio. The current default cost to charge ratio for urban facilities is 0.244; the current default ratio for rural facilities is 0.192;

Step 2: Deduct implantable cost as it is paid separately. This is the cost of furnishing the service;

Step 3: Test to see if outlier meets the 1.75 condition. Is the number from Step 2 more than 1.75 times the APC payment rate? If no, no outlier payment is due; if yes, proceed to Step 4;

Step 4: Test to see if outlier meets the $2,175 threshold test. Add $2,175 to the APC payment rate; is the total more or less than the figure from Step 2 (the cost of furnishing the service)? If greater than the figure in Step 2, no outlier is due; if less than the figure in Step 2, proceed to Step 5;

Step 5: Determine outlier payment:

Cost – (APC payment x 1.75)/2

OR

(Step 2 Amount – Step 3 Amount)/2

Example: ~~As an example as how this might work:~~ Hospital X, an urban facility, bills $90,000 for CPT code 23470 Reconstruct shoulder joint. ~~We will a~~Assume there is a $2,500-cost implantable device used and that the MWCC payment is $~~10,830~~9,601.88.

Step 1: Reduce charges to cost using the default cost to charge ratio:
$90,000 x 0.244 = $21,960

Step 2: Deduct implantable cost as it is paid separately
$21,960 – $2,500 = $19,460

Step 3: Test to see if outlier meets the 1.75 condition
$~~10,830~~9,601.88 x 1.75 = $~~18,952~~16,803.29
Is $19,460 ≥ $~~18,952~~16,803.29? Yes, ~~it~~$19,460 is more than 1.75 times the payment

Step 4: Test to see if outlier meets the $2,175 threshold test
$~~10,830~~9,601.88 + $2,175 = $~~13,005~~11,776.88
~~Is $19,460 ≥ $13,005~~11,776.88~~? Yes, it~~ is ~~more~~ less than ~~$2,175~~$19,460, proceed to Step 5.

Step 5: Determine outlier payment
(Cost – (APC payment x 1.75))/2
($19,460 – ($~~10,830~~9,601.88 x 1.75))/2 = $~~254~~1,328.36
The outlier payment in this case would be $~~254~~1,328.36.

IV. CRITICAL ACCESS HOSPITALS

A. A critical access hospital (CAH) is a small, generally geographically remote facility that is certified to provide outpatient and inpatient services.

B. A CAH may also be granted "swing bed" approval to provide post-hospital skilled nursing facility level care in its inpatient beds.

C. A list of currently participating Mississippi Critical Access hospitals is posted on the MWCC website at http://www.mwcc.ms.gov.

D. Reimbursement

1. Critical access hospitals are reimbursed at ninety percent (90%) of billed charges for inpatient and outpatient services.

2. Swing bed services are reimbursed according to the Skilled Nursing Facility section.

V. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of

E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate 5 digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same

individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same patient.

Forms

I. GUIDELINES

A. Reproduced on the following pages are the forms that should or may be used by providers when billing workers' compensation related services. Instructions are given below.

B. Bills for services rendered should be sent directly to the party responsible for reimbursement. Do not send bills directly to the Medical Cost Containment Division as this will delay payment.

C. The following forms should be used for provider reimbursement:

- CMS-1500 (08/05) (effective July 1, 2007) Electronic equivalent 837p
- UB-04 (effective May 23, 2007) Electronic equivalent 837i
- ~~J400~~ J430D Dental Form (effective ~~January 1, 2007~~2012)

D. The information to include on each form where appropriate is:

1. Claimant's full name and address as shown on the employer's record.
2. Social security number should be entered in the field for insured's ID number; this cuts down on errors and helps correlate the billing to the appropriate file.
3. Correct date of injury. Some claimants have multiple open files and can only be assigned by date.
4. Proper name and address of the employer, not just an individual's name.
5. Name of the insurance payer as registered with the state.
6. Date the claimant's disability should begin per the attending physician.
7. Attending physician's diagnoses and claimant's complaints.
8. Disabilities the claimant has that are not related to this injury.
9. Description of treatment plan, including any prescriptions.
10. Indication if the injury/illness appears to be work related.
11. Indication as to whether the claimant can be released to light or full duty work; full duty is considered to be the work at the time of the accident.
12. Length of time the claimant should be off work as a result of the injury or illness.
13. Date of the visit, the service(s) or procedure(s) performed, and charges.
14. Physician's complete name and address.
15. Physician and provider group national provider identifier (NPI) for billing group and treating physician.
16. Physician's or group's federal tax identification number (tax identification number [TIN] or social security number).
17. Injury/illness as described by the claimant.

E. The following pages have samples of the CMS-1500 (08/05), UB-04, ~~2006~~ 2012 American Dental Association Dental Claim Form ~~J400~~J430D, Request for Resolution of Dispute, and Utilization Review Request Form.

II. Utilization Review Request Form

The form entitled Mississippi Workers' Compensation Utilization Review is a communication tool for use between the provider and the utilization review company. The form can be faxed between the provider and payer as applicable.

The utilization review process is mandatory under the *Mississippi Workers' Compensation Medical Fee Schedule*; however, the use of the Utilization Review Request Form is optional. The use of the form is encouraged if it proves helpful in the timely processing of requests for utilization review of medical services.

Introduction

Pursuant to Mississippi Code Annotated (MCA), §71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of November 1, 2013, and, in the case of inpatient treatment, to services where the discharge date is on or after November 1, 2013. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

This Fee Schedule shall be used by the Workers' Compensation Commission, insurance payers, and self-insurers for approving and paying medical charges of physicians, surgeons, and other qualified health care professionals for services rendered under the Mississippi Workers' Compensation Law. This Fee Schedule applies to all medical services provided to injured workers by physicians, and also covers other medical services arranged for by a physician. In practical terms, this means professional services provided by hospital-employed physicians and other qualified health care professionals, as well as those practicing independently, are reimbursed under this Fee Schedule.

The Commission will require the use of the most current CPT®, CDT, and HCPCS codes and modifiers in effect at the time services are rendered. All coding, billing and other issues, including disputes, associated with a claim, shall be determined in accordance with the CPT rules and guidelines in effect at the time service is rendered, unless otherwise provided in this Fee Schedule or by the Commission. As used in this Fee Schedule, CPT refers to the American Medical Association's *Current Procedural Terminology* codes and nomenclature. CPT is a registered trademark of the American Medical Association. *Current Dental Terminology* (CDT) codes are developed and maintained by the American Dental Association (ADA). HCPCS is an acronym for the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book. However, the inclusion of a service, product or supply identified by a CPT, HCPCS, or CDT code does not necessarily imply coverage, reimbursement or endorsement.

I. FORMAT

This Fee Schedule is comprised of the following sections: Introduction; General Rules; Billing and Reimbursement Rules; Medical Records Rules; Dispute Resolution Rules; Utilization Review Rules; Rules for Modifiers and Code Exceptions; Pharmacy Rules; Other Qualified Health Care Professional Rules; Home Health Rules; Skilled Nursing Facility Rules; Evaluation and Management; Anesthesia; Pain Management; Surgery; Radiology; Pathology and Laboratory; Medicine Services; Therapeutic Services; Dental; Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes; Inpatient Hospital and Outpatient Facility Payment Schedule and Rules; and Forms. Each section listed above has specific instructions (rules/guidelines). The Fee Schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the service(s) they render. **In the event a rule/guideline contained in one of the specific service sections**

conflicts with a general rule/guideline, the specific section rule/guideline will supersede, unless otherwise provided elsewhere in this Fee Schedule.

This Fee Schedule utilizes procedure codes under copyright agreement. The descriptions included are full procedure descriptions. A complete list of modifiers is included in a separate section for easy reference.

II. SCOPE

The *Mississippi Workers' Compensation Medical Fee Schedule* does the following:

A. Establishes rules/guidelines by which the employer shall furnish, or cause to be furnished, to an employee who suffers a bodily injury or occupational disease covered by the Mississippi Workers' Compensation Law, reasonable and necessary medical, surgical, and hospital services and medicines, supplies or other attendance or treatment as necessary. The employer shall provide to the injured employee such medical or dental surgery, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances which are reasonable and necessary to treat, cure, and/or relieve the employee from the effects of the injury/illness, in accordance with MCA §71-3-15 (Rev. 2000), as amended.

B. Establishes a schedule of maximum reimbursement allowances (MRA) for such treatment, attendance, service, device, apparatus, or medicine.

C. Establishes rules/guidelines by which a health care provider shall be paid the lesser of (a) the provider's total billed charge, or (b) the maximum reimbursement allowance (MRA) established under this Fee Schedule.

D. Establishes rules for cost containment to include utilization review of health care and health care services, and provides for the acquisition by an employer/payer, other interested parties, and the Mississippi Workers' Compensation Commission, of the necessary records, medical bills, and other information concerning any health care or health care service under review.

E. Establishes rules for the evaluation of the appropriateness of both the level and quality of health care and health care services provided to injured employees, based upon medically accepted standards.

F. Authorizes employers/payers to withhold payment from, or recover payment from, health facilities or health care providers that have made excessive charges or which have provided unjustified and/or unnecessary treatment, hospitalization, or visits.

G. Provides for the review by the employer/payer or Commission any health facility or health care provider records and/or medical bills that have been determined not to be in compliance with the schedule of charges established herein.

H. Establishes that a health care provider or facility may be required by the employer/payer to explain in writing the medical necessity of health care or health care service that is not usually associated with, is longer and/or more frequent than, the health care or health care service usually accompanying the diagnosis or condition for which the patient is being treated.

I. Provides for medical cost containment review and decision responsibility. The rules and definitions hereunder are not intended to supersede or modify the Workers' Compensation Act, the administrative rules of the Commission, or court decisions interpreting the Act or the Commission's administrative rules.

J. Provides for the monitoring of employers/payers to determine their compliance with the criteria and standards established by this Fee Schedule.

K. Establishes deposition/witness fees.

L. Establishes fees for medical reports.

M. Provides for uniformity in billing of provider services.

N. Establishes rules/guidelines for billing.

O. Establishes rules/guidelines for reporting medical claims for service.

P. Establishes rules/guidelines for obtaining medical services by out-of-state providers.

Q. Establishes rules/guidelines for Utilization Review to include pre-certification, concurrent review, discharge planning and retrospective review.

R. Establishes rules for dispute resolution which includes an appeal process for determining disputes which arise under this Fee Schedule.

S. Establishes a peer review system for determining medical necessity. Peer review is conducted by professional practitioners of the same specialty as the treating medical provider on a particular case.

T. Establishes the list of health care professionals who are considered authorized providers to treat employees under the Mississippi Workers' Compensation Law; and who, by reference in this rule, will be subject to the rules, guidelines and maximum reimbursement limits in this Fee Schedule.

U. Establishes financial and other administrative penalties to be levied against payers or providers who fail to comply with the provisions of the Fee Schedule, including but not limited to interest charges for late billing or payment, percentage penalties for late billing or payment, and additional civil penalties for practices deemed unreasonable by the Commission.

III. MEDICAL NECESSITY

The concept of medical necessity is the foundation of all treatment and reimbursement made under the provision of §71-3-15, Mississippi Code of 1972, as amended. For reimbursement to be made, services and supplies must meet the definition of "medically necessary." The sole use of extraneous guidelines, including but not limited to the Official Disability Guidelines ("ODG"), to determine the appropriateness or extent of treatment or reimbursement is prohibited. Continuation of treatment shall be based on the concept of medical necessity and predicated on objective or appropriate subjective improvements in the patient's clinical status. Arbitrary limits on treatment or reimbursement based solely on diagnosis or guidelines outside this Fee Schedule are not permitted.

A. For the purpose of the Workers' Compensation Program, any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries, is considered "medically necessary." The service must be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be experimental, investigational, or research in nature except in those instances in which prior approval of the payer has been obtained. For purposes of this provision, "peer group" is defined as similarly situated physicians of the same specialty, licensed in the State of Mississippi, and qualified to provide the services in question.

B. Services for which reimbursement is due under this Fee Schedule are those services meeting the definition of "medically necessary" above and includes such testing or other procedures reasonably necessary and required to determine or diagnose whether a work-related injury or illness has been sustained, or which are required for the remedial treatment or diagnosis of an on-the-job injury, a work-related illness, a pre-existing condition affected by the injury or illness, or a complication resulting from the injury or illness, and which are provided for such period as the nature of the injury or process of recovery may require.

C. Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition or if the treatment is not deemed medically necessary for the patient's rehabilitation from the industrial injury.

IV. DEFINITIONS

Act means Mississippi Workers' Compensation Law, Mississippi Code Annotated (MCA), §71-3-1 et seq (Rev. 2000 as amended).

Adjust means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

APC means ambulatory payment classification and guidelines as developed by the Centers for Medicare and Medicaid Services (CMS) and adopted in this Fee Schedule.

Appropriate care means health care that is suitable for a particular patient, condition, occasion, or place.

AWP means Average Wholesale Price; a price generally twenty percent (20%) greater than a manufacturer sells to distributors and large customers and is based on data obtained from manufacturers, distributors, and other suppliers.

Bill means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

Carrier means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation Insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer.

Case means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

CCI (See National Correct Coding Initiative.)

CMS-1500 means the CMS-1500 form and instructions that are used by non-institutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required.

Commission means the Mississippi Workers' Compensation Commission (MWCC).

Consultation means a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. *A second opinion is considered a consultation.*

Controverted claim is a workers' compensation claim which is pending before the Commission and in which the patient or patient's legal representative has filed a Petition to Controvert.

Covered injury or illness means an injury or illness for which treatment is mandated under the Act.

Critical care means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

CPT (Current Procedural Terminology) means a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. The CPT code set is also used by other entities to report outpatient services. Each procedure or service is identified with a five-digit code.

Day means a continuous 24-hour period.

Diagnostic procedure means a service that helps determine the nature and causes of a disease or injury.

Durable medical equipment (DME) means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

Employer Medical Evaluation (EME) means a second opinion evaluation available to the Employer or Carrier pursuant to MCA §71-3-15(1) (Rev. 2000) for the purpose of evaluating temporary or permanent disability, or the medical treatment being rendered to the injured worker.

Expendable medical supply means a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

Follow-up days (FUD) are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

Health care review means the review of a health care case, bill, or both by the payer or the payer's agent.

Incident-to means that services and supplies are commonly furnished as an integral part of the primary service or procedure and not reimbursed separately.

Incidental surgery means surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

Incorrect payment means the provider was not reimbursed according to the rules/guidelines of the Fee Schedule and the payer has failed to provide any reasonable basis for the adjusted payment.

Independent medical examination (IME) means a consultation provided by a physician to evaluate a patient at the request of the Commission. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

Independent procedure means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Inpatient services means services rendered to a person who is admitted as an inpatient to a hospital.

Maximum reimbursement allowance (MRA) means the maximum fee allowed for medical services as set forth in this Fee Schedule.

Medical only case means a case that does not involve more than five (5) days of disability or lost work time and for which only medical treatment is required.

Medically accepted standard means a measure set by a competent authority as the rule for evaluating quality or quantity of health care or health care services and which may be defined in relation to any of the following:

- Professional performance
- Professional credentials
- The actual or predicted effects of care
- The range of variation from the norm

Medically necessary means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries. Utilization management or review decisions shall not be based on application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

Medical record means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

Medical supply means either a piece of durable medical equipment or an expendable medical supply.

National Correct Coding Initiative means the official list of codes from the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Policy Manual that identifies services considered an integral part of a comprehensive code.

NCCI (See National Correct Coding Initiative.)

Observation services means services rendered to a person who is designated or admitted to a hospital or facility as observation status.

Operative report means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

Optometrist means an individual licensed to practice optometry.

Orthotic equipment means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

Orthotist means a person skilled in the construction and application of orthotic equipment.

Outpatient service means services provided to patients at a time when they are not hospitalized as inpatients.

Payer means the employer or self-insured group, carrier, or third-party administrator (TPA) who pays the provider billings.

Pharmacy means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Practitioner means a person licensed, registered, or certified as an acupuncturist, audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, massage therapist, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional or provider.

Primary procedure means the therapeutic procedure most closely related to the principal diagnosis, and in billing, the code with the highest relative value unit (RVU) that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure. Reimbursement for the primary procedure is not dependent on the ordering or re-ordering of codes.

Procedure means a unit of health service.

Procedure code means a five–digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

Properly submitted bill means a request by a provider for payment of health care services submitted to a payer on the appropriate forms with appropriate documentation and within the time frame established under the guidelines of the Fee Schedule.

Prosthesis means an artificial substitute for a missing body part.

Prosthetist means a person skilled in the construction and application of prostheses.

Provider means a facility, health care organization, or a practitioner who provides medical care or services.

Resequenced code means a code that is printed in the CPT book out of numeric sequence but is printed in this Fee Schedule in the numeric order.

Secondary procedure means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

Special report means a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

Specialist means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.

Usual and customary means that when a payment is designated herein as “usual and customary,” the amount of the payment equates to the charge value reported by FAIR Health, Inc. in its FH RV Benchmarks products at the 40th percentile for the applicable geographic area in Mississippi.

V. How to Interpret the Fee Schedule

For each procedure, the Fee Schedule table includes the following columns and details (if applicable):

Code Icons

Add-on Codes

+ denotes procedure codes that are considered “add-on” codes as defined in the CPT book.

Modifier 51 Exempt

⃠ denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book. Modifier 51 exempt services and procedures can be found in Appendix E of *CPT 2013*. Additional codes that should not be subject to modifier 51 have been identified by Optum based upon CPT guidelines and are included in this Fee Schedule using the same CPT icon.

Moderate (Conscious) Sedation

⊙ denotes procedure codes that include conscious sedation as an inherent part of providing the procedure.

Resequenced Codes

# denotes procedure codes that are in numeric order but are considered resequenced and display in a different order within the 2013 CPT book.

Code

This Fee Schedule uses 2013 CPT, CDT, and HCPCS codes.

Description

This Fee Schedule uses 2013 full descriptions.

Relative Value

This column lists the relative value unit (RVU) assigned to each procedure. There are, however, procedures too variable to accept a set value—these are “by report” procedures and are noted BR in the Amount column. Procedures with a 0.00 in the Relative Value column and a $0.00 in the Amount column are not covered or are not reimbursed.

Amount

This column lists the total reimbursable as a monetary amount.

PC Amount

Where there is an identifiable professional and technical component to a procedure, the portion considered to be the professional component is listed. The professional component gives the total reimbursable as a monetary amount. The technical component can be identified as the Amount minus the PC Amount. See Rules for Modifiers and Code Exceptions for additional information.

FUD
Follow-up days included in a surgical procedure's global charge are listed in this column.

Assist Surg
The assistant surgeon column identifies procedures that are approved for an assistant to the primary surgeon whether a physician, physician assistant (PA), registered nurse first assistant (RNFA, RA), or other individual qualified for reimbursement as an assistant under the Fee Schedule.

APC Amount
Ambulatory Payment Classification (APC) is a payment method for facility outpatient services. The APC system as developed by the Centers for Medicare and Medicaid Services (CMS) includes many of the supplies that have previously been separately billed. These supplies will now be bundled into the APC Amount consistent with CMS guidelines. The APC Amount shall constitute the reimbursement amount for both hospital based and freestanding outpatient facilities.

VI. AUTHORIZED PROVIDERS
The following health care providers are recognized by the Mississippi Workers' Compensation Commission as acceptable to provide treatment to injured workers under the terms of the Act, and must comply with the rules, guidelines, billing and reimbursement policies and maximum reimbursement allowance (MRA) contained in this Fee Schedule when providing treatment or service under the terms of the Act:

Acupuncturist (L.A.C.)

Audiologist

Certified Registered Nurse Anesthetist (C.R.N.A.)

Doctor of Chiropractic (D.C.)

Doctor of Dental Surgery (D.D.S.)/Doctor of Dental Medicine (D.D.M.)

Doctor of Osteopathy (D.O.)

Licensed Clinical Social Worker (L.C.S.W.)

Licensed Nursing Assistant

Licensed Practical Nurse (L.P.N.)

Massage Therapist

Medical Doctor (M.D.)

Nurse Practitioner (N.P.)

Occupational Therapist (O.T.)

Optometrist (O.D.)

Oral Surgeon (M.D., D.O., D.M.D., D.D.S.)

Pharmacist (R.Ph.)

Physical Therapist (P.T.)

Physical or Occupational Therapist Assistant (P.T.A., O.T.A.)

Physician Assistant (P.A.)

Podiatrist (D.P.M.)

Prosthetist or Orthotist

Psychologist (Ph.D.)

Registered Nurse (R.N.)

Registered Nurse First Assistant (R.N.F.A., R.A.)

Speech Therapist

All health care providers, as listed herein, are subject to the rules, limitations, exclusions, and maximum reimbursement allowances of this Fee Schedule. Medical treatment under the terms of the Act may be provided by any other person licensed, registered, or certified as a health care professional if approved by the payer or Commission, and in such case, said provider and payer shall be subject to the rules and guidelines, including maximum reimbursement amounts, provided herein.

VII. INFORMATION PROGRAM

The Workers' Compensation Commission shall provide ongoing information regarding this Fee Schedule for providers, payers, their representatives and any other interested persons or parties. This information shall be provided primarily through informational sessions and seminar presentations at our Annual Education Conference as well as the distribution of appropriate information materials via the Commission's website (www.mwcc.ms.gov), and by other means as needed.

General Rules

I. CONFIRMATORY CONSULTATION

As provided in §71-3-15(1) of the Act, and in M.W.C.C. General Rule 9, a payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered. This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation code with modifier 32 appended to indicate a mandated service and paid in accordance with the Fee Schedule.

II. CODING STANDARD

A. The most current version of the American Medical Association's *Current Procedural Terminology* (CPT®) or the *ADA Practical Guide to Dental Procedure Codes* (CDT) in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Fee Schedule.

B. The most current version of HCPCS Level II codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Fee Schedule.

C. Services will be coded according to the appropriate code edits. For the purpose of this Fee Schedule, the National Correct Coding Initiative (NCCI) edits are used, and apply to all sections.

III. DEPOSITION/WITNESS FEES; MEDICAL RECORDS AFFIDAVIT

A. Any health care provider who gives a deposition or is otherwise subpoenaed to appear in proceedings pending before the Commission shall be paid a witness fee as provided by M.W.C.C. Procedural Rule 18(h) in the amount of $25.00 per day plus mileage reimbursement at the rate authorized by MWCC General Rule 14. Procedure code 99075 must be used to bill for a deposition.

B. In addition to the above fee and mileage reimbursement, any health care provider who gives testimony by deposition or who appears in person to testify at a hearing before the Commission shall be paid $500.00 for the first hour and $125.00 per quarter hour thereafter. This fee includes necessary preparation time. In the event a deposition is cancelled through no fault of the provider, the provider shall be entitled to a payment of $250.00 unless notice of said cancellation is given to the provider at least 72 hours in advance. In the event a deposition is cancelled through no fault of the provider within 24 hours of the scheduled time, then, in that event, the provider shall be paid the rate due for the first hour of a deposition. Nothing stated herein shall prohibit a medical provider and a party seeking to take the medical provider's deposition from entering into a separate contract which provides for reimbursement other than as above provided.

C. Pursuant to Mississippi Workers' Compensation Commission Procedural Rule 9, an examining or treating physician may execute an affidavit in lieu of direct testimony. The Physician's Medical Record Custodian is allowed to sign the affidavit in lieu of the physician's signature. Such charge for execution of the affidavit is limited to a maximum reimbursement of $25.00. Reimbursement for copies of medical records that are attached to affidavits shall be made as outlined elsewhere in the Fee Schedule.

IV. IMPAIRMENT RATING

A. In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the *Guides to the Evaluation of Permanent Impairment,* as published and copyrighted by the American Medical Association which is in effect at the time the service is rendered. Only a medical doctor is entitled under these rules to reimbursement for conducting an impairment rating evaluation.

B. A provider is entitled to reimbursement for conducting an impairment rating evaluation and determining the extent of permanent impairment, and should bill for such services using CPT code 99455. The maximum reimbursement for CPT code 99455 shall be $250.00.

V. INDEPENDENT MEDICAL EXAMINATION (IME)

A. An independent medical examination (IME) may be ordered by the Mississippi Workers' Compensation Commission or its Administrative Judges. A practitioner other than the treating practitioner must do the medical examination, and the Commission or Judge shall designate the examiner.

B. An independent medical examination (IME) shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. An IME can only be ordered by the Workers' Compensation Commission or one of its Administrative Judges. A copy of the report must be sent to the patient, or his attorney if represented, the payer, and the Mississippi Workers' Compensation Commission.

C. The fee for the IME may be set by the Commission or Judge, or negotiated by the payer and provider prior to setting the appointment, and in such cases, reimbursement shall be made according to the order of the Commission or Judge, or according to the mutual agreement of the parties. In the absence of an agreement or order regarding reimbursement for an IME, the provider shall bill for the IME using the appropriate level and site-specific consultation code appended with modifier 32 to indicate a mandated service, and shall be reimbursed according to the Fee Schedule.

VI. MAXIMUM MEDICAL IMPROVEMENT

A. When an employee has reached maximum medical improvement (MMI) for the work related injury and/or illness, the physician should promptly, and at least within fourteen (14) days, submit a report to the payer showing the date of maximum medical improvement (MWCC Form B9,27).

B. Maximum medical improvement is reached at such time as the patient reaches the maximum benefit from medical treatment or is as far restored as the permanent character of his injuries will permit and/or the current limits of medical science will permit. Maximum medical improvement may be found even though the employee will require further treatment or care.

VII. OUT-OF-STATE MEDICAL TREATMENT

A. Each employer shall furnish all reasonable and necessary drugs, supplies, hospital care and services, and medical and surgical treatment for the work-related injury or illness. All such care, services, and treatment shall be performed at facilities within the state when available.

B. When billing for out-of-state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, the same quality of care cannot be provided within the state, or more cost-effective care can be provided out-of-state. In determining whether out-of-state treatment is more cost effective, this question must be viewed from both the payer and patient's perspective. Treatment should be provided in an area reasonably convenient to the place of the injury or the residence of the injured employee, in addition to being reasonably suited to the nature of the injury.

C. Reimbursement for out-of-state services shall be based on one of the following, in order of preference: (1) the workers' compensation fee schedule for the state in which services are rendered; or (2) in cases where there is no applicable fee schedule for the state in which services are rendered, or the fee schedule in said state excludes or otherwise does not provide reimbursement allowances for the services rendered, reimbursement should be paid at the usual and customary rate for the geographical area in which the services are rendered; or (3) reimbursement for out-of-state services may be based on the mutual agreement of the parties. The *Mississippi Workers' Compensation Medical Fee Schedule* coding and billing rules must be followed in order for out of state providers to obtain reimbursement.

D. Prior authorization must be obtained from the payer for referral to out-of-state providers. The documentation must include the following:

   1. Name and location of the out-of-state provider,
   2. Justification for an out-of-state provider, including qualifications of the provider and description of services being requested.

VIII. AUTHORIZATION FOR TREATMENT

A. **Prior Authorization.** Providers must request authorization from the payer before service is rendered for the services and supplies listed below:

   1. Non-emergency elective inpatient hospitalization
   2. Non-emergency elective inpatient surgery
   3. Non-emergency elective outpatient surgery
   4. Physical medicine treatments after 15 visits or 30 days, whichever comes first
   5. Rental or purchase of supplies or equipment over the amount of $100.00 per item
   6. Rental or purchase of TENS
   7. Home health services
   8. Pain clinic/therapy programs, including interdisciplinary pain rehabilitation programs
   9. External spinal stimulators
   10. Pain control programs
   11. Work hardening programs, functional capacity testing, ISO kinetic testing
   12. Referral for orthotics or prosthetics
   13. Referral for acupuncture

14. Referral for biofeedback
15. Referral to psychological testing/counseling
16. Referral to substance abuse program
17. Referral to weight reduction program
18. Referral to any non-emergency medical service outside the State of Mississippi
19. Repeat MRI (more than one per injury)
20. Repeat CT Scan (more than one per injury)
21. Intraoperative neurophysiologic monitoring (e.g., SSEP, VEP, DEP, BAEP, MEP)

B. **Response Time.** The payer must respond within two (2) business days to a request of prior authorization for non-emergency services.

C. **Federal Facilities.** Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in this manual.

D. **Pre-certification for Non-emergency Surgery.** Providers must pre-certify all non-emergency surgery. However, certain catastrophic cases require frequent returns to the operating room (O.R.) (e.g., burns may require daily surgical debridement). In such cases, it is appropriate for the provider to obtain certification of the treatment plan to include multiple surgical procedures. The provider's treatment plan must be specific and agreement must be mutual between the provider and the payer regarding the number and frequency of procedures certified.

E. **Retrospective Review.** Failure to obtain pre-certification as required by this Fee Schedule shall not, in and of itself, result in a denial of payment for the services provided. Instead, the payer, if requested to do so by the provider within one (1) year of the date of service or discharge, shall conduct a retrospective review of the services, and if the payer determines that the services provided would have been pre-certified, in whole or in part, if pre-certification had been timely sought by the provider, then the payer shall reimburse the provider for the approved services according to the Fee Schedule, or, if applicable, according to the separate fee agreement between the payer and provider, less a ten percent (10%) penalty for the provider's failure to obtain pre-certification as required by this Fee Schedule. This penalty shall be computed as ten percent (10%) of the total allowed reimbursement. If, upon retrospective review, the payer determines that pre-certification would not have been given, or would not have been given as to part of the requested services, then the payer shall dispute the bill and proceed in accordance with the Billing and Reimbursement Rules as hereafter provided.

F. **Authorization Provided by Employer or Payer.** When authorization for treatment is sought and obtained from the employer, or payer, whether verbally or in writing, and medical treatment is rendered in good faith reliance on this authorization, the provider is entitled to payment from the employer or payer for the initial visit or evaluation, or in emergency cases, for treatment which is medically necessary to stabilize the patient. Reimbursement is not dependent on, and payment is due regardless of, the outcome of medically necessary services which are provided in good faith reliance upon authorization given by the employer or payer.

IX. RETURN TO WORK

If an employee is capable of some form of gainful employment, it is advisable for the physician to release the employee to light work and make a specific report to the payer as to the date of such release and setting out any restrictions on such light work. It can be to the employee's economic advantage to be released to light or alternative work, since he/she can receive compensation based on sixty-six and two-thirds percent (66 2/3%) of the difference between the employee's earnings in such work and the employee's pre-injury average weekly wage. The physician's judgment in such matters is extremely

important, particularly as to whether the patient is medically capable of returning to work in some capacity. Return to work decisions should be based on objective findings, and the physician's return to work assessment should identify, if possible, any alternative duty employment to which the patient may return if return to full duty is not medically advisable.

X. SELECTION OF PROVIDERS

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to surgical/procedure facilities, CAT scans, MRI, x-ray, and laboratory, physical or occupational therapy, including work hardening, functional capacity evaluations, chronic pain programs, or massage therapy shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA §71-3-15 (Rev. 2000).

XI. DRUG SCREENING

Only one (1) drug screen or drug test result shall be eligible for reimbursement for each drug test conducted on the same patient on the same day, except and unless the initial screening results are deemed by the prescribing provider to be inconsistent or inherently unreliable. In that event, a confirmation screening may be ordered by the prescribing provider and paid for by the payer. In addition, treatment may not be discontinued based on the results of a drug test absent a confirmation test, which shall be reimbursed in addition to the initial screening test. Merely duplicate screenings or tests which are rerun to confirm initial results are not otherwise eligible for reimbursement.

XII. MILEAGE REIMBURSEMENT

The payer shall reimburse each claimant for all travel to obtain medical treatment which is being obtained under the provisions of the Mississippi Workers' Compensation Law, including travel to a pharmacy to obtain medication or supplies necessary for treatment of a compensable injury, regardless of the number of miles traveled. There is no minimum distance of travel required for reimbursement, and reimbursement shall be made for each mile of round trip travel necessitated by the compensable injury, at the rate adopted by the Commission and in effect at the time of the travel. Only reasonable and necessary miles traveled are subject to reimbursement.

Billing and Reimbursement Rules

I. GENERAL PROVISIONS

A. **Maximum Reimbursement Allowance (MRA).** Unless the payer and provider have a separate fee contract which provides for a different level of reimbursement, the maximum reimbursement allowance for health care services shall be the lesser of (a) the provider's total billed charge, or (b) the maximum specific fee established by the Fee Schedule. Items or services or procedures which do not have a maximum specific fee established by this Fee Schedule shall be reimbursed at the usual and customary fee as defined in this Fee Schedule, and in such cases, the maximum reimbursement allowance shall be the lesser of (1) the provider's total billed charge, or (2) the usual and customary fee as defined by this Fee Schedule.

If this Fee Schedule does not establish a maximum specific fee for a particular service or procedure, and a usual and customary rate cannot be determined because the FH RV Benchmarks products do not contain a fee for same, then the maximum reimbursement allowance shall be equal to the national Medicare allowance plus thirty percent (30%). In the absence of an established Medicare value, and assuming none of the above provisions apply, the maximum reimbursement allowance shall be the provider's total billed charge. Any new codes will be assigned values and posted on the MWCC website annually, or as needed.

B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.

1. **Repricing Agreements.** Payers and providers may voluntarily enter into repricing agreements designed to contain the cost of workers' compensation health care after the medical care or service has been provided, and in such case, the reimbursement voluntarily agreed to by the parties shall control to the exclusion of the Fee Schedule. However, the time spent by the payer and provider attempting to negotiate a post-care repricing agreement does not extend the time elsewhere provided in this Fee Schedule for billing claims, paying claims, requesting correction of an incorrect payment, requesting reconsideration, seeking dispute resolution, or reviewing and responding to requests for correction or reconsideration or dispute resolution. In addition, applicable interest and penalties related to late billing and/or late payment shall continue to accrue as otherwise provided. Efforts to negotiate a post-care repricing agreement do not justify late billing or payment, and either party may seek further relief in accordance with the rules provided herein should billing or payment not be made within the time otherwise due under these

rules. No party shall be obligated to negotiate or enter into a repricing agreement of any kind whatsoever.

No party, in attempting to negotiate a repricing or other post treatment price reduction agreement, shall state or imply that consent to such an agreement is mandatory, or that the failure to enter into any such agreement may result in audit, delay of payment, or other adverse consequence. If the Commission determines that any party, or other person in privity therewith, has made such false or misleading statements in an effort to coerce another party's consent to a repricing or other price reduction agreement outside the Fee Schedule, the Commission may refer the matter to the appropriate authorities to consider whether such conduct warrants criminal prosecution under §71-3-69 of the Law. This statute declares that any false or misleading statement or representation made for the purpose of wrongfully withholding any benefit or payment otherwise due under the terms of the Workers' Compensation Law shall be considered a felony. In addition, the Commission may levy a civil penalty in an amount not to exceed ten thousand dollars ($10,000.00) if it finds that payment of a just claim has been delayed without reasonable grounds, as provided in §71-3-59(2) of the Law.

C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms: Providers must bill outpatient professional services on the most recently authorized paper or electronic version, 837p, or the CMS-1500 form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform billing form. The electronic version, 837i, or the UB-04 (CMS-1450) is required. Billing must be submitted using the most current paper or electronic forms which are authorized by CMS.

D. **Identification Number.** All professional reimbursement submissions by Covered Healthcare Providers as defined under CMS rules for the implementation of the National Provider Identifier (NPI) must include the National Provider Identifier (NPI) field so as to enable the specific identification of individual providers without the need for other unique provider identification numbers. Providers who do not yet have an NPI should use the CMS default identifier until such time as an NPI is obtained. Providers are required to obtain an NPI within the dates specified by CMS in its implementation rules.

E. **Physician Specialty.** The rules and reimbursement allowances in the *Mississippi Workers' Compensation Medical Fee Schedule* do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.

F. **"No Show" Appointments**. When an appointment is made for a physician visit by the employer or payer, and the claimant/patient does not show, the provider is entitled to payment at the rate allowed for a minimal office visit.

G. **"After Hours" and Other Adjunct Service Codes.** When an office service occurs after a provider's normal business hours, procedure code 99050 may be billed. Other adjunct service codes (99051–99060) may be billed as appropriate. Typically, only a single adjunct service code is reported per encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.

H. **Portable Services.** When procedures are performed using portable equipment, bill the appropriate procedure code. The charge for the procedure includes the cost of the portable equipment.

I. **Injections.**

1. Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.
2. The description must include the name of the medication, strength, and dose injected.
3. When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.

4. Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.
5. Reimbursement for intra-articular and intra-bursal injection medications (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.

J. **Supplies.** Use CPT® code 99070 or specific HCPCS Level II codes to report supplies over and above those usually included with the office visit or service rendered. Do not bill for supplies that are currently included in surgical packages, such as gauze, sponges, and Steri-Strips®. Supplies and materials provided by the physician over and above those usually included with the office visit (drugs, splints, sutures, etc.) may be charged separately and reimbursed at a reasonable rate.

II. INSTRUCTIONS TO PROVIDERS

A. All bills for service must be coded with the appropriate CPT, CDT, or HCPCS Level II code.

B. The medical provider must file the appropriate billing form and necessary documentation within thirty (30) days of rendering services on a newly diagnosed work-related injury or illness. Subsequent billings must be submitted at least every thirty (30) days, or within thirty (30) days of each treatment or visit, whichever last occurs, with the appropriate medical records to substantiate the medical necessity for continued services. Late billings will be subject to discounts, not to exceed one and one-half percent (1.5%) per month of the bill or part thereof which was not timely billed, from the date the billing or part thereof is first due until received by the payer. Any bill or part thereof not submitted to the payer within sixty (60) days after the due date under this rule shall be subject to an additional discount penalty equal to ten percent (10%) of the total bill or part thereof. Any bill for services rendered which is not submitted to the payer within one (1) year after the date of service, or date of discharge for inpatient care, will not be eligible or considered for reimbursement under this Fee Schedule, unless otherwise ordered by the Commission or its Cost Containment Division.

C. Fees in excess of the maximum reimbursement allowance (MRA) must not be billed to the employee, employer, or payer. The provider cannot collect any non-allowed amount (MCA §71-3-15(3) (Rev. 2000)).

D. If it is medically necessary to exceed the Fee Schedule limitations and/or exclusions, substantiating documentation must be submitted by the provider to the payer with the claim form.

E. If a provider believes an incorrect payment was made for services rendered, or disagrees for any reason with the payment and explanation of review tendered by the payer, then the provider may request reconsideration pursuant to the rules set forth herein.

F. If, after the resolution of a reconsideration request or a formal dispute resolution request, or otherwise, the provider is determined to owe a refund to the payer, the amount refunded shall bear interest at the rate of one and one-half percent (1.5%) per month from the date the refunded amount was first received by the provider, until refunded to the payer.

III. INSTRUCTIONS TO PAYERS

A. An employer's/payer's payment shall reflect any adjustments in the bill made through the employer's/payer's bill review program. The employer/payer must provide an explanation of review (EOR) to a health care provider whenever reimbursement differs from the amount billed by the provider. This must be done individually for each bill.

B. In a case where documentation does not indicate the service was performed, the charge for the service may be denied. The EOR must clearly and specifically indicate the reason for the denial.

C. (1) When a billed service is documented, but the code selected by the provider is not, in the payer's/reviewer's estimation, the most accurate code available to describe the service, the reviewer must not deny payment, but shall reimburse based on the revised code. The EOR must clearly and specifically detail the reason(s) for recoding the service or otherwise altering the claim. No claim shall be recoded or otherwise revised or altered without the payer having actually reviewed the medical records associated with the claim which document the service(s) provided.

(2) As an alternative to recoding or altering a claim, the payer may treat the matter under rule E(1) and (2) below by paying any undisputed portion of the bill, and notifying the provider by EOR that the remaining parts of the bill are denied or disputed.

(3) Recoding cannot be used solely for cost containment. Recoding may only be used for the correction of miscoded services. Whenever there is any dispute concerning coding, the provider must be notified immediately and given the opportunity to furnish additional information, although nothing herein suspends the time periods for making payment or giving notice of dispute. Any recoding or so-called "down coding," which is found by the Commission or its Cost Containment Division to be solely for the purpose of cost containment, will subject the party engaging in such conduct to additional penalties as allowed by law.

D. Properly submitted bills must be paid within thirty (30) days of receipt by the payer. Properly submitted bills not fully paid within thirty (30) days of receipt by the payer shall automatically include interest on the unpaid balance at the rate of one and one-half percent (1.5%) per month from the due date of any unpaid remaining balance until such time as the claim is fully paid and satisfied. Properly submitted bills not fully paid within sixty (60) days of receipt will be subject to an additional penalty equal to ten percent (10%) of the unpaid remaining balance, including interest as herein provided.

E. (1) When an employer/payer disputes or otherwise adjusts a bill or portion thereof, the employer/payer shall pay the undisputed or unadjusted portion of the bill within thirty (30) days of receipt of the bill. Failure to pay the undisputed portion when due shall subject the payer to interest and penalty as above provided on the undisputed portion of the bill. If the dispute is ultimately resolved in the provider's favor, interest and penalty on the disputed amounts will apply from the original due date of the bill until paid.

(2) When a payer disputes a bill or portion thereof, the payer shall notify the provider within thirty (30) days of the receipt of the bill of the reasons for disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the payer's action. The payer shall set forth the clear and specific reasons for disputing a bill or portion thereof on the EOR, and shall provide additional documentation if necessary to provide an adequate explanation of the dispute.

F. Reimbursement determinations shall be based on medical necessity of services to either establish a diagnosis or treat an injury/illness. Thus, where service is provided in good faith reliance on authorization given by the employer or payer, reimbursement shall not be dependent on the outcome of medically necessary diagnostic services or treatment.

IV. FACILITY FEE RULES

Please refer to the Pain Management section for the state-specific facility reimbursement rules to be used for outpatient pain management procedures.

Please refer to the Inpatient Hospital and Outpatient Facility Payment Schedule and Rules section for the state-specific facility reimbursement rules to be used for ambulatory surgery center (ASC) procedures and hospital based outpatient departments.

A. **Prepayment Review for Facilities.** The payer must perform a prepayment review on inpatient hospital bills and outpatient surgery bills in order to verify the charges submitted.

1. At a minimum, the pre-payment review should:
    a. Validate that prior authorization was approved according to Fee Schedule guidelines;
    b. Validate that the length of stay and the level of service was appropriate for the diagnosis;
    c. Review the bill for possible overcharges or billing errors;
    d. Determine if an on-site audit is appropriate;
    e. Identify over utilization of services;
    f. Identify those bills and case records that shall be subject to professional review by a physician or appropriate peer.
2. The payer must reimburse the hospital within thirty (30) days of receipt of a valid claim form if prepayment review criteria are met. An exception to the thirty (30) day payment time will be made if additional documentation is requested for prepayment review, and in such cases, payment should be made within thirty (30) days following receipt of this additional documentation if prepayment review criteria are met. If a full audit is scheduled, fifty percent (50%) of the total bill must be paid prior to the audit, and in such event, the payer shall not be liable for interest and penalty as above provided on any additional sums which may be due following completion of the audit. Failure to pay fifty percent (50%) of the total bill prior to the audit shall result in interest and penalty as above provided being added to the total amount determined to be due, from the original due date until paid.
3. If the hospital does not forward copies of requested medical records to the payer after two (2) consecutive written requests following the initial request, or if it fails to submit necessary or adequate documentation to support the hospital services rendered, the payer should perform a charge audit.

B. **Charge Audit.** All charge audits must be performed on-site unless otherwise agreed to by the provider and payer.

1. The following information must be provided to the hospital by the payer/auditor when scheduling an audit:
    a. Patient name
    b. Account number
    c. Date(s) of service
    d. Diagnosis(es)
    e. Total amount of bill
    f. Insurance company
    g. Name of audit requester
    h. Telephone number and address of requester
2. A hospital must schedule a charge audit within thirty (30) days of a request by a payer/auditor.
3. Hospitals shall be reimbursed an audit fee of $50.00 for associated audit costs.
4. When a charge audit is necessary, the auditor must identify additional charges for medically necessary hospital services that were ordered by the authorized physician and were provided, but were not included, on the initial bill.
5. The auditor must review and verify the audit findings with a hospital representative at the conclusion of the audit. The hospital may waive its right to the exit conference.

6. The auditor must provide written explanation of the final reimbursement determination based on the audit findings, whether or not an exit conference is held with the hospital. This written explanation must be provided within thirty (30) days following the conclusion of the audit.

C. When any hospital bill that has been prescreened and found to be correct, or when corrections have been made to the bill as required, or when a hospital bill has been audited and verified as correct, it must be paid within thirty (30) days thereafter.

D. Any hospital bill not paid when due under these rules shall automatically include interest at the rate of one and one-half percent (1.5%) per month from the due date of such bill until paid. Any such bill not paid within sixty (60) days after it is due under these rules will be subject to an additional penalty equal to ten percent (10%) of the total amount due, including interest as herein provided.

E. **Implantables.** An implantable is an item that is implanted into the body for the purpose of permanent placement, and remains in the body as a fixture. Absorbable items, temporary items, or other items used to help place the implant, are not within the definition of "implantable" and are not reimbursed as such.

Implantables are included in the applicable MS-DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement is likewise included in the APC Amount paid to the facility. No separate billing or payment for implants shall be made in either the inpatient or outpatient setting.

V. EXPLANATION OF REVIEW (EOR)

A. Payers must provide an explanation of review (EOR) to health care providers for each bill whenever the payer's reimbursement differs from the amount billed by the provider, or when an original claim is altered or adjusted by the payer. The EOR must be provided within thirty (30) days of receipt of the bill, and must accompany any payment that is being made.

B. A payer may use the listed EOR codes and descriptors or may develop codes of their own to explain why a provider's charge has been reduced or disallowed, or why a claim has been altered or adjusted in some other way. In all cases, the payer must clearly and specifically detail the reasons for adjusting or altering a bill, including references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR. Should the EOR include an alteration in the codes submitted on the original claim, it must be based on a review of the medical records documenting the service.

C. The EOR must contain appropriate identifying information to enable the provider to relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.

D. Acceptable EORs may include manually produced or computerized forms that contain the EOR codes, written explanations, and the appropriate identifying information.

E. The following EOR codes may be used by the payer to explain to the provider why a procedure or service is not reimbursed as billed, provided clear and specific detail is included, along with references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR:

001 These services are not reimbursable under the Workers' Compensation Law for the following reason(s): [Provide specific reason(s) why services are not reimbursable under the Workers' Compensation Law]

002 Charges exceed maximum reimbursement allowance [Specify]

003 Charge is included in the basic surgical allowance [Specify]

004 Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required [Specify]

005 This procedure is included in the basic allowance of another procedure [Specify the other procedure]

006 This procedure is not appropriate to the diagnosis [Specify]

007 This procedure is not within the scope of the license of the billing provider [Specify]

008 Equipment or services are not prescribed by a physician [Specify]

009 This service exceeds reimbursement limitations [Specify]

010 This service is not reimbursable unless billed by a physician [Specify]

011 Incorrect billing form [Specify]

012 Incorrect or incomplete identification number of billing provider [Specify]

013 Medical report required for payment [Specify]

014 Documentation does not justify level of service billed [Specify]

015 Place of service is inconsistent with procedure billed [Specify]

016 Invalid procedure code [Specify]

017 Prior authorization was not obtained [Specify]

VI. REQUEST FOR RECONSIDERATION

A. When, after examination of the explanation of review (EOR) and other documentation, a health care provider is dissatisfied with a payer's payment or dispute of a bill for medical services, reconsideration may be requested by the provider. Any other matter in dispute between the provider and payer may be subject to reconsideration as herein provided at the request of either party, including, but not limited to, a request by the payer for refund of an alleged over-payment. Alleged over-payments should be addressed through the dispute resolution process, if necessary, and not by way of unilateral recoupment initiated by the payer on subsequent billings.

B. A provider or payer must make a written request for reconsideration within thirty (30) days from the receipt of the explanation of review (EOR) or other written documentation evidencing the basis for the dispute. A request for reconsideration must be accompanied by a copy of the bill in question, the payers' explanation of review (EOR), and/or any additional documentation to support the request for reconsideration.

C. The payer or provider, upon receipt of a request for reconsideration, must review and re-evaluate the original bill and accompanying documentation, and, must notify the requesting party thirty (30) days thereafter of the results of the reconsideration. The response must adequately explain the reason(s) for the decision, and cite the specific basis upon which the final determination was made. If the payer finds the provider's request for reconsideration is meritorious, and that additional payment(s) should be made, or if the provider finds the payer's request for refund or other payment is meritorious, the additional payment should be made within the above thirty (30) day period. Any additional payment(s) made in response to a provider's or payer's request for reconsideration shall include interest from the original due date of the bill or payment, and an additional ten percent (10%) penalty if applicable.

D. If the dispute is not resolved within the above time after a proper request for reconsideration has been served by the provider or payer, then either party may request further review by the Commission pursuant to the Dispute Resolution Rules set forth hereafter.

E. Failure to seek reconsideration within the time above provided shall bar and prohibit any further reconsideration or review of the bill or other issue in question unless, for good cause shown, the Commission or its representative extends the time for seeking reconsideration or review under these rules. In no event shall the time for seeking reconsideration hereunder be extended by more than an additional thirty (30) days, and any such request for additional time in which to seek reconsideration or further review must be made in writing to the Commission within the initial thirty (30) day period set forth in paragraph B. above.

F. Requests by either provider or payer for refunds, or for additional payment, or other requests related to the billing or payment of a claim, must be sought in accordance with the specific rules set forth herein. No retrospective audits or dispute requests shall be allowed beyond the time otherwise provided herein for seeking reconsideration and/or review.

Medical Records Rules

I. MEDICAL RECORDS

A. The medical record, which documents the patient's course of treatment, is the responsibility of the provider and is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, failure to submit necessary or adequate documentation to support the services rendered may result in the services being disallowed.

B. A medical provider may not charge any fee for completing a medical report or form required by the Workers' Compensation Commission which is part of the required supporting documentation which accompanies a request for payment. The supporting documentation that is required to substantiate the medical treatment is included in the fee for service and does not warrant a separate fee as it is incidental to providing medical care. CPT® code 99080 is appropriate for billing special reports beyond those required by this Fee Schedule and requested by the payer or their representatives.

C. Medical records must be legible and include, as applicable:

1. Initial office visit notes which document a history and physical examination appropriate to the level of service indicated by the presenting injury/illness or treatment of the ongoing injury/illness;
2. Progress notes which reflect patient complaints, objective findings, assessment of the problem, and plan of care or treatment;
3. Copies of lab, x-ray, or other diagnostic tests that reflect current progress of the patient and/or response to therapy or treatment;
4. Physical medicine/occupational therapy progress notes that reflect the patient's response to treatment/therapy;
5. Operative reports, consultation notes with report, and/or dictated report; and
6. Impairment rating (projected and actual) and anticipated maximum medical improvement (MMI) date.

D. A plan of care should be included in the medical record and should address, as applicable, the following:

1. The disability;
2. Degree of restoration anticipated;
3. Measurable goals;
4. Specific therapies to be used;
5. Frequency and duration of treatments to be provided;
6. Anticipated return to work date;
7. Projected impairment.

E. Health care providers must submit copies of records and reports to payers upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate

documentation to the payer when requested. Only those records for a specific date of injury are considered non-privileged as it relates to a workers' compensation injury. The employer/payer is not privileged to non-work related medical information.

F. Providers must submit documentation for the following:

1. The initial office visit;
2. A progress report if still treating after thirty (30) days;
3. Evaluation for therapy services/treatment (P.T., O.T., C.M.T., O.M.T.);
4. A progress report every thirty (30) days for therapy services/treatment (P.T., O.T., C.M.T., O.M.T.);
5. An operative report or office note (if done in the office) for a surgical procedure;
6. A consultation;
7. The anesthesia record for anesthesia services;
8. A functional capacity or work hardening evaluation;
9. When billing "By Report" (BR), a description of the service is required; this description should include 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;
10. Whenever a modifier is used to describe an unusual circumstance;
11. Whenever the procedure code descriptors include a written report.

G. Hospitals and other inpatient facilities must submit required documentation with the appropriate billing forms as follows:

1. Admission history and physical;
2. Discharge summary;
3. Operative reports;
4. Pathology reports;
5. Radiology reports;
6. Consultations;
7. Other dictated reports;
8. Emergency room records.

H. The Health Insurance Portability & Accountability Act (HIPAA) makes important exceptions concerning the disclosure of protected health information for workers' compensation purposes. For additional information, refer to the MWCC website (mwcc.ms.gov), or consult an attorney and/or the HIPAA resource site maintained by the U. S. Department of Health and Human Services (http://www.hhs.gov/ocr/privacy/).

II. COPIES OF RECORDS

A. **Outpatient Records.** The payer may request additional records or reports from the provider concerning service or treatment provided to a patient other than on an inpatient basis. These additional records and reports will be reimbursed as follows:

1-5 pages — $15.00

6+ pages — $.50 per page in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

As provided by MCA §11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

B. **Inpatient Records.** The payer may request additional records or reports from a facility concerning inpatient service or treatment provided to a patient. Such reports or records requested by the payer will be reimbursed as follows:

   1-5 pages — $15.00/per admission

   6+ pages — $.50 per page/per admission in addition to the above fee

   This applies to copies of microfiche and other electronic media or storage systems.

   There is a maximum reimbursement allowance of fifty dollars ($50.00) for a particular inpatient medical record, exclusive of postage, handling and retrieval charges as set forth below. This is per admission.

   As provided by MCA §11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars ($15.00) for retrieving records stored off the premises where the provider's facility or office is located.

C. Copies of records requested by the patient and/or the patient's attorney or legal representative will be reimbursed by the requesting party according to the provisions of this section on additional reports and records.

D. Documentation submitted by the provider which has not been specifically requested will not be subject to reimbursement.

E. Health care providers may charge up to ten dollars ($10.00) per film for copying x-rays or for providing copies of x-rays via electronic or other magnetic media. (Copies of film do not have to be returned to the provider.)

F. Payers, their representatives, and other parties requesting records and reports must be specific in their requests so as not to place undue demands on provider time for copying records.

G. Providers should respond promptly (within fourteen (14) working days) to requests for additional records and reports.

H. Records requested by the Mississippi Workers' Compensation Commission will be furnished by the provider without charge to the Commission.

I. Any additional reimbursement, including copy service vendors, other than is specifically set forth above, is not required, and providers or their vendors will not be paid any additional amounts.

III. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) AND WORKERS' COMPENSATION

HIPAA makes important exceptions concerning the disclosure of protected health information (PHI) for workers' compensation purposes. The United States Department of Health and Human Services, through its Office for Civil Rights, enforces the HIPAA Law and maintains an informative website with information on HIPAA and its application to workers' compensation claims. See, for example: http://www.hhs.gov/ocr/privacy/.

Dispute Resolution Rules

I. General Provisions

A. Unresolved disputes may be appealed to and resolved by the Mississippi Workers' Compensation Commission.

B. Reconsideration must be sought by the provider or payer prior to a request for resolution of a dispute being sent to the Commission. This provides the payer and provider an opportunity to resolve most concerns in a timely manner.

C. All communication between parties in dispute will be handled by the Mississippi Workers' Compensation Commission, Cost Containment Division. In addition, there will be no communication between the parties in dispute and any Peer Reviewer who might be called upon to assist the Commission in the resolution of a dispute.

II. Forms and Documentation

A. Valid requests for resolution of a dispute must be submitted on the "Request for Resolution of Dispute" form (see the Forms section or http://www.mwcc.state.ms.us/services/feeschedule.asp) along with the following:

1. Copies of the original and resubmitted bills in dispute that include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of any unusual services or circumstances;
2. EOR including the specific reimbursement;
3. Supporting documentation and correspondence;
4. Specific information regarding contact with the payer; and
5. Any other information deemed relevant by the applicant for dispute resolution.

B. A request for Resolution of Dispute must be submitted to:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P.O. Box 5300
Jackson, MS 39296-5300

C. A party, whether payer, provider, patient, or any representative of such parties, shall certify that a copy of the Request for Resolution of Dispute, and any supporting documentation, being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission. This requirement shall also apply when a party files a request seeking review of a dispute by the Commission, or when enforcement of a final decision of the Cost Containment Director is sought.

III. TIME FOR FILING

A Request for Resolution of Dispute must be filed with the Commission within thirty (30) days following the payer's or provider's response to a request for reconsideration of any matter in dispute, or, in cases where the payer or provider fails to respond to a request for reconsideration, within thirty (30) days of the expiration of the time in which said response should have been provided. Failure to file a Request for Resolution of Dispute within this time shall bar any further action on the disputed issue(s) unless, for good cause shown, the Commission or its Cost Containment Director extends the time for filing said request. In no event will the time for filing a Request for Resolution of Dispute be extended more than once or more than an additional twenty (20) days from the time said request was first due to be filed, provided the request for additional time in which to file a Request for Resolution of Dispute is filed within the initial thirty (30) day period provided herein; and, absent compelling circumstances, a dispute resolution request will not be considered by the Cost Containment Division if submitted more than one (1) year after the date of service. The decision to extend the time for filing a Request for Resolution of Dispute based on "good cause" shall be entirely at the discretion of the Commission or its Cost Containment Director. Mere neglect will not constitute "good cause."

IV. PROCEDURE BY COST CONTAINMENT DIVISION

A. Requests for dispute resolution will be reviewed and decided by the Cost Containment Division of the Commission after all required and requested information has been received. Additional time may be required to accommodate a Peer Review. The payer and/or provider may be contacted by telephone or other means for additional information if necessary; however, both parties to a dispute may submit in writing any information or argument they deem relevant to the issue in dispute, if not already submitted with the request for dispute resolution, and this information shall be considered by the Cost Containment Division when rendering a decision. Any written information or argument submitted for consideration by a party to a dispute, without a request from the Commission, must be received by the Cost Containment Division within fourteen (14) days after filing the request for dispute resolution in order to merit consideration.

B. Every effort will be made to resolve disputes by telephone or in writing. The payer and provider may be requested to attend an informal hearing conducted by a Commission representative. Failure to appear at an informal hearing may result in dismissal of the request for dispute resolution.

C. Following review of all documentation submitted for dispute resolution and/or following contact with the payer and/or provider for additional information and/or negotiation, the Cost Containment Division shall render an administrative decision on the request for dispute resolution, and forward it to the involved parties.

D. Cases involving medical care determination may be referred for peer review, but only on request of the Commission. The peer review consultant will render an opinion and submit same to the Commission representative within the time set by the Cost Containment Division. The Commission representative will notify the parties in dispute if a Peer Review has been requested, and of the peer review consultant's determination.

V. COMMISSION REVIEW OF A DISPUTE

A. Any party aggrieved by the decision of the Cost Containment Division shall have twenty (20) days from the date of said decision to request review by the Commission. Failure to file a written request for review with the Commission within this twenty (20) day period shall bar any further review or action with regard to the issue(s) presented. No extension of time within which to file for Commission review of a dispute under these Rules shall be allowed. In the event a request for review is not filed with the Commission within twenty (20) days or within the time allowed by any extension which has

been granted, the parties to the dispute shall have fourteen (14) days thereafter in which to comply with the final decision of the Cost Containment Division.

1. A party to a dispute may, when a written request for review has not been timely filed with the Commission, file with the Commission a written request to compel compliance with the final administrative decision of the Cost Containment Division. The Commission may consider such a request with or without a hearing. A request to compel compliance with the final decision of the Cost Containment Division may be filed at any time following fourteen (14) days after the decision of the Cost Containment Division becomes final, and must be submitted on the form approved by the Commission for this purpose. No such request to compel or enforce compliance with a final decision of the Cost Containment Director shall be considered if filed more than one (1) year after the date of the Cost Containment Director's decision.

   The party seeking relief hereunder shall certify that a copy of the request for relief and any supporting documentation being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission.

B. The request for review by the Commission shall be filed with the Cost Containment Division of the Mississippi Workers' Compensation Commission, and shall be in writing and shall state the grounds on which the requesting party relies. All documentation submitted to and considered by the Cost Containment Division, including the Request for Resolution of Dispute form, along with a copy of the decision of the Cost Containment Division, shall be attached to the request for review which is filed with the Commission. The party seeking relief hereunder shall certify that a copy of the request for review and any supporting documentation being filed with the Commission has been provided to the other interested parties or their representatives by personal delivery, United States mail, facsimile or other electronic submission guaranteed to accomplish receipt, simultaneously with the filing to the Commission.

C. The Commission shall review the issue(s) solely on the basis of the documentation submitted to the Cost Containment Division. No additional documentation not presented to and considered by the Cost Containment Division shall be considered by the Commission on review, unless specifically requested by the Commission, and no hearing or oral argument shall be allowed.

D. The Commission shall consider the request for review and issue a decision.

E. Following the decision of the Commission, or following the conclusion of the dispute resolution process at any stage without an appeal to the Commission, no further audit, adjustment, refund, review, consideration, reconsideration or appeal with respect to the claim in question may be sought by either party.

F. The costs incurred in seeking Commission review, or in seeking compliance with an Administrative Decision rendered by the Cost Containment Director, including reasonable attorney fees, if any, shall be assessed to the party who requested review if that party's position is not sustained by the Commission and to the party who has failed to comply with a prior decision if compliance therewith is ordered by the Commission. Otherwise, each party shall bear their own costs, including attorney's fees.

G. If the Commission determines that a dispute is based on or arises from a billing error, a payment adjustment or error, including but not limited to improper bundling of service codes, unbundling, downcoding, code shifting, or other action by either party to the dispute, or if the Commission determines that a provider or payer has unreasonably refused to comply with the Law, the Rules of the Commission, including this Fee Schedule, or with any decision of the Commission or its representatives, and that this causes proceedings with respect to the billing and/or payment for covered medical services to be instituted or continued or delayed without reasonable grounds, then the Commission may require the responsible party or parties to pay the reasonable expenses,

including attorney's fees, if any, to the opposing party; and, in addition, the Commission may levy against the responsible party or parties a civil penalty not to exceed the sum of ten thousand dollars ($10,000.00), payable to the Commission, as provided in §71-3-59(2) of the Law. The award of costs and penalties as herein provided shall be in addition to interest and penalty charges which may apply under other provisions of this Fee Schedule.

Utilization Review Rules

The Mississippi Workers' Compensation Commission requires mandatory utilization review of certain medical services associated with the provision of medical treatment covered under the Act and subject to the Fee Schedule. "Utilization review" refers to a system for reviewing proposed medical services to make sure that such procedures are medically necessary and represent the most efficient and appropriate use of medical resources given the nature of the injury to the patient and the process of his or her recovery, and that such services are properly and timely reimbursed. These rules are set forth to encourage efficient and timely communication between payers and providers (including agents of either) in order to make sure that medically necessary services are provided and timely reimbursed, and to curtail the use of unnecessary or unreasonable treatment. The provisions herein set forth regarding utilization review are in addition to the requirements of MCA §41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure. In the event of conflict between this Fee Schedule and the above statutes, and any implementing regulations adopted by the Health Department or Board of Medical Licensure, the provisions in this Fee Schedule or other applicable rules of the Mississippi Workers' Compensation Commission shall control.

A payer may provide for utilization review by using personnel or units in-house, by contracting with a third party utilization review agent properly licensed by the MS Department of Health, or by contracting with a Nurse Case Manager or similar person to monitor the care being provided in person working with the patient and provider. An injured worker and/or his or her attorney and any case manager assigned by the payer shall strive to cooperate with one another for the purpose of ensuring the injured worker receives all of the medically necessary care needed for the treatment of the injury and the process of recovery. A payer also may exercise their statutory right to an Employer Medical Evaluation (EME) as provided for in MCA §71-3-15(1) (Rev. 2000) in conjunction with, or in lieu of, ongoing utilization review.

AS STATED IN MCA §41-83-31(a), (b) (Rev. 2009), NO DECISION OR DETERMINATION ADVERSE TO A PATIENT OR HEALTH CARE PROVIDER WHICH MAY RESULT IN THE DENIAL OF PAYMENT, OR IN THE DENIAL OF PRE-CERTIFICATION FOR TREATMENT IN THIS STATE, SHALL BE MADE WITHOUT THE PRIOR EVALUATION AND CONCURRENCE IN THE ADVERSE DETERMINATION BY A PHYSICIAN CURRENTLY LICENSED TO PRACTICE MEDICINE IN THE STATE OF MISSISSIPPI, AND PROPERLY TRAINED IN THE SAME SPECIALTY OR SUB-SPECIALTY AS THE REQUESTING PROVIDER WHO IS SEEKING APPROVAL FOR TREATMENT OR SERVICES.

THIS ADVERSE DETERMINATION MUST BE PROVIDED WITHIN TWO (2) BUSINESS DAYS EITHER BY TELEPHONE OR FACSIMILE OR EMAIL, AND IN WRITING WITHIN ONE (1) BUSINESS DAY THEREAFTER, TO THE REQUESTING PROVIDER. ANY SUCH ADVERSE DETERMINATION MUST INCLUDE WRITTEN DOCUMENTATION CONTAINING THE SPECIFIC EVALUATION, FINDINGS AND CONCURRENCE OF THE MISSISSIPPI LICENSED PHYSICIAN TRAINED IN THE RELEVANT SPECIALTY OR SUB-SPECIALTY, AND MUST REFERENCE ANY SPECIFIC PROVISIONS OF THE MISSISSIPPI WORKERS' COMPENSATION MEDICAL FEE SCHEDULE WHICH ALLEGEDLY JUSTIFIES THE ADVERSE DETERMINATION.

ANY ADVERSE DETERMINATION WHICH DOES NOT COMPLY WITH THIS PROVISION SHALL HAVE NO FORCE OR EFFECT AND SHALL NOT PREVENT THE PROVIDER FROM PROCEEDING WITH THE PROPOSED TREATMENT AND ULTIMATELY BEING REIMBURSED AS THOUGH THE PROPOSED TREATMENT OR SERVICE HAD BEEN TIMELY APPROVED IN ADVANCE.

IF A PAYER ELECTS TO SEEK AN EME IN LIEU OF A UTILIZATION REVIEW, THE INJURED WORKER AND THE PROVIDER MUST BE NOTIFIED OF THIS ELECTION WITHIN THE SAME TWO (2) DAY PERIOD APPLICABLE TO ADVERSE DETERMINATIONS STATED ABOVE.

I. SERVICES REQUIRING UTILIZATION REVIEW

Mandatory utilization review is required for the following:

A. All admissions to inpatient facilities of any type.

B. All surgical procedures, inpatient and outpatient. (All surgical or other invasive procedures which are administered in the context of pain management treatment shall be regulated by the specific guidelines set forth in the Pain Management section of the Fee Schedule. Only in the event a surgically invasive pain management procedure is not specifically addressed in the Pain Management guidelines shall the provisions in this section control.)

C. Repeat MRI scans, repeat CT Scans, repeat EMG/NCS studies, and repeat myelograms (meaning more than one such diagnostic procedure which is being prescribed for the same injury) are subject to mandatory utilization review, except that where surgery has been performed following proper approval, the treating physician is entitled to obtain one repeat of the aforementioned diagnostic procedures post-surgery without having to obtain separate approval for each such procedure. In other words, surgical cases merit two diagnostic procedures of the kind listed herein without the necessity of pre-certification provided one procedure occurs prior to surgical treatment and one procedure occurs post-surgical treatment. The two diagnostic procedures selected by the treating provider hereunder may be the same two diagnostic procedures, or any two of the aforementioned procedures.

D. Work hardening programs, pain management programs, massage therapy, acupuncture, and biofeedback. Biofeedback therapy shall not exceed ten (10) visits or sessions, unless otherwise agreed to by the payer and provider. Back schools are no longer covered under this Fee Schedule. Pain management programs include but are not limited to a “chronic pain inter-disciplinary pain rehabilitation program” for which specific guidelines are set forth in the Therapeutic Services section.

    1. Work Hardening Program Guidelines

        a. Work hardening is an interdisciplinary, individualized, job or goal-specific program of activity with the goal of returning an injured patient to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual’s measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the bio-mechanical, neuromuscular, and cardiovascular functioning of the worker. Approval or certification must be based on whether the proposed work hardening program appears reasonably tailored to accomplish the stated goals.

            (1) A work hardening program must, at a minimum, have the following components:

                - Development of strength and endurance of the individual in relation to the return to work goal;

- Equipment and methods that quantify and measure strength and conditioning levels, i.e., ergometers, dynamometers, treadmills, measured walking tolerances;
- Commercial strength and exercise devices, free weights, circuit training. Goals for each worker are dependent on the demands of their respective jobs;
- Simulation of the critical work demands, the tasks and the environment of the job to which the worker will return. Job simulation tasks that provide for progression in frequency, load, and duration are essential. They must be related to the work goal and include a variety of work stations that offer opportunities to practice work related positions and motions, i.e., clerical, plumbing, electrical;
- Education that stresses body mechanics, work pacing, safety and injury prevention and that promotes worker responsibility and self-management. The education component requires direct therapist and worker interaction;
- Assessment of the need for job modifications. Focus on whether the worker can return to the stated job goal but only with changes, i.e., added equipment, changes in work position or ergonomics, changes at the work site;
- An individualized written plan that identifies observable and measurable goals, the methodology being used to reach these goals, the projected time necessary to accomplish the goal, and the expected outcomes. This plan must be signed by both the provider and the patient;
- This plan needs to be based on a functional capacity (baseline) evaluation and must be completed within the first two (2) days of the program and compared to the critical demands as stated on the job analysis. A comparative analysis (re-evaluation) is done prior to discharge to determine job readiness;
- A reporting system that includes:
  - Documentation of the initial plan;
  - Documentation of progress or lack of progress and future goals;
  - A discharge summary that includes an assessment of the functional capacity level and the achievement of the individual's program goals;
  - A record of the worker's daily attendance including number of days and number of hours per day in the program.

b. Criteria for admission:

(1) The worker must have reached a point in his or her recovery where no further active or invasive treatment intervention is being anticipated;

(2) Physical recovery sufficient to allow participation for a minimum of 4 hours a day for three to five days a week;

(3) Worker's current levels of functioning interfere with his/her ability to carry out specific tasks required in the work place;

(4) A defined return to work goal which includes:

- A documented specific job to which the patient can return, along with a specific job analysis; and
- A return to work goal agreed to by the employer and the patient/employee;
- The facts must show how the worker must be able to benefit from the program;
- The facts must show the worker is motivated to return to work. A worker whose primary limitation is psychological or clouded by significant illness behavior (i.e., significant self-imitation on F.C.E.) is typically not going to be motivated and will not likely benefit.

c. Criteria for discharge from a work hardening program:

- The worker has reached the goal stated in the plan;
- The worker has not progressed according to the program plan;
- The worker has not reached interim goals and is not benefitting from the program, or;
- Number of absences exceeds those allowed by the program (a maximum of two (2) absences is recommended);
- Worker does not adhere to the schedule;
- Completion of the program (the program should take 2 to 4 weeks to complete);
- The previously identified job is no longer available.

2. Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

E. External spinal stimulators.

F. Therapeutic treatments, exclusive of chiropractic treatments, after fifteen (15) visits or thirty (30) days, whichever comes first. If, however, the patient undergoes properly approved surgical intervention, he or she shall be entitled to one round of pre-surgical therapeutic treatment up to fifteen (15) treatments or thirty (30) days, whichever first occurs, as provided immediately above; and, in the discretion of the treating physician, to one additional round of therapeutic treatment following surgery for an additional period of fifteen (15) visits or thirty (30) days, whichever first occurs, both of which treatment rounds may be administered without the necessity for seeking pre-certification or pre-approval. The authorization contained herein for a first and second round of limited therapy treatment following surgery shall apply to all reasonable physical and/or occupational therapy treatments, but does not include chiropractic manipulative treatment which is addressed separately below.

G. Chiropractic manipulative treatments are allowed for up to fifteen (15) visits or thirty (30) days, whichever first occurs, without any need to seek pre-certification or authorization. However, chiropractic manipulative treatments which are proposed beyond the first fifteen (15) visits or thirty (30) days, under any circumstances, must be pre-certified or pre-approved.

Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

H. Psychiatric treatment, whether inpatient or outpatient treatment.

I. Retrospective review of services after they have been provided when properly requested by the patient, patient representative, or provider.

J. Any proposed treatment, procedure or service which is more specifically addressed in another section of this Fee Schedule, such as certain pain management procedures, shall be regulated first by the specific guidelines in place in those sections. These utilization review rules apply only where no other, more specific guidelines are set forth in the individual treatment sections of the Fee Schedule; or, where possible, to supplement more specific treatment guidelines spelled out elsewhere in the Fee Schedule.

II. DEFINITIONS

Case Management. The clinical and administrative process in which timely, individualized, and cost effective medical rehabilitation services are implemented, coordinated, and evaluated, by a nurse, other case manager, or other utilization reviewer employed by the payer, on an ongoing basis for patients who have sustained an injury or illness. Use of case management is optional in Mississippi. Use Mississippi-specific code 9936M for a conference with workers' compensation medical case manager/claims manager.

Certification. A determination by a payer and/or its utilization review organization or agent that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the standard of medical necessity as defined elsewhere in this Fee Schedule.

Clinical Peer. A health professional that holds an unrestricted medical or equivalent license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

Clinical Rationale. A statement or other documentation that taken together provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the worker's condition or treatment plan, and must include a detailed basis for denial or non-certification of the proposed treatment so as to give the provider or patient a sufficient basis for a decision to pursue an appeal. Clinical rationale must include specific reference to any applicable provisions of the *Mississippi Workers' Compensation Medical Fee Schedule* which allegedly support the determination of the reviewer, or a statement attesting to the fact that no such provision(s) exists in the Fee Schedule.

Concurrent Review. Utilization management or review which is conducted during a worker's hospital stay or course of treatment, sometimes called continued stay review.

Discharge Planning. The process of assessing a patient's need for medically appropriate treatment after hospitalization including plans for an appropriate and timely discharge.

Expedited Appeal. An expedited appeal is a request to reconsider a prior determination not to certify imminent or ongoing services, an admission, an extension of stay, or other medical services of an emergency, imminent, or ongoing nature. Also sometimes referred to as a reconsideration request.

First Level Clinical Review. Review conducted by a registered nurse, nurse case manager, or other appropriate licensed or certified health professional. First level clinical review staff may approve requests for admissions, procedures, and services that meet the standard of medical necessity as defined elsewhere in the Fee Schedule, but must refer requests that do not meet this medical necessity standard, in their opinion, to second level clinical peer reviewers for approval or denial.

Notification. Correspondence transmitted by mail, telephone, facsimile, email, and/or other reliable electronic means.

Pre-certification. The review and assessment of proposed medical treatment or services before they occur to determine if such treatment or services meet the definition of medical necessity as set forth elsewhere in this Fee Schedule. The appropriateness of the site or level of care is assessed along with the duration and timing of the proposed services.

Provider. A licensed health care facility, program, agency, or health professional that delivers health care services.

Retrospective Review. Utilization review conducted after services have been provided to the worker.

Second Level Clinical Review. Peer review conducted by appropriate clinical peers when the First Level Clinical Reviewer is unable to determine whether a request for an admission, procedure, or service satisfies the standard of medical necessity as defined elsewhere in this Fee Schedule. A decision to deny, or not certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty or sub-specialty as the requesting provider.

Standard Appeal. A request by or on behalf of the patient or provider to reconsider a prior decision by the payer or its utilization review agent to deny proposed medical treatment or service, including but not limited to, a determination not to certify an admission, extension of stay, or other health care service.

Third Level Clinical Review. Medical necessity review conducted by appropriate clinical peers who were not involved in the first or second level review when a decision not to certify a requested admission, procedure, or service has been appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider. A decision to deny, or not certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty or sub-specialty as the requesting provider.

Utilization Review. Evaluation of the medical necessity and appropriateness of proposed health care services. It includes both prospective and concurrent review, and shall include retrospective review under certain circumstances.

Utilization Reviewer. An entity, organization, or representative thereof, or other person performing utilization review activities or services on behalf of an employer, payer or third-party claims administrator.

Variance. A deviation from a specific standard.

III. STANDARDS

Payers and their utilization review organizations or programs or agents are required to meet the following standards:

A. The payer's utilization reviewer or agent must comply with the licensing and certification requirements of MCA §41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and shall have utilization review personnel, agents or representatives who are properly qualified, trained, supervised, and supported by explicit clinical review criteria and review procedures. In no event shall proposed treatment or services be denied except in accordance with the express provisions stated elsewhere in these Rules and in accordance with MCA §41-83-31 (Rev. 2009).

B. The first level review is performed if the claims adjuster or manager has not already approved the treatment in question, and is performed by individuals who are health care professionals, who possess a current and valid professional license, and who have been trained in the principles and procedures of utilization review.

C. The first level reviewers are required to be supported by a doctor of medicine who has an unrestricted license to practice medicine, and in cases where treatment is being denied or withheld by a utilization reviewer, this determination must be supported in writing by a physician licensed in Mississippi and trained in the relevant specialty or sub-specialty, as previously set forth in these Rules.

D. The second and third level review is performed by clinical peers who hold a current, unrestricted Mississippi license to practice in the same or like specialty as the treating physician whose recommendation is under review, and are oriented in the principles and procedures of utilization review. The second level review shall be conducted for all cases where a clinical determination to certify has not already been made by the payer or payer's agent, and the determination of medical necessity cannot be made by first level clinical reviewers. Second and third level clinical reviewers shall be available within one (1) business day by telephone or other electronic means to discuss the determination with the attending physicians or other ordering providers. In the event more information is required before a determination can be rendered by a second or third level reviewer, the attending/ordering provider must be notified immediately of the delay and given a specific time frame for determination, and a specific explanation of the additional information needed. A requesting provider shall not be required to participate in further discussions where the payer or its agents have unilaterally scheduled such a conference. Further, a request for treatment or service may not be denied solely on grounds the requesting provider fails to participate in a conference which has been unilaterally scheduled by the payer or their agent. Follow-up conferences must be arranged by joint agreement.

E. The payer's utilization reviewer shall maintain all licensing applications, certificates, and other supporting information, including any and all reports, data, studies, etc., along with written policies and procedures for the effective management of its utilization review activities, which shall be made available to the provider, or the Commission, upon request.

F. The payer maintains the responsibility for the oversight of the delegated functions if the payer delegates utilization review responsibility to a vendor. The vendor or organization to which the function is being delegated must be currently certified by the Mississippi Board of Health, Division of Licensure and Certification to perform utilization management in the State of Mississippi. A copy of the license or certification held by the utilization review agent shall be furnished to the provider, or to the Commission, upon request. The payer who has another entity perform utilization review functions or activities on its behalf maintains full responsibility for compliance with the rules.

G. The payer's utilization reviewer shall maintain a telephone review service that provides access to its review staff at a toll free number from at least 9:00 a.m. to 5:00 p.m. CST each normal business day. There should be an established procedure for receiving or redirecting calls after hours or receiving faxed requests. Reviews should be conducted during hospitals' and health professionals' reasonable and normal business hours.

H. The payer's utilization reviewer shall collect only the information necessary to certify the admission procedure or treatment, length of stay, frequency, and duration of services. The utilization reviewer should have a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments to avoid duplicate requests to providers. (Providers may use the Mississippi Workers' Compensation Commission Utilization Review Request Form.)

IV. PROCEDURES FOR REVIEW DETERMINATIONS

The following procedures are required for effective review determination.

A. Initial review determinations must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. The Mississippi Workers' Compensation Utilization Review Request Form may be used to request pre-certification.

B. When an initial determination is made to certify, notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written or electronic notification to the provider or facility rendering the service. If an initial determination to certify is provided by telephone, a written notification of the determination shall be provided within two (2) business days thereafter. The written notification shall include the number of days approved, the new total number of days or services approved, and the date of admission or onset of services.

C. When a determination is made not to certify, notification to the attending or ordering provider or facility must be provided by telephone or electronic means within one (1) business day followed by a written notification within one (1) business day thereafter. The written notification must include the principal reason/clinical rationale for the determination not to certify, including specific reference to any provision of this Fee Schedule relied upon by the reviewer, and instructions for initiating an appeal and/or reconsideration request.

D. The payer or its review agent shall inform the attending physician and/or other ordering provider of their right to initiate an expedited appeal in cases involving emergency or imminent care or admission, or a standard appeal, as the case may permit, of a determination not to certify, and the procedure to do so.

    1. Expedited appeal—When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring imminent or expedited review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone or by electronic mail or facsimile on an expedited basis within one (1) business day.

        a. Each private review agent shall provide for prompt and expeditious access to its consulting physician(s) for such appeals.

        b. Both providers of care and private review agents should attempt to share the maximum information by phone, fax, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.

        c. Expedited appeals, which do not resolve a difference of opinion, may be resubmitted through the standard appeal process, or submitted directly to the Commission's Medical Cost Containment Division as a Request for Resolution of Dispute. A disagreement warranting expedited review or reconsideration does not have to be resubmitted to the payer or utilization review agent through the standard appeal process unless the requesting provider so wishes.

    2. Standard appeal—A standard appeal will be considered as a request for reconsideration, and notification of the appeal decision given to the provider, not later than twenty (20) calendar days after receiving the required documentation for the appeal.

        a. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify treatment or services must be provided the clinical rationale for the determination along with the notification of the appeal decision.

    3. Retrospective review—For retrospective review, the review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided. Retrospective review is not optional or conducted solely at the discretion of the review agent. A

request for review and approval of services already provided must be handled by the payer or its utilization reviewer in the same manner any other request for approval of services is handled.

a. When there is retrospective determination not to certify an admission, stay, or other service, the attending physician or other ordering provider and hospital or facility shall receive written notification, or notification by facsimile or electronic mail, within twenty (20) calendar days after receiving the request for retrospective review and all necessary and supporting documentation.

b. Notification should include the principal reasons for the determination and a statement of the procedure for standard appeal if the determination is adverse to the patient.

4. Emergency admissions or surgical procedures—Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review may be initiated.

a. If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.

b. To overcome a prima facie case for emergency admission as established above, the utilization reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.

E. Failure of the health care provider to provide necessary information for review, after being specifically requested to do so by the payer or its review agent in detail, may result in denial of certification and/or reimbursement.

F. When a payer and provider have completed the utilization review appeals process and cannot agree on a resolution to a dispute, either party, or the patient, can appeal to the Cost Containment Division of the Mississippi Workers' Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a utilization review dispute should be filed with the Commission within twenty (20) calendar days following the conclusion of the underlying appeal process provided by the payer or its utilization reviewer. The Commission shall consider and decide a request for resolution of a utilization review dispute in accordance with the Dispute Resolution Rules provided elsewhere in this Fee Schedule.

G. Failure of a payer or its utilization review agent to timely notify the provider of a decision whether to certify or approve an admission, procedure, service or other treatment shall be deemed to constitute approval by the payer of the requested treatment, and shall obligate the payer to reimburse the provider in accordance with other applicable provisions of this Fee Schedule should the provider elect to proceed with the proposed treatment or service. Timely notification means notification by mail, facsimile, electronic mail, or telephone, followed by written notification, to the provider, within the applicable time periods set forth in these Utilization Review Rules.

H. Upon request of the provider, or the Commission, a payer and/or the review agent must furnish a copy of the license or certification obtained from the State Department of Health, along with all supporting documentation, reports, data, studies, etc., which authorizes the reviewer to engage in utilization review activities in the State of Mississippi. The Commission may, likewise, obtain this information unilaterally from the Mississippi Department of Health pursuant to an agreement with that Agency.

I. Upon a finding by the Commission or an Administrative Judge that a payer, and/or their review agent, has unreasonably delayed a claim without reasonable grounds within the meaning of §71-3-59 of the Law, penalties pursuant to MCA §71-3-59 (Rev. 2000) may be assessed against the payer.

Any payer electing to obtain an Employer Medical Evaluation (EME) pursuant to MCA §71-3-15(1) must do so without unreasonable delay. With respect to an EME sought after the filing of a motion to compel medical treatment by a claimant, failure by the payer to obtain and submit the EME report to the claimant and the Commission within 45 days of the claimant's filing of a motion to compel may be deemed an unreasonable delay. Counsel for both parties may agree to extend the forty-five-day (45-day) limitation, or the Administrative Judge may extend the forty-five-day (45-day) limitation at his or her discretion. The forty-five-day (45-day) limitation does not apply to experts selected by the agreement of both parties to render a second opinion. If an Administrative Judge or the Commission finds that a payer has demonstrated unreasonable delay in seeking or obtaining an EME, regardless of whether a motion to compel medical treatment has been filed, such a finding may result in the imposition of penalties and/or attorney's fees or expenses pursuant to MCA §71-3-59 and/or waiver of the payer's right to an EME.

J. Regardless of the outcome of a dispute arising hereunder regarding certification or approval of a proposed treatment or service, in no event shall the injured worker/patient be held liable for the payment of any portion of a bill related thereto. As provided in §71-3-15(1) of the Law, any dispute over the amount due a medical provider for any reason shall be resolved between the payer and provider, with each holding the claimant harmless from payment of same, regardless of whether the treatment has been provided inside or outside the State of Mississippi.

K. Nothing provided herein shall estop or prevent the patient from obtaining legal counsel and/or seeking relief in the form of a request to compel medical treatment before an Administrative Judge.

Rules for Modifiers and Code Exceptions

Please see the modifier rules in each section of the *Mississippi Workers' Compensation Medical Fee Schedule* for a complete listing of appropriate modifiers for each area.

A. Modifiers must be used by providers to identify procedures or services that are modified due to specific circumstances.

B. When modifier 22 is used to report an increased service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing. When appropriate, the *Mississippi Workers' Compensation Medical Fee Schedule* reimbursement for modifier 22 is one hundred twenty percent (120%) of the maximum reimbursement allowance.

C. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for a modified service or procedure is based on documentation of medical necessity and determined on a case-by-case basis.

D. Modifiers allow health care providers to indicate that a service was altered in some way from the stated description without actually changing the definition of the service.

I. MODIFIERS FOR CPT® (HCPCS LEVEL I) CODES

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow.

This section contains a list of modifiers used with CPT codes. Also consult each practice-area section of the Fee Schedule for additional modifiers.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

Mississippi guideline: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures

When multiple procedures, other than E/M Services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room, (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi guideline: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi guideline: Physician reimbursement is ten percent (10%) of the maximum reimbursement allowance.

82 Assistant Surgeon (when qualified resident surgeon not available)
The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing
When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require permanent dedicated space; hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA Anesthesia Services Performed Personally by Anesthesiologist
Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than 4 Concurrent Anesthesia Procedures
Report modifier AD when the anesthesiologist supervises more than 4 concurrent anesthesia procedures.

AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery
Assistant at surgery services provided by another qualified individual (e.g., physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant) and not another physician are identified by adding modifier AS to the listed applicable surgical procedures. Modifier AS may be appended to any code identified as appropriate for surgical assistance in this Fee Schedule.

Mississippi guideline: AS reimbursement is ten percent (10%) of the maximum reimbursement allowance. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

M1 Nurse Practitioner (Mississippi Modifier)
This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a nurse practitioner.

M2 Physician Assistant (Mississippi Modifier)
This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a physician assistant.

M3 Physical or Occupational Therapist Assistant (Mississippi Modifier)
This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by either a physical therapist assistant or an occupational therapist assistant.

M4 CARF Accredited (Mississippi Modifier)
This modifier should be used in conjunction with CPT code 97799 Unlisted physical medicine/rehabilitation service or procedure, to indicate chronic pain treatment being administered by a CARF accredited provider as part of a pre-approved interdisciplinary pain rehabilitation program.

M5 Chronic Pain Treatment (Mississippi Modifier)
This modifier should be used only in conjunction with CPT code 97799 Unlisted physical medicine/rehabilitation service or procedure, to indicate chronic pain treatment being administered as part of a pre-approved interdisciplinary pain rehabilitation program.

QK Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals
Report modifier QK when the anesthesiologist supervises 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.

QX Qualified Non-Physician Anesthetist with Medical Direction by a Physician
Regional or general anesthesia provided by a qualified non-physician anesthetist with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction of One Qualified Non-Physician Anesthetist by an Anesthesiologist
Report modifier QY when the anesthesiologist supervises one qualified non-physician anesthetist.

QZ CRNA Service without Medical Direction by a Physician
Regional or general anesthesia provided by the CRNA (certified registered nurse anesthetist) or AA (anesthesiologist assistant) without medical direction by a physician may be reported by adding modifier QZ.

II. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE
This section contains a list of modifiers used with ambulatory surgery center and hospital-based outpatient services. Also consult each practice-area section of the Fee Schedule for additional modifiers.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

III. MODIFIERS FOR HCPCS LEVEL II CODES

This section contains a list of commonly used modifiers with HCPCS Level II DME codes. Other HCPCS Level II modifiers, including those which can be used with CPT codes, are acceptable modifiers.

AU Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply

AV Item Furnished in Conjunction with a Prosthetic Device, Prosthetic, or Orthotic

AWItem Furnished in Conjunction with a Surgical Dressing

KC Replacement of Special Power Wheelchair Interface

NU New Equipment

RR Rental (use the RR modifier when DME is to be rented)

Mississippi guideline: Listed amount is the per month allowance.

UE Used Durable Medical Equipment

Mississippi guideline: Used to report the purchase of used durable medical equipment.

IV. CODE EXCEPTIONS

A. **Unlisted Procedure Codes.** If a procedure is performed that is not listed in the Fee Schedule, the provider must bill with the appropriate "Unlisted Procedure" code and submit a narrative report to the payer explaining why it was medically necessary to use an unlisted procedure code.

The CPT book contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed by report (see below).

B. **By Report (BR) Codes.** By report (BR) codes are used by payers to determine the reimbursement for a service or procedure performed by the provider that does not have an established maximum reimbursement allowance (MRA).

1. Reimbursement for procedure codes listed as "BR" must be determined by the payer based on documentation submitted by the provider in a special report attached to the claim form. The required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:
    a. A complete description of the actual procedure or service performed;
    b. The amount of time necessary to complete the procedure or service performed;
    c. Accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.
2. Reimbursement of "BR" procedures should be based on the usual and customary rate.

C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in the CPT book. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory services. These codes do not have an associated relative value or fee.

D. **Category III Codes.** This Fee Schedule does not include Category III codes published in the CPT book. If a provider bills a Category III code, payment may be denied.

E. **Add-On Codes.** The CPT book identifies procedures that are always performed in addition to the primary procedure and designates them with a + symbol. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician or other qualified health care provider that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesions(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)).

Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Add-on codes are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's charge, whichever is less.

Refer to the most current version of the CPT book for a complete list of add-on codes.

F. **Codes Exempt From Modifier 51.** This symbol ⊘ denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book. Modifier 51 exempt services and procedures can be found in Appendix E of CPT 2013.

Additional codes that should not be subject to modifier 51 have been identified by Optum based upon CPT guidelines and are included in this Fee Schedule using the same CPT icon.

Codes exempt from modifier 51 are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's charge, whichever is less.

G. **Moderate (Conscious) Sedation.** To report moderate (conscious) sedation provided by the physician also performing the diagnostic or therapeutic service for which conscious sedation is being provided, see codes 99143–99145. It is not appropriate for the physician performing the sedation and the service for which the conscious sedation is being provided to report the sedation separately when the code is listed with the conscious sedation symbol ⊙. The conscious sedation symbol identifies services that include moderate (conscious) sedation. A list of codes for services that include moderate (conscious) sedation is also included in the most current CPT book.

For procedures listed with ⊙, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service using codes 99148–99150.

Moderate sedation codes are not used to report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.

Pharmacy Rules

I. SCOPE

This section provides specific rules for the dispensing of and payment for medications and other pharmacy services prescribed to treat work-related injury/illness under the terms of the Act.

II. DEFINITIONS

A. **Medications** are defined as drugs prescribed by a licensed health care provider and include name brand and generic drugs as well as patented or over-the-counter drugs, compound drugs and physician-dispensed or repackaged drugs.

B. **Average Wholesale Price** means the AWP based on the most current edition of the *Drug Topics Red Book* in effect at the time the medication is dispensed.

III. RULES

A. Generic Equivalent Drug Products. Unless otherwise specified by the ordering physician, all prescriptions will be filled under the generic name.

   When the physician writes “brand medically necessary” on the prescription, the pharmacist will fill the order with the brand name. When taking telephone orders, the pharmacist will assume the generic brand is to be used unless “brand medically necessary” is specifically ordered by the treating physician. Without exception, the treating physician has the authority to order a brand name medication if he/she feels the trademark drug is substantially more effective.

B. A payer or provider may not prohibit or limit any person from selecting a pharmacy or pharmacist of his/her choice, and may not require any person to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or program, or to obtain medication dispensed by the physician or in the physician’s office, provided the pharmacy or pharmacist selected by the claimant has agreed to be bound by the terms of the Workers’ Compensation Law and this Fee Schedule with regard to the provision of services and the billing and payment therefor.

C. Dietary supplements, including but not limited to minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established as related to the work injury.

D. Not more than one dispensing fee shall be paid per drug within a ten (10) day period.

IV. REIMBURSEMENT

A. Reimbursement for pharmaceuticals ordered for the treatment of work-related injury/illness is as follows:

1. Brand/Trade Name Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
2. Generic Medications: Average Wholesale Price (AWP) plus a five dollar ($5.00) dispensing fee.
3. Over-the-counter medications are reimbursed at usual and customary rates.
4. Dispensing fees are payable only if the prescription is filled under the direct supervision of a registered pharmacist. If a physician dispenses medications from his/her office, a dispensing fee is not allowed.
5. Repackaged and/or Physician Dispensed Medication: If the National Drug Code (NDC) for the drug product as dispensed is a repackaged drug, the maximum allowable fee shall be the lesser of AWP using a) the NDC for the underlying drug product from the original labeler, or b) the therapeutic equivalent drug product from the original labeler NDC.

   For purposes of this provision, "therapeutically equivalent drugs" means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter "A" in the Food and Drug Administration's publication "Approved Drug Products with Therapeutic Equivalence Evaluations" (Orange Book). The Orange Book may be accessed through the Food and Drug Administration website at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm.

   National Drug Code "for the underlying drug product from the original labeler" means the NDC of the drug product actually utilized by the repackager in producing the repackaged product.
6. Compound Medications: Compound drugs or medications shall be billed by listing each drug and its NDC number included in the compound and calculating the charge for each drug separately. Payment shall be based on the sum of the fee for each ingredient, plus a single dispensing fee of five dollars ($5.00). If the NDC for any ingredient is a repackaged drug, reimbursement for the repackaged ingredient(s) shall be as above provided. Reimbursement for a compound cream medication is limited to a maximum total reimbursement of three hundred dollars ($300.00) for one hundred twenty (120) grams per month. Any additional quantity over and above this one hundred twenty (120) gram limit requires further documentation and prior authorization (pre-certification).
7. If information pertaining to the original labeler of the underlying drug product used in repackaged or compound medications is not provided or is otherwise unknown or unavailable, the payer shall reimburse using the lowest priced generic therapeutic equivalent drug product.

B. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule. Supplies and equipment not listed in the Fee Schedule will be reimbursed at the usual and customary rate.

C. Mail-order pharmaceutical services are subject to the rules and reimbursement limitations of this Fee Schedule when supplying medications to Mississippi Workers' Compensation claimants.

Other Qualified Health Care Professional Rules

I. **Nurse Practitioner**

A. Modifier M1 should be attached to the appropriate CPT® code when billing services rendered by the nurse practitioner. The nurse practitioner must use his/her unique identifier to bill for all services. Nurse practitioners must comply with the requirements for a National Provider Identifier (NPI) as specified in the Billing and Reimbursement Rules of this Fee Schedule.

B. The nurse practitioner is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.

C. There is only one fee allowed for each CPT code. It is the decision of the physician or the nurse practitioner as to who will bill for a service when both have shared in the provision of the service. Incorrect billing of the service may cause a delay or improper payment by the payer. The medical doctor (MD) must be on-site on the date of service in order for physician reimbursement to apply.

II **Physician Assistant**

A. Modifier M2 should be attached to the appropriate CPT code(s) when billing services rendered by the physician assistant.

B. The physician assistant is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.

C. The same rules as apply to the nurse practitioners with regard to billing and reimbursement, shall apply to the physician assistant.

III. **Physical Therapist Assistant or Occupational Therapist Assistant**

A. Modifier M3 should be attached to the appropriate CPT code(s) when billing services rendered by a physical therapist assistant or an occupational therapist assistant.

B. The physical therapist assistant or occupational therapist assistant is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.

IV. **Psychology**

When a provider other than a psychiatrist provides psychology services, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, counselors, etc.

Home Health Rules

I. SCOPE

This section of the Fee Schedule pertains to home health services provided to patients who have a work-related injury/illness.

A. The determination that the injury/illness or condition is work related must be made by the payer and home health services shall be pre-certified as medically necessary by the payer's Utilization Management Program.

B. All nursing services and personal care services shall have prior authorization by the payer.

C. A description of needed nursing or other attendant care must accompany the request for authorization.

II. REIMBURSEMENT

A. If a payer and provider have a mutually agreed upon contractual arrangement governing the payment for home health services to injured/ill employees, the payer shall reimburse under the contractual agreement and not according to the Fee Schedule.

B. In the absence of a mutually agreed upon contractual arrangement governing payment for home health service, reimbursement shall be made as in other cases (see Billing and Reimbursement Rules) in an amount equal to billed charges, or the maximum reimbursement allowance (MRA), whichever is less. Billing for home health services is appropriate using the applicable billing form for other institutional providers or facilities.

C. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.

D. A visit is defined as time up to and including the first two hours.

E. The maximum reimbursement allowances (MRA) listed herein are inclusive of mileage and other incidental travel expenses, unless otherwise agreed to by the payer and provider.

F. The hourly rates set forth in this section of the Fee Schedule apply to all hours worked. No additional reimbursement is allowed for overtime hours, unless otherwise agreed to by the parties in a separate fee contract.

III. RATES

A. The following MRAs and codes apply to services provided by or through a home health agency:

Service	Fee Per Visit	Billing Code
Skilled Nursing Care	$110.00	G0154
Physical Therapy	$120.00	G0151
Speech Therapy	$125.00	G0153
Occupational Therapy	$125.00	G0152
Medical Social Services	$125.00	G0155
Home Health Aide	$60.00	G0156

For services that exceed two (2) hours, reimbursement for time in excess of the first two (2) hours shall be pro-rated and based on an hourly rate equal to fifty percent (50%) of the above visit fee. For home health services rendered in two (2) hours or less, reimbursement shall be made for a visit as above provided.

Note: In addition to the Skilled Nursing Care fees above, an additional sum of seven dollars and sixteen cents ($7.16) per visit shall be added to cover the cost of medical supplies, provided the billing form adequately specifies what supplies were utilized.

B. The following Private Duty Rates shall apply:

Skilled Nursing Care – R.N.	$44.00 per hour
Skilled Nursing Care – L.P.N.	$37.00 per hour
Certified Nurse Assistant	$20.00 per hour
Sitter/Attendant	$15.00 per hour

C. Any reimbursement to persons not working under a professional license, such as a spouse or relative, will be at the rate of eight dollars ($8.00) per hour unless otherwise negotiated by the payer and caregiver or provider.

D. Professional providers not assigned a MRA for home health services and who have not negotiated their rates with the payer prior to provision of home health care, shall be reimbursed at the usual and customary rate, or the total billed charge, whichever is less.

IV. PARENTERAL/ENTERAL THERAPY IN THE HOME SETTING

A. The MRA for this therapy provided in the home setting is a per diem amount and includes necessary supplies for the safe and effective administration of the prescribed therapy. Supplies include set(s), needles, syringes, saline, tubing, dressing kits, saline, heparin, alcohol pads, start kits, catheters, adapters, tape, gauges, pump, poles, and other supplies.

B. Per diem amounts are as follows:

Parenteral therapy (with or without antibiotics)	Daily – $ 165.00
	Twice a day – $ 190.00
	Three times a day – $ 215.00
	Four times a day – $ 265.00
	5 or more times a day – $ 335.00
Total Parental Nutrition (TPN):	1-1.6 Liters per day – $280.00
	1.7-2.4 Liters per day – $350.00
	More than 2.4 liters per day – $385.00
LIPIDS:	10% – $75.00
	20% – $95.00
Enteral Therapy:	$24.00 per day

C. Medications for Parenteral/Enteral Therapy are reimbursed at AWP.

Skilled Nursing Facility Rules

I. **Reimbursement**

The maximum reimbursement allowance for medical care provided within the confines of a freestanding skilled nursing facility, a hospital based skilled nursing facility, or a swing bed facility, shall be four hundred dollars ($400.00) per day. This rate covers and includes all routine and ancillary health care services provided to a claimant during each day of a covered skilled nursing facility stay.

II. **Excluded Services**

The following services are excluded from the daily skilled nursing facility rate, and shall be reimbursed separately and in addition to the above daily rate:

- Cardiac catheterization
- Angiography
- Magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans
- Radiation therapy and chemotherapy
- Emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in:
  (a) serious impairment of bodily function(s)
  (b) serious or permanent dysfunction of any bodily organ or part or system
  (c) permanently placing the person's health in jeopardy, or
  (d) other serious medical consequence
- Outpatient services when provided in a hospital or other free standing outpatient facility separate from the skilled nursing facility
- Customized prosthetic services
- Ambulance transportation related to any of the above services
- Services provided independent of the facility by physicians, and other qualified health care professionals (e.g., NP, PA, CRNA, psychologist).

III. **Exclusions**

As in other cases, the above provisions shall not apply to any mutual agreement or contract entered into by the payer and provider which sets forth the terms for the provision of skilled nursing facility services and reimbursement therefor.

Evaluation and Management

This section contains rules and codes used to report evaluation and management (E/M) services. Rules and Guidelines follow the current CPT® Guidelines as stated.

Note: Rules used by all physicians in reporting their services are presented in the General Rules section.

I. DEFINITIONS AND RULES

Definitions and rules pertaining to E/M services are as follows:

A. **Consultations.** The CPT book defines a consultation as "a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem." (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

In order to qualify as a consultation the following criteria must be met:

- The verbal or written request for a consult must be documented in the patient's medical record;
- The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record;
- The consulting physician must provide a written report to the requesting physician or other appropriate source.

A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation codes 99241–99245 for office or other outpatient consultations and 99251–99255 for inpatient consultations, with modifier 32 appended to indicate a mandated service.

Evaluation and management consultation services will continue to be reported with CPT codes 99241–99245 for outpatient consultation services and codes 99251–99255 for inpatient consultation services. The rules and guidelines regarding the definition, documentation, and reporting of consultation services as contained in the CPT book will apply unless superseded by these guidelines. Consultation services will be reimbursed at the lesser of the Fee Schedule amount or the billed amount.

B. **Referral.** Subject to the definition of “consultation” provided in this Fee Schedule, a referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in the Evaluation and Management section).

C. **New and Established Patient Service.** Several code subcategories in the Evaluation and Management section are based on the patient’s status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

- *New Patient.* A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, for this same injury or within the past three years.
- *Established Patient.* An established patient is a patient who has been treated for the same injury by any physician, of the same specialty, who belongs to the same group practice.

D. **E/M Service Components.** The first three components of history, examination, and medical decision making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation or consultation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.

1. The history component is categorized by four levels:
    a. *Problem Focused.* Chief complaint; brief history of present illness or problem.
    b. *Expanded Problem Focused.* Chief complaint; brief history of present illness; problem-pertinent system review.
    c. *Detailed.* Chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient’s problems.
    d. *Comprehensive.* Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness, plus a review of all additional body systems; **complete** past, family, and social history.
2. The physical exam component is similarly divided into four levels of complexity:
    a. *Problem Focused.* A limited examination of the affected body area or organ system.
    b. *Expanded Problem Focused.* A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
    c. *Detailed.* An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
    d. *Comprehensive.* A general multi-system examination or a complete examination of a single organ system.

    The CPT book identifies the following body areas:

    - Head, including the face
    - Neck
    - Chest, including breasts and axilla
    - Abdomen
    - Genitalia, groin, buttocks
    - Back

- Each extremity

The CPT book identifies the following organ systems:

- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

3. Medical decision making is the final piece of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:
    a. The number of possible diagnoses and/or the number of management options that must be considered.
    b. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
    c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

E. **Contributory Components.**

1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than fifty percent (50%) of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:
    a. Diagnostic results, impressions, and/or recommended diagnostic studies;
    b. Prognosis;
    c. Risks and benefits of management (treatment) options;
    d. Instructions for management (treatment) and/or follow-up;
    e. Importance of compliance with chosen management (treatment) options;
    f. Risk factor reduction;
    g. Patient and family education.
2. E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient

and/or family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.

F. **Interpretation of Diagnostic Studies in the Emergency Room**

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.
2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.
3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.
4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

   Example: In many emergency departments (EDs), an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiologist reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.
5. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

II. General Guidelines

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.
- Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.

III. Office or Other Outpatient Services (99201–99215)

Use the Office or Other Outpatient Services codes to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

IV. Hospital Observation Services (99217–99226)

CPT codes 99217 through 99226 report E/M services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.

V. Observation Care Discharge Services (99217)

A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

B. If a patient is admitted to and subsequently discharged from observation status on the same date, see codes 99234–99236 as appropriate.

C. Do not report observation care discharge CPT code 99217 in conjunction with a hospital admission.

VI. Hospital Inpatient Services (99221–99239)

Codes 99221–99239 are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a "partial hospital" setting. These codes are to be used to report these partial hospitalization services.

VII. Consultations (99241–99255)

Consultations in *CPT 2013* fall under two subcategories: Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When required by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241–99245 for office or other outpatient consultation or 99251–99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

VIII. Emergency Department Services (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. An emergency department is defined as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281–99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201–99215) and reimbursement will be made accordingly.

IX. Critical Care Services (99291–99300)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same individual.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94002–94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed which are not listed above should be reported separately when performed in conjunction with critical services reported with code 99291–99292.

The critical care codes 99291 and 99292 are used to report the total duration of time spent in provision of critical care services to a critically ill or critically injured patient, even if the time spent providing care on that date is not continuous. For any given period of time spent providing critical care services, the

individual must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

X. Nursing Facility Services (99304–99318)

Codes 99304–99318 are used to report evaluation and management services to patients in nursing facilities (skilled nursing facilities (SNFs)) intermediate care facilities (ICFs), or long-term care facilities (LTCFs).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as a medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.

XI. Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324–99340)

The evaluation and management codes are used to report evaluation and management services in a facility that provides room, board, and other personal assistance services generally on a long-term basis. They also are used to report evaluation and management services in an assisted living facility.

XII. Home Services (99341–99350)

Services and care provided in a private residence are coded from this subcategory.

XIII. Prolonged Services (99354–99359)

Codes 99354–99357 are used when a physician or other qualified health care professional provides prolonged service involving direct patient contact that is provided beyond the usual service in either the inpatient or outpatient setting. Codes 99358–99359 are used when a physician or other qualified health care professional provides prolonged service for patient management where face-to-face services have or will occur on another date of service.

XIV. Physician Standby Services (99360)

Code 99360 is used to report physician or other qualified health care professional standby service that is requested by another individual and that involves prolonged attendance without direct (face-to-face) patient contact. Care or services may not be provided to other patients during this period. This code is not used to report time spent proctoring another individual. It is also not used if the period of standby ends with the performance of a procedure subject to a “surgical” package by the individual who was on standby.

XV. CASE MANAGEMENT SERVICES (99363–99368)

Case management is a process in which a physician or other qualified health care professional is responsible for direct care of a patient, and, additionally, for coordinating, managing access to, initiating, and/or supervising other health care services needed by the patient.

Mississippi guideline: Use Mississippi specific code 9936M for a conference with workers' compensation medical case manager/claims manager.

XVI. CARE PLAN OVERSIGHT SERVICES (99339–99340, 99374–99380)

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, domiciliary, or non-face-to-face services. The complexity and the approximate time of the care plan oversight services provided within a thirty (30) day period determine code selection.

Only one individual may report care plan oversight services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient. These codes should not be used for supervision of patients in nursing facilities or under the care of home health agencies unless they require recurrent supervision of therapy.

XVII. SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450–99456)

These codes are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued.

XVIII. OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

This is an unlisted code to report E/M services not specifically defined in the CPT book.

XIX. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows:

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Anesthesia

I. INTRODUCTION

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The 2013 American Society of Anesthesiologists' (ASA) *Relative Value Guide*® is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT® codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at $50.00 per unit.

Total anesthesia value is defined in the following formula:

(Base units + time units + modifying units) x conversion factor = reimbursement

II. BASE UNITS

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

III. TIME UNITS

Anesthesia time begins when the anesthesiologist starts the preparation of the patient for anesthesia in the preoperative area, the operating room or a similar area, and ends when the injured employee is placed under postoperative care, such as transfer to the recovery room.

The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

IV. SPECIAL CIRCUMSTANCES

A. **Physical Status Modifiers**

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

Status	Description	Base Units
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A patient declared brain-dead whose organs are being removed for donor purposes	0

The above six levels are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

B. **Qualifying Circumstances**

1. Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative condition, and/or unusual risk factors. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.

CPT	Description	Units
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)	1
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5

99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)	2

2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

V. MONITORED ANESTHESIA CARE

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to ensure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

VI. REIMBURSEMENT FOR ANESTHESIA SERVICES

A. **Criteria for Reimbursement**

Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiology Assistant (AA).
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:
    a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
    b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

B. **Reimbursement**

1. The maximum reimbursement allowance (MRA) for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.
2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.
3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report (BR).

4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated by report. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value).
5. Payment for covered anesthesia services is as follows:
    a. When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the Billing and Reimbursement Rules of this Fee Schedule.
    b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).
    c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the Fee Schedule for that procedure.
6. Anesthesiologists, CRNAs, and AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

    AA Anesthesia services performed personally by anesthesiologist

    AD Medical supervision by a physician: more than 4 concurrent anesthesia procedures

    QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals

    QX Qualified non-physician anesthetist with medical direction by a physician

    QY Medical direction of one qualified non-physician anesthetist by an anesthesiologist

    QZ CRNA service without medical direction by a physician

VII. ANESTHESIA MODIFIERS

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in anesthesia are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one hundred and twenty percent (120%) of the maximum reimbursement allowance.

23 Unusual Anesthesia
Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

53 Discontinued Procedure
Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service
Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA Anesthesia Services Performed Personally by Anesthesiologist
Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than 4 Concurrent Anesthesia Procedures
Report modifier AD when the anesthesiologist supervises more than 4 concurrent anesthesia procedures.

QK Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals

Report modifier QK when the anesthesiologist supervises 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.

QX Qualified Non-Physician Anesthetist with Medical Direction by a Physician

Regional or general anesthesia provided by a qualified non-physician anesthetist with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction of One Qualified Non-Physician Anesthetist by an Anesthesiologist

Report modifier QY when the anesthesiologist supervises one qualified non-physician anesthetist.

QZ CRNA Service without Medical Direction by a Physician

Regional or general anesthesia provided by the CRNA (certified registered nurse anesthetist) or AA (anesthesiologist assistant) without medical direction by a physician may be reported by adding modifier QZ.

Pain Management

I. INTRODUCTION

In addition to the General Rules, this section provides specific rules for Pain Management services.

Utilization review (UR) is expected and welcomed as part of the process in which Interventional Pain Management (IPM) procedures are performed. The objectives to this IPM portion of the Fee Schedule are to minimize or eliminate unnecessary, ineffective or inappropriate treatment, while at the same time facilitating the performance of appropriate, effective and necessary treatment. Rendering unnecessary treatment less costly via lowered reimbursement fails to meet these objectives, as the payer still reimburses for unnecessary treatment, and the patient is still subjected to the risks, however diminutive, inherent in all treatment. Delaying or even denying necessary treatment is equally undesirable. It is well documented that the chances of returning the injured worker with back-related pain to their initial level of work activity—or even any level of work—decrease significantly with increasing time off work. Therefore, expedience of appropriate care is as desirous as elimination of unnecessary—and potentially injurious—care.

To these ends, this portion of the Fee Schedule has been developed to give practitioners maximum flexibility in proceeding with demonstrably effective care, by decreasing or even eliminating some aspects of UR, while giving payers means to more objectively evaluate the effectiveness of care, project the cost of future IPM treatment, and avoid having to evaluate unnecessary and inappropriate care and unproven new technologies.

To be effective, these rules adopt the following strategies:

1. Providers must restrict treatment to indications recognized by established medical practice.

2. Providers must demonstrate more objectively the effectiveness of previously provided treatment in order to repeat or continue it.

3. Providers must give detailed descriptions of the specific treatment provided, and must archive images of that treatment that can be provided upon request of the payers.

4. Payers/URs must approve or deny treatment within the rules provided by the IPM portion of the Fee Schedule, and not involve extraneous outside guidelines.

5. Any UR personnel involved in the denial of care must cite the specific section of the IPM Fee Schedule used as a basis for that denial. Failure to do so will result in automatic adjudication in favor of the provider.

II. REIMBURSEMENT FOR PAIN MANAGEMENT SERVICES

A. **Use of Fluoroscopy**

Reimbursement for the use of fluoroscopy (CPT® codes 77002 and 77003) is based on the Fee Schedule, regardless of the number of procedures performed, and may only be billed once per date of service.

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 Cervical (stellate ganglion) sympathetic block, or CPT code 64520 Thoracic or lumbar blocks.

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (i.e., cervical epidural or sacroiliac joint), and including facet nerve neurolytic agent destruction.

All procedures performed fluoroscopically MUST have stored images (hard copy or digital) showing final needle placement in at least two (2) views (typically PA, lateral or oblique) demonstrating final needle placement AND disbursement of contrast (when not contraindicated). These images must be available upon request (with appropriate HIPAA compliance) by payers, or reimbursement may be denied.

B. **Reimbursement for Injection/Destruction Procedures**

1. The current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (e.g., 64490 is for injection of cervical facet single or first level, and 64491 and 64492 are used for additional levels).
2. Facet injections and medial branch blocks are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional service levels (but not more) for facet or medial branch blocks in the cervical/thoracic (64491 and 64492) or lumbar (64494 and 64495) for a maximum of three (3) procedure levels reimbursed per treatment session or day. Additional injected site levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side. Nerve destructive procedures are only reimbursed for a maximum of two (2) anatomical levels. A higher number of diagnostic injections are allowed because some providers may want to block a larger anatomical level with the initial block to determine what, if any, response is noted to the initial diagnostic injection. This prevents adding further levels during additional diagnostic injections. The likelihood of true three (3) level involvement is exceedingly rare, such that further localization of the involved levels is expected prior to destructive lesioning.
3. Reimbursement for injection/destruction procedure codes is made on the basis of joint levels, not nerves treated (e.g., destruction by neurolytic agent of the L4–L5 facets counts as one (1) level/nerve and should be billed as 64622 (first level/nerve)). There are two nerves supplying each joint but reimbursement is based upon joint(s) treated, not the nerves treated. This applies to CPT codes 64622, 64623 (lumbar), and 64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. Additionally, bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical condition for which multiple injections would be appropriate. For bilateral injections, this includes the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:

- Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4/5 disc herniation affecting the traversing L5 nerve root).
- Multiple dermatomal nerve root involvement.

A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.

Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.

5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.
6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This maximum applies to facet joint injections and nerve blocks, codes 64490–64495. Nerve destruction procedures, codes 64622–64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

C. **Multiple Procedure Reimbursement**

Only one (1) type of pain management procedure is reimbursable on a given date of service, unless otherwise approved by the payer. This rule does not include multiple level injections or bilateral procedures of the same type, with appropriate modifiers. This also does not include separate procedures performed as part of a single primary service, such as implantation of a spinal cord stimulator.

"Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level or bilateral injections of a single procedure in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply. Diagnostic injections of more than one type in the same anatomic area on the same date of service are prohibited, and will not be reimbursed without prior authorization.

Example: A three-level lumbar facet injection would be billed as 64493 for the first level, 64494 for the second level, and 64495 for the third level.

III. Reimbursement for Refill of Pain Pumps

A. **Code 95990.** This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.

B. **Evaluation and Management Services.** Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional or other cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and payment will be allowed if supported by the documentation.

C. **Drugs.** Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.

D. **Compounding Fee.** If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at $157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

IV. DIAGNOSTIC INJECTIONS AND PROCEDURES

A. Valid diagnostic injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. Analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.

B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to the procedure, and level of alertness during discography could result in denial of reimbursement.

C. Medial branch (facet nerve) or *diagnostic* intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient's response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.

D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed in the treatment facility after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. Subsequent pain scores must be documented at least hourly for two (2) hours after the procedure. The documentation available must also include the drugs used during the procedure, and comments on the patient's level of alertness in the treatment facility at each time period when the pain or response is evaluated. If the patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, that which may be provided by lying in a recovery bed.

E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation, depending on the experience level of the practitioner ordering or administering the medication. Proper documentation of a lack of undue influence of sedation and analgesics must be provided to support a request for reimbursement for diagnostic procedures.

F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections, would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is not a requirement for reimbursement.

V. THERAPEUTIC SERVICES

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

VI. GENERAL RULES

A. This Fee Schedule does not recognize a "series" of epidural injections, regardless of number. A trial of epidural injections is permitted provided there is appropriate documentation of a recognized indication for this procedure. Only a single injection can be approved unless there is documentation of analgesic response consistent with response to the injection. Further injections require a positive analgesic response in order to be repeated. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue epidural treatment. If there is no documented residual pain relief after two (2) injections, no further epidural injections will be considered medically necessary.

1. There is no recognized "series" of epidural injections, and repeat injections are contingent upon proper documentation of clinical responses as stated above. Repeat injections (up to two (2) additional injections, for a total of three (3) per twelve (12) month period), however, do NOT require prior approval as long as the appropriate responses are properly documented. Specifically, the first injection must provide at least a temporary analgesic response independent of any local anesthetic response or from sedatives or analgesics administered to the patient during the procedure. Typically, this means there should have been some benefit that occurred sometime after the first treatment day. Subsequent epidural injections must provide progressive and durable (persistent) relief of the targeted pain.
2. Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

B. Reimbursement will be limited to three (3) epidural pain injections in a twelve (12) month period unless the payer gives prior approval for more than three (3) such injections. Separate billing for the drug injected is not appropriate and will not be reimbursed.

C. Epidural Injections (Transforaminal and Interlaminar):

Transforaminal epidural injections are used for and are indicated for both diagnostic and therapeutic purposes.

Diagnostically, they may be used to:

- Determine whether a pain is somatic, visceral, sympathetic or functional.
- Determine which spinal nerve(s) (if any) are involved in the patient's pain process. This information may at times be used to determine the anatomical nerve root(s) involved for the purpose of surgical intervention.
- To determine if there is a component of pain related to involvement of a spinal nerve.
- To determine the source of pain when there is no clear pathology or conflicting pathology on imaging or EMG/NCV.
- To differentiate central from somatic pain following an injury to the central nervous system

1. **Diagnostic Epidural Injections**
   Diagnostic transforaminal injections are often repeated due to the high incidence (up to forty percent (40%)) of false positive injections. Typically, local anesthetics of different durations of action (e.g., lidocaine and bupivacaine) are used for two consecutive injections to determine an appropriate duration of effect. Some practitioners may also use a placebo injection (typically

saline) to further refine the patient's response. In order to be a "successful" ("positive") diagnostic procedure the patient must experience at least seventy-five percent (75%) relief of the index pain (pain suspected as being radicular). Pain levels should be measured during provocative testing pre- and postprocedure, if necessary, to insure that the patient is experiencing their usual discomfort prior to the procedure. The same provocative test should be repeated during each of the subsequent time intervals, and for at least two (2) hours. The provocative test(s) used should be one(s) that the patient is able to perform unassisted and that would not result in injury to the patient.

As with other diagnostic injections, excessive sedation and any narcotics should be avoided to evade impairing the patient's ability to determine a positive analgesic response to the injection. Diagnostic epidural injections are subject to the "diagnostic injection" rules specified in Section III, Subsection D.

Interlaminar epidural injections are seldom used for diagnostic purposes because the generalized regional spread of local anesthetic with spinal injection makes it impractical if not impossible to selectively block a specific nerve.

2. **Therapeutic Epidural Injections**
Therapeutically, epidural injections may be used (typically with steroids) for the treatment of radiating pain (upper/lower extremity, buttock and rarely dermatomal chest wall or abdominal pain from thoracic nerve root involvement), related to spinal nerve or dorsal root ganglion irritation, inflammation or compression. The pathology causing the radiating pain is often, but not exclusively, caused by pathology involving adjacent intervertebral discs, such as protrusions, herniations or bulges. Degenerative changes within the discs may also result in inflammatory processes that may cause radicular pain. Other causes may involve either central or lateral recess stenosis caused by facet joint pathology, ligamental hypertrophy and disc pathology.

Therapeutic injections for pain in the lumbar spine are typically transforaminal as these have been demonstrated by the available medical literature to be more effective than interlaminar injections for radicular pain. An exception would be the patient who is allergic to contrast media, as transforaminal epidural injections must be performed fluoroscopically with contrast. Cervical and thoracic therapeutic epidural injections are most often interlaminar, as this approach is inherently safer and less technically demanding, and the available medical literature does not suggest a clear therapeutic advantage to either a transforaminal or interlaminar technique. However, to be reimbursed, both cervical and interlaminar epidural steroid injections must be performed fluoroscopically, typically with contrast injection, unless there is a documented contrast allergy. The fluoroscopic guidance requirement for lumbar interlaminar epidural injections represents a change from previous Fee Schedules, and is now required to reflect a growing national trend of use of fluoroscopy with all epidural injections. The technical failure rate of non-fluoroscopic ("blind") epidural injections is documented to be as high as twenty-five percent (25%), and considering the benefit of interlaminar epidural injections for radicular pain is suspect at best, there is now the requirement for fluoroscopy with all epidural steroid injections.

Epidural blood patches do not require fluoroscopic guidance, though this is preferred.

The specific cause of radiating pain may not always be obvious on imaging, such as MRI, CT or x-rays. Normal imaging, or even abnormal imaging in which the pathology is on the side opposite the pain, or at a level that would not be expected to cause the patient's particular anatomical pain pattern, can occur. However, the absence of such pathology does not rule out inflammation or irritation of a spinal nerve or dorsal root ganglion. Therefore, the indications for a trial of epidural steroid injections are based on the patient's clinical presentation, not imaging.

All nerve root pain or radiating pain is not caused by damage (nerve or axon loss) to the nerve or dorsal root ganglion. When there is only inflammation or irritation of the nerve, there may be radi-

ating pain in the absence of physical exam findings of nerve damage such as altered or absent motor, sensory, or reflex function. In fact, actual nerve damage is not treated by steroid injections, as the latter does not accelerate the regeneration of new nerve (axon) regeneration. Therefore, EMG/NCV testing demonstrating nerve or axon loss is not necessary as an indication for a trial of epidural steroid injections. EMG testing can be superfluous when there is obvious nerve injury and imaging that demonstrate the etiology of the nerve injury (i.e., large disc herniation with appropriate nerve motor/sensory/reflex pathology). EMG/NCV testing is not capable of detecting co-existing nerve injury and inflammation so positive EMG/NCV is not a contraindication to a trial of epidural steroid injections.

A trial of epidural steroids injections may be indicated when there is radiating pain (extremity or buttock) with or without co-existing back pain. There is no acceptable "series" of epidural steroid injections as repeat injections are indicated based on the response to the preceding epidural injection. Repeat injections would typically occur two to four (2–4) weeks after the initial treatment, contingent upon some degree of continuing radiating pain. Repeat injections cannot be performed within two (2) weeks of the previous epidural injection.

In order to repeat an epidural injection, there must have been a positive analgesic response (pain improvement or functional improvement) to the previous injection. For the first injection, this relief may be temporary, but cannot be attributed solely to a local anesthetic effect or intra-procedural sedation (i.e., relief for the first few hours after injection). Additionally, in order to repeat an epidural injection, there must be continued radiating pain, and not only residual axial (back/neck) pain. After a second epidural injection, there must be some degree of *residual/durable* relief of the radiating component of pain that has persisted to the time of the patient's follow up visit.

Epidural injections (with or without steroids) may be used for the treatment of sympathetically mediated/maintained pain in the complex of conditions often referred to as "reflex sympathetic dystrophy" (RSD), "causalgia", complex regional pain syndrome type I and II (CRPS). This type of pain is typically distinctive, and does not typically radiate as does radicular pain related to nerve root inflammation or irritation. However, sympathetic pain may occur in the presence of nerve root injury (causalgia, CRPS II) where there is usually a component of radiating pain as well. The frequency of injection for these conditions may be (in rare cases) multiple times per week, and repeated as long as debilitating pain persists. However, as with other effective treatments, a trend towards improvement should be a necessary criterion for continued use of the treatment. It is, however, due to the complexity and variable presentation of these conditions, impractical to define a specific number of permissible injections, and providers and payers must rely on the demonstrable response and durability of relief provided by the treatment to determine the appropriateness of care.

3. **Initiation and Continuation of Epidural Injections**
It is necessary to obtain prior approval by the payer or appropriate utilization reviewer before initiating a trial of epidural injections. It is NOT necessary to obtain prior approval to repeat an injection as long as it is performed according to the rules outlined above. If the appropriate rules are followed, denial of reimbursement for repeated procedures will result in automatic adjudication favorable to the provider and may result in appropriate penalties and/or fines to the payer.

There will be a maximum of three (3) epidural injections per anatomical (cervical/thoracic/lumbar) area allowed within a given one (1) year time period. There may be times when additional injections are indicated (re-injury, intervening surgery, etc.,) but this is subject to prior approval by the payer, who has the sole authority to allow more than three (3) injections per one (1) year period.

Repeat trials of epidural injections may be considered after one (1) year if the preceding trial provided several months of demonstrable benefit. In order to be considered effective, this benefit must include greater than thirty percent (30%) improvement in pain scores, and documentation of either 1) significant reduction of daily narcotic consumption, defined as a sustained reduction

(several months) of at least thirty percent (30%) of the daily narcotic use prior to initiation of the trial of epidural injections, or 2) ability to work for a sustained period of time (several months) at least at sedentary work level or the work level as determined by a valid Functional Capacity Rating (FCE). Also, no patient can be considered for a repeat trial of epidural steroid injections, if after the preceding trial (in a similar anatomical area) they are unable to reduce narcotic consumption to less than 100 mg morphine equivalent per day.

If, after an initial trial of epidural injections, it is suspected that there is a new nerve injury involving a different anatomical nerve, a trial of epidural injections may be indicated independent of the response to the initial trial of epidural injections. However, as this would represent a separate nerve injury, causation would have to be established prior to initiation of further treatment related to a work injury.

4. **Documentation Requirements for Epidural Injections (Adopted and Adapted from CMS MLN Matters #SE1102 rev)**

Documentation in the medical record must contain the initial evaluation including history and physical examination; diagnosis, pain, and disability of moderate to severe degree; site of injection with name and dosage of drug instilled; and the patient's response to the prior injections.

a. Documentation of conservative therapies that were tried and failed except in acute situations such as acute disc herniation with disabling and debilitating pain, reflex sympathetic dystrophy, postoperative and obstetric pain and intractable pain secondary to carcinoma.

b. All documentation must be maintained in the patient's medical record and available to the payer upon request.

c. The record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician responsible for and providing the care of the patient.

d. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

e. The patient's record should document an appropriate history and physical examination by the provider or provider's representative specifying the medical indications requiring his/her presence when applicable. The indications should be recorded by the provider performing the injection in their respective notes.

5. ICD-9 Codes for Epidural Injections

The following ICD-9-CM codes apply to the CPT/HCPCS codes 64479, 64480, 64483, and 64484:

337.21	REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB
337.22	REFLEX SYMPATHETIC DYSTROPHY OF THE LOWER LIMB
337.29	REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
354.4	CAUSALGIA OF UPPER LIMB
355.0	LESION OF SCIATIC NERVE

355.71	CAUSALGIA OF LOWER LIMB
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2	DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03	SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
805.00–805.08	CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
953.0	INJURY TO CERVICAL NERVE ROOT
953.1	INJURY TO DORSAL NERVE ROOT
953.2	INJURY TO LUMBAR NERVE ROOT
953.3	INJURY TO SACRAL NERVE ROOT

D. **Therapeutic and Diagnostic Services**

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region. For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet-related pain continues past twelve (12) months, further injections are limited to a total of two (2) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type. This rule applies to cervical, thoracic, and lumbar facet joint and facet joint nerve injections. Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above. Nerve-destructive procedures (e.g. radiofrequency facet nerve neurotomy, codes 64622, 64623, 64626, 64627) do not count as an additional therapeutic procedure for the purpose of this rule.

A “different anatomical area” refers to the lumbar, thoracic, and cervical areas. Injections within the lumbar spine, for example, are considered to be within the same anatomical area regardless of the actual lumbar joint/nerve level, or which side (right or left), is treated, and all limits would apply in this anatomical area. The same rule applies to the thoracic and cervical anatomical areas, regardless of the level or laterality treated within the same anatomical area.

In order to be a “successful” (“positive”) diagnostic facet procedure (either intra-articular or medial branch block(s)), the patient must experience at least seventy-five percent (75%) relief of the index pain (pain being treated by the procedure). Additionally, this index pain must be at least fifty percent (50%) of the patient’s total pain.

Pain levels should be measured during provocative testing pre- and postprocedure. The same provocative test should be repeated during each of the subsequent time intervals as described in these rules. The provocative test(s) used should be one(s) that the patient is able to perform unassisted and that would not result in injury to the patient.

Facet nerve (medial branch ablation) for cervical, thoracic or lumbar nerves will only be reimbursed once per seven (7) month period. Repeat (medial branch) ablation is contingent upon documentation of at least six (6) month’s measurable (greater than thirty percent (30%) improvement in pain scores, and documentation of either 1) reduction of daily narcotic consumption of at least thirty percent (30%) from the daily use noted prior to the procedure, or 2) ability to work at least at a sedentary work level or work level as determined by a valid Functional Capacity Evaluation (FCE). Also, no patient can be considered for a repeat neuroablative procedure (e.g., neurotomy) if after the preceding neuroablative procedure (at similar anatomical levels) they are unable to reduce narcotic consumption to less than 100 mg morphine equivalent per day.

In order to perform a repeat therapeutic facet joint injection (cervical, thoracic, or lumbar; codes 64490–64495), there must be documentation of a significant analgesic response that persists for at least four (4) weeks. This relief must be at least fifty percent (50%) of the pain in the specific anatomical area targeted by the injection, and there must be documentation of a durable (also four (4) weeks) measurable improvement in the range of motion, or documentation of normal motion, of the involved joint area being treated.

E. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Fee Schedule.

F. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 OR 20553 is allowed per date of service.

1. Trigger Point Injections (Adopted and Adapted from CMS MLN Matters #SE1102 rev.)

- Trigger point injection refers to the injection of local anesthetics or anti-inflammatory medications into myofascial trigger points. Trigger points are self-sustaining irritative foci that occur in skeletal muscle in response to strain, as well as mechanical overload phenomena. These trigger points produce a referred pain pattern characteristic for the individual involved muscle.

- Trigger point injections are an integral part of comprehensive pain management, and may be used concurrently in support of other conservative modalities. Conservative therapy may include analgesics, physical therapy, ultrasound, range of motion, chiropractic intervention (within the defined limits of the Fee Schedule benefit) and active exercises. The diagnosis of trigger points requires a detailed history and thorough physical examination.

- The following clinical features are consistently present and are helpful in making the diagnosis:
  - History of onset of the painful condition and its presumed cause (e.g., injury or sprain)
  - Distribution pattern of pain consistent with the referral pattern of trigger points
  - Range of motion restriction
  - Muscular deconditioning in the affected area
  - Focal tenderness of a trigger point
  - Palpable taut band of muscle in which trigger point is located
  - Local taut response to snapping palpation
  - Reproduction of referred pain pattern upon stimulation of trigger point
- The goal is to treat the cause of pain, not just the symptoms. With this intent, it is expected that trigger point injections may be performed as frequently as weekly while in a physical therapy program. In order to be repeated in the same muscle group, there must be at least a fifty percent (50%) persistent benefit from the previous injection. For patients not in therapy, trigger point injections can be performed monthly, as long as there is a documented fifty percent (50%) residual benefit, and progressive relief (pain intensity and duration of relief) with the preceding injection. After six months, if similar pain persists, the patient should be re-evaluated regarding the etiology of the complaint, and the available treatment options reconsidered. The payer may consider payment for additional trigger point injections upon review.

2. **ICD-9 Codes for Trigger Point Injections**
   The following ICD-9-CM codes apply to the CPT/HCPCS codes 20552 and 20553.

720.1	SPINAL ENTHESOPATHY
723.9	UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.32	LATERAL EPICONDYLITIS
726.39	OTHER ENTHESOPATHY OF ELBOW REGION
726.5	ENTHESOPATHY OF HIP REGION
726.71	ACHILLES BURSITIS OR TENDINITIS
726.72	TIBIALIS TENDINITIS
726.79	OTHER ENTHESOPATHY OF ANKLE AND TARSUS
726.90	ENTHESOPATHY OF UNSPECIFIED SITE
729.0–729.1	RHEUMATISM UNSPECIFIED AND FIBROSITIS - MYALGIA AND MYOSITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED

G. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedures(s). Therefore, an additional fee for the fluoroscopy (CPT code 77002) is not warranted and will not be reimbursed. This code may only be used once per twelve (12) month period.

H. Epidurography (CPT code 72275) is no longer reimbursable under this Fee Schedule.

I. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus

injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.

J. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the *Mississippi Workers' Compensation Medical Fee Schedule:*

1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (22899);
2. Intraventricular administration of Morphine;
3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider;
4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies;
5. Percutaneous disc nucleoplasty;
6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.
7. X-STOP fusion devices.
8. MILD (minimally invasive lumbar decompression) procedures.
9. Non-Invasive Pain Procedure (NIP procedure or NIPP)
10. Alpha-Stim unit
11. ReBuilder and Low Laser treatment

K. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:

1. Facet injections (64490–64495) (fluoroscopy is included in the procedure code)
2. Sacroiliac (SI) injections (27096)
3. Transforaminal epidural steroid injections (64479, 64480, 64483, 64484)
4. Cervical translaminar/interlaminar epidural injections (62310)
5. Additional information, adopted and adapted from CMS LCD L27512:

    a. Facet Joint Block (Adopted and Adapted from CMS MLN Matters #SE1102 rev.)

    Paravertebral facet joint nerve block (medial branch) and intraarticular facet joint injections are used to both diagnose and treat lumbar zygapophysial (facet joint) pain. Facet joint pain syndrome is a challenging diagnosis as there are no specific history, physical examination, or radiological imaging findings that point exclusively to the diagnosis. However, this diagnosis is considered if the patient describes nonspecific, usually mechanical low back pain that is located in the paravertebral area of the cervical, thoracic, and lumbar spine. Typically, though certainly not consistently, the pain is aggravated by loading the facets, typically with extension or rotation of the involved area of the spine. A detailed physical examination of the spine should be performed on all patients. Radiological imaging is often done as part of the workup of persistent chronic back pain to exclude other diagnoses.

    Facet joint or nerve block is one method used to diagnose a suspected component of pain related to the facet joints of the cervical, thoracic, and lumbar spine. Often the patient presents with chronic neck, thoracic, or back pain of a mechanical nature that lacks a strong radicular

component, has no associated neurologic deficits, and is often aggravated by hyperextension, lateral bending or rotation of the spine.

A local anesthetic is injected to temporarily denervate the facet joint. After a satisfactory block has been obtained, the patient is asked to repeat the maneuver or activities that produced their pain on exam. Temporary or prolonged abolition of the spinal pain suggests that facet joints were a source of the symptoms.

A detailed pain history and appropriate exam is essential. Response to previous treatment should also be documented.

Imaging guidance must be used for both diagnostic and therapeutic injections to assure that the needle is properly placed, and the injected substance reaches the intended target zone. Imaging also helps determine aberrant injection patterns such as intravascular injections.

The following ICD-9-CM codes are considered indications for facet interventions and apply to the CPT/HCPCS codes 64490, 64491, 64492, 64493, 64494 and 64495:

Code	Description
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
723.1	CERVICALGIA
724.2	LUMBAGO

b. **Sacroiliac (SI) Joint Injections**

The following ICD-9-CM codes apply to the CPT/HCPCS codes 27096

Code	Description
720.0	ANKYLOSING SPONDYLITIS
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
724.6	DISORDERS OF SACRUM
846.0–846.9	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN - UNSPECIFIED SITE OF SACROILIAC REGION SPRAIN

Injections of the sacroiliac joint may be used to diagnose the cause of or to treat low back pain.

Pain arising from the SI joint may mimic pain originating from the lumbar disc, lumbar facet, or hip joint. Pain is typically a mechanical axial back pain below the L5 level, and is usually unilateral. There may be associated somatic referred leg pain involving the posterior thigh. The pain may also be experienced anteriorly, in the area of the anterior iliac spine. Except in the presence of clear pathology (tumor, fracture, infection), clinical diagnosis of SI joint pain is difficult and often one of exclusion.

The differential diagnosis of SI joint pain requires a detailed history and thorough physical exam. Imaging with radiographs, MRI, bone scans and CT scans do not consistently differentiate symptomatic from asymptomatic individuals.

SI joint injection can be done diagnostically or therapeutically. These are defined as follows:

- Diagnostic injections — either an anesthetic is injected for immediate pain relief or contrast media is injected into the joint for evaluation of the integrity (or lack thereof) of the articular cartilage and morphologic features of the joint space and capsule.

- Therapeutic injections — a steroid and/or anesthetic is injected into the SI joint for immediate and potentially lasting pain relief.

Both therapeutic and diagnostic sacroiliac joint injections require the use of image guidance. Injections performed without the use of image guidance, should be billed, and will be reimbursed, as a trigger point injection. CPT code 27096 requires the use of imaging confirmation of intra-articular needle positioning.

L. Any analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, does not allow for separate billing of analgesia/sedation.

M. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Unless there is a contraindication to contrast media (e.g., documented allergy) it is expected that contrast injection AND a written description of the contrast spread pattern be included in the procedure report. Generic descriptions such as “the procedure was performed in the usual fashion,” “the needle was placed on (next to, by, etc.) the nerve/joint/target,” “the needle was placed in the correct anatomical location,” or similar wording, which was templated or otherwise lacking an actual detailed anatomical description of needle placement or contrast pattern (where appropriate), is inadequate and subsequent cause for denial of payment. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.

N. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). Discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discogram is not considered medically necessary. Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.

When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should not be additionally reported.

Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).

O. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.

P. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly:

1. **Definitions**: For the purpose of this provision, the following terms have the meanings indicated:

    a. **Chronic Pain.** A pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the purposes of this regulation to have “de facto” chronic pain and subject to the same requirements of this regulation. “Terminal Disease Pain” should not be confused with “Chronic Pain.” For the purpose of this section, “Terminal Disease Pain” is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

    b. **Acute Pain.** The normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration. Title 21 CFR Part 1301 Food and Drugs.

    c. **Addiction.** A neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

    d. **Physical Dependence.** A physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.

    e. **Substance Abuse.** The use of any substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

    f. **Tolerance.** A physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.

2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other

drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.

3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

    a Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.

    b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.

    c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.

    d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.

4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or

continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of "detoxification treatment," or "maintenance treatment," and no physician shall administer or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless they are properly registered in accordance with MCA §303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient's chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this Fee Schedule, as follows: not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

Q. Radiographic Codes in Pain Management. Fluoroscopic imaging is reported with codes 77002 and 77003.

Codes 72010–72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

R. Soft Tissue Injections. "Myofascial, myoneural, and trigger point injections" are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are not to be used for "myofascial, myoneural or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and not for "myofascial, myoneural, or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

S. Implantation of spinal cord stimulators.

1. The following conditions must be met for consideration of spinal cord stimulators.

- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
- There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
- During the trial stimulation, the patient must report functional improvement, decreased use of medications, and at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
- Psychological screening must be used to determine if the patient is free from:
  - Substance abuse issues
  - Untreated psychiatric conditions
  - Major psychiatric illness that could impair the patient's ability to respond appropriately to the trial stimulation

2. Reimbursement for implantation is limited to a maximum of two (2) leads and a maximum of sixteen (16) electrodes, regardless of the number used.

T. Sacroiliac joint injections (code 27096) require documentation of at least a four (4) week durable analgesic benefit of at least fifty (50%) pain relief in the anatomical area being targeted by the injection. A maximum of two (2) therapeutic sacroiliac joint injections is allowed per twelve (12) month period. This rule is limited only to the joint injected, and not the contralateral joint (i.e., right or left sided joint).

U. All Interventional Pain Management (IPM) procedures must be billed with the appropriate CPT codes and modifiers (where applicable) using accepted ICD-9 codes as the indications for the procedures. Providers MUST use acceptable codes in order to initiate or maintain treatment. Failure to do so is cause for denial of treatment until the proper appropriate codes are submitted.

Payers/URs must use the rules of this Fee Schedule to deny requested treatment. Failure to cite the specific section of the IPM portion of the *Mississippi Workers' Compensation Medical Fee Schedule* will result in automatic adjudication for the provider without appeal. "Specific" refers to citing the actual section, and appropriate subsections directly from the guidelines. Failure to have the Fee Schedule available during the review would obviously make such citation unachievable, resulting in automatic adjudication for the provider. ***No outside guidelines can be used to deny IPM care requested in accordance with the Fee Schedule.***

Any analgesia/sedation used in the performance of the IPM procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, does not allow for separate billing of analgesia/sedation.

VII. MODIFIERS

Please see the appropriate section (e.g., Surgery, Radiology) for applicable modifiers.

Surgery

I. GENERAL GUIDELINES

A. **Global Reimbursement**
The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery. The State of Mississippi follows the surgical package definition from *CPT® 2013.*

B. **Normal, Uncomplicated Follow-Up (FU) Care**

Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow-up days (FUD) column for each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.

The maximum reimbursement allowance covers all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

C. **Follow-up for Diagnostic Procedures**
When a procedure is done for diagnostic purposes, the follow-up does not include care of the condition itself, only recovery/recovery care for the procedure itself.

D. **Follow-up Care for Therapeutic Surgical Procedures**
When a procedure is therapeutic in nature, the follow-up care includes routine post-op care and recovery. Any care needed for complications, care needed that is not part of routine post-op recovery, or any care that is not due to the procedure itself, may warrant additional charges.

E. **Separate Procedures**
Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific “separate procedure” code.

F. **Additional Surgical Procedure(s)**
When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

G. **Microsurgery, Operating Microscope, and Use of Code 69990**
When an operating microscope is used during an operative procedure, it should be billed with code 69990. Modifier 51 is not reported with this code. This code is not reimbursed for use of corrective vision apparatus or magnifying devices. CPT code 69990 should not be billed with the following codes that include the use of the operating microscope: 15756–15758; 15842; 19364; 19368; 20955–20962; 20969–20973; 22551, 22552, 22856–22861, 26551–26554; 26556; 31526; 31531; 31536; 31541; 31545; 31546; 31561; 31571; 43116; 43496; 49906; 61548; 63075–63078; 64727; 64820–64823; 65091–68850. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services. (For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique.) Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.

H. **Unique Techniques**
A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.

I. **Surgical Destruction**
Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

J. **Incidental Procedure(s)**
An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

K. **Endoscopic Procedures**
When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

L. **Biopsy Procedures**
A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

M. **Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs**
The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. Normal wound repair is considered part of the nerve, blood vessel and/or tendon repair. Additional reimbursement for wound repair is only warranted if it is a complex wound, and modifier 59 should be used to identify such.

N. **Suture Removal**
Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

O. **Joint Manipulation Under Anesthesia**
There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the MRA for manipulation may be allowed.

P. **Supplies and Materials**
Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

Q. **Plastic and Metallic Implants**
Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

R. **Aspirations and Injections**
1. Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

2. When joint injections/trigger point injections are performed, ultrasound guidance is considered integral to the procedure and will not be separately reimbursed.

S. **Surgical Assistant**
1. Physician Surgical Assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).
2. Registered Nurse Surgical Assistant or Physician Assistant
    a. A physician assistant, or registered nurse who has completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).
    b. The maximum reimbursement allowance for the physician assistant or the registered nurse first assistant (RNFA) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.
    c. Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or RNFA at the same surgical encounter.
    d. Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA.
    e. CPT codes with modifier AS should be used to bill for physician assistant or RNFA services on a CMS-1500 form or electronic claim and should be submitted with the charge for the surgeon's services.
3. The Fee Schedule includes a column indicating which procedures are approved for assistant services with Y (yes) or N (no). If a surgical procedure is approved/precertified for a code with a Y in the "Assist Surg" column, the assistant is implied and does not require separate approval/precertification for reimbursement.

T. **Operative Reports**
An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services, and should document the use of assistant services.

U. **Needle Procedures**
Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

V. **Therapeutic Procedures**
Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526–20610, 64400–64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

W. **Anesthesia by Surgeon**
In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

X. **Therapeutic/Diagnostic Injections**
Injections are considered incidental to the procedure when performed with a related invasive procedure.

Y. **Intervertebral Biomechanical Device(s) and Use of Code 22851**
Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training, experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependent on a specific manufacturer, shape, or material of which it is constructed. Qualifying devices are machine cut to specific dimensions for precise application to an intervertebral defect. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a machine cut hexahedron cortical, cancellous, or corticocancellous allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

Z. **Intra-operative neurophysiologic monitoring (e.g., SSEP, MEP, BAEP, TES, DEP, VEP).**
All intra-operative neurophysiologic monitoring requires pre-authorization. Reimbursement for intra-operative neurophysiologic monitoring will not be allowed in the following cases, unless mutually agreed to by the payer and the provider:

1. Neuromuscular junction testing of each nerve during intraoperative monitoring;
2. Intraoperative monitoring during peripheral nerve entrapment releases, such as carpal release, ulnar nerve transposition at the elbow, and tarsal tunnel release;

3. During decompression of cervical nerve roots without myelopathy;
4. During placement of cervical instrumentation absent evidence of myelopathy;
5. During lumbar discectomy for radiculopathy; or
6. During lumbar decompression for treatment of stenosis without the need for instrumentation.

II. MULTIPLE PROCEDURES

A. **Multiple Procedure Reimbursement Rule**
Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second and subsequent procedures

B. **Bilateral Procedure Reimbursement Rule**
Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below:

69300 50 Otoplasty, protruding ear, with or without size reduction

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is one hundred dollars ($100.00) and it is performed bilaterally, reimbursement shall be one hundred fifty dollars ($150.00). However, if the procedure description states "bilateral," reimbursement shall be as listed in the Fee Schedule since the fee was calculated for provision of the procedure bilaterally.

C. **Multiple Procedures—Different Areas Rule**
When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

D. **Multiple Procedure Billing Rules**
1. The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

III. REPAIR OF WOUNDS

A. Wound classifications of simple, intermediate, or complex are expected to be consistent with current CPT descriptions/definitions/guidelines.

B. Reporting
   1. The use of appropriate codes should be consistent with the current CPT guidelines.
   2. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

IV. MUSCULOSKELETAL SYSTEM

A. **Casting and Strapping**
   This applies to severe muscle sprains or strains that require casting or strapping.
   1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
   2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.
   3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
   4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

B. **Fracture Care**
   1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.
   2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
   3. The phrase “with manipulation” describes reduction of a fracture.
   4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate “repeat procedure” by the same physician.
   5. The term “complicated” appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the “complicated” descriptor to justify reimbursement.

C. **Bone, Cartilage, and Fascia Grafts**

1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.

D. **Arthroscopy**

Note: Diagnostic arthroscopy is considered to be included in a surgical arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.
3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

E. **Arthrodesis Procedures**

Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.

To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement “including minimal discectomy” to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.

F. **External Spinal Stimulators Post Fusion**

1. The following criteria are established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
    a. Patient has had a previously failed spinal fusion, and/or
    b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
    c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion
2. The external spinal stimulator is not approved by the Mississippi Workers’ Compensation Commission for use in primary spinal fusions.
3. The external spinal stimulator will be reimbursed by report (BR).
4. Precertification is required for use of the external spinal stimulator.

G. **Carpal Tunnel Release**

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast

- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

V. BURNS, LOCAL TREATMENT

A. **Degree of Burns**

1. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
2. Codes 16020–16030 must be used when billing for treatment of partial-thickness burns only.
3. The claim form must be accompanied by a report substantiating the services performed.
4. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000–11001. Modifier 51 does not apply.

B. **Percentage of Total Body Surface (TBS) Area**

The following definitions apply to codes 16020–16030:

1. "Small" means a burn that encompasses five percent (5%) of TBS area or less.
2. "Medium" means a burn that encompasses five percent to ten percent (5%–10%) of TBS or that involves the whole face, or a whole extremity.
3. "Large" means a burn that encompasses greater than ten percent (10%) TBS area.

C. **Reimbursement**

1. To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
2. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

VI. NERVE BLOCKS

A. **Diagnostic or Therapeutic**

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.
    a. The name of the medication(s), dosage, and volume must be identified.

b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

B. **Anesthetic**
When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

VII. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in surgery are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

Mississippi guideline: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, an unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of an additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professional, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi guideline: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi guideline: Physician reimbursement is ten percent (10%) of the maximum reimbursement allowance.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery

Assistant at surgery services provided by another qualified individual (e.g., physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant) and not another physician are identified by adding modifier AS to the listed applicable surgical procedures. Modifier AS may be appended to any code identified as appropriate for surgical assistance in this Fee Schedule.

Mississippi guideline: Modifier AS reimbursement is ten percent (10%) of the maximum reimbursement allowance. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

Radiology

I. SCOPE

The following guidelines apply to radiology services provided in offices, clinics, and under some circumstances in hospital x-ray departments. This section also contains guidelines that include nuclear medicine and diagnostic ultrasound.

II. GUIDELINES

A. **Total Fee**
A total fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the Amount column represent the total reimbursement.

B. **Professional Component**
The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. Values in the PC Amount column are intended for the services of a radiologist for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

C. **Technical Component**
The technical component includes charges made by the institution or clinic to cover the services of technologists and other staff members, the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by HCPCS Level II modifier TC. The technical component amount is calculated by subtracting the PC Amount from the Amount for the total reimbursement.

D. **Review of X-rays**
Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is inherent to the evaluation and management code:

- The physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere.

- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.
- CPT® code 76140 Consultation on x-ray examination made elsewhere, written report, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services.
- This provision is for payment of a second interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation requests the expertise of another physician (i.e., expertise of a radiologist). CPT code 76140 is to be used when a second opinion is required for a radiological procedure. Reimbursement is limited to the PC Amount listed in the Fee Schedule for that procedure.

E. **Additional X-rays**

No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic or digital media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

F. **Contrast Material**

1. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).
2. Low osmolar contrast material and paramagnetic contrast materials shall only be billed when not included in the descriptor of the procedure. When appropriately billed, the contrast media is reimbursed according to the maximum reimbursement allowance (MRA) listed in the HCPCS section of the Fee Schedule. Supplies are considered incidental to the administration of the contrast and are not separately reimbursable.
3. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration is included as part of the procedure.
4. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and does not command a separate fee.

G. **Urologic Procedures**

In the case of urologic procedures (e.g., CPT codes 74400–74485), insertion of a urethral catheter is part of the procedure and is not separately billed.

H. **Separate or Multiple Procedures**

1. When multiple procedures are performed on the same day or at the same session, it is appropriate to designate them by separate entries. Surgical procedures performed in conjunction with a radiology procedure will be subject to the rules and regulations of the Surgery section.
2. When x-rays of multiple sections of a body area are billed separately, the total reimbursement must not exceed the maximum reimbursement allowance of the complete body area.

I. **Outpatient CT Scans and MRIs**

CT scans and MRIs, when performed on an outpatient basis, are subject to the limitations of the Fee Schedule, regardless of site of service.

J. **Unlisted Service or Procedure**
A service or procedure may be provided that is not listed in the most recent edition of the CPT book. When reporting such a service, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report. Unlisted procedure codes are listed in the CPT book.

K. **Special Report**
Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used, and a full report of the findings. Additional information provided should include an acceptable definition or description of the extent and nature of the procedure, as well as information regarding the need for the procedure. Also essential is data regarding the equipment necessary to perform the service, as well as the time and effort required. Special reports to justify the necessity of a service do not warrant a separate fee.

L. **By Report (BR)**
"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

M. **Radiology Supervision and Interpretation Procedures**
There are times when a single physician may perform the procedure and supervise the imaging and interpretation. On other occasions, one physician may perform the procedure, and the imaging supervision with interpretation may be performed by another physician. The appropriate radiology codes are to be used for supervision and interpretation of the imaging. The appropriate surgical codes are to be used for the procedure, including necessary local anesthesia, placement of needle or catheters, injection of contrast media, etc. The surgical codes are subject to the rules and regulations of the Surgery section, and the radiology codes are subject to this section of radiology rules and regulations.

N. **Written Report(s)**
A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

O. **Facility Fee**
The Facility Fee for outpatient services is the APC Amount.

III. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in radiology (including nuclear medicine and diagnostic ultrasound) are as follows:

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Service
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

50 Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure
Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was

started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Pathology and Laboratory

I. GUIDELINES

A. **Pathology Services**
Pathology and Laboratory services are provided for evaluating the nature of disease or a change in body tissue and organs due to injury and/or caused by a disease.

B. **Separate or Multiple Procedures**
When multiple procedures are performed on the same date or at the same session, it is appropriate to designate them by separate entries.

C. **Unlisted Service or Procedures**
Unlisted codes are used for laboratory/pathology services which do not currently have a CPT® code. All unlisted codes require an explanation and report. A list of unlisted codes may be found in the CPT book.

D. **Special Report**
Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used and a full report of the findings. Special reports to justify the necessity of a service do not warrant a separate fee.

E. **By Report (BR)**
"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

F. **Facility Fee**
The Facility Fee for outpatient services is the APC Amount.

II. GENERAL INFORMATION AND INSTRUCTIONS

A. **Panel Tests**

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (80048–80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

B. **Handling and Collection Process**

1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

C. **Global, Professional, and Technical Components**

Some procedures in the Pathology and Laboratory section are considered global fees (Amount) and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC Amount in addition to the Amount. For procedures listed with a PC Amount, the TC reimbursement rate is calculated by subtracting the PC Amount from the Amount. The professional component should be billed with modifier 26.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results
- A written report, not a computer generated report, is submitted with the request for payment\

D. **Occupational Blood Exposure Testing/Treatment**

1. Work related Blood Exposures should minimally meet the appropriate CDC Guidelines for Management of Occupational Blood Exposures.
2. The CDC Guidelines are updated at intervals and the most current guidelines should be used.
3. Current information can be obtained at www.cdc.gov.

E. **Drug Screens**

1. Post-Accident Drug Screens should comply with MCA §71-7-1 and other state and federal regulations with which the employer must comply. Reimbursement will either be made by the payer/carrier or the employer.
2. Other drug screens: The only codes reimbursed by workers' compensation for drug screens other than Post-Accident are G0431 thru G0435.

III. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple

modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in pathology and laboratory are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was

started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require permanent dedicated space; hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Medicine Services

In addition to the general rules, this section applies unique guidelines for medicine specialties. Therapeutic services and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

I. GUIDELINES

A. **Unlisted Services or Procedures**
Unlisted codes are used for medical services which do not currently have a CPT® code. All unlisted codes require an explanation and report. Unlisted codes are listed in the CPT book.

B. **Multiple Procedures**
It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. **Separate Procedures**
Separate procedures are commonly carried out as an integral component of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific “separate procedure” code.

D. **By Report (BR) Procedures**
By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. “BR” procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

E. **Special Report**
Any test/service that is not provided routinely should be reported with the appropriate code designating the service and the billing for that test/service should include a description of the procedure, the process used, and a full report of the findings. Special reports to justify the necessity of a service do not warrant a separate fee.

F. **Materials Supplied by Physician**
Supplies and materials usually included in an office visit are included in the reimbursement for the office visit. Other unusual supplies and materials should be identified with CPT code 99070 or specific HCPCS Level II code. Reimbursement shall be limited to the Fee Schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this Fee Schedule.

G. **Audiological Function Tests**
The audiometric tests (92551–92597) are reimbursed based on the AMA CPT Guidelines. All descriptors refer to testing of both ears.

H. **Psychological Services**

1. Payment for a psychiatric diagnostic interview/evaluation includes history and mental status determination, development of a treatment plan when necessary and the preparation of a written report that must be submitted with the required billing form. Use of an E/M code with a diagnostic interview/evaluation is not appropriate.
2. Psychotherapy codes from the current CPT manual are used regardless of place of service. The CPT code most closely matching the length of the session must be billed.
3. Use of an E/M code with a psychotherapy code should follow the guidelines from the CPT book and the American Psychiatric Association.
4. A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors, etc.

I. **Electromyography (EMG)**

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day, with supporting documentation required as outlined in the Evaluation and Management section. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

J. **Manipulative Services**

Chiropractic and Osteopathic manipulative services, which are medicine services, will be discussed in the Therapeutic Services section.

II. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used in Medicine Services are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional

component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Mississippi guideline: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only
When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only
When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For the treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This

circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Therapeutic Services

I. SCOPE

A. **Therapeutic Services**
Therapeutic services are an integral part of the healing process for a variety of injured workers. Recognizing this, the Fee Schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Therapeutic Services section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, licensed occupational therapists, and speech pathologists.

B. **Selection of Providers**
Physical or occupational therapy, including work hardening, functional capacity evaluations, chronic pain programs, or massage therapy shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician, the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.

C. **Physical Medical Assessment**
1. An assessment must be performed to determine if a patient will benefit from therapeutic services.
2. When a physician examines a patient and an assessment for therapeutic services is performed, the billing for the office visit includes the therapeutic assessment.
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists. Procedure code 92506 is to be used for initial assessment by a speech pathologist.

D. **Plan of Care**
1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain:
    a. The specific therapies to be provided, including the frequency and duration of each
    b. The estimated duration of the therapeutic regimen
    c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)
2. The initial plan of care must be signed by the treating physician and submitted to the payer within fourteen (14) days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.

3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.
4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.
5. Preparation of a care plan does not warrant a separate fee.

E. **Qualifications for Reimbursement**

1. The patient's condition must have the potential for restoration of function.
2. The treatment must be prescribed by the authorized attending or treating physician.
3. The treatment must be specific to the injury and have the potential to improve the patient's condition.
4. The physician or therapist must be on-site during the provision of services.

II. REIMBURSEMENT

A. **Guidelines**

1. Visits for therapy may not exceed one visit per day without prior approval from the payer.
2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:
    a. The treatment must be medically necessary.
    b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of the payer representative giving authorization for the continued therapy.
3. Reimbursement is limited to no more than four (4) therapies concurrently at the same visit. In the event of multiple treatment areas, an additional four (4) therapies per treatment day may be allowed at the payer's discretion and with pre-authorization. In the event of multiple treatment areas, the second and subsequent areas are subject to the multiple procedure rule.
4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will not be allowed in the treatment of work-related injury/illness.
5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.
6. Only one (1) work hardening or work conditioning program is reimbursed per injury.
7. The Physical Therapist Assistant or Occupational Therapist Assistant shall be reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure. Mississippi modifier "M3" should be attached to the appropriate CPT® code(s) when billing services rendered by a Physical Therapist Assistant or an Occupational Therapist Assistant.
8. NCCI edits or other bundle/unbundle edits do not apply to the CPT codes in the Therapeutic Services section, other than the stated rules provided in this section.

B. **Treatment Areas**

1. Spinal areas are recognized as the following five distinct regions:
    - Cranial
    - Cervical

- Thoracic
- Lumbar
- Sacral

Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral).

2. Pelvis
3. Upper extremity (either left or right) is recognized as the following six distinct regions:
   - Shoulder
   - Upper arm
   - Elbow
   - Forearm
   - Wrist
   - Hand
4. Lower extremity (either left or right) is recognized as the following eight distinct regions:
   - Hip
   - Thigh
   - Knee
   - Calf
   - Ankle
   - Foot
5. Rib cage
6. Anterior trunk

C. **Tests and Measurements**

1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 Total evaluation of body, including hands.
2. Functional capacity evaluation (FCE) must have pre-authorization from the payer before scheduling the tests.
3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a thirty (30) day period for the same body area.

D. **Fabrication of Orthotics**

1. Procedure code 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.
2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes section of the Fee Schedule. For orthotics and supplies not listed in the DME section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider’s cost and an invoice may be required by the payer before reimbursement is made.

E. **Re-evaluation of an Established Patient**
A physician, physical therapist, occupational therapist, or speech therapist may charge and be reimbursed for a re-evaluation for therapeutic services only if new symptoms present the need for re-examination and evaluation as follows:

1. There is a definitive change in the patient's condition
2. The patient fails to respond to treatment and there is a need to change the treatment plan
3. The patient has completed the therapy regimen and is ready to receive discharge instructions

III. WORK HARDENING RULES

Refer to the Utilization Review Rules section for specific requirements related to work hardening.

IV. FUNCTIONAL CAPACITY EVALUATIONS

A. **The functional capacity evaluation (FCE) is utilized for the following purposes:**
1. To determine the highest level of safe functionality and of maximal medical improvement.
2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
3. To objectively set restrictions and guidelines for return to work.
4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
5. To determine whether additional treatment or referral to a work hardening program is indicated.
6. To assess outcome at the conclusion of a work hardening program.

B. **General Requirements**
1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated.
2. The FCE requires prior authorization by the payer.

C. The FCE should be billed using code 97750 Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Reimbursement of an FCE is limited to a maximum of 20 units. Documentation must include start and stop times for testing.

V. TENS UNITS

A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.

B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

VI. SUPPLIES, EQUIPMENT, ORTHOTICS, AND PROSTHETICS

A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than one hundred dollars ($100.00) per

item for workers' compensation patients. When submitting bills, include the appropriate HCPCS Level II code. If there is not an appropriate HCPCS code, use CPT code 99070.

B. The payer has sole right of selection of vendors.

VII. Other Instructions

A. Charges will not be reimbursed for publications, books, or digital media unless prior approval of the payer is obtained.

B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.

C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.

D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.

E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.

F. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.

G. Non-surgical debridement should be billed as CPT code 97597, 97598, or 97602.

VIII. Back Schools

Back schools are no longer covered services under this Fee Schedule.

IX. Massage Therapy

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

X. Chiropractic Manipulative Treatment

Chiropractic manipulative treatments are allowed for up to fifteen (15) visits or thirty (30) days, whichever first occurs, without any need to seek pre-certification or authorization. However, chiropractic manipulative treatments which are proposed beyond the first fifteen (15) visits or thirty (30) days, under any circumstances, must be pre-certified or pre-approved.

Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

XI. ELECTROMYOGRAM (EMG) AND NERVE CONDUCTION STUDY (NCS)

A. Only a licensed physical medicine doctor or a neurologist is entitled to reimbursement for performing an electromyogram (EMG) and/or a nerve conduction study (NCS).

B. Reimbursement is not allowed under this Fee Schedule for automated nerve conduction studies.

C. Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

XII. CHRONIC PAIN—INTER-DISCIPLINARY PAIN REHABILITATION PROGRAM

A. The Inter-Disciplinary Pain Rehabilitation (IDPR) program is based on the bio-psychosocial approach to managing chronic pain, and uses both physical medicine treatments as well as psychological treatments and therapy to manage the chronic pain patient. A goal oriented, team approach is used in an effort to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain. This is an outpatient program.

B. Pre-authorization is required in order to utilize an inter-disciplinary pain rehabilitation program to treat the chronic pain patient. A specific IDPR program plan must be submitted to the payer as part of the pre-authorization process.

C. The following guidelines shall be used to assist in pre-authorization, and concurrent review:

1. Persons considered suitable candidates for an inter-disciplinary pain rehabilitation program are those:
    a. who are likely to benefit from the program design;
    b. whose symptoms are deemed by a pain management provider to constitute chronic pain syndrome; and
    c. whose medical, psychological, or other conditions do not prohibit participation in this program.
2. Mental Health Evaluation: an initial evaluation to determine the injured worker's readiness or suitability for this type of treatment may be performed prior to initiation of treatment. This evaluation is not considered part of the IDPR program and shall be billed separately.
3. Due to the nature of intensity of the program, both group and individual therapy may be part of the IDPR program. If the program plan for a particular patient includes individual psychotherapy, it shall be billed as part of the program, and not separately. If the program does not include psychotherapy services, such services may be billed separately, if used, subject to applicable pre-authorization requirements.
4. Psychological treatments which are part of the IDPR program may be rendered by a psychiatrist, psychologist, licensed counselor, or licensed social worker.
5. The IDPR program shall always include a component designed to reduce the patient's dependence on and/or addiction to pain medications.
6. An individual plan of treatment shall be supervised by a doctor within a therapeutic environment. Although some time is spent with a doctor on a one-to-one basis, more than fifty percent (50%) of the time may be spent in direct care under the supervision of the physical therapist, occupational therapist, mental health provider, or other licensed member of the IDPR team.

7. Program supervision shall be provided by a doctor who is trained and experienced in the treatment of patients with chronic pain syndrome. The program supervisor shall:
    a. provide direct, on-site supervision of the daily pain management activities;
    b. participate in the initial and final evaluation of the patient;
    c. write the treatment plan for the patient, and write changes to the plan based on the patient's documented response to the treatment and/or based on documented changes in the patient's condition;
    d. direct the members of the IDPR team and review the patient's progress on a regular and consistent basis.
8. Participation in an IDPR program requires a minimum attendance of four (4) hours per day during the first week. The program shall not exceed eight (8) hours per day, except that workers who actually have experience working in a job for more than eight (8) hours per day may be allowed to participate for up to ten (10) hours per day, at the discretion of the program supervisor
9. Daily treatment and patient response shall be documented and provided to the payer at least every two (2) weeks.
10. Discharged/exit criteria shall include but not be limited to:
    a. the appropriate use of medications;
    b. decreased intensity of subjective pain;
    c. increased ability of the injured worker to manage pain;
    d. reduced health care use related to the chronic pain;
    e. return to work; and/or
    f. non-compliance with the program, or failure to obtain meaningful benefit after a reasonable period of time.

D. Billing. The IDPR program shall be billed using CPT 97799 Unlisted physical medicine/rehabilitation service or procedure, and appended with modifier M5 to indicate chronic pain treatment. The total number of hours shall be indicated in the units column of the bill, or in some other conspicuous place on the bill. CARF accredited providers shall also add M4 as an additional modifier.

E. Reimbursement. Reimbursement shall be as agreed to by the parties, or a maximum of one hundred twenty-five dollars ($125.00) per hour for CARF accredited providers. Providers without CARF accreditation shall be paid eighty percent (80%) of the maximum reimbursement allowance for CARF accredited providers. Units of less than one hour shall be prorated in fifteen (15) minute increments. A single fifteen (15) minute increment shall be reimbursed if the time is equal to or greater than eight (8) minutes and less than twenty-three (23) minutes.

XIII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Certain procedures or treatments, such as VAX-D therapy, are considered investigational or experimental for purposes of this Fee Schedule, and are not approved for reimbursement.

XIV. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple

modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with therapeutic services are as follows.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Mississippi guideline: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement. When appropriate, the Fee Schedule reimbursement for modifier 22 is one-hundred twenty percent (120%) of the maximum reimbursement allowance.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M Services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

Mississippi guideline: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the Fee Schedule.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Dental

Current Dental Terminology (CDT), codes D0120–D999, are developed, maintained, and copyrighted by the American Dental Association (ADA). CDT is updated annually. The current edition is *CDT 2013,* which is used in this Fee Schedule.

Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and its Code Maintenance Committee.

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

I. DEFINITION

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the Fee Schedule contains HCPCS Level II codes. (See the Dental section for dental codes.) HCPCS Level II codes that are excluded from the Fee Schedule are Alcohol/Drug Abuse Treatment Services (H0001–H2037), and National Codes for State Medicaid Agencies (T1000–T5999). Code categories included in this section are as follows:

Transportation Services Including Ambulance	A0021–A0999
Medical/Surgical Supplies	A4206–A8004
Administrative, Misc., and Investigational	A9150–A9999
Enteral and Parenteral Therapy	B4000–B9999
Outpatient PPS	C1300–C9899
Durable Medical Equipment (DME)	E0100–E9999
Procedures/Professional Services (Temporary)	G0008–G9186
Drugs and Biologicals	J0120–J9999
K Codes (Temporary)	K0001–K9999

Orthotic Procedures	L0000–L4999
Prosthetic Procedures	L5000–L9999
Medical Services	M0000–M0301
Pathology and Laboratory Services	P0000–P9999
Q Codes (Temporary)	Q0035–Q9969
Diagnostic Radiology Services	R0000–R5999
Temporary National Codes (Non-Medicare)	S0000–S9999
Vision Services	V0000–V2999
Hearing Services	V5000–V5999

II. GUIDELINES

A. **Transportation Services Including Ambulance (A0021–A0999)**

1. Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.
2. Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:

   D Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes

   E Residential, domiciliary, custodial facility (other than 1819 facility)

   G Hospital-based ESRD facility

   H Hospital

   I Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

   J Free-standing ESRD facility

   N Skilled nursing facility (SNF)

   P Physician’s office

   R Residence

   S Scene of accident or acute event

   X Intermediate stop at physician’s office on way to hospital (includes HMO non-hospital facility, clinic, etc. destination code only).

   Note: Modifier X can only be used as a destination code in the second position of a modifier.
3. Transportation codes can also be found in the S codes. See S0207, S0208, S0209, and S0215.

B. **Medical and Surgical Supplies (A4206–A8004)**

1. These A codes include a wide variety of medical, surgical, and some DME related supplies and services.
2. For rules related to DME supplies, accessories, maintenance, and repair, see F. Durable Medical Equipment below.

C. **Administrative, Miscellaneous, and Investigational (A9150–A9999)**

1. These A codes include nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

D. **Enteral and Parenteral Therapy (B4000–B9999)**

1. B codes include supplies, formulae, nutrition solutions and infusion pumps.

E. **Outpatient PPS (C1300–C9899)**

1. C codes include drugs, biologicals, and devices used by hospitals.

   Non-OPPS hospitals, Critical Access Hospitals (CAHs), Indian Health Services ospitals (HIS), hospitals located in American Samoa, Guam, Saipan, or the Virgin Islands, and Maryland waiver hospitals may report these codes at their discretion.
2. These codes are only used for facility (technical) services.

F. **Durable Medical Equipment (DME) (E0100–E8002)**

1. E codes include durable medical equipment such as canes, crutches, walkers, commodes, decubitus care, bath and toilet aids, hospital beds, oxygen and related respiratory equipment, monitoring equipment, pacemakers, patient lifts, safety equipment, restraints, traction equipment, fracture frames, wheelchairs, and artificial kidney machines.
2. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.
3. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.
4. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.
5. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

G. **Procedures/Professional Services (Temporary) (G0008–G9186)**

1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.
2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.
3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

H. **Drugs and Biologicals (J0120–J9999)**

1. J codes include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressive drugs, inhalation solutions, and other miscellaneous drugs and solutions.
2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).
3. Additional codes for drugs and biologicals may be found in the Q codes and S codes.

I. **Temporary Codes (K0001–K9999)**

1. K codes are temporary codes used to report durable medical equipment that do not yet have a permanent national code.
2. For rules related to DME supplies, accessories, maintenance, and repair, see F. Durable Medical Equipment above.

J. **Orthotic Procedures and Devices (L0000–L4999) and Prosthetic Procedures (L5000–L9900)**

1. L codes include orthotic and prosthetic procedures and devices as well as scoliosis equipment, orthopedic shoes, and prosthetic implants.
2. The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.

K. **Medical Services (M0000–M0301)**

1. M codes include office services, cellular therapy, prolotherapy, intragastric hypothermia, IV chelation therapy, and fabric wrapping of an abdominal aneurysm.
2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

L. **Pathology and Laboratory Services (P0000–P9999)**

1. P codes include chemistry, toxicology, and microbiology tests, screening Papanicolaou procedures, and various blood products.
2. Blood and blood product codes report the supply of the blood or blood product only.
3. The administration of blood or blood product is reported separately.
4. Code 36430 for transfusion of blood or blood components is reported only once per encounter regardless of the number of units provided.

L. **Temporary Codes (Q0035–Q9969)**

1. Q codes include temporary codes developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for:
    a. Oral anti-emetic drugs
    b. Casting supplies
    c. Splint supplies
    d. Low osmolar contrast
    e. High osmolar contrast
    f. Other supplies/services

2. Cast supplies and splints should be reported with the appropriate code from Q4001–Q4051. These codes report the cost of the supply only.
3. Cast supplies and splints are reported in addition to the CPT code for fracture management.
4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.
5. Refer to the CPT guidelines for rules related to reporting fracture management and cast application.

N. **Diagnostic Radiology Services (R0000–R5999)**
1. R codes are used for the transportation of portable x-ray and/or EKG equipment.
2. Only a single reasonable transportation charge is allowed for each trip to a single location.
3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.

O. **Temporary National Codes (Non-Medicare) (S0000–S9999)**
1. The S codes are used by the private sector to report drugs, services, and supplies for which there are no national codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.
2. See J codes for reporting rules related to drugs and biologicals.

P. **Vision Services (V0000–V2999)**
1. These V codes include vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.

Q. **Hearing Services (V5000-V5999)**
1. These V codes include hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative systems.

R. The Facility Fee for outpatient services is the APC Amount.

III. MODIFIERS

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

AU Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply

AV Item Furnished in Conjunction with a Prosthetic Device, Prosthetic, or Orthotic

AW Item Furnished in Conjunction with a Surgical Dressing

KC Replacement of Special Power Wheelchair Interface

NU New Equipment

RR Rental (use the RR modifier when DME is to be rented)

Mississippi guideline: Listed amount is the per-month allowance

UE Used durable medical equipment

Mississippi guideline: Used to report the purchase of used durable medical equipment.

Inpatient Hospital and Outpatient Facility Payment Schedule and Rules

I. INPATIENT AND OUTPATIENT CARE RULES

A. **Definition:**
For purposes of this schedule, “inpatient” means being admitted to a hospital setting for twenty-four (24) hours or more. An inpatient admission does not require official admission to the hospital.

B. **Billing and Reimbursement Rules for Inpatient Care:**

1. Facilities must submit the bill for inpatient services within thirty (30) days after discharge. For those cases involving extended hospitalization, interim bills must be submitted every thirty (30) days.
2. Reimbursement for acute inpatient hospital services shall be the maximum reimbursement allowance fixed by the rules set forth in this section of the Fee Schedule, regardless of the total charge.
3. Non-covered charges include but are not necessarily limited to:
    a. Convenience items;
    b. Charges for services not related to the work injury/illness;
    c. Services that were not certified by the payer or their representative as medically necessary.
4. When reviewing surgical claims, including for outlier consideration, the following apply:
    a. Most operative procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesiologist/anesthetist. Because these services are integral to the operating room environment, they are considered as part of the OR fee and are not separately reimbursed, nor are they included separately in the total charge for outlier consideration:
        1. Cardiac monitors
        2. Oximetry
        3. Blood pressure monitor

4. Lasers
5. Microscopes
6. Video equipment
7. Set up fees
8. Additional OR staff
9. Gowns
10. Gloves
11. Drapes
12. Towels
13. Mayo stand covers
14. On-call or call-back fees
15. After-hours fees

b. Billing for surgery packs as well as individual items in the packs is not allowed and shall not be included in the total charge for outlier consideration.

c. A majority of invasive procedures requires availability of vascular and/or airway access; therefore, the work associated with obtaining this access is included in the cost of the service, i.e., anesthesia—airway access is associated with general anesthesia and is included in the anesthesia charges.

d. Recovery room and ICU rates include the charge for cardiac monitoring and oximeter. It is assumed the patient is placed in these special areas for monitoring and specialized care which is bundled into the special care rate. Call-back fees are not reimbursed for recovery room.

e. Separate reimbursement is not allowed for setting up portable equipment at the patient's bedside.

f. The following items do not qualify for separate reimbursement regardless of inpatient or outpatient status, and are not included in the total charge for outlier consideration:

1. Applicators, cotton balls, band-aides
2. Syringes
3. Aspirin
4. Thermometers, blood pressure apparatus
5. Water pitchers
6. Alcohol preps
7. Ice bags

g. Separate reimbursement is not allowed for equipment such as compressive devices, or other equipment used during the operative or immediate postoperative period.

5. Maximum reimbursement is set for the following line item charges.

a. IV pump/daily – $50.00

b. Venipuncture reimbursement is limited to $4.25 per collection. A collection fee is not appropriate for finger stick, throat culture, or stool specimen collection

c. Pharmacy add-mixture/dispensing fee is limited to $4.50 per mixture

C. **Implants, Durable Medical Equipment, and Supplies**

Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Unless otherwise specifically provided herein, implantables used in the inpatient setting are included in the applicable MS-DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables.

Implantables used in the outpatient setting, are included in the applicable APC payment for outpatient services, and therefore, the provider of outpatient services is not required to furnish the payer with an invoice for implantables.

D. **Reimbursement Methodology**

The inpatient maximum reimbursement allowable (MRA) totals are provided by MS-DRG in this Fee Schedule. As of the effective date of this publication, the MS-DRG MRA is based upon the 2013 CMS relative weights multiplied by the base rate as determined herein. (This methodology includes inpatient psych admissions.) Any MS-DRGs outside of this Fee Schedule shall be reimbursed at seventy-five percent (75%) of charges. MS-DRG MRAs represent payment in full, unless the outlier payment is applicable, or unless a contract between the payer and provider governs reimbursement, or unless otherwise specifically stated in this Fee Schedule.

1. MS-DRG Payment is calculated by multiplying the Base Rate times the Relative Weight for the MS-DRG.
2. The Base Rate for Mississippi is the current National Medicare Base Rate in effect as of the date of discharge, multiplied by two (2). This is posted annually on the Mississippi Workers' Compensation Commission (MWCC) website, Fee Schedule section.
3. Common Medicare add-ons, such as for teaching hospitals (GME), DSH and Capital PPS, will not be allowed, and shall be considered as already included in the enhanced MS-DRG Payment under this Fee Schedule.
4. All implantables shall be included in the applicable MS-DRG reimbursement for inpatient treatment, and shall not be reimbursed separately in addition to the MS-DRG payment.
5. Outlier Payments. To provide additional reimbursement for cases where the MS-DRG payment is deemed inadequate by the Commission to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

   The amount eligible for outlier reimbursement is equal to Total Charges minus MS-DRG Payment minus Implantable Charges minus Non-Covered or Non-Qualified charges (as provided in Part I.B. above) minus the Outlier Threshold. The Outlier Threshold amount shall be specific to each facility and shall be equal to one-half (1/2) of the Medicare MS-DRG outlier threshold in effect for each facility at the time of discharge.
6. Any amount determined to be eligible for additional outlier reimbursement shall be reimbursed at fifteen percent (15%) above the facility's cost for the outlier eligible charges. Cost is determined using the facility's cost-to-charge ratio, as determined by Medicare (CMS), which is in effect at the time of discharge. These cost-to-charge ratios are posted annually on the MWCC website, Fee Schedule section. Outlier payment is figured by multiplying the eligible outlier amount by the cost-to-charge ratio, and then adding fifteen percent (15%) to compute the additional outlier payment due.

E. **Emergency Room Services**

Emergency room facility fees, supplies, and treatment are reimbursed according to the Ambulatory Payment Classification system, as set forth herein under the heading "Ambulatory Surgery Center/Outpatient Facility Reimbursement." Laboratory and radiology services are reimbursed at the technical amount calculated from the data listed in the corresponding section of this Fee Schedule.

The technical amount is calculated by subtracting the PC Amount from the Amount. Physician services are to be billed on an appropriate CMS claim form and paid according to the proper section.

F. **Observation Services**

1. **Definition**
   Observation services are those services furnished by a hospital on the hospital's premises, and include use of a bed and periodic monitoring by a hospital's staff. The service must be reasonable and necessary to evaluate a patient's condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.

2. **General Guidelines**

   a. Observation begins when the patient monitoring begins and ends when the order for discharge is written or given verbally by the physician.

   b. On rare occasions, an observation stay may be extended to forty-eight (48) hours. In such cases, medical necessity must be established and pre-authorization must be given for payment by the payer.

   c. Services which are NOT considered necessary for observation are as follows:

      1. Services that are not reasonable and necessary for the diagnosis and treatment of the work related injury, but are provided for convenience of the patient, family, or physician

      2. Any substitution of an outpatient observation for a medically appropriate inpatient admission

      3. Services ordered as inpatient by the physician but billed as outpatient by the facility

      4. Standing orders for observation following outpatient surgery

      5. Test preparation for a surgical procedure

      6. Continued care of a patient who has had a significant procedure as identified with OPPS indicator S or T

   d. Observation is not reimbursable for routine preparation furnished prior to an outpatient service or recovery after an outpatient service. Please refer to the criteria for observation services.

3. **Billing and Reimbursement**

   a. Observation status is billed at an hourly monitoring rate. The hourly rate is all inclusive with the exception of *non-significant ancillary services*.

   b. Observation is billed at the rate of $300.00 for the first three (3) hours and $80.00 per hour thereafter. Laboratory and radiology are reimbursed according to the Fee Schedule payment limits.

   c. Revenue code 762 is used to bill observation charges.

   d. Observation services provided to a patient who is subsequently admitted as an inpatient should be included on the inpatient claim.

G. **Stand-alone Services**

When services are provided as an outpatient service, and are not performed as a surgical procedure, medical procedure, or emergency room service, then reimbursement equals the technical amount calculated from the data listed in the corresponding section of this Fee Schedule. The technical amount is calculated by subtracting the PC Amount from the Amount.

H. **Disputed Medical Charges; Abusive or Unfair Billing**

1. Disputes over charges, fees, services, or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Fee Schedule.

2. If the Commission determines that the charge amount for items substantially and consistently exceeds the facility's mark-up ratio, or if a facility's charges for other services or MS-DRGs is substantially and consistently higher than the average charges made for the same services or MS-DRGs by other facilities in the State, then the Commission may consider this to be an indication of abusive or unfair billing practices, and may order the facility in question to appear and show cause why penalties and other sanctions as allowed by Law should not be imposed on said facility for such abusive billing practices.

   For purposes of this provision, the mark-up ratio shall be the inverse of the facility's cost-to-charge ratio. The average charges by facilities for service or MS-DRGs may be determined by reference to the publicly available MedPAR file for Medicare inpatient admissions, with due consideration being given to the differences between the Medicare inpatient population and the workers' compensation inpatient population.

II. INPATIENT REHABILITATION FACILITIES (IRFS)

A. Inpatient Rehabilitation Facility Reimbursement Methodology
MWCC reimbursement for inpatient rehabilitation facilities (IRFs) will be based upon the CMS prospective payment system (PPS).

1. The Fee Schedule MRA for IRFs will be two (2) times the IRF CMS pricer calculation, unless the payer and provider have a separate contract governing the reimbursement of services provided by an IRF, or unless total billed charges are less.

2. The IRF reimbursement due under this Fee Schedule will be calculated using the CMS IRF pricer calculation in effect on the date of discharge.

3. The CMS IRF pricer is used only for facilities that have met the CMS qualifications for IRF.

4. Reimbursement for IRFs is not calculated using the MS-DRG methodology.

5. The CMS IRF pricer is available at: http://www.cms.hhs.gov/PCPricer

B. **CMS Inpatient Rehabilitation Facility Reimbursement**
Medicare regulations define inpatient rehabilitation facilities (IRFs) in the Code of Federal Regulations, Part 412, and subpart B. Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412. The IRF must be currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), licensed by the State, and certified by Medicare as an IRF at the time the patient is treated.

The IRF must possess a Medicare/Medicaid provider number, or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025–3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g., 25TXXX.

Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Fee Schedule shall be the IRF PPS calculated rate multiplied by two (2). Other inpatient MS-DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the *Federal Register*, prior to October 1 of each year.

IRF reimbursement is based upon the case mix group (CMG) to which the patient is assigned. MWCC will accept the CMG assigned by the Medicare CMG grouper. The CMG must be reported on

the claim with revenue code 0024. This code indicates that this claim is being paid under the PPS and the revenue code can appear on a claim only once.

The *Federal Register* explains the formula for calculating the IRF PPS rate. The rates are calculated on case mix group (CMG) assignment from the combinations of ICD-9-CM codes with additional factors of labor share, wage index, rural adjustment (if applicable) and low income percentage (LIP) for a final adjusted IRF PPS reimbursement.

This calculated IRF PPS reimbursement is multiplied by two (2) for the MWCC reimbursement rate.

	Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)
x	Labor Share (FY 2014 *Federal Register* Table 4)
=	Labor portion of federal payment
x	CBSA Based Wage Index (See *Federal Register* Table I) Jackson, MS
=	Wage-Adjusted Amount
+	Non-labor amount (Unadjusted federal PPS less labor portion of federal payment)
=	Wage-adjusted federal payment
x	Rural Adjustment (See *Federal Register*)
=	Wage and rural adjusted federal payment
x	LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)
=	Wage, rural and LIP adjusted federal PPS payment rate
x	2 (MWCC reimbursement adjustment)
=	MWCC IRF PPS adjusted payment

MWCC will use the Medicare Pricer for the appropriate year and based on the date of discharge which is available as a free download from: http://www.cms.hhs.gov/PCPricer. The Medicare pricer returns the payment rate specific to the facility.

III. AMBULATORY SURGERY CENTER/OUTPATIENT FACILITY REIMBURSEMENT

A. Reimbursement for all hospital-based outpatient and freestanding ambulatory surgery center services shall be based on the Ambulatory Payment Classification (APC) system as developed by the Centers for Medicare and Medicaid Services (CMS) using relative weights effective April 1, 2013 and a Base Rate of $92.00.

B. For implantables used in the outpatient setting, reimbursement is included in the Fee Schedule APC Amount as listed.

C. Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT®/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the MRA, the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the APC MRA, the lesser of the charge is paid to the facility.

5. The payment rate for an APC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
    - Nursing and technician services
    - Use of the facility
    - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
    - Implantables
    - Materials for anesthesia
    - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery:
    - Pharmacy
    - Medical/surgical supplies
    - Sterile supplies
    - Laboratory and radiology services with no APC Amount
    - Operating room services
    - Anesthesia
    - Ambulatory surgical care
    - Recovery room
    - Treatment or observation room
7. Pre-op workup services are included in the APC Amount and do not warrant separate reimbursement regardless of the date of service.
8. The ASC payment rate (APC Amount) has been added to the CPT code listing of fees in the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
9. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
10. Procedures not assigned an APC Amount will be reimbursed according to the lesser of total billed charges or usual and customary rate.

D. Status code “N” items and services are packaged into APC rates, and are paid under OPPS; payment is packaged into payment for other services including outliers. Therefore, there is no separate APC payment. Status code “P” (partial hospitalization) is also paid under OPPS.

   Status code “Q” is paid at 100 percent of the APC MRA. Status code “T” is subject to the OPPS multiple procedure reduction.

E. Outlier Payments: In an effort to target outliers to high cost and complex cases where a very costly service could cause a facility to incur a significant financial loss, the following outlier payment formula is to be used to calculate the appropriate, additional reimbursement:

   Step 1: Reduce charges to cost using the default cost to charge ratio. The current default cost to charge ratio for urban facilities is 0.244; the current default ratio for rural facilities is 0.192;

   Step 2: Deduct implantable cost as it is paid separately. This is the cost of furnishing the service;

   Step 3: Test to see if outlier meets the 1.75 condition. Is the number from Step 2 more than 1.75 times the APC payment rate? If no, no outlier payment is due; if yes, proceed to Step 4;

Step 4: Test to see if outlier meets the $2,175 threshold test. Add $2,175 to the APC payment rate; is the total more or less than the figure from Step 2 (the cost of furnishing the service)? If greater than the figure in Step 2, no outlier is due; if less than the figure in Step 2, proceed to Step 5;

Step 5: Determine outlier payment:

Cost – (APC payment x 1.75)/2

OR

(Step 2 Amount – Step 3 Amount)/2

Example: Hospital X, an urban facility, bills $90,000 for CPT code 23470 Reconstruct shoulder joint. Assume there is a $2,500-cost implantable device used and that the MWCC payment is $9,601.88.

Step 1: Reduce charges to cost using the default cost to charge ratio:
$90,000 x 0.244 = $21,960

Step 2: Deduct implantable cost as it is paid separately
$21,960 – $2,500 = $19,460

Step 3: Test to see if outlier meets the 1.75 condition
$9,601.88 x 1.75 = $16,803.29
Is $19,460 ≥ $16,803.29? Yes, $19,460 is more than 1.75 times the payment

Step 4: Test to see if outlier meets the $2,175 threshold test
$9,601.88 + $2,175 = $11,776.88
$11,776.88 is less than $19,460, proceed to Step 5.

Step 5: Determine outlier payment
(Cost – (APC payment x 1.75))/2
($19,460 – ($9,601.88 x 1.75))/2 = $1,328.36
The outlier payment in this case would be $1,328.36.

IV. CRITICAL ACCESS HOSPITALS

A. A critical access hospital (CAH) is a small, generally geographically remote facility that is certified to provide outpatient and inpatient services.

B. A CAH may also be granted “swing bed” approval to provide post-hospital skilled nursing facility level care in its inpatient beds.

C. A list of currently participating Mississippi Critical Access hospitals is posted on the MWCC website at http://www.mwcc.ms.gov.

D. Reimbursement

1. Critical access hospitals are reimbursed at ninety percent (90%) of billed charges for inpatient and outpatient services.
2. Swing bed services are reimbursed according to the Skilled Nursing Facility section.

V. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate 5 digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Forms

I. GUIDELINES

A. Reproduced on the following pages are the forms that should or may be used by providers when billing workers' compensation related services. Instructions are given below.

B. Bills for services rendered should be sent directly to the party responsible for reimbursement. Do not send bills directly to the Medical Cost Containment Division as this will delay payment.

C. The following forms should be used for provider reimbursement:

- CMS-1500 (08/05) (effective July 1, 2007) Electronic equivalent 837p
- UB-04 (effective May 23, 2007) Electronic equivalent 837i
- J430D Dental Form (effective 2012)

D. The information to include on each form where appropriate is:

1. Claimant's full name and address as shown on the employer's record.
2. Social security number should be entered in the field for insured's ID number; this cuts down on errors and helps correlate the billing to the appropriate file.
3. Correct date of injury. Some claimants have multiple open files and can only be assigned by date.
4. Proper name and address of the employer, not just an individual's name.
5. Name of the insurance payer as registered with the state.
6. Date the claimant's disability should begin per the attending physician.
7. Attending physician's diagnoses and claimant's complaints.
8. Disabilities the claimant has that are not related to this injury.
9. Description of treatment plan, including any prescriptions.
10. Indication if the injury/illness appears to be work related.
11. Indication as to whether the claimant can be released to light or full duty work; full duty is considered to be the work at the time of the accident.
12. Length of time the claimant should be off work as a result of the injury or illness.
13. Date of the visit, the service(s) or procedure(s) performed, and charges.
14. Physician's complete name and address.
15. Physician and provider group national provider identifier (NPI) for billing group and treating physician.
16. Physician's or group's federal tax identification number (tax identification number [TIN] or social security number).
17. Injury/illness as described by the claimant.

E. The following pages have samples of the CMS-1500 (08/05), UB-04, 2012 American Dental Association Dental Claim Form J430D, Request for Resolution of Dispute, and Utilization Review Request Form.

II. Utilization Review Request Form

The form entitled Mississippi Workers' Compensation Utilization Review is a communication tool for use between the provider and the utilization review company. The form can be faxed between the provider and payer as applicable.

The utilization review process is mandatory under the *Mississippi Workers' Compensation Medical Fee Schedule*; however, the use of the Utilization Review Request Form is optional. The use of the form is encouraged if it proves helpful in the timely processing of requests for utilization review of medical services.

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00100	Anesthesia for procedures on salivary glands, including biopsy	5.00		5.00	
00102	Anesthesia for procedures involving plastic repair of cleft lip	6.00		6.00	
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)	5.00		5.00	
00104	Anesthesia for electroconvulsive therapy	4.00		4.00	
00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified	5.00		5.00	
00124	Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy	4.00		4.00	
00126	Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy	4.00		4.00	
00140	Anesthesia for procedures on eye; not otherwise specified	5.00		5.00	
00142	Anesthesia for procedures on eye; lens surgery	4.00		6.00	
00144	Anesthesia for procedures on eye; corneal transplant	6.00		6.00	
00145	Anesthesia for procedures on eye; vitreoretinal surgery	6.00		6.00	
00147	Anesthesia for procedures on eye; iridectomy	6.00		6.00	
00148	Anesthesia for procedures on eye; ophthalmoscopy	4.00		4.00	
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified	5.00		5.00	
00162	Anesthesia for procedures on nose and accessory sinuses; radical surgery	7.00		7.00	
00164	Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue	4.00		4.00	
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	5.00		5.00	
00172	Anesthesia for intraoral procedures, including biopsy; repair of cleft palate	6.00		6.00	
00174	Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor	6.00		6.00	
00176	Anesthesia for intraoral procedures, including biopsy; radical surgery	7.00		7.00	2097.37**
00190	Anesthesia for procedures on facial bones or skull; not otherwise specified	5.00		5.00	
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)	7.00		7.00	2097.37**
00210	Anesthesia for intracranial procedures; not otherwise specified	11.00		11.00	
00211	Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma	10.00		10.00	2097.37**
00212	Anesthesia for intracranial procedures; subdural taps	5.00		5.00	
00214	Anesthesia for intracranial procedures; burr holes, including ventriculography	9.00		9.00	2097.37**
00215	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)	9.00		9.00	2097.37**
00216	Anesthesia for intracranial procedures; vascular procedures	15.00		15.00	
00218	Anesthesia for intracranial procedures; procedures in sitting position	13.00		13.00	
00220	Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures	10.00		10.00	
00222	Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve	6.00		6.00	
00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified	5.00		5.00	
00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older	6.00		6.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00322	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; needle biopsy of thyroid	3.00		3.00	
00326	Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age	8.00		8.00	
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.00		10.00	
00352	Anesthesia for procedures on major vessels of neck; simple ligation	5.00		5.00	
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	3.00		3.00	
00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)	5.00		5.00	
00404	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast	5.00		5.00	
00406	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast with internal mammary node dissection	13.00		13.00	
00410	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias	4.00		4.00	
00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified	5.00		5.00	
00452	Anesthesia for procedures on clavicle and scapula; radical surgery	6.00		6.00	2097.37**
00454	Anesthesia for procedures on clavicle and scapula; biopsy of clavicle	3.00		3.00	
00470	Anesthesia for partial rib resection; not otherwise specified	6.00		6.00	
00472	Anesthesia for partial rib resection; thoracoplasty (any type)	10.00		10.00	
00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)	13.00		13.00	2097.37**
00500	Anesthesia for all procedures on esophagus	15.00		15.00	
00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified	6.00		6.00	
00522	Anesthesia for closed chest procedures; needle biopsy of pleura	4.00		4.00	
00524	Anesthesia for closed chest procedures; pneumocentesis	4.00		4.00	2097.37**
00528	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing 1 lung ventilation	8.00		8.00	
00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing 1 lung ventilation	11.00		11.00	
00530	Anesthesia for permanent transvenous pacemaker insertion	4.00		4.00	
00532	Anesthesia for access to central venous circulation	4.00		4.00	
00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	7.00		7.00	
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	10.00		10.00	
00539	Anesthesia for tracheobronchial reconstruction	18.00		18.00	
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified	12.00		12.00	2097.37**

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation	15.00		15.00	
00542	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication	15.00		15.00	2097.37**
00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty	15.00		15.00	2097.37**
00548	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi	17.00		17.00	
00550	Anesthesia for sternal debridement	10.00		10.00	
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.00		15.00	2097.37**
00561	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age	25.00		25.00	2097.37**
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after origi	20.00		20.00	2097.37**
00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest	25.00		25.00	
00566	Anesthesia for direct coronary artery bypass grafting; without pump oxygenator	25.00		25.00	
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.00		18.00	2097.37**
00580	Anesthesia for heart transplant or heart/lung transplant	20.00		20.00	2097.37**
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified	10.00		10.00	
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position	13.00		13.00	2097.37**
00620	Anesthesia for procedures on thoracic spine and cord; not otherwise specified	10.00		10.00	
00622	Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy	13.00		13.00	2097.37**
00625	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing 1 lung ventilation	13.00		13.00	
00626	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; utilizing 1 lung ventilation	15.00		15.00	
00630	Anesthesia for procedures in lumbar region; not otherwise specified	8.00		8.00	
00632	Anesthesia for procedures in lumbar region; lumbar sympathectomy	7.00		7.00	2097.37**
00634	Anesthesia for procedures in lumbar region; chemonucleolysis	10.00		10.00	
00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	4.00		4.00	
00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	3.00		3.00	
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.00		13.00	2097.37**

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00700	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified	4.00		4.00	
00702	Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy	4.00		4.00	
00730	Anesthesia for procedures on upper posterior abdominal wall	5.00		5.00	
00740	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum	5.00		5.00	
00750	Anesthesia for hernia repairs in upper abdomen; not otherwise specified	4.00		4.00	
00752	Anesthesia for hernia repairs in upper abdomen; lumbar and ventral (incisional) hernias and/or wound dehiscence	6.00		6.00	
00754	Anesthesia for hernia repairs in upper abdomen; omphalocele	7.00		7.00	
00756	Anesthesia for hernia repairs in upper abdomen; transabdominal repair of diaphragmatic hernia	7.00		7.00	
00770	Anesthesia for all procedures on major abdominal blood vessels	15.00		15.00	
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.00		7.00	
00792	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)	13.00		13.00	2097.37**
00794	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure)	8.00		8.00	2097.37**
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.00		30.00	2097.37**
00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	11.00		11.00	
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified	4.00		4.00	
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy	5.00		5.00	2097.37**
00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum	5.00		5.00	
00820	Anesthesia for procedures on lower posterior abdominal wall	5.00		5.00	
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	4.00		4.00	
00832	Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias	6.00		6.00	
00834	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age	5.00		5.00	
00836	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants younger than 37 weeks gestational age at birth and younger than 50 weeks gestational age at time of surgery	6.00		6.00	
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	6.00		6.00	
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis	4.00		4.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00844	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection	7.00		7.00	2097.37**
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy	8.00		8.00	2097.37**
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration	8.00		8.00	2097.37**
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	6.00		6.00	
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified	6.00		6.00	
00862	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy	7.00		7.00	
00864	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy	8.00		8.00	2097.37**
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)	7.00		7.00	2097.37**
00866	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy	10.00		10.00	2097.37**
00868	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)	10.00		10.00	2097.37**
00870	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy	5.00		5.00	
00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath	7.00		7.00	
00873	Anesthesia for lithotripsy, extracorporeal shock wave; without water bath	5.00		5.00	
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified	15.00		15.00	
00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation	10.00		10.00	2097.37**
00902	Anesthesia for; anorectal procedure	5.00		5.00	
00904	Anesthesia for; radical perineal procedure	7.00		7.00	2097.37**
00906	Anesthesia for; vulvectomy	4.00		4.00	
00908	Anesthesia for; perineal prostatectomy	6.00		6.00	2097.37**
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified	3.00		3.00	
00912	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of bladder tumor(s)	5.00		5.00	
00914	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate	5.00		5.00	
00916	Anesthesia for transurethral procedures (including urethrocystoscopy); post-transurethral resection bleeding	5.00		5.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
00918	Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus	5.00		5.00	
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified	3.00		3.00	
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral	3.00		3.00	
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles	6.00		6.00	
00924	Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral	4.00		4.00	
00926	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal	4.00		4.00	
00928	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, abdominal	6.00		6.00	
00930	Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral	4.00		4.00	
00932	Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis	4.00		4.00	2097.37**
00934	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal lymphadenectomy	6.00		6.00	2097.37**
00936	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal and iliac lymphadenectomy	8.00		8.00	2097.37**
00938	Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)	4.00		4.00	
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	3.00		3.00	
00942	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); colpotomy, vaginectomy, colporrhaphy, and open urethral procedures	4.00		4.00	
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy	6.00		6.00	2097.37**
00948	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage	4.00		4.00	
00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy	5.00		5.00	
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	4.00		4.00	
01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	5.00		5.00	
01120	Anesthesia for procedures on bony pelvis	6.00		6.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
01130	Anesthesia for body cast application or revision	3.00		3.00	
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	15.00		15.00	2097.37**
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	10.00		10.00	2097.37**
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint	4.00		4.00	
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint	8.00		8.00	
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	12.00		12.00	
01180	Anesthesia for obturator neurectomy; extrapelvic	3.00		3.00	
01190	Anesthesia for obturator neurectomy; intrapelvic	4.00		4.00	
01200	Anesthesia for all closed procedures involving hip joint	4.00		4.00	
01202	Anesthesia for arthroscopic procedures of hip joint	4.00		4.00	
01210	Anesthesia for open procedures involving hip joint; not otherwise specified	6.00		6.00	
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	10.00		10.00	2097.37**
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.00		8.00	2097.37**
01215	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	10.00		10.00	
01220	Anesthesia for all closed procedures involving upper 2/3 of femur	4.00		4.00	
01230	Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified	6.00		6.00	
01232	Anesthesia for open procedures involving upper 2/3 of femur; amputation	5.00		5.00	2097.37**
01234	Anesthesia for open procedures involving upper 2/3 of femur; radical resection	8.00		8.00	2097.37**
01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg	4.00		4.00	
01260	Anesthesia for all procedures involving veins of upper leg, including exploration	3.00		3.00	
01270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified	8.00		8.00	
01272	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery ligation	4.00		4.00	2097.37**
01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy	6.00		6.00	2097.37**
01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area	4.00		4.00	
01340	Anesthesia for all closed procedures on lower 1/3 of femur	4.00		4.00	
01360	Anesthesia for all open procedures on lower 1/3 of femur	5.00		5.00	
01380	Anesthesia for all closed procedures on knee joint	3.00		3.00	
01382	Anesthesia for diagnostic arthroscopic procedures of knee joint	3.00		3.00	
01390	Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella	3.00		3.00	
01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella	4.00		4.00	
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified	4.00		4.00	
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.00		7.00	2097.37**
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee	5.00		5.00	2097.37**

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
01420	Anesthesia for all cast applications, removal, or repair involving knee joint	3.00		3.00	
01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified	3.00		3.00	
01432	Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula	6.00		6.00	
01440	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified	8.00		8.00	
01442	Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft	8.00		8.00	2097.37**
01444	Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm	8.00		8.00	2097.37**
01462	Anesthesia for all closed procedures on lower leg, ankle, and foot	3.00		3.00	
01464	Anesthesia for arthroscopic procedures of ankle and/or foot	3.00		3.00	
01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified	3.00		3.00	
01472	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft	5.00		5.00	
01474	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; gastrocnemius recession (eg, Strayer procedure)	5.00		5.00	
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified	3.00		3.00	
01482	Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)	4.00		4.00	
01484	Anesthesia for open procedures on bones of lower leg, ankle, and foot; osteotomy or osteoplasty of tibia and/or fibula	4.00		4.00	
01486	Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement	7.00		7.00	2097.37**
01490	Anesthesia for lower leg cast application, removal, or repair	3.00		3.00	
01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified	8.00		8.00	
01502	Anesthesia for procedures on arteries of lower leg, including bypass graft; embolectomy, direct or with catheter	6.00		6.00	2097.37**
01520	Anesthesia for procedures on veins of lower leg; not otherwise specified	3.00		3.00	
01522	Anesthesia for procedures on veins of lower leg; venous thrombectomy, direct or with catheter	5.00		5.00	
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla	5.00		5.00	
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint	4.00		4.00	
01622	Anesthesia for diagnostic arthroscopic procedures of shoulder joint	4.00		4.00	
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.00		5.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation	9.00		9.00	2097.37**
01636	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation	15.00		15.00	2097.37**
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.00		10.00	2097.37**
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified	6.00		6.00	
01652	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm	10.00		10.00	2097.37**
01654	Anesthesia for procedures on arteries of shoulder and axilla; bypass graft	8.00		8.00	2097.37**
01656	Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft	10.00		10.00	2097.37**
01670	Anesthesia for all procedures on veins of shoulder and axilla	4.00		4.00	
01680	Anesthesia for shoulder cast application, removal or repair; not otherwise specified	3.00		3.00	
01682	Anesthesia for shoulder cast application, removal or repair; shoulder spica	4.00		4.00	
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified	3.00		3.00	
01712	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open	5.00		5.00	
01714	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenoplasty, elbow to shoulder	5.00		5.00	
01716	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenodesis, rupture of long tendon of biceps	5.00		5.00	
01730	Anesthesia for all closed procedures on humerus and elbow	3.00		3.00	
01732	Anesthesia for diagnostic arthroscopic procedures of elbow joint	3.00		3.00	
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified	4.00		4.00	
01742	Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus	5.00		5.00	
01744	Anesthesia for open or surgical arthroscopic procedures of the elbow; repair of nonunion or malunion of humerus	5.00		5.00	
01756	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures	6.00		6.00	2097.37**
01758	Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus	5.00		5.00	
01760	Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement	7.00		7.00	
01770	Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified	6.00		6.00	
01772	Anesthesia for procedures on arteries of upper arm and elbow; embolectomy	6.00		6.00	
01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified	3.00		3.00	
01782	Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy	4.00		4.00	
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.00		3.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	3.00		3.00	
01829	Anesthesia for diagnostic arthroscopic procedures on the wrist	3.00		3.00	
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified	3.00		3.00	
01832	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; total wrist replacement	6.00		6.00	
01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified	6.00		6.00	
01842	Anesthesia for procedures on arteries of forearm, wrist, and hand; embolectomy	6.00		6.00	
01844	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)	6.00		6.00	
01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified	3.00		3.00	
01852	Anesthesia for procedures on veins of forearm, wrist, and hand; phleborrhaphy	4.00		4.00	
01860	Anesthesia for forearm, wrist, or hand cast application, removal, or repair	3.00		3.00	
01916	Anesthesia for diagnostic arteriography/venography	5.00		5.00	
01920	Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)	7.00		7.00	
01922	Anesthesia for non-invasive imaging or radiation therapy	7.00		7.00	
01924	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; not otherwise specified	6.00		6.00	
01925	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; carotid or coronary	8.00		8.00	
01926	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; intracranial, intracardiac, or aortic	10.00		10.00	
01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified	5.00		5.00	
01931	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, transvenous intrahepatic portosystemic shunt[s] [TIPS])	7.00		7.00	
01932	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular	7.00		7.00	
01933	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial	8.00		8.00	
01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	5.00		5.00	
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic	5.00		5.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
01951	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 4% total body surface area	3.00		3.00	
01952	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area	5.00		5.00	
01953	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional 9% total body surface area or part thereof (List separa	1.00		1.00	
01958	Anesthesia for external cephalic version procedure	5.00		5.00	
01960	Anesthesia for vaginal delivery only	5.00		5.00	
01961	Anesthesia for cesarean delivery only	7.00		7.00	
01962	Anesthesia for urgent hysterectomy following delivery	8.00		8.00	
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care	10.00		10.00	
01965	Anesthesia for incomplete or missed abortion procedures	4.00		4.00	
01966	Anesthesia for induced abortion procedures	4.00		4.00	
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	5.00		5.00	
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	3.00		3.00	
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	5.00		5.00	
01990	Physiological support for harvesting of organ(s) from brain-dead patient	7.00		7.00	2097.37**
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position	3.00		3.00	
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position	5.00		5.00	
01996	Daily hospital management of epidural or subarachnoid continuous drug administration	3.00		3.00	
01999	Unlisted anesthesia procedure(s)	0.00		0.00	
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)	1.00		1.00	
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5.00		5.00	
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5.00		5.00	

Anesthesia Fees

Code	Description	2013 Base Unit	2013 APC Amount	2010 Base Unit	2010 APC Amount
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)	2.00		2.00	

** CMS APC ERROR

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
10021		Fine needle aspiration; without imaging guidance	4.53	378.26		XXX	0	158.18	282.23	137.80
10022		Fine needle aspiration; with imaging guidance	4.15	346.53		XXX	0	445.75	303.11	419.39
10040		Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	3.03	253.01		010	1	92.29	184.54	80.15
10060		Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	3.47	289.75		010	1	161.85	207.08	132.75
10061		Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	6.12	511.02		010	1	161.85	361.56	132.75
10080		Incision and drainage of pilonidal cyst; simple	5.45	455.08		010	1	161.85	348.20	132.75
10081		Incision and drainage of pilonidal cyst; complicated	8.24	688.04		010	1	936.06	532.73	1150.97
10120		Incision and removal of foreign body, subcutaneous tissues; simple	4.59	383.27		010	1	270.47	279.73	255.17
10121		Incision and removal of foreign body, subcutaneous tissues; complicated	8.30	693.05		010	1	1447.15	524.38	1595.60
10140		Incision and drainage of hematoma, seroma or fluid collection	4.89	408.32		010	1	936.06	289.75	1150.97
10160		Puncture aspiration of abscess, hematoma, bulla, or cyst	3.91	326.49		010	1	161.85	242.15	132.75
10180		Incision and drainage, complex, postoperative wound infection	7.44	621.24		010	1	1701.78	455.08	1769.66
11000		Debridement of extensive eczematous or infected skin; up to 10% of body surface	1.62	135.27		000	1	270.47	102.71	140.54
11001		Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)	0.63	52.61		ZZZ	1	92.29	45.09	80.15
11004		Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	16.94	1414.49		000	1		1178.19	2097.37**
11005		Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	22.97	1918.00		000	0		1586.50	2097.37**
11006		Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure	20.65	1724.28		000	1		1473.78	2097.37**
11008		Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	8.07	673.85		ZZZ	0		582.00	2097.37**
11010		Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	14.92	1245.82		010	1	433.96	940.21	397.82
11011		Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	16.16	1349.36		000	1	433.96	1090.51	397.82
11012		Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	21.33	1781.06		000	1	433.96	1558.11	397.82
11042		Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	3.53	294.76		000	1	270.47	151.97	255.17
11043		Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	6.89	575.32		000	1	270.47	542.75	255.17
11044		Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	9.48	791.58		000	1	752.91	727.29	748.01
11045		Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	1.26	105.21		ZZZ	0	270.47	New	
11046		Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	2.18	182.03		ZZZ	0	270.47	New	
11047		Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	3.68	307.28		ZZZ	0	433.96	New	
11055		Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	1.42	118.57		000	1	92.29	89.35	80.15
11056		Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	1.73	144.46		000	1	92.29	110.22	80.15

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
11057		Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	1.94	161.99		000	1	137.98	135.27	80.15
11100		Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	3.13	261.36		000	1	137.98	181.20	140.54
11101		Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.96	80.16		ZZZ	1	92.29	61.79	80.15
11200		Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	2.63	219.61		010	1	92.29	153.64	80.15
11201		Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	0.56	46.76		ZZZ	1	92.29	36.74	80.15
11300		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	2.95	246.33		000	0	92.29	127.76	80.15
11301		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	3.62	302.27		000	0	92.29	167.84	80.15
11302		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	4.27	356.55		000	0	92.29	201.24	80.15
11303		Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	4.70	392.45		000	0	137.98	240.48	140.54
11305		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	2.95	246.33		000	0	92.29	131.93	80.15
11306		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	3.65	304.78		000	0	92.29	178.69	80.15
11307		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	4.32	360.72		000	0	92.29	208.75	80.15
11308		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	4.57	381.60		000	0	137.98	244.66	80.15
11310		Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	3.43	286.41		000	0	92.29	156.98	80.15
11311		Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	3.34	278.89		000	0	92.29	194.56	80.15
11312		Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	4.86	405.81		000	0	137.98	224.62	80.15
11313		Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	5.59	466.77		000	0	137.98	288.91	80.15
11400		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	3.73	311.46		010	1	433.96	233.80	397.82
11401		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	4.49	374.92		010	1	433.96	275.55	397.82
11402		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	4.99	416.67		010	1	433.96	306.45	397.82
11403		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	5.75	480.13		010	1	752.91	353.21	748.01
11404		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm	6.52	544.42		010	1	1447.15	402.47	1595.60
11406		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	9.33	779.06		010	1	1447.15	551.94	1595.60
11420		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	3.70	308.95		010	1	752.91	231.30	748.01
11421		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	4.74	395.79		010	1	752.91	294.76	748.01

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
11422		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	5.27	440.05		010	1	752.91	328.16	748.01
11423		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	6.07	506.85		010	1	1447.15	386.61	1595.60
11424		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	6.97	582.00		010	1	1447.15	441.72	1595.60
11426		Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	9.88	824.98		010	1	2142.94	632.93	2132.75
11440		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	4.09	341.52		010	1	433.96	263.03	397.82
11441		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	5.06	422.51		010	1	433.96	319.81	397.82
11442		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	5.65	471.78		010	1	752.91	357.38	748.01
11443		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	6.71	560.29		010	1	752.91	434.20	748.01
11444		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm	8.39	700.57		010	1	752.91	547.76	748.01
11446		Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	11.57	966.10		010	1	2142.94	730.63	2132.75
11450		Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair	11.48	958.58		090	1	2142.94	686.37	2132.75
11451		Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repai	14.62	1220.77		090	0	2142.94	911.82	2132.75
11462		Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair	11.25	939.38		090	0	2142.94	677.19	2132.75
11463		Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repai	14.59	1218.27		090	0	2142.94	936.87	2132.75
11470		Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair	12.48	1042.08		090	1	2142.94	741.48	2132.75
11471		Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair	15.52	1295.92		090	0	2142.94	964.43	2132.75
11600		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less	5.80	484.30		010	1	752.91	349.03	748.01
11601		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm	6.87	573.65		010	1	433.96	403.31	397.82
11602		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm	7.46	622.91		010	1	433.96	434.20	397.82
11603		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm	8.47	707.25		010	1	752.91	498.50	748.01
11604		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm	9.44	788.24		010	1	752.91	553.61	748.01
11606		Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm	13.46	1123.91		010	1	1447.15	772.38	1595.60
11620		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	5.88	490.98		010	1	752.91	349.03	748.01
11621		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	6.92	577.82		010	1	433.96	404.98	397.82
11622		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	7.71	643.79		010	1	752.91	455.91	748.01
11623		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	9.01	752.34		010	1	752.91	541.08	1595.60
11624		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	10.13	845.86		010	1	1447.15	617.90	1595.60
11626		Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	12.21	1019.54		010	1	2142.94	773.21	2132.75
11640		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	6.06	506.01		010	1	433.96	360.72	748.01

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11641		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm	7.16	597.86		010	1	433.96	438.38	748.01
11642		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	8.15	680.53		010	1	433.96	506.01	748.01
11643		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	9.59	800.77		010	1	752.91	602.04	748.01
11644		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm	11.81	986.14		010	1	1447.15	752.34	1595.60
11646		Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm	15.35	1281.73		010	1	2142.94	1000.33	2132.75
11719		Trimming of nondystrophic nails, any number	0.34	28.39		000	1	36.63	37.58	40.45
11720		Debridement of nail(s) by any method(s); 1 to 5	0.96	80.16		000	1	92.29	58.45	80.15
11721		Debridement of nail(s) by any method(s); 6 or more	1.32	110.22		000	1	92.29	86.01	80.15
11730		Avulsion of nail plate, partial or complete, simple; single	2.93	244.66		000	1	92.29	187.04	80.15
11732		Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)	1.05	87.68		ZZZ	1	92.29	87.68	80.15
11740		Evacuation of subungual hematoma	1.48	123.58		000	1	36.63	81.83	40.45
11750		Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;	6.66	556.11		010	1	433.96	396.63	397.82
11752		Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx	9.60	801.60		010	1	2142.94	564.46	2132.75
11755		Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	4.03	336.51		000	0	433.96	251.34	397.82
11760		Repair of nail bed	7.07	590.35		010	1	110.62	374.08	123.49
11762		Reconstruction of nail bed with graft	8.53	712.26		010	1	1434.08	507.68	1463.98
11765		Wedge excision of skin of nail fold (eg, for ingrown toenail)	5.00	417.50		010	1	92.29	227.96	80.15
11770		Excision of pilonidal cyst or sinus; simple	8.37	698.90		010	1	2142.94	516.03	2132.75
11771		Excision of pilonidal cyst or sinus; extensive	17.13	1430.36		090	1	2142.94	1003.67	2132.75
11772		Excision of pilonidal cyst or sinus; complicated	20.85	1740.98		090	1	2142.94	1253.34	2132.75
11900		Injection, intralesional; up to and including 7 lesions	1.67	139.45		000	1	92.29	101.04	80.15
11901		Injection, intralesional; more than 7 lesions	2.08	173.68		000	1	92.29	125.25	80.15
11920		Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	5.19	433.37		000	0	324.43	423.35	287.32
11921		Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	5.99	500.17		000	0	324.43	474.28	287.32
11922		Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	1.86	155.31		ZZZ	0	324.43	133.60	287.32
11950		Subcutaneous injection of filling material (eg, collagen); 1 cc or less	2.15	179.53		000	0	324.43	157.82	123.49
11951		Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	3.17	264.70		000	0	324.43	217.10	123.49
11952		Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	4.15	346.53		000	0	324.43	293.09	123.49
11954		Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	4.74	395.79		000	0	110.62	349.03	123.49
11960		Insertion of tissue expander(s) for other than breast, including subsequent expansion	27.78	2319.63		090	1	1948.12	1811.12	2182.33
11970		Replacement of tissue expander with permanent prosthesis	18.31	1528.89		090	1	4434.79	1194.89	4247.50
11971		Removal of tissue expander(s) without insertion of prosthesis	14.35	1198.23		090	0	2142.94	994.49	2132.75
11976		Removal, implantable contraceptive capsules	4.32	360.72		000	0	433.96	294.76	397.82
11980		Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	3.05	254.68		000	1	64.04	213.76	61.03
11981		Insertion, non-biodegradable drug delivery implant	4.07	339.85		XXX	0	64.04	268.04	61.03
11982		Removal, non-biodegradable drug delivery implant	4.59	383.27		XXX	0	64.04	312.29	61.03

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11983		Removal with reinsertion, non-biodegradable drug delivery implan	6.25	521.88		XXX	0	64.04	465.93	61.03
12001		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	2.72	227.12		000	1	110.62	302.27	123.49
12002		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	3.29	274.72		000	1	110.62	320.64	123.49
12004		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	3.86	322.31		000	1	110.62	375.75	123.49
12005		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	4.99	416.67		000	1	110.62	468.44	123.49
12006		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm	6.03	503.51		000	1	110.62	581.16	123.49
12007		Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm	6.86	572.81		000	1	110.62	657.15	123.49
12011		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	3.32	277.22		000	1	110.62	319.81	123.49
12013		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	3.63	303.11		000	1	110.62	351.54	123.49
12014		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	4.24	354.04		000	1	110.62	414.16	123.49
12015		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	5.17	431.70		000	1	110.62	519.37	123.49
12016		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	6.42	536.07		000	1	110.62	614.56	123.49
12017		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	4.52	377.42		000	0	110.62	543.59	123.49
12018		Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	5.99	500.17		000	2	324.43	652.14	123.49
12020		Treatment of superficial wound dehiscence; simple closure	8.47	707.25		010	1	507.49	540.25	404.76
12021		Treatment of superficial wound dehiscence; with packing	5.12	427.52		010	1	324.43	312.29	287.32
12031		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	7.18	599.53		010	1	324.43	401.64	123.49
12032		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	9.17	765.70		010	1	324.43	550.27	287.32
12034		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	9.39	784.07		010	1	324.43	536.91	123.49
12035		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	11.69	976.12		010	1	324.43	725.62	123.49
12036		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	12.74	1063.79		010	1	324.43	810.79	287.32
12037		Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm	14.01	1169.84		010	0	324.43	911.82	287.32
12041		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	7.29	608.72		010	1	110.62	435.04	123.49
12042		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	8.67	723.95		010	1	324.43	519.37	123.49
12044		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	10.84	905.14		010	1	324.43	571.98	123.49
12045		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm	12.11	1011.19		010	1	324.43	743.15	287.32
12046		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm	16.14	1347.69		010	0	324.43	889.28	287.32
12047		Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	17.70	1477.95		010	2	324.43	924.35	287.32
12051		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	7.79	650.47		010	1	324.43	494.32	123.49

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12052		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	8.83	737.31		010	1	324.43	529.39	123.49
12053		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	10.43	870.91		010	1	324.43	569.47	123.49
12054		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	11.13	929.36		010	1	110.62	621.24	123.49
12055		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	14.22	1187.37		010	1	324.43	777.39	287.32
12056		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	16.43	1371.91		010	0	324.43	996.16	287.32
12057		Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	16.58	1384.43		010	2	324.43	1035.40	287.32
13100		Repair, complex, trunk; 1.1 cm to 2.5 cm	10.05	839.18		010	1	507.49	603.71	404.76
13101		Repair, complex, trunk; 2.6 cm to 7.5 cm	11.94	996.99		010	1	507.49	733.13	404.76
13102		Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)	3.66	305.61		ZZZ	1	324.43	206.25	404.76
13120		Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	10.53	879.26		010	1	324.43	627.09	287.32
13121		Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	12.85	1072.98		010	1	324.43	792.42	287.32
13122		Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	4.01	334.84		ZZZ	1	110.62	244.66	123.49
13131		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	11.58	966.93		010	1	324.43	685.54	287.32
13132		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	14.29	1193.22		010	1	507.49	1049.60	404.76
13133		Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)	5.31	443.39		ZZZ	1	324.43	323.15	287.32
13150		Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	11.24	938.54		010	1	507.49	718.94	404.76
13151		Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	12.65	1056.28		010	1	507.49	777.39	404.76
13152		Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	14.36	1199.06		010	1	507.49	1045.42	404.76
13153		Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	5.77	481.80		ZZZ	1	324.43	362.39	287.32
13160		Secondary closure of surgical wound or dehiscence, extensive or complicated	24.07	2009.85		090	1	1948.12	1614.89	2182.33
14000		Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	18.76	1566.46		090	1	1434.08	1241.65	1463.98
14001		Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	24.01	2004.84		090	1	1434.08	1612.39	1463.98
14020		Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	20.98	1751.83		090	1	1434.08	1378.59	1463.98
14021		Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	26.13	2181.86		090	1	1434.08	1795.25	1463.98
14040		Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	22.89	1911.32		090	1	1434.08	1451.23	1463.98
14041		Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	28.22	2356.37		090	1	1434.08	1962.25	1463.98
14060		Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	23.26	1942.21		090	1	1434.08	1491.31	1463.98
14061		Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	30.33	2532.56		090	1	1434.08	2129.25	1463.98
14301		Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	32.28	2695.38		090	2	1948.12	2379.75	2182.33
14302		Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	6.48	541.08		ZZZ	2	1948.12	522.71	2182.33
14350		Filleted finger or toe flap, including preparation of recipient site	21.06	1758.51		090	0	1948.12	1518.87	2182.33

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15002		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	10.47	874.25		000	0	507.49	658.82	404.76
15003		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additio	2.29	191.22		ZZZ	0	507.49	146.13	404.76
15004		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or	12.03	1004.51		000	0	324.43	794.09	404.76
15005		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or	3.72	310.62		ZZZ	0	507.49	245.49	404.76
15040		Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	7.80	651.30		000	1	324.43	536.91	287.32
15050		Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	17.18	1434.53		090	1	324.43	1044.59	404.76
15100		Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	25.78	2152.63		090	1	1948.12	1832.83	2182.33
15101		Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	5.63	470.11		ZZZ	1	1948.12	435.87	2182.33
15110		Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	26.01	2171.84		090	1	507.49	1783.56	404.76
15111		Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	3.39	283.07		ZZZ	1	507.49	259.69	404.76
15115		Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	25.89	2161.82		090	1	1434.08	1707.58	404.76
15116		Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to co	4.47	373.25		ZZZ	1	324.43	340.68	404.76
15120		Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	25.49	2128.42		090	1	1948.12	1827.82	2182.33
15121		Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition	6.26	522.71		ZZZ	1	1948.12	584.50	2182.33
15130		Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	20.26	1691.71		090	1	1434.08	1423.68	1463.98
15131		Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	2.66	222.11		ZZZ	1	1434.08	212.09	1463.98
15135		Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	26.23	2190.21		090	1	1434.08	1739.31	1463.98
15136		Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code	2.70	225.45		ZZZ	1	1434.08	199.57	1463.98
15150		Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	20.65	1724.28		090	1	324.43	1475.45	404.76
15151		Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	3.51	293.09		ZZZ	1	324.43	274.72	404.76

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
15152		Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	4.59	383.27		ZZZ	1	324.43	337.34	404.76
15155		Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	22.79	1902.97		090	1	324.43	1493.82	404.76
15156		Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	4.72	394.12		ZZZ	1	324.43	359.05	404.76
15157		Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in add	5.45	455.08		ZZZ	1	324.43	398.30	404.76
15200		Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	24.93	2081.66		090	1	1434.08	1552.27	1463.98
15201		Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	4.49	374.92		ZZZ	1	1434.08	319.81	1463.98
15220		Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	23.21	1938.04		090	1	1434.08	1460.42	1463.98
15221		Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	4.16	347.36		ZZZ	1	507.49	290.58	404.76
15240		Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	28.03	2340.51		090	1	1434.08	1729.29	1463.98
15241		Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	5.57	465.10		ZZZ	1	324.43	364.90	404.76
15260		Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	30.39	2537.57		090	1	1434.08	1825.31	1463.98
15261		Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	6.51	543.59		ZZZ	1	1434.08	415.83	1463.98
15271		Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4.03	336.51		000	1	324.43	New	
15272		Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.75	62.63		ZZZ	1	110.62	New	
15273		Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	8.07	673.85		000	1	507.49	New	
15274		Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part ther	1.82	151.97		ZZZ	1	324.43	New	
15275		Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4.55	379.93		000	1	324.43	New	
15276		Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separatel	1.01	84.34		ZZZ	1	110.62	New	
15277		Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of	8.81	735.64		000	1	507.49	New	
15278		Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part the	2.19	182.87		ZZZ	1	324.43	New	
15570		Formation of direct or tubed pedicle, with or without transfer; trunk	27.49	2295.42		090	1	1948.12	1788.57	2182.33

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
15572		Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs	26.34	2199.39		090	1	1948.12	1647.46	2182.33
15574		Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	27.37	2285.40		090	1	1948.12	1778.55	2182.33
15576		Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraora	24.34	2032.39		090	1	1948.12	1579.82	2182.33
15600		Delay of flap or sectioning of flap (division and inset); at trunk	9.87	824.15		090	0	1948.12	755.68	2182.33
15610		Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs	10.77	899.30		090	0	1948.12	624.58	2182.33
15620		Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	13.31	1111.39		090	1	1948.12	922.68	2182.33
15630		Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips	13.94	1163.99		090	1	1948.12	912.66	2182.33
15650		Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location	15.25	1273.38		090	0	1948.12	979.46	2182.33
15731		Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)	33.88	2828.98		090	0	1948.12	2180.19	2182.33
15732		Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	38.84	3243.14		090	1	1948.12	3088.67	2182.33
15734		Muscle, myocutaneous, or fasciocutaneous flap; trunk	44.82	3742.47		090	2	1948.12	3160.48	2182.33
15736		Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	39.61	3307.44		090	1	1948.12	2909.98	2182.33
15738		Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	42.06	3512.01		090	2	1948.12	3066.12	2182.33
15740		Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel	30.41	2539.24		090	1	1434.08	1841.18	1463.98
15750		Flap; neurovascular pedicle	27.27	2277.05		090	2	1948.12	1829.49	2182.33
15756		Free muscle or myocutaneous flap with microvascular anastomosis	69.53	5805.76		090	2		4827.14	2097.37**
15757		Free skin flap with microvascular anastomosis	68.64	5731.44		090	2		4808.77	2097.37**
15758		Free fascial flap with microvascular anastomosis	68.56	5724.76		090	2		4814.61	2097.37**
15760		Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area	25.73	2148.46		090	1	1948.12	1641.61	2182.33
15770		Graft; derma-fat-fascia	20.29	1694.22		090	2	1948.12	1300.93	2182.33
15775		Punch graft for hair transplant; 1 to 15 punch grafts	8.64	721.44		000	0	110.62	678.02	123.49
15776		Punch graft for hair transplant; more than 15 punch grafts	14.16	1182.36		000	0	110.62	891.78	123.49
15777		Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)	5.90	492.65		ZZZ	1	1434.08	New	
15780		Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	27.57	2302.10		090	0	2142.94	1662.49	2132.75
15781		Dermabrasion; segmental, face	16.72	1396.12		090	1	433.96	1011.19	397.82
15782		Dermabrasion; regional, other than face	17.12	1429.52		090	0	433.96	1174.01	397.82
15783		Dermabrasion; superficial, any site (eg, tattoo removal)	14.65	1223.28		090	0	270.47	948.56	255.17
15786		Abrasion; single lesion (eg, keratosis, scar)	7.49	625.42		010	1	92.29	452.57	80.15
15787		Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	1.51	126.09		ZZZ	1	92.29	114.40	80.15
15788		Chemical peel, facial; epidermal	14.38	1200.73		090	1	92.29	764.86	80.15
15789		Chemical peel, facial; dermal	16.58	1384.43		090	1	137.98	1085.50	140.54
15792		Chemical peel, nonfacial; epidermal	13.50	1127.25		090	0	137.98	737.31	140.54
15793		Chemical peel, nonfacial; dermal	14.95	1248.33		090	0	92.29	812.46	80.15
15819		Cervicoplasty	21.91	1829.49		090	0	324.43	1457.91	287.32
15820		Blepharoplasty, lower eyelid	17.60	1469.60		090	0	1948.12	1063.79	2182.33
15821		Blepharoplasty, lower eyelid; with extensive herniated fat pad	18.63	1555.61		090	0	1948.12	1139.78	2182.33
15822		Blepharoplasty, upper eyelid;	13.67	1141.45		090	1	1948.12	847.53	2182.33
15823		Blepharoplasty, upper eyelid; with excessive skin weighting down lid	18.80	1569.80		090	1	1948.12	1302.60	2182.33
15824		Rhytidectomy; forehead	33.79	2821.47		000	0	1948.12	1873.07	2182.33
15825		Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap	38.02	3174.67		000	0	1948.12	2107.21	2182.33
15826		Rhytidectomy; glabellar frown lines	27.46	2292.91		000	0	1948.12	1521.87	2182.33
15828		Rhytidectomy; cheek, chin, and neck	71.82	5996.97		000	0	1948.12	3980.28	2182.33
15829		Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	80.26	6701.71		000	0	1948.12	4448.55	2182.33

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
15830		Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	34.92	2915.82		090	2	2142.94	2361.38	2132.75
15832		Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	27.99	2337.17		090	2	2142.94	1786.90	2132.75
15833		Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	26.20	2187.70		090	0	2142.94	1666.66	2132.75
15834		Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	26.71	2230.29		090	0	2142.94	1679.19	2132.75
15835		Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	28.18	2353.03		090	0	2142.94	1731.79	2132.75
15836		Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	23.74	1982.29		090	0	1447.15	1467.10	1595.60
15837		Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	26.67	2226.95		090	0	1447.15	1521.37	1595.60
15838		Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	17.07	1425.35		090	0	1447.15	1138.11	1595.60
15839		Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	26.13	2181.86		090	0	1447.15	1625.75	1595.60
15840		Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	30.41	2539.24		090	1	1948.12	2026.55	2182.33
15841		Graft for facial nerve paralysis; free muscle graft (including obtaining graft)	47.60	3974.60		090	2	1948.12	3360.04	2182.33
15842		Graft for facial nerve paralysis; free muscle flap by microsurgical technique	78.65	6567.28		090	2	1948.12	5354.02	2182.33
15845		Graft for facial nerve paralysis; regional muscle transfer	30.43	2540.91		090	2	1948.12	1890.44	2182.33
15847		Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	14.79	1234.97		YYY	2	2142.94	819.47	2132.75
15850		Removal of sutures under anesthesia (other than local), same surgeon	2.60	217.10		XXX	9	270.47	185.37	255.17
15851		Removal of sutures under anesthesia (other than local), other surgeon	3.00	250.50		000	1	270.47	202.07	255.17
15852		Dressing change (for other than burns) under anesthesia (other than local)	1.37	114.40		000	1	64.04	97.70	61.03
15860		Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	3.30	275.55		000	0	64.04	232.13	61.03
15876		Suction assisted lipectomy; head and neck	0.00	BR		000	0	1948.12	BR	2182.33
15877		Suction assisted lipectomy; trunk	0.00	BR		000	0	1948.12	BR	2182.33
15878		Suction assisted lipectomy; upper extremity	0.00	BR		000	0	1948.12	BR	2182.33
15879		Suction assisted lipectomy; lower extremity	0.00	BR		000	0	1948.12	BR	2182.33
15920		Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture	18.21	1520.54		090	0	433.96	1169.00	397.82
15922		Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure	23.50	1962.25		090	2	1948.12	1487.14	2182.33
15931		Excision, sacral pressure ulcer, with primary suture;	20.31	1695.89		090	1	2142.94	1324.31	2132.75
15933		Excision, sacral pressure ulcer, with primary suture; with ostectomy	25.38	2119.23		090	0	2142.94	1644.12	2132.75
15934		Excision, sacral pressure ulcer, with skin flap closure;	27.53	2298.76		090	1	1948.12	1831.16	2182.33
15935		Excision, sacral pressure ulcer, with skin flap closure; with ostectomy	32.99	2754.67		090	2	1948.12	2207.74	2182.33
15936		Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	26.69	2228.62		090	1	1434.08	1801.10	1463.98
15937		Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy	31.03	2591.01		090	1	1948.12	2105.04	2182.33
15940		Excision, ischial pressure ulcer, with primary suture;	20.76	1733.46		090	1	2142.94	1378.59	2132.75
15941		Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy	27.20	2271.20		090	0	2142.94	1830.32	2132.75
15944		Excision, ischial pressure ulcer, with skin flap closure;	27.03	2257.01		090	0	1948.12	1774.38	2182.33
15945		Excision, ischial pressure ulcer, with skin flap closure; with ostectomy	29.63	2474.11		090	0	1948.12	1972.27	2182.33
15946		Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure	48.88	4081.48		090	1	1948.12	3249.82	2182.33
15950		Excision, trochanteric pressure ulcer, with primary suture	17.46	1457.91		090	1	2142.94	1133.10	2132.75
15951		Excision, trochanteric pressure ulcer, with primary suture; with ostectomy	23.85	1991.48		090	0	2142.94	1642.45	2132.75
15952		Excision, trochanteric pressure ulcer, with skin flap closure;	27.37	2285.40		090	2	1434.08	1695.89	1463.98
15953		Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy	29.90	2496.65		090	1	1434.08	1912.15	1463.98
15956		Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	34.50	2880.75		090	1	1434.08	2310.45	1463.98
15958		Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy	35.17	2936.70		090	1	1434.08	2342.18	1463.98
15999		Unlisted procedure, excision pressure ulcer	0.00	BR		YYY	0	433.96	BR	397.82

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
16000		Initial treatment, first degree burn, when no more than local treatment is required	2.05	171.18		000	1	92.29	142.79	80.15
16020		Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	2.45	204.58		000	1	137.98	171.18	140.54
16025		Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	4.41	368.24		000	1	137.98	298.10	140.54
16030		Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)	5.50	459.25		000	1	137.98	353.21	140.54
16035		Escharotomy; initial incision	5.87	490.15		000	1	137.98	445.06	140.54
16036		Escharotomy; each additional incision (List separately in addition to code for primary procedure	2.38	198.73		ZZZ	1		177.02	2097.37**
17000		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	2.45	204.58		010	1	92.29	139.45	80.15
17003		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	0.20	16.70		ZZZ	1	36.63	15.03	40.45
17004		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	5.08	424.18		010	1	270.47	340.68	255.17
17106		Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	10.09	842.52		090	1	270.47	763.19	255.17
17107		Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	13.13	1096.36		090	1	270.47	1347.69	255.17
17108		Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	19.15	1599.03		090	0	270.47	1817.80	255.17
17110		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	3.36	280.56		010	1	92.29	192.89	80.15
17111		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	3.98	332.33		010	1	137.98	227.96	140.54
17250		Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)	2.42	202.07		000	1	137.98	146.96	140.54
17260		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less	2.82	235.47		010	1	137.98	183.70	140.54
17261		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	4.34	362.39		010	1	137.98	247.16	140.54
17262		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	5.26	439.21		010	1	137.98	303.11	140.54
17263		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm	5.74	479.29		010	1	137.98	334.84	140.54
17264		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm	6.16	514.36		010	1	137.98	361.56	140.54
17266		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm	6.96	581.16		010	1	270.47	415.83	255.17
17270		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	4.54	379.09		010	1	137.98	263.03	140.54
17271		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	4.92	410.82		010	1	137.98	285.57	140.54
17272		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	5.59	466.77		010	1	137.98	327.32	140.54
17273		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm	6.23	520.21		010	1	270.47	367.40	255.17
17274		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm	7.34	612.89		010	1	270.47	441.72	255.17
17276		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm	8.50	709.75		010	1	270.47	521.88	255.17

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
17280		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	4.25	354.88		010	1	137.98	243.82	140.54
17281		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	5.34	445.89		010	1	270.47	313.13	255.17
17282		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	6.12	511.02		010	1	270.47	362.39	255.17
17283		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm	7.31	610.39		010	1	270.47	443.39	255.17
17284		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm	8.31	693.89		010	1	270.47	521.04	255.17
17286		Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm	10.75	897.63		010	1	270.47	676.35	255.17
17311		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	19.53	1630.76		000	1	474.58	1386.94	449.90
17312		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	11.69	976.12		ZZZ	1	474.58	836.67	449.90
17313		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	17.82	1487.97		000	1	474.58	1266.70	449.90
17314		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	10.84	905.14		ZZZ	1	474.58	774.88	449.90
17315		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	2.32	193.72		ZZZ	1	474.58	163.66	449.90
17340		Cryotherapy (CO2 slush, liquid N2) for acne	1.52	126.92		010	1	92.29	91.02	80.15
17360		Chemical exfoliation for acne (eg, acne paste, acid)	3.87	323.15		010	1	137.98	242.15	80.15
17380		Electrolysis epilation, each 30 minutes	2.23	186.21		000	0	137.98	99.53	80.15
17999		Unlisted procedure, skin, mucous membrane and subcutaneous tissue	0.00	BR		YYY	0	36.63	BR	40.45
19000		Puncture aspiration of cyst of breast;	3.35	279.73		000	1	445.75	232.13	419.39
19001		Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure)	0.78	65.13		ZZZ	1	158.18	55.95	137.80
19020		Mastotomy with exploration or drainage of abscess, deep	14.38	1200.73		090	1	1701.78	851.70	1769.66
19030		Injection procedure only for mammary ductogram or galactogram	4.77	398.30		000	1		353.21	
19100		Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure	4.57	381.60		000	1	445.75	281.40	419.39
19101		Biopsy of breast; open, incisional	10.33	862.56		010	1	2403.13	644.62	2257.10
19102		Biopsy of breast; percutaneous, needle core, using imaging guidance	6.39	533.57		000	1	806.61	469.27	712.60
19103		Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	16.62	1387.77		000	1	1443.01	1221.61	1413.47
19105		Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	59.52	4969.92		000	1	3172.31	4137.43	3115.54
19110		Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct	14.81	1236.64		090	1	2403.13	869.24	2257.10

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
19112		Excision of lactiferous duct fistula	14.09	1176.52		090	0	2403.13	829.16	2257.10
19120		Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions	14.74	1230.79		090	1	2403.13	889.28	2257.10
19125		Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	16.36	1366.06		090	1	2403.13	976.95	2257.10
19126		Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure)	4.72	394.12		ZZZ	1	2403.13	330.66	2257.10
19260		Excision of chest wall tumor including ribs	36.23	3025.21		090	2	1447.15	2413.15	1595.60
19271		Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy	48.91	4083.99		090	2		3316.62	2097.37**
19272		Excision of chest wall tumor involving ribs, with plastic reconstruction; with mediastinal lymphadenectomy	54.10	4517.35		090	2		3654.80	2097.37**
19290		Preoperative placement of needle localization wire, breast	4.70	392.45		000	1	64.04	335.67	
19291		Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)	2.01	167.84		ZZZ	1		148.63	
19295		Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	2.81	234.64		ZZZ	0	64.04	215.43	
19296		Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	126.89	10595.32		000	0	5885.38	9898.09	5309.79
19297		Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in a	2.75	229.63		ZZZ	0	5885.38	193.72	5309.79
19298		Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance	34.37	2869.90		000	0	5885.38	3608.87	5309.79
19300		Mastectomy for gynecomastia	15.68	1309.28		090	1	2403.13	1061.29	2257.10
19301		Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)	19.26	1608.21		090	0	2403.13	808.28	2257.10
19302		Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	26.54	2216.09		090	2	4174.67	1717.60	3829.95
19303		Mastectomy, simple, complete	29.82	2489.97		090	2	3172.31	1735.97	3115.54
19304		Mastectomy, subcutaneous	17.11	1428.69		090	2	3172.31	1073.81	3115.54
19305		Mastectomy, radical, including pectoral muscles, axillary lymph nodes	33.40	2788.90		090	2		2124.24	2097.37**
19306		Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	35.52	2965.92		090	2		2209.41	2097.37**
19307		Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	35.37	2953.40		090	2	4174.67	2221.94	3829.95
19316		Mastopexy	22.96	1917.16		090	2	3172.31	1584.00	3115.54
19318		Reduction mammaplasty	33.12	2765.52		090	2	4174.67	2353.03	3829.95
19324		Mammaplasty, augmentation; without prosthetic implant	14.61	1219.94		090	0	4174.67	973.61	3829.95
19325		Mammaplasty, augmentation; with prosthetic implant	19.40	1619.90		090	0	5885.38	1297.59	5309.79
19328		Removal of intact mammary implant	14.90	1244.15		090	1	3172.31	974.45	3115.54
19330		Removal of mammary implant material	19.01	1587.34		090	1	3172.31	1245.82	3115.54
19340		Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	30.16	2518.36		090	1	4174.67	819.14	3829.95
19342		Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	27.74	2316.29		090	0	5885.38	1836.17	5309.79
19350		Nipple/areola reconstruction	24.85	2074.98		090	1	2403.13	1870.40	2257.10
19355		Correction of inverted nipples	21.03	1756.01		090	0	3172.31	1511.35	3115.54
19357		Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	45.49	3798.42		090	2	5885.38	3100.36	5309.79

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
19361		Breast reconstruction with latissimus dorsi flap, without prosthetic implan	47.33	3952.06		090	2		3124.57	2097.37**
19364		Breast reconstruction with free flap	82.52	6890.42		090	2		5671.32	2097.37**
19366		Breast reconstruction with other technique	41.47	3462.75		090	2	3172.31	2841.51	3115.54
19367		Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	53.68	4482.28		090	2		3709.07	2097.37**
19368		Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	66.01	5511.84		090	2		4564.11	2097.37**
19369		Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	61.27	5116.05		090	2		4200.89	2097.37**
19370		Open periprosthetic capsulotomy, breast	20.62	1721.77		090	1	3172.31	1361.89	3115.54
19371		Periprosthetic capsulectomy, breast	23.59	1969.77		090	1	3172.31	1573.14	3115.54
19380		Revision of reconstructed breast	23.25	1941.38		090	1	4174.67	1533.06	3829.95
19396		Preparation of moulage for custom breast implant	8.94	746.49		000	0	3172.31	350.70	3115.54
19499		Unlisted procedure, breast	0.00	BR		YYY	0	2403.13	BR	2257.10
20005		Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)	9.31	777.39		010	1	752.91	600.37	2007.54
20100		Exploration of penetrating wound (separate procedure); neck	17.75	1482.13		010	2	643.20	1232.46	694.83
20101		Exploration of penetrating wound (separate procedure); ches	13.91	1161.49		010	1	1948.12	782.40	2182.33
20102		Exploration of penetrating wound (separate procedure); abdomen/flank/back	14.94	1247.49		010	1	1948.12	948.56	2182.33
20103		Exploration of penetrating wound (separate procedure); extremity	17.63	1472.11		010	0	936.06	1159.82	1150.97
20150		Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	29.87	2494.15		090	2	4434.79	1870.40	4247.50
20200		Biopsy, muscle; superficial	6.29	525.22		000	1	1447.15	384.10	1595.60
20205		Biopsy, muscle; deep	8.78	733.13		000	1	1447.15	526.89	1595.60
20206		Biopsy, muscle, percutaneous needle	7.07	590.35		000	1	806.61	591.18	712.60
20220		Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	5.00	417.50		000	1	752.91	441.72	748.01
20225		Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur	16.07	1341.85		000	1	1447.15	1953.07	1595.60
20240		Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)	6.60	551.10		010	1	2142.94	484.30	2132.75
20245		Biopsy, bone, open; deep (eg, humerus, ischium, femur)	18.57	1550.60		010	1	2142.94	1300.93	2132.75
20250		Biopsy, vertebral body, open; thoracic	11.56	965.26		010	1	2975.93	769.87	2007.54
20251		Biopsy, vertebral body, open; lumbar or cervica	12.46	1040.41		010	2	2975.93	865.90	2007.54
20500		Injection of sinus tract; therapeutic (separate procedure)	3.15	263.03		010	1	643.20	271.38	694.83
20501		Injection of sinus tract; diagnostic (sinogram)	3.48	290.58		000	1		288.91	
20520		Removal of foreign body in muscle or tendon sheath; simple	6.12	511.02		010	1	433.96	394.12	397.82
20525		Removal of foreign body in muscle or tendon sheath; deep or complicated	14.67	1224.95		010	1	2142.94	1026.22	2132.75
20526		Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunne	2.25	213.75		000	1	235.58	181.45	233.06
20527		Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture	2.25	187.88		000	1	235.58	New	
20550		Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar fascia)	1.72	143.62		000	1	235.58	121.08	233.06
20551		Injection(s); single tendon origin/insertion	1.78	148.63		000	1	235.58	118.57	233.06
20552		Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	1.64	136.94		000	1	235.58	111.06	233.06
20553		Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	1.91	159.49		000	1	235.58	124.42	233.06
20555		Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)	9.75	814.13		000	0	2975.93	662.76	2897.26
20600		Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	1.39	116.07		000	1	235.58	111.06	233.06
20605		Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	1.93	183.35		000	1	235.58	137.75	233.06
20610		Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	1.78	169.10		000	1	235.58	171.00	233.06
20612		Aspiration and/or injection of ganglion cyst(s) any locatior	1.79	149.47		000	1	235.58	120.24	233.06
20615		Aspiration and injection for treatment of bone cyst	7.27	607.05		010	1	445.75	465.93	419.39

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
20650		Insertion of wire or pin with application of skeletal traction, including removal (separate procedure	6.16	514.36		010	1	2975.93	394.96	2007.54
20660		Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	7.15	597.03		000	1	514.57	500.17	437.22
20661		Application of halo, including removal; cranial	15.21	1270.04		090	1		914.33	2097.37**
20662		Application of halo, including removal; pelvic	12.59	1051.27		090	0	2006.48	964.43	2007.54
20663		Application of halo, including removal; femoral	13.99	1168.17		090	0	2975.93	910.99	2007.54
20664		Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)	26.09	2178.52		090	1		1498.83	2097.37**
20665		Removal of tongs or halo applied by another individua	3.06	255.51		010	0	64.04	281.40	61.03
20670		Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	11.72	978.62		010	1	1447.15	1017.03	1595.60
20680		Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate	18.79	1568.97		090	0	2142.94	1210.75	2132.75
20690		Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation systen	17.51	1462.09		090	1	2975.93	530.23	2897.26
20692		Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	33.18	2770.53		090	2	2975.93	873.41	2897.26
20693		Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	13.55	1131.43		090	1	2975.93	966.10	2007.54
20694		Removal, under anesthesia, of external fixation system	12.76	1065.46		090	1	2006.48	933.53	2007.54
20696		Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of	34.06	2844.01		090	2	2975.93	2257.01	2897.26
20697		Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	64.56	5390.76		000	2	1077.75	2929.18	1677.55
20802		Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputatior	67.89	5668.82		090	2		5324.80	2097.37**
20805		Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputatior	90.82	7583.47		090	2		6939.69	2097.37**
20808		Replantation, hand (includes hand through metacarpophalangeal joints), complete amputatior	107.21	8952.04		090	2		8762.49	2097.37**
20816		Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	58.66	4898.11		090	2		5642.93	2097.37**
20822		Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	54.14	4520.69		090	2	2665.47	4970.76	2574.99
20824		Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputatior	63.33	5288.06		090	2		5599.51	2097.37**
20827		Replantation, thumb (includes distal tip to MP joint), complete amputatior	55.63	4645.11		090	2		5139.43	2097.37**
20838		Replantation, foot, complete amputation	76.94	6424.49		090	2		4967.42	2097.37**
20900		Bone graft, any donor area; minor or small (eg, dowel or button)	12.83	1071.31		000	2	2975.93	1234.13	2897.26
20902		Bone graft, any donor area; major or large	9.09	759.02		000	2	2975.93	1261.69	2897.26
20910		Cartilage graft; costochondral	13.48	1125.58		090	0	1948.12	888.44	2182.33
20912		Cartilage graft; nasal septum	14.45	1206.58		090	0	1948.12	1001.17	2182.33
20920		Fascia lata graft; by stripper	11.83	987.81		090	1	1434.08	818.30	1463.98
20922		Fascia lata graft; by incision and area exposure, complex or shee	18.37	1533.90		090	2	1434.08	1202.40	1463.98
20924		Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	15.05	1256.68		090	2	2975.93	1055.44	2897.26
20926		Tissue grafts, other (eg, paratenon, fat, dermis)	13.16	1098.86		090	1	1434.08	890.95	404.76
20930		Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in additior to code for primary procedure)	3.54	295.59		XXX	9		269.29	2097.37**
20931		Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure	3.30	313.50		ZZZ	1		291.65	2097.37**
20936		Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)	3.70	308.95		XXX	9		409.73	2097.37**
20937		Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	4.93	411.66		ZZZ	2		369.07	2097.37**
20938		Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	5.42	452.57		ZZZ	2		403.31	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
20950		Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome	7.81	652.14		000	0	161.85	626.25	132.75
20955		Bone graft with microvascular anastomosis; fibula	74.50	6220.75		090	2		5320.62	2097.37**
20956		Bone graft with microvascular anastomosis; iliac crest	78.23	6532.21		090	2		5647.11	2097.37**
20957		Bone graft with microvascular anastomosis; metatarsal	66.95	5590.33		090	2		5365.71	2097.37**
20962		Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsa	64.38	5375.73		090	2		5602.85	2097.37**
20969		Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	82.90	6922.15		090	2		5890.09	2097.37**
20970		Free osteocutaneous flap with microvascular anastomosis; iliac crest	81.21	6781.04		090	2		5895.10	2097.37**
20972		Free osteocutaneous flap with microvascular anastomosis; metatarsa	64.21	5361.54		090	2	5583.26	5423.33	4789.83
20973		Free osteocutaneous flap with microvascular anastomosis; great toe with web space	83.20	6947.20		090	2	5583.26	5883.41	4789.83
20974		Electrical stimulation to aid bone healing; noninvasive (nonoperative)	2.30	192.05		000	1		120.24	
20975		Electrical stimulation to aid bone healing; invasive (operative)	5.24	437.54		000	2		376.59	
20979		Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative	1.57	131.10		000	1	64.04	116.90	61.03
20982		Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	106.52	8894.42		000	1	4434.79	9100.67	4247.50
20985		Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	4.33	361.56		ZZZ	0		308.28	
20999		Unlisted procedure, musculoskeletal system, general	0.00	BR		YYY	0	2006.48	BR	2007.54
21010		Arthrotomy, temporomandibular joint	22.71	1896.29		090	0	4230.05	1479.62	2276.44
21011		Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	10.52	878.42		090	2	752.91	708.92	748.01
21012		Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	10.02	836.67		090	2	752.91	759.02	748.01
21013		Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	15.61	1303.44		090	2	752.91	1100.53	748.01
21014		Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	15.48	1292.58		090	2	752.91	1171.51	748.01
21015		Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	21.14	1765.19		090	1	1447.15	883.43	1595.60
21016		Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater	30.76	2568.46		090	2	2142.94	2354.70	2132.75
21025		Excision of bone (eg, for osteomyelitis or bone abscess); mandible	26.70	2229.45		090	1	4230.05	1970.60	3919.59
21026		Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	18.75	1565.63		090	1	2321.87	1140.61	3919.59
21029		Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	23.55	1966.43		090	0	2321.87	1480.46	3919.59
21030		Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	15.70	1310.95		090	1	2321.87	952.74	2276.44
21031		Excision of torus mandibularis	11.84	988.64		090	1	2321.87	733.13	2276.44
21032		Excision of maxillary torus palatinus	12.09	1009.52		090	1	2321.87	746.49	2276.44
21034		Excision of malignant tumor of maxilla or zygoma	39.68	3313.28		090	2	4230.05	2707.91	3919.59
21040		Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	15.79	1318.47		090	1	2321.87	957.75	2276.44
21044		Excision of malignant tumor of mandible;	26.41	2205.24		090	2	2321.87	1786.07	3919.59
21045		Excision of malignant tumor of mandible; radical resection	36.51	3048.59		090	2		2474.94	2097.37**
21046		Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	33.09	2763.02		090	0	4230.05	2194.38	3919.59
21047		Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion[s])	38.63	3225.61		090	2	4230.05	2716.26	3919.59
21048		Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	33.95	2834.83		090	0	4230.05	2233.63	3919.59
21049		Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion[s])	36.25	3026.88		090	2	4230.05	2574.31	3919.59
21050		Condylectomy, temporomandibular joint (separate procedure)	25.96	2167.66		090	0	4230.05	1753.50	3919.59
21060		Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	24.64	2057.44		090	2	4230.05	1632.43	3919.59
21070		Coronoidectomy (separate procedure)	19.14	1598.19		090	0	4230.05	1318.47	3919.59

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
21073		Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	11.81	986.14		090	0	2321.87	744.24	694.83
21076		Impression and custom preparation; surgical obturator prosthesis	29.48	2461.58		010	0	2321.87	2113.39	2276.44
21077		Impression and custom preparation; orbital prosthesis	73.95	6174.83		090	0	4230.05	5265.51	3919.59
21079		Impression and custom preparation; interim obturator prosthesis	49.95	4170.83		090	1	4230.05	3576.31	3919.59
21080		Impression and custom preparation; definitive obturator prosthesis	56.08	4682.68		090	1	4230.05	4064.78	3919.59
21081		Impression and custom preparation; mandibular resection prosthesis	51.73	4319.46		090	0	4230.05	3690.70	3919.59
21082		Impression and custom preparation; palatal augmentation prosthesis	49.14	4103.19		090	0	4230.05	3350.02	3919.59
21083		Impression and custom preparation; palatal lift prosthesis	45.82	3825.97		090	0	4230.05	3173.84	3919.59
21084		Impression and custom preparation; speech aid prosthesis	53.49	4466.42		090	0	4230.05	3618.06	3919.59
21085		Impression and custom preparation; oral surgical splint	24.86	2075.81		010	0	643.20	1444.55	1567.36
21086		Impression and custom preparation; auricular prosthesis	55.11	4601.69		090	0	4230.05	3936.19	3919.59
21087		Impression and custom preparation; nasal prosthesis	54.57	4556.60		090	0	4230.05	3889.43	3919.59
21088		Impression and custom preparation; facial prosthesis	0.00	BR		090	0	4230.05	BR	3919.59
21089		Unlisted maxillofacial prosthetic procedure	0.00	BR		YYY	1	100.74	BR	105.07
21100		Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure	18.33	1530.56		090	0	4230.05	1380.26	3919.59
21110		Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	24.40	2037.40		090	1	643.20	1371.91	694.83
21116		Injection procedure for temporomandibular joint arthrography	4.60	384.10		000	1		386.61	
21120		Genioplasty; augmentation (autograft, allograft, prosthetic material)	19.02	1588.17		090	1	4230.05	1298.43	2276.44
21121		Genioplasty; sliding osteotomy, single piece	23.18	1935.53		090	2	2321.87	1485.47	2276.44
21122		Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	20.93	1747.66		090	2	2321.87	1436.20	2276.44
21123		Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts	26.08	2177.68		090	2	2321.87	1847.86	2276.44
21125		Augmentation, mandibular body or angle; prosthetic materia	105.85	8838.48		090	2	2321.87	5757.33	2276.44
21127		Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	119.73	9997.46		090	2	4230.05	5547.74	3919.59
21137		Reduction forehead; contouring only	20.86	1741.81		090	2	2321.87	1488.81	2276.44
21138		Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	24.80	2070.80		090	2	4230.05	1883.76	3919.59
21139		Reduction forehead; contouring and setback of anterior frontal sinus wal	29.39	2454.07		090	2	4230.05	2087.50	3919.59
21141		Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	40.57	3387.60		090	2		2742.98	2097.37**
21142		Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graf	41.70	3481.95		090	2		2725.44	2097.37**
21143		Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	44.13	3684.86		090	2		2776.38	2097.37**
21145		Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	44.52	3717.42		090	2		3149.62	2097.37**
21146		Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	47.94	4002.99		090	2		3253.16	2097.37**
21147		Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	51.48	4298.58		090	2		3347.52	2097.37**
21150		Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	45.38	3789.23		090	2	4230.05	3471.93	3919.59
21151		Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	55.36	4622.56		090	2		4038.06	2097.37**
21154		Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	59.49	4967.42		090	2		4443.04	2097.37**
21155		Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	63.88	5333.98		090	2		4956.56	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
21159		Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	76.18	6361.03		090	2		6042.90	2097.37**
21160		Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	77.12	6439.52		090	2		6096.34	2097.37**
21172		Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	55.57	4640.10		090	2	4230.05	3556.27	3919.59
21175		Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	71.87	6001.15		090	2	4230.05	4304.43	3919.59
21179		Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	42.16	3520.36		090	2		3044.41	2097.37**
21180		Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	45.48	3797.58		090	2		3433.52	2097.37**
21181		Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracrania	19.83	1655.81		090	0	4230.05	1490.48	2276.44
21182		Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less	62.63	5229.61		090	2		4169.16	2097.37**
21183		Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting grea	70.69	5902.62		090	2		4675.17	2097.37**
21184		Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting grea	65.19	5443.37		090	2		5189.53	2097.37**
21188		Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	47.04	3927.84		090	2		3360.88	2097.37**
21193		Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graf	37.11	3098.69		090	2	4230.05	2586.83	2097.37**
21194		Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	40.65	3394.28		090	2		2887.43	2097.37**
21195		Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixatior	40.04	3343.34		090	2	2321.87	2763.85	3919.59
21196		Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixatior	43.97	3671.50		090	2		2979.28	2097.37**
21198		Osteotomy, mandible, segmental;	34.72	2899.12		090	2	2321.87	2312.12	3919.59
21199		Osteotomy, mandible, segmental; with genioglossus advancemen	29.91	2497.49		090	2	4230.05	2079.99	3919.59
21206		Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	37.72	3149.62		090	2	4230.05	2290.41	3919.59
21208		Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	58.97	4924.00		090	0	4230.05	3003.50	3919.59
21209		Osteoplasty, facial bones; reduction	25.47	2126.75		090	2	4230.05	1579.82	3919.59
21210		Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	70.30	5870.05		090	1	4230.05	3434.36	3919.59
21215		Graft, bone; mandible (includes obtaining graft)	126.03	10523.51		090	1	4230.05	5445.87	3919.59
21230		Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	21.97	1834.50		090	0	2321.87	1587.34	3919.59
21235		Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	22.18	1852.03		090	1	1480.23	1422.01	2276.44
21240		Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft	32.78	2737.13		090	2	4230.05	2327.98	3919.59
21242		Arthroplasty, temporomandibular joint, with allograf	29.98	2503.33		090	2	4230.05	2132.59	3919.59
21243		Arthroplasty, temporomandibular joint, with prosthetic joint replacemen	49.62	4143.27		090	2	4230.05	3464.42	3919.59
21244		Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	32.08	2678.68		090	2	4230.05	2095.85	3919.59
21245		Reconstruction of mandible or maxilla, subperiosteal implant; partia	33.71	2814.79		090	2	4230.05	2249.49	3919.59
21246		Reconstruction of mandible or maxilla, subperiosteal implant; complete	24.49	2044.92		090	2	4230.05	1780.22	3919.59
21247		Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	47.23	3943.71		090	2		3382.59	2097.37**
21248		Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partia	33.10	2763.85		090	1	4230.05	2095.02	3919.59
21249		Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	45.08	3764.18		090	0	4230.05	2988.47	3919.59

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
21255		Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	39.76	3319.96		090	2		2854.87	2097.37**
21256		Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	36.62	3057.77		090	2	4230.05	2382.26	3919.59
21260		Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	36.82	3074.47		090	2	4230.05	2408.98	3919.59
21261		Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	64.45	5381.58		090	2	4230.05	4647.61	3919.59
21263		Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancemen	55.63	4645.11		090	2	4230.05	4013.01	3919.59
21267		Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	49.92	4168.32		090	2	4230.05	3257.34	3919.59
21268		Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	53.24	4445.54		090	2		3917.82	2097.37**
21270		Malar augmentation, prosthetic material	29.50	2463.25		090	2	4230.05	1814.46	3919.59
21275		Secondary revision of orbitocraniofacial reconstructior	25.21	2105.04		090	2	4230.05	1652.47	3919.59
21280		Medial canthopexy (separate procedure)	17.71	1478.79		090	0	4230.05	1048.76	3919.59
21282		Lateral canthopexy	11.72	978.62		090	1	1480.23	701.40	1567.36
21295		Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach	5.93	495.16		090	0	643.20	363.23	694.83
21296		Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	13.35	1114.73		090	0	2321.87	801.60	2276.44
21299		Unlisted craniofacial and maxillofacial procedure	0.00	BR		YYY	0	100.74	BR	105.07
21310		Closed treatment of nasal bone fracture without manipulatior	4.10	342.35		000	1	100.74	231.30	105.07
21315		Closed treatment of nasal bone fracture; without stabilizatior	8.67	723.95		010	1	1480.23	503.51	1567.36
21320		Closed treatment of nasal bone fracture; with stabilizatior	7.92	661.32		010	1	1480.23	484.30	1567.36
21325		Open treatment of nasal fracture; uncomplicated	14.26	1190.71		090	0	2321.87	1012.86	2276.44
21330		Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixatior	17.14	1431.19		090	0	2321.87	1238.31	2276.44
21335		Open treatment of nasal fracture; with concomitant open treatment of fractured septun	21.91	1829.49		090	1	2321.87	1497.16	2276.44
21336		Open treatment of nasal septal fracture, with or without stabilizatior	19.60	1636.60		090	0	2462.57	1312.62	2356.77
21337		Closed treatment of nasal septal fracture, with or without stabilizatior	12.45	1039.58		090	0	1480.23	774.88	1567.36
21338		Open treatment of nasoethmoid fracture; without external fixatior	22.88	1910.48		090	0	4230.05	1657.48	2276.44
21339		Open treatment of nasoethmoid fracture; with external fixatior	25.83	2156.81		090	2	2321.87	1806.94	2276.44
21340		Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	24.54	2049.09		090	0	4230.05	1623.24	3919.59
21343		Open treatment of depressed frontal sinus fracture	36.85	3076.98		090	2		2415.66	2097.37**
21344		Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	46.43	3876.91		090	2		3120.40	2097.37**
21345		Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	25.31	2113.39		090	0	2321.87	1563.12	2276.44
21346		Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixatior	27.47	2293.75		090	1	4230.05	1939.71	2097.37**
21347		Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	33.36	2785.56		090	2		2385.60	2097.37**
21348		Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	35.19	2938.37		090	2		2338.84	2097.37**
21355		Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	13.12	1095.52		010	0	4230.05	860.89	3919.59
21356		Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)	15.24	1272.54		010	0	2321.87	980.29	2276.44
21360		Open treatment of depressed malar fracture, including zygomatic arch and malar tripoc	15.95	1331.83		090	2	4230.05	1072.98	2276.44
21365		Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	33.23	2774.71		090	2	4230.05	2251.16	3919.59

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
21366		Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	38.38	3204.73		090	2		2520.87	2097.37**
21385		Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation	20.53	1714.26		090	2	4230.05	1456.24	3919.59
21386		Open treatment of orbital floor blowout fracture; periorbital approach	21.00	1753.50		090	2	4230.05	1356.88	3919.59
21387		Open treatment of orbital floor blowout fracture; combined approach	22.08	1843.68		090	2	4230.05	1555.61	3919.59
21390		Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant	24.15	2016.53		090	2	4230.05	1544.75	3919.59
21395		Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	29.34	2449.89		090	2	4230.05	1949.73	2097.37**
21400		Closed treatment of fracture of orbit, except blowout; without manipulation	5.94	495.99		090	0	643.20	341.52	694.83
21401		Closed treatment of fracture of orbit, except blowout; with manipulation	14.32	1195.72		090	2	643.20	951.07	1567.36
21406		Open treatment of fracture of orbit, except blowout; without implan	16.81	1403.64		090	2	4230.05	1098.03	3919.59
21407		Open treatment of fracture of orbit, except blowout; with implan	19.65	1640.78		090	2	4230.05	1301.77	3919.59
21408		Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft	26.69	2228.62		090	2	4230.05	1796.92	3919.59
21421		Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	24.63	2056.61		090	0	4230.05	1334.33	2276.44
21422		Open treatment of palatal or maxillary fracture (LeFort I type)	19.93	1664.16		090	2		1379.42	2097.37**
21423		Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	24.92	2080.82		090	2		1648.29	2097.37**
21431		Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	22.42	1872.07		090	2		1432.03	2097.37**
21432		Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixatio	21.59	1802.77		090	2		1381.93	2097.37**
21433		Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	52.35	4371.23		090	2		3484.46	2097.37**
21435		Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	40.92	3416.82		090	2		2689.54	2097.37**
21436		Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	53.21	4443.04		090	2		3955.40	2097.37**
21440		Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	17.88	1492.98		090	0	2321.87	937.71	2276.44
21445		Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	23.33	1948.06		090	2	2321.87	1390.28	2276.44
21450		Closed treatment of mandibular fracture; without manipulation	18.91	1578.99		090	0	296.47	972.78	312.33
21451		Closed treatment of mandibular fracture; with manipulation	23.22	1938.87		090	0	1480.23	1318.47	694.83
21452		Percutaneous treatment of mandibular fracture, with external fixatior	17.36	1449.56		090	0	1480.23	1255.01	1567.36
21453		Closed treatment of mandibular fracture with interdental fixatior	28.03	2340.51		090	0	4230.05	1523.88	3919.59
21454		Open treatment of mandibular fracture with external fixatior	16.21	1353.54		090	0	4230.05	1119.74	2276.44
21461		Open treatment of mandibular fracture; without interdental fixatior	66.33	5538.56		090	1	4230.05	3154.63	3919.59
21462		Open treatment of mandibular fracture; with interdental fixatior	69.71	5820.79		090	2	4230.05	3528.71	3919.59
21465		Open treatment of mandibular condylar fracture	28.13	2348.86		090	2	4230.05	1882.09	3919.59
21470		Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	36.04	3009.34		090	2	4230.05	2426.51	3919.59
21480		Closed treatment of temporomandibular dislocation; initial or subsequen	3.01	251.34		000	1	100.74	192.89	105.07
21485		Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	21.42	1788.57		090	0	2321.87	1155.64	1567.36
21490		Open treatment of temporomandibular dislocation	27.77	2318.80		090	2	4230.05	1892.11	3919.59
21495		Open treatment of hyoid fracture	21.78	1818.63		090	2	1480.23	1259.18	1567.36
21497		Interdental wiring, for condition other than fracture	22.85	1907.98		090	0	643.20	1154.81	1567.36
21499		Unlisted musculoskeletal procedure, head	0.00	BR		YYY	0	100.74	BR	105.07
21501		Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax	13.91	1161.49		090	1	1701.78	861.72	1769.66
21502		Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy	15.01	1253.34		090	2	2006.48	1091.35	2007.54

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21510		Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thora	13.37	1116.40		090	0		975.28	2097.37**
21550		Biopsy, soft tissue of neck or thorax	7.95	663.83		010	1	1447.15	482.63	1595.60
21552		Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greate	13.27	1108.05		090	2	2142.94	1013.69	2132.75
21554		Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	21.64	1806.94		090	2	2142.94	1663.32	2132.75
21555		Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	12.66	1057.11		090	1	1447.15	842.52	1595.60
21556		Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	15.93	1330.16		090	1	2142.94	817.47	2132.75
21557		Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm	28.56	2384.76		090	2	1447.15	1187.37	1595.60
21558		Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater	39.75	3319.13		090	2	2142.94	3122.90	2132.75
21600		Excision of rib, partial	16.93	1413.66		090	2	2975.93	1098.86	2897.26
21610		Costotransversectomy (separate procedure)	33.74	2817.29		090	2	2975.93	2166.83	2897.26
21615		Excision first and/or cervical rib;	19.14	1598.19		090	2		1427.85	2097.37**
21616		Excision first and/or cervical rib; with sympathectomy	25.02	2089.17		090	2		1749.33	2097.37**
21620		Ostectomy of sternum, partial	15.34	1280.89		090	2		1095.52	2097.37**
21627		Sternal debridement	16.40	1369.40		090	2		1137.27	2097.37**
21630		Radical resection of sternum;	36.44	3042.74		090	2		2610.21	2097.37**
21632		Radical resection of sternum; with mediastinal lymphadenectomy	36.45	3043.58		090	2		2583.49	2097.37**
21685		Hyoid myotomy and suspension	29.80	2488.30		090	2	2321.87	1998.16	694.83
21700		Division of scalenus anticus; without resection of cervical rib	11.13	929.36		090	2	2006.48	856.71	2007.54
21705		Division of scalenus anticus; with resection of cervical rib	16.55	1381.93		090	2		1305.11	2097.37**
21720		Division of sternocleidomastoid for torticollis, open operation; without cast applicatior	15.72	1312.62		090	2	2006.48	750.67	2007.54
21725		Division of sternocleidomastoid for torticollis, open operation; with cast applicatior	14.63	1221.61		090	2	161.85	1071.31	132.75
21740		Reconstructive repair of pectus excavatum or carinatum; oper	36.10	3014.35		090	2		2227.78	2097.37**
21742		Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	44.45	3711.58		090	2	4434.79	2224.27	4247.50
21743		Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	58.50	4884.75		090	2	4434.79	2926.68	4247.50
21750		Closure of median sternotomy separation with or without debridement (separate procedure	20.58	1718.43		090	2		1484.63	2097.37**
21800		Closed treatment of rib fracture, uncomplicated, each	3.45	288.08		090	1	172.42	192.89	151.16
21805		Open treatment of rib fracture without fixation, each	8.09	675.52		090	0	2462.57	516.03	2356.77
21810		Treatment of rib fracture requiring external fixation (flail chest)	15.60	1302.60		090	2		1017.87	2097.37**
21820		Closed treatment of sternum fracture	4.31	359.89		090	1	172.42	263.86	151.16
21825		Open treatment of sternum fracture with or without skeletal fixatior	16.42	1371.07		090	2		1181.53	2097.37**
21899		Unlisted procedure, neck or thorax	0.00	BR		YYY	0	100.74	BR	105.07
21920		Biopsy, soft tissue of back or flank; superficial	7.92	661.32		010	1	752.91	465.93	748.01
21925		Biopsy, soft tissue of back or flank; deep	13.54	1130.59		090	1	2142.94	828.32	2132.75
21930		Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	14.33	1196.56		090	1	1447.15	918.50	1595.60
21931		Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	13.99	1168.17		090	2	2142.94	1061.29	2132.75
21932		Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	19.64	1639.94		090	2	1447.15	1523.88	1595.60
21933		Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	21.89	1827.82		090	2	2142.94	1680.02	2132.75
21935		Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm	30.62	2556.77		090	1	1447.15	2369.73	1595.60
21936		Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5 cm or greater	41.72	3483.62		090	2	2142.94	3252.33	2132.75
22010		Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	28.20	2354.70		090	0		1810.28	2097.37**
22015		Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	26.84	2241.14		090	1		1795.25	2097.37**
22100		Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	27.72	2314.62		090	2	4848.92	1629.92	4488.88

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
22101		Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	26.13	2181.86		090	2	4848.92	1629.92	4488.88
22102		Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar	23.97	2001.50		090	2	4848.92	1634.10	4488.88
22103		Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)	4.16	347.36		ZZZ	2	4848.92	306.45	4488.88
22110		Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	32.11	2681.19		090	2		2032.39	2097.37**
22112		Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	31.80	2655.30		090	2		2021.54	2097.37**
22114		Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	29.68	2478.28		090	2		2031.56	2097.37**
22116		Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	4.10	342.35		ZZZ	2		308.12	2097.37**
22206		Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	69.75	5824.13		090	2		4749.36	2097.37**
22207		Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	70.71	5904.29		090	2		4688.88	2097.37**
22208		Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	17.33	1447.06		ZZZ	2		1202.04	2097.37**
22210		Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervica	52.57	4389.60		090	2		3618.06	2097.37**
22212		Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	43.78	3655.63		090	2		2976.78	2097.37**
22214		Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumba	44.00	3674.00		090	2		3016.86	2097.37**
22216		Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)	10.72	895.12		ZZZ	2		806.61	2097.37**
22220		Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervica	48.30	4033.05		090	2		3264.85	2097.37**
22222		Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	42.92	3583.82		090	2	4848.92	3013.52	4488.88
22224		Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumba	47.11	3933.69		090	2		3232.29	2097.37**
22226		Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	10.74	896.79		ZZZ	2		799.10	2097.37**
22305		Closed treatment of vertebral process fracture(s)	5.77	481.80		090	1	172.42	378.26	151.16
22310		Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing	9.14	763.19		090	1	514.57	556.95	437.22
22315		Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing by manipulation or traction	26.39	2203.57		090	1	1077.75	1710.92	1677.55
22318		Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting	48.55	4053.93		090	2		3253.16	2097.37**
22319		Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	54.21	4526.54		090	2		3611.38	2097.37**
22325		Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	42.87	3579.65		090	2		2806.44	2097.37**
22326		Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical	44.23	3693.21		090	2		2970.93	2097.37**
22327		Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	44.20	3690.70		090	2		2906.64	2097.37**

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22328		Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary proce	8.34	696.39		ZZZ	2		603.71	2097.37**
22505		Manipulation of spine requiring anesthesia, any regior	3.65	304.78		010	1	1340.50	251.34	1394.50
22520		Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	68.69	5735.62		010	1	2975.93	5577.80	2897.26
22521		Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	68.76	5741.46		010	1	2975.93	5193.70	2897.26
22522		Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	6.57	548.60		ZZZ	1	2975.93	524.38	2897.26
22523		Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	16.64	1580.80		010	1	7563.12	1491.50	8084.19
22524		Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	15.81	1501.95		010	1	7563.12	1433.55	8084.19
22525		Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumba	7.55	717.25		ZZZ	1	7563.12	581.16	8084.19
22526		Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	0.00	0.00		010	9		4436.36	2097.37**
22527		Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 o more additional levels (List separately in addition to code for primary procedure)	0.00	0.00		ZZZ	9		3607.20	2097.37**
22532		Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	52.96	4422.16		090	2		3520.36	2097.37**
22533		Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	49.75	4154.13		090	2		3244.81	2097.37**
22534		Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	10.70	893.45		ZZZ	2		793.25	2097.37**
22548		Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	58.26	4864.71		090	2		3795.08	2097.37**
22551		Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	50.95	7730.18		090	2	4848.92	0.00	
22552		Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	11.63	2214.83		ZZZ	2		0.00	
22554		Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	37.80	3591.00		090	2	4848.92	3255.65	2097.37**
22556		Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	49.43	4127.41		090	2		3400.96	2097.37**
22558		Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	45.75	4346.25		090	2		3515.00	2097.37**
22585		Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	9.88	938.60		ZZZ	2		883.50	2097.37**
22586		Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	45.25	4298.75		090	2		New	

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22590		Arthrodesis, posterior technique, craniocervical (occiput-C2)	46.99	3923.67		090	2		3129.58	2097.37**
22595		Arthrodesis, posterior technique, atlas-axis (C1-C2)	44.76	3737.46		090	2		2972.60	2097.37**
22600		Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segmen	38.44	3209.74		090	2		2541.74	2097.37**
22610		Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	37.58	3137.93		090	2		2520.87	2097.37**
22612		Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	47.36	4499.20		090	2	4848.92	4116.35	4488.88
22614		Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	11.54	1096.30		ZZZ	2	4848.92	1028.85	4488.88
22630		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	45.93	4363.35		090	2		3968.15	2097.37**
22632		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	9.43	895.85		ZZZ	2		838.85	2097.37**
22633		Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	54.55	8384.64		090	2		New	
22634		Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspa	14.64	2261.30		ZZZ	2		New	
22800		Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	40.31	3365.89		090	2		2797.25	2097.37**
22802		Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	62.12	5187.02		090	2		4478.11	2097.37**
22804		Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	71.45	5966.08		090	2		5189.53	2097.37**
22808		Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	54.16	4522.36		090	2		3774.20	2097.37**
22810		Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	60.22	5028.37		090	2		4243.47	2097.37**
22812		Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	65.45	5465.08		090	2		4605.03	2097.37**
22818		Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	65.08	5434.18		090	2		4638.43	2097.37**
22819		Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	81.28	6786.88		090	2		5247.98	2097.37**
22830		Exploration of spinal fusion	24.19	2298.05		090	2		1906.65	2097.37**
22840		Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary proced	22.51	2138.45		ZZZ	2		2006.40	2097.37**
22841		Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	11.35	947.73		XXX	9		819.47	2097.37**
22842		Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	22.53	2140.35		ZZZ	2		2009.25	2097.37**
22843		Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	23.96	2000.66		ZZZ	2		1772.71	2097.37**
22844		Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	28.82	2406.47		ZZZ	2		2184.36	2097.37**
22845		Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	21.75	2066.25		ZZZ	2		1930.40	2097.37**
22846		Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	22.56	2143.20		ZZZ	2		2002.60	2097.37**

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22847		Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	25.74	2445.30		ZZZ	2		1837.84	2097.37**
22848		Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	10.54	880.09		ZZZ	2		794.92	2097.37**
22849		Reinsertion of spinal fixation device	38.61	3667.95		090	2		2709.58	2097.37**
22850		Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	21.56	1800.26		090	2		1477.12	2097.37**
22851		Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)	12.06	1145.70		ZZZ	2	2975.93	1074.45	2007.54
22852		Removal of posterior segmental instrumentation	20.64	1960.80		090	2		1607.40	2097.37**
22855		Removal of anterior instrumentation	33.32	3165.40		090	2		2872.80	2097.37**
22856		Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	49.53	4705.35		090	2	4848.92	3634.76	2097.37**
22857		Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	42.31	3532.89		090	2		3054.43	2097.37**
22861		Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	66.06	6275.70		090	2		4095.68	2097.37**
22862		Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	55.97	4673.50		090	2		3724.10	2097.37**
22864		Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervica	59.00	5605.00		090	2		3633.09	2097.37**
22865		Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumba	61.95	5172.83		090	2		3626.41	2097.37**
22899		Unlisted procedure, spine	0.00	BR		YYY	2	2975.93	BR	2007.54
22900		Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	16.72	1396.12		090	2	2142.94	799.93	2132.75
22901		Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greate	19.68	1643.28		090	2	2142.94	1499.66	2132.75
22902		Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	13.07	1091.35		090	2	1447.15	946.06	1595.60
22903		Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greate	12.93	1079.66		090	2	2142.94	991.98	2132.75
22904		Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm	31.18	2603.53		090	2	1447.15	2348.02	1595.60
22905		Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greate	39.37	3287.40		090	2	2142.94	3045.25	2132.75
22999		Unlisted procedure, abdomen, musculoskeletal system	0.00	BR		YYY	0	2006.48	BR	2007.54
23000		Removal of subdeltoid calcareous deposits, open	17.81	1487.14		090	2	1447.15	1083.83	1595.60
23020		Capsular contracture release (eg, Sever type procedure)	20.48	1710.08		090	2	2975.93	1432.03	4247.50
23030		Incision and drainage, shoulder area; deep abscess or hematoma	13.45	1123.08		010	1	1701.78	899.30	1769.66
23031		Incision and drainage, shoulder area; infected bursa	12.90	1077.15		010	1	1701.78	872.58	1769.66
23035		Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	20.23	1689.21		090	2	2006.48	1466.26	2007.54
23040		Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	21.38	1785.23		090	2	2975.93	1491.31	2897.26
23044		Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body	16.91	1411.99		090	1	2975.93	1184.87	2897.26
23065		Biopsy, soft tissue of shoulder area; superficial	6.59	550.27		010	1	752.91	404.98	748.01
23066		Biopsy, soft tissue of shoulder area; deep	16.66	1391.11		090	1	2142.94	1008.68	2132.75
23071		Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greate	12.48	1042.08		090	2	2142.94	942.72	2132.75
23073		Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greate	20.52	1713.42		090	2	2142.94	1561.45	2132.75
23075		Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	14.24	1189.04		090	1	1447.15	516.03	1595.60
23076		Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	16.03	1338.51		090	1	1447.15	1137.27	1595.60
23077		Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm	33.72	2815.62		090	2	1447.15	2398.12	1595.60
23078		Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greate	42.58	3555.43		090	2	2142.94	3168.83	2132.75
23100		Arthrotomy, glenohumeral joint, including biopsy	14.91	1244.99		090	2	2006.48	1006.18	2007.54
23101		Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage	13.25	1106.38		090	1	2975.93	931.86	2897.26
23105		Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy	18.99	1585.67		090	2	2975.93	1320.97	2897.26
23106		Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy	14.79	1234.97		090	1	2975.93	987.81	2897.26

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
23107		Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body	19.66	1641.61		090	2	2975.93	1376.08	2897.26
23120		Claviculectomy; partial	17.47	1458.75		090	2	2975.93	1164.83	2897.26
23125		Claviculectomy; total	21.02	1755.17		090	2	2975.93	1457.08	2897.26
23130		Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	18.13	1513.86		090	1	4434.79	1255.84	4247.50
23140		Excision or curettage of bone cyst or benign tumor of clavicle or scapula	15.80	1319.30		090	1	2006.48	1043.75	2007.54
23145		Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)	20.61	1720.94		090	2	2975.93	1409.48	2897.26
23146		Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograf	18.45	1540.58		090	0	2975.93	1280.89	2897.26
23150		Excision or curettage of bone cyst or benign tumor of proximal humerus	19.63	1639.11		090	2	2975.93	1330.99	2897.26
23155		Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)	23.52	1963.92		090	2	2975.93	1631.59	2897.26
23156		Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograf	20.12	1680.02		090	2	2975.93	1397.79	2897.26
23170		Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	16.66	1391.11		090	1	2975.93	1110.55	2897.26
23172		Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	16.85	1406.98		090	2	2975.93	1123.91	2897.26
23174		Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	22.52	1880.42		090	2	2975.93	1557.28	2897.26
23180		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	19.89	1660.82		090	1	2975.93	1498.83	2897.26
23182		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	19.70	1644.95		090	2	2975.93	1430.36	2897.26
23184		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	21.82	1821.97		090	2	2975.93	1609.88	2897.26
23190		Ostectomy of scapula, partial (eg, superior medial angle)	16.94	1414.49		090	2	2975.93	1150.63	2897.26
23195		Resection, humeral head	22.40	1870.40		090	2	2975.93	1538.07	2897.26
23200		Radical resection of tumor; clavicle	44.85	3744.98		090	2		1817.80	2097.37**
23210		Radical resection of tumor; scapula	52.64	4395.44		090	2		1893.78	2097.37**
23220		Radical resection of tumor, proximal humerus	57.81	4827.14		090	2		2229.45	2097.37**
23330		Removal of foreign body, shoulder; subcutaneous	8.24	688.04		010	0	752.91	460.92	748.01
23331		Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)	17.61	1470.44		090	0	2142.94	1218.27	2132.75
23332		Removal of foreign body, shoulder; complicated (eg, total shoulder)	26.20	2187.70		090	2		1840.34	2097.37**
23350		Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	3.84	320.64		000	1		349.87	
23395		Muscle transfer, any type, shoulder or upper arm; single	38.17	3187.20		090	2	4434.79	2661.15	4247.50
23397		Muscle transfer, any type, shoulder or upper arm; multiple	33.76	2818.96		090	2	7563.12	2393.11	8084.19
23400		Scapulopexy (eg, Sprengels deformity or for paralysis)	28.75	2400.63		090	2	2975.93	2033.23	2897.26
23405		Tenotomy, shoulder area; single tendon	18.65	1557.28		090	2	2975.93	1312.62	2897.26
23406		Tenotomy, shoulder area; multiple tendons through same incision	22.89	1911.32		090	2	2975.93	1643.28	2897.26
23410		Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	24.42	2039.07		090	2	4434.79	1882.93	4247.50
23412		Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	25.33	2115.06		090	2	4434.79	2004.00	4247.50
23415		Coracoacromial ligament release, with or without acromioplasty	20.70	1728.45		090	1	4434.79	1541.41	4247.50
23420		Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	28.80	2736.00		090	2	4434.79	2487.10	4247.50
23430		Tenodesis of long tendon of biceps	22.28	2116.60		090	2	4434.79	1763.20	4247.50
23440		Resection or transplantation of long tendon of biceps	22.44	1873.74		090	2	2975.93	1604.04	4247.50
23450		Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	28.09	2345.52		090	2	7563.12	2002.33	8084.19
23455		Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	29.71	2480.79		090	2	7563.12	2135.93	8084.19
23460		Capsulorrhaphy, anterior, any type; with bone block	32.26	2693.71		090	2	7563.12	2308.78	8084.19
23462		Capsulorrhaphy, anterior, any type; with coracoid process transfe	31.62	2640.27		090	2	4434.79	2252.83	4247.50
23465		Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	33.12	2765.52		090	2	7563.12	2346.35	8084.19
23466		Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	33.36	3169.20		090	2	4434.79	2614.40	4247.50
23470		Arthroplasty, glenohumeral joint; hemiarthroplasty	35.74	2984.29		090	2	12387.27	2563.45	10830.36
23472		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	43.34	3618.89		090	2		3153.80	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
23473		Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	48.27	4030.55		090	2	12387.27	New	
23474		Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	52.15	4354.53		090	2		New	
23480		Osteotomy, clavicle, with or without internal fixation	24.31	2029.89		090	1	4434.79	1724.28	4247.50
23485		Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	28.40	2371.40		090	2	7563.12	2024.88	8084.19
23490		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	25.54	2132.59		090	2	7563.12	1708.41	4247.50
23491		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus	30.04	2508.34		090	2	7563.12	2145.12	8084.19
23500		Closed treatment of clavicular fracture; without manipulation	6.60	551.10		090	1	172.42	420.01	151.16
23505		Closed treatment of clavicular fracture; with manipulation	10.57	882.60		090	1	1077.75	691.38	1677.55
23515		Open treatment of clavicular fracture, includes internal fixation, when performed	21.46	1791.91		090	2	6502.42	1195.72	5970.68
23520		Closed treatment of sternoclavicular dislocation; without manipulation	6.92	577.82		090	0	514.57	428.36	437.22
23525		Closed treatment of sternoclavicular dislocation; with manipulation	11.32	945.22		090	0	514.57	692.22	437.22
23530		Open treatment of sternoclavicular dislocation, acute or chronic	17.01	1420.34		090	2	4855.82	1135.60	4146.21
23532		Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	18.53	1547.26		090	2	2462.57	1285.90	2356.77
23540		Closed treatment of acromioclavicular dislocation; without manipulation	6.75	563.63		090	1	172.42	429.19	151.16
23545		Closed treatment of acromioclavicular dislocation; with manipulation	10.48	875.08		090	0	514.57	619.57	437.22
23550		Open treatment of acromioclavicular dislocation, acute or chronic	16.95	1415.33		090	2	4855.82	1180.69	4146.21
23552		Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	19.54	1631.59		090	2	4855.82	1364.39	4146.21
23570		Closed treatment of scapular fracture; without manipulation	6.97	582.00		090	1	172.42	448.40	151.16
23575		Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)	11.99	1001.17		090	0	514.57	755.68	437.22
23585		Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	29.17	2435.70		090	2	6502.42	1431.19	5970.68
23600		Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation	9.88	824.98		090	1	172.42	635.44	151.16
23605		Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal traction	13.94	1163.99		090	1	1077.75	939.38	1677.55
23615		Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	26.32	2197.72		090	2	6502.42	1683.36	5970.68
23616		Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	36.82	3074.47		090	2	6502.42	3065.29	5970.68
23620		Closed treatment of greater humeral tuberosity fracture; without manipulation	8.14	679.69		090	1	172.42	515.20	151.16
23625		Closed treatment of greater humeral tuberosity fracture; with manipulation	11.41	952.74		090	1	1077.75	758.18	1677.55
23630		Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	23.31	1946.39		090	2	6502.42	1201.57	5970.68
23650		Closed treatment of shoulder dislocation, with manipulation; without anesthesia	9.48	791.58		090	1	172.42	587.84	151.16
23655		Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	11.95	997.83		090	1	1340.50	754.01	1394.50
23660		Open treatment of acute shoulder dislocation	17.38	1451.23		090	2	4855.82	1192.38	4146.21
23665		Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation	12.74	1063.79		090	1	514.57	835.00	437.22
23670		Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	26.10	2179.35		090	2	6502.42	1266.70	5970.68
23675		Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation	16.41	1370.24		090	1	172.42	1100.53	151.16

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
23680		Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	27.58	2302.93		090	2	4855.82	1574.81	4146.21
23700		Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	5.82	552.90		010	1	1340.50	458.85	1394.50
23800		Arthrodesis, glenohumeral joint;	30.38	2536.73		090	2	7563.12	2104.20	8084.19
23802		Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft	38.03	3175.51		090	2	7563.12	2459.08	4247.50
23900		Interthoracoscapular amputation (forequarter)	41.05	3427.68		090	2		2768.86	2097.37**
23920		Disarticulation of shoulder;	33.38	2787.23		090	2		2231.96	2097.37**
23921		Disarticulation of shoulder; secondary closure or scar revision	14.18	1184.03		090	1	1434.08	906.81	1463.98
23929		Unlisted procedure, shoulder	0.00	BR		YYY	2	172.42	BR	151.16
23930		Incision and drainage, upper arm or elbow area; deep abscess or hematoma	10.77	899.30		010	1	1701.78	757.35	1769.66
23931		Incision and drainage, upper arm or elbow area; bursa	8.71	727.29		010	1	936.06	619.57	1769.66
23935		Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	15.13	1263.36		090	0	2006.48	1036.24	2007.54
24000		Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	14.18	1184.03		090	0	2975.93	970.27	2897.26
24006		Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure	21.13	1764.36		090	2	2975.93	1472.94	2897.26
24065		Biopsy, soft tissue of upper arm or elbow area; superficia	7.83	653.81		010	1	1447.15	460.09	1595.60
24066		Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)	18.87	1575.65		090	1	1447.15	1193.22	1595.60
24071		Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greate	12.08	1008.68		090	2	2142.94	914.33	2132.75
24073		Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	20.45	1707.58		090	2	2142.94	1569.80	2132.75
24075		Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	14.94	1247.49		090	1	1447.15	953.57	1595.60
24076		Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	16.16	1349.36		090	1	1447.15	957.75	1595.60
24077		Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm	30.78	2570.13		090	1	1447.15	1673.34	1595.60
24079		Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; 5 cm or greater	39.25	3277.38		090	2	2142.94	2921.67	2132.75
24100		Arthrotomy, elbow; with synovial biopsy only	12.46	1040.41		090	2	2006.48	817.47	2007.54
24101		Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	14.88	1242.48		090	2	2975.93	1028.72	2897.26
24102		Arthrotomy, elbow; with synovectomy	18.27	1525.55		090	2	2975.93	1275.05	2897.26
24105		Excision, olecranon bursa	10.49	875.92		090	1	2006.48	685.54	2007.54
24110		Excision or curettage of bone cyst or benign tumor, humerus	17.47	1458.75		090	1	2006.48	1203.24	2007.54
24115		Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)	21.86	1825.31		090	2	2975.93	1485.47	2897.26
24116		Excision or curettage of bone cyst or benign tumor, humerus; with allograf	25.52	2130.92		090	2	2975.93	1810.28	2897.26
24120		Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process	15.74	1314.29		090	0	2006.48	1075.48	2007.54
24125		Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)	18.42	1538.07		090	2	2975.93	1202.40	2897.26
24126		Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft	19.26	1608.21		090	2	2975.93	1305.11	2897.26
24130		Excision, radial head	15.08	1259.18		090	1	2975.93	1045.42	2897.26
24134		Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	22.15	1849.53		090	2	2975.93	1606.54	2897.26
24136		Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	18.72	1563.12		090	1	2975.93	1309.28	2897.26
24138		Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	20.08	1676.68		090	2	2975.93	1365.23	2897.26
24140		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	20.81	1737.64		090	2	2975.93	1555.61	2897.26
24145		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	17.57	1467.10		090	1	2975.93	1320.14	2897.26

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
24147		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process	18.50	1544.75		090	1	2975.93	1369.40	2897.26
24149		Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)	34.74	2900.79		090	2	2975.93	2348.02	2897.26
24150		Radical resection of tumor, shaft or distal humerus	46.02	3842.67		090	2	4434.79	2028.22	4247.50
24152		Radical resection of tumor, radial head or neck	39.99	3339.17		090	2	4434.79	1509.68	4247.50
24155		Resection of elbow joint (arthrectomy)	25.27	2110.05		090	2	2975.93	1745.99	4247.50
24160		Implant removal; elbow joint	17.98	1501.33		090	1	2975.93	1255.01	2897.26
24164		Implant removal; radial head	14.79	1234.97		090	1	2975.93	1026.22	2897.26
24200		Removal of foreign body, upper arm or elbow area; subcutaneous	6.19	516.87		010	0	433.96	421.68	397.82
24201		Removal of foreign body, upper arm or elbow area; deep (subfascial or intramuscular)	16.92	1412.82		090	1	1447.15	1184.87	1595.60
24220		Injection procedure for elbow arthrography	4.80	400.80		000	0		384.94	
24300		Manipulation, elbow, under anesthesia	12.44	1038.74		090	1	1340.50	809.95	1394.50
24301		Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331	22.15	1849.53		090	2	2975.93	1565.63	2897.26
24305		Tendon lengthening, upper arm or elbow, each tendor	17.12	1429.52		090	0	2975.93	1199.06	2897.26
24310		Tenotomy, open, elbow to shoulder, each tendor	14.21	1186.54		090	0	2006.48	982.80	2007.54
24320		Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	23.14	1932.19		090	2	2975.93	1573.14	4247.50
24330		Flexor-plasty, elbow (eg, Steindler type advancement)	21.28	1776.88		090	2	7563.12	1492.98	8084.19
24331		Flexor-plasty, elbow (eg, Steindler type advancement); with extensor advancemen	23.30	1945.55		090	2	4434.79	1642.45	4247.50
24332		Tenolysis, triceps	18.20	1519.70		090	1	2975.93	1231.63	2007.54
24340		Tenodesis of biceps tendon at elbow (separate procedure)	18.29	1527.22		090	2	4434.79	1274.21	4247.50
24341		Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	22.31	1862.89		090	2	4434.79	1461.25	4247.50
24342		Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graf	23.06	1925.51		090	2	4434.79	1644.95	4247.50
24343		Repair lateral collateral ligament, elbow, with local tissue	20.96	1750.16		090	2	2975.93	1452.90	2897.26
24344		Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft	32.55	2717.93		090	2	7563.12	2254.50	8084.19
24345		Repair medial collateral ligament, elbow, with local tissue	20.85	1740.98		090	2	2975.93	1444.55	2897.26
24346		Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft	32.59	2721.27		090	2	7563.12	2240.31	4247.50
24357		Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneou	13.13	1096.36		090	0	2975.93	898.80	2897.26
24358		Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open	15.57	1300.10		090	0	2975.93	1055.04	2897.26
24359		Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment	19.56	1633.26		090	0	2975.93	1294.44	2897.26
24360		Arthroplasty, elbow; with membrane (eg, fascial)	26.62	2222.77		090	2	3699.98	1873.74	3637.36
24361		Arthroplasty, elbow; with distal humeral prosthetic replacemen	29.78	2486.63		090	2	12387.27	2101.70	10830.36
24362		Arthroplasty, elbow; with implant and fascia lata ligament reconstructior	31.38	2620.23		090	2	5741.03	2181.86	5296.66
24363		Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow	43.06	3595.51		090	2	12387.27	3056.10	10830.36
24365		Arthroplasty, radial head;	18.95	1582.33		090	2	3699.98	1331.83	3637.36
24366		Arthroplasty, radial head; with implant	20.15	1682.53		090	2	12387.27	1426.18	10830.36
24370		Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component	45.62	3809.27		090	2	12387.27	New	
24371		Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component	52.56	4388.76		090	2	12387.27	New	
24400		Osteotomy, humerus, with or without internal fixatior	24.40	2037.40		090	2	7563.12	1715.09	4247.50
24410		Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	32.04	2675.34		090	2	4434.79	2181.02	4247.50
24420		Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876	29.45	2459.08		090	2	4434.79	2047.42	4247.50
24430		Repair of nonunion or malunion, humerus; without graft (eg, compression technique	31.37	2619.40		090	2	7563.12	2121.74	8084.19
24435		Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft	31.98	2670.33		090	2	7563.12	2186.03	8084.19

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
24470		Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)	17.26	1441.21		090	2	4434.79	1402.80	4247.50
24495		Decompression fasciotomy, forearm, with brachial artery exploration	19.17	1600.70		090	0	2975.93	1408.65	2897.26
24498		Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft	25.72	2147.62		090	2	7563.12	1828.65	8084.19
24500		Closed treatment of humeral shaft fracture; without manipulation	10.78	900.13		090	1	172.42	685.54	151.16
24505		Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction	15.02	1254.17		090	1	172.42	1004.51	151.16
24515		Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	26.03	2173.51		090	2	6502.42	1826.15	5970.68
24516		Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	25.52	2130.92		090	2	6502.42	1808.61	5970.68
24530		Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation	11.43	954.41		090	1	172.42	739.81	151.16
24535		Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction	18.38	1534.73		090	1	514.57	1255.01	437.22
24538		Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension	22.12	1847.02		090	1	2462.57	1556.44	2356.77
24545		Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	27.58	2302.93		090	2	6502.42	1651.63	5970.68
24546		Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; with intercondylar extension	30.86	2576.81		090	2	6502.42	2338.00	5970.68
24560		Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation	9.73	812.46		090	1	172.42	617.07	151.16
24565		Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation	15.93	1330.16		090	1	172.42	1037.07	151.16
24566		Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	21.37	1784.40		090	1	2462.57	1431.19	2356.77
24575		Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	21.83	1822.81		090	2	6502.42	1662.49	5970.68
24576		Closed treatment of humeral condylar fracture, medial or lateral; without manipulation	10.29	859.22		090	1	172.42	649.63	151.16
24577		Closed treatment of humeral condylar fracture, medial or lateral; with manipulation	16.39	1368.57		090	1	172.42	1079.66	437.22
24579		Open treatment of humeral condylar fracture, medial or lateral, includes internal fixation, when performed	24.83	2073.31		090	2	6502.42	1786.07	5970.68
24582		Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	24.08	2010.68		090	1	2462.57	1609.05	2356.77
24586		Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);	32.05	2676.18		090	2	6502.42	2296.25	5970.68
24587		Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty	32.10	2680.35		090	2	6502.42	2273.71	5970.68
24600		Treatment of closed elbow dislocation; without anesthesia	11.00	918.50		090	1	172.42	748.16	151.16
24605		Treatment of closed elbow dislocation; requiring anesthesia	14.03	1171.51		090	1	1340.50	926.85	1394.50
24615		Open treatment of acute or chronic elbow dislocation	21.12	1763.52		090	2	6502.42	1491.31	5970.68
24620		Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation	16.49	1376.92		090	0	1077.75	1126.42	1677.55
24635		Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed	20.00	1670.00		090	2	6502.42	2303.77	5970.68
24640		Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	4.31	359.89		010	0	172.42	248.00	151.16
24650		Closed treatment of radial head or neck fracture; without manipulation	7.91	660.49		090	1	172.42	504.34	151.16
24655		Closed treatment of radial head or neck fracture; with manipulation	13.17	1099.70		090	1	514.57	875.92	437.22
24665		Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed;	19.39	1619.07		090	2	4855.82	1341.85	4146.21
24666		Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed; with radial head prosthetic replacement	21.77	1817.80		090	2	6502.42	1518.87	5970.68
24670		Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]); without manipulation	8.79	733.97		090	1	172.42	565.30	151.16

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24675		Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]); with manipulation	13.69	1143.12		090	1	172.42	914.33	151.16
24685		Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	19.50	1628.25		090	2	4855.82	1403.64	4146.21
24800		Arthrodesis, elbow joint; local	24.59	2053.27		090	2	4434.79	1690.88	4247.50
24802		Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft	29.65	2475.78		090	2	7563.12	2093.35	4247.50
24900		Amputation, arm through humerus; with primary closure	21.77	1817.80		090	2		1459.58	2097.37**
24920		Amputation, arm through humerus; open, circular (guillotine)	19.80	1653.30		090	2		1457.08	2097.37**
24925		Amputation, arm through humerus; secondary closure or scar revisior	16.81	1403.64		090	2	2006.48	1119.74	2007.54
24930		Amputation, arm through humerus; re-amputation	22.93	1914.66		090	2		1522.21	2097.37**
24931		Amputation, arm through humerus; with implant	22.69	1894.62		090	2		1693.38	2097.37**
24935		Stump elongation, upper extremity	31.15	2601.03		090	0	7563.12	2090.84	8084.19
24940		Cineplasty, upper extremity, complete procedure	31.45	2626.08		090	2		1756.01	2097.37**
24999		Unlisted procedure, humerus or elbow	0.00	BR		YYY	0	172.42	BR	151.16
25000		Incision, extensor tendon sheath, wrist (eg, deQuervains disease	10.05	839.18		090	1	2006.48	840.01	2007.54
25001		Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	10.27	857.55		090	1	2006.48	668.00	2007.54
25020		Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve	17.21	1437.04		090	1	2975.93	1269.20	2897.26
25023		Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve	33.11	2764.69		090	0	2975.93	2374.74	2897.26
25024		Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve	23.35	1949.73		090	1	2975.93	1530.56	2897.26
25025		Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve	36.28	3029.38		090	0	2975.93	2302.10	2897.26
25028		Incision and drainage, forearm and/or wrist; deep abscess or hematoma	15.75	1315.13		090	1	2006.48	1107.21	2007.54
25031		Incision and drainage, forearm and/or wrist; bursa	10.39	867.57		090	0	2006.48	976.95	2007.54
25035		Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess	17.34	1447.89		090	0	2006.48	1705.91	2007.54
25040		Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body	16.66	1391.11		090	0	2975.93	1233.30	2897.26
25065		Biopsy, soft tissue of forearm and/or wrist; superficial	7.77	648.80		010	1	752.91	455.08	748.01
25066		Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular)	10.66	890.11		090	1	2142.94	923.51	2132.75
25071		Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	12.66	1057.11		090	2	2142.94	957.75	2132.75
25073		Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	15.79	1318.47		090	2	2142.94	1193.22	2132.75
25075		Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	14.57	1216.60		090	1	1447.15	800.77	1595.60
25076		Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	15.34	1280.89		090	1	1447.15	1176.52	1595.60
25077		Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm	26.21	2188.54		090	1	1447.15	1805.27	1595.60
25078		Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater	34.66	2894.11		090	2	2142.94	2550.09	2132.75
25085		Capsulotomy, wrist (eg, contracture)	13.41	1119.74		090	2	2006.48	1047.93	2007.54
25100		Arthrotomy, wrist joint; with biopsy	10.32	861.72		090	0	2006.48	764.86	2007.54
25101		Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	12.05	1006.18		090	0	2975.93	888.44	2897.26
25105		Arthrotomy, wrist joint; with synovectomy	14.35	1198.23		090	0	2975.93	1100.53	2897.26
25107		Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex	18.26	1524.71		090	2	2975.93	1319.30	2897.26
25109		Excision of tendon, forearm and/or wrist, flexor or extensor, each	15.93	1330.16		090	1	2006.48	1035.40	2007.54
25110		Excision, lesion of tendon sheath, forearm and/or wrist	10.12	845.02		090	1	2006.48	900.97	2007.54
25111		Excision of ganglion, wrist (dorsal or volar); primary	9.56	798.26		090	1	2006.48	682.20	2007.54
25112		Excision of ganglion, wrist (dorsal or volar); recurrent	11.51	961.09		090	1	2006.48	826.65	2007.54

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25115		Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors	22.45	1874.58		090	1	2006.48	1945.55	2007.54
25116		Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	17.83	1488.81		090	0	2006.48	1659.98	2007.54
25118		Synovectomy, extensor tendon sheath, wrist, single compartment	11.33	946.06		090	1	2975.93	845.86	2897.26
25119		Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal uln	14.76	1232.46		090	2	2975.93	1137.27	2897.26
25120		Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);	14.79	1234.97		090	0	2975.93	1467.93	2897.26
25125		Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)	17.69	1477.12		090	0	2975.93	1642.45	2897.26
25126		Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft	17.73	1480.46		090	2	2975.93	1676.68	2897.26
25130		Excision or curettage of bone cyst or benign tumor of carpal bones	13.30	1110.55		090	0	2975.93	976.95	2897.26
25135		Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)	16.58	1384.43		090	2	2975.93	1207.41	2897.26
25136		Excision or curettage of bone cyst or benign tumor of carpal bones; with allograf	14.67	1224.95		090	2	2975.93	1067.13	2897.26
25145		Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wris	15.36	1282.56		090	2	2975.93	1492.15	2897.26
25150		Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); uln	16.75	1398.63		090	1	2975.93	1289.24	2897.26
25151		Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	17.37	1450.40		090	2	2975.93	1641.61	2897.26
25170		Radical resection of tumor, radius or ulna	43.72	3650.62		090	2	2975.93	2169.33	4247.50
25210		Carpectomy; 1 bone	14.49	1209.92		090	0	2975.93	1067.13	2897.26
25215		Carpectomy; all bones of proximal row	18.23	1522.21		090	2	2975.93	1392.78	2897.26
25230		Radial styloidectomy (separate procedure)	12.77	1066.30		090	1	2975.93	951.07	2897.26
25240		Excision distal ulna partial or complete (eg, Darrach type or matched resection)	12.71	1061.29		090	0	2975.93	1005.34	2897.26
25246		Injection procedure for wrist arthrography	4.78	399.13		000	1		384.94	
25248		Exploration with removal of deep foreign body, forearm or wris	12.28	1025.38		090	1	2006.48	1121.41	2007.54
25250		Removal of wrist prosthesis; (separate procedure)	15.74	1314.29		090	2	2975.93	1078.82	2897.26
25251		Removal of wrist prosthesis; complicated, including total wrist	21.32	1780.22		090	2	2975.93	1470.44	2897.26
25259		Manipulation, wrist, under anesthesia	12.45	1039.58		090	1	1077.75	807.45	1677.55
25260		Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	18.73	1563.96		090	1	2975.93	1719.27	2897.26
25263		Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle	18.70	1561.45		090	2	2975.93	1710.92	2897.26
25265		Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	22.18	1852.03		090	2	2975.93	1977.28	2897.26
25270		Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	14.57	1216.60		090	0	2975.93	1452.90	2897.26
25272		Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle	16.44	1372.74		090	0	2975.93	1602.37	2897.26
25274		Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	19.83	1655.81		090	0	2975.93	1821.97	2897.26
25275		Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	20.04	1673.34		090	0	2975.93	1383.60	2897.26
25280		Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon	16.71	1395.29		090	0	2975.93	1605.71	2897.26
25290		Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon	12.95	1081.33		090	1	2975.93	1599.03	2897.26
25295		Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendor	15.47	1291.75		090	1	2006.48	1512.19	2007.54
25300		Tenodesis at wrist; flexors of fingers	20.45	1707.58		090	2	2975.93	1453.74	2897.26
25301		Tenodesis at wrist; extensors of fingers	19.06	1591.51		090	2	2975.93	1391.11	2897.26
25310		Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	18.31	1528.89		090	2	2975.93	1722.61	4247.50
25312		Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon	21.28	1776.88		090	2	4434.79	1920.50	4247.50

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
25315		Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist	22.82	1905.47		090	2	2975.93	2037.40	4247.50
25316		Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	26.45	2208.58		090	2	7563.12	2352.20	8084.19
25320		Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	29.30	2446.55		090	2	4434.79	1995.65	4247.50
25332		Arthroplasty, wrist, with or without interposition, with or without external or internal fixatio	25.00	2087.50		090	2	3699.98	1761.85	3637.36
25335		Centralization of wrist on ulna (eg, radial club hand)	26.84	2241.14		090	2	4434.79	2029.89	4247.50
25337		Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint	26.33	2198.56		090	1	4434.79	1884.60	4247.50
25350		Osteotomy, radius; distal third	19.93	1664.16		090	2	4434.79	1864.56	4247.50
25355		Osteotomy, radius; middle or proximal third	22.70	1895.45		090	2	4434.79	2052.43	4247.50
25360		Osteotomy; ulna	19.41	1620.74		090	2	4434.79	1823.64	4247.50
25365		Osteotomy; radius AND ulna	27.08	2261.18		090	2	7563.12	2350.53	4247.50
25370		Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	29.80	2488.30		090	2	4434.79	2493.31	4247.50
25375		Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	26.83	2240.31		090	2	4434.79	2461.58	4247.50
25390		Osteoplasty, radius OR ulna; shortening	22.72	1897.12		090	2	4434.79	2054.10	4247.50
25391		Osteoplasty, radius OR ulna; lengthening with autograf	29.47	2460.75		090	2	7563.12	2528.38	4247.50
25392		Osteoplasty, radius AND ulna; shortening (excluding 64876)	30.00	2505.00		090	2	2975.93	2508.34	2897.26
25393		Osteoplasty, radius AND ulna; lengthening with autograf	33.42	2790.57		090	2	4434.79	2846.52	4247.50
25394		Osteoplasty, carpal bone, shortening	23.22	1938.87		090	2	4434.79	1584.83	4247.50
25400		Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique	23.75	1983.13		090	2	7563.12	2155.14	4247.50
25405		Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft	30.60	2555.10		090	2	7563.12	2641.94	8084.19
25415		Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique	28.62	2389.77		090	2	7563.12	2472.44	8084.19
25420		Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft	34.55	2884.93		090	2	7563.12	2899.12	8084.19
25425		Repair of defect with autograft; radius OR ulna	28.49	2378.92		090	2	7563.12	2829.82	4247.50
25426		Repair of defect with autograft; radius AND ulna	33.21	2773.04		090	2	4434.79	2735.46	4247.50
25430		Insertion of vascular pedicle into carpal bone (eg, Hori procedure)	21.01	1754.34		090	1	4434.79	1432.86	4247.50
25431		Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	23.38	1952.23		090	2	4434.79	1645.79	4247.50
25440		Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	22.72	1897.12		090	2	7563.12	1675.85	8084.19
25441		Arthroplasty with prosthetic replacement; distal radius	27.09	2262.02		090	2	12387.27	1968.10	10830.36
25442		Arthroplasty with prosthetic replacement; distal ulna	23.23	1939.71		090	2	12387.27	1664.16	10830.36
25443		Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)	23.15	1933.03		090	2	5741.03	1593.18	5296.66
25444		Arthroplasty with prosthetic replacement; lunate	23.27	1943.05		090	2	5741.03	1718.43	5296.66
25445		Arthroplasty with prosthetic replacement; trapezium	21.32	1780.22		090	1	5741.03	1504.67	5296.66
25446		Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist	34.39	2871.57		090	2	12387.27	2450.73	10830.36
25447		Arthroplasty, interposition, intercarpal or carpometacarpal joints	24.47	2043.25		090	2	3699.98	1664.99	3637.36
25449		Revision of arthroplasty, including removal of implant, wrist join	30.77	2569.30		090	2	3699.98	2156.81	3637.36
25450		Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna	18.28	1526.38		090	1	4434.79	1499.66	4247.50
25455		Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna	17.43	1455.41		090	1	4434.79	1613.22	4247.50
25490		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radiu	20.65	1724.28		090	2	4434.79	1898.79	4247.50
25491		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna	21.91	1829.49		090	2	4434.79	1994.82	4247.50
25492		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna	23.46	1958.91		090	2	4434.79	2298.76	4247.50
25500		Closed treatment of radial shaft fracture; without manipulation	8.19	683.87		090	1	172.42	511.02	151.16
25505		Closed treatment of radial shaft fracture; with manipulation	15.09	1260.02		090	1	514.57	1005.34	437.22

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
25515		Open treatment of radial shaft fracture, includes internal fixation, when performec	19.90	1661.65		090	2	4855.82	1445.39	4146.21
25520		Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)	16.92	1412.82		090	1	514.57	1122.24	437.22
25525		Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed	23.20	1937.20		090	2	4855.82	1939.71	4146.21
25526		Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (Galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibr	28.32	2364.72		090	2	4855.82	2252.00	4146.21
25530		Closed treatment of ulnar shaft fracture; without manipulatior	7.92	661.32		090	1	172.42	497.66	151.16
25535		Closed treatment of ulnar shaft fracture; with manipulation	14.67	1224.95		090	1	172.42	961.09	151.16
25545		Open treatment of ulnar shaft fracture, includes internal fixation, when performec	18.53	1547.26		090	2	4855.82	1429.52	4146.21
25560		Closed treatment of radial and ulnar shaft fractures; without manipulatior	8.41	702.24		090	1	172.42	518.54	151.16
25565		Closed treatment of radial and ulnar shaft fractures; with manipulatior	15.64	1305.94		090	1	514.57	1051.27	437.22
25574		Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius OR ulna	20.04	1673.34		090	2	6502.42	1251.67	5970.68
25575		Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed; of radius AND ulna	26.71	2230.29		090	2	6502.42	1838.67	5970.68
25600		Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation	9.92	828.32		090	1	172.42	570.31	151.16
25605		Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation	16.45	1373.58		090	1	514.57	1207.41	437.22
25606		Percutaneous skeletal fixation of distal radial fracture or epiphyseal separatior	19.70	1644.95		090	1	2462.57	1416.16	2356.77
25607		Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixatior	21.85	1824.48		090	2	6502.42	1422.01	5970.68
25608		Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	24.43	2039.91		090	2	6502.42	1627.42	5970.68
25609		Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	31.03	2591.01		090	2	6502.42	2074.98	5970.68
25622		Closed treatment of carpal scaphoid (navicular) fracture; without manipulatior	9.20	768.20		090	1	172.42	584.50	151.16
25624		Closed treatment of carpal scaphoid (navicular) fracture; with manipulatior	14.28	1192.38		090	0	514.57	921.84	437.22
25628		Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performec	21.29	1777.72		090	2	4855.82	1471.27	4146.21
25630		Closed treatment of carpal bone fracture (excluding carpal scaphoid [navicular]); without manipulation, each bone	9.18	766.53		090	1	172.42	598.70	151.16
25635		Closed treatment of carpal bone fracture (excluding carpal scaphoid [navicular]); with manipulation, each bone	13.62	1137.27		090	0	172.42	881.76	437.22
25645		Open treatment of carpal bone fracture (other than carpal scaphoid [navicular]), each bone	16.90	1411.15		090	2	4855.82	1185.70	4146.21
25650		Closed treatment of ulnar styloid fracture	9.65	805.78		090	1	172.42	622.91	151.16
25651		Percutaneous skeletal fixation of ulnar styloid fracture	14.43	1204.91		090	0	2462.57	949.40	2356.77
25652		Open treatment of ulnar styloid fracture	18.45	1540.58		090	1	4855.82	1264.19	4146.21
25660		Closed treatment of radiocarpal or intercarpal dislocation, 1 or more bones, with manipulatior	12.25	1022.88		090	0	172.42	800.77	151.16
25670		Open treatment of radiocarpal or intercarpal dislocation, 1 or more bones	17.89	1493.82		090	2	2462.57	1270.04	2356.77
25671		Percutaneous skeletal fixation of distal radioulnar dislocatior	15.82	1320.97		090	1	2462.57	1058.78	2356.77
25675		Closed treatment of distal radioulnar dislocation with manipulatior	13.30	1110.55		090	0	172.42	864.23	151.16
25676		Open treatment of distal radioulnar dislocation, acute or chronic	18.69	1560.62		090	2	2462.57	1314.29	2356.77
25680		Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulatior	14.28	1192.38		090	0	172.42	910.99	151.16
25685		Open treatment of trans-scaphoperilunar type of fracture dislocatior	21.79	1819.47		090	2	2462.57	1512.19	2356.77
25690		Closed treatment of lunate dislocation, with manipulatior	14.34	1197.39		090	0	1077.75	938.54	1677.55
25695		Open treatment of lunate dislocation	18.76	1566.46		090	2	2462.57	1315.13	2356.77
25800		Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)	21.65	1807.78		090	2	7563.12	1600.70	8084.19

Medical Fees

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25805		Arthrodesis, wrist; with sliding graft	25.01	2088.34		090	2	7563.12	1835.33	4247.50
25810		Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)	25.66	2142.61		090	2	7563.12	1822.81	8084.19
25820		Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)	18.29	1527.22		090	2	4434.79	1290.08	4247.50
25825		Arthrodesis, wrist; with autograft (includes obtaining graft)	22.44	1873.74		090	2	7563.12	1571.47	8084.19
25830		Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)	28.53	2382.26		090	2	7563.12	2053.27	8084.19
25900		Amputation, forearm, through radius and ulna;	21.05	1757.68		090	0		1799.43	2097.37**
25905		Amputation, forearm, through radius and ulna; open, circular (guillotine)	20.78	1735.13		090	2		1776.05	2097.37**
25907		Amputation, forearm, through radius and ulna; secondary closure or scar revisior	18.18	1518.03		090	2	2006.48	1590.68	2007.54
25909		Amputation, forearm, through radius and ulna; re-amputatior	20.30	1695.05		090	2	2006.48	1768.53	2097.37**
25915		Krukenberg procedure	30.52	2548.42		090	2		2902.46	2097.37**
25920		Disarticulation through wrist;	20.70	1728.45		090	0		1415.33	2097.37**
25922		Disarticulation through wrist; secondary closure or scar revisior	17.21	1437.04		090	2	2006.48	1238.31	2007.54
25924		Disarticulation through wrist; re-amputation	20.33	1697.56		090	2		1411.15	2097.37**
25927		Transmetacarpal amputation;	24.28	2027.38		090	0		1692.55	2097.37**
25929		Transmetacarpal amputation; secondary closure or scar revisior	17.71	1478.79		090	2	1434.08	1155.64	1463.98
25931		Transmetacarpal amputation; re-amputation	22.04	1840.34		090	1	2006.48	1588.17	2007.54
25999		Unlisted procedure, forearm or wrist	0.00	BR		YYY	0	172.42	BR	151.16
26010		Drainage of finger abscess; simple	8.07	673.85		010	1	161.85	563.63	132.75
26011		Drainage of finger abscess; complicated (eg, felon)	11.86	990.31		010	1	936.06	875.92	1150.97
26020		Drainage of tendon sheath, digit and/or palm, each	12.94	1080.49		090	1	1529.32	869.24	1554.06
26025		Drainage of palmar bursa; single, bursa	12.58	1050.43		090	0	1529.32	852.54	1554.06
26030		Drainage of palmar bursa; multiple bursa	14.62	1220.77		090	0	1529.32	1002.84	1554.06
26034		Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess	16.03	1338.51		090	1	1529.32	1086.34	1554.06
26035		Decompression fingers and/or hand, injection injury (eg, grease gun)	25.46	2125.91		090	0	1529.32	1621.57	1554.06
26037		Decompressive fasciotomy, hand (excludes 26035)	16.93	1413.66		090	0	1529.32	1168.17	1554.06
26040		Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous	9.23	770.71		090	1	1529.32	627.92	2574.99
26045		Fasciotomy, palmar (eg, Dupuytren's contracture); open, partia	13.92	1162.32		090	1	2665.47	955.24	2574.99
26055		Tendon sheath incision (eg, for trigger finger)	17.01	1420.34		090	1	1529.32	1348.53	1554.06
26060		Tenotomy, percutaneous, single, each digit	7.93	662.16		090	0	1529.32	535.24	1554.06
26070		Arthrotomy, with exploration, drainage, or removal of loose or foreign body; carpometacarpal join	9.20	768.20		090	1	1529.32	593.69	1554.06
26075		Arthrotomy, with exploration, drainage, or removal of loose or foreign body; metacarpophalangeal joint, each	9.74	813.29		090	1	1529.32	639.61	1554.06
26080		Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	11.61	969.44		090	1	1529.32	777.39	1554.06
26100		Arthrotomy with biopsy; carpometacarpal joint, each	9.99	834.17		090	0	1529.32	657.15	1554.06
26105		Arthrotomy with biopsy; metacarpophalangeal joint, each	10.07	840.85		090	0	1529.32	673.85	1554.06
26110		Arthrotomy with biopsy; interphalangeal joint, each	9.57	799.10		090	1	1529.32	641.28	1554.06
26111		Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	12.39	1034.57		090	2	2142.94	928.52	2132.75
26113		Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	16.22	1354.37		090	2	2142.94	1221.61	2132.75
26115		Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	15.21	1270.04		090	1	1447.15	1368.57	1595.60
26116		Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	15.61	1303.44		090	1	1447.15	979.46	1595.60
26117		Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm	22.21	1854.54		090	1	1447.15	1325.98	1595.60
26118		Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater	31.48	2628.58		090	2	2142.94	2396.45	2132.75
26121		Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	17.68	1476.28		090	1	2665.47	1229.96	2574.99

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
26123		Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);	24.67	2059.95		090	1	2665.47	1645.79	2574.99
26125		Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition	8.02	669.67		ZZZ	1	1529.32	597.03	1554.06
26130		Synovectomy, carpometacarpal joint	13.60	1135.60		090	1	1529.32	926.85	1554.06
26135		Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit	16.30	1361.05		090	0	2665.47	1136.44	2574.99
26140		Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint	14.96	1249.16		090	1	1529.32	1032.06	1554.06
26145		Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon	15.17	1266.70		090	1	1529.32	1048.76	1554.06
26160		Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	17.42	1454.57		090	1	1529.32	1263.36	1554.06
26170		Excision of tendon, palm, flexor or extensor, single, each tendor	12.04	1005.34		090	0	1529.32	821.64	1554.06
26180		Excision of tendon, finger, flexor or extensor, each tendor	13.15	1098.03		090	0	1529.32	897.63	1554.06
26185		Sesamoidectomy, thumb or finger (separate procedure)	16.38	1367.73		090	2	1529.32	1041.25	1554.06
26200		Excision or curettage of bone cyst or benign tumor of metacarpal	13.35	1114.73		090	0	1529.32	921.84	1554.06
26205		Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft)	17.87	1492.15		090	1	2665.47	1241.65	2574.99
26210		Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger	13.12	1095.52		090	1	1529.32	896.79	1554.06
26215		Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)	16.80	1402.80		090	1	1529.32	1131.43	1554.06
26230		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	14.79	1234.97		090	0	1529.32	1039.58	1554.06
26235		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); proximal or middle phalanx of finger	14.57	1216.60		090	0	1529.32	1016.20	1554.06
26236		Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger	13.08	1092.18		090	1	1529.32	900.13	1554.06
26250		Radical resection of tumor, metacarpal	31.73	2649.46		090	0	1529.32	1172.34	1554.06
26260		Radical resection of tumor, proximal or middle phalanx of finger	23.81	1988.14		090	2	1529.32	1117.23	1554.06
26262		Radical resection of tumor, distal phalanx of finger	18.83	1572.31		090	2	1529.32	934.37	1554.06
26320		Removal of implant from finger or hand	10.28	858.38		090	1	1447.15	701.40	1595.60
26340		Manipulation, finger joint, under anesthesia, each joint	10.10	843.35		090	1	514.57	632.10	437.22
26341		Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	2.94	245.49		010	1	514.57	New	
26350		Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	21.21	1771.04		090	1	2665.47	1646.62	2574.99
26352		Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon	24.31	2029.89		090	2	2665.47	1847.86	2574.99
26356		Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	32.50	2713.75		090	1	2665.47	2306.27	2574.99
26357		Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon	25.85	2158.48		090	2	2665.47	1953.90	2574.99
26358		Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon	27.27	2277.05		090	2	2665.47	2075.81	2574.99
26370		Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendor	22.49	1877.92		090	0	2665.47	1776.88	2574.99
26372		Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	26.29	2195.22		090	2	2665.47	2039.91	2574.99

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
26373		Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon	25.24	2107.54		090	2	2665.47	1943.05	2574.99
26390		Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	24.59	2053.27		090	2	2665.47	1837.84	2574.99
26392		Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	28.60	2388.10		090	2	2665.47	2189.37	2574.99
26410		Repair, extensor tendon, hand, primary or secondary; without free graft, each tendor	16.82	1404.47		090	1	1529.32	1318.47	1554.06
26412		Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon	20.50	1711.75		090	0	2665.47	1568.97	2574.99
26415		Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	23.63	1973.11		090	0	2665.47	1590.68	2574.99
26416		Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	22.35	1866.23		090	1	2665.47	1870.40	2574.99
26418		Repair, extensor tendon, finger, primary or secondary; without free graft, each tendor	17.29	1443.72		090	1	1529.32	1320.97	1554.06
26420		Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon	21.04	1756.84		090	2	2665.47	1638.27	2574.99
26426		Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger	14.86	1240.81		090	1	2665.47	1548.93	2574.99
26428		Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger	22.15	1849.53		090	0	2665.47	1700.06	2574.99
26432		Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)	14.86	1240.81		090	1	1529.32	1141.45	1554.06
26433		Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger	15.79	1318.47		090	1	1529.32	1227.45	1554.06
26434		Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)	19.24	1606.54		090	2	2665.47	1427.02	2574.99
26437		Realignment of extensor tendon, hand, each tendor	18.41	1537.24		090	1	1529.32	1401.97	1554.06
26440		Tenolysis, flexor tendon; palm OR finger, each tendor	18.37	1533.90		090	1	1529.32	1460.42	1554.06
26442		Tenolysis, flexor tendon; palm AND finger, each tendor	28.56	2384.76		090	1	2665.47	2054.94	2574.99
26445		Tenolysis, extensor tendon, hand OR finger, each tendor	17.18	1434.53		090	1	1529.32	1373.58	1554.06
26449		Tenolysis, complex, extensor tendon, finger, including forearm, each tendor	20.63	1722.61		090	0	2665.47	1938.87	2574.99
26450		Tenotomy, flexor, palm, open, each tendor	11.91	994.49		090	0	1529.32	894.29	1554.06
26455		Tenotomy, flexor, finger, open, each tendor	12.05	1006.18		090	0	1529.32	886.77	1554.06
26460		Tenotomy, extensor, hand or finger, open, each tendor	11.69	976.12		090	1	1529.32	860.89	1554.06
26471		Tenodesis; of proximal interphalangeal joint, each joint	18.20	1519.70		090	0	1529.32	1372.74	1554.06
26474		Tenodesis; of distal joint, each joint	17.54	1464.59		090	2	1529.32	1337.67	1554.06
26476		Lengthening of tendon, extensor, hand or finger, each tendor	17.30	1444.55		090	1	1529.32	1298.43	1554.06
26477		Shortening of tendon, extensor, hand or finger, each tendor	17.23	1438.71		090	1	1529.32	1308.45	1554.06
26478		Lengthening of tendon, flexor, hand or finger, each tendor	18.43	1538.91		090	0	1529.32	1416.16	1554.06
26479		Shortening of tendon, flexor, hand or finger, each tendor	18.30	1528.05		090	2	1529.32	1397.79	1554.06
26480		Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	22.35	1866.23		090	0	2665.47	1735.13	2574.99
26483		Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; with free tendon graft (includes obtaining graft), each tendon	24.95	2083.33		090	2	2665.47	1917.16	2574.99
26485		Transfer or transplant of tendon, palmar; without free tendon graft, each tendor	23.91	1996.49		090	2	2665.47	1849.53	2574.99
26489		Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon	27.75	2317.13		090	0	2665.47	1806.94	2574.99
26490		Opponensplasty; superficialis tendon transfer type, each tendor	23.42	1955.57		090	0	2665.47	1727.62	2574.99
26492		Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendor	26.10	2179.35		090	2	2665.47	1902.13	2574.99
26494		Opponensplasty; hypothenar muscle transfer	23.67	1976.45		090	2	2665.47	1748.49	2574.99
26496		Opponensplasty; other methods	25.20	2104.20		090	0	2665.47	1873.74	2574.99

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
26497		Transfer of tendon to restore intrinsic function; ring and small finger	25.44	2124.24		090	2	2665.47	1888.77	2574.99
26498		Transfer of tendon to restore intrinsic function; all 4 fingers	33.68	2812.28		090	2	2665.47	2486.63	2574.99
26499		Correction claw finger, other methods	24.39	2036.57		090	2	2665.47	1792.75	2574.99
26500		Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure	18.51	1545.59		090	0	1529.32	1406.98	1554.06
26502		Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	21.08	1760.18		090	2	2665.47	1563.12	2574.99
26508		Release of thenar muscle(s) (eg, thumb contracture)	18.98	1584.83		090	0	1529.32	1431.19	1554.06
26510		Cross intrinsic transfer, each tendon	17.68	1476.28		090	0	2665.47	1346.86	2574.99
26516		Capsulodesis, metacarpophalangeal joint; single digit	20.70	1728.45		090	0	2665.47	1570.64	2574.99
26517		Capsulodesis, metacarpophalangeal joint; 2 digits	24.24	2024.04		090	2	2665.47	1830.32	2574.99
26518		Capsulodesis, metacarpophalangeal joint; 3 or 4 digits	24.74	2065.79		090	2	2665.47	1831.16	2574.99
26520		Capsulectomy or capsulotomy; metacarpophalangeal joint, each join	19.36	1616.56		090	1	1529.32	1523.04	1554.06
26525		Capsulectomy or capsulotomy; interphalangeal joint, each join	19.38	1618.23		090	1	1529.32	1532.23	1554.06
26530		Arthroplasty, metacarpophalangeal joint; each join	15.88	1325.98		090	2	3699.98	1093.02	3637.36
26531		Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each join	18.42	1538.07		090	2	5741.03	1274.21	5296.66
26535		Arthroplasty, interphalangeal joint; each joint	12.39	1034.57		090	1	3699.98	777.39	3637.36
26536		Arthroplasty, interphalangeal joint; with prosthetic implant, each join	21.14	1765.19		090	0	5741.03	1359.38	5296.66
26540		Repair of collateral ligament, metacarpophalangeal or interphalangeal join	19.47	1625.75		090	0	1529.32	1481.29	1554.06
26541		Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft)	23.57	1968.10		090	2	2665.47	1787.74	2574.99
26542		Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (eg, adductor advancement)	20.09	1677.52		090	0	1529.32	1522.21	1554.06
26545		Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each join	20.87	1742.65		090	0	2665.47	1547.26	2574.99
26546		Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)	29.36	2451.56		090	2	2665.47	2091.68	2574.99
26548		Repair and reconstruction, finger, volar plate, interphalangeal joint	22.52	1880.42		090	0	2665.47	1698.39	2574.99
26550		Pollicization of a digit	48.75	4070.63		090	2	2665.47	3247.32	2574.99
26551		Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graf	86.29	7205.22		090	2		6773.52	2097.37**
26553		Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single	79.65	6650.78		090	2		5652.95	2097.37**
26554		Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	93.14	7777.19		090	2		7803.08	2097.37**
26555		Transfer, finger to another position without microvascular anastomosis	40.49	3380.92		090	2	2665.47	2909.98	2574.99
26556		Transfer, free toe joint, with microvascular anastomosis	85.74	7159.29		090	2		6386.92	2097.37**
26560		Repair of syndactyly (web finger) each web space; with skin flaps	17.58	1467.93		090	2	1529.32	1240.81	1554.06
26561		Repair of syndactyly (web finger) each web space; with skin flaps and grafts	27.93	2332.16		090	2	2665.47	1917.16	2574.99
26562		Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails	37.52	3132.92		090	2	2665.47	2787.23	2574.99
26565		Osteotomy; metacarpal, each	20.15	1682.53		090	2	2665.47	1512.19	2574.99
26567		Osteotomy; phalanx of finger, each	20.10	1678.35		090	0	2665.47	1523.04	2574.99
26568		Osteoplasty, lengthening, metacarpal or phalanx	26.73	2231.96		090	2	2665.47	1990.64	2574.99
26580		Repair cleft hand	44.57	3721.60		090	2	1529.32	2747.15	1554.06
26587		Reconstruction of polydactylous digit, soft tissue and bone	31.00	2588.50		090	2	1529.32	1960.58	1554.06
26590		Repair macrodactylia, each digit	37.79	3155.47		090	2	1529.32	2715.42	1554.06
26591		Repair, intrinsic muscles of hand, each muscle	13.07	1091.35		090	0	2665.47	1022.04	2574.99
26593		Release, intrinsic muscles of hand, each muscle	17.72	1479.62		090	1	1529.32	1328.49	1554.06
26596		Excision of constricting ring of finger, with multiple Z-plasties	22.51	1879.59		090	2	1529.32	1505.51	1554.06
26600		Closed treatment of metacarpal fracture, single; without manipulation, each bone	8.89	742.32		090	1	172.42	517.70	151.16
26605		Closed treatment of metacarpal fracture, single; with manipulation, each bone	9.69	809.12		090	1	172.42	631.26	151.16
26607		Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone	13.59	1134.77		090	0	1077.75	973.61	1677.55
26608		Percutaneous skeletal fixation of metacarpal fracture, each bone	14.21	1186.54		090	0	2462.57	982.80	2356.77
26615		Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	17.13	1430.36		090	1	4855.82	907.65	4146.21

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
26641		Closed treatment of carpometacarpal dislocation, thumb, with manipulatior	11.03	921.01		090	0	172.42	707.25	151.16
26645		Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	12.75	1064.63		090	0	514.57	811.62	437.22
26650		Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	14.23	1188.21		090	1	2462.57	1051.27	2356.77
26665		Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), includes internal fixation, when performed	18.70	1561.45		090	1	4855.82	1192.38	4146.21
26670		Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia	9.91	827.49		090	0	172.42	653.81	151.16
26675		Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia	13.58	1133.93		090	0	172.42	862.56	437.22
26676		Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint	14.93	1246.66		090	1	2462.57	1032.90	2356.77
26685		Open treatment of carpometacarpal dislocation, other than thumb; includes internal fixation, when performed, each joint	17.25	1440.38		090	1	2462.57	1122.24	2356.77
26686		Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple, or delayed reduction	18.51	1545.59		090	2	6502.42	1270.04	5970.68
26700		Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	9.74	813.29		090	1	172.42	614.56	151.16
26705		Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia	12.40	1035.40		090	0	172.42	809.12	151.16
26706		Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulatior	13.11	1094.69		090	1	1077.75	875.08	1677.55
26715		Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	17.09	1427.02		090	0	2462.57	959.42	2356.77
26720		Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	6.00	501.00		090	1	172.42	375.75	151.16
26725		Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each	10.13	845.86		090	1	172.42	683.03	151.16
26727		Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each	13.96	1165.66		090	1	2462.57	967.77	2356.77
26735		Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each	17.74	1481.29		090	1	2462.57	984.47	2356.77
26740		Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each	6.88	574.48		090	1	172.42	433.37	151.16
26742		Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each	10.99	917.67		090	1	172.42	744.82	151.16
26746		Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	21.95	1832.83		090	1	2462.57	968.60	2356.77
26750		Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, eacl	5.56	464.26		090	1	172.42	350.70	151.16
26755		Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, eacl	9.47	790.75		090	1	172.42	627.92	151.16
26756		Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, eacl	12.49	1042.92		090	0	2462.57	854.21	2356.77
26765		Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each	14.95	1248.33		090	1	2462.57	730.63	2356.77
26770		Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesi	8.33	695.56		090	1	172.42	528.56	151.16
26775		Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia	11.56	965.26		090	1	1340.50	749.00	1394.50
26776		Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulatior	13.18	1100.53		090	1	2462.57	910.99	2356.77
26785		Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single	16.27	1358.55		090	1	2462.57	744.82	2356.77
26820		Fusion in opposition, thumb, with autogenous graft (includes obtaining graft	23.32	1947.22		090	2	2665.47	1745.99	2574.99

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
26841		Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation	21.60	1803.60		090	0	2665.47	1649.96	2574.99
26842		Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)	23.25	1941.38		090	2	2665.47	1763.52	2574.99
26843		Arthrodesis, carpometacarpal joint, digit, other than thumb, each	21.88	1826.98		090	2	2665.47	1616.56	2574.99
26844		Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)	24.06	2009.01		090	2	2665.47	1805.27	2574.99
26850		Arthrodesis, metacarpophalangeal joint, with or without internal fixation	20.41	1704.24		090	0	2665.47	1553.94	2574.99
26852		Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	23.36	1950.56		090	2	2665.47	1745.99	2574.99
26860		Arthrodesis, interphalangeal joint, with or without internal fixation	16.73	1396.96		090	1	2665.47	1276.72	2574.99
26861		Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)	3.03	253.01		ZZZ	1	2665.47	226.29	2574.99
26862		Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)	21.38	1785.23		090	2	2665.47	1605.71	2574.99
26863		Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	6.94	579.49		ZZZ	2	2665.47	505.18	2574.99
26910		Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	21.15	1766.03		090	1	2665.47	1549.76	2574.99
26951		Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	19.40	1619.90		090	1	1529.32	1309.28	1554.06
26952		Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)	19.09	1594.02		090	1	1529.32	1454.57	1554.06
26989		Unlisted procedure, hands or fingers	0.00	BR		YYY	1	172.42	BR	151.16
26990		Incision and drainage, pelvis or hip joint area; deep abscess or hematoma	18.64	1556.44		090	1	2006.48	1273.38	2007.54
26991		Incision and drainage, pelvis or hip joint area; infected bursa	21.29	1777.72		090	0	2006.48	1493.82	2007.54
26992		Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess	28.54	2383.09		090	0		2015.69	2097.37**
27000		Tenotomy, adductor of hip, percutaneous (separate procedure)	12.60	1052.10		090	1	2006.48	932.70	2007.54
27001		Tenotomy, adductor of hip, open	16.15	1348.53		090	2	2975.93	1123.91	2897.26
27003		Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	17.70	1477.95		090	2	2975.93	1199.90	2897.26
27005		Tenotomy, hip flexor(s), open (separate procedure)	21.56	1800.26		090	2		1524.71	2097.37**
27006		Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure	21.92	1830.32		090	2	2975.93	1535.57	2897.26
27025		Fasciotomy, hip or thigh, any type	27.36	2284.56		090	0		1810.28	2097.37**
27027		Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral	25.09	2095.02		090	0	2975.93	1817.80	2007.54
27030		Arthrotomy, hip, with drainage (eg, infection)	26.80	2237.80		090	2		1980.62	2097.37**
27033		Arthrotomy, hip, including exploration or removal of loose or foreign body	28.84	2408.14		090	2	4434.79	2043.25	4247.50
27035		Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves	29.70	2479.95		090	2	2975.93	2381.42	4247.50
27036		Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	29.94	2499.99		090	2		2068.30	2097.37**
27040		Biopsy, soft tissue of pelvis and hip area; superficial	10.22	853.37		010	1	752.91	671.34	748.01
27041		Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular	20.26	1691.71		090	1	752.91	1404.47	748.01
27043		Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	14.00	1169.00		090	1	2142.94	1059.62	2132.75
27045		Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	22.09	1844.52		090	2	2142.94	1683.36	2132.75
27047		Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	14.12	1179.02		090	1	1447.15	1242.48	1595.60
27048		Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	18.12	1513.02		090	2	1447.15	957.75	1595.60
27049		Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm	40.12	3350.02		090	2	1447.15	2012.35	1595.60
27050		Arthrotomy, with biopsy; sacroiliac joint	12.00	1002.00		090	0	2006.48	754.84	2007.54

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27052		Arthrotomy, with biopsy; hip joint	17.25	1440.38		090	2	2006.48	1123.08	2007.54
27054		Arthrotomy with synovectomy, hip joint	20.39	1702.57		090	2		1401.13	2097.37**
27057		Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral	28.11	2347.19		090	0	2006.48	2056.61	2007.54
27059		Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater	53.28	4448.88		090	2	2142.94	4126.57	2132.75
27060		Excision; ischial bursa	13.85	1156.48		090	1	2006.48	867.57	2007.54
27062		Excision; trochanteric bursa or calcification	13.60	1135.60		090	1	2006.48	924.35	2007.54
27065		Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed	15.39	1285.07		090	2	2006.48	1015.36	2007.54
27066		Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	24.11	2013.19		090	2	2975.93	1665.83	2897.26
27067		Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; with autograft requiring separate incision	30.64	2558.44		090	2	2975.93	2100.86	2897.26
27070		Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg osteomyelitis or bone abscess); superficial	25.20	2104.20		090	2		1743.48	2097.37**
27071		Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg osteomyelitis or bone abscess); deep (subfascial or intramuscular)	27.27	2277.05		090	2		1893.78	2097.37**
27075		Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	62.04	5180.34		090	2		4786.22	2097.37**
27076		Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	75.06	6267.51		090	2		3307.44	2097.37**
27077		Radical resection of tumor; innominate bone, total	83.72	6990.62		090	2		5546.07	2097.37**
27078		Radical resection of tumor; ischial tuberosity and greater trochanter of femur	61.18	5108.53		090	2		2085.83	2097.37**
27080		Coccygectomy, primary	15.31	1278.39		090	2	2975.93	990.31	2897.26
27086		Removal of foreign body, pelvis or hip; subcutaneous tissue	7.81	652.14		010	0	752.91	526.05	748.01
27087		Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular)	18.69	1560.62		090	2	2006.48	1302.60	2007.54
27090		Removal of hip prosthesis; (separate procedure)	24.65	2058.28		090	2		1737.64	2097.37**
27091		Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	47.37	3955.40		090	2		3284.89	2097.37**
27093		Injection procedure for hip arthrography; without anesthesia	5.75	480.13		000	1		450.07	
27095		Injection procedure for hip arthrography; with anesthesia	7.21	602.04		000	1		557.78	
27096		Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	5.02	419.17		000	1		435.87	
27097		Release or recession, hamstring, proximal	20.12	1680.02		090	2	2975.93	1353.54	2897.26
27098		Transfer, adductor to ischium	20.60	1720.10		090	2	2975.93	1311.79	2897.26
27100		Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft	24.48	2044.08		090	2	4434.79	1694.22	4247.50
27105		Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	25.66	2142.61		090	2	4434.79	1777.72	4247.50
27110		Transfer iliopsoas; to greater trochanter of femur	28.69	2395.62		090	2	4434.79	1958.08	4247.50
27111		Transfer iliopsoas; to femoral neck	26.63	2223.61		090	2	4434.79	1841.18	4247.50
27120		Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)	38.22	3191.37		090	2		2660.31	2097.37**
27122		Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)	32.61	2722.94		090	2		2307.94	2097.37**
27125		Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	33.62	2807.27		090	2		2317.13	2097.37**
27130		Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	42.75	3569.63		090	2		2998.49	2097.37**
27132		Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograf	49.70	4149.95		090	2		3516.19	2097.37**
27134		Revision of total hip arthroplasty; both components, with or without autograft or allograf	56.77	4740.30		090	2		4102.36	2097.37**
27137		Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograf	43.68	3647.28		090	2		3121.23	2097.37**
27138		Revision of total hip arthroplasty; femoral component only, with or without allograf	45.41	3791.74		090	2		3248.15	2097.37**
27140		Osteotomy and transfer of greater trochanter of femur (separate procedure)	26.60	2221.10		090	2		1881.26	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27146		Osteotomy, iliac, acetabular or innominate bone	38.05	3177.18		090	2		2638.60	2097.37**
27147		Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip	43.49	3631.42		090	2		3022.70	2097.37**
27151		Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	47.06	3929.51		090	2		2882.42	2097.37**
27156		Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	50.70	4233.45		090	2		3597.18	2097.37**
27158		Osteotomy, pelvis, bilateral (eg, congenital malformation)	37.58	3137.93		090	2		2669.50	2097.37**
27161		Osteotomy, femoral neck (separate procedure)	36.00	3006.00		090	2		2555.10	2097.37**
27165		Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cas	40.78	3405.13		090	2		2820.63	2097.37**
27170		Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	34.88	2912.48		090	2		2459.91	2097.37**
27175		Treatment of slipped femoral epiphysis; by traction, without reductior	19.76	1649.96		090	0		1359.38	2097.37**
27176		Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	27.22	2272.87		090	2		1882.93	2097.37**
27177		Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	32.99	2754.67		090	2		2301.26	2097.37**
27178		Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	27.22	2272.87		090	2		1834.50	2097.37**
27179		Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure	28.90	2413.15		090	2	7563.12	2032.39	8084.19
27181		Open treatment of slipped femoral epiphysis; osteotomy and internal fixatior	33.30	2780.55		090	2		2176.01	2097.37**
27185		Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femu	20.05	1674.18		090	1		1538.07	2097.37**
27187		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	29.44	2458.24		090	2		2085.83	2097.37**
27193		Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulatior	14.03	1171.51		090	1	172.42	945.22	151.16
27194		Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia	21.01	1754.34		090	0	1340.50	1513.02	1394.50
27200		Closed treatment of coccygeal fracture	5.40	450.90		090	1	172.42	346.53	151.16
27202		Open treatment of coccygeal fracture	15.82	1320.97		090	2	4855.82	1921.34	4146.21
27215		Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed	17.68	1476.28		090	9		1530.56	2097.37**
27216		Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)	26.20	2187.70		090	9		2196.89	2097.37**
27217		Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)	24.60	2054.10		090	9		2120.07	2097.37**
27218		Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)	33.87	2828.15		090	9		2815.62	2097.37**
27220		Closed treatment of acetabulum (hip socket) fracture(s); without manipulatior	15.79	1318.47		090	1	172.42	1062.12	151.16
27222		Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction	28.66	2393.11		090	1		2034.90	2097.37**
27226		Open treatment of posterior or anterior acetabular wall fracture, with internal fixatior	31.32	2615.22		090	2		2046.59	2097.37**
27227		Open treatment of acetabular fracture(s) involving anterior or posterior (1) column, or a fracture running transversely across the acetabulum, with internal fixation	49.16	4104.86		090	2		3478.61	2097.37**
27228		Open treatment of acetabular fracture(s) involving anterior and posterior (2) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with	55.92	4669.32		090	2		3996.31	2097.37**
27230		Closed treatment of femoral fracture, proximal end, neck; without manipulatior	14.21	1186.54		090	1	172.42	956.08	151.16
27232		Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	22.58	1885.43		090	1		1605.71	2097.37**
27235		Percutaneous skeletal fixation of femoral fracture, proximal end, neck	26.96	2251.16		090	1	2975.93	1904.64	2897.26
27236		Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacemen	35.52	2965.92		090	2		2442.38	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27238		Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; without manipulation	13.77	1149.80		090	1	514.57	917.67	437.22
27240		Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	28.52	2381.42		090	1		1969.77	2097.37**
27244		Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	36.51	3048.59		090	2		2425.68	2097.37**
27245		Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	36.52	3469.40		090	2		3390.55	2097.37**
27246		Closed treatment of greater trochanteric fracture, without manipulation	11.47	957.75		090	1	514.57	785.74	437.22
27248		Open treatment of greater trochanteric fracture, includes internal fixation, when performed	22.04	1840.34		090	2		1624.08	2097.37**
27250		Closed treatment of hip dislocation, traumatic; without anesthesia	5.37	448.40		000	1	172.42	971.94	151.16
27252		Closed treatment of hip dislocation, traumatic; requiring anesthesia	22.54	1882.09		090	1	1340.50	1560.62	1394.50
27253		Open treatment of hip dislocation, traumatic, without internal fixation	27.94	2332.99		090	2		1984.80	2097.37**
27254		Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	37.36	3119.56		090	2		2651.96	2097.37**
27256		Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation	9.15	764.03		010	0	172.42	627.92	151.16
27257		Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; with manipulation, requiring anesthesia	9.90	826.65		010	0	1340.50	688.88	1394.50
27258		Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	32.82	2740.47		090	2		2305.44	2097.37**
27259		Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	45.92	3834.32		090	2		3197.22	2097.37**
27265		Closed treatment of post hip arthroplasty dislocation; without anesthesia	12.06	1007.01		090	1	172.42	819.97	151.16
27266		Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	17.28	1442.88		090	1	1340.50	1197.39	1394.50
27267		Closed treatment of femoral fracture, proximal end, head; without manipulation	13.06	1090.51		090	2	172.42	842.52	151.16
27268		Closed treatment of femoral fracture, proximal end, head; with manipulation	15.98	1334.33		090	2		1036.56	2097.37**
27269		Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	36.79	3071.97		090	2		2463.72	2097.37**
27275		Manipulation, hip joint, requiring general anesthesia	5.46	455.91		010	1	1340.50	375.75	1394.50
27280		Arthrodesis, sacroiliac joint (including obtaining graft)	30.95	2584.33		090	2		2132.59	2097.37**
27282		Arthrodesis, symphysis pubis (including obtaining graft)	25.33	2115.06		090	2		1700.90	2097.37**
27284		Arthrodesis, hip joint (including obtaining graft);	47.83	3993.81		090	2		3392.61	2097.37**
27286		Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	48.88	4081.48		090	2		3408.47	2097.37**
27290		Interpelviabdominal amputation (hindquarter amputation)	48.05	4012.18		090	2		3261.51	2097.37**
27295		Disarticulation of hip	37.38	3121.23		090	2		2627.75	2097.37**
27299		Unlisted procedure, pelvis or hip joint	0.00	BR		YYY	2	172.42	BR	151.16
27301		Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region	20.26	1691.71		090	1	1701.78	1389.44	1769.66
27303		Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess	18.98	1584.83		090	2		1323.48	2097.37**
27305		Fasciotomy, iliotibial (tenotomy), open	14.40	1202.40		090	2	2006.48	962.76	2007.54
27306		Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure	10.83	904.31		090	2	2006.48	801.60	2007.54
27307		Tenotomy, percutaneous, adductor or hamstring; multiple tendons	14.29	1193.22		090	0	2975.93	972.78	2007.54
27310		Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection	21.73	1814.46		090	2	2975.93	1494.65	2897.26
27323		Biopsy, soft tissue of thigh or knee area; superficial	8.28	691.38		010	1	752.91	498.50	748.01
27324		Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)	11.77	982.80		090	1	2142.94	776.55	2132.75
27325		Neurectomy, hamstring muscle	16.56	1382.76		090	2	1734.81	1047.93	1707.08
27326		Neurectomy, popliteal (gastrocnemius)	15.29	1276.72		090	2	1734.81	993.65	1707.08
27327		Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	13.96	1165.66		090	1	2142.94	894.29	2132.75
27328		Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	18.52	1546.42		090	1	1447.15	850.03	1595.60

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27329		Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm	30.65	2559.28		090	2	1447.15	2100.86	1595.60
27330		Arthrotomy, knee; with synovial biopsy only	12.33	1029.56		090	1	2975.93	820.81	2897.26
27331		Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies	14.20	1185.70		090	2	2975.93	976.95	2897.26
27332		Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR latera	19.06	1591.51		090	2	2975.93	1320.14	2897.26
27333		Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND latera	17.42	1454.57		090	2	2975.93	1200.73	2897.26
27334		Arthrotomy, with synovectomy, knee; anterior OR posterio	20.36	1700.06		090	2	2975.93	1407.81	2897.26
27335		Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	22.71	1896.29		090	2	2975.93	1592.35	2897.26
27337		Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greate	12.49	1042.92		090	2	2142.94	944.39	2132.75
27339		Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greate	22.30	1862.05		090	2	2142.94	1700.90	2132.75
27340		Excision, prepatellar bursa	11.11	927.69		090	1	2006.48	747.33	2007.54
27345		Excision of synovial cyst of popliteal space (eg, Baker's cyst)	14.32	1195.72		090	2	2006.48	986.97	2007.54
27347		Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee	15.76	1315.96		090	2	2006.48	1025.38	2007.54
27350		Patellectomy or hemipatellectomy	19.42	1621.57		090	2	2975.93	1344.35	2897.26
27355		Excision or curettage of bone cyst or benign tumor of femur	17.93	1497.16		090	2	2975.93	1250.00	2897.26
27356		Excision or curettage of bone cyst or benign tumor of femur; with allograf	21.92	1830.32		090	2	2975.93	1522.21	2897.26
27357		Excision or curettage of bone cyst or benign tumor of femur; with autograft (includes obtaining graft	24.16	2017.36		090	2	2975.93	1694.22	2897.26
27358		Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)	8.18	683.03		ZZZ	2	2975.93	621.24	2897.26
27360		Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	25.39	2120.07		090	2	2975.93	1773.54	2897.26
27364		Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5 cm or greater	46.06	3846.01		090	2	2142.94	3552.93	2132.75
27365		Radical resection of tumor, femur or knee	61.20	5110.20		090	2		2532.56	2097.37**
27370		Injection procedure for knee arthrography	4.98	415.83		000	1		368.24	
27372		Removal of foreign body, deep, thigh region or knee area	18.38	1534.73		090	0	2142.94	1256.68	2132.75
27380		Suture of infrapatellar tendon; primary	17.74	1481.29		090	2	2975.93	1237.47	2007.54
27381		Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graf	23.74	1982.29		090	2	2975.93	1676.68	2007.54
27385		Suture of quadriceps or hamstring muscle rupture; primary	17.23	1438.71		090	2	2975.93	1325.98	2007.54
27386		Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft	24.80	2070.80		090	2	2975.93	1742.65	2007.54
27390		Tenotomy, open, hamstring, knee to hip; single tendor	13.36	1115.56		090	2	2006.48	900.97	2007.54
27391		Tenotomy, open, hamstring, knee to hip; multiple tendons, 1 leg	17.14	1431.19		090	0	2006.48	1184.03	2007.54
27392		Tenotomy, open, hamstring, knee to hip; multiple tendons, bilatera	21.13	1764.36		090	2	2975.93	1461.25	2007.54
27393		Lengthening of hamstring tendon; single tendor	15.17	1266.70		090	2	2975.93	1050.43	2897.26
27394		Lengthening of hamstring tendon; multiple tendons, 1 leg	19.36	1616.56		090	2	2975.93	1356.88	2897.26
27395		Lengthening of hamstring tendon; multiple tendons, bilatera	26.03	2173.51		090	2	4434.79	1831.16	4247.50
27396		Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon	18.28	1526.38		090	2	2975.93	1278.39	2897.26
27397		Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); multiple tendons	27.17	2268.70		090	2	4434.79	1831.16	4247.50
27400		Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)	20.61	1720.94		090	2	4434.79	1384.43	4247.50
27403		Arthrotomy with meniscus repair, knee	19.04	1589.84		090	2	2975.93	1336.00	2897.26
27405		Repair, primary, torn ligament and/or capsule, knee; collatera	20.16	1683.36		090	2	4434.79	1402.80	4247.50
27407		Repair, primary, torn ligament and/or capsule, knee; cruciate	23.50	1962.25		090	2	7563.12	1614.89	8084.19
27409		Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	28.59	2387.27		090	2	7563.12	2006.51	4247.50
27412		Autologous chondrocyte implantation, knee	48.96	4088.16		090	2	7563.12	3419.33	8084.19
27415		Osteochondral allograft, knee, open	40.71	3399.29		090	2	7563.12	2884.93	8084.19
27416		Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s]	29.03	2424.01		090	0	4434.79	1935.36	4247.50
27418		Anterior tibial tubercleplasty (eg, Maquet type procedure)	24.72	2064.12		090	2	4434.79	1735.97	4247.50

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27420		Reconstruction of dislocating patella; (eg, Hauser type procedure)	21.62	1805.27		090	2	4434.79	1558.95	4247.50
27422		Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)	22.10	1845.35		090	2	4434.79	1553.10	4247.50
27424		Reconstruction of dislocating patella; with patellectomy	22.17	1851.20		090	2	4434.79	1553.94	4247.50
27425		Lateral retinacular release, open	13.37	1116.40		090	1	2975.93	916.00	2897.26
27427		Ligamentous reconstruction (augmentation), knee; extra-articular	21.31	1779.39		090	2	7563.12	1491.31	4247.50
27428		Ligamentous reconstruction (augmentation), knee; intra-articular (open)	33.07	2761.35		090	2	7563.12	2270.37	8084.19
27429		Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	37.07	3095.35		090	2	7563.12	2535.90	8084.19
27430		Quadricepsplasty (eg, Bennett or Thompson type)	22.03	1839.51		090	2	4434.79	1541.41	4247.50
27435		Capsulotomy, posterior capsular release, knee	24.10	2012.35		090	2	2975.93	1636.60	4247.50
27437		Arthroplasty, patella; without prosthesis	19.61	1637.44		090	1	3699.98	1370.24	3637.36
27438		Arthroplasty, patella; with prosthesis	25.00	2087.50		090	2	5741.03	1741.81	5296.66
27440		Arthroplasty, knee, tibial plateau;	23.65	1974.78		090	2	3699.98	1501.33	3637.36
27441		Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	24.42	2039.07		090	2	3699.98	1593.18	3637.36
27442		Arthroplasty, femoral condyles or tibial plateau(s), knee	25.81	2155.14		090	2	3699.98	1816.96	3637.36
27443		Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	24.21	2021.54		090	2	3699.98	1708.41	3637.36
27445		Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	37.15	3102.03		090	2		2643.61	2097.37**
27446		Arthroplasty, knee, condyle and plateau; medial OR lateral compartmen	32.79	2737.97		090	2	12387.27	2358.04	10830.36
27447		Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	45.64	3810.94		090	2		3228.11	2097.37**
27448		Osteotomy, femur, shaft or supracondylar; without fixatior	24.42	2039.07		090	2		1720.10	2097.37**
27450		Osteotomy, femur, shaft or supracondylar; with fixatior	30.16	2518.36		090	2		2136.77	2097.37**
27454		Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)	38.47	3212.25		090	2		2693.71	2097.37**
27455		Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); before epiphyseal closure	27.91	2330.49		090	2		1977.28	2097.37**
27457		Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); after epiphyseal closure	28.47	2377.25		090	2		2035.73	2097.37**
27465		Osteoplasty, femur; shortening (excluding 64876)	37.04	3092.84		090	2		2449.06	2097.37**
27466		Osteoplasty, femur; lengthening	34.98	2920.83		090	2		2472.44	2097.37**
27468		Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfe	39.71	3315.79		090	2		2775.54	2097.37**
27470		Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	34.94	2917.49		090	2		2460.75	2097.37**
27472		Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	37.53	3133.76		090	2		2670.33	2097.37**
27475		Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur	19.64	1639.94		090	1	2975.93	1371.07	2897.26
27477		Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proxima	21.72	1813.62		090	1		1522.21	2097.37**
27479		Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula	25.59	2136.77		090	2	2975.93	1922.17	2897.26
27485		Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	19.90	1661.65		090	1		1399.46	2097.37**
27486		Revision of total knee arthroplasty, with or without allograft; 1 componen	41.77	3487.80		090	2		2944.21	2097.37**
27487		Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial componen	52.15	4354.53		090	2		3721.60	2097.37**
27488		Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	35.69	2980.12		090	2		2485.80	2097.37**
27495		Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femu	33.47	2794.75		090	2		2376.41	2097.37**
27496		Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor)	16.19	1351.87		090	1	2975.93	1038.74	2897.26
27497		Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve	17.29	1443.72		090	0	2006.48	1112.22	2007.54
27498		Decompression fasciotomy, thigh and/or knee, multiple compartments	19.43	1622.41		090	2	2975.93	1229.96	2897.26

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27499		Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	20.79	1735.97		090	2	2975.93	1371.07	2897.26
27500		Closed treatment of femoral shaft fracture, without manipulation	15.42	1287.57		090	1	514.57	1048.76	437.22
27501		Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation	15.00	1252.50		090	0	172.42	1030.39	151.16
27502		Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	22.89	1911.32		090	1	1077.75	1646.62	1677.55
27503		Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction	23.86	1992.31		090	0	172.42	1661.65	151.16
27506		Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	39.72	3316.62		090	2		2747.99	2097.37**
27507		Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	28.85	2408.98		090	2		2071.64	2097.37**
27508		Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation	15.75	1315.13		090	1	172.42	1061.29	151.16
27509		Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation	19.26	1608.21		090	0	2462.57	1349.36	2356.77
27510		Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	20.40	1703.40		090	1	514.57	1447.06	437.22
27511		Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	29.54	2466.59		090	2		2137.60	2097.37**
27513		Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	36.73	3066.96		090	2		2839.00	2097.37**
27514		Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	28.66	2393.11		090	2		2772.20	2097.37**
27516		Closed treatment of distal femoral epiphyseal separation; without manipulation	15.21	1270.04		090	1	172.42	993.65	151.16
27517		Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction	20.36	1700.06		090	0	172.42	1370.24	151.16
27519		Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed	26.35	2200.23		090	2		2332.99	2097.37**
27520		Closed treatment of patellar fracture, without manipulation	9.79	817.47		090	1	172.42	629.59	151.16
27524		Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	22.39	1869.57		090	2	4855.82	1577.32	4146.21
27530		Closed treatment of tibial fracture, proximal (plateau); without manipulation	9.14	763.19		090	1	172.42	785.74	151.16
27532		Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction	18.37	1533.90		090	1	1077.75	1258.35	1677.55
27535		Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	26.59	2220.27		090	2		1859.55	2097.37**
27536		Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	35.33	2950.06		090	2		2462.42	2097.37**
27538		Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation	14.22	1187.37		090	0	172.42	941.05	151.16
27540		Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	24.10	2012.35		090	2		1964.76	2097.37**
27550		Closed treatment of knee dislocation; without anesthesia	14.94	1247.49		090	0	172.42	989.48	151.16
27552		Closed treatment of knee dislocation; requiring anesthesia	18.66	1558.11		090	0	1340.50	1280.89	1394.50
27556		Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction	25.93	2165.16		090	2		2257.84	2097.37**
27557		Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	30.96	2585.16		090	2		2592.68	2097.37**
27558		Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	35.26	2944.21		090	2		2650.29	2097.37**
27560		Closed treatment of patellar dislocation; without anesthesia	11.00	918.50		090	1	172.42	709.75	151.16
27562		Closed treatment of patellar dislocation; requiring anesthesia	14.40	1202.40		090	0	1340.50	910.15	1394.50

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27566		Open treatment of patellar dislocation, with or without partial or total patellectom	26.48	2211.08		090	2	4855.82	1871.24	4146.21
27570		Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	4.50	375.75		010	1	1340.50	301.44	1394.50
27580		Arthrodesis, knee, any technique	42.71	3566.29		090	2		3037.73	2097.37**
27590		Amputation, thigh, through femur, any level	24.30	2029.05		090	2		1694.22	2097.37**
27591		Amputation, thigh, through femur, any level; immediate fitting technique including first cas	28.78	2403.13		090	2		1903.80	2097.37**
27592		Amputation, thigh, through femur, any level; open, circular (guillotine)	20.78	1735.13		090	2		1437.87	2097.37**
27594		Amputation, thigh, through femur, any level; secondary closure or scar revisior	15.26	1274.21		090	1	2006.48	1047.09	2007.54
27596		Amputation, thigh, through femur, any level; re-amputatior	21.92	1830.32		090	1		1521.37	2097.37**
27598		Disarticulation at knee	21.96	1833.66		090	2		1542.25	2097.37**
27599		Unlisted procedure, femur or knee	0.00	BR		YYY	2	172.42	BR	151.16
27600		Decompression fasciotomy, leg; anterior and/or lateral compartments only	12.46	1040.41		090	1	2006.48	881.76	2007.54
27601		Decompression fasciotomy, leg; posterior compartment(s) only	13.26	1107.21		090	1	2006.48	905.14	2007.54
27602		Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)	14.99	1251.67		090	2	2975.93	1083.00	2007.54
27603		Incision and drainage, leg or ankle; deep abscess or hematoma	16.29	1360.22		090	1	1701.78	1061.29	1769.66
27604		Incision and drainage, leg or ankle; infected bursa	14.65	1223.28		090	0	2975.93	912.66	2007.54
27605		Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	10.41	869.24		010	0	2043.42	842.52	1991.95
27606		Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	8.51	710.59		010	1	2006.48	635.44	2007.54
27607		Incision (eg, osteomyelitis or bone abscess), leg or ankle	18.11	1512.19		090	1	2006.48	1255.84	2007.54
27610		Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	19.35	1615.73		090	1	2975.93	1361.05	2897.26
27612		Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	16.62	1387.77		090	2	2975.93	1189.88	2897.26
27613		Biopsy, soft tissue of leg or ankle area; superficial	7.75	647.13		010	1	752.91	464.26	748.01
27614		Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular)	17.68	1476.28		090	1	2142.94	1105.54	2132.75
27615		Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm	30.41	2539.24		090	0	1447.15	1882.09	1595.60
27616		Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater	37.28	3112.88		090	0	2142.94	2899.12	2132.75
27618		Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	13.51	1128.09		090	1	1447.15	955.24	1595.60
27619		Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	14.24	1189.04		090	1	1447.15	1546.42	1595.60
27620		Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	13.52	1128.92		090	2	2975.93	972.78	2897.26
27625		Arthrotomy, with synovectomy, ankle	17.20	1436.20		090	2	2975.93	1257.51	2897.26
27626		Arthrotomy, with synovectomy, ankle; including tenosynovectom	18.51	1545.59		090	2	2975.93	1356.88	2897.26
27630		Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle	17.01	1420.34		090	1	2006.48	1065.46	2007.54
27632		Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	12.41	1036.24		090	2	2142.94	931.86	2132.75
27634		Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	20.28	1693.38		090	2	2142.94	1519.70	2132.75
27635		Excision or curettage of bone cyst or benign tumor, tibia or fibula	17.56	1466.26		090	1	2975.93	1244.15	2897.26
27637		Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)	22.58	1885.43		090	2	2975.93	1572.31	2897.26
27638		Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograf	23.08	1927.18		090	2	2975.93	1636.60	2897.26
27640		Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	24.82	2072.47		090	1	2975.93	1883.76	4247.50
27641		Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	19.74	1648.29		090	1	2975.93	1517.20	2897.26
27645		Radical resection of tumor; tibia	52.64	4395.44		090	2		2265.36	2097.37**
27646		Radical resection of tumor; fibula	45.70	3815.95		090	2		2031.56	2097.37**
27647		Radical resection of tumor; talus or calcaneus	30.56	2551.76		090	2	2975.93	1728.45	4247.50
27648		Injection procedure for ankle arthrography	4.97	415.00		000	0		354.04	
27650		Repair, primary, open or percutaneous, ruptured Achilles tendon	19.86	1658.31		090	2	4434.79	1482.13	4247.50
27652		Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	20.26	1691.71		090	1	7563.12	1581.49	8084.19
27654		Repair, secondary, Achilles tendon, with or without graf	21.00	1753.50		090	2	4434.79	1479.62	4247.50

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27656		Repair, fascial defect of leg	19.33	1614.06		090	2	2006.48	1107.21	2007.54
27658		Repair, flexor tendon, leg; primary, without graft, each tendor	11.29	942.72		090	2	2006.48	810.79	2007.54
27659		Repair, flexor tendon, leg; secondary, with or without graft, each tendor	14.51	1211.59		090	2	2006.48	1072.14	2007.54
27664		Repair, extensor tendon, leg; primary, without graft, each tendor	10.89	909.32		090	0	2975.93	779.06	2897.26
27665		Repair, extensor tendon, leg; secondary, with or without graft, each tendor	12.42	1037.07		090	2	2975.93	889.28	2897.26
27675		Repair, dislocating peroneal tendons; without fibular osteotomy	14.61	1219.94		090	2	2006.48	1094.69	2007.54
27676		Repair, dislocating peroneal tendons; with fibular osteotomy	18.58	1551.43		090	2	2975.93	1304.27	2897.26
27680		Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendor	12.94	1080.49		090	1	2975.93	924.35	2897.26
27681		Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	16.26	1357.71		090	1	2975.93	1087.17	2897.26
27685		Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure	20.08	1676.68		090	2	2975.93	1215.76	2897.26
27686		Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	16.43	1371.91		090	1	2975.93	1196.56	2897.26
27687		Gastrocnemius recession (eg, Strayer procedure)	13.66	1140.61		090	2	2975.93	984.47	2897.26
27690		Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	18.84	1573.14		090	2	4434.79	1297.59	4247.50
27691		Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	22.44	1873.74		090	2	4434.79	1536.40	4247.50
27692		Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)	3.14	262.19		ZZZ	2	4434.79	240.48	4247.50
27695		Repair, primary, disrupted ligament, ankle; collateral	14.37	1199.90		090	1	2975.93	1054.61	2897.26
27696		Repair, primary, disrupted ligament, ankle; both collateral ligaments	16.68	1392.78		090	1	2975.93	1259.18	2897.26
27698		Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	19.15	1599.03		090	2	2975.93	1395.29	2897.26
27700		Arthroplasty, ankle;	17.57	1467.10		090	2	3699.98	1289.24	3637.36
27702		Arthroplasty, ankle; with implant (total ankle)	28.91	2413.99		090	2		2109.21	2097.37**
27703		Arthroplasty, ankle; revision, total ankle	33.61	2806.44		090	2		2403.13	2097.37**
27704		Removal of ankle implant	17.47	1458.75		090	1	2006.48	1153.14	2007.54
27705		Osteotomy; tibia	22.58	1885.43		090	2	4434.79	1614.89	4247.50
27707		Osteotomy; fibula	12.12	1012.02		090	1	2975.93	817.47	2007.54
27709		Osteotomy; tibia and fibula	34.71	2898.29		090	2	2975.93	2164.32	2897.26
27712		Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure	32.77	2736.30		090	2		2248.66	2097.37**
27715		Osteoplasty, tibia and fibula, lengthening or shortening	31.54	2633.59		090	2		2225.28	2097.37**
27720		Repair of nonunion or malunion, tibia; without graft, (eg, compression technique	26.11	2180.19		090	2	4855.82	1844.52	4146.21
27722		Repair of nonunion or malunion, tibia; with sliding graft	26.39	2203.57		090	2	6502.42	1837.00	5970.68
27724		Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft	37.58	3137.93		090	2		2696.22	2097.37**
27725		Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	36.19	3021.87		090	2		2482.46	2097.37**
27726		Repair of fibula nonunion and/or malunion with internal fixation	28.96	2418.16		090	1	4855.82	1815.24	4146.21
27727		Repair of congenital pseudarthrosis, tibia	30.72	2565.12		090	2		2135.10	2097.37**
27730		Arrest, epiphyseal (epiphysiodesis), open; distal tibia	17.41	1453.74		090	1	2975.93	1228.29	2897.26
27732		Arrest, epiphyseal (epiphysiodesis), open; distal fibula	13.34	1113.89		090	1	2975.93	874.25	2897.26
27734		Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula	18.36	1533.06		090	1	2975.93	1290.91	2897.26
27740		Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula	18.28	1526.38		090	2	2975.93	1487.97	2897.26
27742		Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur	20.11	1679.19		090	2	4434.79	1409.48	4247.50
27745		Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	22.54	1882.09		090	2	7563.12	1584.83	8084.19
27750		Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation	10.45	872.58		090	1	172.42	678.86	151.16
27752		Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction	16.11	1345.19		090	1	1077.75	1087.17	1677.55
27756		Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)	17.26	1441.21		090	2	2462.57	1173.18	2356.77

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
27758		Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage	26.49	2211.92		090	2	4855.82	1845.35	4146.21
27759		Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	29.64	2474.94		090	2	6502.42	2102.53	5970.68
27760		Closed treatment of medial malleolus fracture; without manipulatior	10.13	845.86		090	1	172.42	654.64	151.16
27762		Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	14.32	1195.72		090	1	1077.75	983.63	1677.55
27766		Open treatment of medial malleolus fracture, includes internal fixation, when performec	18.21	1520.54		090	1	4855.82	1359.38	4146.21
27767		Closed treatment of posterior malleolus fracture; without manipulatior	8.52	711.42		090	1	172.42	514.08	151.16
27768		Closed treatment of posterior malleolus fracture; with manipulation	13.16	1098.86		090	1	172.42	797.16	151.16
27769		Open treatment of posterior malleolus fracture, includes internal fixation, when performec	21.82	1821.97		090	1	4855.82	1372.56	4146.21
27780		Closed treatment of proximal fibula or shaft fracture; without manipulatior	9.29	775.72		090	1	172.42	582.00	151.16
27781		Closed treatment of proximal fibula or shaft fracture; with manipulation	12.55	1047.93		090	1	1077.75	844.19	1677.55
27784		Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performec	21.33	1781.06		090	1	4855.82	1181.53	4146.21
27786		Closed treatment of distal fibular fracture (lateral malleolus); without manipulatior	9.59	800.77		090	1	172.42	621.24	151.16
27788		Closed treatment of distal fibular fracture (lateral malleolus); with manipulatior	12.71	1061.29		090	1	172.42	859.22	151.16
27792		Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	19.54	1631.59		090	1	4855.82	1264.19	4146.21
27808		Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	10.14	846.69		090	1	172.42	649.63	151.16
27810		Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	14.16	1182.36		090	1	172.42	964.43	437.22
27814		Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	23.02	2186.90		090	2	4855.82	1908.55	4146.21
27816		Closed treatment of trimalleolar ankle fracture; without manipulation	9.63	804.11		090	1	172.42	616.23	151.16
27818		Closed treatment of trimalleolar ankle fracture; with manipulation	14.58	1217.43		090	1	514.57	999.50	437.22
27822		Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	25.12	2097.52		090	2	4855.82	1923.01	4146.21
27823		Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	28.44	2374.74		090	2	6502.42	2177.68	5970.68
27824		Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	9.40	784.90		090	1	172.42	610.39	151.16
27825		Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	16.25	1356.88		090	0	1077.75	1117.23	1677.55
27826		Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	25.00	2087.50		090	2	4855.82	1495.49	4146.21
27827		Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	32.33	2699.56		090	2	6502.42	2412.32	5970.68
27828		Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	38.53	3217.26		090	2	6502.42	2732.96	5970.68
27829		Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	20.49	1710.92		090	2	4855.82	1046.26	4146.21
27830		Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	11.41	952.74		090	0	172.42	698.90	151.16
27831		Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia	11.92	995.32		090	0	1077.75	771.54	1677.55
27832		Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	22.46	1875.41		090	2	4855.82	1072.98	4146.21
27840		Closed treatment of ankle dislocation; without anesthesia	11.22	936.87		090	1	172.42	698.90	437.22
27842		Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation	14.80	1235.80		090	1	1340.50	982.80	1394.50

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27846		Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	21.80	1820.30		090	2	4855.82	1546.42	4146.21
27848		Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation	24.06	2009.01		090	2	4855.82	1801.10	4146.21
27860		Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	5.34	445.89		010	0	1340.50	369.07	1394.50
27870		Arthrodesis, ankle, open	30.80	2571.80		090	2	7563.12	2191.88	8084.19
27871		Arthrodesis, tibiofibular joint, proximal or distal	20.50	1711.75		090	2	7563.12	1451.23	8084.19
27880		Amputation, leg, through tibia and fibula;	27.60	2304.60		090	2		1879.59	2097.37**
27881		Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	26.56	2217.76		090	2		1876.25	2097.37**
27882		Amputation, leg, through tibia and fibula; open, circular (guillotine)	18.40	1536.40		090	0		1355.21	2097.37**
27884		Amputation, leg, through tibia and fibula; secondary closure or scar revisior	17.48	1459.58		090	1	2006.48	1217.43	2007.54
27886		Amputation, leg, through tibia and fibula; re-amputatior	19.98	1668.33		090	1		1386.94	2097.37**
27888		Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves	20.28	1693.38		090	2		1494.65	2097.37**
27889		Ankle disarticulation	19.60	1636.60		090	1	2975.93	1443.72	2897.26
27892		Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve	16.46	1374.41		090	0	2975.93	1130.59	2897.26
27893		Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	18.25	1523.88		090	0	2975.93	1125.58	2897.26
27894		Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve	26.02	2172.67		090	2	2975.93	1710.92	2897.26
27899		Unlisted procedure, leg or ankle	0.00	BR		YYY	0	172.42	BR	151.16
28001		Incision and drainage, bursa, foot	8.31	693.89		010	1	936.06	505.18	1150.97
28002		Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	13.52	1128.92		010	1	2006.48	939.38	2007.54
28003		Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple area	22.02	1838.67		090	1	2006.48	1320.14	2007.54
28005		Incision, bone cortex (eg, osteomyelitis or bone abscess), foo	17.22	1437.87		090	1	2043.42	1289.24	1991.95
28008		Fasciotomy, foot and/or toe	13.06	1090.51		090	1	2043.42	800.77	1991.95
28010		Tenotomy, percutaneous, toe; single tendor	6.98	582.83		090	1	2043.42	455.91	1991.95
28011		Tenotomy, percutaneous, toe; multiple tendons	9.78	816.63		090	1	2043.42	651.30	1991.95
28020		Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint	16.49	1376.92		090	1	2043.42	974.45	1991.95
28022		Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint	14.94	1247.49		090	1	2043.42	876.75	1991.95
28024		Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint	14.02	1170.67		090	1	2043.42	847.53	1991.95
28035		Release, tarsal tunnel (posterior tibial nerve decompression)	16.03	1338.51		090	1	1734.81	967.77	1707.08
28039		Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greate	15.77	1316.80		090	2	2142.94	1072.14	2132.75
28041		Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greate	13.77	1149.80		090	0	2142.94	1009.52	2132.75
28043		Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	12.23	1021.21		090	1	1447.15	647.13	1595.60
28045		Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	15.10	1260.85		090	0	1447.15	895.96	1595.60
28046		Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 cm	21.81	1821.14		090	1	1447.15	1674.18	1595.60
28047		Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greate	30.10	2513.35		090	2	2142.94	2125.91	2132.75
28050		Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	12.94	1080.49		090	1	2043.42	824.15	1991.95
28052		Arthrotomy with biopsy; metatarsophalangeal join	13.51	1128.09		090	1	2043.42	785.74	1991.95
28054		Arthrotomy with biopsy; interphalangeal join	11.42	953.57		090	0	2043.42	726.45	1991.95
28055		Neurectomy, intrinsic musculature of foot	11.15	931.03		090	0	1734.81	829.99	1707.08
28060		Fasciectomy, plantar fascia; partial (separate procedure)	15.75	1315.13		090	1	2043.42	948.56	1991.95

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28062		Fasciectomy, plantar fascia; radical (separate procedure)	17.72	1479.62		090	1	2043.42	1137.27	1991.95
28070		Synovectomy; intertarsal or tarsometatarsal joint, each	16.24	1356.04		090	1	2043.42	926.02	1991.95
28072		Synovectomy; metatarsophalangeal joint, each	15.55	1298.43		090	1	2043.42	909.32	1991.95
28080		Excision, interdigital (Morton) neuroma, single, each	16.07	1341.85		090	0	2043.42	870.07	1991.95
28086		Synovectomy, tendon sheath, foot; flexor	16.73	1396.96		090	2	2043.42	1088.84	1991.95
28088		Synovectomy, tendon sheath, foot; extensor	14.88	1242.48		090	0	2043.42	850.03	1991.95
28090		Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot	14.37	1199.90		090	1	2043.42	849.20	1991.95
28092		Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each	13.04	1088.84		090	1	2043.42	781.56	1991.95
28100		Excision or curettage of bone cyst or benign tumor, talus or calcaneus	18.67	1558.95		090	2	2043.42	1168.17	1991.95
28102		Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	17.09	1427.02		090	2	5583.26	1158.15	4789.83
28103		Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograf	11.59	967.77		090	2	5583.26	945.22	4789.83
28104		Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus	15.80	1319.30		090	2	2043.42	942.72	1991.95
28106		Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	13.48	1125.58		090	2	5583.26	995.32	4789.83
28107		Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	15.61	1303.44		090	2	5583.26	1057.11	4789.83
28108		Excision or curettage of bone cyst or benign tumor, phalanges of foo	13.37	1116.40		090	1	2043.42	782.40	1991.95
28110		Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure	14.16	1182.36		090	1	2043.42	827.49	1991.95
28111		Ostectomy, complete excision; first metatarsal head	15.38	1284.23		090	1	2043.42	982.80	1991.95
28112		Ostectomy, complete excision; other metatarsal head (second, third or fourth)	15.08	1259.18		090	1	2043.42	907.65	1991.95
28113		Ostectomy, complete excision; fifth metatarsal head	18.06	1508.01		090	0	2043.42	1050.43	1991.95
28114		Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	32.54	2717.09		090	2	2043.42	1998.16	1991.95
28116		Ostectomy, excision of tarsal coalition	23.22	1938.87		090	1	2043.42	1382.76	1991.95
28118		Ostectomy, calcaneus;	18.12	1513.02		090	2	2043.42	1079.66	1991.95
28119		Ostectomy, calcaneus; for spur, with or without plantar fascial release	15.99	1335.17		090	1	2043.42	959.42	1991.95
28120		Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	20.66	1725.11		090	1	2043.42	1113.89	1991.95
28122		Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	18.23	1522.21		090	2	2043.42	1256.68	1991.95
28124		Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	14.46	1207.41		090	1	2043.42	872.58	1991.95
28126		Resection, partial or complete, phalangeal base, each toe	12.09	1009.52		090	1	2043.42	693.89	1991.95
28130		Talectomy (astragalectomy)	21.69	1811.12		090	2	2043.42	1347.69	1991.95
28140		Metatarsectomy	18.20	1519.70		090	1	2043.42	1221.61	1991.95
28150		Phalangectomy, toe, each toe	13.06	1090.51		090	1	2043.42	792.42	1991.95
28153		Resection, condyle(s), distal end of phalanx, each toe	12.69	1059.62		090	1	2043.42	718.10	1991.95
28160		Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, eacl	12.83	1071.31		090	1	2043.42	745.66	1991.95
28171		Radical resection of tumor; tarsal (except talus or calcaneus)	24.95	2083.33		090	2	2043.42	1303.44	1991.95
28173		Radical resection of tumor; metatarsal	22.91	1912.99		090	1	2043.42	1434.53	1991.95
28175		Radical resection of tumor; phalanx of toe	14.55	1214.93		090	1	2043.42	1032.06	1991.95
28190		Removal of foreign body, foot; subcutaneous	7.87	657.15		010	1	752.91	463.43	748.01
28192		Removal of foreign body, foot; deep	14.43	1204.91		090	1	1447.15	887.61	1595.60
28193		Removal of foreign body, foot; complicated	16.25	1356.88		090	1	752.91	1001.17	748.01
28200		Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendor	14.76	1232.46		090	1	2043.42	864.23	1991.95
28202		Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft	17.96	1499.66		090	2	2043.42	1218.27	1991.95
28208		Repair, tendon, extensor, foot; primary or secondary, each tendor	14.28	1192.38		090	1	2043.42	822.48	1991.95

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28210		Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft	17.56	1466.26		090	2	5583.26	1097.19	4789.83
28220		Tenolysis, flexor, foot; single tendon	13.61	1136.44		090	1	2043.42	819.14	1991.95
28222		Tenolysis, flexor, foot; multiple tendons	15.48	1292.58		090	1	2043.42	956.91	1991.95
28225		Tenolysis, extensor, foot; single tendon	12.57	1049.60		090	1	2043.42	711.42	1991.95
28226		Tenolysis, extensor, foot; multiple tendons	18.16	1516.36		090	1	2043.42	839.18	1991.95
28230		Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure	13.11	1094.69		090	1	2043.42	792.42	1991.95
28232		Tenotomy, open, tendon flexor; toe, single tendon (separate procedure	11.93	996.16		090	1	2043.42	702.24	1991.95
28234		Tenotomy, open, extensor, foot or toe, each tendor	12.57	1049.60		090	1	2043.42	718.94	1991.95
28238		Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	20.17	1684.20		090	2	5583.26	1307.61	4789.83
28240		Tenotomy, lengthening, or release, abductor hallucis muscle	13.27	1108.05		090	1	2043.42	804.11	1991.95
28250		Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)	17.59	1468.77		090	2	2043.42	1025.38	1991.95
28260		Capsulotomy, midfoot; medial release only (separate procedure)	20.43	1705.91		090	2	2043.42	1279.22	1991.95
28261		Capsulotomy, midfoot; with tendon lengthening	28.94	2416.49		090	0	2043.42	1866.23	1991.95
28262		Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	43.85	3661.48		090	2	2043.42	2669.50	1991.95
28264		Capsulotomy, midtarsal (eg, Heyman type procedure)	29.22	2439.87		090	2	5583.26	1622.41	4789.83
28270		Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	15.02	1254.17		090	1	2043.42	866.73	1991.95
28272		Capsulotomy; interphalangeal joint, each joint (separate procedure)	11.96	998.66		090	1	2043.42	711.42	1991.95
28280		Syndactylization, toes (eg, webbing or Kelikian type procedure	15.89	1326.82		090	0	2043.42	999.50	1991.95
28285		Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy	16.19	1351.87		090	1	2043.42	844.19	1991.95
28286		Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	13.77	1149.80		090	1	2043.42	830.83	1991.95
28288		Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	18.41	1537.24		090	1	2043.42	1043.75	1991.95
28289		Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint	22.37	1867.90		090	2	2043.42	1392.78	1991.95
28290		Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)	17.92	1496.32		090	1	3167.72	1061.29	2877.35
28292		Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	23.89	1994.82		090	2	3167.72	1416.16	2877.35
28293		Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implan	31.58	2636.93		090	2	3167.72	1906.31	2877.35
28294		Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)	22.60	1887.10		090	2	3167.72	1396.96	2877.35
28296		Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	21.52	1796.92		090	2	3167.72	1511.35	2877.35
28297		Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus-type procedure	24.80	2070.80		090	2	3167.72	1589.01	2877.35
28298		Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy	21.88	1826.98		090	2	3167.72	1335.17	2877.35
28299		Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	26.87	2243.65		090	2	3167.72	1740.98	2877.35
28300		Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	19.60	1636.60		090	2	5583.26	1418.67	4789.83
28302		Osteotomy; talus	21.24	1773.54		090	2	2043.42	1392.78	1991.95
28304		Osteotomy, tarsal bones, other than calcaneus or talus	24.56	2050.76		090	2	5583.26	1502.17	4789.83
28305		Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	19.33	1614.06		090	2	5583.26	1444.55	4789.83
28306		Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	18.82	1571.47		090	2	2043.42	1117.23	1991.95
28307		Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	21.50	1795.25		090	0	2043.42	1444.55	1991.95
28308		Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	17.15	1432.03		090	2	2043.42	986.97	1991.95

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
28309		Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	26.52	2214.42		090	0	5583.26	1882.09	4789.83
28310		Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	16.55	1381.93		090	1	2043.42	987.81	1991.95
28312		Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	15.60	1302.60		090	1	2043.42	893.45	1991.95
28313		Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	16.00	1336.00		090	1	2043.42	925.18	1991.95
28315		Sesamoidectomy, first toe (separate procedure)	14.64	1222.44		090	1	2043.42	869.24	1991.95
28320		Repair, nonunion or malunion; tarsal bones	18.28	1526.38		090	2	5583.26	1356.04	4789.83
28322		Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft	23.95	1999.83		090	2	5583.26	1521.37	4789.83
28340		Reconstruction, toe, macrodactyly; soft tissue resection	17.47	1458.75		090	1	2043.42	1171.51	1991.95
28341		Reconstruction, toe, macrodactyly; requiring bone resection	20.23	1689.21		090	1	2043.42	1346.86	1991.95
28344		Reconstruction, toe(s); polydactyly	12.99	1084.67		090	1	2043.42	868.40	1991.95
28345		Reconstruction, toe(s); syndactyly, with or without skin graft(s), each wel	15.79	1318.47		090	0	2043.42	1067.13	1991.95
28360		Reconstruction, cleft foot	32.46	2710.41		090	2	5583.26	2081.66	4789.83
28400		Closed treatment of calcaneal fracture; without manipulation	7.62	636.27		090	1	172.42	494.32	151.16
28405		Closed treatment of calcaneal fracture; with manipulation	11.39	951.07		090	0	1077.75	805.78	1677.55
28406		Percutaneous skeletal fixation of calcaneal fracture, with manipulation	15.76	1315.96		090	0	2462.57	1120.57	2356.77
28415		Open treatment of calcaneal fracture, includes internal fixation, when performed	33.08	2762.18		090	2	6502.42	2601.86	5970.68
28420		Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	37.25	3110.38		090	2	4855.82	2539.24	4146.21
28430		Closed treatment of talus fracture; without manipulation	7.16	597.86		090	1	172.42	464.26	151.16
28435		Closed treatment of talus fracture; with manipulation	10.85	905.98		090	0	172.42	627.09	151.16
28436		Percutaneous skeletal fixation of talus fracture, with manipulation	13.51	1128.09		090	1	2462.57	901.80	2356.77
28445		Open treatment of talus fracture, includes internal fixation, when performed	31.69	2646.12		090	2	4855.82	2393.11	4146.21
28446		Open osteochondral autograft, talus (includes obtaining graft[s])	36.29	3030.22		090	2	5583.26	2370.48	4789.83
28450		Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	6.57	548.60		090	1	172.42	425.85	151.16
28455		Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	7.84	654.64		090	0	172.42	564.46	151.16
28456		Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	9.67	807.45		090	1	2462.57	578.66	2356.77
28465		Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	18.10	1511.35		090	1	4855.82	1128.92	4146.21
28470		Closed treatment of metatarsal fracture; without manipulation, each	6.71	560.29		090	1	172.42	429.19	151.16
28475		Closed treatment of metatarsal fracture; with manipulation, each	7.66	639.61		090	1	172.42	534.40	151.16
28476		Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	10.43	870.91		090	0	2462.57	708.08	2356.77
28485		Open treatment of metatarsal fracture, includes internal fixation, when performed, each	15.72	1312.62		090	1	4855.82	939.38	4146.21
28490		Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	4.46	372.41		090	1	172.42	266.37	151.16
28495		Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	5.41	451.74		090	1	172.42	326.49	151.16
28496		Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation	13.87	1158.15		090	1	2462.57	876.75	2356.77
28505		Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	20.22	1688.37		090	1	2462.57	1000.33	2356.77
28510		Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	3.75	313.13		090	1	172.42	227.12	151.16
28515		Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	4.90	409.15		090	1	172.42	293.09	151.16
28525		Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	17.32	1446.22		090	0	2462.57	908.48	2356.77
28530		Closed treatment of sesamoid fracture	3.47	289.75		090	0	172.42	217.10	151.16
28531		Open treatment of sesamoid fracture, with or without internal fixation	10.80	901.80		090	1	2462.57	794.09	2356.77
28540		Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	5.84	487.64		090	0	172.42	388.28	151.16
28545		Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	8.96	748.16		090	0	2462.57	435.87	2356.77

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
28546		Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulatior	17.60	1469.60		090	0	2462.57	882.60	2356.77
28555		Open treatment of tarsal bone dislocation, includes internal fixation, when performec	26.72	2231.12		090	2	4855.82	1393.62	4146.21
28570		Closed treatment of talotarsal joint dislocation; without anesthesia	4.89	408.32		090	0	172.42	353.21	437.22
28575		Closed treatment of talotarsal joint dislocation; requiring anesthesia	11.02	920.17		090	0	1077.75	625.42	1677.55
28576		Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulatior	11.85	989.48		090	0	2462.57	739.81	2356.77
28585		Open treatment of talotarsal joint dislocation, includes internal fixation, when performec	26.47	2210.25		090	2	2462.57	1384.43	2356.77
28600		Closed treatment of tarsometatarsal joint dislocation; without anesthesia	5.66	472.61		090	0	172.42	407.48	151.16
28605		Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	9.91	827.49		090	0	172.42	516.03	151.16
28606		Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulatior	11.86	990.31		090	1	2462.57	825.82	2356.77
28615		Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performec	23.58	1968.93		090	2	4855.82	1432.03	4146.21
28630		Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	4.76	397.46		010	0	172.42	285.57	151.16
28635		Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	5.23	436.71		010	0	1340.50	341.52	1394.50
28636		Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulatior	9.16	764.86		010	1	2462.57	576.99	2356.77
28645		Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	19.94	1664.99		090	1	2462.57	822.48	2356.77
28660		Closed treatment of interphalangeal joint dislocation; without anesthesia	3.54	295.59		010	1	172.42	210.42	151.16
28665		Closed treatment of interphalangeal joint dislocation; requiring anesthesia	4.68	390.78		010	0	1340.50	295.59	1394.50
28666		Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulatior	5.79	483.47		010	1	2462.57	437.54	2356.77
28675		Open treatment of interphalangeal joint dislocation, includes internal fixation, when performec	17.62	1471.27		090	1	2462.57	847.53	2356.77
28705		Arthrodesis; pantalar	38.20	3189.70		090	2	5583.26	2774.71	4789.83
28715		Arthrodesis; triple	27.87	2327.15		090	2	7563.12	2052.43	8084.19
28725		Arthrodesis; subtalar	23.11	1929.69		090	2	5583.26	1717.60	4789.83
28730		Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	21.90	1828.65		090	2	5583.26	1754.34	4789.83
28735		Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	23.29	1944.72		090	2	5583.26	1681.69	4789.83
28737		Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	20.54	1715.09		090	2	5583.26	1491.31	4789.83
28740		Arthrodesis, midtarsal or tarsometatarsal, single joint	25.77	2151.80		090	2	5583.26	1694.22	4789.83
28750		Arthrodesis, great toe; metatarsophalangeal joint	25.02	2089.17		090	0	5583.26	1695.89	4789.83
28755		Arthrodesis, great toe; interphalangeal joint	15.49	1293.42		090	1	2043.42	948.56	1991.95
28760		Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	23.66	1975.61		090	2	5583.26	1467.93	4789.83
28800		Amputation, foot; midtarsal (eg, Chopart type procedure)	16.42	1371.07		090	2		1214.93	2097.37**
28805		Amputation, foot; transmetatarsal	22.19	1852.87		090	0	2043.42	1520.54	1991.95
28810		Amputation, metatarsal, with toe, single	13.14	1097.19		090	0	2043.42	927.69	1991.95
28820		Amputation, toe; metatarsophalangeal joint	17.50	1461.25		090	1	2043.42	1052.94	1991.95
28825		Amputation, toe; interphalangeal joint	16.63	1388.61		090	1	2043.42	908.48	1991.95
28890		Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	9.90	826.65		090	1	2975.93	743.99	2897.26
28899		Unlisted procedure, foot or toes	0.00	BR		YYY	0	172.42	BR	151.16
29000		Application of halo type body cast (see 20661-20663 for insertion	8.39	700.57		000	0	121.96	486.81	96.09
29010		Application of Risser jacket, localizer, body; only	7.24	604.54		000	0	244.00	467.60	213.90
29015		Application of Risser jacket, localizer, body; including head	8.87	740.65		000	0	244.00	460.92	213.90
29020		Application of turnbuckle jacket, body; only	6.19	516.87		000	0	121.96	460.92	96.09
29025		Application of turnbuckle jacket, body; including head	8.91	743.99		000	0	121.96	489.31	96.09
29035		Application of body cast, shoulder to hips;	6.76	564.46		000	0	244.00	459.25	213.90
29040		Application of body cast, shoulder to hips; including head, Minerva type	6.91	576.99		000	0	121.96	426.69	96.09
29044		Application of body cast, shoulder to hips; including 1 thigh	8.75	730.63		000	0	244.00	519.37	213.90
29046		Application of body cast, shoulder to hips; including both thighs	8.04	671.34		000	0	244.00	506.01	213.90

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29049		Application, cast; figure-of-eight	3.00	250.50		000	0	121.96	182.87	96.09
29055		Application, cast; shoulder spica	6.77	565.30		000	0	244.00	405.81	213.90
29058		Application, cast; plaster Velpeau	3.70	308.95		000	0	121.96	236.31	96.09
29065		Application, cast; shoulder to hand (long arm)	2.92	243.82		000	1	244.00	187.88	213.90
29075		Application, cast; elbow to finger (short arm)	2.63	219.61		000	1	244.00	172.85	213.90
29085		Application, cast; hand and lower forearm (gauntlet)	2.88	240.48		000	1	121.96	183.70	96.09
29086		Application, cast; finger (eg, contracture)	2.39	199.57		000	1	121.96	134.44	96.09
29105		Application of long arm splint (shoulder to hand)	2.66	222.11		000	1	121.96	175.35	96.09
29125		Application of short arm splint (forearm to hand); static	1.98	165.33		000	1	121.96	134.44	96.09
29126		Application of short arm splint (forearm to hand); dynamic	2.34	195.39		000	1	121.96	160.32	96.09
29130		Application of finger splint; static	1.23	102.71		000	1	69.58	81.00	96.09
29131		Application of finger splint; dynamic	1.57	131.10		000	1	69.58	102.71	96.09
29200		Strapping; thorax	1.59	132.77		000	1	69.58	109.39	96.09
29240		Strapping; shoulder (eg, Velpeau)	1.72	143.62		000	1	69.58	126.09	96.09
29260		Strapping; elbow or wrist	1.56	130.26		000	1	69.58	105.21	96.09
29280		Strapping; hand or finger	1.53	127.76		000	1	69.58	105.21	96.09
29305		Application of hip spica cast; 1 leg	7.51	627.09		000	0	244.00	461.76	213.90
29325		Application of hip spica cast; 1 and 1/2 spica or both legs	8.30	693.05		000	0	244.00	506.01	213.90
29345		Application of long leg cast (thigh to toes);	4.13	344.86		000	1	244.00	270.54	213.90
29355		Application of long leg cast (thigh to toes); walker or ambulatory type	4.29	358.22		000	1	244.00	278.06	213.90
29358		Application of long leg cast brace	4.87	406.65		000	1	244.00	300.60	213.90
29365		Application of cylinder cast (thigh to ankle)	3.74	312.29		000	1	244.00	242.15	213.90
29405		Application of short leg cast (below knee to toes);	2.47	206.25		000	1	244.00	177.86	213.90
29425		Application of short leg cast (below knee to toes); walking or ambulatory type	2.37	197.90		000	1	244.00	191.22	213.90
29435		Application of patellar tendon bearing (PTB) cast	3.63	303.11		000	1	244.00	234.64	213.90
29440		Adding walker to previously applied cast	1.34	111.89		000	1	121.96	105.21	96.09
29445		Application of rigid total contact leg cast	4.10	342.35		000	1	244.00	303.11	213.90
29450		Application of clubfoot cast with molding or manipulation, long or short leg	4.32	360.72		000	1	121.96	303.11	96.09
29505		Application of long leg splint (thigh to ankle or toes)	2.54	212.09		000	1	121.96	154.48	96.09
29515		Application of short leg splint (calf to foot)	2.18	182.03		000	1	121.96	136.94	96.09
29520		Strapping; hip	1.46	121.91		000	0	69.58	111.06	96.09
29530		Strapping; knee	1.58	131.93		000	1	69.58	109.39	96.09
29540		Strapping; ankle and/or foot	1.11	92.69		000	1	69.58	81.00	96.09
29550		Strapping; toes	0.95	79.33		000	1	69.58	78.49	96.09
29580		Strapping; Unna boot	1.59	132.77		000	1	121.96	102.71	96.09
29581		Application of multi-layer compression system; leg (below knee), including ankle and foo	1.89	157.82		000	0	121.96	200.40	96.09
29582		Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed	2.14	178.69		000	0	69.58	New	
29583		Application of multi-layer compression system; upper arm and forearm	1.33	111.06		000	0	69.58	New	
29584		Application of multi-layer compression system; upper arm, forearm, hand, and fingers	2.14	178.69		000	0	69.58	New	
29700		Removal or bivalving; gauntlet, boot or body cast	2.00	167.00		000	1	121.96	125.25	96.09
29705		Removal or bivalving; full arm or full leg cast	2.00	167.00		000	1	121.96	135.27	96.09
29710		Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.	3.72	310.62		000	0	244.00	243.82	213.90
29715		Removal or bivalving; turnbuckle jacket	2.42	202.07		000	0	121.96	175.35	96.09
29720		Repair of spica, body cast or jacket	2.53	211.26		000	1	121.96	157.82	96.09
29730		Windowing of cast	1.96	163.66		000	1	121.96	132.77	96.09
29740		Wedging of cast (except clubfoot casts)	2.81	234.64		000	1	121.96	193.72	96.09
29750		Wedging of clubfoot cast	3.23	269.71		000	0	121.96	197.90	96.09
29799		Unlisted procedure, casting or strapping	0.00	BR		YYY	0	121.96	BR	96.09

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
29800		Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	15.31	1278.39		090	0	2724.18	1128.09	2728.39
29804		Arthroscopy, temporomandibular joint, surgica	19.39	1619.07		090	2	2724.18	1365.23	2728.39
29805		Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure	14.09	1176.52		090	1	2724.18	985.30	2728.39
29806		Arthroscopy, shoulder, surgical; capsulorrhaphy	31.54	2633.59		090	1	5005.82	2227.78	4451.68
29807		Arthroscopy, shoulder, surgical; repair of SLAP lesior	30.75	2921.25		090	1	5005.82	2470.95	4451.68
29819		Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	17.48	1459.58		090	1	5005.82	1230.79	4451.68
29820		Arthroscopy, shoulder, surgical; synovectomy, partia	16.10	1344.35		090	2	5005.82	1134.77	4451.68
29821		Arthroscopy, shoulder, surgical; synovectomy, complete	17.56	1466.26		090	2	5005.82	1240.81	4451.68
29822		Arthroscopy, shoulder, surgical; debridement, limited	17.16	1432.86		090	2	2724.18	1206.58	2728.39
29823		Arthroscopy, shoulder, surgical; debridement, extensive	18.72	1778.40		090	2	5005.82	1497.20	4451.68
29824		Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	20.22	1920.90		090	2	2724.18	1581.75	2728.39
29825		Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulatio	17.47	1458.75		090	2	5005.82	1229.12	4451.68
29826		Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	5.19	493.05		ZZZ	2	2724.18	1605.50	4451.68
29827		Arthroscopy, shoulder, surgical; with rotator cuff repai	31.93	3033.35		090	2	5005.82	2619.15	4451.68
29828		Arthroscopy, shoulder, surgical; biceps tenodesis	27.48	2294.58		090	2	5005.82	1831.20	4451.68
29830		Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure	13.55	1131.43		090	1	2724.18	947.73	2728.39
29834		Arthroscopy, elbow, surgical; with removal of loose body or foreign body	14.63	1221.61		090	2	2724.18	1032.90	2728.39
29835		Arthroscopy, elbow, surgical; synovectomy, partia	15.11	1261.69		090	2	2724.18	1057.11	2728.39
29836		Arthroscopy, elbow, surgical; synovectomy, complete	17.15	1432.03		090	2	2724.18	1214.93	2728.39
29837		Arthroscopy, elbow, surgical; debridement, limitec	15.78	1317.63		090	2	2724.18	1110.55	2728.39
29838		Arthroscopy, elbow, surgical; debridement, extensive	17.58	1670.10		090	0	2724.18	1414.55	2728.39
29840		Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure	13.50	1127.25		090	0	2724.18	921.01	2728.39
29843		Arthroscopy, wrist, surgical; for infection, lavage and drainage	14.43	1204.91		090	2	2724.18	986.97	2728.39
29844		Arthroscopy, wrist, surgical; synovectomy, partia	14.81	1236.64		090	2	2724.18	1037.07	2728.39
29845		Arthroscopy, wrist, surgical; synovectomy, complete	17.21	1437.04		090	2	2724.18	1173.18	2728.39
29846		Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement	15.46	1290.91		090	0	2724.18	1086.34	2728.39
29847		Arthroscopy, wrist, surgical; internal fixation for fracture or instability	16.17	1350.20		090	2	5005.82	1122.24	4451.68
29848		Endoscopy, wrist, surgical, with release of transverse carpal ligamen	15.20	1269.20		090	1	2724.18	1002.00	2728.39
29850		Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	18.56	1549.76		090	0	2724.18	1144.79	2728.39
29851		Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	27.65	2308.78		090	2	5005.82	1964.76	4451.68
29855		Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)	23.41	1954.74		090	2	5005.82	1653.30	4451.68
29856		Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, includes internal fixation, when performed (includes arthroscopy)	29.56	2468.26		090	2	5005.82	2111.72	4451.68
29860		Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure	19.85	1657.48		090	2	5005.82	1344.35	4451.68
29861		Arthroscopy, hip, surgical; with removal of loose body or foreign body	21.64	1806.94		090	2	5005.82	1478.79	4451.68
29862		Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty and/or resection of labrum	24.38	2035.73		090	2	5005.82	1654.97	4451.68
29863		Arthroscopy, hip, surgical; with synovectomy	24.40	2037.40		090	2	5005.82	1633.26	4451.68
29866		Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	31.18	2603.53		090	0	5005.82	2198.56	4451.68
29867		Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	37.93	3167.16		090	0	5005.82	2661.98	4451.68

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
29868		Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	49.57	4139.10		090	0	5005.82	3577.14	4451.68
29870		Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure	17.73	1480.46		090	1	2724.18	849.20	2728.39
29871		Arthroscopy, knee, surgical; for infection, lavage and drainage	15.34	1280.89		090	1	2724.18	1063.79	2728.39
29873		Arthroscopy, knee, surgical; with lateral release	15.71	1311.79		090	1	2724.18	1072.98	2728.39
29874		Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	16.05	1340.18		090	0	2724.18	1114.73	2728.39
29875		Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure	14.80	1235.80		090	0	2724.18	1037.91	2728.39
29876		Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral	19.57	1634.10		090	1	2724.18	1339.34	2728.39
29877		Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty	18.59	1552.27		090	0	2724.18	1266.70	2728.39
29879		Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	19.79	1880.05		090	0	2724.18	1543.75	2728.39
29880		Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	16.84	1599.80		090	0	2724.18	1612.15	2728.39
29881		Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	16.21	1539.95		090	0	2724.18	1501.95	2728.39
29882		Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	20.86	1741.81		090	1	2724.18	1424.51	2728.39
29883		Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	25.00	2087.50		090	0	2724.18	1760.18	2728.39
29884		Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	18.53	1547.26		090	2	2724.18	1261.69	2728.39
29885		Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	22.38	1868.73		090	2	5005.82	1532.23	4451.68
29886		Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesior	18.93	1580.66		090	1	2724.18	1290.91	2728.39
29887		Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixatior	22.30	1862.05		090	2	2724.18	1524.71	2728.39
29888		Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstructior	29.40	2454.90		090	2	7563.12	2078.32	8084.19
29889		Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstructior	36.28	3029.38		090	2	7563.12	2524.21	8084.19
29891		Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	20.27	1692.55		090	2	5005.82	1437.87	4451.68
29892		Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	18.33	1530.56		090	2	7563.12	1497.16	8084.19
29893		Endoscopic plantar fasciotomy	18.53	1547.26		090	1	2043.42	1088.84	1991.95
29894		Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	15.48	1292.58		090	2	2724.18	1083.00	2728.39
29895		Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partia	14.36	1199.06		090	2	2724.18	1059.62	2728.39
29897		Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limitec	15.33	1280.06		090	2	2724.18	1113.06	2728.39
29898		Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	16.87	1408.65		090	2	2724.18	1235.80	2728.39
29899		Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	31.25	2609.38		090	2	5005.82	2198.56	4451.68
29900		Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy	13.40	1118.90		090	0	2724.18	976.95	2728.39
29901		Arthroscopy, metacarpophalangeal joint, surgical; with debridemen	15.92	1329.32		090	0	2724.18	1081.33	2728.39
29902		Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)	18.07	1508.85		090	0	2724.18	1107.21	2728.39
29904		Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body	18.96	1583.16		090	2	2724.18	1228.92	2728.39
29905		Arthroscopy, subtalar joint, surgical; with synovectomy	20.56	1716.76		090	2	2724.18	1324.68	2728.39
29906		Arthroscopy, subtalar joint, surgical; with debridement	21.03	1756.01		090	2	2724.18	1395.24	2728.39
29907		Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	26.03	2173.51		090	2	5005.82	1708.56	4451.68
29914		Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	30.03	2507.51		090	2	5005.82	New	
29915		Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion	30.63	2557.61		090	2	5005.82	New	
29916		Arthroscopy, hip, surgical; with labral repair	30.66	2560.11		090	2	5005.82	New	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
29999		Unlisted procedure, arthroscopy	0.00	BR		YYY	0	2724.18	BR	2728.39
30000		Drainage abscess or hematoma, nasal, internal approach	7.15	597.03		010	0	296.47	450.90	312.33
30020		Drainage abscess or hematoma, nasal septum	7.26	606.21		010	1	296.47	404.14	312.33
30100		Biopsy, intranasal	4.39	366.57		000	1	643.20	250.50	694.83
30110		Excision, nasal polyp(s), simple	7.13	595.36		010	1	643.20	414.16	1567.36
30115		Excision, nasal polyp(s), extensive	13.08	1092.18		090	1	2321.87	839.18	1567.36
30117		Excision or destruction (eg, laser), intranasal lesion; internal approach	27.45	2292.08		090	1	1480.23	1438.71	1567.36
30118		Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy	22.92	1913.82		090	1	2321.87	1541.41	2276.44
30120		Excision or surgical planing of skin of nose for rhinophyma	15.76	1315.96		090	1	2321.87	993.65	2276.44
30124		Excision dermoid cyst, nose; simple, skin, subcutaneous	8.66	723.11		090	1	2321.87	558.62	694.83
30125		Excision dermoid cyst, nose; complex, under bone or cartilage	18.34	1531.39		090	2	4230.05	1261.69	3919.59
30130		Excision inferior turbinate, partial or complete, any method	11.57	966.10		090	1	2321.87	743.15	1567.36
30140		Submucous resection inferior turbinate, partial or complete, any method	13.51	1128.09		090	1	2321.87	815.80	2276.44
30150		Rhinectomy; partial	23.09	1928.02		090	1	4230.05	1656.64	3919.59
30160		Rhinectomy; total	23.24	1940.54		090	2	4230.05	1626.58	3919.59
30200		Injection into turbinate(s), therapeutic	3.54	295.59		000	1	643.20	204.58	694.83
30210		Displacement therapy (Proetz type)	4.63	386.61		010	1	643.20	270.54	694.83
30220		Insertion, nasal septal prosthesis (button)	9.51	794.09		010	1	1480.23	505.18	694.83
30300		Removal foreign body, intranasal; office type procedure	7.25	605.38		010	1	64.04	462.59	61.03
30310		Removal foreign body, intranasal; requiring general anesthesia	6.29	525.22		010	0	1480.23	413.33	1567.36
30320		Removal foreign body, intranasal; by lateral rhinotomy	13.72	1145.62		090	0	2321.87	941.05	1567.36
30400		Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	30.58	2553.43		090	0	2321.87	2140.11	3919.59
30410		Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	35.70	2980.95		090	2	4230.05	2601.03	3919.59
30420		Rhinoplasty, primary; including major septal repair	41.27	3446.05		090	1	4230.05	2803.10	3919.59
30430		Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	26.88	2244.48		090	2	2321.87	1933.86	2276.44
30435		Rhinoplasty, secondary; intermediate revision (bony work with osteotomies	33.62	2807.27		090	2	4230.05	2559.28	3919.59
30450		Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	44.90	3749.15		090	2	4230.05	3332.49	3919.59
30460		Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	24.48	2044.08		090	2	4230.05	1629.09	3919.59
30462		Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	43.13	3601.36		090	2	4230.05	3294.91	3919.59
30465		Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	29.55	2467.43		090	0	4230.05	1971.44	3919.59
30520		Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	18.91	1578.99		090	1	2321.87	1124.75	2276.44
30540		Repair choanal atresia; intranasal	20.77	1734.30		090	2	4230.05	1370.24	3919.59
30545		Repair choanal atresia; transpalatine	25.33	2115.06		090	2	4230.05	1963.09	3919.59
30560		Lysis intranasal synechia	8.42	703.07		010	1	296.47	506.01	312.33
30580		Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	19.37	1617.40		090	1	4230.05	1239.98	3919.59
30600		Repair fistula; oronasal	17.35	1448.73		090	0	4230.05	1142.28	3919.59
30620		Septal or other intranasal dermatoplasty (does not include obtaining graft	19.12	1596.52		090	1	4230.05	1224.11	3919.59
30630		Repair nasal septal perforations	18.94	1581.49		090	0	2321.87	1237.47	2276.44
30801		Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	7.14	596.19		010	1	1480.23	433.37	694.83
30802		Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)	8.94	746.49		010	1	1480.23	551.94	1567.36
30901		Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	2.89	241.32		000	1	100.74	210.42	105.07
30903		Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	6.36	531.06		000	1	100.74	360.72	105.07
30905		Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initia	7.91	660.49		000	1	100.74	460.09	105.07

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
30906		Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	8.64	721.44		000	1	100.74	526.89	105.07
30915		Ligation arteries; ethmoidal	17.35	1448.73		090	1	2526.85	1143.12	2423.04
30920		Ligation arteries; internal maxillary artery, transantra	25.07	2093.35		090	1	2526.85	1629.09	2423.04
30930		Fracture nasal inferior turbinate(s), therapeutic	3.77	314.80		010	1	2321.87	239.65	1567.36
30999		Unlisted procedure, nose	0.00	BR		YYY	0	100.74	BR	105.07
31000		Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium	5.60	467.60		010	1	296.47	335.67	312.33
31002		Lavage by cannulation; sphenoid sinus	6.11	510.19		010	0	643.20	413.33	694.83
31020		Sinusotomy, maxillary (antrotomy); intranasa	14.90	1244.15		090	1	2321.87	951.90	2276.44
31030		Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyp	20.91	1745.99		090	1	4230.05	1421.17	3919.59
31032		Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyp	17.24	1439.54		090	1	4230.05	1135.60	3919.59
31040		Pterygomaxillary fossa surgery, any approach	22.79	1902.97		090	1	2321.87	1565.63	2276.44
31050		Sinusotomy, sphenoid, with or without biopsy	14.63	1221.61		090	1	4230.05	966.93	3919.59
31051		Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s	19.48	1626.58		090	1	4230.05	1267.53	3919.59
31070		Sinusotomy frontal; external, simple (trephine operation)	13.37	1116.40		090	1	4230.05	847.53	2276.44
31075		Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type	23.51	1963.09		090	2	4230.05	1557.28	3919.59
31080		Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation	30.97	2586.00		090	2	4230.05	2110.88	3919.59
31081		Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation	45.24	3777.54		090	2	4230.05	2442.38	3919.59
31084		Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision	34.57	2886.60		090	2	4230.05	2302.93	3919.59
31085		Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision	47.96	4004.66		090	2	4230.05	2450.73	3919.59
31086		Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision	33.62	2807.27		090	2	4230.05	2231.96	3919.59
31087		Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision	32.32	2698.72		090	2	4230.05	2211.92	3919.59
31090		Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid	30.93	2582.66		090	1	4230.05	1940.54	3919.59
31200		Ethmoidectomy; intranasal, anterior	17.41	1453.74		090	1	2321.87	1133.93	3919.59
31201		Ethmoidectomy; intranasal, total	22.43	1872.91		090	1	2321.87	1454.57	3919.59
31205		Ethmoidectomy; extranasal, total	27.32	2281.22		090	2	2321.87	1786.90	3919.59
31225		Maxillectomy; without orbital exenteration	55.84	4662.64		090	2		3579.65	2097.37**
31230		Maxillectomy; with orbital exenteration (en bloc)	61.80	5160.30		090	2		4017.19	2097.37**
31231		Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	6.43	536.91		000	1	184.33	371.58	168.02
31233		Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	8.11	677.19		000	0	184.33	531.90	168.02
31235		Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	9.18	766.53		000	0	1744.26	617.07	1974.92
31237		Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure	9.88	824.98		000	1	1744.26	667.17	1974.92
31238		Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	10.10	843.35		000	0	1744.26	688.04	1974.92
31239		Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	20.71	1729.29		010	0	2614.78	1378.59	2669.30
31240		Nasal/sinus endoscopy, surgical; with concha bullosa resection	4.79	399.97		000	0	2614.78	349.03	1974.92
31254		Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior	8.09	675.52		000	1	2614.78	600.37	2669.30
31255		Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior	11.83	987.81		000	1	2614.78	890.95	2669.30
31256		Nasal/sinus endoscopy, surgical, with maxillary antrostomy	5.87	490.15		000	1	2614.78	435.04	2669.30
31267		Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	9.39	784.07		000	1	2614.78	702.24	2669.30
31276		Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	14.92	1245.82		000	1	2614.78	1123.08	2669.30
31287		Nasal/sinus endoscopy, surgical, with sphenoidotomy	6.89	575.32		000	0	2614.78	511.86	2669.30
31288		Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	7.98	666.33		000	0	2614.78	593.69	2669.30
31290		Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid regior	34.35	2868.23		010	0		2432.36	2097.37**
31291		Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid regior	36.52	3049.42		010	0		2565.96	2097.37**
31292		Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompressior	29.67	2477.45		010	0	2614.78	2105.04	2669.30

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31293		Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompressior	32.20	2688.70		010	0	2614.78	2290.41	2669.30
31294		Nasal/sinus endoscopy, surgical; with optic nerve decompressior	36.83	3075.31		010	0	2614.78	2636.93	2669.30
31295		Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	65.54	5472.59		000	2	2614.78	New	
31296		Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation	66.53	5555.26		000	2	2614.78	New	
31297		Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation	65.64	5480.94		000	0	2614.78	New	
31299		Unlisted procedure, accessory sinuses	0.00	BR		YYY	0	100.74	BR	105.07
31300		Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectom	37.82	3157.97		090	2	2321.87	2499.16	2276.44
31320		Laryngotomy (thyrotomy, laryngofissure); diagnostic	20.08	1676.68		090	0	4230.05	1297.59	3919.59
31360		Laryngectomy; total, without radical neck dissectior	62.08	5183.68		090	2		3765.85	2097.37**
31365		Laryngectomy; total, with radical neck dissectior	76.72	6406.12		090	2		4766.18	2097.37**
31367		Laryngectomy; subtotal supraglottic, without radical neck dissectior	66.02	5512.67		090	2		4218.42	2097.37**
31368		Laryngectomy; subtotal supraglottic, with radical neck dissectior	73.04	6098.84		090	2		4791.23	2097.37**
31370		Partial laryngectomy (hemilaryngectomy); horizonta	62.10	5185.35		090	2		4010.51	2097.37**
31375		Partial laryngectomy (hemilaryngectomy); laterovertica	58.97	4924.00		090	2		3751.66	2097.37**
31380		Partial laryngectomy (hemilaryngectomy); anterovertica	58.16	4856.36		090	2		3727.44	2097.37**
31382		Partial laryngectomy (hemilaryngectomy); antero-latero-vertica	63.75	5323.13		090	2		4045.58	2097.37**
31390		Pharyngolaryngectomy, with radical neck dissection; without reconstructior	85.34	7125.89		090	2		5374.90	2097.37**
31395		Pharyngolaryngectomy, with radical neck dissection; with reconstructior	89.70	7489.95		090	2		5786.55	2097.37**
31400		Arytenoidectomy or arytenoidopexy, external approacl	30.07	2510.85		090	2	4230.05	2034.90	3919.59
31420		Epiglottidectomy	25.01	2088.34		090	2	4230.05	1682.53	3919.59
31500		Intubation, endotracheal, emergency procedure	3.23	269.71		000	1	207.48	232.97	223.90
31502		Tracheotomy tube change prior to establishment of fistula tract	1.03	86.01		000	1	130.23	74.32	128.96
31505		Laryngoscopy, indirect; diagnostic (separate procedure)	2.56	213.76		000	1	99.72	168.67	73.02
31510		Laryngoscopy, indirect; with biopsy	6.48	541.08		000	0	1744.26	426.69	1974.92
31511		Laryngoscopy, indirect; with removal of foreign body	6.55	546.93		000	1	184.33	430.86	168.02
31512		Laryngoscopy, indirect; with removal of lesior	6.34	529.39		000	0	1744.26	427.52	1974.92
31513		Laryngoscopy, indirect; with vocal cord injectior	3.95	329.83		000	0	184.33	283.90	168.02
31515		Laryngoscopy direct, with or without tracheoscopy; for aspiratior	6.38	532.73		000	1	1744.26	432.53	1974.92
31520		Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn	4.70	392.45		000	0	184.33	329.83	168.02
31525		Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn	7.65	638.78		000	1	1744.26	511.02	1974.92
31526		Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope	4.71	393.29		000	1	1744.26	341.52	1974.92
31527		Laryngoscopy direct, with or without tracheoscopy; with insertion of obturato	5.84	487.64		000	0	2614.78	411.66	2669.30
31528		Laryngoscopy direct, with or without tracheoscopy; with dilation, initia	4.33	361.56		000	0	2614.78	305.61	1974.92
31529		Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequer	4.84	404.14		000	0	2614.78	349.87	1974.92
31530		Laryngoscopy, direct, operative, with foreign body removal	5.88	490.98		000	1	1744.26	427.52	1974.92
31531		Laryngoscopy, direct, operative, with foreign body removal; with operating microscope or telescop	6.33	528.56		000	0	1744.26	465.10	1974.92
31535		Laryngoscopy, direct, operative, with biopsy	5.67	473.45		000	1	1744.26	410.82	1974.92
31536		Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescop	6.30	526.05		000	1	1744.26	460.92	1974.92
31540		Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis	7.23	603.71		000	1	1744.26	529.39	1974.92
31541		Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	7.89	658.82		000	1	2614.78	580.33	1974.92
31545		Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)	10.82	903.47		000	1	2614.78	769.04	2669.30
31546		Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft)	16.41	1370.24		000	1	2614.78	1185.70	2669.30
31560		Laryngoscopy, direct, operative, with arytenoidectomy	9.34	779.89		000	0	2614.78	682.20	2669.30
31561		Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope or telescop	10.21	852.54		000	0	2614.78	745.66	2669.30
31570		Laryngoscopy, direct, with injection into vocal cord(s), therapeutic	10.32	861.72		000	1	1744.26	753.17	1974.92

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31571		Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope	7.44	621.24		000	1	2614.78	546.09	2669.30
31575		Laryngoscopy, flexible fiberoptic; diagnostic	3.47	289.75		000	1	184.33	242.15	168.02
31576		Laryngoscopy, flexible fiberoptic; with biopsy	6.84	571.14		000	1	1744.26	457.58	1974.92
31577		Laryngoscopy, flexible fiberoptic; with removal of foreign body	7.44	621.24		000	0	435.08	506.01	402.32
31578		Laryngoscopy, flexible fiberoptic; with removal of lesion	8.54	713.09		000	0	1744.26	576.99	2669.30
31579		Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	6.41	535.24		000	1	435.08	476.79	402.32
31580		Laryngoplasty; for laryngeal web, 2-stage, with keel insertion and removal	36.79	3071.97		090	2	4230.05	2448.22	3919.59
31582		Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy	56.99	4758.67		090	1	4230.05	3908.64	3919.59
31584		Laryngoplasty; with open reduction of fracture	45.18	3772.53		090	2		3107.04	2097.37**
31587		Laryngoplasty, cricoid split	29.87	2494.15		090	2		1964.76	2097.37**
31588		Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy	34.30	2864.05		090	2	4230.05	2277.88	3919.59
31590		Laryngeal reinnervation by neuromuscular pedicle	27.14	2266.19		090	2	4230.05	1867.90	3919.59
31595		Section recurrent laryngeal nerve, therapeutic (separate procedure), unilatera	23.05	1924.68		090	2	4230.05	1561.45	3919.59
31599		Unlisted procedure, larynx	0.00	BR		YYY	0	100.74	BR	105.07
31600		Tracheostomy, planned (separate procedure)	11.75	981.13		000	1	2321.87	851.70	2276.44
31601		Tracheostomy, planned (separate procedure); younger than 2 years	7.70	642.95		000	2	2321.87	551.10	2276.44
31603		Tracheostomy, emergency procedure; transtrachea	6.60	551.10		000	1	643.20	478.46	694.83
31605		Tracheostomy, emergency procedure; cricothyroid membrane	5.42	452.57		000	1	643.20	393.29	694.83
31610		Tracheostomy, fenestration procedure with skin flaps	21.53	1797.76		090	1	4230.05	1431.19	2276.44
31611		Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)	16.38	1367.73		090	2	2321.87	1060.45	2276.44
31612		Tracheal puncture, percutaneous with transtracheal aspiration and/or injection	2.55	212.93		000	0	4230.05	166.17	2276.44
31613		Tracheostoma revision; simple, without flap rotation	13.86	1157.31		090	1	2321.87	878.42	2276.44
31614		Tracheostoma revision; complex, with flap rotation	22.98	1918.83		090	1	4230.05	1416.16	3919.59
31615		Tracheobronchoscopy through established tracheostomy incision	5.51	460.09		000	1	643.20	379.09	694.83
31620		Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])	8.67	723.95		ZZZ	1		592.85	
31622		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	9.60	801.60		000	1	985.48	687.21	945.70
31623		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	10.16	848.36		000	1	985.48	754.84	945.70
31624		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	9.56	798.26		000	1	985.48	700.57	945.70
31625		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	10.23	854.21		000	1	985.48	745.66	945.70
31626		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	13.65	1139.78		000	0	2028.28	977.79	945.70
31627		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	41.36	3453.56		ZZZ	0		2696.22	
31628		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	11.53	962.76		000	1	985.48	886.77	945.70
31629		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	18.63	1555.61		000	1	2028.28	1464.59	945.70
31630		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	5.98	499.33		000	1	2028.28	447.56	2362.04
31631		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	6.81	568.64		000	1	2028.28	495.16	2362.04

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31632		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	2.15	179.53		ZZZ	1	985.48	161.99	945.70
31633		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	2.64	220.44		ZZZ	1	985.48	191.22	945.70
31634		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	60.60	5060.10		000	2	2028.28	New	
31635		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	10.57	882.60		000	1	985.48	786.57	945.70
31636		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus	6.62	552.77		000	1	2028.28	488.48	2362.04
31637		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)	2.19	182.87		ZZZ	1	985.48	173.68	945.70
31638		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	7.57	632.10		000	1	2028.28	541.08	2362.04
31640		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with excision of tumor	7.65	638.78		000	1	2028.28	570.31	2362.04
31641		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	7.67	640.45		000	1	2028.28	555.28	2362.04
31643		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application	5.24	437.54		000	1	985.48	378.26	945.70
31645		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)	9.73	812.46		000	1	985.48	672.18	945.70
31646		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent	8.82	736.47		000	1	985.48	613.73	945.70
31647		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	6.64	554.44		000	1	2028.28	New	
31648		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	6.94	579.49		000	1	2028.28	New	
31649		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	2.18	182.03		ZZZ	1	985.48	New	
31651		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code	2.31	192.89		ZZZ	1	2028.28	New	
31660		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	6.66	556.11		000	1	2028.28	New	
31661		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	7.03	587.01		000	1	2028.28	New	
31717		Catheterization with bronchial brush biopsy	8.12	678.02		000	1	435.08	809.95	402.32
31720		Catheter aspiration (separate procedure); nasotrachea	1.47	122.75		000	1	45.26	111.06	37.00
31725		Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside	2.72	227.12		000	1		204.58	2097.37**
31730		Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy	38.00	3173.00		000	1	435.08	897.63	402.32
31750		Tracheoplasty; cervical	41.66	3478.61		090	2	4230.05	2666.16	3919.59
31755		Tracheoplasty; tracheopharyngeal fistulization, each stage	52.44	4378.74		090	2	4230.05	3400.12	3919.59
31760		Tracheoplasty; intrathoracic	40.98	3421.83		090	2		2874.91	2097.37**

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31766		Carinal reconstruction	53.00	4425.50		090	2		3843.51	2097.37**
31770		Bronchoplasty; graft repair	39.72	3316.62		090	2		2825.64	2097.37**
31775		Bronchoplasty; excision stenosis and anastomosis	40.81	3407.64		090	2		3016.86	2097.37**
31780		Excision tracheal stenosis and anastomosis; cervica	35.23	2941.71		090	2		2479.12	2097.37**
31781		Excision tracheal stenosis and anastomosis; cervicothoracic	45.67	3813.45		090	2		3000.99	2097.37**
31785		Excision of tracheal tumor or carcinoma; cervical	32.12	2682.02		090	2	2321.87	2261.18	2276.44
31786		Excision of tracheal tumor or carcinoma; thoracic	43.03	3593.01		090	2		3203.06	2097.37**
31800		Suture of tracheal wound or injury; cervica	22.05	1841.18		090	0		1427.02	2097.37**
31805		Suture of tracheal wound or injury; intrathoracic	24.44	2040.74		090	2		1738.47	2097.37**
31820		Surgical closure tracheostomy or fistula; without plastic repair	13.32	1112.22		090	0	2321.87	844.19	2276.44
31825		Surgical closure tracheostomy or fistula; with plastic repair	18.30	1528.05		090	0	2321.87	1191.55	2276.44
31830		Revision of tracheostomy scar	13.60	1135.60		090	0	2321.87	855.88	2276.44
31899		Unlisted procedure, trachea, bronchi	0.00	BR		YYY	0	985.48	BR	945.70
32035		Thoracostomy; with rib resection for empyema	21.74	1815.29		090	2		1439.54	2097.37**
32036		Thoracostomy; with open flap drainage for empyema	23.40	1953.90		090	2		1572.31	2097.37**
32096		Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilatera	24.27	2026.55		090	2		New	
32097		Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	24.27	2026.55		090	2		New	
32098		Thoracotomy, with biopsy(ies) of pleura	23.53	1964.76		090	2		New	
32100		Thoracotomy; with exploration	24.48	2044.08		090	2		2031.56	2097.37**
32110		Thoracotomy; with control of traumatic hemorrhage and/or repair of lung tear	43.81	3658.14		090	2		3038.57	2097.37**
32120		Thoracotomy; for postoperative complications	26.18	2186.03		090	2		1793.58	2097.37**
32124		Thoracotomy; with open intrapleural pneumonolysis	27.89	2328.82		090	2		1908.81	2097.37**
32140		Thoracotomy; with cyst(s) removal, includes pleural procedure when performed	29.71	2480.79		090	2		2043.25	2097.37**
32141		Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed	45.60	3807.60		090	2		2891.61	2097.37**
32150		Thoracotomy; with removal of intrapleural foreign body or fibrin deposi	30.10	2513.35		090	2		2054.94	2097.37**
32151		Thoracotomy; with removal of intrapulmonary foreign body	30.16	2518.36		090	2		2117.56	2097.37**
32160		Thoracotomy; with cardiac massage	23.67	1976.45		090	2		1538.91	2097.37**
32200		Pneumonostomy; with open drainage of abscess or cys	33.95	2834.83		090	2		2288.74	2097.37**
32201		Pneumonostomy; with percutaneous drainage of abscess or cys	27.52	2297.92		000	1	532.02	2007.34	506.30
32215		Pleural scarification for repeat pneumothorax	24.05	2008.18		090	2		1677.52	2097.37**
32220		Decortication, pulmonary (separate procedure); tota	47.66	3979.61		090	2		3344.18	2097.37**
32225		Decortication, pulmonary (separate procedure); partia	29.85	2492.48		090	2		2058.28	2097.37**
32310		Pleurectomy, parietal (separate procedure)	27.51	2297.09		090	2		1912.99	2097.37**
32320		Decortication and parietal pleurectomy	47.90	3999.65		090	2		3327.48	2097.37**
32400		Biopsy, pleura; percutaneous needle	4.47	373.25		000	1	920.55	314.80	881.50
32405		Biopsy, lung or mediastinum, percutaneous needle	13.59	1134.77		000	1	920.55	207.92	881.50
32440		Removal of lung, pneumonectomy;	46.83	3910.31		090	2		3387.60	2097.37**
32442		Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	91.19	7614.37		090	2		5866.71	2097.37**
32445		Removal of lung, pneumonectomy; extrapleura	105.34	8795.89		090	2		6447.87	2097.37**
32480		Removal of lung, other than pneumonectomy; single lobe (lobectomy	44.30	3699.05		090	2		3193.88	2097.37**
32482		Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy	47.42	3959.57		090	2		3397.62	2097.37**
32484		Removal of lung, other than pneumonectomy; single segment (segmentectomy	42.96	3587.16		090	2		3067.79	2097.37**
32486		Removal of lung, other than pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	70.15	5857.53		090	2		4654.29	2097.37**
32488		Removal of lung, other than pneumonectomy; with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)	71.14	5940.19		090	2		4725.27	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
32491		Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed	44.01	3674.84		090	2		3147.12	2097.37**
32501		Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)	7.27	607.05		ZZZ	2		531.06	2097.37**
32503		Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)	54.08	4515.68		090	2		3939.53	2097.37**
32504		Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction	61.07	5099.35		090	2		4489.80	2097.37**
32505		Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initia	28.71	2397.29		090	2		New	
32506		Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	4.93	411.66		ZZZ	2		New	
32507		Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition t code for primary procedure)	4.93	411.66		ZZZ	2		New	
32540		Extrapleural enucleation of empyema (empyemectomy)	51.61	4309.44		090	2		3300.76	2097.37**
32550		Insertion of indwelling tunneled pleural catheter with cuf	24.33	2031.56		000	1	2914.41	1811.04	2777.67
32551		Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	5.23	436.71		000	1	532.02	377.16	506.30
32552		Removal of indwelling tunneled pleural catheter with cuf	5.78	482.63		010	0	532.02	418.34	128.96
32553		Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	17.59	1468.77		000	2	1270.08	1345.19	1254.56
32554		Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidanc	16.65	1390.28		000	1	532.02	New	
32555		Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidanc	19.20	1603.20		000	1	532.02	New	
32556		Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidanc	17.55	1465.43		000	1	532.02	New	
32557		Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidanc	28.49	2378.92		000	1	532.02	New	
32560		Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)	7.59	633.77		000	1	532.02	665.28	506.30
32561		Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day	2.84	237.14		000	2	532.02	217.94	506.30
32562		Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	2.57	214.60		000	2	532.02	193.72	506.30
32601		Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy	9.24	771.54		000	0	3308.75	667.17	3101.23
32604		Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biops	14.34	1197.39		000	0	3308.75	1042.92	3101.23
32606		Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biops	13.81	1153.14		000	0	3308.75	1003.67	3101.23
32607		Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilatera	9.58	799.93		000	0	3308.75	New	
32608		Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	11.79	984.47		000	0	3308.75	New	
32609		Thoracoscopy; with biopsy(ies) of pleura	8.12	678.02		000	0	3308.75	New	
32650		Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)	20.03	1672.51		090	2		1474.61	2097.37**
32651		Thoracoscopy, surgical; with partial pulmonary decortication	32.78	2737.13		090	2		2175.18	2097.37**
32652		Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysi	49.64	4144.94		090	2		3274.87	2097.37**
32653		Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposi	31.60	2638.60		090	2		2109.21	2097.37**
32654		Thoracoscopy, surgical; with control of traumatic hemorrhage	35.25	2943.38		090	2		2308.78	2097.37**
32655		Thoracoscopy, surgical; with resection-plication of bullae, includes any pleural procedure when performed	28.72	2398.12		090	2		1967.26	2097.37**
32656		Thoracoscopy, surgical; with parietal pleurectomy	23.92	1997.32		090	2		1771.04	2097.37**
32658		Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac	21.41	1787.74		090	2		1594.85	2097.37**
32659		Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage	21.86	1825.31		090	2		1616.56	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
32661		Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	23.93	1998.16		090	2		1775.21	2097.37**
32662		Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass	26.69	2228.62		090	2		1993.98	2097.37**
32663		Thoracoscopy, surgical; with lobectomy (single lobe)	41.86	3495.31		090	2		2944.21	2097.37**
32664		Thoracoscopy, surgical; with thoracic sympathectomy	25.41	2121.74		090	2		1873.74	2097.37**
32665		Thoracoscopy, surgical; with esophagomyotomy (Heller type	36.40	3039.40		090	2		2480.79	2097.37**
32666		Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilatera	26.73	2231.96		090	2		New	
32667		Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	4.93	411.66		ZZZ	2		New	
32668		Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)	4.95	413.33		ZZZ	2		New	
32669		Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy	40.19	3355.87		090	2		New	
32670		Thoracoscopy, surgical; with removal of 2 lobes (bilobectomy)	47.92	4001.32		090	2		New	
32671		Thoracoscopy, surgical; with removal of lung (pneumonectomy)	53.11	4434.69		090	2		New	
32672		Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed	45.46	3795.91		090	2		New	
32673		Thoracoscopy, surgical; with resection of thymus, unilateral or bilatera	35.81	2990.14		090	2		New	
32674		Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	6.42	536.07		ZZZ	2		New	
32701		Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	6.55	546.93		XXX	0		New	
32800		Repair lung hernia through chest wall	28.27	2360.55		090	2		1948.89	2097.37**
32810		Closure of chest wall following open flap drainage for empyema (Clagett type procedure	27.03	2257.01		090	2		1895.45	2097.37**
32815		Open closure of major bronchial fistula	83.87	7003.15		090	2		5096.01	2097.37**
32820		Major reconstruction, chest wall (posttraumatic)	42.19	3522.87		090	2		2896.62	2097.37**
32850		Donor pneumonectomy(s) (including cold preservation), from cadaver donor	0.00	BR		XXX	9		BR	2097.37**
32851		Lung transplant, single; without cardiopulmonary bypass	98.00	8183.00		090	2		5708.90	2097.37**
32852		Lung transplant, single; with cardiopulmonary bypass	107.05	8938.68		090	2		6427.83	2097.37**
32853		Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	136.93	11433.66		090	2		6828.63	2097.37**
32854		Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	145.53	12151.76		090	2		7378.06	2097.37**
32855		Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral	0.00	BR		XXX	2		BR	2097.37**
32856		Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral	0.00	BR		XXX	2		BR	2097.37**
32900		Resection of ribs, extrapleural, all stages	41.58	3471.93		090	2		2848.19	2097.37**
32905		Thoracoplasty, Schede type or extrapleural (all stages)	39.93	3334.16		090	2		2839.00	2097.37**
32906		Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula	49.27	4114.05		090	2		3515.35	2097.37**
32940		Pneumonolysis, extraperiosteal, including filling or packing procedures	36.93	3083.66		090	2		2608.54	2097.37**
32960		Pneumothorax, therapeutic, intrapleural injection of air	4.55	379.93		000	1	532.02	291.42	506.30
32997		Total lung lavage (unilateral)	10.53	879.26		000	1		753.17	2097.37**
32998		Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	90.77	7579.30		000	2	5220.48	6188.19	4683.68
32999		Unlisted procedure, lungs and pleura	0.00	BR		YYY	1	532.02	BR	506.30
33010		Pericardiocentesis; initial	3.49	291.42		000	1	532.02	250.50	506.30
33011		Pericardiocentesis; subsequent	3.54	295.59		000	0	532.02	254.68	506.30
33015		Tube pericardiostomy	15.03	1255.01		090	1		1103.87	2097.37**
33020		Pericardiotomy for removal of clot or foreign body (primary procedure)	26.25	2191.88		090	2		1826.98	2097.37**
33025		Creation of pericardial window or partial resection for drainage	24.01	2004.84		090	2		1698.39	2097.37**
33030		Pericardiectomy, subtotal or complete; without cardiopulmonary bypass	59.94	5004.99		090	2		2698.72	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33031		Pericardiectomy, subtotal or complete; with cardiopulmonary bypass	74.30	6204.05		090	2		2997.65	2097.37**
33050		Resection of pericardial cyst or tumor	30.01	2505.84		090	2		2094.18	2097.37**
33120		Excision of intracardiac tumor, resection with cardiopulmonary bypass	62.93	5254.66		090	2		3310.78	2097.37**
33130		Resection of external cardiac tumor	41.69	3481.12		090	2		2888.27	2097.37**
33140		Transmyocardial laser revascularization, by thoracotomy; (separate procedure	47.49	3965.42		090	2		3264.85	2097.37**
33141		Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)	3.95	329.83		ZZZ	2		364.06	2097.37**
33202		Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)	23.29	1944.72		090	1		1649.96	2097.37**
33203		Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy	24.07	2009.85		090	1		1686.70	2097.37**
33206		Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atria	13.50	1127.25		090	1	10617.60	979.46	10840.90
33207		Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricula	14.30	1194.05		090	1	10617.60	1142.28	10840.90
33208		Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	15.45	1290.08		090	1	13141.57	1069.64	12963.78
33210		Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)	5.23	436.71		000	1	4858.53	377.42	4462.48
33211		Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	5.34	445.89		000	1	4858.53	389.95	4462.48
33212		Insertion of pacemaker pulse generator only; with existing single leac	9.83	820.81		090	1	8530.53	738.98	8950.99
33213		Insertion of pacemaker pulse generator only; with existing dual leads	10.26	856.71		090	1	9952.64	838.34	9863.95
33214		Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	14.26	1190.71		090	0	13141.57	1052.94	12963.78
33215		Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode	8.98	749.83		090	1	2171.38	671.34	2092.01
33216		Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillato	11.08	925.18		090	1	4858.53	826.65	4462.48
33217		Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillato	11.02	920.17		090	1	4858.53	826.65	4462.48
33218		Repair of single transvenous electrode, permanent pacemaker or pacing cardioverter-defibrillato	11.62	970.27		090	1	2171.38	850.03	2092.01
33220		Repair of 2 transvenous electrodes for permanent pacemaker or pacing cardioverter-defibrillato	11.71	977.79		090	1	2171.38	855.88	2092.01
33221		Insertion of pacemaker pulse generator only; with existing multiple leads	10.70	893.45		090	1	9952.64	New	
33222		Revision or relocation of skin pocket for pacemaker	10.25	855.88		090	1	1434.08	771.54	1463.98
33223		Revision of skin pocket for cardioverter-defibrillator	12.24	1022.04		090	0	1434.08	917.67	1463.98
33224		Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of	14.90	1244.15		000	1	13141.57	1081.33	18614.21
33225		Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for pri	13.41	1119.74		ZZZ	1	13141.57	961.09	18614.21
33226		Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	14.33	1196.56		000	1	2171.38	1043.75	2092.01
33227		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	10.23	854.21		090	1	8530.53	New	
33228		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	10.67	890.95		090	1	9952.64	New	
33229		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	11.10	926.85		090	1	9952.64	New	
33230		Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads	11.58	966.93		090	1	29042.50	New	
33231		Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads	12.01	1002.84		090	1	29042.50	New	
33233		Removal of permanent pacemaker pulse generator only	7.02	586.17		090	1	2171.38	543.59	2092.01
33234		Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	14.38	1200.73		090	1	2171.38	1060.45	2092.01

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33235		Removal of transvenous pacemaker electrode(s); dual lead system	18.79	1568.97		090	1	2171.38	1387.77	2092.01
33236		Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	23.83	1989.81		090	0		1695.05	2097.37**
33237		Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system	25.34	2115.89		090	0		1813.62	2097.37**
33238		Removal of permanent transvenous electrode(s) by thoracotomy	28.26	2359.71		090	0		2004.00	2097.37**
33240		Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead	11.14	930.19		090	1	29042.50	1005.34	29712.33
33241		Removal of pacing cardioverter-defibrillator pulse generator only	6.60	551.10		090	1	2171.38	509.35	2092.01
33243		Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy	40.93	3417.66		090	2		2881.59	2097.37**
33244		Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction	25.21	2105.04		090	1	2171.38	1880.42	2092.01
33249		Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber	26.72	2231.12		090	1	39579.89	1934.70	37604.22
33250		Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass	44.34	3702.39		090	2		3104.53	2097.37**
33251		Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass	48.86	4079.81		090	2		3425.17	2097.37**
33254		Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	41.25	3444.38		090	2		2880.75	2097.37**
33255		Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	49.54	4136.59		090	2		3466.09	2097.37**
33256		Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	58.78	4908.13		090	2		4140.77	2097.37**
33257		Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	17.63	1472.11		ZZZ	2		1246.56	2097.37**
33258		Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	19.84	1656.64		ZZZ	2		1408.68	2097.37**
33259		Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	25.59	2136.77		ZZZ	2		1850.52	2097.37**
33261		Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	49.08	4098.18		090	2		3424.34	2097.37**
33262		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system	11.16	931.86		090	1	29042.50	New	
33263		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system	11.60	968.60		090	1	29042.50	New	
33264		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system	12.03	1004.51		090	1	29042.50	New	
33265		Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	40.87	3412.65		090	2		2880.75	2097.37**
33266		Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	55.73	4653.46		090	2		3941.20	2097.37**
33282		Implantation of patient-activated cardiac event recorder	9.48	791.58		090	1	7602.81	714.76	7118.85
33284		Removal of an implantable, patient-activated cardiac event recorder	6.83	570.31		090	1	752.91	531.90	748.01
33300		Repair of cardiac wound; without bypass	73.42	6130.57		090	2		4497.31	2097.37**
33305		Repair of cardiac wound; with cardiopulmonary bypass	122.84	10257.14		090	2		7223.59	2097.37**
33310		Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass	35.10	2930.85		090	2		2519.20	2097.37**
33315		Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass	57.59	4808.77		090	2		3129.58	2097.37**
33320		Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass	31.65	2642.78		090	2		2256.17	2097.37**

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33321		Suture repair of aorta or great vessels; with shunt bypass	35.92	2999.32		090	2		2626.08	2097.37**
33322		Suture repair of aorta or great vessels; with cardiopulmonary bypass	41.91	3499.49		090	2		2917.49	2097.37**
33330		Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass	45.90	3832.65		090	2		2971.77	2097.37**
33332		Insertion of graft, aorta or great vessels; with shunt bypass	42.10	3515.35		090	2		2948.39	2097.37**
33335		Insertion of graft, aorta or great vessels; with cardiopulmonary bypass	56.57	4723.60		090	2		4000.49	2097.37**
33361		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	39.75	3319.13		000	0		New	
33362		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	43.49	3631.42		000	0		New	
33363		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	45.03	3760.01		000	0		New	
33364		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	47.91	4000.49		000	0		New	
33365		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	52.54	4387.09		000	0		New	
33367		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	18.45	1540.58		ZZZ	0		New	
33368		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure	22.36	1867.06		ZZZ	0		New	
33369		Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	29.52	2464.92		ZZZ	0		New	
33400		Valvuloplasty, aortic valve; open, with cardiopulmonary bypass	68.57	5725.60		090	2		4747.81	2097.37**
33401		Valvuloplasty, aortic valve; open, with inflow occlusion	42.73	3567.96		090	2		3180.52	2097.37**
33403		Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass	45.04	3760.84		090	2		3318.29	2097.37**
33404		Construction of apical-aortic conduit	52.78	4407.13		090	2		3874.40	2097.37**
33405		Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	68.02	5679.67		090	2		5006.66	2097.37**
33406		Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand	86.61	7231.94		090	2		5990.29	2097.37**
33410		Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	76.44	6382.74		090	2		5258.00	2097.37**
33411		Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus	100.97	8431.00		090	2		6732.61	2097.37**
33412		Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure	95.83	8001.81		090	2		5442.53	2097.37**
33413		Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	97.12	8109.52		090	2		6764.34	2097.37**
33414		Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow trac	64.80	5410.80		090	2		4534.89	2097.37**
33415		Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	61.35	5122.73		090	2		4162.48	2097.37**
33416		Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)	61.22	5111.87		090	2		4246.81	2097.37**
33417		Aortoplasty (gusset) for supravalvular stenosis	50.09	4182.52		090	2		3638.10	2097.37**
33420		Valvotomy, mitral valve; closed heart	43.07	3596.35		090	1		2866.56	2097.37**
33422		Valvotomy, mitral valve; open heart, with cardiopulmonary bypass	50.78	4240.13		090	2		3667.32	2097.37**
33425		Valvuloplasty, mitral valve, with cardiopulmonary bypass	82.37	6877.90		090	2		5273.03	2097.37**
33426		Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	71.79	5994.47		090	2		5068.45	2097.37**
33427		Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	73.56	6142.26		090	2		5412.47	2097.37**
33430		Replacement, mitral valve, with cardiopulmonary bypass	83.91	7006.49		090	2		5715.58	2097.37**
33460		Valvectomy, tricuspid valve, with cardiopulmonary bypass	73.08	6102.18		090	2		4670.16	2097.37**
33463		Valvuloplasty, tricuspid valve; without ring insertion	92.88	7755.48		090	2		5820.79	2097.37**
33464		Valvuloplasty, tricuspid valve; with ring insertion	73.66	6150.61		090	2		4873.06	2097.37**
33465		Replacement, tricuspid valve, with cardiopulmonary bypass	83.03	6933.01		090	2		5348.18	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33468		Tricuspid valve repositioning and plication for Ebstein anomaly	73.86	6167.31		090	2		3980.45	2097.37**
33470		Valvotomy, pulmonary valve, closed heart; transventricular	39.16	3269.86		090	2		2538.40	2097.37**
33471		Valvotomy, pulmonary valve, closed heart; via pulmonary artery	41.43	3459.41		090	2		2768.86	2097.37**
33472		Valvotomy, pulmonary valve, open heart; with inflow occlusion	39.42	3291.57		090	2		2909.98	2097.37**
33474		Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass	65.06	5432.51		090	2		4259.34	2097.37**
33475		Replacement, pulmonary valve	70.77	5909.30		090	2		4877.24	2097.37**
33476		Right ventricular resection for infundibular stenosis, with or without commissurotomy	46.00	3841.00		090	2		3173.00	2097.37**
33478		Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection	47.52	3967.92		090	2		3427.68	2097.37**
33496		Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)	50.29	4199.22		090	2		3613.05	2097.37**
33500		Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass	47.54	3969.59		090	2		3360.88	2097.37**
33501		Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass	34.04	2842.34		090	2		2310.45	2097.37**
33502		Repair of anomalous coronary artery from pulmonary artery origin; by ligation	38.66	3228.11		090	2		2766.36	2097.37**
33503		Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass	39.51	3299.09		090	0		2654.47	2097.37**
33504		Repair of anomalous coronary artery from pulmonary artery origin; by graft, with cardiopulmonary bypass	44.31	3699.89		090	2		3131.25	2097.37**
33505		Repair of anomalous coronary artery from pulmonary artery origin; with construction of intrapulmonary artery tunnel (Takeuchi procedure)	62.17	5191.20		090	2		4127.41	2097.37**
33506		Repair of anomalous coronary artery from pulmonary artery origin; by translocation from pulmonary artery to aorta	61.36	5123.56		090	2		4464.75	2097.37**
33507		Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation	51.47	4297.75		090	2		3793.41	2097.37**
33508		Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)	0.48	40.08		ZZZ	2		35.07	
33510		Coronary artery bypass, vein only; single coronary venous graf	58.29	4867.22		090	2		4285.22	2097.37**
33511		Coronary artery bypass, vein only; 2 coronary venous grafts	64.01	5344.84		090	2		4630.91	2097.37**
33512		Coronary artery bypass, vein only; 3 coronary venous grafts	72.72	6072.12		090	2		5126.07	2097.37**
33513		Coronary artery bypass, vein only; 4 coronary venous grafts	74.80	6245.80		090	2		5271.36	2097.37**
33514		Coronary artery bypass, vein only; 5 coronary venous grafts	78.87	6585.65		090	2		5499.31	2097.37**
33516		Coronary artery bypass, vein only; 6 or more coronary venous grafts	82.26	6868.71		090	2		5722.26	2097.37**
33517		Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)	5.62	469.27		ZZZ	2		379.93	2097.37**
33518		Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)	12.36	1032.06		ZZZ	2		805.78	2097.37**
33519		Coronary artery bypass, using venous graft(s) and arterial graft(s); 3 venous grafts (List separately in addition to code for primary procedure)	16.34	1364.39		ZZZ	2		1086.34	2097.37**
33521		Coronary artery bypass, using venous graft(s) and arterial graft(s); 4 venous grafts (List separately in addition to code for primary procedure)	19.64	1639.94		ZZZ	2		1332.66	2097.37**
33522		Coronary artery bypass, using venous graft(s) and arterial graft(s); 5 venous grafts (List separately in addition to code for primary procedure)	22.05	1841.18		ZZZ	2		1539.74	2097.37**
33523		Coronary artery bypass, using venous graft(s) and arterial graft(s); 6 or more venous grafts (List separately in addition to code for primary procedure)	25.05	2091.68		ZZZ	2		1772.71	2097.37**
33530		Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)	15.77	1316.80		ZZZ	2		1018.70	2097.37**
33533		Coronary artery bypass, using arterial graft(s); single arterial graf	56.03	4678.51		090	2		4205.90	2097.37**
33534		Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	66.24	5531.04		090	2		4801.25	2097.37**
33535		Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	73.80	6162.30		090	2		5254.66	2097.37**
33536		Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	79.02	6598.17		090	2		5595.34	2097.37**
33542		Myocardial resection (eg, ventricular aneurysmectomy)	79.15	6609.03		090	2		5155.29	2097.37**
33545		Repair of postinfarction ventricular septal defect, with or without myocardial resection	92.84	7752.14		090	2		6117.21	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33548		Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)	89.31	7457.39		090	2		6140.59	2097.37**
33572		Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)	6.93	578.66		ZZZ	2		506.01	2097.37**
33600		Closure of atrioventricular valve (mitral or tricuspid) by suture or patch	51.46	4296.91		090	2		3677.34	2097.37**
33602		Closure of semilunar valve (aortic or pulmonary) by suture or patch	49.36	4121.56		090	2		3572.97	2097.37**
33606		Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure	52.52	4385.42		090	2		3832.65	2097.37**
33608		Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery	53.91	4501.49		090	2		3941.20	2097.37**
33610		Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect	55.21	4610.04		090	2		3814.28	2097.37**
33611		Repair of double outlet right ventricle with intraventricular tunnel repair	58.86	4914.81		090	2		4177.51	2097.37**
33612		Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction	59.26	4948.21		090	2		4401.29	2097.37**
33615		Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)	59.68	4983.28		090	2		4130.75	2097.37**
33617		Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	64.63	5396.61		090	2		4742.80	2097.37**
33619		Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	81.50	6805.25		090	2		5872.56	2097.37**
33620		Application of right and left pulmonary artery bands (eg, hybrid approach stage 1	43.47	3629.75		090	2		New	
33621		Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	26.05	2175.18		090	2		New	
33622		Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left	102.45	8554.58		090	2		New	
33641		Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	49.27	4114.05		090	2		3314.12	2097.37**
33645		Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage	52.26	4363.71		090	2		3384.26	2097.37**
33647		Repair of atrial septal defect and ventricular septal defect, with direct or patch closure	54.83	4578.31		090	2		3602.19	2097.37**
33660		Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	53.01	4426.34		090	2		3842.67	2097.37**
33665		Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair	57.76	4822.96		090	2		4070.63	2097.37**
33670		Repair of complete atrioventricular canal, with or without prosthetic valve	59.51	4969.09		090	2		4215.92	2097.37**
33675		Closure of multiple ventricular septal defects;	59.48	4966.58		090	2		4595.01	2097.37**
33676		Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)	63.99	5343.17		090	2		4740.30	2097.37**
33677		Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset	63.60	5310.60		090	2		4927.34	2097.37**
33681		Closure of single ventricular septal defect, with or without patch	55.30	4617.55		090	2		3982.12	2097.37**
33684		Closure of single ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)	57.04	4762.84		090	2		4121.56	2097.37**
33688		Closure of single ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset	56.85	4746.98		090	2		3851.02	2097.37**
33690		Banding of pulmonary artery	36.01	3006.84		090	2		2497.49	2097.37**
33692		Complete repair tetralogy of Fallot without pulmonary atresia	61.92	5170.32		090	2		3802.59	2097.37**
33694		Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch	61.55	5139.43		090	2		4206.73	2097.37**
33697		Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	61.49	5134.42		090	2		4546.58	2097.37**
33702		Repair sinus of Valsalva fistula, with cardiopulmonary bypass	46.76	3904.46		090	2		3369.23	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33710		Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect	64.15	5356.53		090	2		3760.84	2097.37**
33720		Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass	46.35	3870.23		090	2		3359.21	2097.37**
33722		Closure of aortico-left ventricular tunnel	49.05	4095.68		090	2		3338.33	2097.37**
33724		Repair of isolated partial anomalous pulmonary venous return (eg, Scimitar Syndrome	46.02	3842.67		090	2		3284.89	2097.37**
33726		Repair of pulmonary venous stenosis	64.15	5356.53		090	2		4325.30	2097.37**
33730		Complete repair of anomalous pulmonary venous return (supracardiac, intracardiac, or infracardiac types)	60.51	5052.59		090	2		4286.06	2097.37**
33732		Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane	49.85	4162.48		090	2		3617.22	2097.37**
33735		Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation	38.75	3235.63		090	2		2573.47	2097.37**
33736		Atrial septectomy or septostomy; open heart with cardiopulmonary bypass	42.52	3550.42		090	2		3038.57	2097.37**
33737		Atrial septectomy or septostomy; open heart, with inflow occlusion	40.26	3361.71		090	2		2790.57	2097.37**
33750		Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation	42.74	3568.79		090	2		2631.09	2097.37**
33755		Shunt; ascending aorta to pulmonary artery (Waterston type operation	40.44	3376.74		090	2		2671.17	2097.37**
33762		Shunt; descending aorta to pulmonary artery (Potts-Smith type operation	40.29	3364.22		090	2		2732.12	2097.37**
33764		Shunt; central, with prosthetic graft	39.02	3258.17		090	2		2768.86	2097.37**
33766		Shunt; superior vena cava to pulmonary artery for flow to 1 lung (classical Glenn procedure	41.05	3427.68		090	2		2975.94	2097.37**
33767		Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure	42.95	3586.33		090	2		3137.93	2097.37**
33768		Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)	13.16	1098.86		ZZZ	2		913.49	2097.37**
33770		Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	66.29	5535.22		090	2		4549.08	2097.37**
33771		Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect	69.10	5769.85		090	2		4517.35	2097.37**
33774		Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;	54.41	4543.24		090	2		3947.05	2097.37**
33775		Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	58.27	4865.55		090	2		4032.22	2097.37**
33776		Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect	61.56	5140.26		090	2		4286.06	2097.37**
33777		Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction	59.62	4978.27		090	2		4192.54	2097.37**
33778		Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type)	71.07	5934.35		090	2		5093.50	2097.37**
33779		Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band	73.75	6158.13		090	2		4684.35	2097.37**
33780		Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	75.05	6266.68		090	2		5039.23	2097.37**
33781		Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction	73.40	6128.90		090	2		4870.56	2097.37**
33782		Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation	96.29	8040.22		090	2		6745.97	2097.37**
33783		Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	104.03	8686.51		090	2		7359.69	2097.37**
33786		Total repair, truncus arteriosus (Rastelli type operation)	68.71	5737.29		090	2		4896.44	2097.37**
33788		Reimplantation of an anomalous pulmonary artery	48.89	4082.32		090	2		3334.99	2097.37**
33800		Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	27.57	2302.10		090	2		2160.15	2097.37**
33802		Division of aberrant vessel (vascular ring);	34.80	2905.80		090	2		2294.58	2097.37**
33803		Division of aberrant vessel (vascular ring); with reanastomosis	34.75	2901.63		090	2		2559.28	2097.37**
33813		Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	38.44	3209.74		090	2		2725.44	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33814		Obliteration of aortopulmonary septal defect; with cardiopulmonary bypas	46.10	3849.35		090	2		3314.12	2097.37**
33820		Repair of patent ductus arteriosus; by ligation	29.33	2449.06		090	2		2142.61	2097.37**
33822		Repair of patent ductus arteriosus; by division, younger than 18 year	32.01	2672.84		090	2		2232.79	2097.37**
33824		Repair of patent ductus arteriosus; by division, 18 years and olde	35.38	2954.23		090	2		2555.10	2097.37**
33840		Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	37.48	3129.58		090	2		2605.20	2097.37**
33845		Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graf	40.36	3370.06		090	2		2889.94	2097.37**
33851		Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement	38.51	3215.59		090	2		2765.52	2097.37**
33852		Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	42.28	3530.38		090	2		2920.83	2097.37**
33853		Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass	55.36	4622.56		090	2		4003.83	2097.37**
33860		Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performe	96.60	8066.10		090	2		6396.10	2097.37**
33863		Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	94.59	7898.27		090	2		6546.40	2097.37**
33864		Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	96.61	8066.94		090	2		6693.12	2097.37**
33870		Transverse arch graft, with cardiopulmonary bypas	75.74	6324.29		090	2		5500.98	2097.37**
33875		Descending thoracic aorta graft, with or without bypas	82.63	6899.61		090	2		4244.31	2097.37**
33877		Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypas	109.73	9162.46		090	2		7141.76	2097.37**
33880		Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thora	54.62	4560.77		090	2		3881.92	2097.37**
33881		Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending t	46.89	3915.32		090	2		3350.86	2097.37**
33883		Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	33.96	2835.66		090	2		2472.44	2097.37**
33884		Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separatel	12.38	1033.73		ZZZ	2		890.95	2097.37**
33886		Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	29.60	2471.60		090	2		2145.95	2097.37**
33889		Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	24.04	2007.34		000	2		1788.57	2097.37**
33891		Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	29.57	2469.10		000	2		2297.92	2097.37**
33910		Pulmonary artery embolectomy; with cardiopulmonary bypas	79.46	6634.91		090	2		3481.95	2097.37**
33915		Pulmonary artery embolectomy; without cardiopulmonary bypas	41.16	3436.86		090	2		2784.73	2097.37**
33916		Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypas	126.22	10539.37		090	2		3368.39	2097.37**
33917		Repair of pulmonary artery stenosis by reconstruction with patch or graf	43.71	3649.79		090	2		3176.34	2097.37**
33920		Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery	54.58	4557.43		090	2		3914.48	2097.37**
33922		Transection of pulmonary artery with cardiopulmonary bypas	42.03	3509.51		090	2		2990.14	2097.37**
33924		Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	8.50	709.75		ZZZ	2		641.28	2097.37**
33925		Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass	51.36	4288.56		090	2		3862.71	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
33926		Repair of pulmonary artery arborization anomalies by unifocalization; with cardiopulmonary bypas	72.81	6079.64		090	2		5281.38	2097.37**
33930		Donor cardiectomy-pneumonectomy (including cold preservation)	0.00	BR		XXX	9		BR	2097.37**
33933		Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation	0.00	BR		XXX	2		BR	2097.37**
33935		Heart-lung transplant with recipient cardiectomy-pneumonectomy	150.11	12534.19		090	2		7675.32	2097.37**
33940		Donor cardiectomy (including cold preservation)	0.00	BR		XXX	9		BR	2097.37**
33944		Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for impla	0.00	BR		XXX	2		BR	2097.37**
33945		Heart transplant, with or without recipient cardiectomy	145.65	12161.78		090	2		9195.02	2097.37**
33960		Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day	29.58	2469.93		000	2		2100.03	2097.37**
33961		Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day	16.44	1372.74		XXX	1		1180.69	2097.37**
33967		Insertion of intra-aortic balloon assist device, percutaneous	7.66	639.61		000	0		559.45	2097.37**
33968		Removal of intra-aortic balloon assist device, percutaneous	1.00	83.50		000	1		74.32	2097.37**
33970		Insertion of intra-aortic balloon assist device through the femoral artery, open approach	10.57	882.60		000	2		770.71	2097.37**
33971		Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graf	21.45	1791.08		090	1		1501.33	2097.37**
33973		Insertion of intra-aortic balloon assist device through the ascending aorta	15.37	1283.40		000	2		1126.42	2097.37**
33974		Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft	27.21	2272.04		090	1		1923.01	2097.37**
33975		Insertion of ventricular assist device; extracorporeal, single ventricle	39.58	3304.93		XXX	2		2363.05	2097.37**
33976		Insertion of ventricular assist device; extracorporeal, biventricular	48.10	4016.35		XXX	2		2635.26	2097.37**
33977		Removal of ventricular assist device; extracorporeal, single ventricle	33.91	2831.49		XXX	2		2630.25	2097.37**
33978		Removal of ventricular assist device; extracorporeal, biventricular	40.50	3381.75		XXX	2		2921.67	2097.37**
33979		Insertion of ventricular assist device, implantable intracorporeal, single ventricle	58.48	4883.08		XXX	2		5266.35	2097.37**
33980		Removal of ventricular assist device, implantable intracorporeal, single ventricle	53.60	4475.60		XXX	2		7690.35	2097.37**
33981		Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	25.22	2105.87		XXX	2		0.00	2097.37**
33982		Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	61.91	5169.49		XXX	2		0.00	2097.37**
33983		Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	69.21	5779.04		XXX	2		0.00	2097.37**
33990		Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only	12.93	1079.66		XXX	2		New	
33991		Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture	18.84	1573.14		XXX	2		New	
33992		Removal of percutaneous ventricular assist device at separate and distinct session from insertion	6.15	513.53		XXX	2		New	
33993		Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	5.40	450.90		XXX	2		New	
33999		Unlisted procedure, cardiac surgery	0.00	BR		YYY	2	532.02	BR	506.30
34001		Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision	29.61	2472.44		090	2		2048.26	2097.37**
34051		Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision	30.19	2520.87		090	2		2085.83	2097.37**
34101		Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	18.45	1540.58		090	2	3999.56	1359.38	3729.70
34111		Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	18.46	1541.41		090	2	3999.56	1360.22	3729.70
34151		Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision	42.90	3582.15		090	2		3115.39	2097.37**

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34201		Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	31.69	2646.12		090	2	3999.56	2056.61	3729.70
34203		Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	29.40	2454.90		090	2	3999.56	2170.17	3729.70
34401		Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incisior	43.97	3671.50		090	2		3109.54	2097.37**
34421		Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incisior	22.35	1866.23		090	2	3999.56	1629.92	3729.70
34451		Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	50.03	4177.51		090	2		3372.57	2097.37**
34471		Thrombectomy, direct or with catheter; subclavian vein, by neck incisior	32.69	2729.62		090	1	3999.56	2167.66	3729.70
34490		Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incisior	18.94	1581.49		090	1	3999.56	1363.56	3729.70
34501		Valvuloplasty, femoral vein	27.57	2302.10		090	2	3999.56	2130.09	3729.70
34502		Reconstruction of vena cava, any method	46.25	3861.88		090	2		3390.10	2097.37**
34510		Venous valve transposition, any vein donor	35.48	2962.58		090	2	3999.56	2422.34	3729.70
34520		Cross-over vein graft to venous system	30.46	2543.41		090	2	3999.56	2343.85	3729.70
34530		Saphenopopliteal vein anastomosis	28.51	2380.59		090	2	3999.56	2183.53	3729.70
34800		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	34.20	2855.70		090	2		2545.08	2097.37**
34802		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)	37.87	3162.15		090	2		2758.01	2097.37**
34803		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)	39.11	3265.69		090	2		2833.99	2097.37**
34804		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis	37.89	3163.82		090	2		2754.67	2097.37**
34805		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis	36.29	3030.22		090	2		2619.40	2097.37**
34806		Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for pr	3.09	258.02		ZZZ	2		220.08	2097.37**
34808		Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	6.25	521.88		ZZZ	2		467.60	2097.37**
34812		Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilatera	10.24	855.04		000	2		779.89	2097.37**
34813		Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	7.22	602.87		ZZZ	2		539.41	2097.37**
34820		Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral	14.87	1241.65		000	2		1110.55	2097.37**
34825		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel	21.26	1775.21		090	2		1553.94	2097.37**
34826		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)	6.20	517.70		ZZZ	2		455.91	2097.37**
34830		Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	54.17	4523.20		090	2		4098.18	2097.37**
34831		Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	58.24	4863.04		090	2		4237.63	2097.37**
34832		Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	58.24	4863.04		090	2		4405.46	2097.37**
34833		Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral	18.53	1547.26		000	2		1387.77	2097.37**
34834		Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral	8.37	698.90		000	2		634.60	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
34900		Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis	27.16	2267.86		090	2		2030.72	2097.37**
35001		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision	34.79	2904.97		090	2		2546.75	2097.37**
35002		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision	34.42	2874.07		090	2		2681.19	2097.37**
35005		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery	35.09	2930.02		090	2		2299.59	2097.37**
35011		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision	30.54	2550.09		090	2	3446.22	2236.13	4257.51
35013		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision	38.21	3190.54		090	2		2765.52	2097.37**
35021		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	37.99	3172.17		090	2		2669.50	2097.37**
35022		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision	43.41	3624.74		090	2		3002.66	2097.37**
35045		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery	30.19	2520.87		090	2	2772.73	2158.48	2097.37**
35081		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	53.75	4488.13		090	2		3789.23	2097.37**
35082		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	66.95	5590.33		090	2		4834.65	2097.37**
35091		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, ren	54.84	4579.14		090	2		4149.95	2097.37**
35092		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	79.64	6649.94		090	2		5768.18	2097.37**
35102		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, exter	58.06	4848.01		090	2		4121.56	2097.37**
35103		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	68.71	5737.29		090	2		5015.01	2097.37**
35111		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery	40.22	3358.37		090	2		3089.50	2097.37**
35112		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	56.02	4677.67		090	2		3744.98	2097.37**
35121		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery	50.30	4200.05		090	2		3710.74	2097.37**
35122		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	64.58	5392.43		090	2		4348.68	2097.37**

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35131		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)	42.50	3548.75		090	2		3150.46	2097.37**
35132		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)	49.95	4170.83		090	2		3785.06	2097.37**
35141		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)	34.08	2845.68		090	2		2512.52	2097.37**
35142		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)	40.65	3394.28		090	2		2984.29	2097.37**
35151		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery	38.22	3191.37		090	2		2833.16	2097.37**
35152		Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery	42.98	3588.83		090	2		3269.86	2097.37**
35180		Repair, congenital arteriovenous fistula; head and neck	27.82	2322.97		090	2	2772.73	1765.19	3246.08
35182		Repair, congenital arteriovenous fistula; thorax and abdomen	52.77	4406.30		090	2		3781.72	2097.37**
35184		Repair, congenital arteriovenous fistula; extremities	31.93	2666.16		090	2	2772.73	2281.22	3246.08
35188		Repair, acquired or traumatic arteriovenous fistula; head and neck	27.85	2325.48		090	2	3999.56	1918.83	3729.70
35189		Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen	46.80	3907.80		090	2		3536.23	2097.37**
35190		Repair, acquired or traumatic arteriovenous fistula; extremities	23.20	1937.20		090	2	2772.73	1667.50	3246.08
35201		Repair blood vessel, direct; neck	28.76	2401.46		090	2	2772.73	2095.02	3246.08
35206		Repair blood vessel, direct; upper extremity	23.71	1979.79		090	2	2772.73	1712.59	3246.08
35207		Repair blood vessel, direct; hand, finger	22.43	1872.91		090	1	3999.56	1538.91	3729.70
35211		Repair blood vessel, direct; intrathoracic, with bypass	41.60	3473.60		090	2		2982.62	2097.37**
35216		Repair blood vessel, direct; intrathoracic, without bypass	61.56	5140.26		090	2		3811.78	2097.37**
35221		Repair blood vessel, direct; intra-abdominal	43.68	3647.28		090	2		3074.47	2097.37**
35226		Repair blood vessel, direct; lower extremity	25.60	2137.60		090	2	752.91	1900.46	748.01
35231		Repair blood vessel with vein graft; neck	36.40	3039.40		090	2	2772.73	2596.85	3246.08
35236		Repair blood vessel with vein graft; upper extremity	30.06	2510.01		090	2	2772.73	2180.19	3246.08
35241		Repair blood vessel with vein graft; intrathoracic, with bypass	43.54	3635.59		090	2		3112.88	2097.37**
35246		Repair blood vessel with vein graft; intrathoracic, without bypass	43.95	3669.83		090	2		3402.63	2097.37**
35251		Repair blood vessel with vein graft; intra-abdomina	51.45	4296.08		090	2		3678.18	2097.37**
35256		Repair blood vessel with vein graft; lower extremity	31.23	2607.71		090	2	2772.73	2306.27	3246.08
35261		Repair blood vessel with graft other than vein; neck	32.05	2676.18		090	2	3446.22	2287.90	4257.51
35266		Repair blood vessel with graft other than vein; upper extremity	26.29	2195.22		090	2	3446.22	1916.33	4257.51
35271		Repair blood vessel with graft other than vein; intrathoracic, with bypass	41.93	3501.16		090	2		2964.25	2097.37**
35276		Repair blood vessel with graft other than vein; intrathoracic, without bypass	43.95	3669.83		090	2		3124.57	2097.37**
35281		Repair blood vessel with graft other than vein; intra-abdomina	49.57	4139.10		090	2		3516.19	2097.37**
35286		Repair blood vessel with graft other than vein; lower extremity	28.60	2388.10		090	2	3446.22	2115.89	4257.51
35301		Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	32.22	2690.37		090	2		2362.22	2097.37**
35302		Thromboendarterectomy, including patch graft, if performed; superficial femoral artery	34.65	2893.28		090	2		2442.38	2097.37**
35303		Thromboendarterectomy, including patch graft, if performed; popliteal artery	38.24	3193.04		090	2		2682.86	2097.37**
35304		Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery	39.39	3289.07		090	2		2791.41	2097.37**
35305		Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vesse	37.86	3161.31		090	2		2682.86	2097.37**
35306		Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure)	13.67	1141.45		ZZZ	2		1005.34	2097.37**

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35311		Thromboendarterectomy, including patch graft, if performed; subclavian, innominate, by thoracic incision	46.88	3914.48		090	2		3364.22	2097.37**
35321		Thromboendarterectomy, including patch graft, if performed; axillary-brachia	27.28	2277.88		090	2	2772.73	2014.86	3246.08
35331		Thromboendarterectomy, including patch graft, if performed; abdominal aorta	44.73	3734.96		090	2		3284.06	2097.37**
35341		Thromboendarterectomy, including patch graft, if performed; mesenteric, celiac, or rena	42.22	3525.37		090	2		3133.76	2097.37**
35351		Thromboendarterectomy, including patch graft, if performed; iliac	39.32	3283.22		090	2		2888.27	2097.37**
35355		Thromboendarterectomy, including patch graft, if performed; iliofemora	31.83	2657.81		090	2		2350.53	2097.37**
35361		Thromboendarterectomy, including patch graft, if performed; combined aortoiliac	46.81	3908.64		090	2		3542.91	2097.37**
35363		Thromboendarterectomy, including patch graft, if performed; combined aortoiliofemora	52.67	4397.95		090	2		3789.23	2097.37**
35371		Thromboendarterectomy, including patch graft, if performed; common femora	25.23	2106.71		090	2		1872.07	2097.37**
35372		Thromboendarterectomy, including patch graft, if performed; deep (profunda) femora	30.14	2516.69		090	2		2244.48	2097.37**
35390		Reoperation, carotid, thromboendarterectomy, more than 1 month after original operation (List separately in addition to code for primary procedure)	4.86	405.81		ZZZ	2		362.39	2097.37**
35400		Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)	4.54	379.09		ZZZ	0		346.53	2097.37**
35450		Transluminal balloon angioplasty, open; renal or other visceral artery	15.56	1299.26		000	2		1148.96	2097.37**
35452		Transluminal balloon angioplasty, open; aortic	10.90	910.15		000	2		804.11	2097.37**
35458		Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vesse	14.94	1247.49		000	2	5190.09	1095.52	4621.59
35460		Transluminal balloon angioplasty, open; venous	9.56	798.26		000	1	5190.09	701.40	4621.59
35471		Transluminal balloon angioplasty, percutaneous; renal or visceral artery	78.12	6523.02		000	1	5190.09	8459.39	4621.59
35472		Transluminal balloon angioplasty, percutaneous; aortic	59.03	4929.01		000	0	5190.09	5581.14	4621.59
35475		Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vesse	48.14	4019.69		000	1	5190.09	5268.85	4621.59
35476		Transluminal balloon angioplasty, percutaneous; venous	44.42	3709.07		000	1	5190.09	4025.54	4621.59
35500		Harvest of upper extremity vein, 1 segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)	9.78	816.63		ZZZ	2	1491.99	723.11	1627.16
35501		Bypass graft, with vein; common carotid-ipsilateral internal carotic	46.24	3861.04		090	2		3289.07	2097.37**
35506		Bypass graft, with vein; carotid-subclavian or subclavian-carotic	41.10	3431.85		090	2		2903.30	2097.37**
35508		Bypass graft, with vein; carotid-vertebral	41.25	3444.38		090	2		2965.09	2097.37**
35509		Bypass graft, with vein; carotid-contralateral carotic	43.51	3633.09		090	2		3200.56	2097.37**
35510		Bypass graft, with vein; carotid-brachial	37.85	3160.48		090	2		2800.59	2097.37**
35511		Bypass graft, with vein; subclavian-subclavian	39.15	3269.03		090	2		2641.11	2097.37**
35512		Bypass graft, with vein; subclavian-brachia	37.13	3100.36		090	2		2746.32	2097.37**
35515		Bypass graft, with vein; subclavian-vertebra	40.92	3416.82		090	2		2940.87	2097.37**
35516		Bypass graft, with vein; subclavian-axillary	37.55	3135.43		090	2		2593.51	2097.37**
35518		Bypass graft, with vein; axillary-axillary	39.87	3329.15		090	2		2666.16	2097.37**
35521		Bypass graft, with vein; axillary-femora	43.03	3593.01		090	2		2849.02	2097.37**
35522		Bypass graft, with vein; axillary-brachia	38.12	3183.02		090	2		2674.51	2097.37**
35523		Bypass graft, with vein; brachial-ulnar or -radia	39.19	3272.37		090	2		2729.16	2097.37**
35525		Bypass graft, with vein; brachial-brachial	35.00	2922.50		090	2		2534.23	2097.37**
35526		Bypass graft, with vein; aortosubclavian, aortoinnominate, or aortocarotic	52.71	4401.29		090	2		3832.65	2097.37**
35531		Bypass graft, with vein; aortoceliac or aortomesenteric	61.96	5173.66		090	2		4514.85	2097.37**
35533		Bypass graft, with vein; axillary-femoral-femoral	46.32	3867.72		090	2		3500.32	2097.37**
35535		Bypass graft, with vein; hepatorena	52.16	4355.36		090	2		4512.34	2097.37**
35536		Bypass graft, with vein; splenorena	61.70	5151.95		090	2		3939.53	2097.37**
35537		Bypass graft, with vein; aortoiliac	64.08	5350.68		090	2		4716.92	2097.37**
35538		Bypass graft, with vein; aortobi-iliac	71.73	5989.46		090	2		5268.85	2097.37**
35539		Bypass graft, with vein; aortofemoral	67.39	5627.07		090	2		4952.39	2097.37**
35540		Bypass graft, with vein; aortobifemoral	78.61	6563.94		090	1		5520.19	2097.37**
35556		Bypass graft, with vein; femoral-popliteal	43.16	3603.86		090	2		3051.93	2097.37**
35558		Bypass graft, with vein; femoral-femoral	38.10	3181.35		090	2		2743.81	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
35560		Bypass graft, with vein; aortorena	52.40	4375.40		090	2		4000.49	2097.37**
35563		Bypass graft, with vein; ilioiliac	40.70	3398.45		090	2		3083.66	2097.37**
35565		Bypass graft, with vein; iliofemoral	40.48	3380.08		090	2		2964.25	2097.37**
35566		Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels	51.46	4296.91		090	2		3663.98	2097.37**
35570		Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibia	41.82	3491.97		090	2		3497.82	2097.37**
35571		Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	40.87	3412.65		090	2		3047.75	2097.37**
35572		Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)	10.52	878.42		ZZZ	2		773.21	
35583		In-situ vein bypass; femoral-popliteal	44.39	3706.57		090	2		3161.31	2097.37**
35585		In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery	51.61	4309.44		090	2		3735.79	2097.37**
35587		In-situ vein bypass; popliteal-tibial, peronea	42.00	3507.00		090	2		3150.46	2097.37**
35600		Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)	7.72	644.62		ZZZ	2		565.30	2097.37**
35601		Bypass graft, with other than vein; common carotid-ipsilateral internal carotic	43.37	3621.40		090	2		3096.18	2097.37**
35606		Bypass graft, with other than vein; carotid-subclaviar	36.17	3020.20		090	2		2628.58	2097.37**
35612		Bypass graft, with other than vein; subclavian-subclaviar	32.18	2687.03		090	2		2055.77	2097.37**
35616		Bypass graft, with other than vein; subclavian-axillary	33.39	2788.07		090	2		2471.60	2097.37**
35621		Bypass graft, with other than vein; axillary-femora	33.81	2823.14		090	2		2505.84	2097.37**
35623		Bypass graft, with other than vein; axillary-popliteal or -tibia	40.40	3373.40		090	2		3062.78	2097.37**
35626		Bypass graft, with other than vein; aortosubclavian, aortoinnominate, or aortocarotic	47.96	4004.66		090	2		3486.13	2097.37**
35631		Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorena	56.60	4726.10		090	2		4205.90	2097.37**
35632		Bypass graft, with other than vein; ilio-celiac	49.54	4136.59		090	2		4282.72	2097.37**
35633		Bypass graft, with other than vein; ilio-mesenteric	55.20	4609.20		090	2		4623.40	2097.37**
35634		Bypass graft, with other than vein; iliorena	48.48	4048.08		090	2		4192.54	2097.37**
35636		Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis	49.03	4094.01		090	2		3693.21	2097.37**
35637		Bypass graft, with other than vein; aortoiliac	53.21	4443.04		090	2		3755.00	2097.37**
35638		Bypass graft, with other than vein; aortobi-iliac	54.20	4525.70		090	2		3814.28	2097.37**
35642		Bypass graft, with other than vein; carotid-vertebra	30.42	2540.07		090	2		2309.61	2097.37**
35645		Bypass graft, with other than vein; subclavian-vertebra	33.61	2806.44		090	2		2256.17	2097.37**
35646		Bypass graft, with other than vein; aortobifemora	52.73	4402.96		090	2		3881.92	2097.37**
35647		Bypass graft, with other than vein; aortofemora	47.88	3997.98		090	2		3498.65	2097.37**
35650		Bypass graft, with other than vein; axillary-axillary	32.70	2730.45		090	2		2399.79	2097.37**
35654		Bypass graft, with other than vein; axillary-femoral-femora	41.96	3503.66		090	2		3105.37	2097.37**
35656		Bypass graft, with other than vein; femoral-poplitea	33.35	2784.73		090	2		2450.73	2097.37**
35661		Bypass graft, with other than vein; femoral-femora	33.47	2794.75		090	2		2456.57	2097.37**
35663		Bypass graft, with other than vein; ilioiliac	38.74	3234.79		090	2		2840.67	2097.37**
35665		Bypass graft, with other than vein; iliofemora	36.16	3019.36		090	2		2669.50	2097.37**
35666		Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	39.18	3271.53		090	2		2879.08	2097.37**
35671		Bypass graft, with other than vein; popliteal-tibial or -peroneal artery	34.62	2890.77		090	2		2534.23	2097.37**
35681		Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure)	2.44	203.74		ZZZ	2		181.20	2097.37**
35682		Bypass graft; autogenous composite, 2 segments of veins from 2 locations (List separately in addition to code for primary procedure)	10.78	900.13		ZZZ	0		812.46	2097.37**
35683		Bypass graft; autogenous composite, 3 or more segments of vein from 2 or more locations (List separately in addition to code for primary procedure)	12.53	1046.26		ZZZ	0		958.58	2097.37**
35685		Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)	6.10	509.35		ZZZ	2	2772.73	456.75	3246.08
35686		Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)	5.04	420.84		ZZZ	2	2772.73	378.26	3246.08
35691		Transposition and/or reimplantation; vertebral to carotid artery	29.11	2430.69		090	2		2249.49	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
35693		Transposition and/or reimplantation; vertebral to subclavian artery	25.78	2152.63		090	2		1969.77	2097.37**
35694		Transposition and/or reimplantation; subclavian to carotid artery	30.39	2537.57		090	2		2342.18	2097.37**
35695		Transposition and/or reimplantation; carotid to subclavian artery	31.55	2634.43		090	2		2401.46	2097.37**
35697		Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to code for primary procedure)	4.52	377.42		ZZZ	2		339.85	2097.37**
35700		Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery, or other distal vessels, more than 1 month after original operation (List separately in addition to code for primary procedure)	4.68	390.78		ZZZ	2		349.03	2097.37**
35701		Exploration (not followed by surgical repair), with or without lysis of artery; carotid arter	17.27	1442.05		090	2		1189.04	2097.37**
35721		Exploration (not followed by surgical repair), with or without lysis of artery; femoral arter	13.94	1163.99		090	2		1017.03	2097.37**
35741		Exploration (not followed by surgical repair), with or without lysis of artery; popliteal arter	15.68	1309.28		090	2		1114.73	2097.37**
35761		Exploration (not followed by surgical repair), with or without lysis of artery; other vessels	11.90	993.65		090	2	2772.73	824.98	3246.08
35800		Exploration for postoperative hemorrhage, thrombosis or infection; neck	21.73	1814.46		090	2		1053.77	2097.37**
35820		Exploration for postoperative hemorrhage, thrombosis or infection; ches	60.50	5051.75		090	2		3653.96	2097.37**
35840		Exploration for postoperative hemorrhage, thrombosis or infection; abdomer	35.61	2973.44		090	2		1361.05	2097.37**
35860		Exploration for postoperative hemorrhage, thrombosis or infection; extremity	25.75	2150.13		090	2	2772.73	894.29	3246.08
35870		Repair of graft-enteric fistula	38.30	3198.05		090	2		2865.72	2097.37**
35875		Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula)	18.36	1533.06		090	1	3999.56	1332.66	3729.70
35876		Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft	29.12	2431.52		090	2	3999.56	2130.92	3729.70
35879		Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplast	28.56	2384.76		090	2	3999.56	2097.52	3729.70
35881		Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition	31.49	2629.42		090	2	3999.56	2339.67	3729.70
35883		Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, Dacron, ePTFE, bovine pericardium)	37.21	3107.04		090	2	3999.56	2747.15	3729.70
35884		Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft	38.16	3186.36		090	2	3999.56	2917.49	3729.70
35901		Excision of infected graft; neck	15.37	1283.40		090	2		1138.11	2097.37**
35903		Excision of infected graft; extremity	17.50	1461.25		090	2	2772.73	1300.93	3246.08
35905		Excision of infected graft; thorax	51.65	4312.78		090	2		3927.84	2097.37**
35907		Excision of infected graft; abdomen	58.70	4901.45		090	2		4321.96	2097.37**
36000		Introduction of needle or intracatheter, vein	0.78	65.13		XXX	9		59.29	
36002		Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm	4.87	406.65		000	1	199.63	384.94	209.78
36005		Injection procedure for extremity venography (including introduction of needle or intracatheter	9.92	828.32		000	0		726.45	
36010		Introduction of catheter, superior or inferior vena cava	15.40	1285.90		XXX	1		1633.26	
36011		Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein	25.97	2168.50		XXX	1		2397.29	
36012		Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	26.61	2221.94		XXX	1		1877.08	
36013		Introduction of catheter, right heart or main pulmonary artery	25.01	2088.34		XXX	1		1945.55	
36014		Selective catheter placement, left or right pulmonary artery	25.04	2090.84		XXX	1		1881.26	
36015		Selective catheter placement, segmental or subsegmental pulmonary artery	26.94	2249.49		XXX	1		2130.09	
36100		Introduction of needle or intracatheter, carotid or vertebral artery	15.82	1320.97		XXX	1		1237.47	
36120		Introduction of needle or intracatheter; retrograde brachial artery	13.41	1119.74		XXX	1		1022.04	
36140		Introduction of needle or intracatheter; extremity artery	13.62	1137.27		XXX	1		1179.02	
36147		Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, inj	25.98	2169.33		XXX	2	923.72	1776.88	218.44
36148		Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)	8.10	676.35		ZZZ	2		559.45	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
36160		Introduction of needle or intracatheter, aortic, translumbar	15.76	1315.96		XXX	1		1295.92	
36200		Introduction of catheter, aorta	19.51	1629.09		000	1		1558.11	
36215		Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	33.96	2835.66		XXX	1		2593.51	
36216		Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	37.84	3159.64		XXX	1		2807.27	
36217		Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	65.11	5436.69		XXX	1		4905.63	
36218		Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	6.02	502.67		ZZZ	1		475.95	
36221		Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the ce	34.27	2861.55		000	1	2863.77	New	
36222		Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the c	42.44	3543.74		000	1	2863.77	New	
36223		Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the e	46.43	3876.91		000	1	2863.77	New	
36224		Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and ce	50.43	4210.91		000	1	4683.54	New	
36225		Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when per	46.09	3848.52		000	1	2863.77	New	
36226		Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	51.41	4292.74		000	1	4683.54	New	
36227		Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	7.40	617.90		ZZZ	1		New	
36228		Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral arter	35.29	2946.72		ZZZ	1		New	
36245		Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	30.60	2555.10		XXX	1		2979.28	
36246		Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	27.47	2293.75		000	1		2864.05	
36247		Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	49.05	4095.68		000	1		4538.23	
36248		Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriat	4.69	391.62		ZZZ	1		399.97	
36251		Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of	44.70	3732.45		000	1	2863.77	New	
36252		Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of	48.88	4081.48		000	1	2863.77	New	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
36253		Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image post	68.16	5691.36		000	1	2863.77	New	
36254		Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image post	70.78	5910.13		000	1	2863.77	New	
36260		Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	19.24	1606.54		090	1	2874.31	1251.67	2775.79
36261		Revision of implanted intra-arterial infusion pump	12.11	1011.19		090	2	2171.38	770.71	2092.01
36262		Removal of implanted intra-arterial infusion pump	9.21	769.04		090	1	2171.38	576.99	2092.01
36299		Unlisted procedure, vascular injection	0.00	BR		YYY	0		BR	
36400		Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein	0.87	72.65		XXX	1		55.11	
36405		Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein	0.79	65.97		XXX	1		48.43	
36406		Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein	0.59	49.27		XXX	1		38.41	
36410		Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)	0.51	42.59		XXX	1		39.25	
36415		Collection of venous blood by venipuncture	0.09	7.52		XXX	9		9.60	
36416		Collection of capillary blood specimen (eg, finger, heel, ear stick)	0.09	7.52		XXX	9		9.60	
36420		Venipuncture, cutdown; younger than age 1 yea	1.54	128.59		XXX	0	30.23	103.54	21.16
36425		Venipuncture, cutdown; age 1 or over	1.18	98.53		XXX	1	30.23	80.16	21.16
36430		Transfusion, blood or blood components	1.02	85.17		XXX	1	335.98	87.68	308.30
36440		Push transfusion, blood, 2 years or younger	1.74	145.29		XXX	0	335.98	113.56	308.30
36450		Exchange transfusion, blood; newborn	3.15	263.03		XXX	0	335.98	246.33	308.30
36455		Exchange transfusion, blood; other than newborn	3.33	278.06		XXX	1	335.98	274.72	308.30
36460		Transfusion, intrauterine, fetal	10.79	900.97		XXX	2	335.98	735.64	308.30
36468		Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	0.00	BR		000	0	92.29	BR	80.15
36469		Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	0.00	BR		000	0	137.98	BR	80.15
36470		Injection of sclerosing solution; single vein	4.68	390.78		010	1	137.98	310.62	80.15
36471		Injection of sclerosing solution; multiple veins, same leg	5.33	445.06		010	1	137.98	381.60	80.15
36475		Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	53.27	4448.05		000	1	3902.06	4507.33	4106.21
36476		Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in a	11.84	988.64		ZZZ	1	2526.85	885.94	2423.04
36478		Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	41.72	3483.62		000	1	2526.85	4113.21	2423.04
36479		Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition t	12.02	1003.67		ZZZ	1	2526.85	902.64	2423.04
36481		Percutaneous portal vein catheterization by any method	64.41	5378.24		000	1		775.72	
36500		Venous catheterization for selective organ blood sampling	5.31	443.39		000	1		390.78	
36510		Catheterization of umbilical vein for diagnosis or therapy, newborn	2.87	239.65		000	0		356.55	
36511		Therapeutic apheresis; for white blood cells	2.84	237.14		000	1	1226.42	194.56	1089.03
36512		Therapeutic apheresis; for red blood cells	2.74	228.79		000	1	1226.42	196.23	1089.03
36513		Therapeutic apheresis; for platelets	2.92	243.82		000	1	1226.42	201.24	1089.03
36514		Therapeutic apheresis; for plasma pheresis	16.22	1354.37		000	1	1226.42	1417.00	1089.03
36515		Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion	65.60	5477.60		000	1	3726.68	5223.76	3038.51

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
36516		Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	63.98	5342.33		000	1	3726.68	6391.93	3038.51
36522		Photopheresis, extracorporeal	42.81	3574.64		000	1	3726.68	2893.28	3038.51
36555		Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of ag	7.79	650.47		000	1	1014.12	656.31	1018.23
36556		Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or olde	7.08	591.18		000	1	1014.12	615.40	1018.23
36557		Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age	23.69	1978.12		010	0	2262.94	2054.10	2310.24
36558		Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	24.08	2010.68		010	0	2262.94	2026.55	2310.24
36560		Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	42.44	3543.74		010	0	2874.31	2808.94	2775.79
36561		Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	36.81	3073.64		010	0	2874.31	2806.44	2775.79
36563		Insertion of tunneled centrally inserted central venous access device with subcutaneous pum	41.89	3497.82		010	0	2874.31	2687.87	2775.79
36565		Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)	31.03	2591.01		010	0	2874.31	2410.65	2775.79
36566		Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	173.28	14468.88		010	0	2874.31	4475.60	2775.79
36568		Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age	8.86	739.81		000	1	1014.12	740.65	1018.23
36569		Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	7.44	621.24		000	1	1014.12	699.73	1018.23
36570		Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years o age	36.51	3048.59		010	0	2262.94	2991.81	2310.24
36571		Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	40.48	3380.08		010	0	2262.94	3035.23	2310.24
36575		Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	5.20	434.20		000	0	567.16	387.44	581.26
36576		Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	11.82	986.97		010	0	1014.12	810.79	1018.23
36578		Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	16.02	1337.67		010	0	2262.94	1158.15	2310.24
36580		Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	6.54	546.09		000	1	1014.12	628.76	1018.23
36581		Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	23.62	1972.27		010	0	2262.94	1805.27	2310.24
36582		Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	34.25	2859.88		010	0	2874.31	2454.07	2775.79
36583		Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	43.01	3591.34		010	0	2874.31	2459.08	2775.79
36584		Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port o pump, through same venous access	6.13	511.86		000	1	1014.12	620.41	1018.23
36585		Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	37.45	3127.08		010	0	2262.94	2572.64	2310.24
36589		Removal of tunneled central venous catheter, without subcutaneous port or pum	5.00	417.50		010	0	567.16	368.24	581.26
36590		Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	8.92	744.82		010	0	1014.12	571.98	1018.23
36591		Collection of blood specimen from a completely implantable venous access device	0.70	58.45		XXX	0	63.38	46.20	55.92
36592		Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	0.81	67.64		XXX	0	63.38	57.12	55.92

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
36593		Declotting by thrombolytic agent of implanted vascular access device or cathete	0.93	77.66		XXX	0	222.75	81.48	218.44
36595		Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	17.26	1441.21		000	1	2262.94	1581.49	2310.24
36596		Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	4.09	341.52		000	1	1014.12	342.35	1018.23
36597		Repositioning of previously placed central venous catheter under fluoroscopic guidance	3.77	314.80		000	1	1014.12	287.24	1018.23
36598		Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report	3.31	276.39		000	0	222.75	270.54	218.44
36600		Arterial puncture, withdrawal of blood for diagnosis	0.94	78.49		XXX	1	30.23	66.80	21.16
36620		Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	1.49	124.42		000	1		110.22	
36625		Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown	3.14	262.19		000	1		223.78	
36640		Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown	3.91	326.49		000	1	2874.31	259.69	2775.79
36660		Catheterization, umbilical artery, newborn, for diagnosis or therapy	2.18	182.03		000	0		148.63	2097.37**
36680		Placement of needle for intraosseous infusion	1.76	146.96		000	0	158.18	136.94	137.80
36800		Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein	4.94	412.49		000	1	3457.08	349.03	2824.92
36810		Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)	6.41	535.24		000	1	3457.08	468.44	2824.92
36815		Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure	4.50	375.75		000	1	3457.08	321.48	2824.92
36818		Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	20.45	1707.58		090	2	3999.56	1523.88	3729.70
36819		Arteriovenous anastomosis, open; by upper arm basilic vein transposition	22.46	1875.41		090	2	3999.56	1751.83	3729.70
36820		Arteriovenous anastomosis, open; by forearm vein transposition	24.58	2052.43		090	2	3999.56	1753.50	3729.70
36821		Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure	21.15	1766.03		090	2	3999.56	1164.83	3729.70
36822		Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)	11.73	979.46		090	1		833.33	2097.37**
36823		Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites	40.02	3341.67		090	1		2725.44	2097.37**
36825		Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	24.25	2024.88		090	2	3999.56	1270.04	3729.70
36830		Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)	19.98	1668.33		090	2	3999.56	1455.41	3729.70
36831		Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	13.88	1158.98		090	2	3999.56	1007.01	3729.70
36832		Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	17.63	1472.11		090	2	3999.56	1284.23	3729.70
36833		Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	19.93	1664.16		090	2	3999.56	1449.56	3729.70
36835		Insertion of Thomas shunt (separate procedure)	12.86	1073.81		090	1	3457.08	991.15	2824.92
36838		Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	35.06	2927.51		090	2	3999.56	2609.38	3729.70
36860		External cannula declotting (separate procedure); without balloon cathete	6.29	525.22		000	1	222.75	340.68	218.44
36861		External cannula declotting (separate procedure); with balloon cathete	4.78	399.13		000	1	3457.08	330.66	2824.92
36870		Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	57.26	4781.21		090	1	3446.22	4549.08	4257.51
37140		Venous anastomosis, open; portocaval	68.18	5693.03		090	1		2895.78	2097.37**
37145		Venous anastomosis, open; renoportal	63.43	5296.41		090	2		3103.70	2097.37**
37160		Venous anastomosis, open; caval-mesenteric	64.99	5426.67		090	2		2721.27	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
37180		Venous anastomosis, open; splenorenal, proxima	62.53	5221.26		090	2		3073.64	2097.37**
37181		Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)	68.17	5692.20		090	2		3290.74	2097.37**
37182		Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imag	24.68	2060.78		000	0		1843.68	2097.37**
37183		Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated	181.24	15133.54		000	0	11168.05	880.93	8871.97
37184		Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	70.58	5893.43		000	1	3999.56	6175.66	3729.70
37185		Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same v	22.49	1877.92		ZZZ	1	3999.56	2018.20	3729.70
37186		Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, pro	43.43	3626.41		ZZZ	1	3999.56	4169.16	3729.70
37187		Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	65.23	5446.71		000	1	3999.56	6006.99	3729.70
37188		Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	54.71	4568.29		000	1	3999.56	5185.35	3729.70
37191		Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	82.18	6862.03		000	1	3902.06	New	
37192		Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when perfo	53.59	4474.77		000	1	2874.31	New	
37193		Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when	51.17	4272.70		000	1	2874.31	New	
37195		Thrombolysis, cerebral, by intravenous infusion	29.41	2455.74		XXX	0	222.75	702.40	218.44
37197		Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	46.57	3888.60		000	1	2874.31	New	
37200		Transcatheter biopsy	6.52	544.42		000	1	2874.31	485.97	2775.79
37202		Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)	9.79	817.47		000	1	1491.99	723.11	1627.16
37204		Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	26.38	2202.73		000	1	9896.50	1963.92	8510.25
37205		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	134.13	11199.86		000	0	11168.05	986.14	8871.97
37206		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	79.32	6623.22		ZZZ	0	11168.05	457.58	8871.97
37207		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	12.94	1080.49		000	2	11168.05	967.77	8871.97

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37208		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)	6.20	517.70		ZZZ	2	11168.05	467.60	8871.97
37210		Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intra	111.31	9294.39		000	1	11168.05	4689.36	8871.97
37211		Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	11.95	997.83		000	1	1014.12	New	
37212		Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	10.55	880.93		000	1	1014.12	New	
37213		Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up ca	7.37	615.40		000	1	2262.94	New	
37214		Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up ca	4.33	361.56		000	1	2262.94	New	
37215		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	32.29	2696.22		090	0		2341.34	8871.97
37216		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection	29.97	2502.50		090	9		2174.34	2097.37**
37220		Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	100.67	8405.95		000	1	5190.09	New	
37221		Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	147.25	12295.38		000	0	11168.05	New	
37222		Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	28.32	2364.72		ZZZ	0	5190.09	New	
37223		Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for prima	82.17	6861.20		ZZZ	0	5190.09	New	
37224		Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with translumina angioplasty	121.25	10124.38		000	0	5190.09	New	
37225		Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	348.11	29067.19		000	0	11168.05	New	
37226		Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with translumina stent placement(s), includes angioplasty within the same vessel, when performed	286.08	23887.68		000	0	11168.05	New	
37227		Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with translumina stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	470.33	39272.56		000	0	18830.42	New	
37228		Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	172.90	14437.15		000	0	5190.09	New	
37229		Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	342.86	28628.81		000	0	11168.05	New	
37230		Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	261.34	21821.89		000	0	11168.05	New	
37231		Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	417.21	34837.04		000	0	18830.42	New	

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37232		Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	38.36	3203.06		ZZZ	0	5190.09	New	
37233		Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	45.88	3830.98		ZZZ	0	11168.05	New	
37234		Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for p	124.13	10364.86		ZZZ	0	5190.09	New	
37235		Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in additi	126.60	10571.10		ZZZ	0	5190.09	New	
37250		Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	3.20	267.20		ZZZ	0		239.65	
37251		Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)	2.40	200.40		ZZZ	0		181.20	
37500		Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	19.58	1634.93		090	1	3902.06	1537.24	4106.21
37501		Unlisted vascular endoscopy procedure	0.00	BR		YYY	1	2526.85	BR	2423.04
37565		Ligation, internal jugular vein	23.11	1929.69		090	0	2772.73	1468.77	3246.08
37600		Ligation; external carotid artery	21.34	1781.89		090	2	2772.73	1560.62	3246.08
37605		Ligation; internal or common carotid artery	24.55	2049.93		090	2	3902.06	1781.06	4106.21
37606		Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp	17.34	1447.89		090	2	2526.85	1144.79	2423.04
37607		Ligation or banding of angioaccess arteriovenous fistula	11.55	964.43		090	1	2526.85	823.31	2423.04
37609		Ligation or biopsy, temporal artery	9.63	804.11		010	1	1447.15	627.09	1595.60
37615		Ligation, major artery (eg, post-traumatic, rupture); neck	15.57	1300.10		090	2	2526.85	977.79	2423.04
37616		Ligation, major artery (eg, post-traumatic, rupture); chest	32.75	2734.63		090	2		2284.56	2097.37**
37617		Ligation, major artery (eg, post-traumatic, rupture); abdomen	40.19	3355.87		090	2		2768.03	2097.37**
37618		Ligation, major artery (eg, post-traumatic, rupture); extremity	11.80	985.30		090	2		799.10	2097.37**
37619		Ligation of inferior vena cava	50.84	4245.14		090	2	3902.06	New	
37650		Ligation of femoral vein	14.08	1175.68		090	1	2526.85	1096.36	2423.04
37660		Ligation of common iliac vein	34.07	2844.85		090	2		2609.38	2097.37**
37700		Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	7.71	643.79		090	1	2526.85	551.94	2423.04
37718		Ligation, division, and stripping, short saphenous vein	13.44	1122.24		090	1	2526.85	868.40	2423.04
37722		Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	14.72	1229.12		090	1	3902.06	1033.73	4106.21
37735		Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	19.51	1629.09		090	1	3902.06	1376.92	4106.21
37760		Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	18.47	1542.25		090	1	2526.85	1351.87	2423.04
37761		Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	16.72	1396.12		090	2	2526.85	1327.65	2423.04
37765		Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	20.22	1688.37		090	1	2526.85	976.95	2423.04
37766		Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	24.04	2007.34		090	1	2526.85	1178.19	2423.04
37780		Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure	7.78	649.63		090	1	2526.85	565.30	2423.04
37785		Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	11.02	920.17		090	1	2526.85	763.19	2423.04
37788		Penile revascularization, artery, with or without vein graf	41.50	3465.25		090	2		2754.67	2097.37**
37790		Penile venous occlusive procedure	14.11	1178.19		090	0	3580.63	1058.78	3181.04
37799		Unlisted procedure, vascular surgery	0.00	BR		YYY	0	63.38	BR	55.92

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
38100		Splenectomy; total (separate procedure)	34.01	2839.84		090	2		2152.63	2097.37**
38101		Splenectomy; partial (separate procedure)	34.34	2867.39		090	2		2194.38	2097.37**
38102		Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)	7.67	640.45		ZZZ	2		541.92	2097.37**
38115		Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy	37.48	3129.58		090	2		2385.60	2097.37**
38120		Laparoscopy, surgical, splenectomy	31.15	2601.03		090	2	4498.73	2069.13	4271.34
38129		Unlisted laparoscopy procedure, spleen	0.00	BR		YYY	2	3522.03	BR	3470.14
38200		Injection procedure for splenoportography	4.23	353.21		000	0		285.57	
38204		Management of recipient hematopoietic progenitor cell donor search and cell acquisition	2.95	246.33		XXX	9		155.31	
38205		Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	2.36	197.06		000	0		172.01	
38206		Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	2.41	201.24		000	0	1226.42	172.01	1089.03
38207		Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	1.30	108.55		XXX	9	335.98	35.91	308.30
38208		Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	0.83	69.31		XXX	9	335.98	43.42	308.30
38209		Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, pe donor	0.35	29.23		XXX	9	335.98	19.21	308.30
38210		Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	2.31	192.89		XXX	9	562.20	73.48	527.74
38211		Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	2.10	175.35		XXX	9	562.20	55.11	527.74
38212		Transplant preparation of hematopoietic progenitor cells; red blood cell removal	1.37	114.40		XXX	9	562.20	36.74	527.74
38213		Transplant preparation of hematopoietic progenitor cells; platelet depletion	0.35	29.23		XXX	9	562.20	19.21	527.74
38214		Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	1.19	99.37		XXX	9	562.20	19.21	527.74
38215		Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	1.37	114.40		XXX	9	562.20	42.59	527.74
38220		Bone marrow; aspiration only	4.85	404.98		XXX	0	348.84	374.08	282.67
38221		Bone marrow; biopsy, needle or trocar	4.93	411.66		XXX	0	348.84	412.49	282.67
38230		Bone marrow harvesting for transplantation; allogeneic	6.12	511.02		000	0	3726.68	661.32	3038.51
38232		Bone marrow harvesting for transplantation; autologous	6.12	511.02		000	0	3726.68	New	
38240		Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	4.86	405.81		XXX	0	3726.68	261.36	3038.51
38241		Hematopoietic progenitor cell (HPC); autologous transplantation	4.83	403.31		XXX	0	3726.68	262.19	3038.51
38242		Allogeneic lymphocyte infusions	3.38	282.23		000	0	1226.42	198.73	1089.03
38243		Hematopoietic progenitor cell (HPC); HPC boost	3.42	285.57		000	0	1226.42	New	
38300		Drainage of lymph node abscess or lymphadenitis; simple	8.61	718.94		010	1	936.06	536.07	1150.97
38305		Drainage of lymph node abscess or lymphadenitis; extensive	13.85	1156.48		090	1	1701.78	914.33	1769.66
38308		Lymphangiotomy or other operations on lymphatic channels	13.48	1125.58		090	2	2347.96	884.27	2244.61
38380		Suture and/or ligation of thoracic duct; cervical approach	17.15	1432.03		090	2		1142.28	2097.37**
38381		Suture and/or ligation of thoracic duct; thoracic approach	23.97	2001.50		090	2		1712.59	2097.37**
38382		Suture and/or ligation of thoracic duct; abdominal approach	20.02	1671.67		090	2		1377.75	2097.37**
38500		Biopsy or excision of lymph node(s); open, superficial	10.00	835.00		010	1	2347.96	632.10	2244.61
38505		Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary	3.79	316.47		000	1	806.61	263.86	712.60
38510		Biopsy or excision of lymph node(s); open, deep cervical node(s)	15.65	1306.78		010	1	2347.96	1018.70	2244.61
38520		Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	13.88	1158.98		090	1	2347.96	922.68	2244.61
38525		Biopsy or excision of lymph node(s); open, deep axillary node(s	12.99	1084.67		090	1	2347.96	821.64	2244.61
38530		Biopsy or excision of lymph node(s); open, internal mammary node(s	16.41	1370.24		090	2	2347.96	1074.65	2244.61
38542		Dissection, deep jugular node(s)	15.49	1293.42		090	2	4736.10	865.90	4446.07
38550		Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection	15.20	1269.20		090	0	2347.96	931.86	2244.61
38555		Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection	28.14	2349.69		090	2	2347.96	1991.48	2244.61
38562		Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	20.70	1728.45		090	2		1401.97	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
38564		Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic	20.70	1728.45		090	2		1395.29	2097.37**
38570		Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	15.59	1301.77		010	2	4498.73	1123.91	4271.34
38571		Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	22.81	1904.64		010	2	6607.04	1698.39	6653.06
38572		Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	27.98	2336.33		010	2	4498.73	1998.16	4271.34
38589		Unlisted laparoscopy procedure, lymphatic system	0.00	BR		YYY	2	3522.03	BR	3470.14
38700		Suprahyoid lymphadenectomy	24.10	2012.35		090	2	2347.96	1528.05	2244.61
38720		Cervical lymphadenectomy (complete)	40.09	3347.52		090	2	2347.96	2512.52	2244.61
38724		Cervical lymphadenectomy (modified radical neck dissection)	43.36	3620.56		090	2		2712.08	2097.37**
38740		Axillary lymphadenectomy; superficial	20.53	1714.26		090	2	4736.10	1318.47	4446.07
38745		Axillary lymphadenectomy; complete	25.96	2167.66		090	2	4736.10	1681.69	4446.07
38746		Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	6.42	536.07		ZZZ	2		557.78	2097.37**
38747		Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure)	7.81	652.14		ZZZ	2		551.10	2097.37**
38760		Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure	24.91	2079.99		090	2	2347.96	1664.99	2244.61
38765		Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	37.93	3167.16		090	2		2575.14	2097.37**
38770		Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	23.40	1953.90		090	2		1671.67	2097.37**
38780		Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)	30.02	2506.67		090	2		2157.64	2097.37**
38790		Injection procedure; lymphangiography	2.47	206.25		000	1		170.34	
38792		Injection procedure; radioactive tracer for identification of sentinel node	1.21	101.04		000	1	253.62	81.83	244.54
38794		Cannulation, thoracic duct	8.70	726.45		090	0		641.28	
38900		Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	4.03	336.51		ZZZ	2		New	
38999		Unlisted procedure, hemic or lymphatic system	0.00	BR		YYY	0	335.98	BR	308.30
39000		Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach	15.03	1255.01		090	2		1018.70	2097.37**
39010		Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy	23.76	1983.96		090	2		1731.79	2097.37**
39200		Resection of mediastinal cyst	26.18	2186.03		090	2		1901.30	2097.37**
39220		Resection of mediastinal tumor	34.16	2852.36		090	2		2422.34	2097.37**
39400		Mediastinoscopy, includes biopsy(ies), when performed	15.27	1275.05		010	1	3308.75	1060.45	3101.23
39499		Unlisted procedure, mediastinum	0.00	BR		YYY	2		BR	2097.37**
39501		Repair, laceration of diaphragm, any approach	25.25	2108.38		090	2		1719.27	2097.37**
39503		Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	180.52	15073.42		090	2		11811.08	2097.37**
39540		Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	25.71	2146.79		090	2		1746.82	2097.37**
39541		Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	27.91	2330.49		090	2		1878.75	2097.37**
39545		Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic	26.80	2237.80		090	2		1871.24	2097.37**
39560		Resection, diaphragm; with simple repair (eg, primary suture)	23.48	1960.58		090	2		1616.56	2097.37**
39561		Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap)	37.16	3102.86		090	2		2467.43	2097.37**
39599		Unlisted procedure, diaphragm	0.00	BR		YYY	2		BR	2097.37**
40490		Biopsy of lip	3.92	327.32		000	1	296.47	242.15	312.33
40500		Vermilionectomy (lip shave), with mucosal advancement	15.56	1299.26		090	1	1480.23	952.74	1567.36
40510		Excision of lip; transverse wedge excision with primary closure	14.74	1230.79		090	1	2321.87	947.73	2276.44
40520		Excision of lip; V-excision with primary direct linear closure	14.99	1251.67		090	1	1480.23	1013.69	1567.36
40525		Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)	16.73	1396.96		090	1	2321.87	1148.13	2276.44
40527		Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)	18.62	1554.77		090	0	4230.05	1356.88	2276.44

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
40530		Resection of lip, more than 1/4, without reconstructior	16.49	1376.92		090	1	2321.87	1098.03	2276.44
40650		Repair lip, full thickness; vermilion only	13.64	1138.94		090	0	643.20	858.38	694.83
40652		Repair lip, full thickness; up to half vertical height	15.12	1262.52		090	0	643.20	1000.33	694.83
40654		Repair lip, full thickness; over 1/2 vertical height, or complex	17.43	1455.41		090	1	643.20	1161.49	694.83
40700		Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilatera	29.55	2467.43		090	0	4230.05	1890.44	3919.59
40701		Plastic repair of cleft lip/nasal deformity; primary bilateral, 1-stage procedure	32.23	2691.21		090	2	4230.05	2365.56	3919.59
40702		Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages	28.54	2383.09		090	2	4230.05	1830.32	3919.59
40720		Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	31.17	2602.70		090	0	4230.05	2054.10	3919.59
40761		Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	32.85	2742.98		090	1	4230.05	2172.67	3919.59
40799		Unlisted procedure, lips	0.00	BR		YYY	2	100.74	BR	105.07
40800		Drainage of abscess, cyst, hematoma, vestibule of mouth; simple	6.60	551.10		010	1	161.85	365.73	132.75
40801		Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated	9.70	809.95		010	1	643.20	571.98	694.83
40804		Removal of embedded foreign body, vestibule of mouth; simple	6.76	564.46		010	0	64.04	391.62	61.03
40805		Removal of embedded foreign body, vestibule of mouth; complicated	12.23	1021.21		010	0	2321.87	618.74	694.83
40806		Incision of labial frenum (frenotomy)	3.58	298.93		000	0	296.47	191.22	312.33
40808		Biopsy, vestibule of mouth	5.85	488.48		010	1	296.47	321.48	312.33
40810		Excision of lesion of mucosa and submucosa, vestibule of mouth; without repai	6.45	538.58		010	1	1480.23	365.73	1567.36
40812		Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repai	8.88	741.48		010	1	1480.23	526.05	1567.36
40814		Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repai	11.84	988.64		090	1	2321.87	719.77	1567.36
40816		Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	12.40	1035.40		090	1	2321.87	756.51	2276.44
40818		Excision of mucosa of vestibule of mouth as donor graft	10.84	905.14		090	0	296.47	666.33	312.33
40819		Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	9.56	798.26		090	0	1480.23	565.30	694.83
40820		Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)	8.38	699.73		010	1	1480.23	460.09	1567.36
40830		Closure of laceration, vestibule of mouth; 2.5 cm or less	8.32	694.72		010	0	296.47	467.60	312.33
40831		Closure of laceration, vestibule of mouth; over 2.5 cm or complex	10.53	879.26		010	0	643.20	616.23	694.83
40840		Vestibuloplasty; anterior	24.57	2051.60		090	2	2321.87	1590.68	2276.44
40842		Vestibuloplasty; posterior, unilateral	24.48	2044.08		090	0	4230.05	1602.37	2276.44
40843		Vestibuloplasty; posterior, bilateral	33.28	2778.88		090	2	2321.87	2059.11	2276.44
40844		Vestibuloplasty; entire arch	40.68	3396.78		090	2	4230.05	2708.74	3919.59
40845		Vestibuloplasty; complex (including ridge extension, muscle repositioning	44.18	3689.03		090	0	4230.05	2994.31	3919.59
40899		Unlisted procedure, vestibule of mouth	0.00	BR		YYY	0	100.74	BR	105.07
41000		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingua	5.00	417.50		010	1	643.20	306.45	1567.36
41005		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficia	7.22	602.87		010	0	296.47	402.47	312.33
41006		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid	11.09	926.02		090	0	2321.87	686.37	2276.44
41007		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space	10.94	913.49		090	0	2321.87	694.72	1567.36
41008		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	11.56	965.26		090	0	1480.23	697.23	1567.36
41009		Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	12.27	1024.55		090	0	296.47	743.99	312.33
41010		Incision of lingual frenum (frenotomy)	6.45	538.58		010	0	643.20	371.58	694.83
41015		Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingua	13.71	1144.79		090	0	296.47	807.45	312.33
41016		Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submenta	13.25	1106.38		090	0	2321.87	833.33	694.83
41017		Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibula	13.52	1128.92		090	0	1480.23	838.34	694.83
41018		Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	15.66	1307.61		090	0	643.20	963.59	694.83

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
41019		Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	13.48	1125.58		000	0	2321.87	978.60	2276.44
41100		Biopsy of tongue; anterior 2/3	5.22	435.87		010	1	643.20	322.31	694.83
41105		Biopsy of tongue; posterior 1/3	5.29	441.72		010	1	1480.23	317.30	1567.36
41108		Biopsy of floor of mouth	4.61	384.94		010	1	433.96	268.04	397.82
41110		Excision of lesion of tongue without closure	6.66	556.11		010	1	1480.23	384.94	1567.36
41112		Excision of lesion of tongue with closure; anterior 2/3	10.34	863.39		090	1	1480.23	617.90	1567.36
41113		Excision of lesion of tongue with closure; posterior 1/3	11.25	939.38		090	1	1480.23	681.36	1567.36
41114		Excision of lesion of tongue with closure; with local tongue flap	19.15	1599.03		090	0	2321.87	1299.26	2276.44
41115		Excision of lingual frenum (frenectomy)	7.79	650.47		010	0	643.20	441.72	694.83
41116		Excision, lesion of floor of mouth	10.31	860.89		090	1	2321.87	587.84	1567.36
41120		Glossectomy; less than 1/2 tongue	32.11	2681.19		090	2	2321.87	2121.74	2276.44
41130		Glossectomy; hemiglossectomy	39.57	3304.10		090	2		2562.62	2097.37**
41135		Glossectomy; partial, with unilateral radical neck dissection	64.86	5415.81		090	2		4272.70	2097.37**
41140		Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	65.87	5500.15		090	2		4473.10	2097.37**
41145		Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	83.15	6943.03		090	2		5504.32	2097.37**
41150		Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	66.01	5511.84		090	2		4372.90	2097.37**
41153		Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	71.57	5976.10		090	2		4696.04	2097.37**
41155		Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	89.74	7493.29		090	2		5708.06	2097.37**
41250		Repair of laceration 2.5 cm or less; floor of mouth and/or anterior 2/3 of tongue	8.37	698.90		010	0	100.74	410.82	105.07
41251		Repair of laceration 2.5 cm or less; posterior 1/3 of tongue	9.17	765.70		010	0	296.47	460.92	312.33
41252		Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	9.77	815.80		010	0	643.20	583.67	694.83
41500		Fixation of tongue, mechanical, other than suture (eg, K-wire)	14.23	1188.21		090	0	1480.23	908.48	2276.44
41510		Suture of tongue to lip for micrognathia (Douglas type procedure)	13.53	1129.76		090	0	1480.23	919.34	1567.36
41512		Tongue base suspension, permanent suture technique	19.14	1598.19		090	0	2321.87	1348.53	694.83
41520		Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	10.81	902.64		090	0	2321.87	639.61	694.83
41530		Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	103.52	8643.92		010	0	2321.87	6639.09	2276.44
41599		Unlisted procedure, tongue, floor of mouth	0.00	BR		YYY	0	100.74	BR	105.07
41800		Drainage of abscess, cyst, hematoma from dentoalveolar structures	8.60	718.10		010	1	161.85	362.39	132.75
41805		Removal of embedded foreign body from dentoalveolar structures; soft tissues	7.69	642.12		010	0	2321.87	372.41	2276.44
41806		Removal of embedded foreign body from dentoalveolar structures; bone	11.05	922.68		010	0	1480.23	583.67	1567.36
41820		Gingivectomy, excision gingiva, each quadrant	7.58	632.93		000	0	2321.87	468.27	694.83
41821		Operculectomy, excision pericoronal tissues	1.71	142.79		000	0	643.20	105.38	694.83
41822		Excision of fibrous tuberosities, dentoalveolar structures	8.92	744.82		010	0	1480.23	542.75	1567.36
41823		Excision of osseous tuberosities, dentoalveolar structures	13.09	1093.02		090	0	4230.05	795.76	2276.44
41825		Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	6.60	551.10		010	1	1480.23	380.76	1567.36
41826		Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	9.69	809.12		010	1	2321.87	460.09	2276.44
41827		Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair	13.54	1130.59		090	1	2321.87	792.42	2276.44
41828		Excision of hyperplastic alveolar mucosa, each quadrant (specify)	9.30	776.55		010	0	2321.87	594.52	1567.36
41830		Alveolectomy, including curettage of osteitis or sequestrectomy	12.01	1002.84		010	0	2321.87	727.29	1567.36
41850		Destruction of lesion (except excision), dentoalveolar structures	3.79	316.47		000	0	2321.87	234.13	1567.36
41870		Periodontal mucosal grafting	9.48	791.58		000	0	4230.05	585.34	2276.44
41872		Gingivoplasty, each quadrant (specify)	11.77	982.80		090	0	2321.87	680.53	1567.36
41874		Alveoloplasty, each quadrant (specify)	11.42	953.57		090	0	2321.87	696.39	2276.44
41899		Unlisted procedure, dentoalveolar structures	0.00	BR		YYY	0	100.74	BR	105.07
42000		Drainage of abscess of palate, uvula	6.26	522.71		010	0	296.47	313.13	312.33
42100		Biopsy of palate, uvula	4.64	387.44		010	1	643.20	287.24	694.83
42104		Excision, lesion of palate, uvula; without closure	6.72	561.12		010	1	1480.23	368.24	1567.36

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
42106		Excision, lesion of palate, uvula; with simple primary closure	8.45	705.58		010	1	1480.23	474.28	1567.36
42107		Excision, lesion of palate, uvula; with local flap closure	14.22	1187.37		090	1	4230.05	863.39	2276.44
42120		Resection of palate or extensive resection of lesion	30.36	2535.06		090	2	2321.87	1899.63	3919.59
42140		Uvulectomy, excision of uvula	8.01	668.84		090	1	1480.23	455.91	694.83
42145		Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty	21.43	1789.41		090	1	4230.05	1389.44	2276.44
42160		Destruction of lesion, palate or uvula (thermal, cryo or chemical)	7.22	602.87		010	0	1480.23	493.49	1567.36
42180		Repair, laceration of palate; up to 2 cm	7.55	630.43		010	0	296.47	466.77	312.33
42182		Repair, laceration of palate; over 2 cm or complex	9.81	819.14		010	0	2321.87	648.80	3919.59
42200		Palatoplasty for cleft palate, soft and/or hard palate only	25.72	2147.62		090	2	4230.05	1849.53	3919.59
42205		Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	26.77	2235.30		090	2	4230.05	1939.71	3919.59
42210		Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	30.85	2575.98		090	2	4230.05	2224.44	3919.59
42215		Palatoplasty for cleft palate; major revision	22.05	1841.18		090	2	4230.05	1497.99	3919.59
42220		Palatoplasty for cleft palate; secondary lengthening procedure	15.76	1315.96		090	2	4230.05	1158.98	3919.59
42225		Palatoplasty for cleft palate; attachment pharyngeal flap	26.92	2247.82		090	2	2321.87	2119.23	3919.59
42226		Lengthening of palate, and pharyngeal flap	27.32	2281.22		090	2	4230.05	2013.19	3919.59
42227		Lengthening of palate, with island flap	25.61	2138.44		090	2	4230.05	1995.65	3919.59
42235		Repair of anterior palate, including vomer flap	22.54	1882.09		090	2	2321.87	1613.22	1567.36
42260		Repair of nasolabial fistula	25.61	2138.44		090	2	2321.87	1703.40	2276.44
42280		Maxillary impression for palatal prosthesis	5.12	427.52		010	0	296.47	302.27	312.33
42281		Insertion of pin-retained palatal prosthesis	6.38	532.73		010	0	1480.23	384.10	1567.36
42299		Unlisted procedure, palate, uvula	0.00	BR		YYY	2	100.74	BR	105.07
42300		Drainage of abscess; parotid, simple	6.49	541.92		010	1	643.20	397.46	1567.36
42305		Drainage of abscess; parotid, complicated	12.95	1081.33		090	0	2321.87	883.43	1567.36
42310		Drainage of abscess; submaxillary or sublingual, intraora	5.06	422.51		010	0	296.47	316.47	312.33
42320		Drainage of abscess; submaxillary, externa	7.76	647.96		010	0	296.47	474.28	312.33
42330		Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraora	7.19	600.37		010	1	1480.23	447.56	1567.36
42335		Sialolithotomy; submandibular (submaxillary), complicated, intraora	11.62	970.27		090	1	2321.87	696.39	1567.36
42340		Sialolithotomy; parotid, extraoral or complicated intraora	14.39	1201.57		090	0	1480.23	893.45	1567.36
42400		Biopsy of salivary gland; needle	3.29	274.72		000	1	806.61	206.25	712.60
42405		Biopsy of salivary gland; incisional	9.12	761.52		010	1	2321.87	601.20	2276.44
42408		Excision of sublingual salivary cyst (ranula)	14.00	1169.00		090	0	2321.87	879.26	1567.36
42409		Marsupialization of sublingual salivary cyst (ranula)	10.41	869.24		090	2	2321.87	625.42	1567.36
42410		Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection	18.76	1566.46		090	2	4230.05	1280.06	3919.59
42415		Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	31.67	2644.45		090	2	4230.05	2314.62	3919.59
42420		Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	35.53	2966.76		090	2	4230.05	2661.98	3919.59
42425		Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve	25.12	2097.52		090	2	4230.05	1755.17	3919.59
42426		Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection	40.39	3372.57		090	2		2845.68	2097.37**
42440		Excision of submandibular (submaxillary) gland	12.45	1039.58		090	2	4230.05	952.74	3919.59
42450		Excision of sublingual gland	13.98	1167.33		090	0	4230.05	877.59	2276.44
42500		Plastic repair of salivary duct, sialodochoplasty; primary or simple	13.39	1118.07		090	0	2321.87	837.51	2276.44
42505		Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	17.08	1426.18		090	1	4230.05	1101.37	3919.59
42507		Parotid duct diversion, bilateral (Wilke type procedure);	15.74	1314.29		090	2	4230.05	1037.07	3919.59
42508		Parotid duct diversion, bilateral (Wilke type procedure); with excision of 1 submandibular gland	21.75	1816.13		090	2	2321.87	1459.58	3919.59
42509		Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands	24.53	2048.26		090	0	4230.05	1773.54	3919.59
42510		Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts	19.17	1600.70		090	2	4230.05	1297.59	3919.59
42550		Injection procedure for sialography	3.97	331.50		000	1		344.02	
42600		Closure salivary fistula	14.83	1238.31		090	0	1480.23	948.56	1567.36

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
42650		Dilation salivary duct	2.59	216.27		000	1	1480.23	157.82	694.83
42660		Dilation and catheterization of salivary duct, with or without injectior	3.76	313.96		000	0	296.47	207.08	312.33
42665		Ligation salivary duct, intraoral	9.82	819.97		090	0	4230.05	571.98	2276.44
42699		Unlisted procedure, salivary glands or ducts	0.00	BR		YYY	2	100.74	BR	105.07
42700		Incision and drainage abscess; peritonsillar	5.91	493.49		010	1	296.47	358.22	312.33
42720		Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approacl	13.78	1150.63		010	0	1480.23	904.31	1567.36
42725		Incision and drainage abscess; retropharyngeal or parapharyngeal, external approacl	24.39	2036.57		090	2	4230.05	1652.47	3919.59
42800		Biopsy; oropharynx	4.95	413.33		010	1	1480.23	299.77	1567.36
42802		Biopsy; hypopharynx	7.24	604.54		010	1	1480.23	505.18	1567.36
42804		Biopsy; nasopharynx, visible lesion, simple	6.16	514.36		010	1	1480.23	406.65	1567.36
42806		Biopsy; nasopharynx, survey for unknown primary lesior	6.89	575.32		010	1	2321.87	460.09	2276.44
42808		Excision or destruction of lesion of pharynx, any methoc	7.02	586.17		010	1	2321.87	446.73	2276.44
42809		Removal of foreign body from pharynx	5.32	444.22		010	1	64.04	341.52	61.03
42810		Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	12.11	1011.19		090	2	2321.87	749.83	2276.44
42815		Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx	17.05	1423.68		090	2	4230.05	1115.56	3919.59
42820		Tonsillectomy and adenoidectomy; younger than age 12	8.78	733.13		090	0	2321.87	598.70	2276.44
42821		Tonsillectomy and adenoidectomy; age 12 or over	9.13	762.36		090	0	2321.87	629.59	2276.44
42825		Tonsillectomy, primary or secondary; younger than age 12	7.98	666.33		090	0	4230.05	529.39	2276.44
42826		Tonsillectomy, primary or secondary; age 12 or over	7.64	637.94		090	1	2321.87	519.37	2276.44
42830		Adenoidectomy, primary; younger than age 12	6.35	530.23		090	0	4230.05	419.17	2276.44
42831		Adenoidectomy, primary; age 12 or over	6.84	571.14		090	0	2321.87	453.41	2276.44
42835		Adenoidectomy, secondary; younger than age 12	5.90	492.65		090	0	2321.87	384.10	2276.44
42836		Adenoidectomy, secondary; age 12 or over	7.33	612.06		090	0	2321.87	499.33	2276.44
42842		Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	30.35	2534.23		090	0	4230.05	1881.26	2276.44
42844		Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	41.51	3466.09		090	2	4230.05	2728.78	3919.59
42845		Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	66.81	5578.64		090	2		4450.55	2097.37**
42860		Excision of tonsil tags	5.78	482.63		090	0	4230.05	378.26	2276.44
42870		Excision or destruction lingual tonsil, any method (separate procedure)	17.90	1494.65		090	0	2321.87	1148.96	2276.44
42890		Limited pharyngectomy	42.82	3575.47		090	2	4230.05	2687.03	3919.59
42892		Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	56.75	4738.63		090	2	4230.05	3485.29	3919.59
42894		Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastomosis	71.41	5962.74		090	2		4505.66	2097.37**
42900		Suture pharynx for wound or injury	10.21	852.54		010	0	2321.87	723.11	694.83
42950		Pharyngoplasty (plastic or reconstructive operation on pharynx	24.37	2034.90		090	2	4230.05	1631.59	2276.44
42953		Pharyngoesophageal repair	29.18	2436.53		090	2		2130.09	2097.37**
42955		Pharyngostomy (fistulization of pharynx, external for feeding	23.13	1931.36		090	2	2321.87	1524.71	2276.44
42960		Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple	5.16	430.86		010	0	100.74	348.20	105.07
42961		Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); complicated, requiring hospitalization	12.86	1073.81		090	2		862.56	2097.37**
42962		Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); with secondary surgical intervention	15.71	1311.79		090	1	2321.87	1067.13	3919.59
42970		Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery	12.42	1037.07		090	1	100.74	800.77	105.07
42971		Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization	13.86	1157.31		090	2		941.05	2097.37**
42972		Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); with secondary surgica intervention	15.49	1293.42		090	2	1480.23	1067.97	1567.36

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
42999		Unlisted procedure, pharynx, adenoids, or tonsils	0.00	BR		YYY	0	100.74	BR	105.07
43020		Esophagotomy, cervical approach, with removal of foreign body	15.89	1326.82		090	2	643.20	1113.89	694.83
43030		Cricopharyngeal myotomy	15.65	1306.78		090	2	2321.87	1083.83	1567.36
43045		Esophagotomy, thoracic approach, with removal of foreign body	39.00	3256.50		090	2		2726.28	2097.37**
43100		Excision of lesion, esophagus, with primary repair; cervical approach	18.89	1577.32		090	2		1290.91	2097.37**
43101		Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach	30.14	2516.69		090	2		2114.22	2097.37**
43107		Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)	75.66	6317.61		090	2		5229.61	2097.37**
43108		Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	138.09	11530.52		090	2		7975.09	2097.37**
43112		Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty	79.76	6659.96		090	2		5603.69	2097.37**
43113		Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	128.12	10698.02		090	2		7894.09	2097.37**
43116		Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	155.42	12977.57		090	2		8872.71	2097.37**
43117		Partial esophagectomy, distal 2/3, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)	73.21	6113.04		090	2		5102.69	2097.37**
43118		Partial esophagectomy, distal 2/3, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	112.67	9407.95		090	2		6673.32	2097.37**
43121		Partial esophagectomy, distal 2/3, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty	85.35	7126.73		090	2		5410.80	2097.37**
43122		Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty	75.91	6338.49		090	2		5172.83	2097.37**
43123		Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	132.78	11087.13		090	2		7997.63	2097.37**
43124		Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	113.68	9492.28		090	2		6801.08	2097.37**
43130		Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach	23.62	1972.27		090	2	4230.05	1627.42	3919.59
43135		Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach	44.33	3701.56		090	2		2870.73	2097.37**
43200		Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	6.59	550.27		000	1	804.30	462.59	797.57
43201		Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance	9.61	802.44		000	1	1195.63	575.32	797.57
43202		Esophagoscopy, rigid or flexible; with biopsy, single or multiple	8.86	739.81		000	1	804.30	608.72	797.57
43204		Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices	6.72	561.12		000	1	804.30	443.39	797.57
43205		Esophagoscopy, rigid or flexible; with band ligation of esophageal varices	6.68	557.78		000	0	1195.63	445.89	797.57
43206		Esophagoscopy, rigid or flexible; with optical endomicroscopy	0.00	BR		YYY	1	1195.63	New	
43215		Esophagoscopy, rigid or flexible; with removal of foreign body	4.61	384.94		000	1	1195.63	315.63	797.57
43216		Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	6.81	568.64		000	0	2409.04	326.49	797.57
43217		Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	11.81	986.14		000	1	1195.63	811.62	797.57
43219		Esophagoscopy, rigid or flexible; with insertion of plastic tube or sten	5.10	425.85		000	1	2731.14	347.36	2415.74
43220		Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter	3.80	317.30		000	1	1195.63	256.35	797.57
43226		Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wir	4.21	351.54		000	1	1195.63	283.07	797.57
43227		Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	6.34	529.39		000	1	1195.63	422.51	797.57

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
43228		Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	6.65	555.28		000	1	2409.04	446.73	2213.21
43231		Esophagoscopy, rigid or flexible; with endoscopic ultrasound examinatior	5.67	473.45		000	0	1195.63	377.42	797.57
43232		Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	7.76	647.96		000	0	1195.63	527.72	797.57
43235		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	9.16	764.86		000	1	804.30	628.76	797.57
43236		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance	11.74	980.29		000	1	804.30	777.39	797.57
43237		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	6.97	582.00		000	0	1195.63	480.13	797.57
43238		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasou	8.66	723.11		000	0	1195.63	588.68	797.57
43239		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	10.56	881.76		000	1	804.30	717.27	797.57
43240		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst	11.79	984.47		000	1	1195.63	796.59	797.57
43241		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement	4.66	389.11		000	1	804.30	310.62	797.57
43242		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examinat	12.58	1050.43		000	0	1195.63	841.68	797.57
43243		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices	7.96	664.66		000	1	804.30	531.90	797.57
43244		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices	8.77	732.30		000	0	1195.63	587.84	797.57
43245		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)	5.61	468.44		000	1	1195.63	376.59	797.57
43246		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube	7.50	626.25		000	0	1195.63	503.51	797.57
43247		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body	5.98	499.33		000	1	804.30	399.97	797.57
43248		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	5.61	468.44		000	1	804.30	374.92	797.57
43249		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	5.18	432.53		000	1	1195.63	346.53	797.57
43250		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	5.65	471.78		000	1	1195.63	379.09	797.57
43251		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	6.51	543.59		000	1	1195.63	435.04	797.57
43252		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy	0.00	BR		YYY	1	1195.63	New	
43255		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method	8.40	701.40		000	1	1195.63	561.96	797.57

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43256		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)	7.57	632.10		000	1	2731.14	506.85	2415.74
43257		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal refl	9.64	804.94		000	1	2409.04	623.75	2213.21
43258		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	7.95	663.83		000	1	1195.63	530.23	797.57
43259		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate	9.03	754.01		000	0	1195.63	600.37	797.57
43260		Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	10.29	859.22		000	1	2228.37	690.55	2061.91
43261		Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	10.81	902.64		000	1	2228.37	726.45	2061.91
43262		Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	12.70	1060.45		000	1	2228.37	852.54	2061.91
43263		Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	12.56	1048.76		000	1	2228.37	844.19	2061.91
43264		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts	15.22	1270.87		000	1	2228.37	1023.71	2061.91
43265		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy o calculus/calculi, any method	17.08	1426.18		000	1	2228.37	1148.13	2061.91
43267		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube	12.60	1052.10		000	1	2228.37	850.87	2061.91
43268		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or sten into bile or pancreatic duct	12.89	1076.32		000	1	2731.14	862.56	2415.74
43269		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent	14.06	1174.01		000	1	2731.14	946.06	2415.74
43271		Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)	12.69	1059.62		000	1	2228.37	852.54	2061.91
43272		Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	12.72	1062.12		000	0	2228.37	854.21	2061.91
43273		Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)	3.74	312.29		ZZZ	0	2228.37	285.57	2061.91
43279		Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performe	38.15	3185.53		090	2		2672.00	2097.37**
43280		Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures	31.99	2671.17		090	2	6607.04	2137.60	6653.06
43281		Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	45.58	3805.93		090	2	6607.04	3562.95	2097.37**
43282		Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	51.22	4276.87		090	2		4007.17	2097.37**
43283		Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	4.62	385.77		ZZZ	2		New	
43289		Unlisted laparoscopy procedure, esophagus	0.00	BR		YYY	2	3522.03	BR	3470.14
43300		Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula	18.56	1549.76		090	2		1292.58	2097.37**
43305		Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula	32.66	2727.11		090	2		2307.94	2097.37**
43310		Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	44.32	3700.72		090	2		3171.33	2097.37**
43312		Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	47.61	3975.44		090	2		3482.79	2097.37**

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43313		Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	92.16	7695.36		090	2		5612.87	2097.37**
43314		Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula	86.03	7183.51		090	2		6131.41	2097.37**
43320		Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	41.21	3441.04		090	2		2730.45	2097.37**
43325		Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	39.69	3314.12		090	2		2629.42	2097.37**
43327		Esophagogastric fundoplasty partial or complete; laparotomy	24.15	2016.53		090	2		New	
43328		Esophagogastric fundoplasty partial or complete; thoracotomy	34.49	2879.92		090	2		New	
43330		Esophagomyotomy (Heller type); abdominal approach	39.45	3294.08		090	2		2582.66	2097.37**
43331		Esophagomyotomy (Heller type); thoracic approach	40.15	3352.53		090	2		2778.88	2097.37**
43332		Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	34.38	2870.73		090	2		New	
43333		Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	37.37	3120.40		090	2		New	
43334		Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	37.05	3093.68		090	2		New	
43335		Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	39.49	3297.42		090	2		New	
43336		Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	45.16	3770.86		090	2		New	
43337		Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	48.65	4062.28		090	2		New	
43338		Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	3.44	287.24		ZZZ	2		New	
43340		Esophagojejunostomy (without total gastrectomy); abdominal approach	40.68	3396.78		090	2		2672.84	2097.37**
43341		Esophagojejunostomy (without total gastrectomy); thoracic approach	44.40	3707.40		090	2		2891.61	2097.37**
43350		Esophagostomy, fistulization of esophagus, external; abdominal approach	35.79	2988.47		090	2		2265.36	2097.37**
43351		Esophagostomy, fistulization of esophagus, external; thoracic approach	39.43	3292.41		090	2		2661.98	2097.37**
43352		Esophagostomy, fistulization of esophagus, external; cervical approach	32.00	2672.00		090	2		2195.22	2097.37**
43360		Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	67.38	5626.23		090	2		4686.02	2097.37**
43361		Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and	75.15	6275.03		090	2		5202.05	2097.37**
43400		Ligation, direct, esophageal varices	46.31	3866.89		090	2		2954.23	2097.37**
43401		Transection of esophagus with repair, for esophageal varices	46.32	3867.72		090	2		3025.21	2097.37**
43405		Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	43.12	3600.52		090	2		2897.45	2097.37**
43410		Suture of esophageal wound or injury; cervical approach	32.66	2727.11		090	2		2001.50	2097.37**
43415		Suture of esophageal wound or injury; transthoracic or transabdominal approach	76.68	6402.78		090	2		3434.36	2097.37**
43420		Closure of esophagostomy or fistula; cervical approach	30.48	2545.08		090	0	2321.87	1978.95	2276.44
43425		Closure of esophagostomy or fistula; transthoracic or transabdominal approach	42.71	3566.29		090	2		2964.25	2097.37**
43450		Dilation of esophagus, by unguided sound or bougie, single or multiple passes	4.74	395.79		000	1	623.18	333.17	543.69
43453		Dilation of esophagus, over guide wire	9.15	764.03		000	1	623.18	633.77	543.69
43456		Dilation of esophagus, by balloon or dilator, retrograde	18.60	1553.10		000	1	623.18	1341.01	543.69
43458		Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia	11.88	991.98		000	1	1195.63	810.79	797.57
43460		Esophagogastric tamponade, with balloon (Sengstaken type	6.69	558.62		000	1		440.05	2097.37**
43496		Free jejunum transfer with microvascular anastomosis	0.00	BR		090	2		BR	2097.37**
43499		Unlisted procedure, esophagus	0.00	BR		YYY	1	804.30	BR	797.57
43500		Gastrotomy; with exploration or foreign body remova	23.28	1943.88		090	2		1496.32	2097.37**

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43501		Gastrotomy; with suture repair of bleeding ulcer	39.76	3319.96		090	2		2598.52	2097.37**
43502		Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss	44.96	3754.16		090	2		2958.41	2097.37**
43510		Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	26.99	2253.67		090	2	804.30	1806.11	797.57
43520		Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation	20.38	1701.73		090	2		1385.27	2097.37**
43605		Biopsy of stomach, by laparotomy	24.73	2064.96		090	2		1600.70	2097.37**
43610		Excision, local; ulcer or benign tumor of stomach	28.98	2419.83		090	2		1894.62	2097.37**
43611		Excision, local; malignant tumor of stomach	36.07	3011.85		090	2		2348.86	2097.37**
43620		Gastrectomy, total; with esophagoenterostomy	57.75	4822.13		090	2		3847.68	2097.37**
43621		Gastrectomy, total; with Roux-en-Y reconstructior	66.67	5566.95		090	2		4306.93	2097.37**
43622		Gastrectomy, total; with formation of intestinal pouch, any type	67.60	5644.60		090	2		4407.13	2097.37**
43631		Gastrectomy, partial, distal; with gastroduodenostomy	42.83	3576.31		090	2		2833.99	2097.37**
43632		Gastrectomy, partial, distal; with gastrojejunostomy	59.79	4992.47		090	2		3689.03	2097.37**
43633		Gastrectomy, partial, distal; with Roux-en-Y reconstructior	56.60	4726.10		090	2		3545.41	2097.37**
43634		Gastrectomy, partial, distal; with formation of intestinal pouch	62.58	5225.43		090	2		3899.45	2097.37**
43635		Vagotomy when performed with partial distal gastrectomy (List separately in addition to code[s] for primary procedure)	3.29	274.72		ZZZ	2		232.13	2097.37**
43640		Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	34.84	2909.14		090	2		2256.17	2097.37**
43641		Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective	35.50	2964.25		090	2		2287.90	2097.37**
43644		Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	51.11	4267.69		090	2		3375.91	2097.37**
43645		Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	54.51	4551.59		090	2		3635.59	2097.37**
43647		Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	0.00	BR		YYY	2	8762.33	BR	7889.49
43648		Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	0.00	BR		YYY	2	3522.03	BR	3470.14
43651		Laparoscopy, surgical; transection of vagus nerves, trunca	19.44	1623.24		090	2	6607.04	1266.70	6653.06
43652		Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	22.66	1892.11		090	2	6607.04	1508.85	6653.06
43653		Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)	17.11	1428.69		090	2	4498.73	1067.13	4271.34
43659		Unlisted laparoscopy procedure, stomach	0.00	BR		YYY	2	3522.03	BR	3470.14
43752		Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	1.19	99.37		000	1	147.41	83.50	115.75
43753		Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed	0.60	50.10		000	2	64.04	New	
43754		Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis	2.93	244.66		000	2	64.04	New	
43755		Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administrat	4.42	369.07		000	2	85.82	New	
43756		Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)	6.80	567.80		000	2	147.41	New	
43757		Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration	9.54	796.59		000	2	147.41	New	
43760		Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	15.63	1305.11		000	1	222.75	488.48	218.44
43761		Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	3.43	286.41		000	1	804.30	254.68	797.57
43770		Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	33.13	2766.36		090	2	6607.04	2161.82	2097.37**
43771		Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	37.62	3141.27		090	2		2470.77	2097.37**

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43772		Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	28.19	2353.87		090	2		1861.22	2097.37**
43773		Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	37.58	3137.93		090	2		2471.60	2097.37**
43774		Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	28.42	2373.07		090	2		1869.57	2097.37**
43775		Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	39.69	3314.12		YYY	2		2990.97	2097.37**
43800		Pyloroplasty	27.50	2296.25		090	2		1796.92	2097.37**
43810		Gastroduodenostomy	30.04	2508.34		090	2		1941.38	2097.37**
43820		Gastrojejunostomy; without vagotomy	39.57	3304.10		090	2		2424.01	2097.37**
43825		Gastrojejunostomy; with vagotomy, any type	38.16	3186.36		090	2		2503.33	2097.37**
43830		Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)	20.77	1734.30		090	2	2409.04	1323.48	2213.21
43831		Gastrostomy, open; neonatal, for feeding	17.79	1485.47		090	2	804.30	1105.54	797.57
43832		Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure	30.92	2581.82		090	2		2039.07	2097.37**
43840		Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	40.12	3350.02		090	2		2472.44	2097.37**
43842		Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	33.81	2823.14		090	9		2403.13	2097.37**
43843		Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	37.81	3157.14		090	2		2437.37	2097.37**
43845		Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	57.95	4838.83		090	2		3760.84	2097.37**
43846		Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	48.00	4008.00		090	2		3148.79	2097.37**
43847		Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	53.16	4438.86		090	2		3462.75	2097.37**
43848		Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	56.87	4748.65		090	2		3746.65	2097.37**
43850		Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	48.01	4008.84		090	2		3147.12	2097.37**
43855		Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	49.79	4157.47		090	2		3285.73	2097.37**
43860		Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	48.19	4023.87		090	2		3183.86	2097.37**
43865		Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	50.37	4205.90		090	2		3334.16	2097.37**
43870		Closure of gastrostomy, surgical	21.13	1764.36		090	2	2409.04	1346.86	797.57
43880		Closure of gastrocolic fistula	47.02	3926.17		090	2		3119.56	2097.37**
43881		Implantation or replacement of gastric neurostimulator electrodes, antrum, oper	0.00	BR		YYY	2		BR	2097.37**
43882		Revision or removal of gastric neurostimulator electrodes, antrum, oper	0.00	BR		YYY	2		BR	2097.37**
43886		Gastric restrictive procedure, open; revision of subcutaneous port component only	10.93	912.66		090	2	1948.12	627.92	2182.33
43887		Gastric restrictive procedure, open; removal of subcutaneous port component only	9.83	820.81		090	2	1434.08	595.36	404.76
43888		Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	13.74	1147.29		090	2	1948.12	850.87	2182.33
43999		Unlisted procedure, stomach	0.00	BR		YYY	0	804.30	BR	797.57
44005		Enterolysis (freeing of intestinal adhesion) (separate procedure)	32.32	2698.72		090	2		2118.40	2097.37**
44010		Duodenotomy, for exploration, biopsy(s), or foreign body remova	25.76	2150.96		090	2		1658.31	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
44015		Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)	4.18	349.03		ZZZ	2		295.59	2097.37**
44020		Enterotomy, small intestine, other than duodenum; for exploration, biopsy(s), or foreign body removal	28.80	2404.80		090	2		1865.39	2097.37**
44021		Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube	28.87	2410.65		090	2		1880.42	2097.37**
44025		Colotomy, for exploration, biopsy(s), or foreign body remova	29.28	2444.88		090	2		1898.79	2097.37**
44050		Reduction of volvulus, intussusception, internal hernia, by laparotomy	27.66	2309.61		090	2		1810.28	2097.37**
44055		Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)	44.18	3689.03		090	2		2884.93	2097.37**
44100		Biopsy of intestine by capsule, tube, peroral (1 or more specimens)	3.36	280.56		000	1	1195.63	228.79	797.57
44110		Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy	25.17	2101.70		090	2		1621.57	2097.37**
44111		Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies	29.18	2436.53		090	2		1902.13	2097.37**
44120		Enterectomy, resection of small intestine; single resection and anastomosis	36.11	3015.19		090	2		2338.84	2097.37**
44121		Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	7.09	592.02		ZZZ	2		501.00	2097.37**
44125		Enterectomy, resection of small intestine; with enterostomy	34.93	2916.66		090	2		2288.74	2097.37**
44126		Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering	72.64	6065.44		090	2		4721.09	2097.37**
44127		Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering	83.91	7006.49		090	2		5460.90	2097.37**
44128		Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	7.13	595.36		ZZZ	2		501.84	2097.37**
44130		Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	38.85	3243.98		090	2		2363.89	2097.37**
44132		Donor enterectomy (including cold preservation), open; from cadaver donor	0.00	BR		XXX	0		BR	2097.37**
44133		Donor enterectomy (including cold preservation), open; partial, from living donor	0.00	BR		XXX	0		BR	2097.37**
44135		Intestinal allotransplantation; from cadaver donor	0.00	BR		XXX	0		BR	2097.37**
44136		Intestinal allotransplantation; from living donor	0.00	BR		XXX	0		BR	2097.37**
44137		Removal of transplanted intestinal allograft, complete	0.00	BR		XXX	2		BR	2097.37**
44139		Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	3.55	296.43		ZZZ	2		250.50	2097.37**
44140		Colectomy, partial; with anastomosis	39.65	3310.78		090	2		2624.41	2097.37**
44141		Colectomy, partial; with skin level cecostomy or colostomy	54.14	4520.69		090	2		3323.30	2097.37**
44143		Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure	49.30	4116.55		090	2		3214.75	2097.37**
44144		Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	52.44	4378.74		090	2		3298.25	2097.37**
44145		Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	49.06	4096.51		090	2		3288.23	2097.37**
44146		Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	62.85	5247.98		090	2		4008.00	2097.37**
44147		Colectomy, partial; abdominal and transanal approach	57.36	4789.56		090	2		3507.84	2097.37**
44150		Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	55.67	4648.45		090	2		3523.70	2097.37**
44151		Colectomy, total, abdominal, without proctectomy; with continent ileostomy	63.66	5315.61		090	2		4033.05	2097.37**
44155		Colectomy, total, abdominal, with proctectomy; with ileostomy	61.85	5164.48		090	2		3961.24	2097.37**
44156		Colectomy, total, abdominal, with proctectomy; with continent ileostomy	68.55	5723.93		090	2		4375.40	2097.37**
44157		Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed	64.44	5380.74		090	2		4301.92	2097.37**
44158		Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed	66.15	5523.53		090	2		4412.98	2097.37**
44160		Colectomy, partial, with removal of terminal ileum with ileocolostomy	36.74	3067.79		090	2		2401.46	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
44180		Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure	27.19	2270.37		090	2	4498.73	647.96	4271.34
44186		Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)	19.36	1616.56		090	2	4498.73	490.98	4271.34
44187		Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	33.12	2765.52		090	2		2149.29	2097.37**
44188		Laparoscopy, surgical, colostomy or skin level cecostomy	36.61	3056.94		090	2		2365.56	2097.37**
44202		Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	41.01	3424.34		090	2		2717.93	2097.37**
44203		Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	7.10	592.85		ZZZ	2		498.50	2097.37**
44204		Laparoscopy, surgical; colectomy, partial, with anastomosis	45.60	3807.60		090	2		3045.25	2097.37**
44205		Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	39.69	3314.12		090	2		2664.49	2097.37**
44206		Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	52.07	4347.85		090	2	6607.04	3439.37	6653.06
44207		Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	54.12	4519.02		090	2	6607.04	3626.41	6653.06
44208		Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	59.12	4936.52		090	2	6607.04	3942.87	6653.06
44210		Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	53.41	4459.74		090	2		3507.84	2097.37**
44211		Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed	66.58	5559.43		090	2		4325.30	2097.37**
44212		Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	61.51	5136.09		090	2		4030.55	2097.37**
44213		Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	5.56	464.26		ZZZ	2	3522.03	394.96	3470.14
44227		Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis	49.43	4127.41		090	2		3286.56	2097.37**
44238		Unlisted laparoscopy procedure, intestine (except rectum)	0.00	BR		YYY	2	3522.03	BR	3470.14
44300		Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)	24.99	2086.67		090	2		1619.07	2097.37**
44310		Ileostomy or jejunostomy, non-tube	30.95	2584.33		090	2		2033.23	2097.37**
44312		Revision of ileostomy; simple (release of superficial scar) (separate procedure)	17.54	1464.59		090	0	1948.12	1124.75	2182.33
44314		Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	29.89	2495.82		090	2		1947.22	2097.37**
44316		Continent ileostomy (Kock procedure) (separate procedure)	41.74	3485.29		090	2		2690.37	2097.37**
44320		Colostomy or skin level cecostomy;	35.67	2978.45		090	2		2310.45	2097.37**
44322		Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	30.13	2515.86		090	2		1849.53	2097.37**
44340		Revision of colostomy; simple (release of superficial scar) (separate procedure)	18.68	1559.78		090	1	1948.12	1138.11	2182.33
44345		Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	31.29	2612.72		090	2		2021.54	2097.37**
44346		Revision of colostomy; with repair of paracolostomy hernia (separate procedure	35.16	2935.86		090	2		2260.35	2097.37**
44360		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	4.69	391.62		000	1	968.45	311.46	898.25
44361		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	5.15	430.03		000	1	968.45	343.19	898.25
44363		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body	6.15	513.53		000	0	968.45	412.49	898.25
44364		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	6.56	547.76		000	0	1429.56	438.38	898.25
44365		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	5.85	488.48		000	0	1429.56	391.62	898.25

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
44366		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	7.73	645.46		000	1	1429.56	516.03	898.25
44369		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	7.90	659.65		000	0	1429.56	526.05	898.25
44370		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	8.55	713.93		000	0	2731.14	567.80	2415.74
44372		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube	7.67	640.45		000	1	1429.56	513.53	898.25
44373		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	6.14	512.69		000	1	1429.56	409.99	898.25
44376		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	9.02	753.17		000	0	968.45	607.88	898.25
44377		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	9.55	797.43		000	0	968.45	640.45	898.25
44378		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	12.25	1022.88		000	0	1429.56	821.64	898.25
44379		Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	13.06	1090.51		000	0	2731.14	864.23	2415.74
44380		Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.03	169.51		000	1	968.45	135.27	898.25
44382		Ileoscopy, through stoma; with biopsy, single or multiple	2.44	203.74		000	1	968.45	161.16	898.25
44383		Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation	4.78	399.13		000	1	2731.14	351.54	2415.74
44385		Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	8.14	679.69		000	1	891.86	460.92	830.29
44386		Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple	11.11	927.69		000	0	891.86	732.30	830.29
44388		Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	10.96	915.16		000	1	891.86	679.69	830.29
44389		Colonoscopy through stoma; with biopsy, single or multiple	12.38	1033.73		000	1	891.86	819.97	830.29
44390		Colonoscopy through stoma; with removal of foreign body	14.59	1218.27		000	0	891.86	925.18	830.29
44391		Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	15.55	1298.43		000	0	891.86	1085.50	830.29
44392		Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	13.70	1143.95		000	1	891.86	880.93	830.29
44393		Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	15.68	1309.28		000	1	891.86	993.65	830.29
44394		Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	15.44	1289.24		000	1	891.86	1029.56	830.29
44397		Colonoscopy through stoma; with transendoscopic stent placement (includes predilation	8.21	685.54		000	1	2731.14	546.93	2415.74
44500		Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)	0.71	59.29		000	0	567.16	52.61	581.26
44602		Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	41.56	3470.26		090	2		2588.50	2097.37**
44603		Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations	47.76	3987.96		090	2		2951.73	2097.37**
44604		Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	31.20	2605.20		090	2		2064.96	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
44605		Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy	38.55	3218.93		090	2		2554.27	2097.37**
44615		Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction	31.82	2656.97		090	2		2086.67	2097.37**
44620		Closure of enterostomy, large or small intestine;	25.74	2149.29		090	2		1653.30	2097.37**
44625		Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal	30.27	2527.55		090	2		1971.44	2097.37**
44626		Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	47.41	3958.74		090	2		3164.65	2097.37**
44640		Closure of intestinal cutaneous fistula	41.46	3461.91		090	2		2749.66	2097.37**
44650		Closure of enteroenteric or enterocolic fistula	42.91	3582.99		090	2		2856.54	2097.37**
44660		Closure of enterovesical fistula; without intestinal or bladder resection	39.19	3272.37		090	2		2694.55	2097.37**
44661		Closure of enterovesical fistula; with intestine and/or bladder resection	45.71	3816.79		090	2		3078.65	2097.37**
44680		Intestinal plication (separate procedure)	31.64	2641.94		090	2		2050.76	2097.37**
44700		Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	30.24	2525.04		090	2		2009.01	2097.37**
44701		Intraoperative colonic lavage (List separately in addition to code for primary procedure	4.92	410.82		ZZZ	2		346.53	
44705		Preparation of fecal microbiota for instillation, including assessment of donor specimen	0.00	BR		XXX	9		New	
44715		Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein	0.00	BR		XXX	2		BR	2097.37**
44720		Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each	7.38	616.23		XXX	2		540.25	2097.37**
44721		Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each	11.27	941.05		XXX	2		794.92	2097.37**
44799		Unlisted procedure, intestine	0.00	BR		YYY	1	2389.99	BR	2479.05
44800		Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	22.68	1893.78		090	2		1472.11	2097.37**
44820		Excision of lesion of mesentery (separate procedure)	24.88	2077.48		090	2		1617.40	2097.37**
44850		Suture of mesentery (separate procedure)	22.33	1864.56		090	2		1437.87	2097.37**
44899		Unlisted procedure, Meckel's diverticulum and the mesentery	0.00	BR		YYY	2		BR	2097.37**
44900		Incision and drainage of appendiceal abscess; open	22.96	1917.16		090	2		1444.55	2097.37**
44901		Incision and drainage of appendiceal abscess; percutaneous	26.97	2252.00		000	1	1443.01	2409.81	1413.47
44950		Appendectomy;	18.98	1584.83		090	2	2389.99	1254.17	2479.05
44955		Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	2.46	205.41		ZZZ	2	2389.99	174.52	2479.05
44960		Appendectomy; for ruptured appendix with abscess or generalized peritonitis	25.82	2155.97		090	2		1664.16	2097.37**
44970		Laparoscopy, surgical, appendectomy	17.82	1487.97		090	2	4498.73	1140.61	4271.34
44979		Unlisted laparoscopy procedure, appendix	0.00	BR		YYY	2	3522.03	BR	3470.14
45000		Transrectal drainage of pelvic abscess	12.66	1057.11		090	1	2360.12	768.20	1287.06
45005		Incision and drainage of submucosal abscess, rectum	8.33	695.56		010	1	1649.83	506.85	1287.06
45020		Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	17.02	1421.17		090	1	1649.83	977.79	1287.06
45100		Biopsy of anorectal wall, anal approach (eg, congenital megacolon	9.04	754.84		090	1	1649.83	541.08	2185.85
45108		Anorectal myomectomy	11.06	923.51		090	1	2360.12	664.66	2185.85
45110		Proctectomy; complete, combined abdominoperineal, with colostomy	55.12	4602.52		090	2		3602.19	2097.37**
45111		Proctectomy; partial resection of rectum, transabdominal approach	32.37	2702.90		090	2		2111.72	2097.37**
45112		Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis	55.96	4672.66		090	2		3723.27	2097.37**
45113		Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	59.13	4937.36		090	2		3808.44	2097.37**
45114		Proctectomy, partial, with anastomosis; abdominal and transsacral approach	53.58	4473.93		090	2		3479.45	2097.37**
45116		Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type	46.67	3896.95		090	2		3135.43	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
45119		Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed	58.03	4845.51		090	2		3810.94	2097.37**
45120		Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	46.83	3910.31		090	2		3045.25	2097.37**
45121		Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	51.28	4281.88		090	2		3355.03	2097.37**
45123		Proctectomy, partial, without anastomosis, perineal approach	33.39	2788.07		090	2		2137.60	2097.37**
45126		Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(	84.65	7068.28		090	2		5598.68	2097.37**
45130		Excision of rectal procidentia, with anastomosis; perineal approach	32.53	2716.26		090	2		2095.02	2097.37**
45135		Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	40.55	3385.93		090	2		2582.66	2097.37**
45136		Excision of ileoanal reservoir with ileostomy	54.22	4527.37		090	2		3568.79	2097.37**
45150		Division of stricture of rectum	11.80	985.30		090	0	2360.12	741.48	2185.85
45160		Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach	30.29	2529.22		090	2	2360.12	1907.98	2185.85
45171		Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	18.09	1510.52		090	2	2360.12	1343.52	1287.06
45172		Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)	24.36	2034.06		090	2	3052.30	1844.52	2185.85
45190		Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	20.60	1720.10		090	1	2360.12	1273.38	2185.85
45300		Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	3.81	318.14		000	1	542.25	167.84	526.59
45303		Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie	30.24	2525.04		000	1	923.14	1612.39	843.05
45305		Proctosigmoidoscopy, rigid; with biopsy, single or multiple	6.11	510.19		000	1	923.14	317.30	843.05
45307		Proctosigmoidoscopy, rigid; with removal of foreign body	7.17	598.70		000	0	1975.34	339.01	2081.03
45308		Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	6.56	547.76		000	1	923.14	263.03	843.05
45309		Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	6.72	561.12		000	1	923.14	424.18	843.05
45315		Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	7.09	592.02		000	1	923.14	371.58	843.05
45317		Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	7.54	629.59		000	1	923.14	349.87	843.05
45320		Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)	7.51	627.09		000	1	1975.34	396.63	2081.03
45321		Proctosigmoidoscopy, rigid; with decompression of volvulus	3.24	270.54		000	1	1975.34	146.96	2081.03
45327		Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation	3.85	321.48		000	1	2731.14	197.06	2415.74
45330		Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	4.27	356.55		000	1	542.25	273.05	526.59
45331		Sigmoidoscopy, flexible; with biopsy, single or multiple	5.14	429.19		000	1	542.25	353.21	526.59
45332		Sigmoidoscopy, flexible; with removal of foreign body	9.21	769.04		000	1	542.25	577.82	526.59
45333		Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	9.34	779.89		000	1	542.25	569.47	843.05
45334		Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	4.89	408.32		000	1	923.14	325.65	843.05
45335		Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	8.71	727.29		000	1	542.25	430.86	526.59
45337		Sigmoidoscopy, flexible; with decompression of volvulus, any method	4.28	357.38		000	1	923.14	283.07	526.59
45338		Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	10.00	835.00		000	1	923.14	639.61	843.05
45339		Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	10.63	887.61		000	1	923.14	593.69	843.05
45340		Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures	15.58	1300.93		000	1	923.14	754.01	843.05
45341		Sigmoidoscopy, flexible; with endoscopic ultrasound examination	4.69	391.62		000	1	923.14	308.95	843.05

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
45342		Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	7.13	595.36		000	1	923.14	471.78	843.05
45345		Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation	5.22	435.87		000	1	2731.14	344.02	2415.74
45355		Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple	6.13	511.86		000	1	891.86	413.33	830.29
45378		Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	12.07	1007.85		000	1	891.86	819.97	830.29
45379		Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body	15.52	1295.92		000	1	891.86	1033.73	830.29
45380		Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	14.38	1200.73		000	1	891.86	973.61	830.29
45381		Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance	14.49	1209.92		000	1	891.86	946.06	830.29
45382		Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipola cautery, laser, heater probe, stapler, plasma coagulator)	18.73	1563.96		000	1	891.86	1299.26	830.29
45383		Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	17.36	1449.56		000	1	891.86	1154.81	830.29
45384		Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	14.30	1194.05		000	1	891.86	960.25	830.29
45385		Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	16.18	1351.03		000	1	891.86	1096.36	830.29
45386		Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more stricture	20.99	1752.67		000	1	891.86	1408.65	830.29
45387		Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)	10.29	859.22		000	1	2731.14	691.38	2415.74
45391		Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examinatior	8.81	735.64		000	1	891.86	595.36	830.29
45392		Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	11.30	943.55		000	1	891.86	747.33	830.29
45395		Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	59.14	4938.19		090	2		3893.61	2097.37**
45397		Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed	64.11	5353.19		090	2		4210.07	2097.37**
45400		Laparoscopy, surgical; proctopexy (for prolapse)	34.37	2869.90		090	2		2261.18	2097.37**
45402		Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resectior	45.49	3798.42		090	2		3027.71	2097.37**
45499		Unlisted laparoscopy procedure, rectum	0.00	BR		YYY	2	3522.03	BR	3470.14
45500		Proctoplasty; for stenosis	15.84	1322.64		090	0	2360.12	949.40	2185.85
45505		Proctoplasty; for prolapse of mucous membrane	17.79	1485.47		090	1	3052.30	1036.24	2934.60
45520		Perirectal injection of sclerosing solution for prolapse	4.93	411.66		000	1	137.98	211.26	80.15
45540		Proctopexy (eg, for prolapse); abdominal approach	31.47	2627.75		090	2		2054.94	2097.37**
45541		Proctopexy (eg, for prolapse); perineal approach	27.71	2313.79		090	2	3052.30	1745.15	2934.60
45550		Proctopexy (eg, for prolapse); with sigmoid resection, abdominal approach	43.56	3637.26		090	2		2837.33	2097.37**
45560		Repair of rectocele (separate procedure)	20.70	1728.45		090	2	3052.30	1384.43	2934.60
45562		Exploration, repair, and presacral drainage for rectal injury	33.19	2771.37		090	2		2100.03	2097.37**
45563		Exploration, repair, and presacral drainage for rectal injury; with colostomy	48.78	4073.13		090	2		3115.39	2097.37**
45800		Closure of rectovesical fistula;	35.25	2943.38		090	2		2329.65	2097.37**
45805		Closure of rectovesical fistula; with colostomy	43.28	3613.88		090	2		2699.56	2097.37**
45820		Closure of rectourethral fistula;	32.54	2717.09		090	2		2324.64	2097.37**
45825		Closure of rectourethral fistula; with colostomy	43.52	3633.92		090	2		2841.51	2097.37**
45900		Reduction of procidentia (separate procedure) under anesthesia	6.10	509.35		010	0	566.80	376.59	489.23
45905		Dilation of anal sphincter (separate procedure) under anesthesia other than loca	5.07	423.35		010	1	1649.83	321.48	2185.85
45910		Dilation of rectal stricture (separate procedure) under anesthesia other than loca	5.86	489.31		010	1	1649.83	379.09	2185.85
45915		Removal of fecal impaction or foreign body (separate procedure) under anesthesia	10.02	836.67		010	1	1649.83	621.24	1287.06
45990		Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	3.17	264.70		000	0	1649.83	215.43	2185.85
45999		Unlisted procedure, rectum	0.00	BR		YYY	0	566.80	BR	489.23

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
46020		Placement of seton	8.40	701.40		010	1	2360.12	460.09	2185.85
46030		Removal of anal seton, other marker	4.28	357.38		010	0	566.80	228.79	489.23
46040		Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	16.17	1350.20		090	1	1649.83	926.85	2185.85
46045		Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia	13.02	1087.17		090	1	2360.12	743.15	2185.85
46050		Incision and drainage, perianal abscess, superficial	6.26	522.71		010	1	566.80	328.16	1287.06
46060		Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	14.32	1195.72		090	1	1649.83	819.97	2185.85
46070		Incision, anal septum (infant)	6.56	547.76		090	0	1649.83	399.13	1287.06
46080		Sphincterotomy, anal, division of sphincter (separate procedure)	7.58	632.93		010	1	1649.83	424.18	2185.85
46083		Incision of thrombosed hemorrhoid, external	5.39	450.07		010	1	197.05	326.49	184.15
46200		Fissurectomy, including sphincterotomy, when performed	13.58	1133.93		090	1	2360.12	666.33	2185.85
46220		Excision of single external papilla or tag, anus	6.34	529.39		010	1	1649.83	338.18	1287.06
46221		Hemorrhoidectomy, internal, by rubber band ligation(s)	8.26	689.71		010	1	566.80	435.87	489.23
46230		Excision of multiple external papillae or tags, anus	8.36	698.06		010	1	1649.83	485.14	2185.85
46250		Hemorrhoidectomy, external, 2 or more columns/groups	14.06	1174.01		090	1	2360.12	809.12	2185.85
46255		Hemorrhoidectomy, internal and external, single column/group	15.37	1283.40		090	1	2360.12	913.49	2185.85
46257		Hemorrhoidectomy, internal and external, single column/group; with fissurectomy	12.64	1055.44		090	1	2360.12	739.81	2185.85
46258		Hemorrhoidectomy, internal and external, single column/group; with fistulectomy, including fissurectomy, when performed	13.94	1163.99		090	0	2360.12	817.47	2185.85
46260		Hemorrhoidectomy, internal and external, 2 or more columns/groups	14.22	1187.37		090	1	2360.12	846.69	2185.85
46261		Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	15.70	1310.95		090	1	2360.12	955.24	2185.85
46262		Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	16.64	1389.44		090	1	2360.12	986.97	2185.85
46270		Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	15.35	1281.73		090	1	2360.12	843.35	2185.85
46275		Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric	16.33	1363.56		090	1	2360.12	870.07	2185.85
46280		Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed	14.13	1179.86		090	1	2360.12	819.97	2185.85
46285		Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage	16.25	1356.88		090	1	2360.12	807.45	2185.85
46288		Closure of anal fistula with rectal advancement flap	16.39	1368.57		090	1	3052.30	971.11	2185.85
46320		Excision of thrombosed hemorrhoid, external	5.61	468.44		010	1	1649.83	319.81	2185.85
46500		Injection of sclerosing solution, hemorrhoids	7.33	612.06		010	1	566.80	344.02	1287.06
46505		Chemodenervation of internal anal sphincter	8.73	728.96		010	1	1649.83	506.01	2185.85
46600		Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.73	227.96		000	1	64.04	169.51	61.03
46604		Anoscopy; with dilation (eg, balloon, guide wire, bougie	19.66	1641.61		000	1	923.14	941.05	843.05
46606		Anoscopy; with biopsy, single or multiple	7.03	587.01		000	1	923.14	386.61	526.59
46608		Anoscopy; with removal of foreign body	7.22	602.87		000	0	923.14	484.30	843.05
46610		Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	7.06	589.51		000	1	1975.34	450.07	2081.03
46611		Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique	5.37	448.40		000	0	923.14	419.17	843.05
46612		Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	8.58	716.43		000	0	1975.34	632.93	2081.03
46614		Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	3.92	327.32		000	1	542.25	366.57	526.59
46615		Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	4.40	367.40		000	0	1975.34	431.70	2081.03
46700		Anoplasty, plastic operation for stricture; adult	19.57	1634.10		090	1	2360.12	1177.35	2185.85
46705		Anoplasty, plastic operation for stricture; infant	15.41	1286.74		090	2		940.21	2097.37**
46706		Repair of anal fistula with fibrin glue	5.08	424.18		010	1	2360.12	313.13	2934.60

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
46707		Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	13.88	1158.98		090	0	3052.30	1027.05	2934.60
46710		Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach	32.78	2737.13		090	2		2041.58	2097.37**
46712		Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach	60.38	5041.73		090	2		4274.37	2097.37**
46715		Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)	14.78	1234.13		090	2		944.39	2097.37**
46716		Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula	33.01	2756.34		090	2		2119.23	2097.37**
46730		Repair of high imperforate anus without fistula; perineal or sacroperineal approach	53.75	4488.13		090	2		3465.25	2097.37**
46735		Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches	59.92	5003.32		090	2		4078.14	2097.37**
46740		Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	59.03	4929.01		090	2		3844.34	2097.37**
46742		Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches	71.54	5973.59		090	2		4670.16	2097.37**
46744		Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach	99.58	8314.93		090	2		6693.36	2097.37**
46746		Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;	103.32	8627.22		090	2		7504.98	2097.37**
46748		Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps	113.59	9484.77		090	2		7526.69	2097.37**
46750		Sphincteroplasty, anal, for incontinence or prolapse; adult	22.72	1897.12		090	2	3052.30	1432.86	2934.60
46751		Sphincteroplasty, anal, for incontinence or prolapse; child	17.93	1497.16		090	2		1199.90	2097.37**
46753		Graft (Thiersch operation) for rectal incontinence and/or prolapse	17.58	1467.93		090	1	2360.12	1077.15	2185.85
46754		Removal of Thiersch wire or suture, anal canal	9.12	761.52		010	0	1649.83	534.40	2185.85
46760		Sphincteroplasty, anal, for incontinence, adult; muscle transplant	32.72	2732.12		090	2	3052.30	2040.74	2934.60
46761		Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)	27.65	2308.78		090	2	3052.30	1769.37	2934.60
46762		Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter	27.60	2304.60		090	2	3052.30	1693.38	2934.60
46900		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	7.39	617.07		010	1	270.47	394.96	255.17
46910		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	7.82	652.97		010	1	1829.09	420.01	1939.18
46916		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	7.00	584.50		010	1	137.98	426.69	140.54
46917		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	14.09	1176.52		010	1	1829.09	910.15	1939.18
46922		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	8.23	687.21		010	1	1829.09	450.07	1939.18
46924		Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	16.57	1383.60		010	1	1829.09	974.45	1939.18
46930		Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	6.27	523.55		090	0	566.80	436.71	489.23
46940		Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initia	6.99	583.67		010	1	1649.83	378.26	2185.85
46942		Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); subsequent	6.62	552.77		010	0	566.80	342.35	489.23
46945		Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group	9.45	789.08		090	1	2360.12	480.96	1287.06
46946		Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups	9.56	798.26		090	1	2360.12	547.76	1287.06
46947		Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	11.45	956.08		090	1	3052.30	709.75	2934.60
46999		Unlisted procedure, anus	0.00	BR		YYY	0	566.80	BR	489.23
47000		Biopsy of liver, needle; percutaneous	11.03	921.01		000	1	920.55	496.83	881.50

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
47001		Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (List separately in addition to code for primary procedure)	3.02	252.17		ZZZ	1		214.60	
47010		Hepatotomy; for open drainage of abscess or cyst, 1 or 2 stages	35.60	2972.60		090	2		2293.75	2097.37**
47011		Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages	5.33	445.06		000	1	1443.01	393.29	1413.47
47015		Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	34.43	2874.91		090	2		2164.32	2097.37**
47100		Biopsy of liver, wedge	25.11	2096.69		090	2		1597.36	2097.37**
47120		Hepatectomy, resection of liver; partial lobectomy	68.63	5730.61		090	2		4546.58	2097.37**
47122		Hepatectomy, resection of liver; trisegmentectomy	100.64	8403.44		090	2		6795.23	2097.37**
47125		Hepatectomy, resection of liver; total left lobectomy	90.41	7549.24		090	2		6092.16	2097.37**
47130		Hepatectomy, resection of liver; total right lobectomy	96.86	8087.81		090	2		6556.42	2097.37**
47133		Donor hepatectomy (including cold preservation), from cadaver donor	0.00	BR		XXX	9		BR	2097.37**
47135		Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	144.20	12040.70		090	2		9640.91	2097.37**
47136		Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age	123.70	10328.95		090	2		8178.83	2097.37**
47140		Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)	105.31	8793.39		090	2		6729.27	2097.37**
47141		Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)	115.60	9652.60		090	2		8002.64	2097.37**
47142		Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	138.53	11567.26		090	2		8801.74	2097.37**
47143		Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and comm	0.00	BR		XXX	2		BR	2097.37**
47144		Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and comm	0.00	BR		090	2		BR	2097.37**
47145		Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and comm	0.00	BR		XXX	2		BR	2097.37**
47146		Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each	9.65	805.78		XXX	2		680.53	2097.37**
47147		Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each	11.26	940.21		XXX	2		794.09	2097.37**
47300		Marsupialization of cyst or abscess of liver	33.58	2803.93		090	2		2130.92	2097.37**
47350		Management of liver hemorrhage; simple suture of liver wound or injury	40.52	3383.42		090	2		2636.10	2097.37**
47360		Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	55.38	4624.23		090	2		3585.49	2097.37**
47361		Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver	89.00	7431.50		090	2		5941.03	2097.37**
47362		Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	42.81	3574.64		090	2		2707.07	2097.37**
47370		Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	36.55	3051.93		090	2	11714.80	2435.70	10023.94
47371		Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	37.09	3097.02		090	2	11714.80	2449.89	10023.94
47379		Unlisted laparoscopic procedure, liver	0.00	BR		YYY	2	3522.03	BR	3470.14
47380		Ablation, open, of 1 or more liver tumor(s); radiofrequency	42.32	3533.72		090	2		2837.33	2097.37**
47381		Ablation, open, of 1 or more liver tumor(s); cryosurgical	43.66	3645.61		090	2		2882.42	2097.37**
47382		Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	152.55	12737.93		010	1	5220.48	1707.58	4683.68
47399		Unlisted procedure, liver	0.00	BR		YYY	1	445.75	BR	419.39
47400		Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	63.50	5302.25		090	2		4093.17	2097.37**
47420		Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty	39.80	3323.30		090	2		2593.51	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
47425		Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	40.41	3374.24		090	2		2616.89	2097.37**
47460		Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)	37.52	3132.92		090	2		2429.02	2097.37**
47480		Cholecystotomy or cholecystostomy, open, with exploration, drainage, or removal of calculus (separate procedure)	26.07	2176.85		090	2		1612.39	2097.37**
47490		Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation	9.84	821.64		010	1	2615.99	1084.67	2803.45
47500		Injection procedure for percutaneous transhepatic cholangiography	2.84	237.14		000	1		208.75	
47505		Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)	1.09	91.02		000	0		80.16	
47510		Introduction of percutaneous transhepatic catheter for biliary drainage	13.85	1156.48		090	1	2615.99	1032.06	2803.45
47511		Introduction of percutaneous transhepatic stent for internal and external biliary drainage	16.96	1416.16		090	1	2615.99	1265.03	2803.45
47525		Change of percutaneous biliary drainage catheter	15.03	1255.01		000	1	1550.17	1680.02	1396.15
47530		Revision and/or reinsertion of transhepatic tube	41.94	3501.99		090	1	1550.17	3197.22	1396.15
47550		Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	4.85	404.98		ZZZ	2		340.68	2097.37**
47552		Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)	9.19	767.37		000	1	2615.99	679.69	2803.45
47553		Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple	9.17	765.70		000	1	2615.99	674.68	2803.45
47554		Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calcul	14.37	1199.90		000	1	2615.99	1030.39	2803.45
47555		Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent	10.85	905.98		000	1	2615.99	804.94	2803.45
47556		Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent	12.33	1029.56		000	1	5220.48	909.32	2803.45
47560		Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy	7.86	656.31		000	0	3522.03	551.94	3470.14
47561		Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy	8.65	722.28		000	0	3522.03	595.36	3470.14
47562		Laparoscopy, surgical; cholecystectomy	19.49	1627.42		090	2	4498.73	1417.83	4271.34
47563		Laparoscopy, surgical; cholecystectomy with cholangiography	21.16	1766.86		090	2	4498.73	1472.94	4271.34
47564		Laparoscopy, surgical; cholecystectomy with exploration of common duc	32.97	2753.00		090	2	4498.73	1710.92	4271.34
47570		Laparoscopy, surgical; cholecystoenterostomy	22.92	1913.82		090	2		1522.21	2097.37**
47579		Unlisted laparoscopy procedure, biliary tract	0.00	BR		YYY	2	3522.03	BR	3470.14
47600		Cholecystectomy;	31.60	2638.60		090	2		1987.30	2097.37**
47605		Cholecystectomy; with cholangiography	33.25	2776.38		090	2		1897.12	2097.37**
47610		Cholecystectomy with exploration of common duct	37.06	3094.51		090	2		2429.85	2097.37**
47612		Cholecystectomy with exploration of common duct; with choledochoenterostomy	37.41	3123.74		090	2		2448.22	2097.37**
47620		Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography	40.69	3397.62		090	2		2660.31	2097.37**
47630		Biliary duct stone extraction, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique)	16.16	1349.36		090	1	2615.99	1166.50	2803.45
47700		Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	31.21	2606.04		090	2		2019.03	2097.37**
47701		Portoenterostomy (eg, Kasai procedure)	51.20	4275.20		090	0		3385.93	2097.37**
47711		Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic	45.77	3821.80		090	2		3011.01	2097.37**
47712		Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic	58.95	4922.33		090	2		3869.39	2097.37**
47715		Excision of choledochal cyst	39.36	3286.56		090	2		2523.37	2097.37**
47720		Cholecystoenterostomy; direct	34.16	2852.36		090	2		2172.67	2097.37**
47721		Cholecystoenterostomy; with gastroenterostomy	40.07	3345.85		090	2		2568.46	2097.37**
47740		Cholecystoenterostomy; Roux-en-Y	38.83	3242.31		090	2		2488.30	2097.37**
47741		Cholecystoenterostomy; Roux-en-Y with gastroenterostomy	43.63	3643.11		090	2		2818.96	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
47760		Anastomosis, of extrahepatic biliary ducts and gastrointestinal trac	66.38	5542.73		090	2		4102.36	2097.37**
47765		Anastomosis, of intrahepatic ducts and gastrointestinal trac	89.48	7471.58		090	2		5211.24	2097.37**
47780		Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal trac	72.80	6078.80		090	2		4453.06	2097.37**
47785		Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal trac	95.37	7963.40		090	2		5731.44	2097.37**
47800		Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	46.72	3901.12		090	2		3046.08	2097.37**
47801		Placement of choledochal stent	30.00	2505.00		090	2		2077.48	2097.37**
47802		U-tube hepaticoenterostomy	45.13	3768.36		090	2		2904.97	2097.37**
47900		Suture of extrahepatic biliary duct for pre-existing injury (separate procedure	40.68	3396.78		090	2		2634.43	2097.37**
47999		Unlisted procedure, biliary tract	0.00	BR		YYY	1	2615.99	BR	2803.45
48000		Placement of drains, peripancreatic, for acute pancreatitis;	54.58	4557.43		090	2		3627.24	2097.37**
48001		Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy	67.99	5677.17		090	2		4496.48	2097.37**
48020		Removal of pancreatic calculus	34.84	2909.14		090	2		2217.76	2097.37**
48100		Biopsy of pancreas, open (eg, fine needle aspiration, needle core biopsy, wedge biopsy	26.21	2188.54		090	2		1687.54	2097.37**
48102		Biopsy of pancreas, percutaneous needle	15.79	1318.47		010	1	920.55	1060.45	881.50
48105		Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis	83.98	7012.33		090	2		5518.52	2097.37**
48120		Excision of lesion of pancreas (eg, cyst, adenoma)	32.79	2737.97		090	2		2125.08	2097.37**
48140		Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostom	46.04	3844.34		090	2		3012.68	2097.37**
48145		Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	48.17	4022.20		090	2		3131.25	2097.37**
48146		Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure	55.17	4606.70		090	2		3574.64	2097.37**
48148		Excision of ampulla of Vater	36.91	3081.99		090	2		2358.04	2097.37**
48150		Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	91.42	7633.57		090	2		6078.80	2097.37**
48152		Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	85.13	7108.36		090	2		5610.37	2097.37**
48153		Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	91.09	7606.02		090	2		6076.30	2097.37**
48154		Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	85.50	7139.25		090	2		5640.43	2097.37**
48155		Pancreatectomy, total	53.74	4487.29		090	2		3451.06	2097.37**
48160		Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	92.46	7720.41		XXX	9		4682.68	2097.37**
48400		Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)	3.27	273.05		ZZZ	0		216.27	2097.37**
48500		Marsupialization of pancreatic cyst	34.13	2849.86		090	2		2150.13	2097.37**
48510		External drainage, pseudocyst of pancreas; oper	32.07	2677.85		090	2		2056.61	2097.37**
48511		External drainage, pseudocyst of pancreas; percutaneous	28.01	2338.84		000	1	1443.01	2025.71	1413.47
48520		Internal anastomosis of pancreatic cyst to gastrointestinal tract; direc	32.32	2698.72		090	2		2090.01	2097.37**
48540		Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y	38.66	3228.11		090	2		2529.22	2097.37**
48545		Pancreatorrhaphy for injury	39.75	3319.13		090	2		2527.55	2097.37**
48547		Duodenal exclusion with gastrojejunostomy for pancreatic injury	52.83	4411.31		090	2		3428.51	2097.37**
48548		Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation	49.05	4095.68		090	2		3216.42	2097.37**
48550		Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	0.00	BR		XXX	9		BR	2097.37**
48551		Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arte	0.00	BR		XXX	2		BR	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
48552		Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each	6.90	576.15		XXX	2		464.26	2097.37**
48554		Transplantation of pancreatic allograft	76.29	6370.22		090	2		4701.89	2097.37**
48556		Removal of transplanted pancreatic allograft	37.89	3163.82		090	2		2319.63	2097.37**
48999		Unlisted procedure, pancreas	0.00	BR		YYY	2	445.75	BR	419.39
49000		Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure	22.80	1903.80		090	2		1506.34	2097.37**
49002		Reopening of recent laparotomy	30.89	2579.32		090	2		1880.42	2097.37**
49010		Exploration, retroperitoneal area with or without biopsy(s) (separate procedure	27.64	2307.94		090	2		1826.98	2097.37**
49020		Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; oper	46.97	3922.00		090	2		3068.63	2097.37**
49021		Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous	26.48	2211.08		000	1	1443.01	1975.61	1413.47
49040		Drainage of subdiaphragmatic or subphrenic abscess; oper	29.71	2480.79		090	2		1912.15	2097.37**
49041		Drainage of subdiaphragmatic or subphrenic abscess; percutaneous	27.59	2303.77		000	1	1443.01	1933.86	1413.47
49060		Drainage of retroperitoneal abscess; open	32.45	2709.58		090	1		2144.28	2097.37**
49061		Drainage of retroperitoneal abscess; percutaneous	26.95	2250.33		000	1	1443.01	1913.82	1413.47
49062		Drainage of extraperitoneal lymphocele to peritoneal cavity, oper	21.84	1823.64		090	2		1474.61	2097.37**
49082		Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	5.31	443.39		000	1	532.02	New	
49083		Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	9.57	799.10		000	1	532.02	New	
49084		Peritoneal lavage, including imaging guidance, when performed	2.99	249.67		000	1	532.02	New	
49180		Biopsy, abdominal or retroperitoneal mass, percutaneous needle	4.82	402.47		000	1	920.55	379.93	881.50
49203		Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less	35.19	2938.37		090	2		2313.36	2097.37**
49204		Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1-10.0 cm diameter	44.87	3746.65		090	2		2949.24	2097.37**
49205		Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter	51.53	4302.76		090	2		3374.28	2097.37**
49215		Excision of presacral or sacrococcygeal tumor	65.04	5430.84		090	2		4339.50	2097.37**
49220		Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	28.07	2343.85		090	2		1882.09	2097.37**
49250		Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	17.35	1448.73		090	1	2389.99	1117.23	2479.05
49255		Omentectomy, epiploectomy, resection of omentum (separate procedure)	23.50	1962.25		090	2		1519.70	2097.37**
49320		Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	9.73	812.46		010	2	3522.03	652.97	3470.14
49321		Laparoscopy, surgical; with biopsy (single or multiple)	10.31	860.89		010	2	3522.03	682.20	3470.14
49322		Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple	11.01	919.34		010	2	3522.03	749.00	3470.14
49323		Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity	19.22	1604.87		090	2	3522.03	1239.98	3470.14
49324		Laparoscopy, surgical; with insertion of tunneled intraperitoneal cathete	11.69	976.12		010	2	3522.03	765.70	3470.14
49325		Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	12.48	1042.08		010	2	3522.03	824.98	3470.14
49326		Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)	5.54	462.59		ZZZ	2	3522.03	376.59	3470.14
49327		Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List sepa	3.80	317.30		ZZZ	2	3522.03	New	
49329		Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	0.00	BR		YYY	2	3522.03	BR	3470.14
49400		Injection of air or contrast into peritoneal cavity (separate procedure)	4.03	336.51		000	1		394.12	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
49402		Removal of peritoneal foreign body from peritoneal cavity	25.30	2112.55		090	1	2389.99	1647.46	2479.05
49411		Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	16.24	1356.04		000	0	1270.08	1167.33	1254.56
49412		Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to co	2.39	199.57		ZZZ	0		New	
49418		Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological superv	44.14	3685.69		000	0	2914.41	New	
49419		Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable	12.95	1081.33		090	1	3457.08	889.28	2824.92
49421		Insertion of tunneled intraperitoneal catheter for dialysis, oper	6.77	565.30		000	1	2914.41	765.70	2777.67
49422		Removal of tunneled intraperitoneal catheter	11.32	945.22		010	1	2171.38	774.88	2092.01
49423		Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)	16.74	1397.79		000	0	1550.17	1258.35	1396.15
49424		Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)	4.42	369.07		000	0		353.21	
49425		Insertion of peritoneal-venous shunt	22.33	1864.56		090	2		1499.66	2097.37**
49426		Revision of peritoneal-venous shunt	18.57	1550.60		090	1	2389.99	1275.05	2479.05
49427		Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shun	1.32	110.22		000	0		96.86	
49428		Ligation of peritoneal-venous shunt	12.80	1068.80		010	1		886.77	2097.37**
49429		Removal of peritoneal-venous shunt	13.09	1093.02		010	1	2171.38	917.67	2092.01
49435		Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (List separately in addition to code for primary procedure)	3.51	293.09		ZZZ	2	1550.17	242.15	1396.15
49436		Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	5.60	467.60		010	2	1550.17	361.56	1396.15
49440		Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	32.08	2678.68		010	0	1195.63	2455.32	797.57
49441		Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	36.03	3008.51		010	0	1195.63	2908.08	797.57
49442		Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	28.63	2390.61		010	0	1649.83	2370.48	1287.06
49446		Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	30.46	2543.41		000	0	1195.63	2425.08	797.57
49450		Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	20.52	1713.42		000	0	567.16	1701.00	581.26
49451		Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	22.38	1868.73		000	0	567.16	1800.96	581.26
49452		Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	27.48	2294.58		000	0	567.16	2201.64	581.26
49460		Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation an	22.63	1889.61		000	0	567.16	1805.16	581.26
49465		Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report	5.04	420.84		000	0	158.44	375.48	118.41
49491		Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible	23.50	1962.25		090	2	3133.77	1479.62	2915.18

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
49492		Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	27.55	2300.43		090	2	3133.77	1806.11	2915.18
49495		Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; reducible	11.69	976.12		090	2	3133.77	770.71	2915.18
49496		Repair, initial inguinal hernia, full term infant younger than age 6 months, or preterm infant older than 50 weeks postconception age and younger than age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated	16.94	1414.49		090	2	3133.77	1147.29	2915.18
49500		Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	11.09	926.02		090	2	3133.77	762.36	2915.18
49501		Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	17.95	1498.83		090	2	3133.77	1142.28	2915.18
49505		Repair initial inguinal hernia, age 5 years or older; reducible	15.45	1290.08		090	2	3133.77	993.65	2915.18
49507		Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulatec	17.37	1450.40		090	2	3133.77	1227.45	2915.18
49520		Repair recurrent inguinal hernia, any age; reducible	18.71	1562.29		090	2	3133.77	1219.94	2915.18
49521		Repair recurrent inguinal hernia, any age; incarcerated or strangulatec	21.18	1768.53		090	2	3133.77	1493.82	2915.18
49525		Repair inguinal hernia, sliding, any age	16.97	1417.00		090	2	3133.77	1100.53	2915.18
49540		Repair lumbar hernia	20.01	1670.84		090	2	3133.77	1309.28	2915.18
49550		Repair initial femoral hernia, any age; reducible	17.08	1426.18		090	2	3133.77	1108.05	2915.18
49553		Repair initial femoral hernia, any age; incarcerated or strangulatec	18.70	1561.45		090	2	3133.77	1210.75	2915.18
49555		Repair recurrent femoral hernia; reducible	17.68	1476.28		090	2	3133.77	1153.97	2915.18
49557		Repair recurrent femoral hernia; incarcerated or strangulated	21.37	1784.40		090	2	3133.77	1402.80	2915.18
49560		Repair initial incisional or ventral hernia; reducible	21.80	1820.30		090	2	3133.77	1440.38	2915.18
49561		Repair initial incisional or ventral hernia; incarcerated or strangulatec	27.47	2293.75		090	2	3133.77	1807.78	2915.18
49565		Repair recurrent incisional or ventral hernia; reducible	22.72	1897.12		090	2	3133.77	1482.96	2915.18
49566		Repair recurrent incisional or ventral hernia; incarcerated or strangulatec	27.76	2317.96		090	2	3133.77	1826.15	2915.18
49568		Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	7.84	654.64		ZZZ	2	3133.77	551.10	2915.18
49570		Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)	12.43	1037.91		090	2	3133.77	779.06	2915.18
49572		Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulatec	15.32	1279.22		090	2	3133.77	956.08	2915.18
49580		Repair umbilical hernia, younger than age 5 years; reducible	9.97	832.50		090	2	3133.77	599.53	2915.18
49582		Repair umbilical hernia, younger than age 5 years; incarcerated or strangulatec	14.37	1199.90		090	2	3133.77	895.12	2915.18
49585		Repair umbilical hernia, age 5 years or older; reducible	13.22	1103.87		090	2	3133.77	837.51	2915.18
49587		Repair umbilical hernia, age 5 years or older; incarcerated or strangulatec	14.15	1181.53		090	2	3133.77	995.32	2915.18
49590		Repair spigelian hernia	16.99	1418.67		090	2	3133.77	1098.03	2915.18
49600		Repair of small omphalocele, with primary closure	21.62	1805.27		090	2	3133.77	1413.66	2915.18
49605		Repair of large omphalocele or gastroschisis; with or without prosthesis	144.90	12099.15		090	2		9643.42	2097.37**
49606		Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	33.38	2787.23		090	2		2246.15	2097.37**
49610		Repair of omphalocele (Gross type operation); first stage	18.30	1528.05		090	2		1325.98	2097.37**
49611		Repair of omphalocele (Gross type operation); second stage	15.25	1273.38		090	2		1273.38	2097.37**
49650		Laparoscopy, surgical; repair initial inguinal hernia	12.74	1063.79		090	2	4498.73	820.81	4271.34
49651		Laparoscopy, surgical; repair recurrent inguinal hernia	16.58	1384.43		090	2	4498.73	1059.62	4271.34
49652		Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	20.36	1700.06		090	2	6607.04	1623.24	6653.06
49653		Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	25.39	2120.07		090	2	6607.04	2031.56	6653.06

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
49654		Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	23.08	1927.18		090	2	6607.04	1865.39	6653.06
49655		Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	28.16	2351.36		090	2	6607.04	2246.15	6653.06
49656		Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	25.02	2089.17		090	2	6607.04	1870.40	6653.06
49657		Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	35.90	2997.65		090	2	6607.04	2697.89	6653.06
49659		Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	0.00	BR		YYY	2	3522.03	BR	3470.14
49900		Suture, secondary, of abdominal wall for evisceration or dehiscence	24.26	2025.71		090	2		1577.32	2097.37**
49904		Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)	43.22	3608.87		090	1		3099.52	2097.37**
49905		Omental flap, intra-abdominal (List separately in addition to code for primary procedure	10.34	863.39		ZZZ	2		733.97	2097.37**
49906		Free omental flap with microvascular anastomosis	0.00	BR		090	1		BR	2097.37**
49999		Unlisted procedure, abdomen, peritoneum and omentum	0.00	BR		YYY	1	2389.99	BR	2479.05
50010		Renal exploration, not necessitating other specific procedures	21.53	1797.76		090	2		1459.58	2097.37**
50020		Drainage of perirenal or renal abscess; open	31.15	2601.03		090	1	2462.59	2116.73	2327.38
50021		Drainage of perirenal or renal abscess; percutaneous	28.15	2350.53		000	1	1443.01	2042.41	1413.47
50040		Nephrostomy, nephrotomy with drainage	26.79	2236.97		090	1		1935.53	2097.37**
50045		Nephrotomy, with exploration	26.91	2246.99		090	2		1946.39	2097.37**
50060		Nephrolithotomy; removal of calculus	32.87	2744.65		090	2		2400.63	2097.37**
50065		Nephrolithotomy; secondary surgical operation for calculus	34.87	2911.65		090	2		2424.84	2097.37**
50070		Nephrolithotomy; complicated by congenital kidney abnormality	34.20	2855.70		090	2		2507.51	2097.37**
50075		Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)	42.03	3509.51		090	2		3082.82	2097.37**
50080		Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm	25.13	2098.36		090	1	4207.02	1833.66	4256.75
50081		Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm	36.87	3078.65		090	2	4207.02	2687.87	4256.75
50100		Transection or repositioning of aberrant renal vessels (separate procedure)	29.87	2494.15		090	2		2110.05	2097.37**
50120		Pyelotomy; with exploration	27.40	2287.90		090	2		1991.48	2097.37**
50125		Pyelotomy; with drainage, pyelostomy	30.39	2537.57		090	2		2090.01	2097.37**
50130		Pyelotomy; with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)	29.81	2489.14		090	2		2165.99	2097.37**
50135		Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality	32.37	2702.90		090	2		2361.38	2097.37**
50200		Renal biopsy; percutaneous, by trocar or needle	17.84	1489.64		000	1	920.55	314.80	881.50
50205		Renal biopsy; by surgical exposure of kidney	22.18	1852.03		090	2		1454.57	2097.37**
50220		Nephrectomy, including partial ureterectomy, any open approach including rib resection	30.31	2530.89		090	2		2160.98	2097.37**
50225		Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	34.69	2896.62		090	2		2501.66	2097.37**
50230		Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	36.97	3087.00		090	2		2694.55	2097.37**
50234		Nephrectomy with total ureterectomy and bladder cuff; through same incision	37.54	3134.59		090	2		2738.80	2097.37**
50236		Nephrectomy with total ureterectomy and bladder cuff; through separate incision	42.30	3532.05		090	2		3095.35	2097.37**
50240		Nephrectomy, partial	38.23	3192.21		090	2		2765.52	2097.37**
50250		Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	35.20	2939.20		090	2		2570.97	2097.37**
50280		Excision or unroofing of cyst(s) of kidney	27.71	2313.79		090	2		1987.30	2097.37**
50290		Excision of perinephric cyst	25.95	2166.83		090	2		1896.29	2097.37**
50300		Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilatera	0.00	BR		XXX	9		BR	2097.37**
50320		Donor nephrectomy (including cold preservation); open, from living donor	42.60	3557.10		090	2		2797.25	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
50323		Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal ve	0.00	BR		XXX	2		BR	2097.37**
50325		Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as nec	0.00	BR		XXX	2		BR	2097.37**
50327		Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each	6.32	527.72		XXX	2		432.53	2097.37**
50328		Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each	5.52	460.92		XXX	2		379.09	2097.37**
50329		Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each	5.09	425.02		XXX	2		362.39	2097.37**
50340		Recipient nephrectomy (separate procedure)	28.24	2358.04		090	2		1745.15	2097.37**
50360		Renal allotransplantation, implantation of graft; without recipient nephrectomy	76.07	6351.85		090	2		4719.42	2097.37**
50365		Renal allotransplantation, implantation of graft; with recipient nephrectomy	84.50	7055.75		090	2		5347.34	2097.37**
50370		Removal of transplanted renal allograft	35.53	2966.76		090	2		2184.36	2097.37**
50380		Renal autotransplantation, reimplantation of kidney	59.53	4970.76		090	2		3532.89	2097.37**
50382		Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	35.94	3000.99		000	1	2462.59	3222.27	2327.38
50384		Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation	28.78	2403.13		000	1	1459.44	3015.19	1553.37
50385		Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	34.62	2890.77		000	0	2462.59	2924.88	2327.38
50386		Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	22.41	1871.24		000	0	657.63	1889.16	650.57
50387		Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation	16.78	1401.13		000	0	1550.17	1551.43	1396.15
50389		Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)	9.09	759.02		000	1	657.63	1019.54	650.57
50390		Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous	2.82	235.47		000	1	920.55	208.75	881.50
50391		Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)	3.55	296.43		000	1	105.77	288.91	99.93
50392		Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	5.23	436.71		000	1	1459.44	391.62	1553.37
50393		Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous	6.35	530.23		000	1	2462.59	475.12	2327.38
50394		Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	3.05	254.68		000	1		265.53	
50395		Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous	5.24	437.54		000	1	2462.59	393.29	2327.38
50396		Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral cathete	3.28	273.88		000	0	197.05	254.68	184.15
50398		Change of nephrostomy or pyelostomy tube	15.12	1262.52		000	1	1550.17	1374.41	1396.15
50400		Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple	33.44	2792.24		090	2		2429.85	2097.37**
50405		Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidn	40.25	3360.88		090	2		2921.67	2097.37**
50500		Nephrorrhaphy, suture of kidney wound or injury	37.30	3114.55		090	2		2470.77	2097.37**
50520		Closure of nephrocutaneous or pyelocutaneous fistula	29.91	2497.49		090	2		2195.22	2097.37**
50525		Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach	43.30	3615.55		090	2		2765.52	2097.37**
50526		Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach	41.87	3496.15		090	2		2914.15	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
50540		Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (1 operation)	33.10	2763.85		090	2		2435.70	2097.37**
50541		Laparoscopy, surgical; ablation of renal cysts	26.57	2218.60		090	2	3522.03	1943.88	3470.14
50542		Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	33.68	2812.28		090	2	11714.80	2452.40	10023.94
50543		Laparoscopy, surgical; partial nephrectomy	43.00	3590.50		090	2	4498.73	3131.25	4271.34
50544		Laparoscopy, surgical; pyeloplasty	35.96	3002.66		090	2	4498.73	2656.97	3470.14
50545		Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	38.72	3233.12		090	2		2850.69	2097.37**
50546		Laparoscopy, surgical; nephrectomy, including partial ureterectomy	34.75	2901.63		090	2		2524.21	2097.37**
50547		Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living dono	47.32	3951.22		090	2		3162.15	2097.37**
50548		Laparoscopy, surgical; nephrectomy with total ureterectomy	38.84	3243.14		090	2		2875.74	2097.37**
50549		Unlisted laparoscopy procedure, renal	0.00	BR		YYY	2	3522.03	BR	3470.14
50551		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	10.40	868.40		000	0	657.63	809.12	650.57
50553		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	11.21	936.04		000	1	2462.59	845.02	2327.38
50555		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	11.91	994.49		000	0	657.63	935.20	650.57
50557		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	12.12	1012.02		000	0	2462.59	933.53	2327.38
50561		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	13.75	1148.13		000	0	2462.59	1052.94	2327.38
50562		Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor	16.78	1401.13		090	2	657.63	1263.36	650.57
50570		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service;	14.15	1181.53		000	0	657.63	1063.79	650.57
50572		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	15.33	1280.06		000	0	657.63	1163.16	650.57
50574		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service; with biopsy	16.31	1361.89		000	0	657.63	1224.95	650.57
50575		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, inci	20.59	1719.27		000	1	3531.09	1549.76	3301.16
50576		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	16.25	1356.88		000	0	1459.44	1221.61	1553.37
50580		Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography exclusive of radiologic service; with removal of foreign body or calculus	17.52	1462.92		000	0	1459.44	1315.96	1553.37
50590		Lithotripsy, extracorporeal shock wave	20.99	1752.67		090	1	3661.65	1913.82	3771.86
50592		Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	94.61	7899.94		010	1	5220.48	11412.78	4683.68
50593		Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	139.84	11676.64		010	2	5220.48	10348.80	4683.68
50600		Ureterotomy with exploration or drainage (separate procedure)	27.09	2262.02		090	2		1973.11	2097.37**
50605		Ureterotomy for insertion of indwelling stent, all types	28.62	2389.77		090	2		1961.42	2097.37**
50610		Ureterolithotomy; upper 1/3 of ureter	27.28	2277.88		090	2		2034.06	2097.37**
50620		Ureterolithotomy; middle 1/3 of ureter	26.10	2179.35		090	2		1899.63	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
50630		Ureterolithotomy; lower 1/3 of ureter	25.78	2152.63		090	2		1866.23	2097.37**
50650		Ureterectomy, with bladder cuff (separate procedure)	29.94	2499.99		090	2		2171.00	2097.37**
50660		Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach	32.99	2754.67		090	2		2409.81	2097.37**
50684		Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter	3.15	263.03		000	1		455.91	
50686		Manometric studies through ureterostomy or indwelling ureteral catheter	4.43	369.91		000	0	105.77	380.76	99.93
50688		Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit	2.35	196.23		010	1	1550.17	178.69	1396.15
50690		Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service	2.87	239.65		000	1		235.47	
50700		Ureteroplasty, plastic operation on ureter (eg, stricture)	26.73	2231.96		090	2		1969.77	2097.37**
50715		Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis	35.14	2934.19		090	2		2446.55	2097.37**
50722		Ureterolysis for ovarian vein syndrome	31.14	2600.19		090	2		2152.63	2097.37**
50725		Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	31.80	2655.30		090	2		2339.67	2097.37**
50727		Revision of urinary-cutaneous anastomosis (any type urostomy)	14.70	1227.45		090	2	1818.44	1052.94	1826.02
50728		Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	20.20	1686.70		090	2		1483.80	2097.37**
50740		Ureteropyelostomy, anastomosis of ureter and renal pelvis	36.11	3015.19		090	2		2334.66	2097.37**
50750		Ureterocalycostomy, anastomosis of ureter to renal calyx	33.27	2778.05		090	2		2403.97	2097.37**
50760		Ureteroureterostomy	32.87	2744.65		090	2		2312.95	2097.37**
50770		Transureteroureterostomy, anastomosis of ureter to contralateral ureter	33.27	2778.05		090	2		2429.02	2097.37**
50780		Ureteroneocystostomy; anastomosis of single ureter to bladder	32.09	2679.52		090	2		2302.10	2097.37**
50782		Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	35.43	2958.41		090	2		2327.15	2097.37**
50783		Ureteroneocystostomy; with extensive ureteral tailoring	32.53	2716.26		090	2		2433.19	2097.37**
50785		Ureteroneocystostomy; with vesico-psoas hitch or bladder flap	34.95	2918.33		090	2		2535.06	2097.37**
50800		Ureteroenterostomy, direct anastomosis of ureter to intestine	26.90	2246.15		090	2		1919.67	2097.37**
50810		Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis	38.69	3230.62		090	2		2644.45	2097.37**
50815		Ureterocolon conduit, including intestine anastomosis	35.29	2946.72		090	2		2559.28	2097.37**
50820		Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)	38.16	3186.36		090	2		2747.15	2097.37**
50825		Continent diversion, including intestine anastomosis using any segment of small and/or large intestine (Kock pouch or Camey enterocystoplasty)	47.93	4002.16		090	2		3477.78	2097.37**
50830		Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)	51.96	4338.66		090	2		3817.62	2097.37**
50840		Replacement of all or part of ureter by intestine segment, including intestine anastomosis	35.49	2963.42		090	2		2569.30	2097.37**
50845		Cutaneous appendico-vesicostomy	36.20	3022.70		090	2		2618.56	2097.37**
50860		Ureterostomy, transplantation of ureter to skin	27.29	2278.72		090	2		1984.80	2097.37**
50900		Ureterorrhaphy, suture of ureter (separate procedure)	24.61	2054.94		090	2		1767.70	2097.37**
50920		Closure of ureterocutaneous fistula	25.46	2125.91		090	2		1848.69	2097.37**
50930		Closure of ureterovisceral fistula (including visceral repair)	34.14	2850.69		090	2		2327.15	2097.37**
50940		Deligation of ureter	25.64	2140.94		090	2		1863.72	2097.37**
50945		Laparoscopy, surgical; ureterolithotomy	28.08	2344.68		090	2	4498.73	2081.66	4271.34
50947		Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement	39.96	3336.66		090	2	4498.73	2975.94	4271.34
50948		Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement	36.76	3069.46		090	2	4498.73	2720.43	4271.34
50949		Unlisted laparoscopy procedure, ureter	0.00	BR		YYY	2	3522.03	BR	3470.14
50951		Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	10.85	905.98		000	0	657.63	842.52	650.57
50953		Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	11.52	961.92		000	0	657.63	884.27	650.57

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50955		Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	12.29	1026.22		000	0	2462.59	1057.11	2327.38
50957		Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	12.40	1035.40		000	0	2462.59	946.89	2327.38
50961		Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	11.17	932.70		000	0	2462.59	860.89	2327.38
50970		Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	10.68	891.78		000	0	657.63	802.44	650.57
50972		Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	10.34	863.39		000	0	657.63	775.72	650.57
50974		Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	13.63	1138.11		000	0	1459.44	1018.70	1553.37
50976		Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	13.44	1122.24		000	0	1459.44	1002.00	1553.37
50980		Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	10.26	856.71		000	0	2462.59	767.37	2327.38
51020		Cystotomy or cystostomy; with fulguration and/or insertion of radioactive materia	13.63	1138.11		090	2	2462.59	960.25	2327.38
51030		Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesior	13.64	1138.94		090	0	2462.59	975.28	2327.38
51040		Cystostomy, cystotomy with drainage	8.42	703.07		090	2	2462.59	609.55	2327.38
51045		Cystotomy, with insertion of ureteral catheter or stent (separate procedure	14.34	1197.39		090	2	657.63	976.12	650.57
51050		Cystolithotomy, cystotomy with removal of calculus, without vesical neck resectior	13.69	1143.12		090	2	2462.59	973.61	2327.38
51060		Transvesical ureterolithotomy	16.84	1406.14		090	2	3531.09	1206.58	3301.16
51065		Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus	16.76	1399.46		090	0	2462.59	1196.56	2327.38
51080		Drainage of perivesical or prevesical space abscess	11.86	990.31		090	2	1701.78	844.19	1769.66
51100		Aspiration of bladder; by needle	1.82	151.97		000	1	197.05	139.44	184.15
51101		Aspiration of bladder; by trocar or intracatheter	3.74	312.29		000	1	105.77	286.44	99.93
51102		Aspiration of bladder; with insertion of suprapubic catheter	6.69	558.62		000	1	1818.44	738.36	1826.02
51500		Excision of urachal cyst or sinus, with or without umbilical hernia repair	18.42	1538.07		090	2	3133.77	1341.85	2915.18
51520		Cystotomy; for simple excision of vesical neck (separate procedure)	17.20	1436.20		090	2	2462.59	1244.99	2327.38
51525		Cystotomy; for excision of bladder diverticulum, single or multiple (separate procedure)	24.87	2076.65		090	2		1796.92	2097.37**
51530		Cystotomy; for excision of bladder tumor	22.97	1918.00		090	2		1620.74	2097.37**
51535		Cystotomy for excision, incision, or repair of ureterocele	22.50	1878.75		090	2	2462.59	1677.52	2327.38
51550		Cystectomy, partial; simple	28.11	2347.19		090	2		2002.33	2097.37**
51555		Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location	36.81	3073.64		090	2		2656.14	2097.37**
51565		Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy	37.47	3128.75		090	2		2717.09	2097.37**
51570		Cystectomy, complete; (separate procedure)	42.69	3564.62		090	2		3087.00	2097.37**
51575		Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	52.47	4381.25		090	2		3842.67	2097.37**
51580		Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations	54.66	4564.11		090	2		3981.28	2097.37**
51585		Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	60.84	5080.14		090	2		4441.37	2097.37**
51590		Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;	55.74	4654.29		090	2		4063.95	2097.37**
51595		Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	63.14	5272.19		090	2		4608.37	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
51596		Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder	67.84	5664.64		090	2		4942.37	2097.37**
51597		Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination there	66.22	5529.37		090	2		4788.73	2097.37**
51600		Injection procedure for cystography or voiding urethrocystography	5.43	453.41		000	1		472.61	
51605		Injection procedure and placement of chain for contrast and/or chain urethrocystography	1.11	92.69		000	1		82.67	
51610		Injection procedure for retrograde urethrocystography	3.13	261.36		000	1		266.37	
51700		Bladder irrigation, simple, lavage and/or instillation	2.44	203.74		000	1	197.05	202.91	184.15
51701		Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine	1.62	135.27		000	1	64.04	161.99	61.03
51702		Insertion of temporary indwelling bladder catheter; simple (eg, Foley	2.10	175.35		000	1	64.04	202.91	61.03
51703		Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	3.80	317.30		000	1	105.77	337.34	99.93
51705		Change of cystostomy tube; simple	2.68	223.78		000	1	197.05	268.04	184.15
51710		Change of cystostomy tube; complicated	2.73	227.96		000	1	567.16	387.44	581.26
51715		Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	8.47	707.25		000	0	3061.66	641.28	2861.27
51720		Bladder instillation of anticarcinogenic agent (including retention time)	3.16	263.86		000	1	299.71	268.04	275.52
51725		Simple cystometrogram (CMG) (eg, spinal manometer)	5.59	466.77	184.54	000	0	299.71	566.13	275.52
51726		Complex cystometrogram (ie, calibrated electronic equipment)	7.88	657.98	206.25	000	1	299.71	762.36	275.52
51727		Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique	9.43	787.41	263.03	000	0	299.71	674.68	275.52
51728		Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique	9.38	783.23	253.84	000	0	299.71	673.85	275.52
51729		Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique	10.21	852.54	309.79	000	0	299.71	724.78	275.52
51736		Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	0.45	37.58	20.04	XXX	0	64.04	106.88	99.93
51741		Complex uroflowmetry (eg, calibrated electronic equipment)	0.46	38.41	20.04	XXX	1	105.77	171.18	99.93
51784		Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	5.72	477.62	185.37	000	1	105.77	458.42	99.93
51785		Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	7.63	637.11	192.89	000	0	197.05	500.17	184.15
51792		Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)	6.35	530.23	134.44	000	0	105.77	578.66	99.93
51797		Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	3.34	278.89	96.03	ZZZ	0	197.05	597.86	184.15
51798		Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	0.58	48.43	0.00	XXX	0	64.04	40.08	61.03
51800		Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical neck	30.20	2521.70		090	2		2203.57	2097.37**
51820		Cystourethroplasty with unilateral or bilateral ureteroneocystostomy	31.27	2611.05		090	2		2344.68	2097.37**
51840		Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple	19.43	1622.41		090	2		1405.31	2097.37**
51841		Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair)	23.09	1928.02		090	2		1667.50	2097.37**
51845		Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	17.14	1431.19		090	2	4393.43	1243.32	4102.58
51860		Cystorrhaphy, suture of bladder wound, injury or rupture; simple	21.89	1827.82		090	2	2462.59	1538.07	2327.38
51865		Cystorrhaphy, suture of bladder wound, injury or rupture; complicated	26.12	2181.02		090	2		1877.08	2097.37**
51880		Closure of cystostomy (separate procedure)	13.68	1142.28		090	2	2462.59	992.82	2327.38
51900		Closure of vesicovaginal fistula, abdominal approach	24.06	2009.01		090	2		1736.80	2097.37**
51920		Closure of vesicouterine fistula;	23.93	1998.16		090	2		1611.55	2097.37**
51925		Closure of vesicouterine fistula; with hysterectomy	30.98	2586.83		090	2		2228.62	2097.37**

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51940		Closure, exstrophy of bladder	47.44	3961.24		090	2		3464.42	2097.37**
51960		Enterocystoplasty, including intestinal anastomosis	40.24	3360.04		090	2		2909.14	2097.37**
51980		Cutaneous vesicostomy	20.61	1720.94		090	2		1496.32	2097.37**
51990		Laparoscopy, surgical; urethral suspension for stress incontinence	22.26	1858.71		090	2	4498.73	1621.57	4271.34
51992		Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic	25.28	2110.88		090	2	4498.73	1754.34	4271.34
51999		Unlisted laparoscopy procedure, bladder	0.00	BR		YYY	0	3522.03	BR	3470.14
52000		Cystourethroscopy (separate procedure)	5.95	496.83		000	1	657.63	463.43	650.57
52001		Cystourethroscopy with irrigation and evacuation of multiple obstructing clots	10.73	895.96		000	1	1459.44	865.90	1553.37
52005		Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	7.78	649.63		000	1	2462.59	660.49	2327.38
52007		Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	13.12	1095.52		000	1	2462.59	1498.83	2327.38
52010		Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	10.78	900.13		000	1	657.63	1088.01	650.57
52204		Cystourethroscopy, with biopsy(s)	10.88	908.48		000	1	2462.59	1291.75	2327.38
52214		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	19.58	1634.93		000	1	2462.59	3101.19	2327.38
52224		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	20.45	1707.58		000	1	2462.59	2935.03	2327.38
52234		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	7.09	592.02		000	1	2462.59	527.72	2327.38
52235		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	8.33	695.56		000	1	2462.59	618.74	2327.38
52240		Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)	11.31	944.39		000	1	2462.59	1087.17	2327.38
52250		Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	7.02	586.17		000	1	2462.59	516.87	2327.38
52260		Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	6.09	508.52		000	1	1459.44	448.40	1553.37
52265		Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia	10.86	906.81		000	1	657.63	1234.97	650.57
52270		Cystourethroscopy, with internal urethrotomy; female	10.40	868.40		000	1	1459.44	1110.55	1553.37
52275		Cystourethroscopy, with internal urethrotomy; male	14.03	1171.51		000	1	2462.59	1548.93	2327.38
52276		Cystourethroscopy with direct vision internal urethrotomy	7.67	640.45		000	1	2462.59	567.80	2327.38
52277		Cystourethroscopy, with resection of external sphincter (sphincterotomy	9.42	786.57		000	0	2462.59	699.73	2327.38
52281		Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	7.96	664.66		000	1	1459.44	782.40	1553.37
52282		Cystourethroscopy, with insertion of permanent urethral sten	9.73	812.46		000	1	3531.09	721.44	3301.16
52283		Cystourethroscopy, with steroid injection into stricture	8.00	668.00		000	1	2462.59	634.60	2327.38
52285		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	8.12	678.02		000	1	1459.44	635.44	1553.37
52287		Cystourethroscopy, with injection(s) for chemodenervation of the bladde	9.09	759.02		000	1	1459.44	New	
52290		Cystourethroscopy; with ureteral meatotomy, unilateral or bilatera	7.06	589.51		000	1	2462.59	522.71	2327.38
52300		Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilatera	8.26	689.71		000	0	2462.59	605.38	2327.38
52301		Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilatera	8.45	705.58		000	0	2462.59	621.24	2327.38
52305		Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple	8.04	671.34		000	1	2462.59	599.53	2327.38
52310		Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	7.07	590.35		000	1	1459.44	606.21	1553.37
52315		Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	11.97	999.50		000	1	2462.59	1103.87	2327.38

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
52317		Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	23.65	1974.78		000	1	2462.59	2713.75	2327.38
52318		Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	13.64	1138.94		000	1	2462.59	1024.55	2327.38
52320		Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	7.11	593.69		000	1	2462.59	529.39	2327.38
52325		Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)	9.26	773.21		000	1	2462.59	691.38	2327.38
52327		Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant materia	7.57	632.10		000	1	3531.09	2784.73	3301.16
52330		Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	14.43	1204.91		000	1	2462.59	3265.69	2327.38
52332		Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type	15.07	1258.35		000	1	2462.59	850.03	2327.38
52334		Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	7.42	619.57		000	1	2462.59	549.43	2327.38
52341		Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	8.35	697.23		000	1	2462.59	698.90	2327.38
52342		Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	9.07	757.35		000	1	2462.59	751.50	2327.38
52343		Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	10.09	842.52		000	1	2462.59	828.32	2327.38
52344		Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	10.97	916.00		000	1	2462.59	890.11	2327.38
52345		Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	11.69	976.12		000	0	2462.59	945.22	2327.38
52346		Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	13.21	1103.04		000	0	2462.59	1057.95	2327.38
52351		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	8.92	744.82		000	1	2462.59	670.51	2327.38
52352		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	10.48	875.08		000	1	2462.59	788.24	2327.38
52353		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	11.55	964.43		000	1	3531.09	907.65	3301.16
52354		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	12.28	1025.38		000	1	2462.59	839.18	2327.38
52355		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	13.74	1147.29		000	1	2462.59	1001.17	2327.38
52400		Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	13.81	1153.14		090	1	2462.59	1161.49	2327.38
52402		Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	7.67	640.45		000	0	2462.59	582.83	2327.38
52450		Transurethral incision of prostate	13.63	1138.11		090	1	2462.59	964.43	2327.38
52500		Transurethral resection of bladder neck (separate procedure)	14.14	1180.69		090	1	2462.59	1133.10	2327.38
52601		Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	24.43	2039.91		090	1	3531.09	1709.25	3301.16
52630		Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.62	970.27		090	1	3531.09	919.34	3301.16
52640		Transurethral resection; of postoperative bladder neck contracture	9.17	765.70		090	1	2462.59	836.67	2327.38
52647		Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	52.79	4407.97		090	1	4207.02	6406.96	4256.75

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
52648		Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	54.33	4536.56		090	1	4207.02	6486.28	4256.75
52649		Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are inc	23.56	1967.26		090	0	4207.02	2145.36	4256.75
52700		Transurethral drainage of prostatic abscess	12.76	1065.46		090	0	2462.59	900.13	2327.38
53000		Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra	4.32	360.72		010	1	1986.89	320.64	1854.57
53010		Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, externa	8.56	714.76		090	1	1986.89	608.72	1854.57
53020		Meatotomy, cutting of meatus (separate procedure); except infan	2.81	234.64		000	1	1986.89	206.25	1854.57
53025		Meatotomy, cutting of meatus (separate procedure); infan	2.17	181.20		000	0	1986.89	141.12	1854.57
53040		Drainage of deep periurethral abscess	11.39	951.07		090	0	1986.89	833.33	1854.57
53060		Drainage of Skene's gland abscess or cyst	5.43	453.41		010	1	1986.89	394.12	1854.57
53080		Drainage of perineal urinary extravasation; uncomplicated (separate procedure	12.19	1017.87		090	1	1986.89	1032.06	1854.57
53085		Drainage of perineal urinary extravasation; complicatec	19.16	1599.86		090	2	1986.89	1466.26	1854.57
53200		Biopsy of urethra	4.52	377.42		000	1	1986.89	329.83	1854.57
53210		Urethrectomy, total, including cystostomy; female	22.47	1876.25		090	2	3061.66	1624.08	2861.27
53215		Urethrectomy, total, including cystostomy; male	26.77	2235.30		090	2	1986.89	1957.24	1854.57
53220		Excision or fulguration of carcinoma of urethra	13.18	1100.53		090	0	3061.66	944.39	2861.27
53230		Excision of urethral diverticulum (separate procedure); female	17.71	1478.79		090	2	3061.66	1266.70	2861.27
53235		Excision of urethral diverticulum (separate procedure); male	18.30	1528.05		090	2	1986.89	1330.16	1854.57
53240		Marsupialization of urethral diverticulum, male or female	12.31	1027.89		090	1	3061.66	889.28	2861.27
53250		Excision of bulbourethral gland (Cowper's gland)	12.27	1024.55		090	1	1986.89	828.32	1854.57
53260		Excision or fulguration; urethral polyp(s), distal urethra	5.91	493.49		010	1	1986.89	438.38	1854.57
53265		Excision or fulguration; urethral caruncle	6.37	531.90		010	1	1986.89	487.64	1854.57
53270		Excision or fulguration; Skene's glands	6.19	516.87		010	1	1986.89	445.06	1854.57
53275		Excision or fulguration; urethral prolapse	7.61	635.44		010	1	1986.89	566.97	1854.57
53400		Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)	23.29	1944.72		090	2	3061.66	1681.69	2861.27
53405		Urethroplasty; second stage (formation of urethra), including urinary diversior	25.23	2106.71		090	2	3061.66	1841.18	2861.27
53410		Urethroplasty, 1-stage reconstruction of male anterior urethra	28.31	2363.89		090	2	3061.66	2063.29	2861.27
53415		Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra	32.64	2725.44		090	2		2348.86	2097.37**
53420		Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	24.29	2028.22		090	1	3061.66	1740.98	2861.27
53425		Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	27.03	2257.01		090	2	3061.66	1994.82	2861.27
53430		Urethroplasty, reconstruction of female urethra	28.13	2348.86		090	2	3061.66	2017.36	2861.27
53431		Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)	33.29	2779.72		090	2	3061.66	2434.86	2861.27
53440		Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	21.78	1818.63		090	2	9850.23	1802.77	8944.53
53442		Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	22.66	1892.11		090	2	3061.66	1584.83	2861.27
53444		Insertion of tandem cuff (dual cuff)	22.92	1913.82		090	2	9850.23	1673.34	8944.53
53445		Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	21.80	1820.30		090	2	16145.39	1855.37	14984.34
53446		Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	18.61	1553.94		090	2	3061.66	1353.54	2861.27
53447		Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session	23.38	1952.23		090	2	16145.39	1723.44	14984.34
53448		Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue	36.94	3084.49		090	2		2702.90	2097.37**
53449		Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	17.71	1478.79		090	2	3061.66	1276.72	2861.27
53450		Urethromeatoplasty, with mucosal advancement	11.83	987.81		090	1	3061.66	844.19	2861.27

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
53460		Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure	13.24	1105.54		090	0	1986.89	956.08	1854.57
53500		Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)	21.87	1826.15		090	2	3061.66	1587.34	2861.27
53502		Urethrorrhaphy, suture of urethral wound or injury, female	14.09	1176.52		090	1	1986.89	1020.37	1854.57
53505		Urethrorrhaphy, suture of urethral wound or injury; penile	14.08	1175.68		090	2	3061.66	1014.53	2861.27
53510		Urethrorrhaphy, suture of urethral wound or injury; perinea	18.26	1524.71		090	2	1986.89	1341.01	1854.57
53515		Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous	22.97	1918.00		090	2	3061.66	1682.53	2861.27
53520		Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)	16.11	1345.19		090	1	3061.66	1163.16	2861.27
53600		Dilation of urethral stricture by passage of sound or urethral dilator, male; initia	2.41	201.24		000	1	299.71	194.56	275.52
53601		Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequen	2.35	196.23		000	1	105.77	187.88	99.93
53605		Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia	1.85	154.48		000	1	1459.44	140.28	1553.37
53620		Dilation of urethral stricture by passage of filiform and follower, male; initia	3.37	281.40		000	1	1818.44	291.42	1826.02
53621		Dilation of urethral stricture by passage of filiform and follower, male; subsequen	3.18	265.53		000	1	197.05	277.22	184.15
53660		Dilation of female urethra including suppository and/or instillation; initia	2.07	172.85		000	1	105.77	167.00	99.93
53661		Dilation of female urethra including suppository and/or instillation; subsequen	2.03	169.51		000	1	105.77	167.00	99.93
53665		Dilation of female urethra, general or conduction (spinal) anesthesia	1.12	93.52		000	1	1986.89	83.50	1854.57
53850		Transurethral destruction of prostate tissue; by microwave thermotherapy	61.77	5157.80		090	1	4207.02	7725.42	4256.75
53852		Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	56.80	4742.80		090	1	4207.02	7390.59	4256.75
53855		Insertion of a temporary prostatic urethral stent, including urethral measuremen	23.36	1950.56		000	0	197.05	1508.01	184.15
53860		Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	47.38	3956.23		090	0	1818.44	New	
53899		Unlisted procedure, urinary system	0.00	BR		YYY	0	105.77	BR	99.93
54000		Slitting of prepuce, dorsal or lateral (separate procedure); newborr	4.33	361.56		010	0	1986.89	364.90	1854.57
54001		Slitting of prepuce, dorsal or lateral (separate procedure); except newborr	5.41	451.74		010	1	1986.89	441.72	1854.57
54015		Incision and drainage of penis, deep	8.95	747.33		010	0	1701.78	658.82	1769.66
54050		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	3.95	329.83		010	1	137.98	248.83	80.15
54055		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation	3.53	294.76		010	1	1829.09	239.65	1939.18
54056		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery	4.29	358.22		010	1	92.29	254.68	80.15
54057		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	4.00	334.00		010	1	1829.09	294.76	1939.18
54060		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	5.27	440.05		010	1	1829.09	415.83	1939.18
54065		Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	6.54	546.09		010	1	1829.09	427.52	1939.18
54100		Biopsy of penis; (separate procedure)	5.90	492.65		000	1	1447.15	396.63	1595.60
54105		Biopsy of penis; deep structures	7.66	639.61		010	1	2142.94	637.11	2132.75
54110		Excision of penile plaque (Peyronie disease)	18.06	1508.01		090	2	3580.63	1306.78	3181.04
54111		Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	23.12	1930.52		090	2	3580.63	1685.87	3181.04
54112		Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	27.06	2259.51		090	2	3580.63	1981.46	3181.04
54115		Removal foreign body from deep penile tissue (eg, plastic implant)	13.12	1095.52		090	2	1701.78	944.39	1769.66
54120		Amputation of penis; partial	18.29	1527.22		090	2	3580.63	1310.95	3181.04
54125		Amputation of penis; complete	23.51	1963.09		090	2		1701.73	2097.37**
54130		Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy	34.44	2875.74		090	2		2506.67	2097.37**
54135		Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	43.60	3640.60		090	2		3198.05	2097.37**
54150		Circumcision, using clamp or other device with regional dorsal penile or ring block	4.55	379.93		000	0	2189.07	281.40	2123.25

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54160		Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)	6.42	536.07		010	1	2189.07	540.25	2123.25
54161		Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age	5.72	477.62		010	1	2189.07	410.82	2123.25
54162		Lysis or excision of penile post-circumcision adhesions	7.52	627.92		010	1	2189.07	637.94	2123.25
54163		Repair incomplete circumcision	6.36	531.06		010	1	2189.07	449.23	2123.25
54164		Frenulotomy of penis	5.65	471.78		010	1	2189.07	393.29	2123.25
54200		Injection procedure for Peyronie disease;	3.15	263.03		010	1	197.05	242.15	184.15
54205		Injection procedure for Peyronie disease; with surgical exposure of plaque	15.42	1287.57		090	2	3580.63	1133.10	3181.04
54220		Irrigation of corpora cavernosa for priapism	5.95	496.83		000	1	197.05	506.85	184.15
54230		Injection procedure for corpora cavernosography	2.80	233.80		000	1		205.41	
54231		Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine)	4.07	339.85		000	1	1818.44	291.42	1826.02
54235		Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine	2.63	219.61		000	1	197.05	185.37	184.15
54240		Penile plethysmography	2.91	242.99	154.48	000	0	105.77	209.59	99.93
54250		Nocturnal penile tumescence and/or rigidity test	3.47	289.75	262.19	000	0	197.05	265.53	184.15
54300		Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra	18.55	1548.93		090	2	3580.63	1386.94	3181.04
54304		Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps	21.67	1809.45		090	2	3580.63	1624.08	3181.04
54308		Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm	20.68	1726.78		090	2	3580.63	1540.58	3181.04
54312		Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm	23.65	1974.78		090	2	3580.63	1801.10	3181.04
54316		Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia	28.81	2405.64		090	2	3580.63	2155.97	3181.04
54318		Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair)	20.23	1689.21		090	2	3580.63	1530.56	3181.04
54322		1-stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)	22.56	1883.76		090	2	3580.63	1688.37	3181.04
54324		1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)	27.96	2334.66		090	2	3580.63	2107.54	3181.04
54326		1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra	27.32	2281.22		090	2	3580.63	2049.93	3181.04
54328		1-stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap	27.13	2265.36		090	2	3580.63	1998.99	3181.04
54332		1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	29.28	2444.88		090	2	3580.63	2168.50	3181.04
54336		1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	35.85	2993.48		090	2	3580.63	2689.54	3181.04
54340		Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple	16.50	1377.75		090	2	3580.63	1223.28	3181.04
54344		Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft	27.38	2286.23		090	2	3580.63	2090.84	3181.04
54348		Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)	28.80	2404.80		090	2	3580.63	2121.74	3181.04
54352		Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as f	40.89	3414.32		090	2	3580.63	3126.24	3181.04
54360		Plastic operation on penis to correct angulation	20.84	1740.14		090	2	3580.63	1556.44	3181.04
54380		Plastic operation on penis for epispadias distal to external sphincter	26.55	2216.93		090	2	3580.63	1663.32	3181.04
54385		Plastic operation on penis for epispadias distal to external sphincter; with incontinence	28.84	2408.14		090	2	3580.63	1993.98	3181.04

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
54390		Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladde	37.35	3118.73		090	2		2568.46	2097.37**
54400		Insertion of penile prosthesis; non-inflatable (semi-rigid)	15.32	1279.22		090	1	9850.23	1130.59	8944.53
54401		Insertion of penile prosthesis; inflatable (self-contained)	19.07	1592.35		090	1	16145.39	1362.72	14984.34
54405		Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	23.36	1950.56		090	2	16145.39	1703.40	14984.34
54406		Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	21.11	1762.69		090	2	3580.63	1532.23	3181.04
54408		Repair of component(s) of a multi-component, inflatable penile prosthesis	22.86	1908.81		090	2	3580.63	1639.94	3181.04
54410		Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	24.85	2074.98		090	2	16145.39	1943.05	14984.34
54411		Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	29.65	2475.78		090	2		2119.23	2097.37**
54415		Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	15.32	1279.22		090	2	3580.63	1095.52	3181.04
54416		Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	20.61	1720.94		090	2	16145.39	1459.58	14984.34
54417		Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	25.98	2169.33		090	2		1861.22	2097.37**
54420		Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilatera	20.39	1702.57		090	2	3580.63	1497.16	3181.04
54430		Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilatera	18.54	1548.09		090	2		1347.69	2097.37**
54435		Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	12.09	1009.52		090	1	3580.63	870.07	3181.04
54440		Plastic operation of penis for injury	16.35	1365.23		090	2	3580.63	1170.67	3181.04
54450		Foreskin manipulation including lysis of preputial adhesions and stretching	2.01	167.84		000	1	299.71	168.67	275.52
54500		Biopsy of testis, needle (separate procedure)	2.15	179.53		000	0	1443.01	158.65	1413.47
54505		Biopsy of testis, incisional (separate procedure)	6.09	508.52		010	0	2189.07	453.41	2123.25
54512		Excision of extraparenchymal lesion of testis	15.62	1304.27		090	1	2189.07	1127.25	2123.25
54520		Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	9.53	795.76		090	1	2189.07	688.88	2123.25
54522		Orchiectomy, partial	17.51	1462.09		090	2	2189.07	1262.52	2123.25
54530		Orchiectomy, radical, for tumor; inguinal approach	14.69	1226.62		090	2	3133.77	1148.13	2915.18
54535		Orchiectomy, radical, for tumor; with abdominal exploration	21.51	1796.09		090	2	3580.63	1567.30	3181.04
54550		Exploration for undescended testis (inguinal or scrotal area)	14.26	1190.71		090	2	3133.77	1024.55	2915.18
54560		Exploration for undescended testis with abdominal exploration	19.86	1658.31		090	2	2189.07	1429.52	2123.25
54600		Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	13.12	1095.52		090	1	2189.07	939.38	2123.25
54620		Fixation of contralateral testis (separate procedure)	8.67	723.95		010	1	2189.07	639.61	2123.25
54640		Orchiopexy, inguinal approach, with or without hernia repai	14.03	1171.51		090	0	3133.77	969.44	2915.18
54650		Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens	20.60	1720.10		090	2	3133.77	1517.20	2097.37**
54660		Insertion of testicular prosthesis (separate procedure)	10.37	865.90		090	0	2189.07	740.65	2123.25
54670		Suture or repair of testicular injury	11.76	981.96		090	0	2189.07	855.88	2123.25
54680		Transplantation of testis(es) to thigh (because of scrotal destruction)	22.75	1899.63		090	2	2189.07	1690.04	2123.25
54690		Laparoscopy, surgical; orchiectomy	21.87	1826.15		090	2	4498.73	1395.29	4271.34
54692		Laparoscopy, surgical; orchiopexy for intra-abdominal testis	23.51	1963.09		090	1	6607.04	1634.10	6653.06
54699		Unlisted laparoscopy procedure, testis	0.00	BR		YYY	2	3522.03	BR	3470.14
54700		Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma	6.25	521.88		010	1	2189.07	452.57	2123.25
54800		Biopsy of epididymis, needle	3.74	312.29		000	0	445.75	272.21	419.39
54830		Excision of local lesion of epididymis	10.87	907.65		090	0	2189.07	761.52	2123.25
54840		Excision of spermatocele, with or without epididymectomy	9.33	779.06		090	1	2189.07	677.19	2123.25

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54860		Epididymectomy; unilateral	12.16	1015.36		090	1	2189.07	862.56	2123.25
54861		Epididymectomy; bilateral	16.38	1367.73		090	0	2189.07	1174.01	2123.25
54865		Exploration of epididymis, with or without biopsy	10.43	870.91		090	0	2189.07	733.97	2123.25
54900		Epididymovasostomy, anastomosis of epididymis to vas deferens; unilatera	22.78	1902.13		090	0	2189.07	1604.04	2123.25
54901		Epididymovasostomy, anastomosis of epididymis to vas deferens; bilatera	30.01	2505.84		090	0	2189.07	2181.86	2123.25
55000		Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medicatior	3.43	286.41		000	1	445.75	284.74	419.39
55040		Excision of hydrocele; unilateral	9.89	825.82		090	1	3133.77	705.58	2915.18
55041		Excision of hydrocele; bilateral	14.84	1239.14		090	1	3133.77	1050.43	2915.18
55060		Repair of tunica vaginalis hydrocele (Bottle type)	11.11	927.69		090	0	2189.07	779.06	2123.25
55100		Drainage of scrotal wall abscess	6.39	533.57		010	1	936.06	497.66	1150.97
55110		Scrotal exploration	11.30	943.55		090	1	2189.07	794.09	2123.25
55120		Removal of foreign body in scrotum	10.49	875.92		090	0	2189.07	728.96	2123.25
55150		Resection of scrotum	14.31	1194.89		090	2	2189.07	1003.67	2123.25
55175		Scrotoplasty; simple	10.58	883.43		090	0	2189.07	743.99	2123.25
55180		Scrotoplasty; complicated	20.06	1675.01		090	0	2189.07	1438.71	2123.25
55200		Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure	12.81	1069.64		090	0	2189.07	1308.45	2123.25
55250		Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	11.34	946.89		090	1	2189.07	1149.80	2123.25
55300		Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilatera	5.41	451.74		000	0		399.97	
55400		Vasovasostomy, vasovasorrhaphy	14.42	1204.07		090	2	2189.07	1063.79	2123.25
55450		Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)	10.47	874.25		010	0	2189.07	916.00	2123.25
55500		Excision of hydrocele of spermatic cord, unilateral (separate procedure)	11.68	975.28		090	0	2189.07	787.41	2123.25
55520		Excision of lesion of spermatic cord (separate procedure)	13.49	1126.42		090	2	2189.07	838.34	2123.25
55530		Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)	10.28	858.38		090	1	2189.07	740.65	2123.25
55535		Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach	12.48	1042.08		090	2	3133.77	886.77	2915.18
55540		Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repai	15.99	1335.17		090	1	3133.77	1022.04	2915.18
55550		Laparoscopy, surgical, with ligation of spermatic veins for varicocele	12.42	1037.07		090	2	4498.73	883.43	4271.34
55559		Unlisted laparoscopy procedure, spermatic cord	0.00	BR		YYY	2	3522.03	BR	3470.14
55600		Vesiculotomy;	12.23	1021.21		090	0	2189.07	882.60	2123.25
55605		Vesiculotomy; complicated	15.10	1260.85		090	0		1072.98	2097.37**
55650		Vesiculectomy, any approach	20.78	1735.13		090	2		1500.50	2097.37**
55680		Excision of Mullerian duct cyst	10.04	838.34		090	0	2189.07	726.45	2123.25
55700		Biopsy, prostate; needle or punch, single or multiple, any approach	6.37	531.90		000	1	1247.80	543.59	1133.61
55705		Biopsy, prostate; incisional, any approach	7.71	643.79		010	1	1247.80	575.32	1133.61
55706		Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	10.63	887.61		010	2	1247.80	902.64	1133.61
55720		Prostatotomy, external drainage of prostatic abscess, any approach; simple	13.08	1092.18		090	2	2462.59	996.16	2327.38
55725		Prostatotomy, external drainage of prostatic abscess, any approach; complicated	17.20	1436.20		090	2	2462.59	1214.93	2327.38
55801		Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	31.58	2636.93		090	2		2287.07	2097.37**
55810		Prostatectomy, perineal radical;	38.05	3177.18		090	2		2769.70	2097.37**
55812		Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy	46.42	3876.07		090	2		3405.97	2097.37**
55815		Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	50.84	4245.14		090	2		3734.12	2097.37**
55821		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	25.25	2108.38		090	2		1831.99	2097.37**
55831		Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	27.29	2278.72		090	2		1986.47	2097.37**
55840		Prostatectomy, retropubic radical, with or without nerve sparing	38.60	3223.10		090	2		2821.47	2097.37**

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55842		Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	41.34	3451.89		090	2		3024.37	2097.37**
55845		Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	47.16	3937.86		090	2		3464.42	2097.37**
55860		Exposure of prostate, any approach, for insertion of radioactive substance	25.29	2111.72		090	1	1818.44	1849.53	1826.02
55862		Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	31.65	2642.78		090	2		2338.00	2097.37**
55865		Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	38.49	3213.92		090	2		2821.47	2097.37**
55866		Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	50.12	4185.02		090	2		3678.18	2097.37**
55870		Electroejaculation	5.11	426.69		000	1	302.00	354.88	310.82
55873		Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring	207.09	17292.02		090	1	10095.04	2436.53	10383.13
55875		Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	22.05	1841.18		090	0	3531.09	1606.54	3301.16
55876		Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	3.95	329.83		000	1	1270.08	323.98	1254.56
55899		Unlisted procedure, male genital system	0.00	BR		YYY	0	105.77	BR	99.93
55920		Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	12.89	1076.32		000	0	2389.99	927.36	2479.05
55970		Intersex surgery; male to female	0.00	BR		XXX	9		BR	2097.37**
55980		Intersex surgery; female to male	0.00	BR		XXX	9		BR	2097.37**
56405		Incision and drainage of vulva or perineal abscess	3.30	275.55		010	1	152.95	231.30	139.31
56420		Incision and drainage of Bartholin's gland abscess	3.68	307.28		010	1	152.95	293.09	139.31
56440		Marsupialization of Bartholin's gland cyst	5.48	457.58		010	1	1876.50	383.27	1827.92
56441		Lysis of labial adhesions	4.28	357.38		010	0	1876.50	315.63	1827.92
56442		Hymenotomy, simple incision	1.44	120.24		000	0	1876.50	100.20	1827.92
56501		Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	3.94	328.99		010	1	1829.09	276.39	1939.18
56515		Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	6.72	561.12		010	1	1829.09	464.26	1939.18
56605		Biopsy of vulva or perineum (separate procedure); 1 lesion	2.47	206.25		000	1	302.00	179.53	310.82
56606		Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)	1.11	92.69		ZZZ	1	152.95	85.17	139.31
56620		Vulvectomy simple; partial	15.25	1273.38		090	2	1876.50	1101.37	1827.92
56625		Vulvectomy simple; complete	18.22	1521.37		090	2	1876.50	1234.97	1827.92
56630		Vulvectomy, radical, partial;	26.76	2234.46		090	2		1785.23	2097.37**
56631		Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy	33.94	2833.99		090	2		2289.57	2097.37**
56632		Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy	39.58	3304.93		090	2		2613.55	2097.37**
56633		Vulvectomy, radical, complete;	34.77	2903.30		090	2		2328.82	2097.37**
56634		Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy	36.95	3085.33		090	2		2480.79	2097.37**
56637		Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy	43.04	3593.84		090	2		2950.06	2097.37**
56640		Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	41.99	3506.17		090	2		2946.72	2097.37**
56700		Partial hymenectomy or revision of hymenal ring	5.63	470.11		010	2	1876.50	385.77	1827.92
56740		Excision of Bartholin's gland or cyst	8.93	745.66		010	1	1876.50	617.90	1827.92
56800		Plastic repair of introitus	7.18	599.53		010	2	1876.50	508.52	1827.92
56805		Clitoroplasty for intersex state	34.32	2865.72		090	2	1876.50	2446.55	1827.92
56810		Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	7.76	647.96		010	2	1876.50	546.93	1827.92
56820		Colposcopy of the vulva;	3.33	278.06		000	1	152.95	234.64	139.31
56821		Colposcopy of the vulva; with biopsy(s)	4.40	367.40		000	1	152.95	315.63	139.31

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57000		Colpotomy; with exploration	5.68	474.28		010	0	1876.50	394.12	1827.92
57010		Colpotomy; with drainage of pelvic abscess	13.06	1090.51		090	0	1876.50	883.43	1827.92
57020		Colpocentesis (separate procedure)	2.81	234.64		000	0	642.61	202.07	619.63
57022		Incision and drainage of vaginal hematoma; obstetrical/postpartum	5.04	420.84		010	0	936.06	348.20	1150.97
57023		Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)	9.32	778.22		010	0	1701.78	644.62	1769.66
57061		Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	3.43	286.41		010	1	1876.50	242.15	1827.92
57065		Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	5.78	482.63		010	1	1876.50	409.15	1827.92
57100		Biopsy of vaginal mucosa; simple (separate procedure)	2.64	220.44		000	1	642.61	188.71	619.63
57105		Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)	4.07	339.85		010	1	1876.50	290.58	1827.92
57106		Vaginectomy, partial removal of vaginal wall	14.51	1211.59		090	2	1876.50	963.59	1827.92
57107		Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	42.12	3517.02		090	2	3405.10	2906.64	3215.96
57109		Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	49.32	4118.22		090	2	3405.10	3311.61	3215.96
57110		Vaginectomy, complete removal of vaginal wall	26.84	2241.14		090	2		1885.43	2097.37**
57111		Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	48.02	4009.67		090	2		3390.94	2097.37**
57112		Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	48.67	4063.95		090	2		3538.73	2097.37**
57120		Colpocleisis (Le Fort type)	15.28	1275.88		090	2	3405.10	1063.79	3215.96
57130		Excision of vaginal septum	5.33	445.06		010	2	1876.50	383.27	1827.92
57135		Excision of vaginal cyst or tumor	5.74	479.29		010	1	1876.50	410.82	1827.92
57150		Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	1.36	113.56		000	1	152.95	127.76	139.31
57155		Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	13.06	1090.51		000	1	642.61	905.14	619.63
57156		Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	5.70	475.95		000	0	302.00	New	
57160		Fitting and insertion of pessary or other intravaginal support device	2.30	192.05		000	1	152.95	160.32	139.31
57170		Diaphragm or cervical cap fitting with instructions	1.81	151.14		000	0	10.64	182.03	12.04
57180		Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure)	4.25	354.88		010	1	152.95	309.79	139.31
57200		Colporrhaphy, suture of injury of vagina (nonobstetrical)	8.97	749.00		090	2	1876.50	606.21	1827.92
57210		Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical	10.96	915.16		090	2	1876.50	757.35	1827.92
57220		Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication	9.60	801.60		090	2	4393.43	657.98	4102.58
57230		Plastic repair of urethrocele	11.87	991.15		090	2	3405.10	803.27	3215.96
57240		Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	19.80	1653.30		090	2	3405.10	1261.69	3215.96
57250		Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	20.21	1687.54		090	2	3405.10	1239.98	3215.96
57260		Combined anteroposterior colporrhaphy;	24.86	2075.81		090	2	3405.10	1584.00	3215.96
57265		Combined anteroposterior colporrhaphy; with enterocele repair	27.22	2272.87		090	2	4393.43	1810.28	4102.58
57267		Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	7.58	632.93		ZZZ	2	3405.10	575.32	3215.96
57268		Repair of enterocele, vaginal approach (separate procedure)	14.45	1206.58		090	2	3405.10	978.62	3215.96
57270		Repair of enterocele, abdominal approach (separate procedure)	23.87	1993.15		090	2		1646.62	2097.37**
57280		Colpopexy, abdominal approach	28.35	2367.23		090	2		1995.65	2097.37**
57282		Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus	14.94	1247.49		090	2	4393.43	1047.93	4102.58
57283		Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy	20.61	1720.94		090	2	4393.43	1434.53	4102.58

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
57284		Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach	24.20	2020.70		090	2	4393.43	1720.10	4102.58
57285		Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	20.04	1673.34		090	2	4393.43	1338.12	4102.58
57287		Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	20.04	1673.34		090	2	3405.10	1416.16	3215.96
57288		Sling operation for stress incontinence (eg, fascia or synthetic)	21.00	1753.50		090	2	4393.43	1664.16	4102.58
57289		Pereyra procedure, including anterior colporrhaphy	21.07	1759.35		090	2	3405.10	1561.45	3215.96
57291		Construction of artificial vagina; without graft	15.93	1330.16		090	2	3405.10	1118.07	3215.96
57292		Construction of artificial vagina; with graft	24.46	2042.41		090	2	3405.10	1736.80	3215.96
57295		Revision (including removal) of prosthetic vaginal graft; vaginal approach	14.23	1188.21		090	2	1876.50	1018.70	1827.92
57296		Revision (including removal) of prosthetic vaginal graft; open abdominal approach	28.42	2373.07		090	2		1939.71	2097.37**
57300		Closure of rectovaginal fistula; vaginal or transanal approach	16.72	1396.12		090	2	3405.10	1078.82	3215.96
57305		Closure of rectovaginal fistula; abdominal approach	27.77	2318.80		090	2		1810.28	2097.37**
57307		Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	31.68	2645.28		090	2		2031.56	2097.37**
57308		Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	19.21	1604.04		090	2		1303.44	2097.37**
57310		Closure of urethrovaginal fistula;	13.34	1113.89		090	2	4393.43	958.58	4102.58
57311		Closure of urethrovaginal fistula; with bulbocavernosus transplant	15.17	1266.70		090	2		1082.16	2097.37**
57320		Closure of vesicovaginal fistula; vaginal approach	15.52	1295.92		090	2	3405.10	1103.04	3215.96
57330		Closure of vesicovaginal fistula; transvesical and vaginal approach	21.35	1782.73		090	2	3405.10	1581.49	3215.96
57335		Vaginoplasty for intersex state	34.66	2894.11		090	2	3405.10	2406.47	3215.96
57400		Dilation of vagina under anesthesia (other than local)	3.97	331.50		000	0	1876.50	282.23	1827.92
57410		Pelvic examination under anesthesia (other than local)	3.21	268.04		000	1	1876.50	221.28	1827.92
57415		Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)	4.76	397.46		010	0	1876.50	323.15	1827.92
57420		Colposcopy of the entire vagina, with cervix if present	3.48	290.58		000	1	302.00	246.33	310.82
57421		Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix	4.68	390.78		000	1	302.00	336.51	310.82
57423		Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	27.41	2288.74		090	2	4393.43	1869.84	4102.58
57425		Laparoscopy, surgical, colpopexy (suspension of vaginal apex	28.89	2412.32		090	2	4498.73	1978.95	3470.14
57426		Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	25.36	2117.56		090	2	1876.50	1972.27	1827.92
57452		Colposcopy of the cervix including upper/adjacent vagina	3.26	272.21		000	1	152.95	232.13	139.31
57454		Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage	4.59	383.27		000	1	302.00	330.66	310.82
57455		Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	4.29	358.22		000	1	302.00	308.12	310.82
57456		Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage	4.05	338.18		000	1	302.00	290.58	310.82
57460		Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	8.59	717.27		000	1	1876.50	696.39	1827.92
57461		Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix	9.69	809.12		000	1	1876.50	768.20	1827.92
57500		Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	3.88	323.98		000	1	642.61	300.60	619.63
57505		Endocervical curettage (not done as part of a dilation and curettage)	3.08	257.18		010	1	642.61	217.10	619.63
57510		Cautery of cervix; electro or thermal	3.94	328.99		010	1	1876.50	287.24	1827.92
57511		Cautery of cervix; cryocautery, initial or repeat	4.38	365.73		010	1	152.95	310.62	139.31
57513		Cautery of cervix; laser ablation	4.33	361.56		010	1	1876.50	303.94	1827.92
57520		Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	9.16	764.86		090	1	1876.50	662.16	1827.92
57522		Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision	7.92	661.32		090	1	1876.50	561.12	1827.92
57530		Trachelectomy (cervicectomy), amputation of cervix (separate procedure)	10.34	863.39		090	2	3405.10	714.76	3215.96
57531		Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy with or without removal of tube(s), with or without removal of ovary(s)	52.08	4348.68		090	2		3564.62	2097.37**
57540		Excision of cervical stump, abdominal approach;	23.34	1948.89		090	2		1622.41	2097.37**
57545		Excision of cervical stump, abdominal approach; with pelvic floor repair	24.61	2054.94		090	2		1725.95	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
57550		Excision of cervical stump, vaginal approach;	12.26	1023.71		090	2	3405.10	839.18	3215.96
57555		Excision of cervical stump, vaginal approach; with anterior and/or posterior repai	18.02	1504.67		090	2	3405.10	1247.49	3215.96
57556		Excision of cervical stump, vaginal approach; with repair of enterocele	16.90	1411.15		090	2	4393.43	1173.18	4102.58
57558		Dilation and curettage of cervical stump	3.76	313.96		010	1	1876.50	263.86	1827.92
57700		Cerclage of uterine cervix, nonobstetrical	9.37	782.40		090	0	1876.50	613.73	1827.92
57720		Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	9.24	771.54		090	2	1876.50	635.44	1827.92
57800		Dilation of cervical canal, instrumental (separate procedure)	1.81	151.14		000	1	1876.50	127.76	1827.92
58100		Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	3.28	273.88		000	1	152.95	236.31	139.31
58110		Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	1.43	119.41		ZZZ	0		107.72	
58120		Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	7.75	647.13		010	1	1876.50	498.50	1827.92
58140		Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	27.51	2297.09		090	2		1904.64	2097.37**
58145		Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach	16.31	1361.89		090	2	3405.10	1130.59	3215.96
58146		Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach	34.53	2883.26		090	2		2430.69	2097.37**
58150		Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	29.89	2495.82		090	2		2052.43	2097.37**
58152		Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)	37.27	3112.05		090	2		2625.24	2097.37**
58180		Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	28.66	2393.11		090	2		1974.78	2097.37**
58200		Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	39.53	3300.76		090	2		2737.13	2097.37**
58210		Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	52.97	4423.00		090	2		3643.94	2097.37**
58240		Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal rese	84.22	7032.37		090	2		5508.50	2097.37**
58260		Vaginal hysterectomy, for uterus 250 g or less	24.76	2067.46		090	2	3405.10	1723.44	3215.96
58262		Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s	27.60	2304.60		090	2	3405.10	1930.52	3215.96
58263		Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	29.63	2474.11		090	2	3405.10	2079.15	3215.96
58267		Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	31.56	2635.26		090	2		2212.75	2097.37**
58270		Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	26.36	2201.06		090	2	3405.10	1852.87	3215.96
58275		Vaginal hysterectomy, with total or partial vaginectomy	29.46	2459.91		090	2		2054.94	2097.37**
58280		Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	31.54	2633.59		090	2		2203.57	2097.37**
58285		Vaginal hysterectomy, radical (Schauta type operation	39.19	3272.37		090	2		2767.19	2097.37**
58290		Vaginal hysterectomy, for uterus greater than 250 g	34.28	2862.38		090	2	4393.43	2432.36	4102.58
58291		Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s	37.29	3113.72		090	2	4393.43	2641.94	4102.58
58292		Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	39.31	3282.39		090	2	4393.43	2791.41	4102.58
58293		Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	40.89	3414.32		090	2		2896.62	2097.37**
58294		Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	36.47	3045.25		090	2	4393.43	2560.11	4102.58
58300		Insertion of intrauterine device (IUD)	2.06	172.01		XXX	9		187.88	2097.37**
58301		Removal of intrauterine device (IUD)	2.87	239.65		000	0	152.95	212.09	139.31

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
58321		Artificial insemination; intra-cervical	2.22	185.37		000	0	302.00	169.51	310.82
58322		Artificial insemination; intra-uterine	2.58	215.43		000	0	302.00	190.38	310.82
58323		Sperm washing for artificial insemination	0.47	39.25		000	0	302.00	56.78	310.82
58340		Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	3.58	298.93		000	1		315.63	
58345		Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	8.35	697.23		010	2	1876.50	579.49	1827.92
58346		Insertion of Heyman capsules for clinical brachytherapy	12.79	1067.97		090	1	1876.50	933.53	1827.92
58350		Chromotubation of oviduct, including materials	2.92	243.82		010	1	3405.10	208.75	3215.96
58353		Endometrial ablation, thermal, without hysteroscopic guidance	30.95	2584.33		010	1	3405.10	3010.18	3215.96
58356		Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	57.78	4824.63		010	2	4393.43	5288.89	4102.58
58400		Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)	13.08	1092.18		090	2		918.50	2097.37**
58410		Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy	24.07	2009.85		090	2		1675.01	2097.37**
58520		Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	24.20	2020.70		090	2		1619.07	2097.37**
58540		Hysteroplasty, repair of uterine anomaly (Strassman type)	27.21	2272.04		090	2		1886.27	2097.37**
58541		Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	25.88	2160.98		090	2	6607.04	1746.82	6653.06
58542		Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	28.91	2413.99		090	2	6607.04	1931.36	6653.06
58543		Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	29.37	2452.40		090	2	6607.04	1963.92	6653.06
58544		Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	31.81	2656.14		090	2	6607.04	2125.91	6653.06
58545		Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	26.79	2236.97		090	2	3522.03	1882.93	3470.14
58546		Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	33.70	2813.95		090	2	4498.73	2388.94	4271.34
58548		Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed	54.43	4544.91		090	2		3719.93	2097.37**
58550		Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less	26.43	2206.91		090	2	6607.04	1853.70	6653.06
58552		Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	29.37	2452.40		090	2	4498.73	2044.08	4271.34
58553		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	33.95	2834.83		090	2	4498.73	2398.96	4271.34
58554		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	39.38	3288.23		090	2	4498.73	2741.31	4271.34
58555		Hysteroscopy, diagnostic (separate procedure)	9.15	764.03		000	0	2170.00	477.62	2060.22
58558		Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	11.93	996.16		000	1	2170.00	613.73	2060.22
58559		Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method	10.25	855.88		000	1	2170.00	738.14	2060.22
58560		Hysteroscopy, surgical; with division or resection of intrauterine septum (any method	11.56	965.26		000	2	3452.38	835.84	3394.08
58561		Hysteroscopy, surgical; with removal of leiomyomata	16.34	1364.39		000	0	3452.38	1185.70	3394.08
58562		Hysteroscopy, surgical; with removal of impacted foreign body	12.34	1030.39		000	1	2170.00	662.99	2060.22
58563		Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	51.01	4259.34		000	0	3452.38	4814.61	3394.08
58565		Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	57.73	4820.46		090	1	4393.43	4443.87	4102.58
58570		Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	27.83	2323.81		090	2	4498.73	1860.60	4271.34
58571		Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	31.05	2592.68		090	2	4498.73	2034.48	4271.34

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
58572		Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	34.62	2890.77		090	2	4498.73	2309.16	4271.34
58573		Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	39.73	3317.46		090	2	4498.73	2598.96	4271.34
58578		Unlisted laparoscopy procedure, uterus	0.00	BR		YYY	2	3522.03	BR	3470.14
58579		Unlisted hysteroscopy procedure, uterus	0.00	BR		YYY	2	2170.00	BR	2060.22
58600		Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilatera	10.95	914.33		090	2	3405.10	764.86	3215.96
58605		Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	9.88	824.98		090	2		693.89	2097.37**
58611		Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	2.31	192.89		ZZZ	2		167.84	2097.37**
58615		Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	7.32	611.22		010	2	1876.50	543.59	1827.92
58660		Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure	20.12	1680.02		090	2	4498.73	1406.98	4271.34
58661		Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	19.23	1605.71		010	2	4498.73	1364.39	4271.34
58662		Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	21.10	1761.85		090	2	4498.73	1487.97	4271.34
58670		Laparoscopy, surgical; with fulguration of oviducts (with or without transection	10.97	916.00		090	1	4498.73	762.36	4271.34
58671		Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring	10.97	916.00		090	1	4498.73	763.19	4271.34
58672		Laparoscopy, surgical; with fimbrioplasty	22.01	1837.84		090	2	4498.73	1586.50	4271.34
58673		Laparoscopy, surgical; with salpingostomy (salpingoneostomy	23.91	1996.49		090	2	4498.73	1712.59	4271.34
58679		Unlisted laparoscopy procedure, oviduct, ovary	0.00	BR		YYY	2	3522.03	BR	3470.14
58700		Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	23.28	1943.88		090	2		1580.66	2097.37**
58720		Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure	21.69	1811.12		090	2		1490.48	2097.37**
58740		Lysis of adhesions (salpingolysis, ovariolysis)	26.28	2194.38		090	2		1827.82	2097.37**
58750		Tubotubal anastomosis	27.58	2302.93		090	2		1910.48	2097.37**
58752		Tubouterine implantation	25.32	2114.22		090	2		1879.59	2097.37**
58760		Fimbrioplasty	24.24	2024.04		090	2		1728.45	2097.37**
58770		Salpingostomy (salpingoneostomy)	25.51	2130.09		090	2	3405.10	1801.10	3215.96
58800		Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); vaginal approach	9.55	797.43		090	1	1876.50	669.67	1827.92
58805		Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach	12.10	1010.35		090	2	3405.10	824.15	3215.96
58820		Drainage of ovarian abscess; vaginal approach, oper	9.39	784.07		090	2	3405.10	657.15	3215.96
58822		Drainage of ovarian abscess; abdominal approach	22.30	1862.05		090	2		1407.81	2097.37**
58823		Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)	27.08	2261.18		000	1	1876.50	2005.67	1827.92
58825		Transposition, ovary(s)	20.80	1736.80		090	2		1455.41	2097.37**
58900		Biopsy of ovary, unilateral or bilateral (separate procedure)	12.71	1061.29		090	2	1876.50	841.68	1827.92
58920		Wedge resection or bisection of ovary, unilateral or bilateral	20.96	1750.16		090	2	3405.10	1469.60	3215.96
58925		Ovarian cystectomy, unilateral or bilatera	22.18	1852.03		090	2	3405.10	1509.68	3215.96
58940		Oophorectomy, partial or total, unilateral or bilateral	15.60	1302.60		090	2		1027.05	2097.37**
58943		Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingecto	33.98	2837.33		090	2		2337.17	2097.37**
58950		Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;	32.60	2722.10		090	2		2220.27	2097.37**
58951		Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	41.79	3489.47		090	2		2868.23	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
58952		Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	47.19	3940.37		090	2		3233.96	2097.37**
58953		Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	58.39	4875.57		090	2		4026.37	2097.37**
58954		Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	63.26	5282.21		090	2		4371.23	2097.37**
58956		Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	39.86	3328.31		090	2		2861.55	2097.37**
58957		Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;	45.74	3819.29		090	2		3007.67	2097.37**
58958		Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	50.16	4188.36		090	2		3329.15	2097.37**
58960		Laparotomy, for staging or restaging of ovarian, tubal, or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aorti	28.01	2338.84		090	2		1919.67	2097.37**
58970		Follicle puncture for oocyte retrieval, any method	6.34	529.39		000	0	302.00	483.47	310.82
58974		Embryo transfer, intrauterine	4.37	364.90		000	2	302.00	374.58	310.82
58976		Gamete, zygote, or embryo intrafallopian transfer, any method	7.15	597.03		000	2	302.00	534.40	310.82
58999		Unlisted procedure, female genital system (nonobstetrical)	0.00	BR		YYY	1	10.64	BR	12.04
59000		Amniocentesis; diagnostic	3.82	318.97		000	1	302.00	288.91	310.82
59001		Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	5.42	452.57		000	1	642.61	395.79	619.63
59012		Cordocentesis (intrauterine), any method	6.12	511.02		000	0	302.00	446.73	310.82
59015		Chorionic villus sampling, any method	4.71	393.29		000	0	302.00	335.67	310.82
59020		Fetal contraction stress test	2.15	179.53	91.85	000	0	152.95	141.95	139.31
59025		Fetal non-stress test	1.45	121.08	73.48	000	0	152.95	93.52	139.31
59030		Fetal scalp blood sampling	3.17	264.70		000	0	302.00	248.83	310.82
59050		Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	1.53	127.76		XXX	0		111.89	
59051		Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only	1.28	106.88		XXX	0		92.69	
59070		Transabdominal amnioinfusion, including ultrasound guidance	12.42	1037.07		000	2	152.95	829.99	139.31
59072		Fetal umbilical cord occlusion, including ultrasound guidance	15.68	1309.28		000	1	302.00	944.39	310.82
59074		Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	12.12	1012.02		000	2	302.00	783.23	310.82
59076		Fetal shunt placement, including ultrasound guidance	15.68	1309.28		000	2	302.00	934.37	310.82
59100		Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	25.21	2105.04		090	2	3405.10	1767.70	3215.96
59120		Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	23.98	2002.33		090	2		1675.85	2097.37**
59121		Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	23.99	2003.17		090	2		1690.04	2097.37**
59130		Surgical treatment of ectopic pregnancy; abdominal pregnancy	24.74	2065.79		090	0		1834.50	2097.37**
59135		Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	24.40	2037.40		090	0		1947.22	2097.37**
59136		Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus	27.56	2301.26		090	2		1857.88	2097.37**
59140		Surgical treatment of ectopic pregnancy; cervical, with evacuation	10.82	903.47		090	2		746.49	2097.37**
59150		Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	23.22	1938.87		090	2	4498.73	1632.43	4271.34
59151		Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	22.56	1883.76		090	2	4498.73	1611.55	4271.34
59160		Curettage, postpartum	6.15	513.53		010	0	1876.50	506.01	1827.92

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
59200		Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)	2.19	182.87		000	1	152.95	169.51	139.31
59300		Episiotomy or vaginal repair, by other than attending	5.85	488.48		000	0	1876.50	410.82	1827.92
59320		Cerclage of cervix, during pregnancy; vagina	4.59	383.27		000	0	1876.50	334.00	1827.92
59325		Cerclage of cervix, during pregnancy; abdomina	6.45	538.58		000	0		522.71	2097.37**
59350		Hysterorrhaphy of ruptured uterus	8.47	707.25		000	2		614.56	2097.37**
59400		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	63.21	5278.04		MMM	1		3729.11	
59409		Vaginal delivery only (with or without episiotomy and/or forceps)	24.58	2052.43		MMM	0	1876.50	1690.88	1827.92
59410		Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	31.34	2616.89		MMM	1		1939.71	
59412		External cephalic version, with or without tocolysis	3.12	260.52		MMM	0	1876.50	226.29	1827.92
59414		Delivery of placenta (separate procedure)	2.76	230.46		MMM	0	1876.50	202.07	1827.92
59425		Antepartum care only; 4-6 visits	13.80	1152.30		MMM	0		913.49	
59426		Antepartum care only; 7 or more visits	24.69	2061.62		MMM	0		1629.09	
59430		Postpartum care only (separate procedure)	5.60	467.60		MMM	1		301.44	
59510		Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	69.87	5834.15		MMM	1		4213.41	
59514		Cesarean delivery only;	27.66	2309.61		MMM	2		1998.16	2097.37**
59515		Cesarean delivery only; including postpartum care	38.01	3173.84		MMM	1		2336.33	
59525		Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	14.62	1220.77		ZZZ	2		1059.62	2097.37**
59610		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	66.25	5531.88		MMM	0		3904.46	
59612		Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	27.59	2303.77		MMM	0	1876.50	1897.12	1827.92
59614		Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	34.33	2866.56		MMM	0		2112.55	
59618		Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	70.81	5912.64		MMM	0		4419.66	
59620		Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	28.57	2385.60		MMM	2		2186.03	2097.37**
59622		Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	39.05	3260.68		MMM	0		2535.06	
59812		Treatment of incomplete abortion, any trimester, completed surgically	9.61	802.44		090	1	1876.50	632.93	1827.92
59820		Treatment of missed abortion, completed surgically; first trimester	11.51	961.09		090	1	1876.50	792.42	1827.92
59821		Treatment of missed abortion, completed surgically; second trimester	11.58	966.93		090	0	1876.50	808.28	1827.92
59830		Treatment of septic abortion, completed surgically	13.18	1100.53		090	0		931.03	2097.37**
59840		Induced abortion, by dilation and curettage	6.52	544.42		010	0	1876.50	460.09	1827.92
59841		Induced abortion, by dilation and evacuation	11.54	963.59		010	0	1876.50	806.61	1827.92
59850		Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	10.18	850.03		090	0		809.12	2097.37**
59851		Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	12.04	1005.34		090	0		854.21	2097.37**
59852		Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	14.89	1243.32		090	0		1163.99	2097.37**
59855		Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;	12.54	1047.09		090	0		884.27	2097.37**
59856		Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	14.70	1227.45		090	0		1065.46	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
59857		Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)	15.18	1267.53		090	0		1227.45	2097.37**
59866		Multifetal pregnancy reduction(s) (MPR)	6.36	531.06		000	2	302.00	516.87	310.82
59870		Uterine evacuation and curettage for hydatidiform mole	14.29	1193.22		090	2	1876.50	969.44	1827.92
59871		Removal of cerclage suture under anesthesia (other than local)	4.05	338.18		000	0	1876.50	292.25	1827.92
59897		Unlisted fetal invasive procedure, including ultrasound guidance, when performed	0.00	BR		YYY	1	10.64	BR	12.04
59898		Unlisted laparoscopy procedure, maternity care and delivery	0.00	BR		YYY	2	3522.03	BR	3470.14
59899		Unlisted procedure, maternity care and delivery	0.00	BR		YYY	2	10.64	BR	12.04
60000		Incision and drainage of thyroglossal duct cyst, infected	5.25	438.38		010	0	643.20	308.95	694.83
60100		Biopsy thyroid, percutaneous core needle	3.30	275.55		000	1	445.75	237.98	419.39
60200		Excision of cyst or adenoma of thyroid, or transection of isthmus	19.73	1647.46		090	2	4736.10	1312.62	4446.07
60210		Partial thyroid lobectomy, unilateral; with or without isthmusectomy	21.11	1762.69		090	2	4736.10	1398.63	4446.07
60212		Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	30.01	2505.84		090	2	4736.10	2010.68	4446.07
60220		Total thyroid lobectomy, unilateral; with or without isthmusectomy	21.10	1761.85		090	2	4736.10	1530.56	4446.07
60225		Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	27.75	2317.13		090	2	4736.10	1841.18	4446.07
60240		Thyroidectomy, total or complete	27.32	2281.22		090	2	4736.10	1973.94	4446.07
60252		Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	39.15	3269.03		090	2	4230.05	2643.61	3919.59
60254		Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	49.50	4133.25		090	2		3446.05	2097.37**
60260		Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	32.43	2707.91		090	2	4230.05	2215.26	3919.59
60270		Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach	40.69	3397.62		090	2		2768.86	2097.37**
60271		Thyroidectomy, including substernal thyroid; cervical approach	31.36	2618.56		090	2	4230.05	2143.45	3919.59
60280		Excision of thyroglossal duct cyst or sinus	13.34	1113.89		090	2	4736.10	877.59	4446.07
60281		Excision of thyroglossal duct cyst or sinus; recurrent	17.66	1474.61		090	2	4736.10	1177.35	4446.07
60300		Aspiration and/or injection, thyroid cyst	3.54	295.59		000	1	445.75	217.56	419.39
60500		Parathyroidectomy or exploration of parathyroid(s)	28.68	2394.78		090	2	4230.05	2024.88	3919.59
60502		Parathyroidectomy or exploration of parathyroid(s); re-exploration	38.20	3189.70		090	2	2321.87	2552.60	3919.59
60505		Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration, sternal split or transthoracic approach	41.50	3465.25		090	2		2818.96	2097.37**
60512		Parathyroid autotransplantation (List separately in addition to code for primary procedure	7.15	597.03		ZZZ	2	2142.94	503.51	2132.75
60520		Thymectomy, partial or total; transcervical approach (separate procedure)	30.80	2571.80		090	2	4230.05	2129.25	3919.59
60521		Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)	33.59	2804.77		090	2		2440.71	2097.37**
60522		Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)	40.89	3414.32		090	2		2937.53	2097.37**
60540		Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);	31.07	2594.35		090	2		2135.93	2097.37**
60545		Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor	35.68	2979.28		090	2		2457.41	2097.37**
60600		Excision of carotid body tumor; without excision of carotid artery	41.28	3446.88		090	2		2930.02	2097.37**
60605		Excision of carotid body tumor; with excision of carotid artery	54.24	4529.04		090	2		3623.90	2097.37**
60650		Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	34.97	2920.00		090	2		2411.48	2097.37**
60659		Unlisted laparoscopy procedure, endocrine system	0.00	BR		YYY	2	3522.03	BR	3470.14
60699		Unlisted procedure, endocrine system	0.00	BR		YYY	2	4736.10	BR	4446.07
61000		Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initia	3.46	288.91		000	1	729.86	214.60	656.59
61001		Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps	3.34	278.89		000	1	729.86	217.10	656.59

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
61020		Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection	4.18	349.03		000	1	729.86	258.85	656.59
61026		Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of medication or other substance for diagnosis or treatment	3.88	323.98		000	1	729.86	273.05	656.59
61050		Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)	3.20	267.20		000	0	729.86	225.45	656.59
61055		Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (eg, C1-C2)	4.05	338.18		000	1	729.86	286.41	656.59
61070		Puncture of shunt tubing or reservoir for aspiration or injection procedure	2.59	216.27		000	1	567.16	168.67	581.26
61105		Twist drill hole for subdural or ventricular puncture	13.94	1163.99		090	0		865.06	2097.37**
61107		Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device	9.29	775.72		000	1		680.53	2097.37**
61108		Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma	27.22	2272.87		090	1		1710.08	2097.37**
61120		Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material)	22.38	1868.73		090	0		1406.14	2097.37**
61140		Burr hole(s) or trephine; with biopsy of brain or intracranial lesion	37.66	3144.61		090	2		2466.59	2097.37**
61150		Burr hole(s) or trephine; with drainage of brain abscess or cyst	40.28	3363.38		090	1		2649.46	2097.37**
61151		Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cys	29.64	2474.94		090	1		1927.18	2097.37**
61154		Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdura	37.94	3167.99		090	2		2443.21	2097.37**
61156		Burr hole(s); with aspiration of hematoma or cyst, intracerebra	36.99	3088.67		090	2		2482.46	2097.37**
61210		Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure)	10.86	906.81		000	1		791.58	2097.37**
61215		Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter	15.21	1270.04		090	1	4194.19	903.47	3741.42
61250		Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery	25.89	2161.82		090	2		1676.68	2097.37**
61253		Burr hole(s) or trephine, infratentorial, unilateral or bilateral	21.89	1827.82		090	2		1873.74	2097.37**
61304		Craniectomy or craniotomy, exploratory; supratentoria	48.71	4067.29		090	2		3291.57	2097.37**
61305		Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)	59.64	4979.94		090	2		3927.84	2097.37**
61312		Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdura	61.71	5152.79		090	2		4055.60	2097.37**
61313		Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebra	59.02	4928.17		090	2		3891.94	2097.37**
61314		Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdura	54.31	4534.89		090	2		3577.14	2097.37**
61315		Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar	61.43	5129.41		090	2		4147.45	2097.37**
61316		Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	2.59	216.27		ZZZ	1		182.03	2097.37**
61320		Craniectomy or craniotomy, drainage of intracranial abscess; supratentoria	56.47	4715.25		090	2		3830.98	2097.37**
61321		Craniectomy or craniotomy, drainage of intracranial abscess; infratentoria	63.18	5275.53		090	2		4191.70	2097.37**
61322		Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	70.51	5887.59		090	2		4554.09	2097.37**
61323		Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy	70.65	5899.28		090	1		4661.81	2097.37**
61330		Decompression of orbit only, transcranial approach	54.86	4580.81		090	2	4230.05	3195.55	3919.59
61332		Exploration of orbit (transcranial approach); with biopsy	56.10	4684.35		090	2		3805.10	2097.37**
61333		Exploration of orbit (transcranial approach); with removal of lesion	62.55	5222.93		090	2		3776.71	2097.37**
61334		Exploration of orbit (transcranial approach); with removal of foreign body	35.86	2994.31		090	2	4230.05	2469.93	3919.59
61340		Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	43.00	3590.50		090	2		2844.85	2097.37**
61343		Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)	65.21	5445.04		090	2		4415.48	2097.37**
61345		Other cranial decompression, posterior fossa	60.51	5052.59		090	2		4059.77	2097.37**
61440		Craniotomy for section of tentorium cerebelli (separate procedure)	54.04	4512.34		090	2		3906.13	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
61450		Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	57.02	4761.17		090	2		3718.26	2097.37**
61458		Craniectomy, suboccipital; for exploration or decompression of cranial nerves	59.60	4976.60		090	2		4032.22	2097.37**
61460		Craniectomy, suboccipital; for section of 1 or more cranial nerves	62.40	5210.40		090	2		4114.05	2097.37**
61470		Craniectomy, suboccipital; for medullary tractotomy	51.24	4278.54		090	2		3704.90	2097.37**
61480		Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy	49.41	4125.74		090	2		3787.56	2097.37**
61490		Craniotomy for lobotomy, including cingulotomy	56.16	4689.36		090	2		3815.12	2097.37**
61500		Craniectomy; with excision of tumor or other bone lesion of skull	39.65	3310.78		090	2		2674.51	2097.37**
61501		Craniectomy; for osteomyelitis	34.16	2852.36		090	2		2265.36	2097.37**
61510		Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	65.00	5427.50		090	2		4321.13	2097.37**
61512		Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentoria	75.67	6318.45		090	2		5161.97	2097.37**
61514		Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentoria	56.62	4727.77		090	2		3792.57	2097.37**
61516		Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentoria	55.09	4600.02		090	2		3712.41	2097.37**
61517		Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)	2.57	214.60		ZZZ	1		183.70	2097.37**
61518		Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	81.97	6844.50		090	2		5541.06	2097.37**
61519		Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma	87.34	7292.89		090	2		5997.81	2097.37**
61520		Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	110.68	9241.78		090	2		7652.78	2097.37**
61521		Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull	94.21	7866.54		090	2		6455.39	2097.37**
61522		Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	64.83	5413.31		090	2		4352.02	2097.37**
61524		Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst	61.76	5156.96		090	2		4148.28	2097.37**
61526		Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	107.96	9014.66		090	1		6947.20	2097.37**
61530		Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	91.03	7601.01		090	1		5882.58	2097.37**
61531		Subdural implantation of strip electrodes through 1 or more burr or trephine hole(s) for long-term seizure monitoring	36.45	3043.58		090	2		2327.15	2097.37**
61533		Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long-term seizure monitoring	45.35	3786.73		090	2		3002.66	2097.37**
61534		Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery	48.90	4083.15		090	2		3208.91	2097.37**
61535		Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)	29.86	2493.31		090	2		1885.43	2097.37**
61536		Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	76.37	6376.90		090	2		5222.93	2097.37**
61537		Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	73.03	6098.01		090	2		4604.19	2097.37**
61538		Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, with electrocorticography during surgery	78.97	6594.00		090	2		4892.27	2097.37**
61539		Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery	69.94	5839.99		090	2		4700.22	2097.37**
61540		Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	64.72	5404.12		090	2		4462.24	2097.37**
61541		Craniotomy with elevation of bone flap; for transection of corpus callosum	63.71	5319.79		090	2		4220.93	2097.37**
61542		Craniotomy with elevation of bone flap; for total hemispherectomy	61.22	5111.87		090	2		4610.87	2097.37**
61543		Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy	64.39	5376.57		090	2		4344.51	2097.37**

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61544		Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus	50.79	4240.97		090	2		3716.59	2097.37**
61545		Craniotomy with elevation of bone flap; for excision of craniopharyngioma	94.32	7875.72		090	2		6350.18	2097.37**
61546		Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	68.36	5708.06		090	2		4590.00	2097.37**
61548		Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotacti	46.14	3852.69		090	2		3076.14	2097.37**
61550		Craniectomy for craniosynostosis; single cranial suture	27.90	2329.65		090	2		1793.58	2097.37**
61552		Craniectomy for craniosynostosis; multiple cranial sutures	31.37	2619.40		090	2		2319.63	2097.37**
61556		Craniotomy for craniosynostosis; frontal or parietal bone flap	50.60	4225.10		090	2		3173.00	2097.37**
61557		Craniotomy for craniosynostosis; bifrontal bone flap	49.99	4174.17		090	2		3366.72	2097.37**
61558		Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts	47.55	3970.43		090	2		3151.29	2097.37**
61559		Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)	53.74	4487.29		090	2		4864.71	2097.37**
61563		Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression	58.72	4903.12		090	2		3819.29	2097.37**
61564		Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression	64.33	5371.56		090	2		4820.46	2097.37**
61566		Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	66.62	5562.77		090	2		4473.10	2097.37**
61567		Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery	75.98	6344.33		090	2		4964.08	2097.37**
61570		Craniectomy or craniotomy; with excision of foreign body from brain	55.43	4628.41		090	2		3643.94	2097.37**
61571		Craniectomy or craniotomy; with treatment of penetrating wound of brain	58.99	4925.67		090	2		3961.24	2097.37**
61575		Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;	74.20	6195.70		090	2		4743.64	2097.37**
61576		Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)	102.08	8523.68		090	2		7327.96	2097.37**
61580		Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	74.16	6192.36		090	1		4901.45	2097.37**
61581		Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	80.46	6718.41		090	1		5242.13	2097.37**
61582		Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	91.93	7676.16		090	2		5575.30	2097.37**
61583		Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	86.63	7233.61		090	2		5771.52	2097.37**
61584		Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration	85.28	7120.88		090	2		5581.98	2097.37**
61585		Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration	96.72	8076.12		090	2		5960.23	2097.37**
61586		Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft	73.95	6174.83		090	2		4332.82	2097.37**
61590		Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization	91.14	7610.19		090	2		6247.47	2097.37**
61591		Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and	92.38	7713.73		090	2		6346.84	2097.37**
61592		Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe	94.80	7915.80		090	2		6310.93	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
61595		Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization	70.85	5915.98		090	1		4661.81	2097.37**
61596		Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery	73.25	6116.38		090	2		5159.47	2097.37**
61597		Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization	86.15	7193.53		090	2		5719.75	2097.37**
61598		Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	84.85	7084.98		090	2		5110.20	2097.37**
61600		Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural	64.03	5346.51		090	2		4184.19	2097.37**
61601		Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft	71.67	5984.45		090	2		4639.26	2097.37**
61605		Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural	65.13	5438.36		090	2		4421.33	2097.37**
61606		Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft	89.16	7444.86		090	2		5987.79	2097.37**
61607		Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural	85.76	7160.96		090	2		5567.78	2097.37**
61608		Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; intradural, including dural repair, with or without graft	96.74	8077.79		090	2		6537.22	2097.37**
61609		Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	18.36	1533.06		ZZZ	2		1339.34	2097.37**
61610		Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	55.34	4620.89		ZZZ	2		3927.84	2097.37**
61611		Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)	10.93	912.66		ZZZ	2		1012.86	2097.37**
61612		Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	41.08	3430.18		ZZZ	2		3458.57	2097.37**
61613		Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	97.75	8162.13		090	2		6306.76	2097.37**
61615		Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural	67.47	5633.75		090	2		4903.12	2097.37**
61616		Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; intradural, including dural repair, with or without graft	98.96	8263.16		090	2		6545.57	2097.37**
61618		Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)	38.87	3245.65		090	2		2573.47	2097.37**
61619		Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occi	43.78	3655.63		090	2		2982.62	2097.37**
61623		Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic s	16.20	1352.70		000	1	9896.50	1156.48	8510.25
61624		Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	32.30	2697.05		000	1		2237.80	2097.37**

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61626		Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	24.84	2074.14		000	1	9896.50	1797.76	8510.25
61630		Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	37.33	3117.06		XXX	2		2742.98	2097.37**
61635		Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	40.56	3386.76		XXX	2		3000.99	2097.37**
61640		Balloon dilatation of intracranial vasospasm, percutaneous; initial vesse	18.18	1518.03		000	9		1222.44	2097.37**
61641		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)	6.39	533.57		ZZZ	9		429.19	2097.37**
61642		Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)	12.78	1067.13		ZZZ	9		859.22	2097.37**
61680		Surgery of intracranial arteriovenous malformation; supratentorial, simple	67.14	5606.19		090	2		4545.74	2097.37**
61682		Surgery of intracranial arteriovenous malformation; supratentorial, complex	123.65	10324.78		090	2		8679.83	2097.37**
61684		Surgery of intracranial arteriovenous malformation; infratentorial, simple	84.22	7032.37		090	2		5789.06	2097.37**
61686		Surgery of intracranial arteriovenous malformation; infratentorial, complex	133.03	11108.01		090	2		9268.50	2097.37**
61690		Surgery of intracranial arteriovenous malformation; dural, simple	64.85	5414.98		090	2		4304.43	2097.37**
61692		Surgery of intracranial arteriovenous malformation; dural, complex	108.26	9039.71		090	2		7452.38	2097.37**
61697		Surgery of complex intracranial aneurysm, intracranial approach; carotid circulatior	124.91	10429.99		090	2		8186.34	2097.37**
61698		Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulatior	136.99	11438.67		090	2		8590.48	2097.37**
61700		Surgery of simple intracranial aneurysm, intracranial approach; carotid circulatior	101.12	8443.52		090	2		7125.89	2097.37**
61702		Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulatior	119.08	9943.18		090	2		7620.21	2097.37**
61703		Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)	40.42	3375.07		090	2		2627.75	2097.37**
61705		Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	77.08	6436.18		090	2		5171.16	2097.37**
61708		Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis	64.17	5358.20		090	2		4210.91	2097.37**
61710		Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intra-arterial embolization, injection procedure, or balloon catheter	48.84	4078.14		090	0		3840.17	2097.37**
61711		Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries	77.32	6456.22		090	2		5282.21	2097.37**
61720		Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus	37.78	3154.63		090	1	3201.45	2345.52	3399.62
61735		Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus	47.22	3942.87		090	1		2897.45	2097.37**
61750		Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion	41.78	3488.63		090	1		2773.04	2097.37**
61751		Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance	40.93	3417.66		090	1		2699.56	2097.37**
61760		Stereotactic implantation of depth electrodes into the cerebrum for long-term seizure monitoring	46.91	3916.99		090	1		2920.83	2097.37**
61770		Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source	48.04	4011.34		090	1	3201.45	3007.67	3399.62
61781		Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	6.90	576.15		ZZZ	0		New	
61782		Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)	5.64	470.94		ZZZ	0		New	
61783		Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	6.91	576.99		ZZZ	0		New	
61790		Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion	26.02	2172.67		090	1	1734.81	1633.26	1707.08

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61791		Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract	33.14	2767.19		090	0	1105.20	2152.63	1207.71
61796		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesior	29.88	2494.98		090	2		1835.33	
61797		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)	6.41	535.24		ZZZ	2		424.18	
61798		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion	40.73	3400.96		090	2		2385.60	
61799		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)	8.85	738.98		ZZZ	2		584.50	
61800		Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)	4.51	376.59		ZZZ	2		293.92	
61850		Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortica	29.26	2443.21		090	2		1862.89	2097.37**
61860		Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortica	46.44	3877.74		090	2		3070.30	2097.37**
61863		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperat	44.74	3735.79		090	2		2998.49	2097.37**
61864		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperat	8.38	699.73		ZZZ	2		969.44	2097.37**
61867		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative	67.66	5649.61		090	2		4404.63	2097.37**
61868		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative	14.75	1231.63		ZZZ	2		1361.05	2097.37**
61870		Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortica	35.21	2940.04		090	2		2333.83	2097.37**
61875		Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortica	28.40	2371.40		090	2		2122.57	2097.37**
61880		Revision or removal of intracranial neurostimulator electrodes	17.16	1432.86		090	2	1949.42	1056.28	1790.80
61885		Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	15.63	1305.11		090	0	21150.63	1174.85	18794.36
61886		Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	25.52	2130.92		090	0	26578.71	1477.12	25053.51
61888		Revision or removal of cranial neurostimulator pulse generator or receiver	11.70	976.95		010	1	3351.98	807.45	2613.83
62000		Elevation of depressed skull fracture; simple, extradural	30.71	2564.29		090	1	2321.87	1624.08	2276.44
62005		Elevation of depressed skull fracture; compound or comminuted, extradura	37.79	3155.47		090	2		2391.44	2097.37**
62010		Elevation of depressed skull fracture; with repair of dura and/or debridement of brair	45.51	3800.09		090	2		3014.35	2097.37**
62100		Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea	47.46	3962.91		090	2		3213.92	2097.37**
62115		Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty	37.13	3100.36		090	2		3190.54	2097.37**
62116		Reduction of craniomegalic skull (eg, treated hydrocephalus); with simple cranioplasty	52.66	4397.11		090	2		3497.82	2097.37**
62117		Reduction of craniomegalic skull (eg, treated hydrocephalus); requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)	46.54	3886.09		090	2		3775.04	2097.37**
62120		Repair of encephalocele, skull vault, including cranioplasty	50.10	4183.35		090	2		3572.13	2097.37**
62121		Craniotomy for repair of encephalocele, skull base	49.35	4120.73		090	2		3334.16	2097.37**
62140		Cranioplasty for skull defect; up to 5 cm diameter	30.91	2580.99		090	2		2078.32	2097.37**
62141		Cranioplasty for skull defect; larger than 5 cm diameter	34.08	2845.68		090	2		2276.21	2097.37**
62142		Removal of bone flap or prosthetic plate of skull	26.49	2211.92		090	2		1710.08	2097.37**
62143		Replacement of bone flap or prosthetic plate of skull	31.14	2600.19		090	2		2025.71	2097.37**
62145		Cranioplasty for skull defect with reparative brain surgery	42.17	3521.20		090	2		2775.54	2097.37**
62146		Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diamete	37.14	3101.19		090	2		2388.10	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
62147		Cranioplasty with autograft (includes obtaining bone grafts); larger than 5 cm diamete	43.27	3613.05		090	2		2837.33	2097.37**
62148		Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure)	3.73	311.46		ZZZ	1		260.52	2097.37**
62160		Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)	5.60	467.60		ZZZ	1		409.99	
62161		Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)	45.13	3768.36		090	2		3031.89	2097.37**
62162		Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	56.10	4684.35		090	2		3719.93	2097.37**
62163		Neuroendoscopy, intracranial; with retrieval of foreign body	36.48	3046.08		090	2		2410.65	2097.37**
62164		Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage	62.07	5182.85		090	2		3900.29	2097.37**
62165		Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	45.91	3833.49		090	0		3067.79	2097.37**
62180		Ventriculocisternostomy (Torkildsen type operation)	47.54	3969.59		090	2		3124.57	2097.37**
62190		Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular	27.59	2303.77		090	1		1745.99	2097.37**
62192		Creation of shunt; subarachnoid/subdural-peritoneal, -pleural, other terminus	29.08	2428.18		090	2		1902.13	2097.37**
62194		Replacement or irrigation, subarachnoid/subdural catheter	11.14	930.19		010	0	729.86	733.97	656.59
62200		Ventriculocisternostomy, third ventricle;	40.90	3415.15		090	2		2734.63	2097.37**
62201		Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method	35.88	2995.98		090	1		2313.79	2097.37**
62220		Creation of shunt; ventriculo-atrial, -jugular, -auricular	30.72	2565.12		090	2		2008.18	2097.37**
62223		Creation of shunt; ventriculo-peritoneal, -pleural, other terminus	31.54	2633.59		090	2		2020.70	2097.37**
62225		Replacement or irrigation, ventricular catheter	15.83	1321.81		090	1	1550.17	946.89	1396.15
62230		Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system	25.23	2106.71		090	2	4194.19	1638.27	3741.42
62252		Reprogramming of programmable cerebrospinal shunt	2.60	217.10	112.73	XXX	0	247.29	202.91	231.68
62256		Removal of complete cerebrospinal fluid shunt system; without replacement	18.00	1503.00		090	2		1109.72	2097.37**
62258		Removal of complete cerebrospinal fluid shunt system; with replacement by similar or other shunt at same operation	33.55	2801.43		090	2		2221.10	2097.37**
62263		Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	21.30	1778.55		010	1	1105.20	1499.66	656.59
62264		Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	13.02	1087.17		010	1	1105.20	956.08	1207.71
62267		Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	7.32	611.22		000	0	445.75	566.97	419.39
62268		Percutaneous aspiration, spinal cord cyst or syrinx	7.75	647.13		000	1	729.86	1247.49	656.59
62269		Biopsy of spinal cord, percutaneous needle	7.81	652.14		000	0	920.55	1465.43	881.50
62270		Spinal puncture, lumbar, diagnostic	4.81	401.64		000	1	376.37	344.86	339.42
62272		Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter	6.18	516.03		000	1	376.37	405.81	339.42
62273		Injection, epidural, of blood or clot patch	5.25	438.38		000	1	729.86	376.59	339.42
62280		Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid	10.15	847.53		010	1	729.86	744.82	656.59
62281		Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	7.37	615.40		010	1	1105.20	646.29	656.59
62282		Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	8.66	723.11		010	1	1105.20	794.92	656.59
62284		Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	5.76	547.20		000	1		583.30	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
62287		Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with d	16.77	1400.30		090	1	3201.45	1148.13	3399.62
62290		Injection procedure for discography, each level; lumbar	10.25	855.88		000	1		781.56	
62291		Injection procedure for discography, each level; cervical or thoracic	9.65	805.78		000	1		697.23	
62292		Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar	17.70	1477.95		090	0	729.86	1101.37	656.59
62294		Injection procedure, arterial, for occlusion of arteriovenous malformation, spina	20.33	1697.56		090	1	729.86	1528.89	656.59
62310		Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed,	7.44	621.24		000	1	729.86	516.87	656.59
62311		Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed,	6.27	523.55		000	1	729.86	486.81	656.59
62318		Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includ	7.19	600.37		000	1	729.86	587.84	656.59
62319		Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includ	5.17	431.70		000	1	1105.20	521.04	656.59
62350		Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	12.03	1004.51		010	1	4194.19	1022.88	3741.42
62351		Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy	26.30	2196.05		090	2	4848.92	1663.32	4488.88
62355		Removal of previously implanted intrathecal or epidural catheter	7.89	658.82		010	0	1105.20	828.32	1207.71
62360		Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	9.32	778.22		010	0	4194.19	544.42	3741.42
62361		Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump	9.86	823.31		010	0	18204.73	890.95	18115.55
62362		Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	11.62	970.27		010	0	18204.73	1115.56	18115.55
62365		Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	8.80	734.80		010	0	3201.45	870.07	3399.62
62367		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill	1.26	105.21		XXX	1	247.29	85.17	231.68
62368		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	1.69	141.12		XXX	1	247.29	116.90	231.68
62369		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	3.79	316.47		XXX	1	247.29	New	
62370		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualifi	3.95	329.83		XXX	1	247.29	New	
63001		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	36.83	3075.31		090	2	4848.92	2434.86	4488.88

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
63003		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic	36.83	3075.31		090	2	4848.92	2460.75	4488.88
63005		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	35.15	2935.03		090	2	4848.92	2332.16	4488.88
63011		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	32.50	2713.75		090	2	4848.92	2179.35	4488.88
63012		Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	35.50	2964.25		090	2	4848.92	2388.94	4488.88
63015		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	44.19	3689.87		090	2	4848.92	2949.22	4488.88
63016		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic	45.02	3759.17		090	2	4848.92	3018.53	4488.88
63017		Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	37.35	3118.73		090	2	4848.92	2464.92	4488.88
63020		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	34.86	3311.70		090	2	4848.92	2993.45	4488.88
63030		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	28.82	2737.90		090	2	4848.92	2478.55	4488.88
63035		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primar	5.66	537.70		ZZZ	2	4848.92	505.40	4488.88
63040		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	41.70	3481.95		090	2	4848.92	2860.71	4488.88
63042		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	38.71	3677.45		090	2	4848.92	3350.65	4488.88
63043		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addi	17.51	1462.09		ZZZ	2		1404.80	2097.37**
63044		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in additi	16.62	1387.77		ZZZ	2		1334.58	2097.37**
63045		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	37.92	3602.40		090	2	4848.92	3256.60	4488.88
63046		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	36.06	3011.01		090	2	4848.92	2429.02	4488.88
63047		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	32.90	3125.50		090	2	4848.92	2822.45	4488.88
63048		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lu	6.28	596.60		ZZZ	2	4848.92	558.60	4488.88
63050		Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments	46.22	3859.37		090	2		2960.91	2097.37**

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63051		Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (eg, wire, suture, mini-pl	50.92	4251.82		090	2		3385.93	2097.37**
63055		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	48.31	4033.89		090	2	4848.92	3284.89	4488.88
63056		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	44.03	4182.85		090	2	4848.92	3818.05	4488.88
63057		Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	9.49	901.55		ZZZ	2	4848.92	843.60	4488.88
63064		Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment	52.46	4380.41		090	2	4848.92	3623.07	4488.88
63066		Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)	6.09	508.52		ZZZ	2	4848.92	432.53	4488.88
63075		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	40.76	3872.20		090	2	4848.92	3526.40	4488.88
63076		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	7.37	700.15		ZZZ	2	4848.92	653.60	4488.88
63077		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace	44.00	3674.00		090	2		3077.81	2097.37**
63078		Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)	5.68	474.28		ZZZ	2		430.03	2097.37**
63081		Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	52.58	4995.10		090	2		4567.60	2097.37**
63082		Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	7.92	752.40		ZZZ	2		703.00	2097.37**
63085		Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment	56.08	4682.68		090	2		3837.66	2097.37**
63086		Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)	5.60	467.60		ZZZ	2		413.33	2097.37**
63087		Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment	70.71	5904.29		090	2		4899.78	2097.37**
63088		Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code	7.59	633.77		ZZZ	2		563.63	2097.37**
63090		Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	58.25	4863.88		090	2		3964.58	2097.37**
63091		Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately	5.25	438.38		ZZZ	2		383.27	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
63101		Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	68.82	5746.47		090	2		4594.17	2097.37**
63102		Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment	66.41	5545.24		090	2		4588.33	2097.37**
63103		Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List se	8.59	717.27		ZZZ	2		614.56	2097.37**
63170		Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumba	47.36	3954.56		090	2		3075.31	2097.37**
63172		Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid spac	41.78	3488.63		090	2		2756.34	2097.37**
63173		Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural spac	51.29	4282.72		090	2		3376.74	2097.37**
63180		Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segment	44.20	3690.70		090	2		2779.72	2097.37**
63182		Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments	48.49	4048.92		090	2		2984.29	2097.37**
63185		Laminectomy with rhizotomy; 1 or 2 segments	35.50	2964.25		090	2		2181.86	2097.37**
63190		Laminectomy with rhizotomy; more than 2 segments	37.30	3114.55		090	2		2528.38	2097.37**
63191		Laminectomy with section of spinal accessory nerve	37.98	3171.33		090	2		2825.64	2097.37**
63194		Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; cervica	36.86	3077.81		090	2		2842.34	2097.37**
63195		Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; thoracic	45.66	3812.61		090	2		2974.27	2097.37**
63196		Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; cervica	40.01	3340.84		090	2		3502.83	2097.37**
63197		Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; thoracic	50.86	4246.81		090	2		3295.75	2097.37**
63198		Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; cervical	47.09	3932.02		090	2		3487.80	2097.37**
63199		Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; thoracic	55.93	4670.16		090	2		3604.70	2097.37**
63200		Laminectomy, with release of tethered spinal cord, lumba	45.68	3814.28		090	2		2971.77	2097.37**
63250		Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervica	87.84	7334.64		090	2		5733.95	2097.37**
63251		Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic	89.83	7500.81		090	2		6079.64	2097.37**
63252		Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumba	89.82	7499.97		090	2		6074.63	2097.37**
63265		Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	49.72	4151.62		090	2		3310.78	2097.37**
63266		Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	51.19	4274.37		090	2		3413.48	2097.37**
63267		Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	41.04	3898.80		090	2		3528.30	2097.37**
63268		Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	43.32	3617.22		090	2		2680.35	2097.37**
63270		Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervica	61.59	5142.77		090	2		4101.52	2097.37**
63271		Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	61.31	5119.39		090	2		4114.05	2097.37**
63272		Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumba	56.71	4735.29		090	2		3795.91	2097.37**
63273		Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacra	55.36	4622.56		090	2		3648.95	2097.37**
63275		Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervica	53.53	4469.76		090	2		3565.45	2097.37**
63276		Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	53.08	4432.18		090	2		3554.60	2097.37**
63277		Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumba	46.25	3861.88		090	2		3132.09	2097.37**
63278		Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacra	47.25	3945.38		090	2		3062.78	2097.37**
63280		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervica	62.87	5249.65		090	2		4232.62	2097.37**
63281		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic	62.19	5192.87		090	2		4188.36	2097.37**
63282		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumba	58.61	4893.94		090	2		3948.72	2097.37**
63283		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacra	56.43	4711.91		090	2		3739.97	2097.37**

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63285		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervica	77.52	6472.92		090	2		5267.18	2097.37**
63286		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic	76.23	6365.21		090	2		5229.61	2097.37**
63287		Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumba	81.32	6790.22		090	2		5476.77	2097.37**
63290		Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level	82.70	6905.45		090	2		5524.36	2097.37**
63295		Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	9.80	818.30		ZZZ	2		642.12	2097.37**
63300		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	54.47	4548.25		090	2		3684.86	2097.37**
63301		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach	63.48	5300.58		090	2		4102.36	2097.37**
63302		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach	64.62	5395.77		090	2		4095.68	2097.37**
63303		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach	68.57	5725.60		090	2		4268.52	2097.37**
63304		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	69.66	5816.61		090	2		4509.84	2097.37**
63305		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach	67.69	5652.12		090	2		4689.36	2097.37**
63306		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach	63.62	5312.27		090	2		4800.42	2097.37**
63307		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach	71.32	5955.22		090	2		4413.81	2097.37**
63308		Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)	9.47	790.75		ZZZ	2		704.74	2097.37**
63600		Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)	27.51	2297.09		090	0	1734.81	1687.54	1707.08
63610		Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	12.97	1083.00		000	0	1734.81	4755.33	1707.08
63615		Stereotactic biopsy, aspiration, or excision of lesion, spinal cord	36.76	3069.46		090	1	1734.81	2237.80	1707.08
63620		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	32.92	2748.82		090	2		1990.64	
63621		Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	7.35	613.73		ZZZ	2		486.81	
63650		Percutaneous implantation of neurostimulator electrode array, epidura	12.90	1077.15		010	1	5676.09	872.58	5992.05
63655		Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidura	24.76	2067.46		090	2	8762.33	1659.15	7889.49
63661		Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	17.62	1471.27		010	2	1949.42	1237.47	1790.80
63662		Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	23.15	1933.03		090	2	1949.42	1589.01	1790.80
63663		Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	24.75	2066.63		010	2	5676.09	1832.83	1790.80
63664		Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	23.70	1978.95		090	2	5676.09	1654.97	1790.80
63685		Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	10.90	910.15		010	2	21150.63	1015.36	18794.36
63688		Revision or removal of implanted spinal neurostimulator pulse generator or receiver	11.03	921.01		010	1	3351.98	829.99	2613.83
63700		Repair of meningocele; less than 5 cm diameter	37.46	3127.91		090	2		2447.39	2097.37**
63702		Repair of meningocele; larger than 5 cm diameter	42.33	3534.56		090	2		2712.08	2097.37**
63704		Repair of myelomeningocele; less than 5 cm diameter	49.11	4100.69		090	2		3125.41	2097.37**

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63706		Repair of myelomeningocele; larger than 5 cm diameter	54.59	4558.27		090	2		3579.65	2097.37**
63707		Repair of dural/cerebrospinal fluid leak, not requiring laminectomy	27.31	2280.39		090	2		1799.43	2097.37**
63709		Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy	32.87	2744.65		090	2		2203.57	2097.37**
63710		Dural graft, spinal	32.86	2743.81		090	2		2191.88	2097.37**
63740		Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; including laminectomy	28.42	2373.07		090	2		1817.80	2097.37**
63741		Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy	19.28	1609.88		090	2	4194.19	1214.93	3741.42
63744		Replacement, irrigation or revision of lumbosubarachnoid shunt	20.47	1709.25		090	2	4194.19	1280.89	3741.42
63746		Removal of entire lumbosubarachnoid shunt system without replacemen	18.02	1504.67		090	0	1105.20	1007.85	1207.71
64400		Injection, anesthetic agent; trigeminal nerve, any division or branch	3.71	309.79		000	1	235.58	237.14	233.06
64402		Injection, anesthetic agent; facial nerve	3.67	306.45		000	1	235.58	232.13	233.06
64405		Injection, anesthetic agent; greater occipital nerve	3.05	254.68		000	1	376.37	222.11	339.42
64408		Injection, anesthetic agent; vagus nerve	2.98	248.83		000	0	235.58	243.82	656.59
64410		Injection, anesthetic agent; phrenic nerve	3.86	322.31		000	0	235.58	309.79	656.59
64412		Injection, anesthetic agent; spinal accessory nerve	4.21	351.54		000	1	376.37	303.94	656.59
64413		Injection, anesthetic agent; cervical plexus	3.78	315.63		000	1	376.37	253.84	339.42
64415		Injection, anesthetic agent; brachial plexus, single	3.56	297.26		000	1	376.37	324.82	339.42
64416		Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	2.30	192.05		000	1	729.86	376.59	656.59
64417		Injection, anesthetic agent; axillary nerve	3.89	324.82		000	1	376.37	339.01	339.42
64418		Injection, anesthetic agent; suprascapular nerve	4.27	356.55		000	1	376.37	308.12	339.42
64420		Injection, anesthetic agent; intercostal nerve, single	3.45	288.08		000	1	376.37	387.44	339.42
64421		Injection, anesthetic agent; intercostal nerves, multiple, regional block	4.68	390.78		000	1	729.86	588.68	656.59
64425		Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	4.07	339.85		000	1	376.37	273.05	339.42
64430		Injection, anesthetic agent; pudendal nerve	4.11	343.19		000	1	729.86	324.82	656.59
64435		Injection, anesthetic agent; paracervical (uterine) nerve	4.09	341.52		000	1	376.37	320.64	339.42
64445		Injection, anesthetic agent; sciatic nerve, single	4.09	341.52		000	1	729.86	321.48	656.59
64446		Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)	2.31	192.89		000	1	729.86	363.23	656.59
64447		Injection, anesthetic agent; femoral nerve, single	3.57	298.10		000	1	376.37	151.97	339.42
64448		Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	2.07	172.85		000	1	729.86	328.16	656.59
64449		Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	2.42	202.07		000	1	729.86	325.65	656.59
64450		Injection, anesthetic agent; other peripheral nerve or branch	2.39	199.57		000	1	376.37	210.42	339.42
64455		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	1.42	118.57		000	0	235.58	111.89	233.06
64479		Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) cervical or thoracic, single level	8.65	722.28		000	1	729.86	722.28	656.59
64480		Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	3.99	333.17		ZZZ	1	376.37	333.17	678.84*
64483		Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) lumbar or sacral, single level	8.68	724.78		000	1	729.86	724.78	656.59
64484		Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	4.14	345.69		ZZZ	1	376.37	345.69	678.84*
64490		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	5.96	497.66		000	2	729.86	420.84	656.59

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64491		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary proced	2.88	240.48		ZZZ	2	235.58	212.09	466.12*
64492		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to co	2.89	241.32		ZZZ	2	235.58	214.60	466.12*
64493		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	5.39	450.07		000	2	729.86	376.59	656.59
64494		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	2.64	220.44		ZZZ	2	235.58	192.89	466.12*
64495		Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code f	2.65	221.28		ZZZ	2	235.58	195.39	466.12*
64505		Injection, anesthetic agent; sphenopalatine ganglior	3.09	258.02		000	1	235.58	211.26	233.06
64508		Injection, anesthetic agent; carotid sinus (separate procedure)	1.93	161.16		000	0	235.58	337.34	233.06
64510		Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	3.91	326.49		000	1	729.86	353.21	656.59
64517		Injection, anesthetic agent; superior hypogastric plexus	5.45	455.08		000	1	729.86	379.09	656.59
64520		Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	5.73	478.46		000	1	729.86	483.47	656.59
64530		Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring	5.93	495.16		000	1	729.86	459.25	656.59
64550		Application of surface (transcutaneous) neurostimulator	0.47	39.25		000	1		35.91	
64553		Percutaneous implantation of neurostimulator electrode array; cranial nerve	6.90	576.15		010	0	5676.09	420.01	5992.05
64555		Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	5.99	500.17		010	1	5676.09	435.04	5992.05
64561		Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	23.91	1996.49		010	1	5676.09	2870.73	5992.05
64565		Percutaneous implantation of neurostimulator electrode array; neuromuscular	5.37	448.40		010	1	5676.09	401.64	5992.05
64566		Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	3.64	303.94		000	0	235.58	New	
64568		Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	18.26	1524.71		090	0	33101.48	New	
64569		Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	23.19	1936.37		090	0	5676.09	New	
64570		Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generato	20.47	1709.25		090	0	3201.45	New	
64575		Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	9.39	784.07		090	1	8762.33	587.01	7889.49
64580		Incision for implantation of neurostimulator electrode array; neuromuscular	9.12	761.52		090	2	8762.33	619.57	7889.49
64581		Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)	19.47	1625.75		090	1	8762.33	1629.09	7889.49
64585		Revision or removal of peripheral neurostimulator electrode array	7.45	622.08		010	1	1949.42	999.50	1790.80
64590		Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	7.86	656.31		010	1	21150.63	778.22	18794.36
64595		Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	7.45	622.08		010	1	3351.98	932.70	2613.83
64600		Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	11.87	991.15		010	1	1105.20	982.80	1207.71
64605		Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	16.49	1376.92		010	0	1734.81	1242.48	1707.08
64610		Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	22.31	1862.89		010	1	1734.81	1422.01	1707.08
64611		Chemodenervation of parotid and submandibular salivary glands, bilatera	3.37	281.40		010	0	235.58	New	

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64612		Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)	4.11	343.19		010	1	235.58	347.36	233.06
64613		Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)	5.15	430.03		010	1	376.37	369.91	339.42
64614		Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)	5.53	461.76		010	1	376.37	409.15	339.42
64615		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	4.23	353.21		010	1	235.58	New	
64620		Destruction by neurolytic agent, intercostal nerve	6.26	522.71		010	1	1105.20	618.74	656.59
64630		Destruction by neurolytic agent; pudendal nerve	6.27	523.55		010	0	729.86	474.28	656.59
64632		Destruction by neurolytic agent; plantar common digital nerve	2.53	211.26		010	0	235.58	191.22	233.06
64633		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	12.24	1022.04		010	1	729.86	New	
64634		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	5.54	462.59		ZZZ	1	235.58	New	
64635		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	12.02	1003.67		010	1	1105.20	New	
64636		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	4.99	416.67		ZZZ	1	729.86	New	
64640		Destruction by neurolytic agent; other peripheral nerve or branch	6.54	546.09		010	1	729.86	546.09	656.59
64650		Chemodenervation of eccrine glands; both axillae	3.75	313.13		000	0	235.58	128.59	233.06
64653		Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	4.52	377.42		000	0	235.58	147.80	233.06
64680		Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	9.60	801.60		010	1	1105.20	715.60	656.59
64681		Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexu	10.93	912.66		010	1	1105.20	989.48	1207.71
64702		Neuroplasty; digital, 1 or both, same digit	14.93	1246.66		090	1	1734.81	862.56	1707.08
64704		Neuroplasty; nerve of hand or foot	9.42	786.57		090	2	1734.81	672.18	1707.08
64708		Neuroplasty, major peripheral nerve, arm or leg, open; other than specified	14.87	1241.65		090	2	1734.81	941.88	1707.08
64712		Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve	16.88	1409.48		090	2	1734.81	1084.67	1707.08
64713		Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus	21.94	1831.99		090	2	1734.81	1503.84	1707.08
64714		Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus	19.00	1586.50		090	2	1734.81	1249.16	1707.08
64716		Neuroplasty and/or transposition; cranial nerve (specify)	16.05	1340.18		090	2	1734.81	1051.27	1707.08
64718		Neuroplasty and/or transposition; ulnar nerve at elbow	17.72	1479.62		090	0	1734.81	1123.91	1707.08
64719		Neuroplasty and/or transposition; ulnar nerve at wrist	11.88	991.98		090	1	1734.81	802.44	1707.08
64721		Neuroplasty and/or transposition; median nerve at carpal tunnel	12.82	1217.90		090	1	1734.81	977.55	1707.08
64722		Decompression; unspecified nerve(s) (specify)	10.86	906.81		090	2	1734.81	645.46	1707.08
64726		Decompression; plantar digital nerve	8.11	677.19		090	1	1734.81	593.69	1707.08
64727		Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)	5.40	450.90		ZZZ	1	1734.81	393.29	1707.08
64732		Transection or avulsion of; supraorbital nerve	13.30	1110.55		090	2	1734.81	753.17	1707.08
64734		Transection or avulsion of; infraorbital nerve	11.59	967.77		090	0	1734.81	835.00	1707.08
64736		Transection or avulsion of; mental nerve	12.86	1073.81		090	2	1734.81	761.52	1707.08
64738		Transection or avulsion of; inferior alveolar nerve by osteotomy	14.84	1239.14		090	2	1734.81	938.54	1707.08
64740		Transection or avulsion of; lingual nerve	13.77	1149.80		090	2	1734.81	930.19	1707.08
64742		Transection or avulsion of; facial nerve, differential or complete	15.00	1252.50		090	2	1734.81	954.41	1707.08
64744		Transection or avulsion of; greater occipital nerve	14.83	1238.31		090	0	1734.81	852.54	1707.08
64746		Transection or avulsion of; phrenic nerve	12.95	1081.33		090	2	1734.81	916.00	1707.08
64752		Transection or avulsion of; vagus nerve (vagotomy), transthoracic	14.69	1226.62		090	2		1000.33	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
64755		Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	27.13	2265.36		090	2		1751.00	2097.37**
64760		Transection or avulsion of; vagus nerve (vagotomy), abdomina	15.29	1276.72		090	2		926.85	2097.37**
64761		Transection or avulsion of; pudendal nerve	13.81	1153.14		090	2	1734.81	868.40	1707.08
64763		Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy	16.59	1385.27		090	2	1734.81	1071.31	1707.08
64766		Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy	17.50	1461.25		090	2	3201.45	1229.12	3399.62
64771		Transection or avulsion of other cranial nerve, extradura	17.15	1432.03		090	2	1734.81	1163.99	1707.08
64772		Transection or avulsion of other spinal nerve, extradura	17.21	1437.04		090	2	1734.81	1118.07	1707.08
64774		Excision of neuroma; cutaneous nerve, surgically identifiable	12.52	1045.42		090	1	1734.81	813.29	1707.08
64776		Excision of neuroma; digital nerve, 1 or both, same digit	11.52	961.92		090	0	1734.81	786.57	1707.08
64778		Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	4.52	377.42		ZZZ	1	1734.81	391.62	1707.08
64782		Excision of neuroma; hand or foot, except digital nerve	13.37	1116.40		090	1	1734.81	901.80	1707.08
64783		Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	6.35	530.23		ZZZ	1	1734.81	465.93	1707.08
64784		Excision of neuroma; major peripheral nerve, except sciatic	21.92	1830.32		090	0	1734.81	1446.22	1707.08
64786		Excision of neuroma; sciatic nerve	31.99	2671.17		090	2	3201.45	2234.46	3399.62
64787		Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision	7.16	597.86		ZZZ	0	1734.81	537.74	1707.08
64788		Excision of neurofibroma or neurolemmoma; cutaneous nerve	12.00	1002.00		090	1	1734.81	744.82	1707.08
64790		Excision of neurofibroma or neurolemmoma; major peripheral nerve	24.53	2048.26		090	0	1734.81	1670.00	1707.08
64792		Excision of neurofibroma or neurolemmoma; extensive (including malignant type)	35.46	2960.91		090	2	3201.45	2117.56	3399.62
64795		Biopsy of nerve	5.77	481.80		000	1	1734.81	397.46	1707.08
64802		Sympathectomy, cervical	15.43	1288.41		090	2	1734.81	1286.74	1707.08
64804		Sympathectomy, cervicothoracic	25.34	2115.89		090	2	1734.81	1938.04	1707.08
64809		Sympathectomy, thoracolumbar	21.21	1771.04		090	2		1721.77	2097.37**
64818		Sympathectomy, lumbar	19.05	1590.68		090	2		1375.25	2097.37**
64820		Sympathectomy; digital arteries, each digit	22.21	1854.54		090	1	1734.81	1518.87	1707.08
64821		Sympathectomy; radial artery	20.74	1731.79		090	1	2665.47	1394.45	2574.99
64822		Sympathectomy; ulnar artery	20.74	1731.79		090	1	2665.47	1388.61	2574.99
64823		Sympathectomy; superficial palmar arch	23.61	1971.44		090	1	2665.47	1601.53	2574.99
64831		Suture of digital nerve, hand or foot; 1 nerve	20.37	1700.90		090	1	3201.45	1470.44	3399.62
64832		Suture of digital nerve, hand or foot; each additional digital nerve (List separately in addition to code for primary procedure)	9.94	829.99		ZZZ	0	3201.45	728.96	3399.62
64834		Suture of 1 nerve; hand or foot, common sensory nerve	22.03	1839.51		090	0	3201.45	1516.36	3399.62
64835		Suture of 1 nerve; median motor thenar	24.13	2014.86		090	2	3201.45	1652.47	3399.62
64836		Suture of 1 nerve; ulnar motor	24.72	2064.12		090	2	3201.45	1639.94	3399.62
64837		Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	10.96	915.16		ZZZ	2	3201.45	809.95	3399.62
64840		Suture of posterior tibial nerve	27.49	2295.42		090	2	3201.45	1780.22	3399.62
64856		Suture of major peripheral nerve, arm or leg, except sciatic; including transpositior	30.07	2510.85		090	1	3201.45	2057.44	3399.62
64857		Suture of major peripheral nerve, arm or leg, except sciatic; without transpositior	31.22	2606.87		090	2	3201.45	2155.97	3399.62
64858		Suture of sciatic nerve	35.88	2995.98		090	2	3201.45	2499.16	3399.62
64859		Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)	7.59	633.77		ZZZ	2	3201.45	552.77	3399.62
64861		Suture of; brachial plexus	38.72	3233.12		090	2	3201.45	2848.19	3399.62
64862		Suture of; lumbar plexus	40.71	3399.29		090	2	3201.45	2821.47	3399.62
64864		Suture of facial nerve; extracranial	26.06	2176.01		090	2	3201.45	1803.60	3399.62
64865		Suture of facial nerve; infratemporal, with or without grafting	33.39	2788.07		090	2	3201.45	2380.59	3399.62
64866		Anastomosis; facial-spinal accessory	34.62	2890.77		090	2		2509.18	2097.37**
64868		Anastomosis; facial-hypoglossal	30.57	2552.60		090	2		2138.44	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
64870		Anastomosis; facial-phrenic	32.50	2713.75		090	2	3201.45	2105.87	3399.62
64872		Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)	3.42	285.57		ZZZ	2	3201.45	258.85	3399.62
64874		Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)	5.23	436.71		ZZZ	2	3201.45	380.76	3399.62
64876		Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)	5.38	449.23		ZZZ	2	3201.45	417.50	3399.62
64885		Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length	33.73	2816.46		090	2	3201.45	2365.56	3399.62
64886		Nerve graft (includes obtaining graft), head or neck; more than 4 cm length	38.67	3228.95		090	2	3201.45	2787.23	3399.62
64890		Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length	31.96	2668.66		090	2	3201.45	2220.27	3399.62
64891		Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length	35.13	2933.36		090	2	3201.45	2114.22	3399.62
64892		Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	32.08	2678.68		090	2	3201.45	2124.24	3399.62
64893		Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length	33.20	2772.20		090	2	3201.45	2300.43	3399.62
64895		Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	40.06	3345.01		090	2	3201.45	2555.94	3399.62
64896		Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	44.09	3681.52		090	2	3201.45	2842.34	3399.62
64897		Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length	38.27	3195.55		090	2	3201.45	2549.26	3399.62
64898		Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length	42.07	3512.85		090	2	3201.45	2774.71	3399.62
64901		Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)	18.64	1556.44		ZZZ	2	3201.45	1291.75	3399.62
64902		Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)	20.01	1670.84		ZZZ	2	3201.45	1481.29	3399.62
64905		Nerve pedicle transfer; first stage	30.91	2580.99		090	2	3201.45	1970.60	3399.62
64907		Nerve pedicle transfer; second stage	36.95	3085.33		090	2	3201.45	2676.18	3399.62
64910		Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	24.42	2039.07		090	2	3201.45	1422.01	3399.62
64911		Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve	30.67	2560.95		090	2	3201.45	1725.11	3399.62
64999		Unlisted procedure, nervous system	0.00	BR		YYY	0	235.58	BR	233.06
65091		Evisceration of ocular contents; without implant	19.79	1652.47		090	0	3654.45	1229.96	3557.46
65093		Evisceration of ocular contents; with implant	19.55	1632.43		090	1	3654.45	1240.81	3557.46
65101		Enucleation of eye; without implant	22.98	1918.83		090	1	3654.45	1405.31	3557.46
65103		Enucleation of eye; with implant, muscles not attached to implan	23.99	2003.17		090	1	3654.45	1464.59	3557.46
65105		Enucleation of eye; with implant, muscles attached to implan	26.43	2206.91		090	2	3654.45	1609.05	3557.46
65110		Exenteration of orbit (does not include skin graft), removal of orbital contents; only	36.96	3086.16		090	2	3654.45	2326.31	3557.46
65112		Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone	42.83	3576.31		090	2	3654.45	2759.68	3557.46
65114		Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap	44.91	3749.99		090	2	3654.45	2849.02	3557.46
65125		Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	14.23	1188.21		090	1	2456.40	947.73	2447.50
65130		Insertion of ocular implant secondary; after evisceration, in scleral shel	22.78	1902.13		090	1	2456.40	1387.77	2447.50
65135		Insertion of ocular implant secondary; after enucleation, muscles not attached to implan	23.10	1928.85		090	1	2456.40	1411.15	2447.50
65140		Insertion of ocular implant secondary; after enucleation, muscles attached to implan	24.50	2045.75		090	1	3654.45	1525.55	3557.46
65150		Reinsertion of ocular implant; with or without conjunctival graft	17.17	1433.70		090	0	2456.40	1135.60	2447.50
65155		Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant	26.32	2197.72		090	1	3654.45	1625.75	3557.46
65175		Removal of ocular implant	19.93	1664.16		090	1	1764.73	1251.67	1655.83
65205		Removal of foreign body, external eye; conjunctival superficia	1.70	141.95		000	1	95.55	108.55	87.11
65210		Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	2.10	175.35		000	1	95.55	132.77	87.11
65220		Removal of foreign body, external eye; corneal, without slit lamp	1.75	146.13		000	1	95.55	110.22	87.11
65222		Removal of foreign body, external eye; corneal, with slit lamp	2.06	172.01		000	1	95.55	146.13	87.11

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
65235		Removal of foreign body, intraocular; from anterior chamber of eye or lens	21.65	1807.78		090	0	1457.10	1260.02	1481.70
65260		Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route	28.28	2361.38		090	2	537.18	1765.19	533.44
65265		Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction	33.90	2830.65		090	2	1860.46	1982.29	1888.96
65270		Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure	8.20	684.70		010	0	1764.73	559.45	1655.83
65272		Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization	15.06	1257.51		090	1	2162.98	971.94	2225.23
65273		Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization	11.24	938.54		090	1		692.22	2097.37**
65275		Repair of laceration; cornea, nonperforating, with or without removal foreign body	17.14	1431.19		090	0	2162.98	1012.86	2225.23
65280		Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	20.95	1749.33		090	0	1860.46	1215.76	1888.96
65285		Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	34.26	2860.71		090	1	3759.00	1898.79	3644.34
65286		Repair of laceration; application of tissue glue, wounds of cornea and/or sclera	21.52	1796.92		090	1	855.12	1391.95	411.03
65290		Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	15.29	1276.72		090	1	2319.15	895.96	2140.17
65400		Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	20.73	1730.96		090	1	1457.10	1254.17	1481.70
65410		Biopsy of cornea	4.46	372.41		000	0	1457.10	283.90	1481.70
65420		Excision or transposition of pterygium; without graft	15.67	1308.45		090	1	1457.10	1037.07	1481.70
65426		Excision or transposition of pterygium; with graft	19.95	1665.83		090	1	2162.98	1279.22	2225.23
65430		Scraping of cornea, diagnostic, for smear and/or culture	3.51	293.09		000	1	95.55	220.44	87.11
65435		Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage	2.47	206.25		000	1	794.29	153.64	696.88
65436		Removal of corneal epithelium; with application of chelating agent (eg, EDTA)	11.97	999.50		090	1	1457.10	710.59	1481.70
65450		Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization	9.93	829.16		090	1	186.92	598.70	178.50
65600		Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)	12.07	1007.85		090	1	1764.73	729.79	1655.83
65710		Keratoplasty (corneal transplant); anterior lamellar	33.63	2808.11		090	2	3828.18	2031.56	3423.16
65730		Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia	37.28	3112.88		090	2	3828.18	2250.33	3423.16
65750		Keratoplasty (corneal transplant); penetrating (in aphakia)	37.30	3114.55		090	2	3828.18	2290.41	3423.16
65755		Keratoplasty (corneal transplant); penetrating (in pseudophakia)	37.26	3111.21		090	2	3828.18	2275.38	3423.16
65756		Keratoplasty (corneal transplant); endothelia	34.83	2908.31		090	2	3828.18	2417.33	3423.16
65757		Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	0.00	BR		ZZZ	0		BR	
65760		Keratomileusis	36.08	3012.68		XXX	9		2926.68	2097.37**
65765		Keratophakia	52.32	4368.72		XXX	9		3394.94	2097.37**
65767		Epikeratoplasty	48.71	4067.29		XXX	9		3160.81	2097.37**
65770		Keratoprosthesis	47.08	3931.18		090	2	11349.40	2612.72	9211.66
65771		Radial keratotomy	19.84	1656.64		XXX	9		1720.85	2097.37**
65772		Corneal relaxing incision for correction of surgically induced astigmatism	13.71	1144.79		090	1	1457.10	840.85	1481.70
65775		Corneal wedge resection for correction of surgically induced astigmatism	16.33	1363.56		090	1	1457.10	1016.20	1481.70
65778		Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	43.19	3606.37		010	0	1457.10	New	
65779		Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured	37.97	3170.50		010	0	1457.10	New	
65780		Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	27.00	2254.50		090	1	3828.18	1658.31	3423.16
65781		Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)	39.30	3281.55		090	2	3828.18	2485.80	3423.16
65782		Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)	35.92	2999.32		090	1	3828.18	2148.46	3423.16
65800		Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous	3.63	303.11		000	1	855.12	293.92	1481.70
65810		Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection	14.19	1184.87		090	1	2162.98	841.68	2225.23
65815		Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection	19.75	1649.13		090	1	2162.98	1256.68	2225.23
65820		Goniotomy	22.24	1857.04		090	0	2162.98	1420.34	411.03
65850		Trabeculotomy ab externo	25.94	2165.99		090	1	2162.98	1575.65	2225.23
65855		Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series	10.38	866.73		010	1	529.96	654.64	483.43
65860		Severing adhesions of anterior segment, laser technique (separate procedure)	10.23	854.21		090	0	529.96	606.21	483.43

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
65865		Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae	14.00	1169.00		090	1	1457.10	902.64	1481.70
65870		Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae	18.28	1526.38		090	1	2162.98	1092.18	2225.23
65875		Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae	19.19	1602.37		090	1	2162.98	1156.48	2225.23
65880		Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions	19.64	1639.94		090	1	1457.10	1220.77	1481.70
65900		Removal of epithelial downgrowth, anterior chamber of eye	28.46	2376.41		090	2	186.80	1801.10	1481.70
65920		Removal of implanted material, anterior segment of eye	23.91	1996.49		090	1	2162.98	1440.38	2225.23
65930		Removal of blood clot, anterior segment of eye	19.71	1645.79		090	1	3841.79	1203.24	2225.23
66020		Injection, anterior chamber of eye (separate procedure); air or liquic	5.59	466.77		010	1	1457.10	374.92	1481.70
66030		Injection, anterior chamber of eye (separate procedure); medicatior	5.08	424.18		010	1	1457.10	334.84	411.03
66130		Excision of lesion, sclera	21.79	1819.47		090	0	2162.98	1377.75	2225.23
66150		Fistulization of sclera for glaucoma; trephination with iridectomy	25.99	2170.17		090	1	2162.98	1582.33	2225.23
66155		Fistulization of sclera for glaucoma; thermocauterization with iridectomy	25.97	2168.50		090	1	3841.79	1573.98	2225.23
66160		Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy	29.24	2441.54		090	1	2162.98	1790.24	2225.23
66165		Fistulization of sclera for glaucoma; iridencleisis or iridotasis	25.49	2128.42		090	2	2162.98	1544.75	2225.23
66170		Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	36.40	3039.40		090	2	2162.98	2160.15	2225.23
66172		Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	45.94	3835.99		090	2	2162.98	2702.90	2225.23
66174		Transluminal dilation of aqueous outflow canal; without retention of device or sten	29.30	2446.55		090	2	3841.79	New	
66175		Transluminal dilation of aqueous outflow canal; with retention of device or sten	33.15	2768.03		090	2	3841.79	New	
66180		Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	35.26	2944.21		090	2	3841.79	2149.29	3819.40
66185		Revision of aqueous shunt to extraocular reservoir	23.18	1935.53		090	2	3841.79	1351.03	2225.23
66220		Repair of scleral staphyloma; without graft	22.67	1892.95		090	2	3759.00	1305.11	3644.34
66225		Repair of scleral staphyloma; with graft	29.06	2426.51		090	1	3841.79	1700.06	3819.40
66250		Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	23.33	1948.06		090	1	1457.10	1475.45	1481.70
66500		Iridotomy by stab incision (separate procedure); except transfixior	10.56	881.76		090	1	186.80	672.18	411.03
66505		Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe	11.56	965.26		090	1	855.12	732.30	411.03
66600		Iridectomy, with corneoscleral or corneal section; for removal of lesior	24.73	2064.96		090	1	2162.98	1473.78	2225.23
66605		Iridectomy, with corneoscleral or corneal section; with cyclectomy	31.16	2601.86		090	1	3841.79	1940.54	2225.23
66625		Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure	13.07	1091.35		090	1	855.12	799.10	1481.70
66630		Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure	17.55	1465.43		090	1	2162.98	1033.73	2225.23
66635		Iridectomy, with corneoscleral or corneal section; optical (separate procedure	17.00	1419.50		090	1	2162.98	1042.92	2225.23
66680		Repair of iris, ciliary body (as for iridodialysis)	16.24	1356.04		090	1	2162.98	931.03	2225.23
66682		Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)	19.89	1660.82		090	1	2162.98	1122.24	2225.23
66700		Ciliary body destruction; diathermy	13.50	1127.25		090	0	1457.10	832.50	1481.70
66710		Ciliary body destruction; cyclophotocoagulation, transsclera	13.72	1145.62		090	1	1457.10	822.48	1481.70
66711		Ciliary body destruction; cyclophotocoagulation, endoscopic	19.02	1588.17		090	1	2162.98	1145.62	1481.70
66720		Ciliary body destruction; cryotherapy	14.43	1204.91		090	1	1457.10	864.23	1481.70
66740		Ciliary body destruction; cyclodialysis	12.97	1083.00		090	1	2162.98	815.80	2225.23
66761		Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)	9.09	759.02		010	1	529.96	840.85	483.43
66762		Iridoplasty by photocoagulation (1 or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle)	14.41	1203.24		090	1	529.96	877.59	483.43
66770		Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)	15.66	1307.61		090	1	529.96	971.94	483.43
66820		Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)	12.13	1012.86		090	1	855.12	774.05	411.03

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66821		Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)	10.14	846.69		090	1	529.96	597.03	483.43
66825		Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	23.08	1927.18		090	0	2162.98	1431.19	2225.23
66830		Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)	21.03	1756.01		090	1	855.12	1300.93	411.03
66840		Removal of lens material; aspiration technique, 1 or more stages	21.74	1815.29		090	1	1457.10	1274.21	1441.58
66850		Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration	24.11	2013.19		090	1	2703.31	1445.39	2765.73
66852		Removal of lens material; pars plana approach, with or without vitrectomy	26.09	2178.52		090	0	2703.31	1549.76	2765.73
66920		Removal of lens material; intracapsular	22.24	1857.04		090	0	2703.31	1384.43	2765.73
66930		Removal of lens material; intracapsular, for dislocated lens	25.26	2109.21		090	0	2703.31	1568.97	2765.73
66940		Removal of lens material; extracapsular (other than 66840, 66850, 66852	24.08	2010.68		090	0	855.12	1427.02	1441.58
66982		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine	24.35	2033.23		090	1	2232.46	1980.62	2214.81
66983		Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure	22.21	1854.54		090	1	2232.46	1293.42	2214.81
66984		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	19.63	1639.11		090	1	2232.46	1415.33	2214.81
66985		Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	23.38	1952.23		090	1	2232.46	1381.93	2214.81
66986		Exchange of intraocular lens	27.50	2296.25		090	1	2232.46	1721.77	2214.81
66990		Use of ophthalmic endoscope (List separately in addition to code for primary procedure	2.62	218.77		ZZZ	1		174.52	
66999		Unlisted procedure, anterior segment of eye	0.00	BR		YYY	0	186.80	BR	411.03
67005		Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	14.83	1238.31		090	1	1860.46	860.89	1888.96
67010		Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy	16.51	1378.59		090	1	3759.00	996.99	3644.34
67015		Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)	17.68	1476.28		090	1	3759.00	1082.16	3644.34
67025		Injection of vitreous substitute, pars plana or limbal approach (fluid-gas exchange), with or without aspiration (separate procedure)	22.47	1876.25		090	1	3759.00	1369.40	1888.96
67027		Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	26.32	2197.72		090	2	3759.00	1565.63	3644.34
67028		Intravitreal injection of a pharmacologic agent (separate procedure)	3.09	258.02		000	1	298.99	415.83	294.24
67030		Discission of vitreous strands (without removal), pars plana approach	15.81	1320.14		090	1	1860.46	951.90	1888.96
67031		Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (1 or more stages)	11.81	986.14		090	1	529.96	717.27	483.43
67036		Vitrectomy, mechanical, pars plana approach	29.11	2430.69		090	2	3759.00	1779.39	3644.34
67039		Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	38.15	3185.53		090	2	3759.00	2287.07	3644.34
67040		Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation	43.09	3598.02		090	2	3759.00	2635.26	3644.34
67041		Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	40.16	3353.36		090	2	3759.00	2348.64	3644.34
67042		Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	45.85	3828.48		090	2	3759.00	2686.32	3644.34
67043		Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation	49.15	4104.03		090	2	3759.00	2821.56	3644.34
67101		Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid	24.23	2023.21		090	1	1860.46	1431.19	1888.96

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67105		Repair of retinal detachment, 1 or more sessions; photocoagulation, with or without drainage of subretinal fluid	21.91	1829.49		090	1	529.96	1325.15	483.43
67107		Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid	37.56	3136.26		090	2	3759.00	2223.61	3644.34
67108		Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolase photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	48.69	4065.62		090	2	3759.00	2961.75	3644.34
67110		Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy	26.37	2201.90		090	1	1860.46	1623.24	1888.96
67112		Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques	40.24	3360.04		090	2	3759.00	2432.36	3644.34
67113		Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include	52.90	4417.15		090	2	3759.00	3099.60	3644.34
67115		Release of encircling material (posterior segment)	15.15	1265.03		090	1	1860.46	890.95	1888.96
67120		Removal of implanted material, posterior segment; extraocular	20.50	1711.75		090	1	1860.46	1239.98	1888.96
67121		Removal of implanted material, posterior segment; intraocular	28.09	2345.52		090	2	3759.00	1654.14	1888.96
67141		Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy	16.20	1352.70		090	1	537.18	956.91	533.44
67145		Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)	16.03	1338.51		090	1	529.96	960.25	483.43
67208		Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; cryotherapy, diathermy	17.71	1478.79		090	1	537.18	1097.19	533.44
67210		Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation	15.84	1322.64		090	1	529.96	1280.06	483.43
67218		Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; radiation by implantation of source (includes removal of source)	40.59	3389.27		090	1	1860.46	2591.01	1888.96
67220		Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions	16.53	1380.26		090	1	537.18	1973.94	533.44
67221		Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)	8.74	729.79		000	1	537.18	610.39	533.44
67225		Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye at single session (List separately in addition to code for primary eye treatment)	0.87	72.65		ZZZ	1	537.18	57.62	533.44
67227		Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), 1 or more sessions, cryotherapy, diathermy	18.08	1509.68		090	1	1860.46	1124.75	1888.96
67228		Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation	30.55	2550.93		090	1	529.96	2014.02	483.43
67229		Treatment of extensive or progressive retinopathy, 1 or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	34.33	2866.56		090	1	529.96	2042.88	483.43
67250		Scleral reinforcement (separate procedure); without graft	24.08	2010.68		090	1	1764.73	1490.48	1655.83
67255		Scleral reinforcement (separate procedure); with graft	26.24	2191.04		090	2	1860.46	1588.17	1888.96
67299		Unlisted procedure, posterior segment	0.00	BR		YYY	0	537.18	BR	533.44
67311		Strabismus surgery, recession or resection procedure; 1 horizontal muscle	18.43	1538.91		090	1	2319.15	1098.03	2140.17
67312		Strabismus surgery, recession or resection procedure; 2 horizontal muscles	22.20	1853.70		090	1	2319.15	1306.78	2140.17
67314		Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)	20.76	1733.46		090	1	2319.15	1222.44	2140.17
67316		Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)	25.00	2087.50		090	0	2319.15	1467.93	2140.17
67318		Strabismus surgery, any procedure, superior oblique muscle	20.79	1735.97		090	1	2319.15	1280.89	2140.17

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67320		Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)	9.40	784.90		ZZZ	1	2319.15	589.51	2140.17
67331		Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)	9.40	784.90		ZZZ	1	2319.15	557.78	2140.17
67332		Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)	10.22	853.37		ZZZ	1	2319.15	607.88	2140.17
67334		Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	8.79	733.97		ZZZ	1	2319.15	547.76	2140.17
67335		Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)	4.57	381.60		ZZZ	1	2319.15	288.08	2140.17
67340		Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	10.45	872.58		ZZZ	2	2319.15	657.15	2140.17
67343		Release of extensive scar tissue without detaching extraocular muscle (separate procedure	20.33	1697.56		090	1	2319.15	1193.22	2140.17
67345		Chemodenervation of extraocular muscle	7.57	632.10		010	1	298.99	447.56	294.24
67346		Biopsy of extraocular muscle	6.31	526.89		000	0	1459.88	380.76	1417.16
67399		Unlisted procedure, ocular muscle	0.00	BR		YYY	2	2319.15	BR	2140.17
67400		Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy	28.81	2405.64		090	1	1764.73	1780.22	1655.83
67405		Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only	23.96	2000.66		090	1	2456.40	1502.17	2447.50
67412		Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion	26.31	2196.89		090	1	1764.73	1674.18	1655.83
67413		Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body	26.57	2218.60		090	2	2456.40	1661.65	2447.50
67414		Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression	40.05	3344.18		090	2	3654.45	2396.45	3557.46
67415		Fine needle aspiration of orbital contents	3.16	263.86		000	0	1764.73	200.40	1655.83
67420		Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion	50.06	4180.01		090	2	3654.45	3117.06	3557.46
67430		Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body	36.94	3084.49		090	2	3654.45	2396.45	3557.46
67440		Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage	36.57	3053.60		090	2	3654.45	2300.43	3557.46
67445		Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression	43.64	3643.94		090	2	3654.45	2635.26	3557.46
67450		Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy	38.02	3174.67		090	2	3654.45	2377.25	3557.46
67500		Retrobulbar injection; medication (separate procedure, does not include supply of medication	2.34	195.39		000	1	186.92	167.84	178.50
67505		Retrobulbar injection; alcohol	2.79	232.97		000	1	298.99	153.64	294.24
67515		Injection of medication or other substance into Tenon's capsule	3.01	251.34		000	1	298.99	161.99	294.24
67550		Orbital implant (implant outside muscle cone); insertion	29.93	2499.16		090	1	3654.45	1844.52	3557.46
67560		Orbital implant (implant outside muscle cone); removal or revision	29.93	2499.16		090	0	2456.40	1870.40	2447.50
67570		Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)	37.92	3166.32		090	2	3654.45	2212.75	3557.46
67599		Unlisted procedure, orbit	0.00	BR		YYY	2	298.99	BR	294.24
67700		Blepharotomy, drainage of abscess, eyelid	8.26	689.71		010	1	298.99	577.82	294.24
67710		Severing of tarsorrhaphy	6.96	581.16		010	1	794.29	497.66	696.88
67715		Canthotomy (separate procedure)	7.38	616.23		010	1	1764.73	516.03	1655.83
67800		Excision of chalazion; single	3.91	326.49		010	1	298.99	242.15	294.24
67801		Excision of chalazion; multiple, same lid	5.04	420.84		010	1	794.29	308.95	696.88
67805		Excision of chalazion; multiple, different lids	6.27	523.55		010	1	298.99	382.43	294.24
67808		Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple	11.48	958.58		090	1	1764.73	665.50	1655.83
67810		Incisional biopsy of eyelid skin including lid margin	5.25	438.38		000	1	298.99	407.48	294.24
67820		Correction of trichiasis; epilation, by forceps only	1.54	128.59		000	1	95.55	104.38	87.11
67825		Correction of trichiasis; epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)	3.99	333.17		010	1	298.99	249.67	294.24

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67830		Correction of trichiasis; incision of lid margin	8.27	690.55		010	1	794.29	567.80	696.88
67835		Correction of trichiasis; incision of lid margin, with free mucous membrane graft	13.70	1143.95		090	0	1764.73	822.48	1655.83
67840		Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	8.48	708.08		010	1	794.29	588.68	696.88
67850		Destruction of lesion of lid margin (up to 1 cm)	6.53	545.26		010	1	794.29	415.00	696.88
67875		Temporary closure of eyelids by suture (eg, Frost suture)	5.30	442.55		000	1	794.29	364.90	696.88
67880		Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy	14.18	1184.03		090	1	1457.10	882.60	1481.70
67882		Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate	17.54	1464.59		090	1	1764.73	1077.15	1655.83
67900		Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	19.72	1646.62		090	1	2456.40	1260.02	2447.50
67901		Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	23.50	1962.25		090	1	1764.73	1138.11	1655.83
67902		Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	22.48	1877.08		090	1	2456.40	1258.35	2447.50
67903		Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	18.42	1538.07		090	1	1764.73	1263.36	1655.83
67904		Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	22.70	1895.45		090	1	1764.73	1401.97	1655.83
67906		Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia	14.99	1251.67		090	1	1764.73	965.26	1655.83
67908		Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	15.36	1282.56		090	1	1764.73	948.56	1655.83
67909		Reduction of overcorrection of ptosis	16.63	1388.61		090	1	1764.73	1072.98	1655.83
67911		Correction of lid retraction	17.44	1456.24		090	1	1764.73	990.31	1655.83
67912		Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight	27.08	2261.18		090	1	1764.73	1951.40	1655.83
67914		Repair of ectropion; suture	11.99	1001.17		090	1	1764.73	793.25	1655.83
67915		Repair of ectropion; thermocauterization	10.74	896.79		090	1	1764.73	723.95	1655.83
67916		Repair of ectropion; excision tarsal wedge	16.60	1386.10		090	1	1764.73	1067.97	1655.83
67917		Repair of ectropion; extensive (eg, tarsal strip operations)	18.14	1514.69		090	1	1764.73	1161.49	1655.83
67921		Repair of entropion; suture	11.53	962.76		090	1	1764.73	758.18	1655.83
67922		Repair of entropion; thermocauterization	10.47	874.25		090	1	1764.73	708.08	1655.83
67923		Repair of entropion; excision tarsal wedge	17.60	1469.60		090	1	1764.73	1118.90	1655.83
67924		Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	18.18	1518.03		090	1	1764.73	1171.51	1655.83
67930		Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness	11.32	945.22		010	1	1764.73	739.81	1655.83
67935		Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness	18.40	1536.40		090	1	1764.73	1183.20	1655.83
67938		Removal of embedded foreign body, eyelid	7.46	622.91		010	1	186.92	525.22	178.50
67950		Canthoplasty (reconstruction of canthus)	17.68	1476.28		090	1	1764.73	1154.81	1655.83
67961		Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to 1/4 of lid margin	17.81	1487.14		090	0	1764.73	1149.80	1655.83
67966		Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over 1/4 of lid margin	23.80	1987.30		090	1	1764.73	1440.38	1655.83
67971		Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to 2/3 of eyelid, 1 stage or first stage	22.53	1881.26		090	1	1764.73	1376.92	1655.83
67973		Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage	29.00	2421.50		090	2	2456.40	1789.41	2447.50
67974		Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage	28.96	2418.16		090	2	1764.73	1781.89	1655.83
67975		Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage	21.32	1780.22		090	1	1764.73	1299.26	1655.83
67999		Unlisted procedure, eyelids	0.00	BR		YYY	0	298.99	BR	294.24

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
68020		Incision of conjunctiva, drainage of cyst	3.65	304.78		010	1	298.99	224.62	294.24
68040		Expression of conjunctival follicles (eg, for trachoma)	2.00	167.00		000	1	95.55	124.42	87.11
68100		Biopsy of conjunctiva	5.21	435.04		000	1	794.29	360.72	411.03
68110		Excision of lesion, conjunctiva; up to 1 cm	7.00	584.50		010	1	1459.88	464.26	1417.16
68115		Excision of lesion, conjunctiva; over 1 cm	9.51	794.09		010	1	1764.73	654.64	1655.83
68130		Excision of lesion, conjunctiva; with adjacent sclera	16.11	1345.19		090	1	1457.10	1083.83	1481.70
68135		Destruction of lesion, conjunctiva	4.76	397.46		010	1	794.29	294.76	696.88
68200		Subconjunctival injection	1.26	105.21		000	1	62.45	81.83	87.11
68320		Conjunctivoplasty; with conjunctival graft or extensive rearrangemen	22.51	1879.59		090	1	2456.40	1409.48	2447.50
68325		Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)	20.50	1711.75		090	1	2456.40	1209.08	2447.50
68326		Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangemen	20.13	1680.86		090	1	1764.73	1176.52	1655.83
68328		Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)	22.06	1842.01		090	0	2456.40	1336.84	2447.50
68330		Repair of symblepharon; conjunctivoplasty, without graf	18.79	1568.97		090	0	2162.98	1191.55	2225.23
68335		Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)	20.21	1687.54		090	1	2456.40	1179.86	2447.50
68340		Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens	16.96	1416.16		090	0	1764.73	1083.83	1655.83
68360		Conjunctival flap; bridge or partial (separate procedure)	16.52	1379.42		090	1	2162.98	1038.74	2225.23
68362		Conjunctival flap; total (such as Gunderson thin flap or purse string flap)	20.49	1710.92		090	1	2162.98	1192.38	2225.23
68371		Harvesting conjunctival allograft, living donor	12.24	1022.04		010	1	2162.98	794.92	1481.70
68399		Unlisted procedure, conjunctiva	0.00	BR		YYY	0	298.99	BR	294.24
68400		Incision, drainage of lacrimal gland	8.84	738.14		010	1	298.99	597.03	294.24
68420		Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy	9.81	819.14		010	1	1764.73	669.67	1655.83
68440		Snip incision of lacrimal punctum	3.19	266.37		010	1	298.99	232.97	294.24
68500		Excision of lacrimal gland (dacryoadenectomy), except for tumor; tota	30.90	2580.15		090	1	2456.40	1782.73	2447.50
68505		Excision of lacrimal gland (dacryoadenectomy), except for tumor; partia	30.25	2525.88		090	1	2456.40	1837.00	2447.50
68510		Biopsy of lacrimal gland	13.90	1160.65		000	0	1764.73	936.04	1655.83
68520		Excision of lacrimal sac (dacryocystectomy)	20.83	1739.31		090	0	2456.40	1280.89	2447.50
68525		Biopsy of lacrimal sac	8.22	686.37		000	1	1764.73	512.69	1655.83
68530		Removal of foreign body or dacryolith, lacrimal passages	13.25	1106.38		010	1	298.99	921.84	294.24
68540		Excision of lacrimal gland tumor; frontal approach	28.15	2350.53		090	1	1764.73	1711.75	1655.83
68550		Excision of lacrimal gland tumor; involving osteotomy	34.47	2878.25		090	1	2456.40	2115.89	2447.50
68700		Plastic repair of canaliculi	18.82	1571.47		090	1	1764.73	1098.86	1655.83
68705		Correction of everted punctum, cautery	7.34	612.89		010	1	298.99	490.98	294.24
68720		Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	23.25	1941.38		090	2	2456.40	1413.66	2447.50
68745		Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube	23.71	1979.79		090	2	2456.40	1421.17	2447.50
68750		Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or sten	24.46	2042.41		090	2	2456.40	1456.24	2447.50
68760		Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery	6.25	521.88		010	1	298.99	415.83	294.24
68761		Closure of the lacrimal punctum; by plug, each	4.55	379.93		010	0	298.99	289.75	294.24
68770		Closure of lacrimal fistula (separate procedure)	19.61	1637.44		090	0	2456.40	960.25	2447.50
68801		Dilation of lacrimal punctum, with or without irrigation	3.85	321.48		010	1	95.55	235.47	87.11
68810		Probing of nasolacrimal duct, with or without irrigation	7.50	626.25		010	1	298.99	508.52	294.24
68811		Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia	6.43	536.91		010	1	1764.73	387.44	1655.83
68815		Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or sten	13.89	1159.82		010	1	1764.73	910.15	1655.83
68816		Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	23.08	1927.18		010	1	1764.73	1306.20	1655.83
68840		Probing of lacrimal canaliculi, with or without irrigation	3.98	332.33		010	1	186.92	232.97	178.50
68850		Injection of contrast medium for dacryocystography	1.75	146.13		000	1		132.77	
68899		Unlisted procedure, lacrimal system	0.00	BR		YYY	0	298.99	BR	294.24
69000		Drainage external ear, abscess or hematoma; simple	5.78	482.63		010	1	161.85	357.38	132.75

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
69005		Drainage external ear, abscess or hematoma; complicatec	6.58	549.43		010	1	936.06	415.83	1769.66
69020		Drainage external auditory canal, abscess	7.24	604.54		010	1	161.85	453.41	132.75
69090		Ear piercing	0.96	80.16		XXX	9		58.53	2097.37**
69100		Biopsy external ear	3.05	254.68		000	1	296.47	209.59	312.33
69105		Biopsy external auditory cana	4.37	364.90		000	1	1480.23	268.04	1567.36
69110		Excision external ear; partial, simple repair	14.13	1179.86		090	1	1447.15	866.73	1595.60
69120		Excision external ear; complete amputation	12.51	1044.59		090	1	2321.87	831.66	2276.44
69140		Excision exostosis(es), external auditory cana	26.86	2242.81		090	0	4230.05	1747.66	2276.44
69145		Excision soft tissue lesion, external auditory cana	12.36	1032.06		090	1	1447.15	714.76	1595.60
69150		Radical excision external auditory canal lesion; without neck dissectior	31.54	2633.59		090	1	2321.87	2176.85	694.83
69155		Radical excision external auditory canal lesion; with neck dissectior	50.24	4195.04		090	2		3430.18	2097.37**
69200		Removal foreign body from external auditory canal; without general anesthesia	3.81	318.14		000	1	64.04	253.84	61.03
69205		Removal foreign body from external auditory canal; with general anesthesia	3.08	257.18		010	1	2142.94	207.92	2132.75
69210		Removal impacted cerumen (separate procedure), 1 or both ears	1.56	130.26		000	1	64.04	101.04	61.03
69220		Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	4.29	358.22		000	1	92.29	266.37	80.15
69222		Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning	6.84	571.14		010	1	643.20	435.04	1567.36
69300		Otoplasty, protruding ear, with or without size reductior	22.51	1879.59		YYY	0	2321.87	1031.23	2276.44
69310		Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)	33.38	2787.23		090	1	4230.05	2204.40	3919.59
69320		Reconstruction external auditory canal for congenital atresia, single stage	46.47	3880.25		090	2	4230.05	3143.78	3919.59
69399		Unlisted procedure, external ear	0.00	BR		YYY	0	100.74	BR	105.07
69400		Eustachian tube inflation, transnasal; with catheterizatior	4.64	387.44		000	1	296.47	258.02	312.33
69401		Eustachian tube inflation, transnasal; without catheterizatior	2.74	228.79		000	1	296.47	160.32	312.33
69405		Eustachian tube catheterization, transtympanic	8.00	668.00		010	0	1480.23	506.85	694.83
69420		Myringotomy including aspiration and/or eustachian tube inflatior	5.94	495.99		010	1	296.47	371.58	312.33
69421		Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	4.53	378.26		010	1	1480.23	314.80	1567.36
69424		Ventilating tube removal requiring general anesthesia	3.98	332.33		000	1	1480.23	251.34	1567.36
69433		Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	6.29	525.22		010	1	643.20	384.94	694.83
69436		Tympanostomy (requiring insertion of ventilating tube), general anesthesia	4.87	406.65		010	1	1480.23	344.02	1567.36
69440		Middle ear exploration through postauricular or ear canal incisior	21.12	1763.52		090	1	4230.05	1347.69	2276.44
69450		Tympanolysis, transcanal	16.73	1396.96		090	0	4230.05	1046.26	3919.59
69501		Transmastoid antrotomy (simple mastoidectomy)	22.24	1857.04		090	1	4230.05	1474.61	3919.59
69502		Mastoidectomy; complete	29.50	2463.25		090	0	4230.05	1955.57	2276.44
69505		Mastoidectomy; modified radical	36.67	3061.95		090	0	4230.05	2456.57	3919.59
69511		Mastoidectomy; radical	37.54	3134.59		090	0	4230.05	2518.36	3919.59
69530		Petrous apicectomy including radical mastoidectomy	50.05	4179.18		090	2	4230.05	3382.59	3919.59
69535		Resection temporal bone, external approach	80.44	6716.74		090	1		5556.93	2097.37**
69540		Excision aural polyp	6.52	544.42		010	1	1480.23	409.99	1567.36
69550		Excision aural glomus tumor; transcanal	31.76	2651.96		090	2	4230.05	2109.21	3919.59
69552		Excision aural glomus tumor; transmastoid	47.48	3964.58		090	2	4230.05	3255.67	3919.59
69554		Excision aural glomus tumor; extended (extratemporal)	75.72	6322.62		090	2		5300.58	2097.37**
69601		Revision mastoidectomy; resulting in complete mastoidectomy	31.75	2651.13		090	0	4230.05	2111.72	3919.59
69602		Revision mastoidectomy; resulting in modified radical mastoidectomy	33.08	2762.18		090	0	4230.05	2189.37	3919.59
69603		Revision mastoidectomy; resulting in radical mastoidectomy	38.34	3201.39		090	0	4230.05	2619.40	3919.59
69604		Revision mastoidectomy; resulting in tympanoplasty	33.79	2821.47		090	1	4230.05	2256.17	3919.59
69605		Revision mastoidectomy; with apicectomy	47.30	3949.55		090	2	4230.05	3199.72	3919.59
69610		Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	11.69	976.12		010	1	2321.87	804.94	2276.44
69620		Myringoplasty (surgery confined to drumhead and donor area	21.32	1780.22		090	1	2321.87	1393.62	2276.44

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
69631		Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	27.05	2258.68		090	1	4230.05	1735.13	3919.59
69632		Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	32.85	2742.98		090	1	4230.05	2147.62	3919.59
69633		Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular repl	31.80	2655.30		090	1	4230.05	2064.96	3919.59
69635		Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	37.43	3125.41		090	1	4230.05	2456.57	3919.59
69636		Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	41.99	3506.17		090	0	4230.05	2809.78	3919.59
69637		Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total	42.09	3514.52		090	0	4230.05	2794.75	3919.59
69641		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	31.68	2645.28		090	1	4230.05	2085.00	3919.59
69642		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	40.62	3391.77		090	1	4230.05	2700.39	3919.59
69643		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	37.15	3102.03		090	1	4230.05	2463.25	3919.59
69644		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	44.93	3751.66		090	1	4230.05	3036.06	3919.59
69645		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	44.07	3679.85		090	1	4230.05	2967.59	3919.59
69646		Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	46.77	3905.30		090	0	4230.05	3158.81	3919.59
69650		Stapes mobilization	24.48	2044.08		090	1	4230.05	1597.36	2276.44
69660		Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	28.11	2347.19		090	1	4230.05	1878.75	3919.59
69661		Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	36.61	3056.94		090	0	4230.05	2470.77	3919.59
69662		Revision of stapedectomy or stapedotomy	35.05	2926.68		090	1	4230.05	2368.06	3919.59
69666		Repair oval window fistula	24.61	2054.94		090	0	2321.87	1614.06	3919.59
69667		Repair round window fistula	24.63	2056.61		090	0	2321.87	1614.06	3919.59
69670		Mastoid obliteration (separate procedure)	28.71	2397.29		090	2	4230.05	1897.96	3919.59
69676		Tympanic neurectomy	25.39	2120.07		090	1	2321.87	1664.16	3919.59
69700		Closure postauricular fistula, mastoid (separate procedure)	20.88	1743.48		090	1	2321.87	1418.67	3919.59
69710		Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	0.00	BR		XXX	9		BR	2097.37**
69711		Removal or repair of electromagnetic bone conduction hearing device in temporal bone	26.26	2192.71		090	2	4230.05	1732.63	3919.59
69714		Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	32.60	2722.10		090	1	12387.27	2186.03	10830.36
69715		Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	40.05	3344.18		090	1	12387.27	2730.45	10830.36
69717		Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	34.15	2851.53		090	1	12387.27	2368.06	10830.36
69718		Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	40.46	3378.41		090	1	12387.27	3082.82	10830.36
69720		Decompression facial nerve, intratemporal; lateral to geniculate ganglion	36.21	3023.54		090	0	4230.05	2369.73	3919.59
69725		Decompression facial nerve, intratemporal; including medial to geniculate ganglion	56.58	4724.43		090	2	4230.05	3872.73	3919.59

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
69740		Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	35.25	2943.38		090	2	4230.05	2397.29	3919.59
69745		Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	37.55	3135.43		090	2	4230.05	2554.27	3919.59
69799		Unlisted procedure, middle ear	0.00	BR		YYY	0	100.74	BR	105.07
69801		Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcana	5.99	500.17		000	0	1480.23	1481.29	2276.44
69805		Endolymphatic sac operation; without shun	31.84	2658.64		090	2	4230.05	2138.44	3919.59
69806		Endolymphatic sac operation; with shun	28.59	2387.27		090	1	4230.05	1913.82	3919.59
69820		Fenestration semicircular canal	26.11	2180.19		090	2	4230.05	1765.19	3919.59
69840		Revision fenestration operation	25.30	2112.55		090	2	4230.05	1910.48	3919.59
69905		Labyrinthectomy; transcanal	27.96	2334.66		090	1	4230.05	1836.17	3919.59
69910		Labyrinthectomy; with mastoidectomy	30.78	2570.13		090	0	4230.05	2079.99	3919.59
69915		Vestibular nerve section, translabyrinthine approach	46.32	3867.72		090	2	4230.05	3157.14	3919.59
69930		Cochlear device implantation, with or without mastoidectomy	36.88	3079.48		090	0	39124.32	2609.38	39105.58
69949		Unlisted procedure, inner ear	0.00	BR		YYY	0	100.74	BR	105.07
69950		Vestibular nerve section, transcranial approach	53.42	4460.57		090	2		3760.01	2097.37**
69955		Total facial nerve decompression and/or repair (may include graft)	59.49	4967.42		090	2	4230.05	4108.20	3919.59
69960		Decompression internal auditory canal	57.76	4822.96		090	2	4230.05	3959.57	3919.59
69970		Removal of tumor, temporal bone	64.34	5372.39		090	2	4230.05	4455.56	3919.59
69979		Unlisted procedure, temporal bone, middle fossa approach	0.00	BR		YYY	0	100.74	BR	105.07
69990		Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	6.37	605.15		ZZZ	2		563.35	
70010		Myelography, posterior fossa, radiological supervision and interpretation	1.84	116.84	30.48	XXX	0	654.85	351.79	658.94
70015		Cisternography, positive contrast, radiological supervision and interpretation	4.63	294.01	108.59	XXX	0	654.85	203.84	658.94
70030		Radiologic examination, eye, for detection of foreign body	0.88	55.88	15.24	XXX	0	59.28	43.82	60.74
70100		Radiologic examination, mandible; partial, less than 4 views	1.05	66.68	16.51	XXX	0	59.28	49.53	60.74
70110		Radiologic examination, mandible; complete, minimum of 4 views	1.20	76.20	22.86	XXX	0	91.38	62.87	60.74
70120		Radiologic examination, mastoids; less than 3 views per side	1.09	69.22	16.51	XXX	0	91.38	56.52	60.74
70130		Radiologic examination, mastoids; complete, minimum of 3 views per side	1.78	113.03	31.12	XXX	0	59.28	84.46	60.74
70134		Radiologic examination, internal auditory meati, complete	1.39	88.27	29.85	XXX	0	91.38	78.11	101.78
70140		Radiologic examination, facial bones; less than 3 views	0.91	57.79	18.42	XXX	0	59.28	54.61	60.74
70150		Radiologic examination, facial bones; complete, minimum of 3 views	1.29	81.92	23.50	XXX	0	91.38	72.39	60.74
70160		Radiologic examination, nasal bones, complete, minimum of 3 views	1.02	64.77	15.88	XXX	0	59.28	49.53	60.74
70170		Dacryocystography, nasolacrimal duct, radiological supervision and interpretation	1.52	96.52	27.94	XXX	0	329.57	86.23	284.44
70190		Radiologic examination; optic foramina	1.10	69.85	19.69	XXX	0	59.28	59.06	60.74
70200		Radiologic examination; orbits, complete, minimum of 4 views	1.32	83.82	25.40	XXX	0	91.38	74.30	60.74
70210		Radiologic examination, sinuses, paranasal, less than 3 views	0.94	59.69	15.88	XXX	0	59.28	53.98	60.74
70220		Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	1.18	74.93	22.86	XXX	0	91.38	69.85	60.74
70240		Radiologic examination, sella turcica	0.91	57.79	17.78	XXX	0	59.28	45.09	60.74
70250		Radiologic examination, skull; less than 4 views	1.13	71.76	22.86	XXX	0	59.28	61.60	60.74
70260		Radiologic examination, skull; complete, minimum of 4 views	1.42	90.17	31.12	XXX	0	91.38	85.73	101.78
70300		Radiologic examination, teeth; single view	0.45	28.58	10.80	XXX	0	46.29	26.67	40.75
70310		Radiologic examination, teeth; partial examination, less than full mouth	1.17	74.30	14.61	XXX	0	46.29	47.63	40.75
70320		Radiologic examination, teeth; complete, full mouth	1.64	104.14	21.59	XXX	0	46.29	73.03	40.75
70328		Radiologic examination, temporomandibular joint, open and closed mouth; unilatera	0.97	61.60	17.15	XXX	0	59.28	47.63	60.74
70330		Radiologic examination, temporomandibular joint, open and closed mouth; bilatera	1.47	93.35	22.86	XXX	0	59.28	76.84	60.74
70332		Temporomandibular joint arthrography, radiological supervision and interpretation	2.14	135.89	48.90	XXX	0	385.31	172.09	358.93
70336		Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	10.77	683.90	132.08	XXX	0	436.69	867.41	472.87
70350		Cephalogram, orthodontic	0.65	41.28	18.42	XXX	0	59.28	38.10	60.74
70355		Orthopantogram (eg, panoramic x-ray)	0.63	40.01	20.32	XXX	0	46.29	50.17	60.74

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
70360		Radiologic examination; neck, soft tissue	0.84	53.34	15.24	XXX	0	59.28	43.18	60.74
70370		Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification techniqu	2.46	156.21	28.58	XXX	0	147.41	116.21	115.75
70371		Complex dynamic pharyngeal and speech evaluation by cine or video recordin	2.75	174.63	76.20	XXX	0	147.41	194.31	115.75
70373		Laryngography, contrast, radiological supervision and interpretatior	2.40	152.40	39.37	XXX	0	329.57	149.86	284.44
70380		Radiologic examination, salivary gland for calculus	1.19	75.57	17.15	XXX	0	59.28	60.33	60.74
70390		Sialography, radiological supervision and interpretatior	3.07	194.95	34.93	XXX	0	329.57	155.58	284.44
70450		Computed tomography, head or brain; without contrast materia	4.92	312.42	76.20	XXX	0	223.93	378.46	263.90
70460		Computed tomography, head or brain; with contrast material(s)	6.45	409.58	100.97	XXX	0	383.35	471.81	401.84
70470		Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	6.52	414.02	114.30	XXX	0	424.87	575.31	451.20
70480		Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	8.27	525.15	115.57	XXX	0	223.93	464.82	263.90
70481		Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	9.58	608.33	124.46	XXX	0	383.35	542.93	401.84
70482		Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	10.61	673.74	130.18	XXX	0	424.87	640.72	451.20
70486		Computed tomography, maxillofacial area; without contrast materia	6.80	431.80	102.87	XXX	0	223.93	428.63	263.90
70487		Computed tomography, maxillofacial area; with contrast material(s)	8.19	520.07	116.84	XXX	0	383.35	513.08	401.84
70488		Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	9.86	626.11	127.64	XXX	0	424.87	623.57	451.20
70490		Computed tomography, soft tissue neck; without contrast materia	6.63	421.01	115.57	XXX	0	223.93	434.98	263.90
70491		Computed tomography, soft tissue neck; with contrast material(s)	7.99	507.37	124.46	XXX	0	383.35	513.08	401.84
70492		Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	9.54	605.79	130.18	XXX	0	424.87	620.40	451.20
70496		Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	14.94	948.69	157.48	XXX	0	437.64	930.91	460.61
70498		Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	15.45	981.08	157.48	XXX	0	437.64	932.18	460.61
70540		Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s	12.17	772.80	121.29	XXX	0	436.69	874.40	472.87
70542		Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s	13.71	870.59	146.69	XXX	0	586.42	1021.72	573.59
70543		Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences	16.83	1068.71	193.04	XXX	0	708.87	1684.02	724.34
70544		Magnetic resonance angiography, head; without contrast material(s	13.71	870.59	107.95	XXX	0	436.69	900.43	472.87
70545		Magnetic resonance angiography, head; with contrast material(s	13.49	856.62	107.95	XXX	0	586.42	899.16	573.59
70546		Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	20.72	1315.72	162.56	XXX	0	708.87	1604.01	724.34
70547		Magnetic resonance angiography, neck; without contrast material(s	13.73	871.86	108.59	XXX	0	436.69	899.80	472.87
70548		Magnetic resonance angiography, neck; with contrast material(s)	14.52	922.02	108.59	XXX	0	586.42	912.50	573.59
70549		Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	20.75	1317.63	161.93	XXX	0	708.87	1603.38	724.34
70551		Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast materia	12.85	815.98	133.35	XXX	0	436.69	901.07	472.87
70552		Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s	14.35	911.23	161.29	XXX	0	586.42	1054.10	573.59
70553		Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	16.81	1067.44	212.73	XXX	0	708.87	1718.31	724.34
70554		Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	14.62	928.37	191.14	XXX	0	436.69	1035.69	472.87
70555		Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	21.82	1385.57	235.59	XXX	0	436.69	1209.10	472.87

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
70557		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	45.45	2886.08	317.50	XXX	0	436.69	2241.23	472.87
70558		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); with contrast material(s)	42.45	2695.58	296.55	XXX	0	586.42	2490.66	573.59
70559		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material(s), followed by contrast material(s) a	42.55	2701.93	297.18	XXX	0	708.87	2950.40	724.34
71010		Radiologic examination, chest; single view, fronta	0.70	44.45	16.51	XXX	0	59.28	43.82	60.74
71015		Radiologic examination, chest; stereo, fronta	0.92	58.42	19.05	XXX	0	59.28	50.80	60.74
71020		Radiologic examination, chest, 2 views, frontal and lateral	0.91	57.79	19.69	XXX	0	59.28	57.79	60.74
71021		Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure	1.13	71.76	24.77	XXX	0	59.28	69.22	60.74
71022		Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections	1.44	91.44	28.58	XXX	0	59.28	74.93	60.74
71023		Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy	1.98	125.73	33.66	XXX	0	147.41	92.71	115.75
71030		Radiologic examination, chest, complete, minimum of 4 views	1.38	87.63	27.31	XXX	0	91.38	77.47	60.74
71034		Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy	2.58	163.83	40.64	XXX	0	147.41	139.70	115.75
71035		Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies	1.08	68.58	15.88	XXX	0	59.28	51.44	60.74
71100		Radiologic examination, ribs, unilateral; 2 views	0.98	62.23	20.32	XXX	0	59.28	55.88	60.74
71101		Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views	1.19	75.57	24.13	XXX	0	91.38	66.04	60.74
71110		Radiologic examination, ribs, bilateral; 3 views	1.23	78.11	24.77	XXX	0	91.38	72.39	60.74
71111		Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views	1.61	102.24	29.21	XXX	0	91.38	86.36	101.78
71120		Radiologic examination; sternum, minimum of 2 views	0.95	60.33	17.78	XXX	0	59.28	58.42	60.74
71130		Radiologic examination; sternoclavicular joint or joints, minimum of 3 views	1.13	71.76	20.32	XXX	0	59.28	64.77	60.74
71250		Computed tomography, thorax; without contrast materia	6.26	397.51	91.44	XXX	0	223.93	485.14	263.90
71260		Computed tomography, thorax; with contrast material(s)	7.83	497.21	112.40	XXX	0	383.35	574.04	401.84
71270		Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections	9.49	602.62	123.83	XXX	0	424.87	706.12	451.20
71275		Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	12.04	764.54	172.72	XXX	0	437.64	935.99	460.61
71550		Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	14.04	891.54	130.81	XXX	0	436.69	918.85	472.87
71551		Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	15.60	990.60	155.58	XXX	0	586.42	1074.42	573.59
71552		Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences	19.84	1259.84	202.57	XXX	0	708.87	1738.00	724.34
71555		Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	13.84	878.84	162.56	XXX	0		941.07	
72010		Radiologic examination, spine, entire, survey study, anteroposterior and latera	2.40	152.40	42.55	XXX	0	91.38	108.59	101.78
72020		Radiologic examination, spine, single view, specify leve	0.71	45.09	13.97	XXX	0	59.28	39.37	60.74
72040		Radiologic examination, spine, cervical; 3 views or less	1.08	68.58	21.59	XXX	0	59.28	59.69	60.74
72050		Radiologic examination, spine, cervical; 4 or 5 views	1.46	92.71	29.21	XXX	0	91.38	85.73	101.78
72052		Radiologic examination, spine, cervical; 6 or more views	1.88	119.38	33.66	XXX	0	91.38	106.05	101.78
72069		Radiologic examination, spine, thoracolumbar, standing (scoliosis)	1.17	74.30	21.59	XXX	0	59.28	53.34	60.74
72070		Radiologic examination, spine; thoracic, 2 views	1.02	64.77	20.32	XXX	0	59.28	59.69	60.74
72072		Radiologic examination, spine; thoracic, 3 views	1.12	71.12	19.69	XXX	0	91.38	66.04	60.74
72074		Radiologic examination, spine; thoracic, minimum of 4 views	1.34	85.09	19.69	XXX	0	59.28	78.11	60.74
72080		Radiologic examination, spine; thoracolumbar, 2 views	1.11	70.49	21.59	XXX	0	59.28	61.60	60.74
72090		Radiologic examination, spine; scoliosis study, including supine and erect studies	1.58	100.33	27.94	XXX	0	91.38	70.49	101.78

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
72100		Radiologic examination, spine, lumbosacral; 2 or 3 views	1.09	69.22	21.59	XXX	0	59.28	63.50	60.74
72110		Radiologic examination, spine, lumbosacral; minimum of 4 views	1.48	93.98	29.21	XXX	0	91.38	87.63	101.78
72114		Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	1.94	123.19	31.12	XXX	0	91.38	111.76	101.78
72120		Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	1.29	81.92	22.23	XXX	0	91.38	79.38	101.78
72125		Computed tomography, cervical spine; without contrast materia	6.40	406.40	95.89	XXX	0	223.93	485.14	263.90
72126		Computed tomography, cervical spine; with contrast materia	7.82	496.57	109.86	XXX	0	383.35	572.14	401.84
72127		Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections	9.36	594.36	114.30	XXX	0	424.87	695.96	451.20
72128		Computed tomography, thoracic spine; without contrast materia	6.27	398.15	89.54	XXX	0	223.93	485.14	263.90
72129		Computed tomography, thoracic spine; with contrast materia	7.85	498.48	109.86	XXX	0	383.35	572.14	401.84
72130		Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	9.41	597.54	114.30	XXX	0	424.87	695.33	451.20
72131		Computed tomography, lumbar spine; without contrast materia	6.25	396.88	89.54	XXX	0	223.93	485.14	263.90
72132		Computed tomography, lumbar spine; with contrast materia	7.83	497.21	109.86	XXX	0	383.35	572.14	401.84
72133		Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	9.36	594.36	113.67	XXX	0	424.87	698.50	451.20
72141		Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	11.38	722.63	144.78	XXX	0	436.69	880.11	472.87
72142		Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	14.64	929.64	173.99	XXX	0	586.42	1065.53	573.59
72146		Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	11.40	723.90	144.78	XXX	0	436.69	942.34	472.87
72147		Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	12.93	821.06	173.36	XXX	0	586.42	1033.78	573.59
72148		Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	11.23	713.11	134.62	XXX	0	436.69	933.45	472.87
72149		Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	14.15	898.53	161.29	XXX	0	586.42	1054.74	573.59
72156		Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	16.82	1068.07	232.41	XXX	0	708.87	1730.38	724.34
72157		Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	15.63	992.51	232.41	XXX	0	708.87	1704.98	724.34
72158		Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	16.46	1045.21	214.63	XXX	0	708.87	1713.23	724.34
72159		Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s	14.16	899.16	160.02	XXX	0		995.05	2097.37**
72170		Radiologic examination, pelvis; 1 or 2 views	0.88	55.88	17.15	XXX	0	59.28	46.99	60.74
72190		Radiologic examination, pelvis; complete, minimum of 3 views	1.32	83.82	20.96	XXX	0	59.28	63.50	60.74
72191		Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	11.96	759.46	163.20	XXX	0	437.64	904.88	460.61
72192		Computed tomography, pelvis; without contrast materia	5.18	328.93	97.16	XXX	0	223.93	473.71	263.90
72193		Computed tomography, pelvis; with contrast material(s)	8.17	518.80	104.78	XXX	0	383.35	549.28	401.84
72194		Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	9.16	581.66	109.86	XXX	0	424.87	675.64	451.20
72195		Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	12.70	806.45	132.72	XXX	0	436.69	889.64	472.87
72196		Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	14.11	895.99	156.21	XXX	0	586.42	1037.59	573.59
72197		Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	17.22	1093.47	202.57	XXX	0	708.87	1699.26	724.34
72198		Magnetic resonance angiography, pelvis, with or without contrast material(s	13.96	886.46	161.29	XXX	0		933.45	
72200		Radiologic examination, sacroiliac joints; less than 3 views	0.90	57.15	15.88	XXX	0	59.28	48.26	60.74

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
72202		Radiologic examination, sacroiliac joints; 3 or more views	1.05	66.68	17.15	XXX	0	59.28	57.79	60.74
72220		Radiologic examination, sacrum and coccyx, minimum of 2 views	0.88	55.88	15.88	XXX	0	59.28	51.44	60.74
72240		Myelography, cervical, radiological supervision and interpretation	3.86	245.11	81.92	XXX	0	654.85	347.98	658.94
72255		Myelography, thoracic, radiological supervision and interpretation	3.68	233.68	82.55	XXX	0	654.85	321.31	658.94
72265		Myelography, lumbosacral, radiological supervision and interpretation	3.79	240.67	74.93	XXX	0	654.85	307.34	658.94
72270		Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation	5.90	374.65	120.02	XXX	0	654.85	469.90	658.94
72275		Epidurography, radiological supervision and interpretation	0.00	0.00	0.00	XXX	9		196.22	
72285		Discography, cervical or thoracic, radiological supervision and interpretation	3.50	222.25	111.13	XXX	0	2233.10	535.94	2358.21
72291		Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance	9.09	577.22	132.72	XXX	0		520.64	
72292		Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance	9.26	588.01	135.26	XXX	0		532.13	
72295		Discography, lumbar, radiological supervision and interpretation	3.07	194.95	80.01	XXX	0	2233.10	485.78	2358.21
73000		Radiologic examination; clavicle, complete	0.88	55.88	15.24	XXX	0	59.28	46.36	60.74
73010		Radiologic examination; scapula, complete	0.98	62.23	17.78	XXX	0	59.28	48.26	60.74
73020		Radiologic examination, shoulder; 1 view	0.72	45.72	13.97	XXX	0	59.28	41.91	60.74
73030		Radiologic examination, shoulder; complete, minimum of 2 views	0.94	59.69	18.42	XXX	0	59.28	52.07	60.74
73040		Radiologic examination, shoulder, arthrography, radiological supervision and interpretation	3.21	203.84	50.17	XXX	0	385.31	182.25	358.93
73050		Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	1.23	78.11	20.32	XXX	0	59.28	60.96	60.74
73060		Radiologic examination; humerus, minimum of 2 views	0.88	55.88	15.88	XXX	0	59.28	51.44	60.74
73070		Radiologic examination, elbow; 2 views	0.87	55.25	14.61	XXX	0	59.28	45.72	60.74
73080		Radiologic examination, elbow; complete, minimum of 3 views	1.02	64.77	15.88	XXX	0	59.28	54.61	60.74
73085		Radiologic examination, elbow, arthrography, radiological supervision and interpretation	3.09	196.22	52.71	XXX	0	385.31	176.53	358.93
73090		Radiologic examination; forearm, 2 views	0.85	53.98	15.24	XXX	0	59.28	46.36	60.74
73092		Radiologic examination; upper extremity, infant, minimum of 2 views	0.99	62.87	15.24	XXX	0	59.28	45.72	60.74
73100		Radiologic examination, wrist; 2 views	0.98	62.23	17.15	XXX	0	59.28	45.72	60.74
73110		Radiologic examination, wrist; complete, minimum of 3 views	1.15	73.03	15.88	XXX	0	59.28	51.44	60.74
73115		Radiologic examination, wrist, arthrography, radiological supervision and interpretation	3.38	214.63	51.44	XXX	0	385.31	158.75	358.93
73120		Radiologic examination, hand; 2 views	0.84	53.34	15.24	XXX	0	59.28	45.09	60.74
73130		Radiologic examination, hand; minimum of 3 views	0.99	62.87	15.88	XXX	0	59.28	49.53	60.74
73140		Radiologic examination, finger(s), minimum of 2 views	1.03	65.41	12.70	XXX	0	59.28	41.91	60.74
73200		Computed tomography, upper extremity; without contrast materia	6.23	395.61	90.81	XXX	0	223.93	430.53	263.90
73201		Computed tomography, upper extremity; with contrast material(s	7.65	485.78	104.78	XXX	0	383.35	506.73	401.84
73202		Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	9.74	618.49	109.86	XXX	0	424.87	629.92	451.20
73206		Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	10.92	693.42	161.29	XXX	0	437.64	845.82	460.61
73218		Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	12.49	793.12	121.92	XXX	0	436.69	882.65	472.87
73219		Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s	13.86	880.11	146.69	XXX	0	586.42	1025.53	573.59
73220		Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences	17.09	1085.22	193.68	XXX	0	708.87	1688.47	724.34
73221		Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s	8.29	526.42	124.46	XXX	0	436.69	866.14	472.87
73222		Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s	13.01	826.14	146.69	XXX	0	586.42	1009.02	573.59
73223		Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences	16.11	1022.99	193.68	XXX	0	708.87	1668.15	724.34
73225		Magnetic resonance angiography, upper extremity, with or without contrast material(s	14.18	900.43	153.04	XXX	0		929.01	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
73500		Radiologic examination, hip, unilateral; 1 view	0.84	53.34	17.78	XXX	0	59.28	44.45	60.74
73510		Radiologic examination, hip, unilateral; complete, minimum of 2 views	1.20	76.20	20.96	XXX	0	59.28	57.79	60.74
73520		Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis	1.25	79.38	25.40	XXX	0	91.38	66.04	101.78
73525		Radiologic examination, hip, arthrography, radiological supervision and interpretation	3.20	203.20	53.34	XXX	0	385.31	177.17	358.93
73530		Radiologic examination, hip, during operative procedure	0.98	62.23	26.67	XXX	0		74.74	
73540		Radiologic examination, pelvis and hips, infant or child, minimum of 2 views	1.37	87.00	20.32	XXX	0	59.28	57.79	60.74
73550		Radiologic examination, femur, 2 views	0.87	55.25	17.15	XXX	0	59.28	51.44	60.74
73560		Radiologic examination, knee; 1 or 2 views	0.95	60.33	17.78	XXX	0	59.28	48.26	60.74
73562		Radiologic examination, knee; 3 views	1.15	73.03	18.42	XXX	0	59.28	54.61	60.74
73564		Radiologic examination, knee; complete, 4 or more views	1.34	85.09	22.23	XXX	0	91.38	62.23	60.74
73565		Radiologic examination, knee; both knees, standing, anteroposterior	1.10	69.85	18.42	XXX	0	59.28	47.63	60.74
73580		Radiologic examination, knee, arthrography, radiological supervision and interpretation	3.97	252.10	53.34	XXX	0	385.31	211.46	358.93
73590		Radiologic examination; tibia and fibula, 2 views	0.84	53.34	15.88	XXX	0	59.28	47.63	60.74
73592		Radiologic examination; lower extremity, infant, minimum of 2 views	0.85	53.98	14.61	XXX	0	59.28	45.72	60.74
73600		Radiologic examination, ankle; 2 views	0.88	55.88	15.24	XXX	0	59.28	45.09	60.74
73610		Radiologic examination, ankle; complete, minimum of 3 views	1.02	64.77	15.88	XXX	0	59.28	50.17	60.74
73615		Radiologic examination, ankle, arthrography, radiological supervision and interpretation	3.20	203.20	52.71	XXX	0	385.31	178.44	358.93
73620		Radiologic examination, foot; 2 views	0.84	53.34	13.97	XXX	0	59.28	45.09	60.74
73630		Radiologic examination, foot; complete, minimum of 3 views	0.96	60.96	15.24	XXX	0	59.28	49.53	60.74
73650		Radiologic examination; calcaneus, minimum of 2 views	0.87	55.25	14.61	XXX	0	59.28	44.45	60.74
73660		Radiologic examination; toe(s), minimum of 2 views	0.93	59.06	12.07	XXX	0	59.28	41.28	60.74
73700		Computed tomography, lower extremity; without contrast materia	6.25	396.88	90.81	XXX	0	223.93	430.53	263.90
73701		Computed tomography, lower extremity; with contrast material(s	7.76	492.76	104.78	XXX	0	383.35	508.00	401.84
73702		Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	9.72	617.22	109.86	XXX	0	424.87	631.19	451.20
73706		Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	12.09	767.72	170.82	XXX	0	437.64	875.67	460.61
73718		Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	12.41	788.04	121.92	XXX	0	436.69	876.30	472.87
73719		Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s	14.09	894.72	146.69	XXX	0	586.42	1023.62	573.59
73720		Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	17.20	1092.20	193.04	XXX	0	708.87	1687.20	724.34
73721		Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast materia	8.29	526.42	124.46	XXX	0	436.69	870.59	472.87
73722		Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s	13.20	838.20	147.96	XXX	0	586.42	1012.83	573.59
73723		Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	16.10	1022.35	193.68	XXX	0	708.87	1666.24	724.34
73725		Magnetic resonance angiography, lower extremity, with or without contrast material(s	14.04	891.54	162.56	XXX	0		936.63	
74000		Radiologic examination, abdomen; single anteroposterior view	0.73	46.36	16.51	XXX	0	59.28	46.99	60.74
74010		Radiologic examination, abdomen; anteroposterior and additional oblique and cone views	1.17	74.30	20.96	XXX	0	59.28	59.69	60.74
74020		Radiologic examination, abdomen; complete, including decubitus and/or erect views	1.22	77.47	24.13	XXX	0	59.28	64.14	60.74
74022		Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	1.47	93.35	28.58	XXX	0	91.38	76.20	101.78
74150		Computed tomography, abdomen; without contrast materia	5.29	335.92	107.32	XXX	0	223.93	469.27	263.90
74160		Computed tomography, abdomen; with contrast material(s)	8.31	527.69	114.94	XXX	0	383.35	577.22	401.84
74170		Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	9.57	607.70	126.37	XXX	0	424.87	720.73	451.20
74174		Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	14.90	946.15	198.12	XXX	0	622.57	New	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
74175		Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	12.11	768.99	171.45	XXX	0	437.64	925.20	460.61
74176		Computed tomography, abdomen and pelvis; without contrast materia	6.83	433.71	156.85	XXX	9	394.84	New	
74177		Computed tomography, abdomen and pelvis; with contrast material(s	10.28	652.78	163.83	XXX	9	622.57	New	
74178		Computed tomography, abdomen and pelvis; without contrast material in 1 or both body regions, followed by contrast material(s) and further sections in 1 or both body regions	12.04	764.54	181.61	XXX	9	622.57	New	
74181		Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s	11.24	713.74	130.81	XXX	0	436.69	859.16	472.87
74182		Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s	15.52	985.52	155.58	XXX	0	586.42	1066.17	573.59
74183		Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	17.28	1097.28	202.57	XXX	0	708.87	1699.90	724.34
74185		Magnetic resonance angiography, abdomen, with or without contrast material(s	13.95	885.83	161.29	XXX	0		934.09	
74190		Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretatior	1.73	109.86	43.82	XXX	0	329.57	80.45	284.44
74210		Radiologic examination; pharynx and/or cervical esophagus	2.36	149.86	31.75	XXX	0	106.72	114.30	118.41
74220		Radiologic examination; esophagus	2.76	175.26	41.91	XXX	0	106.72	125.10	118.41
74230		Swallowing function, with cineradiography/videoradiography	2.74	173.99	47.63	XXX	0	106.72	135.89	118.41
74235		Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	5.49	348.62	121.92	XXX	0		218.38	
74240		Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	3.44	218.44	62.87	XXX	0	158.44	160.66	118.41
74241		Radiologic examination, gastrointestinal tract, upper; with or without delayed films, with KUB	3.60	228.60	61.60	XXX	0	158.44	166.37	118.41
74245		Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial films	5.37	341.00	81.92	XXX	0	158.44	249.56	191.51
74246		Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB	3.88	246.38	62.23	XXX	0	158.44	178.44	118.41
74247		Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB	4.32	274.32	62.23	XXX	0	158.44	186.69	118.41
74249		Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through	5.80	368.30	81.92	XXX	0	158.44	264.80	191.51
74250		Radiologic examination, small intestine, includes multiple serial films;	3.28	208.28	42.55	XXX	0	106.72	139.07	118.41
74251		Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube	12.67	804.55	62.23	XXX	0	158.44	269.24	191.51
74260		Duodenography, hypotonic	10.44	662.94	45.09	XXX	0	106.72	238.76	118.41
74261		Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	15.94	1012.19	215.90	XXX	0	223.93	720.09	263.90
74262		Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	17.58	1116.33	224.16	XXX	0	383.35	808.99	401.84
74263		Computed tomographic (CT) colonography, screening, including image postprocessing	23.13	1468.76	210.82	XXX	9		1242.06	2097.37**
74270		Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB	4.76	302.26	62.23	XXX	0	158.44	193.68	118.41
74280		Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon	6.65	422.28	88.90	XXX	0	158.44	262.26	191.51
74283		Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)	6.01	381.64	178.44	XXX	0	158.44	335.28	118.41
74290		Cholecystography, oral contrast;	2.11	133.99	28.58	XXX	0	106.72	85.09	118.41
74291		Cholecystography, oral contrast; additional or repeat examination or multiple day examination	2.07	131.45	18.42	XXX	0	106.72	61.60	118.41
74300		Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation	1.49	94.62	33.02	XXX	0		97.73	
74301		Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)	0.89	56.52	19.69	ZZZ	0		57.47	
74305		Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation	1.74	110.49	38.74	XXX	0	329.57	97.73	284.44
74320		Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation	2.96	187.96	48.26	XXX	0	415.46	233.68	510.77

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
74327		Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation	4.23	268.61	67.95	XXX	0		187.96	
74328		Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretatior	3.43	217.81	65.41	XXX	0		264.35	
74329		Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	2.97	188.60	66.04	XXX	0		187.33	
74330		Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	4.89	310.52	83.82	XXX	0		281.62	
74340		Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation	3.12	198.12	49.53	XXX	0		137.92	
74355		Percutaneous placement of enteroclysis tube, radiological supervision and interpretatior	4.11	260.99	70.49	XXX	0		206.88	
74360		Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretatior	3.46	219.71	52.71	XXX	0		252.86	
74363		Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	3.60	228.60	80.01	XXX	0		206.88	
74400		Urography (pyelography), intravenous, with or without KUB, with or without tomograph	3.41	216.54	44.45	XXX	0	270.34	163.20	232.17
74410		Urography, infusion, drip technique and/or bolus technique	3.37	214.00	43.82	XXX	0	270.34	177.80	232.17
74415		Urography, infusion, drip technique and/or bolus technique; with nephrotomography	4.18	265.43	44.45	XXX	0	270.34	194.95	232.17
74420		Urography, retrograde, with or without KUE	3.47	220.35	33.02	XXX	0	270.34	114.94	232.17
74425		Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	1.89	120.02	32.39	XXX	0	270.34	114.94	232.17
74430		Cystography, minimum of 3 views, radiological supervision and interpretatior	1.22	77.47	27.94	XXX	0	270.34	107.95	232.17
74440		Vasography, vesiculography, or epididymography, radiological supervision and interpretatior	2.53	160.66	34.93	XXX	0	270.34	120.65	232.17
74445		Corpora cavernosography, radiological supervision and interpretatior	2.88	182.88	104.14	XXX	0	270.34	183.90	232.17
74450		Urethrocystography, retrograde, radiological supervision and interpretatior	2.09	132.72	30.48	XXX	0	270.34	135.64	232.17
74455		Urethrocystography, voiding, radiological supervision and interpretatior	2.55	161.93	29.21	XXX	0	270.34	140.34	232.17
74470		Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation	2.14	135.89	48.90	XXX	0	329.57	137.92	284.44
74475		Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiologica supervision and interpretation	2.92	185.42	48.26	XXX	0	1459.44	280.67	1553.37
74480		Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation	2.92	185.42	48.26	XXX	0	1459.44	280.67	1553.37
74485		Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretatior	2.93	186.06	48.26	XXX	0	1459.44	236.22	1553.37
74710		Pelvimetry, with or without placental localizatior	0.99	62.87	27.94	XXX	0	91.38	90.17	101.78
74740		Hysterosalpingography, radiological supervision and interpretatior	2.33	147.96	33.66	XXX	0	329.57	122.56	284.44
74742		Transcervical catheterization of fallopian tube, radiological supervision and interpretatior	2.54	161.29	56.52	XXX	0		155.19	
74775		Perineogram (eg, vaginogram, for sex determination or extent of anomalies)	2.50	158.75	57.15	XXX	0	270.34	178.18	232.17
75557		Cardiac magnetic resonance imaging for morphology and function without contrast material	10.78	684.53	210.19	XXX	0	436.69	915.84	472.87
75559		Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	14.76	937.26	262.89	XXX	0	436.69	1333.12	472.87
75561		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	14.39	913.77	231.78	XXX	0	708.87	1237.76	724.34
75563		Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	17.00	1079.50	266.70	XXX	0	708.87	1532.16	724.34
75565		Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	1.88	119.38	22.23	ZZZ	0		161.29	
75571		Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	3.36	213.36	50.80	XXX	0	64.04	158.12	61.03
75572		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	9.22	585.47	154.94	XXX	0	344.71	463.55	364.11

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
75573		Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluati	12.59	799.47	225.43	XXX	0	344.71	658.50	364.11
75574		Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluatio	13.61	864.24	212.73	XXX	0	344.71	1021.72	364.11
75600		Aortography, thoracic, without serialography, radiological supervision and interpretatior	6.38	405.13	43.82	XXX	0	2863.77	781.69	2654.78
75605		Aortography, thoracic, by serialography, radiological supervision and interpretatior	4.61	292.74	101.60	XXX	0	2863.77	784.86	2654.78
75625		Aortography, abdominal, by serialography, radiological supervision and interpretatior	4.62	293.37	101.60	XXX	0	2863.77	780.42	2654.78
75630		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	5.48	347.98	158.12	XXX	0	2863.77	866.78	2654.78
75635		Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	13.39	850.27	214.63	XXX	0	437.64	1156.97	460.61
75658		Angiography, brachial, retrograde, radiological supervision and interpretatior	5.46	346.71	114.30	XXX	0	2863.77	802.64	2654.78
75705		Angiography, spinal, selective, radiological supervision and interpretatior	7.34	466.09	195.58	XXX	0	2863.77	869.32	2654.78
75710		Angiography, extremity, unilateral, radiological supervision and interpretatior	5.36	340.36	99.70	XXX	0	2863.77	791.85	2654.78
75716		Angiography, extremity, bilateral, radiological supervision and interpretatior	6.42	407.67	116.84	XXX	0	2863.77	816.61	2654.78
75726		Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	5.38	341.63	102.24	XXX	0	2863.77	783.59	2654.78
75731		Angiography, adrenal, unilateral, selective, radiological supervision and interpretatior	4.98	316.23	101.60	XXX	0	2863.77	787.40	2654.78
75733		Angiography, adrenal, bilateral, selective, radiological supervision and interpretatior	6.19	393.07	116.21	XXX	0	2863.77	822.33	2654.78
75736		Angiography, pelvic, selective or supraselective, radiological supervision and interpretatior	5.20	330.20	99.06	XXX	0	2863.77	787.40	2654.78
75741		Angiography, pulmonary, unilateral, selective, radiological supervision and interpretatior	4.84	307.34	116.84	XXX	0	2863.77	788.04	2654.78
75743		Angiography, pulmonary, bilateral, selective, radiological supervision and interpretatior	5.63	357.51	147.32	XXX	0	2863.77	818.52	2654.78
75746		Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	5.06	321.31	102.87	XXX	0	923.72	780.42	939.06
75756		Angiography, internal mammary, radiological supervision and interpretatior	5.69	361.32	109.86	XXX	0	923.72	800.10	939.06
75774		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	3.02	191.77	32.39	ZZZ	0		707.39	
75791		Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis a	10.05	638.18	150.50	XXX	0	923.72	538.48	218.44
75801		Lymphangiography, extremity only, unilateral, radiological supervision and interpretatior	7.71	489.59	83.19	XXX	0	415.46	454.03	510.77
75803		Lymphangiography, extremity only, bilateral, radiological supervision and interpretatior	7.73	490.86	107.95	XXX	0	415.46	488.51	510.77
75805		Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretatior	7.87	499.75	74.93	XXX	0	415.46	574.68	510.77
75807		Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretatior	8.50	539.75	107.95	XXX	0	415.46	632.14	510.77
75809		Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation	3.12	198.12	43.18	XXX	0	91.38	108.59	101.78
75810		Splenoportography, radiological supervision and interpretatior	15.00	952.50	104.78	XXX	0	2863.77	824.67	2654.78
75820		Venography, extremity, unilateral, radiological supervision and interpretatior	3.78	240.03	62.87	XXX	0	923.72	148.59	939.06
75822		Venography, extremity, bilateral, radiological supervision and interpretatior	4.70	298.45	94.62	XXX	0	923.72	203.20	939.06
75825		Venography, caval, inferior, with serialography, radiological supervision and interpretatior	4.45	282.58	100.97	XXX	0	2863.77	772.80	2654.78
75827		Venography, caval, superior, with serialography, radiological supervision and interpretatior	4.55	288.93	100.33	XXX	0	923.72	772.16	939.06
75831		Venography, renal, unilateral, selective, radiological supervision and interpretatior	4.79	304.17	111.76	XXX	0	2863.77	774.07	2654.78
75833		Venography, renal, bilateral, selective, radiological supervision and interpretatior	5.56	353.06	128.91	XXX	0	2863.77	811.53	2654.78
75840		Venography, adrenal, unilateral, selective, radiological supervision and interpretatior	4.80	304.80	114.30	XXX	0	2863.77	779.78	2654.78
75842		Venography, adrenal, bilateral, selective, radiological supervision and interpretatior	5.72	363.22	134.62	XXX	0	2863.77	808.36	2654.78
75860		Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	4.62	293.37	102.24	XXX	0	923.72	781.69	939.06

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
75870		Venography, superior sagittal sinus, radiological supervision and interpretatior	4.61	292.74	102.87	XXX	0	923.72	777.88	939.06
75872		Venography, epidural, radiological supervision and interpretatior	4.61	292.74	102.87	XXX	0	923.72	795.02	939.06
75880		Venography, orbital, radiological supervision and interpretatior	7.10	450.85	68.58	XXX	0	923.72	147.96	939.06
75885		Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	5.05	320.68	128.27	XXX	0	2863.77	796.93	2654.78
75887		Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	5.00	317.50	126.37	XXX	0	923.72	800.74	939.06
75889		Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	4.65	295.28	101.60	XXX	0	2863.77	772.80	2654.78
75891		Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	4.65	295.28	102.24	XXX	0	2863.77	772.80	2654.78
75893		Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation	3.78	240.03	46.99	XXX	0	2863.77	725.81	2654.78
75894		Transcatheter therapy, embolization, any method, radiological supervision and interpretatior	27.43	1741.81	121.92	XXX	0		1747.01	
75896		Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation	23.88	1516.38	121.29	XXX	0		1701.04	
75898		Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	3.64	231.14	154.94	XXX	0	426.98	316.10	101.78
75901		Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	5.25	333.38	43.82	XXX	0		214.63	
75902		Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	2.27	144.15	35.56	XXX	0		169.55	
75945		Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel	5.18	328.93	36.20	XXX	0	199.63	517.21	209.78
75946		Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)	5.27	334.65	36.83	ZZZ	0		281.62	
75952		Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	6.67	423.55	423.55	XXX	0		563.18	2097.37**
75953		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation	2.03	128.91	128.91	XXX	0		137.92	2097.37**
75954		Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation	3.33	211.46	211.46	XXX	0		252.86	2097.37**
75956		Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thora	10.48	665.48	665.48	XXX	0		999.93	2097.37**
75957		Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending t	8.94	567.69	567.69	XXX	0		930.97	2097.37**
75958		Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	5.96	378.46	378.46	XXX	0		632.14	2097.37**
75959		Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	5.18	328.93	328.93	XXX	0		545.97	2097.37**
75960		Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel	3.73	236.86	72.39	XXX	0		1362.01	
75962		Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	4.50	285.75	47.63	XXX	0	5190.09	898.53	4621.59

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
75964		Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)	2.91	184.79	33.02	ZZZ	0		491.49	
75966		Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation	5.28	335.28	114.94	XXX	0	5190.09	968.38	4621.59
75968		Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	2.64	167.64	31.12	ZZZ	0		492.76	
75970		Transcatheter biopsy, radiological supervision and interpretatior	13.11	832.49	74.93	XXX	0		930.97	
75978		Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	4.46	283.21	47.63	XXX	0	2772.73	892.81	3246.08
75980		Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation	7.92	502.92	130.81	XXX	0		597.66	
75982		Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation	8.97	569.60	130.81	XXX	0		632.14	
75984		Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	3.34	212.09	64.14	XXX	0		188.60	
75989		Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	3.72	236.22	105.41	XXX	0		283.85	
76000		Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	1.56	99.06	15.88	XXX	0	147.41	121.29	115.75
76001		Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)	4.12	261.62	65.41	XXX	0		0.00	
76010		Radiologic examination from nose to rectum for foreign body, single view, chilc	0.81	51.44	16.51	XXX	0	59.28	48.26	60.74
76080		Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	1.81	114.94	48.26	XXX	0	329.57	111.13	284.44
76098		Radiological examination, surgical specimen	0.56	35.56	14.61	XXX	0	415.46	38.10	510.77
76100		Radiologic examination, single plane body section (eg, tomography), other than with urograph	3.05	193.68	57.79	XXX	0	91.38	161.93	101.78
76101		Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	4.60	292.10	65.41	XXX	0	329.57	198.76	284.44
76102		Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	6.15	390.53	66.68	XXX	0	329.57	254.64	284.44
76120		Cineradiography/videoradiography, except where specifically includec	2.27	144.15	34.93	XXX	0	147.41	111.76	115.75
76125		Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	1.32	83.82	26.04	ZZZ	0		86.23	
76140		Consultation on X-ray examination made elsewhere, written repor	0.00	BR		XXX	9		BR	2097.37**
76376		3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent works	1.77	112.40	17.78	XXX	0		205.11	
76377		3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstati	2.43	154.31	71.12	XXX	0		266.07	
76380		Computed tomography, limited or localized follow-up study	4.93	313.06	87.63	XXX	0	127.55	322.58	148.56
76390		Magnetic resonance spectroscopy	13.68	868.68	128.27	XXX	9		816.61	2097.37**
76496		Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	0.00	BR	BR	XXX	0	147.41	BR	115.75
76497		Unlisted computed tomography procedure (eg, diagnostic, interventional	0.00	BR	BR	XXX	0	127.55	BR	148.56
76498		Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	0.00	BR	BR	XXX	0	436.69	BR	472.87
76499		Unlisted diagnostic radiographic procedure	0.00	BR	BR	XXX	0	59.28	BR	60.74

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
76506		Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondar	3.77	239.40	57.79	XXX	0	83.30	167.01	84.51
76510		Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	5.36	340.36	179.71	XXX	0	186.80	267.97	411.03
76511		Ophthalmic ultrasound, diagnostic; quantitative A-scan only	3.04	193.04	97.79	XXX	0	128.14	198.12	131.62
76512		Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan	2.82	179.07	100.33	XXX	0	128.14	186.69	131.62
76513		Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy	2.93	186.06	66.68	XXX	0	128.14	156.21	131.62
76514		Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	0.45	28.58	17.78	XXX	0	30.23	20.32	21.16
76516		Ophthalmic biometry by ultrasound echography, A-scan	2.38	151.13	57.15	XXX	0	83.30	124.46	84.51
76519		Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculatio	2.58	163.83	59.06	XXX	0	128.14	130.81	131.62
76529		Ophthalmic ultrasonic foreign body localizatior	2.42	153.67	61.60	XXX	0	83.30	122.56	84.51
76536		Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentatior	3.67	233.05	50.80	XXX	0	128.14	154.31	131.62
76604		Ultrasound, chest (includes mediastinum), real time with image documentatior	2.64	167.64	49.53	XXX	0	83.30	134.62	84.51
76645		Ultrasound, breast(s) (unilateral or bilateral), real time with image documentatior	2.95	187.33	49.53	XXX	0	83.30	125.73	84.51
76700		Ultrasound, abdominal, real time with image documentation; complete	4.21	267.34	73.03	XXX	0	128.14	207.65	131.62
76705		Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	3.24	205.74	52.71	XXX	0	128.14	153.04	131.62
76770		Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete	3.97	252.10	66.68	XXX	0	128.14	201.30	131.62
76775		Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limitec	3.26	207.01	52.07	XXX	0	128.14	154.94	131.62
76776		Ultrasound, transplanted kidney, real time and duplex Doppler with image documentatior	4.60	292.10	67.95	XXX	0	128.14	207.65	131.62
76800		Ultrasound, spinal canal and contents	3.92	248.92	101.60	XXX	0	128.14	193.04	131.62
76801		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation	3.79	240.67	89.54	XXX	0	128.14	220.98	131.62
76802		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	1.97	125.10	75.57	ZZZ	0	83.30	136.53	84.51
76805		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation	4.43	281.31	90.17	XXX	0	128.14	229.24	131.62
76810		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	2.89	183.52	88.90	ZZZ	0	128.14	163.83	131.62
76811		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	5.57	353.70	174.63	XXX	0	199.63	391.16	209.78
76812		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	6.36	403.86	164.47	ZZZ	0	83.30	275.59	84.51
76813		Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	3.65	231.78	108.59	XXX	0	83.30	210.19	84.51
76814		Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	2.37	150.50	91.44	XXX	0	83.30	139.07	84.51
76815		Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	2.70	171.45	57.79	XXX	0	83.30	149.86	84.51
76816		Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a prev	3.55	225.43	78.11	XXX	0	83.30	160.02	84.51

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
76817		Ultrasound, pregnant uterus, real time with image documentation, transvagina	3.06	194.31	68.58	XXX	0	83.30	163.83	84.51
76818		Fetal biophysical profile; with non-stress testinc	3.70	234.95	96.52	XXX	0	128.14	198.76	131.62
76819		Fetal biophysical profile; without non-stress testinc	2.69	170.82	70.49	XXX	0	128.14	167.01	131.62
76820		Doppler velocimetry, fetal; umbilical artery	1.20	76.20	45.72	XXX	0	83.30	132.72	84.51
76821		Doppler velocimetry, fetal; middle cerebral artery	2.85	180.98	64.77	XXX	0	83.30	168.28	84.51
76825		Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	6.52	414.02	151.13	XXX	0	274.34	297.18	806.35
76826		Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	3.93	249.56	75.57	XXX	0	274.34	143.51	610.09
76827		Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	1.78	113.03	52.07	XXX	0	83.30	150.50	84.51
76828		Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	1.32	83.82	50.80	XXX	0	83.30	112.40	84.51
76830		Ultrasound, transvaginal	2.24	142.24	62.87	XXX	0	128.14	172.72	131.62
76831		Saline infusion sonohysterography (SIS), including color flow Doppler, when performec	3.79	240.67	66.68	XXX	0	199.63	176.53	209.78
76856		Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	3.73	236.86	61.60	XXX	0	128.14	173.99	131.62
76857		Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	2.86	181.61	34.93	XXX	0	83.30	153.04	84.51
76870		Ultrasound, scrotum and contents	3.73	236.86	57.79	XXX	0	128.14	170.18	131.62
76872		Ultrasound, transrectal;	2.16	137.16	61.60	XXX	0	128.14	208.28	131.62
76873		Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	5.09	323.22	141.61	XXX	9	199.63	282.58	131.62
76881		Ultrasound, extremity, nonvascular, real-time with image documentation; complete	3.66	232.41	57.79	XXX	9	128.14	New	
76882		Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	1.04	66.04	44.45	XXX	9	83.30	New	
76885		Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician or other qualified health care professional manipulation)	4.47	283.85	66.68	XXX	0	83.30	182.88	84.51
76886		Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician or other qualified health care professional manipulation)	3.16	200.66	54.61	XXX	0	83.30	154.31	84.51
76930		Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretatior	2.52	160.02	58.42	XXX	0		163.20	
76932		Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretatior	2.57	163.20	60.33	XXX	0		163.20	
76936		Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)	8.43	535.31	180.34	XXX	0	140.12	567.06	146.59
76937		Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry with permanent recording and reporting (Lis	1.07	67.95	27.31	ZZZ	0		57.79	
76940		Ultrasound guidance for, and monitoring of, parenchymal tissue ablatior	4.87	309.25	191.77	XXX	0		298.83	
76941		Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	3.74	237.49	128.27	XXX	0		166.69	
76942		Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	6.13	389.26	60.96	XXX	0		264.16	
76945		Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretatior	2.78	176.53	63.50	XXX	0		160.91	
76946		Ultrasonic guidance for amniocentesis, imaging supervision and interpretatior	0.96	60.96	34.93	XXX	0		114.94	
76948		Ultrasonic guidance for aspiration of ova, imaging supervision and interpretatior	0.99	62.87	36.20	XXX	0		114.30	
76950		Ultrasonic guidance for placement of radiation therapy fields	1.50	95.25	53.98	XXX	0		130.18	
76965		Ultrasonic guidance for interstitial radioelement application	2.64	167.64	121.92	XXX	0		405.13	
76970		Ultrasound study follow-up (specify)	3.02	191.77	37.47	XXX	0	83.30	117.48	84.51
76975		Gastrointestinal endoscopic ultrasound, supervision and interpretatior	3.10	196.85	80.65	XXX	0	199.63	270.13	209.78
76977		Ultrasound bone density measurement and interpretation, peripheral site(s), any methoc	0.21	13.34	5.08	XXX	0	64.04	48.26	61.03
76998		Ultrasonic guidance, intraoperative	1.88	119.38	119.38	XXX	0		0.00	
76999		Unlisted ultrasound procedure (eg, diagnostic, interventional)	0.00	BR	BR	XXX	0	83.30	BR	84.51

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
77001		Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or c	3.56	226.06	34.29	ZZZ	9		138.43	
77002		Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device	2.35	149.23	50.80	XXX	9		125.73	
77003		Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)	2.82	179.07	56.52	XXX	9		121.92	
77011		Computed tomography guidance for stereotactic localizatior	6.66	422.91	111.76	XXX	9		821.69	
77012		Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	3.78	240.03	102.24	XXX	9		541.66	
77013		Computed tomography guidance for, and monitoring of, parenchymal tissue ablatior	15.94	1012.19	364.49	XXX	0		1020.64	
77014		Computed tomography guidance for placement of radiation therapy fields	3.66	232.41	78.11	XXX	9		285.12	
77021		Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	11.50	730.25	136.53	XXX	9		829.95	
77022		Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablatior	19.58	1243.33	385.45	XXX	0		1235.58	
77031		Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	3.82	242.57	145.42	XXX	9		513.08	
77032		Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	1.54	97.79	50.17	XXX	9		117.48	
77051		Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code	0.30	19.05	5.72	ZZZ	9		28.58	
77052		Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code	0.30	19.05	5.72	ZZZ	9		28.58	
77053		Mammary ductogram or galactogram, single duct, radiological supervision and interpretatior	1.76	111.76	31.75	XXX	9	329.57	170.82	284.44
77054		Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretatior	2.37	150.50	40.64	XXX	9	329.57	245.11	284.44
77055		Mammography; unilateral	2.62	166.37	62.87	XXX	9		130.81	
77056		Mammography; bilateral	3.37	214.00	78.74	XXX	9		163.20	
77057		Screening mammography, bilateral (2-view film study of each breast)	2.40	152.40	63.50	XXX	9		137.16	
77058		Magnetic resonance imaging, breast, without and/or with contrast material(s); unilatera	18.54	1177.29	146.69	XXX	9		1347.47	
77059		Magnetic resonance imaging, breast, without and/or with contrast material(s); bilatera	18.40	1168.40	146.69	XXX	9		1666.24	
77071		Manual application of stress performed by physician or other qualified health care professional for joint radiography, including contralateral joint if indicated	1.54	97.79		XXX	0	59.28	48.26	60.74
77072		Bone age studies	0.70	44.45	17.15	XXX	0	59.28	37.47	60.74
77073		Bone length studies (orthoroentgenogram, scanogram)	1.16	73.66	27.31	XXX	0	91.38	70.49	60.74
77074		Radiologic examination, osseous survey; limited (eg, for metastases)	2.10	133.35	40.64	XXX	0	91.38	106.68	101.78
77075		Radiologic examination, osseous survey; complete (axial and appendicular skeleton	3.18	201.93	48.90	XXX	0	91.38	149.23	101.78
77076		Radiologic examination, osseous survey, infant	3.18	201.93	62.87	XXX	0	91.38	121.29	101.78
77077		Joint survey, single view, 2 or more joints (specify)	1.22	77.47	31.12	XXX	0	59.28	90.81	60.74
77078		Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	3.93	249.56	22.23	XXX	0	95.30	241.30	98.07
77080		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	1.48	93.98	18.42	XXX	0	95.30	187.33	98.07
77081		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.84	53.34	20.32	XXX	0	45.46	67.31	39.38
77082		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment	0.84	53.34	15.88	XXX	0	59.28	58.42	60.74
77084		Magnetic resonance (eg, proton) imaging, bone marrow blood supply	13.13	833.76	144.78	XXX	0	436.69	910.59	472.87
77261		Therapeutic radiology treatment planning; simple	2.10	133.35		XXX	0		116.21	
77262		Therapeutic radiology treatment planning; intermediate	3.16	200.66		XXX	0		174.63	

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77263		Therapeutic radiology treatment planning; comple›	4.67	296.55		XXX	0		259.08	
77280		Therapeutic radiology simulation-aided field setting; simple	5.32	337.82	64.14	XXX	0	141.56	300.99	139.26
77285		Therapeutic radiology simulation-aided field setting; intermediate	9.41	597.54	96.52	XXX	0	375.40	491.49	360.29
77290		Therapeutic radiology simulation-aided field setting; comple›	15.62	991.87	143.51	XXX	0	375.40	664.21	360.29
77295		Therapeutic radiology simulation-aided field setting; 3-dimensiona	13.09	831.22	422.28	XXX	0	1270.08	1887.86	1254.56
77299		Unlisted procedure, therapeutic radiology clinical treatment planning	0.00	BR	BR	XXX	0	141.56	BR	139.26
77300		Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, onl	1.96	124.46	57.15	XXX	0	141.56	133.99	139.26
77301		Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	58.50	3714.75	739.14	XXX	0	1270.08	2941.32	1254.56
77305		Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)	1.72	109.22	64.14	XXX	0	141.56	163.20	139.26
77310		Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)	2.48	157.48	96.52	XXX	0	141.56	218.44	139.26
77315		Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)	3.93	249.56	143.51	XXX	0	375.40	287.02	360.29
77321		Special teletherapy port plan, particles, hemibody, total body	2.67	169.55	87.63	XXX	0	375.40	301.63	360.29
77326		Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)	4.30	273.05	85.73	XXX	0	141.56	239.40	139.26
77327		Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)	5.99	380.37	128.27	XXX	0	375.40	347.35	360.29
77328		Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)	8.01	508.64	193.04	XXX	0	375.40	494.03	360.29
77331		Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician	1.82	115.57	80.01	XXX	0	141.56	103.51	139.26
77332		Treatment devices, design and construction; simple (simple block, simple bolus)	2.36	149.86	50.17	XXX	0	260.29	134.62	257.88
77333		Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)	1.50	95.25	77.47	XXX	0	260.29	168.91	257.88
77334		Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	4.41	280.04	113.67	XXX	0	260.29	303.53	257.88
77336		Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	1.29	81.92		XXX	0	141.56	170.18	139.26
77338		Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	14.73	935.36	397.51	XXX	0	375.40	841.38	257.88
77370		Special medical radiation physics consultation	3.47	220.35		XXX	0	141.56	226.06	139.26
77371		Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	38.73	2459.36	0.00	XXX	0	10205.25	1929.13	9935.68
77372		Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	23.07	1464.95	0.00	XXX	0		1464.31	
77373		Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	37.29	2367.92	0.00	XXX	0		2730.50	
77399		Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	0.00	BR	BR	XXX	0	141.56	BR	139.26
77401		Radiation treatment delivery, superficial and/or ortho voltage	0.61	38.74	0.00	XXX	0	123.21	99.06	125.51
77402		Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV	4.56	289.56	0.00	XXX	0	123.21	157.48	125.51

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77403		Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV	3.76	238.76	0.00	XXX	0	123.21	151.13	125.51
77404		Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV	4.18	265.43	0.00	XXX	0	123.21	158.12	125.51
77406		Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater	4.18	265.43	0.00	XXX	0	123.21	158.12	210.01
77407		Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV	6.64	421.64	0.00	XXX	0	123.21	193.68	125.51
77408		Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV	5.18	328.93	0.00	XXX	0	231.59	189.87	125.51
77409		Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV	5.77	366.40	0.00	XXX	0	231.59	199.39	125.51
77411		Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater	5.80	368.30	0.00	XXX	0	231.59	198.76	210.01
77412		Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV	7.06	448.31	0.00	XXX	0	231.59	227.97	210.01
77413		Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV	6.80	431.80	0.00	XXX	0	231.59	227.97	210.01
77414		Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV	7.65	485.78	0.00	XXX	0	231.59	241.94	210.01
77416		Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater	7.64	485.14	0.00	XXX	0	231.59	241.94	210.01
77417		Therapeutic radiology port film(s)	0.42	26.67	0.00	XXX	0		36.20	
77418		Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	11.92	756.92	0.00	XXX	0	624.02	1075.06	569.85
77421		Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	2.19	139.07	35.56	XXX	0		227.33	
77422		High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking	8.31	527.69	0.00	XXX	0	231.59	299.09	210.01
77423		High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	8.47	537.85	0.00	XXX	0	231.59	252.10	210.01
77424		Intraoperative radiation treatment delivery, x-ray, single treatment session	0.00	BR		XXX	9	1262.03	New	
77425		Intraoperative radiation treatment delivery, electrons, single treatment session	0.00	BR		XXX	9	1262.03	New	
77427		Radiation treatment management, 5 treatments	5.24	332.74		XXX	9		295.28	
77431		Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	2.88	182.88		XXX	0		154.31	
77432		Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	11.79	748.67		XXX	0		659.13	
77435		Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	17.80	1130.30		XXX	0		1078.87	
77469		Intraoperative radiation treatment management	8.85	561.98		XXX	0		New	
77470		Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	4.45	282.58	193.04	XXX	0	506.25	757.56	514.87
77499		Unlisted procedure, therapeutic radiology treatment management	0.00	BR	BR	XXX	0		BR	
77520		Proton treatment delivery; simple, without compensation	0.00	BR		XXX	0	1466.32	BR	1274.80
77522		Proton treatment delivery; simple, with compensation	0.00	BR		XXX	0	1466.32	BR	1274.80
77523		Proton treatment delivery; intermediate	0.00	BR		XXX	0	880.30	BR	1667.62
77525		Proton treatment delivery; complex	0.00	BR		XXX	0	880.30	BR	1667.62
77600		Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less	12.68	805.18	143.51	XXX	0	506.25	427.36	514.87
77605		Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm	34.13	2167.26	209.55	XXX	0	506.25	643.26	514.87
77610		Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	32.17	2042.80	142.88	XXX	0	506.25	544.20	514.87
77615		Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators	29.95	1901.83	193.04	XXX	0	506.25	776.61	514.87

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77620		Hyperthermia generated by intracavitary probe(s)	17.27	1096.65	140.97	XXX	0	506.25	432.44	514.87
77750		Infusion or instillation of radioelement solution (includes 3-month follow-up care)	10.60	673.10	462.28	090	0	231.59	513.72	210.01
77761		Intracavitary radiation source application; simple	11.27	715.65	354.33	090	0	530.00	510.54	408.95
77762		Intracavitary radiation source application; intermediate	14.91	946.79	531.50	090	0	530.00	739.14	408.95
77763		Intracavitary radiation source application; complex	21.03	1335.41	800.10	090	0	530.00	1042.67	408.95
77776		Interstitial radiation source application; simple	12.63	802.01	439.42	090	0	530.00	571.50	408.95
77777		Interstitial radiation source application; intermediate	17.10	1085.85	697.87	090	0	530.00	906.15	408.95
77778		Interstitial radiation source application; complex	25.09	1593.22	1045.85	090	0	1129.50	1290.32	1208.77
77785		Remote afterloading high dose rate radionuclide brachytherapy; 1 channe	7.37	468.00	131.45	XXX	0	887.17	347.35	1051.90
77786		Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels	16.37	1039.50	300.36	XXX	0	887.17	965.84	1051.90
77787		Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	28.09	1783.72	453.39	XXX	0	887.17	1488.44	1051.90
77789		Surface application of radiation source	3.47	220.35	106.05	000	0	123.21	142.88	125.51
77790		Supervision, handling, loading of radiation source	2.78	176.53	95.89	XXX	0		127.64	
77799		Unlisted procedure, clinical brachytherapy	0.00	BR	BR	XXX	0	530.00	BR	408.95
78012		Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	2.44	154.94	17.15	XXX	0	147.11	New	
78013		Thyroid imaging (including vascular flow, when performed)	6.17	391.80	33.02	XXX	0	193.57	New	
78014		Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	7.13	452.76	44.45	XXX	0	300.51	New	
78015		Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)	6.55	415.93	58.42	XXX	0	387.14	263.53	392.43
78016		Thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery	8.50	539.75	62.87	XXX	0	387.14	368.30	392.43
78018		Thyroid carcinoma metastases imaging; whole body	9.47	601.35	74.30	XXX	0	387.14	461.01	392.43
78020		Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure	2.49	158.12	50.17	ZZZ	0		143.51	
78070		Parathyroid planar imaging (including subtraction, when performed)	9.02	572.77	69.85	XXX	0	300.51	323.85	299.96
78071		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT	10.63	675.01	105.41	XXX	0	415.46	New	
78072		Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	2.30	146.05	146.05	YYY	0	415.46	New	
78075		Adrenal imaging, cortex and/or medulla	12.97	823.60	62.87	XXX	0	1232.81	508.64	1302.87
78099		Unlisted endocrine procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	193.57	BR	196.92
78102		Bone marrow imaging; limited area	5.13	325.76	47.63	XXX	0	361.16	208.28	349.64
78103		Bone marrow imaging; multiple areas	6.55	415.93	64.14	XXX	0	361.16	299.72	349.64
78104		Bone marrow imaging; whole body	7.51	476.89	69.85	XXX	0	361.16	363.22	349.64
78110		Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	2.79	177.17	17.15	XXX	0	562.20	96.52	527.74
78111		Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	2.55	161.93	17.78	XXX	0	562.20	180.98	527.74
78120		Red cell volume determination (separate procedure); single sampling	2.75	174.63	20.32	XXX	0	562.20	138.43	527.74
78121		Red cell volume determination (separate procedure); multiple samplings	2.33	147.96	24.13	XXX	0	562.20	205.11	527.74
78122		Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	2.97	188.60	38.10	XXX	0	562.20	301.63	527.74
78130		Red cell survival study;	4.85	307.98	55.88	XXX	0	562.20	243.84	527.74
78135		Red cell survival study; differential organ/tissue kinetics (eg, splenic and/or hepatic sequestration	10.81	686.44	58.42	XXX	0	562.20	425.45	527.74
78140		Labeled red cell sequestration, differential organ/tissue (eg, splenic and/or hepatic)	4.07	258.45	55.25	XXX	0	562.20	289.56	527.74
78185		Spleen imaging only, with or without vascular flow	6.42	407.67	35.56	XXX	0	361.16	229.24	349.64
78190		Kinetics, study of platelet survival, with or without differential organ/tissue localization	12.40	787.40	99.70	XXX	0	253.62	516.26	244.54
78191		Platelet survival study	4.86	308.61	55.88	XXX	0	253.62	470.54	244.54
78195		Lymphatics and lymph nodes imaging	10.81	686.44	106.05	XXX	0	361.16	429.26	349.64
78199		Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	361.16	BR	349.64
78201		Liver imaging; static only	5.64	358.14	38.74	XXX	0	405.59	225.43	393.38
78202		Liver imaging; with vascular flow	6.19	393.07	42.55	XXX	0	405.59	264.80	393.38

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78205		Liver imaging (SPECT);	6.43	408.31	61.60	XXX	0	405.59	433.71	393.38
78206		Liver imaging (SPECT); with vascular flow	10.27	652.15	83.19	XXX	0	405.59	579.76	393.38
78215		Liver and spleen imaging; static only	5.91	375.29	43.82	XXX	0	405.59	257.81	393.38
78216		Liver and spleen imaging; with vascular flow	3.72	236.22	48.90	XXX	0	405.59	261.62	393.38
78226		Hepatobiliary system imaging, including gallbladder when present	11.45	727.08	68.58	XXX	0	405.59	New	
78227		Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	15.50	984.25	82.55	XXX	0	405.59	New	
78230		Salivary gland imaging;	5.24	332.74	40.64	XXX	0	331.24	207.65	334.69
78231		Salivary gland imaging; with serial images	3.89	247.02	45.72	XXX	0	331.24	243.21	334.69
78232		Salivary gland function study	2.93	186.06	36.20	XXX	0	331.24	256.54	334.69
78258		Esophageal motility	6.79	431.17	64.77	XXX	0	331.24	290.83	334.69
78261		Gastric mucosa imaging	7.65	485.78	62.23	XXX	0	331.24	352.43	334.69
78262		Gastroesophageal reflux study	7.59	481.97	59.69	XXX	0	331.24	357.51	334.69
78264		Gastric emptying study	8.73	554.36	70.49	XXX	0	331.24	376.56	334.69
78267		Urea breath test, C-14 (isotopic); acquisition for analysis	0.32	20.32	0.00	XXX	9		0.00	
78268		Urea breath test, C-14 (isotopic); analysis	2.72	172.72	0.00	XXX	9		0.00	
78270		Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor	2.58	163.83	17.78	XXX	0	253.62	124.46	244.54
78271		Vitamin B-12 absorption study (eg, Schilling test); with intrinsic factor	2.82	179.07	18.42	XXX	0	253.62	129.54	244.54
78272		Vitamin B-12 absorption studies combined, with and without intrinsic factor	2.84	180.34	24.13	XXX	0	253.62	170.18	244.54
78278		Acute gastrointestinal blood loss imaging	10.56	670.56	87.63	XXX	0	331.24	450.85	334.69
78282		Gastrointestinal protein loss	2.20	139.70	34.93	XXX	0	331.24	193.10	334.69
78290		Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)	10.15	644.53	60.33	XXX	0	331.24	333.38	334.69
78291		Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt	7.74	491.49	77.47	XXX	0	331.24	315.60	334.69
78299		Unlisted gastrointestinal procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	331.24	BR	334.69
78300		Bone and/or joint imaging; limited area	5.45	346.08	55.25	XXX	0	337.58	236.86	334.73
78305		Bone and/or joint imaging; multiple areas	7.17	455.30	73.66	XXX	0	337.58	331.47	334.73
78306		Bone and/or joint imaging; whole body	7.59	481.97	75.57	XXX	0	337.58	372.75	334.73
78315		Bone and/or joint imaging; 3 phase study	10.54	669.29	90.17	XXX	0	337.58	448.95	334.73
78320		Bone and/or joint imaging; tomographic (SPECT)	6.85	434.98	90.17	XXX	0	337.58	459.74	334.73
78350		Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	0.99	62.87	20.32	XXX	9		68.58	2097.37**
78351		Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	0.43	27.31	8.26	XXX	9		24.77	2097.37**
78399		Unlisted musculoskeletal procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	337.58	BR	334.73
78414		Determination of central c-v hemodynamics (non-imaging) (eg, ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	2.20	139.70	41.91	XXX	0	398.63	129.86	413.69
78428		Cardiac shunt detection	5.57	353.70	67.95	XXX	0	398.63	259.08	413.69
78445		Non-cardiac vascular flow imaging (ie, angiography, venography)	5.22	331.47	41.28	XXX	0	426.98	201.93	270.64
78451		Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (	10.59	672.47	121.92	XXX	0	876.84	391.80	1048.58
78452		Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or	14.76	937.26	142.88	XXX	0	876.84	668.66	1048.58
78453		Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	9.20	584.20	88.90	XXX	0	876.84	341.00	1048.58
78454		Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) an	13.23	840.11	118.75	XXX	0	876.84	328.30	1048.58
78456		Acute venous thrombosis imaging, peptide	10.74	681.99	88.27	XXX	9	426.98	440.69	270.64

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
78457		Venous thrombosis imaging, venogram; unilateral	6.17	391.80	68.58	XXX	0	426.98	265.43	270.64
78458		Venous thrombosis imaging, venogram; bilateral	5.66	359.41	74.93	XXX	0	426.98	342.27	270.64
78459		Myocardial imaging, positron emission tomography (PET), metabolic evaluation	12.12	769.62	130.81	XXX	0	1362.48	443.67	1938.45
78466		Myocardial imaging, infarct avid, planar; qualitative or quantitative	5.95	377.83	63.50	XXX	0	398.63	255.27	413.69
78468		Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	6.05	384.18	71.12	XXX	0	398.63	342.27	413.69
78469		Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	6.87	436.25	82.55	XXX	0	398.63	434.34	413.69
78472		Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	7.01	445.14	86.36	XXX	0	398.63	450.22	413.69
78473		Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	8.89	564.52	129.54	XXX	0	398.63	651.51	413.69
78481		Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	5.52	350.52	86.36	XXX	0	398.63	422.28	413.69
78483		Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	7.37	468.00	130.18	XXX	0	398.63	622.30	413.69
78491		Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	13.13	833.76	133.35	XXX	0	1362.48	451.68	1938.45
78492		Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress	16.32	1036.32	165.74	XXX	0	1362.48	563.18	1938.45
78494		Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	6.95	441.33	104.78	XXX	0	398.63	545.47	413.69
78496		Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)	1.33	84.46	43.82	ZZZ	0		408.94	
78499		Unlisted cardiovascular procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	398.63	BR	413.69
78579		Pulmonary ventilation imaging (eg, aerosol or gas)	6.55	415.93	45.72	XXX	0	285.05	New	
78580		Pulmonary perfusion imaging (eg, particulate)	7.19	456.57	64.77	XXX	0	285.05	307.98	279.27
78582		Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	11.52	731.52	98.43	XXX	0	433.99	New	
78597		Quantitative differential pulmonary perfusion, including imaging when performed	7.17	455.30	67.95	XXX	0	285.05	New	
78598		Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	10.70	679.45	77.47	XXX	0	433.99	New	
78599		Unlisted respiratory procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	285.05	BR	279.27
78600		Brain imaging, less than 4 static views;	5.55	352.43	38.74	XXX	0	340.70	288.29	266.10
78601		Brain imaging, less than 4 static views; with vascular flow	6.55	415.93	45.09	XXX	0	591.30	291.47	782.82
78605		Brain imaging, minimum 4 static views;	5.98	379.73	47.63	XXX	0	340.70	284.48	266.10
78606		Brain imaging, minimum 4 static views; with vascular flow	10.07	639.45	55.25	XXX	0	591.30	374.65	782.82
78607		Brain imaging, tomographic (SPECT)	10.64	675.64	104.78	XXX	0	591.30	656.59	782.82
78608		Brain imaging, positron emission tomography (PET); metabolic evaluation	17.25	1095.38	131.45	XXX	0	1362.48	524.13	1403.37
78609		Brain imaging, positron emission tomography (PET); perfusion evaluation	2.21	140.34	140.34	XXX	9		524.13	2097.37**
78610		Brain imaging, vascular flow only	5.35	339.73	26.67	XXX	0	340.70	171.45	266.10
78630		Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	10.46	664.21	60.33	XXX	0	591.30	437.52	782.82
78635		Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography	10.25	650.88	53.34	XXX	0	591.30	305.44	782.82
78645		Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	9.74	618.49	49.53	XXX	0	340.70	344.17	266.10
78647		Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	11.09	704.22	79.38	XXX	0	591.30	585.47	782.82
78650		Cerebrospinal fluid leakage detection and localization	10.11	641.99	53.98	XXX	0	591.30	412.75	782.82
78660		Radiopharmaceutical dacryocystography	5.72	363.22	49.53	XXX	0	340.70	213.36	266.10
78699		Unlisted nervous system procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	340.70	BR	266.10
78700		Kidney imaging morphology;	5.36	340.36	40.64	XXX	0	429.48	257.18	439.73
78701		Kidney imaging morphology; with vascular flow	6.46	410.21	43.82	XXX	0	429.48	298.45	439.73

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
78707		Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	6.97	442.60	83.19	XXX	0	429.48	381.64	439.73
78708		Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	5.15	327.03	105.41	XXX	0	429.48	369.57	439.73
78709		Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	11.12	706.12	123.19	XXX	0	429.48	466.73	439.73
78710		Kidney imaging morphology; tomographic (SPECT)	6.18	392.43	53.98	XXX	0	429.48	430.53	439.73
78725		Kidney function study, non-imaging radioisotopic study	3.35	212.73	33.02	XXX	0	253.62	156.85	244.54
78730		Urinary bladder residual study (List separately in addition to code for primary procedure	2.00	127.00	13.34	ZZZ	0	147.11	121.29	152.24
78740		Ureteral reflux study (radiopharmaceutical voiding cystogram)	7.01	445.14	51.44	XXX	0	429.48	233.68	439.73
78761		Testicular imaging with vascular flow	6.53	414.66	63.50	XXX	0	429.48	290.20	439.73
78799		Unlisted genitourinary procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	429.48	BR	439.73
78800		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	5.74	364.49	59.69	XXX	0	387.14	288.29	392.43
78801		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	7.37	468.00	69.85	XXX	0	648.31	367.67	690.51
78802		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	9.78	621.03	74.93	XXX	0	648.31	469.90	690.51
78803		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	10.30	654.05	93.35	XXX	0	648.31	641.99	690.51
78804		Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	17.23	1094.11	93.35	XXX	0	1232.81	849.63	1302.87
78805		Radiopharmaceutical localization of inflammatory process; limited area	5.52	350.52	64.77	XXX	0	648.31	292.10	690.51
78806		Radiopharmaceutical localization of inflammatory process; whole body	10.03	636.91	74.93	XXX	0	648.31	518.80	690.51
78807		Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)	10.21	648.34	92.08	XXX	0	648.31	630.56	392.43
78808		Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (eg, parathyroid adenoma)	1.35	85.73		XXX	0	253.62	75.57	244.54
78811		Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	18.76	1191.26	142.88	XXX	0	1362.48	435.61	1403.37
78812		Positron emission tomography (PET) imaging; skull base to mid-thigh	22.75	1444.63	173.36	XXX	0	1362.48	537.91	1403.37
78813		Positron emission tomography (PET) imaging; whole body	23.67	1503.05	180.34	XXX	0	1362.48	559.75	1403.37
78814		Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	26.17	1661.80	199.39	XXX	0	1362.48	611.44	1403.37
78815		Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	28.92	1836.42	220.35	XXX	0	1362.48	675.83	1403.37
78816		Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	29.17	1852.30	222.25	XXX	0	1362.48	694.18	1403.37
78999		Unlisted miscellaneous procedure, diagnostic nuclear medicine	0.00	BR	BR	XXX	0	147.11	BR	152.24
79005		Radiopharmaceutical therapy, by oral administration	3.94	250.19	157.48	XXX	0	305.38	297.82	295.05
79101		Radiopharmaceutical therapy, by intravenous administration	4.20	266.70	170.82	XXX	0	305.38	314.96	295.05
79200		Radiopharmaceutical therapy, by intracavitary administration	4.58	290.83	184.79	XXX	0	388.32	319.41	474.25
79300		Radiopharmaceutical therapy, by interstitial radioactive colloid administration	3.88	246.38	147.96	XXX	0	305.38	236.79	295.05
79403		Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	5.58	354.33	201.30	XXX	0	388.32	433.71	474.25
79440		Radiopharmaceutical therapy, by intra-articular administration	4.20	266.70	176.53	XXX	0	388.32	313.06	474.25
79445		Radiopharmaceutical therapy, by intra-arterial particulate administration	6.04	383.54	210.82	XXX	0	305.38	388.49	295.05
79999		Radiopharmaceutical therapy, unlisted procedure	0.00	BR	BR	XXX	0	305.38	BR	295.05
80047		Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	0.34	20.23	0.00	XXX	9		30.00	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
80048		Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	0.34	20.23	0.00	XXX	9		43.67	
80050		General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and	1.20	71.40	0.00	XXX	9		100.14	2097.37**
80051		Electrolyte panel This panel must include the following: Carbon dioxide (bicarbonate) (82374) Chloride (82435) Potassium (84132) Sodium (84295)	0.28	16.66	0.00	XXX	9		36.41	
80053		Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Pot	0.43	25.59	0.00	XXX	9		50.99	
80055		Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (	1.75	104.13	0.00	XXX	9		127.45	2097.37**
80061		Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	0.70	41.65	0.00	XXX	9		69.20	
80069		Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (	0.35	20.83	0.00	XXX	9		45.52	
80074		Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709) Hepatitis B core antibody (HBcAb), IgM antibody (86705) Hepatitis B surface antigen (HBsAg) (87340) Hepatitis C antibody (86803)	1.97	117.22	0.00	XXX	9		180.23	
80076		Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate am	0.33	19.64	0.00	XXX	9		40.04	
80100		Drug screen, qualitative; multiple drug classes chromatographic method, each procedure	0.99	58.91	0.00	XXX	9		76.46	2097.37**
80101		Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class	0.83	49.39	0.00	XXX	9		58.25	2097.37**
80102		Drug confirmation, each procedure	0.53	31.54	0.00	XXX	9		98.29	
80103		Tissue preparation for drug analysis	0.72	42.84	0.00	XXX	9		54.62	
80104		Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	1.05	62.48	0.00	XXX	9		New	
80150		Amikacin	0.61	36.30	0.00	XXX	9		76.46	
80152		Amitriptyline	0.72	42.84	0.00	XXX	9		101.98	
80154		Benzodiazepines	0.75	44.63	0.00	XXX	9		101.03	
80156		Carbamazepine; total	0.59	35.11	0.00	XXX	9		81.93	
80157		Carbamazepine; free	0.54	32.13	0.00	XXX	9		74.67	
80158		Cyclosporine	0.73	43.44	0.00	XXX	9		103.77	
80160		Desipramine	0.70	41.65	0.00	XXX	9		100.14	
80162		Digoxin	0.54	32.13	0.00	XXX	9		76.46	
80164		Dipropylacetic acid (valproic acid)	0.55	32.73	0.00	XXX	9		78.30	
80166		Doxepin	0.63	37.49	0.00	XXX	9		87.41	
80168		Ethosuximide	0.66	39.27	0.00	XXX	9		89.19	
80170		Gentamicin	0.66	39.27	0.00	XXX	9		85.56	
80172		Gold	0.66	39.27	0.00	XXX	9		83.78	
80173		Haloperidol	0.59	35.11	0.00	XXX	9		74.67	
80174		Imipramine	0.70	41.65	0.00	XXX	9		96.51	
80176		Lidocaine	0.59	35.11	0.00	XXX	9		69.20	
80178		Lithium	0.27	16.07	0.00	XXX	9		43.67	
80182		Nortriptyline	0.55	32.73	0.00	XXX	9		80.09	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
80184		Phenobarbital	0.46	27.37	0.00	XXX	9		67.35	
80185		Phenytoin; total	0.54	32.13	0.00	XXX	9		76.46	
80186		Phenytoin; free	0.56	33.32	0.00	XXX	9		80.09	
80188		Primidone	0.67	39.87	0.00	XXX	9		96.51	
80190		Procainamide;	0.68	40.46	0.00	XXX	9		83.78	
80192		Procainamide; with metabolites (eg, n-acetyl procainamide)	0.68	40.46	0.00	XXX	9		92.88	
80194		Quinidine	0.59	35.11	0.00	XXX	9		81.93	
80195		Sirolimus	0.55	32.73	0.00	XXX	9		105.61	
80196		Salicylate	0.29	17.26	0.00	XXX	9		54.62	
80197		Tacrolimus	0.55	32.73	0.00	XXX	9		103.77	
80198		Theophylline	0.57	33.92	0.00	XXX	9		80.09	
80200		Tobramycin	0.65	38.68	0.00	XXX	9		81.93	
80201		Topiramate	0.48	28.56	0.00	XXX	9		81.93	
80202		Vancomycin	0.55	32.73	0.00	XXX	9		74.67	
80299		Quantitation of drug, not elsewhere specified	0.55	32.73	0.00	XXX	9		91.04	
80400		ACTH stimulation panel; for adrenal insufficiency This panel must include the following: Cortisol (82533 x 2)	2.06	122.57	0.00	XXX	9		171.12	
80402		ACTH stimulation panel; for 21 hydroxylase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxyprogesterone (83498 x 2)	3.35	199.33	0.00	XXX	9		278.58	
80406		ACTH stimulation panel; for 3 beta-hydroxydehydrogenase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxypregnenolone (84143 x 2)	3.53	210.04	0.00	XXX	9		293.16	
80408		Aldosterone suppression evaluation panel (eg, saline infusion) This panel must include the following: Aldosterone (82088 x 2), Renin (84244 x 2)	3.83	227.89	0.00	XXX	9		318.62	
80410		Calcitonin stimulation panel (eg, calcium, pentagastrin) This panel must include the following: Calcitonin (82308 x 3)	3.18	189.21	0.00	XXX	9		264.00	
80412		Corticotropic releasing hormone (CRH) stimulation panel This panel must include the following: Cortisol (82533 x 6), Adrenocorticotropic hormone (ACTH) (82024 x 6)	9.86	586.67	0.00	XXX	9		819.32	
80414		Chorionic gonadotropin stimulation panel; testosterone response This panel must include the following: Testosterone (84403 x 2 on 3 pooled blood samples)	1.64	97.58	0.00	XXX	9		136.55	
80415		Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)	1.64	97.58	0.00	XXX	9		136.55	
80416		Renal vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 6)	4.91	292.15	0.00	XXX	9		407.81	
80417		Peripheral vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 2)	2.10	124.95	0.00	XXX	9		174.81	
80418		Combined rapid anterior pituitary evaluation panel This panel must include the following: Adrenocorticotropic hormone (ACTH) (82024 x 4) Luteinizing hormone (LH) (83002 x 4) Follicle stimulating hormone (FSH) (83001 x 4) Prolactin (84146 x 4) Human growth	21.90	1303.05	0.00	XXX	9		1820.70	
80420		Dexamethasone suppression panel, 48 hour This panel must include the following: Free cortisol, urine (82530 x 2) Cortisol (82533 x 2) Volume measurement for timed collection (81050 x 2)	2.74	163.03	0.00	XXX	9		227.59	
80422		Glucagon tolerance panel; for insulinoma This panel must include the following: Glucose (82947 x 3) Insulin (83525 x 3)	1.86	110.67	0.00	XXX	9		154.76	
80424		Glucagon tolerance panel; for pheochromocytoma This panel must include the following: Catecholamines, fractionated (82384 x 2)	1.86	110.67	0.00	XXX	9		154.76	
80426		Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)	5.15	306.43	0.00	XXX	9		427.86	
80428		Growth hormone stimulation panel (eg, arginine infusion, l-dopa administration) This panel must include the following: Human growth hormone (HGH) (83003 x 4)	2.85	169.58	0.00	XXX	9		236.69	
80430		Growth hormone suppression panel (glucose administration) This panel must include the following: Glucose (82947 x 3) Human growth hormone (HGH) (83003 x 4)	2.85	169.58	0.00	XXX	9		236.69	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
80432		Insulin-induced C-peptide suppression panel This panel must include the following: Insulin (83525) C-peptide (84681 x 5) Glucose (82947 x 5)	5.58	332.01	0.00	XXX	9		464.28	
80434		Insulin tolerance panel; for ACTH insufficiency This panel must include the following: Cortisol (82533 x 5) Glucose (82947 x 5)	3.50	208.25	0.00	XXX	9		291.31	
80435		Insulin tolerance panel; for growth hormone deficiency This panel must include the following: Glucose (82947 x 5) Human growth hormone (HGH) (83003 x 5)	3.72	221.34	0.00	XXX	9		309.52	
80436		Metyrapone panel This panel must include the following: Cortisol (82533 x 2), 11 deoxycortisol (82634 x 2)	3.61	214.80	0.00	XXX	9		300.42	
80438		Thyrotropin releasing hormone (TRH) stimulation panel; 1 hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 3)	2.08	123.76	0.00	XXX	9		172.97	
80439		Thyrotropin releasing hormone (TRH) stimulation panel; 2 hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 4)	2.19	130.31	0.00	XXX	9		182.07	
80440		Thyrotropin releasing hormone (TRH) stimulation panel; for hyperprolactinemia This panel must include the following: Prolactin (84146 x 3)	2.19	130.31	0.00	XXX	9		182.07	
80500		Clinical pathology consultation; limited, without review of patient's history and medical records	0.60	35.70		XXX	0	30.22	32.73	22.63
80502		Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	1.92	114.24		XXX	0	16.39	102.34	14.10
81000		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	0.13	7.74	0.00	XXX	9		20.94	
81001		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	0.13	7.74	0.00	XXX	9		20.94	
81002		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	0.10	5.95	0.00	XXX	9		16.36	
81003		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy	0.09	5.36	0.00	XXX	9		17.31	
81005		Urinalysis; qualitative or semiquantitative, except immunoassays	0.09	5.36	0.00	XXX	9		16.36	
81007		Urinalysis; bacteriuria screen, except by culture or dipstick	0.10	5.95	0.00	XXX	9		20.05	
81015		Urinalysis; microscopic only	0.12	7.14	0.00	XXX	9		16.36	
81020		Urinalysis; 2 or 3 glass test	0.15	8.93	0.00	XXX	9		20.05	
81025		Urine pregnancy test, by visual color comparison methods	0.26	15.47	0.00	XXX	9		30.94	
81050		Volume measurement for timed collection, each	0.12	7.14	0.00	XXX	9		16.36	
81099		Unlisted urinalysis procedure	0.00	BR		XXX	9		BR	
81161		DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	0.00	BR		XXX	9		New	
81200		ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	0.00	BR		XXX	9		New	
81201		APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	0.00	BR		XXX	9		New	
81202		APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81203		APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81205		BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)	0.00	BR		XXX	9		New	
81206		BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	0.00	BR		XXX	9		New	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
81207		BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	0.00	BR		XXX	9		New	
81208		BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	0.00	BR		XXX	9		New	
81209		BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	0.00	BR		XXX	9		New	
81210		BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	0.00	BR		XXX	9		New	
81211		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon	0.00	BR		XXX	9		New	
81212		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	0.00	BR		XXX	9		New	
81213		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants	0.00	BR		XXX	9		New	
81214		BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	0.00	BR		XXX	9		New	
81215		BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	0.00	BR		XXX	9		New	
81216		BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81217		BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	0.00	BR		XXX	9		New	
81220		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	0.00	BR		XXX	9		New	
81221		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81222		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81223		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	0.00	BR		XXX	9		New	
81224		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	0.00	BR		XXX	9		New	
81225		CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	0.00	BR		XXX	9		New	
81226		CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	0.00	BR		XXX	9		New	
81227		CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	0.00	BR		XXX	9		New	
81228		Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	0.00	BR		XXX	9		New	
81229		Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities	0.00	BR		XXX	9		New	
81235		EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	0.00	BR		XXX	9		New	
81240		F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	0.00	BR		XXX	9		New	

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81241		F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden varian	0.00	BR		XXX	9		New	
81242		FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	0.00	BR		XXX	9		New	
81243		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	0.00	BR		XXX	9		New	
81244		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	0.00	BR		XXX	9		New	
81245		FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	0.00	BR		XXX	9		New	
81250		G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)	0.00	BR		XXX	9		New	
81251		GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	0.00	BR		XXX	9		New	
81252		GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	0.00	BR		XXX	9		New	
81253		GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81254		GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	0.00	BR		XXX	9		New	
81255		HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)	0.00	BR		XXX	9		New	
81256		HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	0.00	BR		XXX	9		New	
81257		HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Co	0.00	BR		XXX	9		New	
81260		IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	0.00	BR		XXX	9		New	
81261		IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	0.00	BR		XXX	9		New	
81262		IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	0.00	BR		XXX	9		New	
81263		IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	0.00	BR		XXX	9		New	
81264		IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.00	BR		XXX	9		New	
81265		Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample]	0.00	BR		XXX	9		New	
81266		Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition t	0.00	BR		XXX	9		New	
81267		Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	0.00	BR		XXX	9		New	
81268		Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	0.00	BR		XXX	9		New	
81270		JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) varian	0.00	BR		XXX	9		New	

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81275		KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13	0.00	BR		XXX	9		New	
81280		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis	0.00	BR		XXX	9		New	
81281		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); known familial sequence variant	0.00	BR		XXX	9		New	
81282		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); duplication/deletion variants	0.00	BR		XXX	9		New	
81290		MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	0.00	BR		XXX	9		New	
81291		MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	0.00	BR		XXX	9		New	
81292		MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81293		MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81294		MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81295		MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81296		MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81297		MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81298		MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81299		MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81300		MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81301		Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	0.00	BR		XXX	9		New	
81302		MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysi	0.00	BR		XXX	9		New	
81303		MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial varian	0.00	BR		XXX	9		New	
81304		MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	
81310		NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variant	0.00	BR		XXX	9		New	
81315		PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	0.00	BR		XXX	9		New	
81316		PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	0.00	BR		XXX	9		New	
81317		PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81318		PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	0.00	BR		XXX	9		New	
81319		PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	0.00	BR		XXX	9		New	

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81321		PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81322		PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	0.00	BR		XXX	9		New	
81323		PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	0.00	BR		XXX	9		New	
81324		PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	0.00	BR		XXX	9		New	
81325		PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	0.00	BR		XXX	9		New	
81326		PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	0.00	BR		XXX	9		New	
81330		SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	0.00	BR		XXX	9		New	
81331		SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	0.00	BR		XXX	9		New	
81332		SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	0.00	BR		XXX	9		New	
81340		TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	0.00	BR		XXX	9		New	
81341		TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	0.00	BR		XXX	9		New	
81342		TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	0.00	BR		XXX	9		New	
81350		UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	0.00	BR		XXX	9		New	
81355		VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	0.00	BR		XXX	9		New	
81370		HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	0.00	BR		XXX	9		New	
81371		HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	0.00	BR		XXX	9		New	
81372		HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C	0.00	BR		XXX	9		New	
81373		HLA Class I typing, low resolution (eg, antigen equivalents); 1 locus (eg, HLA-A, -B, or -C), eacl	0.00	BR		XXX	9		New	
81374		HLA Class I typing, low resolution (eg, antigen equivalents); 1 antigen equivalent (eg, B*27), eacl	0.00	BR		XXX	9		New	
81375		HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	0.00	BR		XXX	9		New	
81376		HLA Class II typing, low resolution (eg, antigen equivalents); 1 locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.00	BR		XXX	9		New	
81377		HLA Class II typing, low resolution (eg, antigen equivalents); 1 antigen equivalent, eacl	0.00	BR		XXX	9		New	
81378		HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	0.00	BR		XXX	9		New	
81379		HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C	0.00	BR		XXX	9		New	
81380		HLA Class I typing, high resolution (ie, alleles or allele groups); 1 locus (eg, HLA-A, -B, or -C), eacl	0.00	BR		XXX	9		New	
81381		HLA Class I typing, high resolution (ie, alleles or allele groups); 1 allele or allele group (eg, B*57:01P), each	0.00	BR		XXX	9		New	
81382		HLA Class II typing, high resolution (ie, alleles or allele groups); 1 locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each	0.00	BR		XXX	9		New	
81383		HLA Class II typing, high resolution (ie, alleles or allele groups); 1 allele or allele group (eg, HLA-DQB1*06:02P), each	0.00	BR		XXX	9		New	

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81400		Molecular pathology procedure, Level 1(eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	0.00	BR		XXX	9		New	
81401		Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	0.00	BR		XXX	9		New	
81402		Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 e	0.00	BR		XXX	9		New	
81403		Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	0.00	BR		XXX	9		New	
81404		Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	0.00	BR		XXX	9		New	
81405		Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)	0.00	BR		XXX	9		New	
81406		Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	0.00	BR		XXX	9		New	
81407		Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	0.00	BR		XXX	9		New	
81408		Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	0.00	BR		XXX	9		New	
81479		Unlisted molecular pathology procedure	0.00	BR		XXX	9		New	
81500		Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81503		Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin and pre-albumin), utilizing serum, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81506		Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score	0.00	BR		XXX	9		New	
81508		Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81509		Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal serum, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81510		Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81511		Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)	0.00	BR		XXX	9		New	
81512		Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score	0.00	BR		XXX	9		New	
81599		Unlisted multianalyte assay with algorithmic analysis	0.00	BR		XXX	9		New	
82000		Acetaldehyde, blood	0.50	29.75	0.00	XXX	9		83.78	
82003		Acetaminophen	0.82	48.79	0.00	XXX	9		74.67	
82009		Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate); qualitativ	0.18	10.71	0.00	XXX	9		27.31	
82010		Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate); quantitativ	0.33	19.64	0.00	XXX	9		43.67	
82013		Acetylcholinesterase	0.45	26.78	0.00	XXX	9		69.20	
82016		Acylcarnitines; qualitative, each specimen	0.56	33.32	0.00	XXX	9		89.19	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
82017		Acylcarnitines; quantitative, each specimen	0.68	40.46	0.00	XXX	9		89.19	
82024		Adrenocorticotropic hormone (ACTH)	1.56	92.82	0.00	XXX	9		16.36	
82030		Adenosine, 5-monophosphate, cyclic (cyclic AMP)	1.04	61.88	0.00	XXX	9		127.45	
82040		Albumin; serum, plasma or whole blood	0.20	11.90	0.00	XXX	9		20.05	
82042		Albumin; urine or other source, quantitative, each specimen	0.21	12.50	0.00	XXX	9		29.16	
82043		Albumin; urine, microalbumin, quantitative	0.23	13.69	0.00	XXX	9		63.72	
82044		Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)	0.18	10.71	0.00	XXX	9		30.94	
82045		Albumin; ischemia modified	1.37	81.52	0.00	XXX	9		0.00	
82055		Alcohol (ethanol); any specimen except breath	0.44	26.18	0.00	XXX	9		54.62	
82075		Alcohol (ethanol); breath	0.49	29.16	0.00	XXX	9		30.94	
82085		Aldolase	0.39	23.21	0.00	XXX	9		50.99	
82088		Aldosterone	1.65	98.18	0.00	XXX	9		145.66	
82101		Alkaloids, urine, quantitative	1.21	72.00	0.00	XXX	9		91.04	
82103		Alpha-1-antitrypsin; total	0.54	32.13	0.00	XXX	9		72.83	
82104		Alpha-1-antitrypsin; phenotype	0.58	34.51	0.00	XXX	9		103.77	
82105		Alpha-fetoprotein (AFP); serum	0.68	40.46	0.00	XXX	9		85.56	
82106		Alpha-fetoprotein (AFP); amniotic fluid	0.68	40.46	0.00	XXX	9		85.56	
82107		Alpha-fetoprotein (AFP); AFP-L3 fraction isoform and total AFP (including ratio)	2.60	154.70	0.00	XXX	9		100.14	
82108		Aluminum	1.03	61.29	0.00	XXX	9		105.61	
82120		Amines, vaginal fluid, qualitative	0.15	8.93	0.00	XXX	9		0.00	
82127		Amino acids; single, qualitative, each specimen	0.56	33.32	0.00	XXX	9		43.67	
82128		Amino acids; multiple, qualitative, each specimen	0.56	33.32	0.00	XXX	9		45.52	
82131		Amino acids; single, quantitative, each specimen	0.68	40.46	0.00	XXX	9		233.06	
82135		Aminolevulinic acid, delta (ALA)	0.66	39.27	0.00	XXX	9		78.30	
82136		Amino acids, 2 to 5 amino acids, quantitative, each specimen	0.68	40.46	0.00	XXX	9		233.06	
82139		Amino acids, 6 or more amino acids, quantitative, each specimen	0.68	40.46	0.00	XXX	9		233.06	
82140		Ammonia	0.59	35.11	0.00	XXX	9		45.52	
82143		Amniotic fluid scan (spectrophotometric)	0.28	16.66	0.00	XXX	9		69.20	
82145		Amphetamine or methamphetamine	0.63	37.49	0.00	XXX	9		91.04	
82150		Amylase	0.26	15.47	0.00	XXX	9		30.94	
82154		Androstanediol glucuronide	1.16	69.02	0.00	XXX	9		121.98	
82157		Androstenedione	1.18	70.21	0.00	XXX	9		112.87	
82160		Androsterone	1.01	60.10	0.00	XXX	9		109.24	
82163		Angiotensin II	0.83	49.39	0.00	XXX	9		109.24	
82164		Angiotensin I - converting enzyme (ACE)	0.59	35.11	0.00	XXX	9		91.04	
82172		Apolipoprotein, each	0.63	37.49	0.00	XXX	9		60.10	
82175		Arsenic	0.77	45.82	0.00	XXX	9		91.04	
82180		Ascorbic acid (Vitamin C), blood	0.40	23.80	0.00	XXX	9		58.25	
82190		Atomic absorption spectroscopy, each analyte	0.60	35.70	0.00	XXX	9		109.24	
82205		Barbiturates, not elsewhere specified	0.46	27.37	0.00	XXX	9		72.83	
82232		Beta-2 microglobulin	0.65	38.68	0.00	XXX	9		100.14	
82239		Bile acids; total	0.69	41.06	0.00	XXX	9		61.88	
82240		Bile acids; cholylglycine	1.07	63.67	0.00	XXX	9		123.82	
82247		Bilirubin; total	0.20	11.90	0.00	XXX	9		20.05	
82248		Bilirubin; direct	0.20	11.90	0.00	XXX	9		20.05	
82252		Bilirubin; feces, qualitative	0.18	10.71	0.00	XXX	9		20.05	
82261		Biotinidase, each specimen	0.68	40.46	0.00	XXX	9		20.05	
82270		Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	0.13	7.74	0.00	XXX	9		18.21	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
82271		Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources	0.13	7.74	0.00	XXX	9		18.21	
82272		Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	0.13	7.74	0.00	XXX	9		16.36	
82274		Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	0.64	38.08	0.00	XXX	9		63.72	
82286		Bradykinin	0.28	16.66	0.00	XXX	9		145.66	
82300		Cadmium	0.93	55.34	0.00	XXX	9		91.04	
82306		Vitamin D; 25 hydroxy, includes fraction(s), if performed	1.20	71.40	0.00	XXX	9		136.55	
82308		Calcitonin	1.08	64.26	0.00	XXX	9		136.55	
82310		Calcium; total	0.21	12.50	0.00	XXX	9		21.84	
82330		Calcium; ionized	0.55	32.73	0.00	XXX	9		63.72	
82331		Calcium; after calcium infusion test	0.21	12.50	0.00	XXX	9		29.16	
82340		Calcium; urine quantitative, timed specimen	0.24	14.28	0.00	XXX	9		29.16	
82355		Calculus; qualitative analysis	0.47	27.97	0.00	XXX	9		63.72	
82360		Calculus; quantitative analysis, chemical	0.52	30.94	0.00	XXX	9		69.20	
82365		Calculus; infrared spectroscopy	0.52	30.94	0.00	XXX	9		65.57	
82370		Calculus; X-ray diffraction	0.51	30.35	0.00	XXX	9		67.35	
82373		Carbohydrate deficient transferrin	0.73	43.44	0.00	XXX	9		91.04	
82374		Carbon dioxide (bicarbonate)	0.20	11.90	0.00	XXX	9		20.05	
82375		Carboxyhemoglobin; quantitative	0.50	29.75	0.00	XXX	9		56.47	
82376		Carboxyhemoglobin; qualitative	0.24	14.28	0.00	XXX	9		23.68	
82378		Carcinoembryonic antigen (CEA)	0.77	45.82	0.00	XXX	9		94.66	
82379		Carnitine (total and free), quantitative, each specimen	0.68	40.46	0.00	XXX	9		94.66	
82380		Carotene	0.37	22.02	0.00	XXX	9		50.99	
82382		Catecholamines; total urine	0.69	41.06	0.00	XXX	9		87.41	
82383		Catecholamines; blood	1.01	60.10	0.00	XXX	9		109.24	
82384		Catecholamines; fractionated	1.02	60.69	0.00	XXX	9		132.92	
82387		Cathepsin-D	0.84	49.98	0.00	XXX	9		127.45	
82390		Ceruloplasmin	0.43	25.59	0.00	XXX	9		58.25	
82397		Chemiluminescent assay	0.57	33.92	0.00	XXX	9		56.47	
82415		Chloramphenicol	0.51	30.35	0.00	XXX	9		63.72	
82435		Chloride; blood	0.19	11.31	0.00	XXX	9		20.05	
82436		Chloride; urine	0.20	11.90	0.00	XXX	9		23.68	
82438		Chloride; other source	0.20	11.90	0.00	XXX	9		29.16	
82441		Chlorinated hydrocarbons, screen	0.24	14.28	0.00	XXX	9		54.62	
82465		Cholesterol, serum or whole blood, total	0.18	10.71	0.00	XXX	9		21.84	
82480		Cholinesterase; serum	0.32	19.04	0.00	XXX	9		43.67	
82482		Cholinesterase; RBC	0.31	18.45	0.00	XXX	9		61.88	
82485		Chondroitin B sulfate, quantitative	0.83	49.39	0.00	XXX	9		91.04	
82486		Chromatography, qualitative; column (eg, gas liquid or HPLC), analyte not elsewhere specified	0.73	43.44	0.00	XXX	9		91.04	
82487		Chromatography, qualitative; paper, 1-dimensional, analyte not elsewhere specified	0.65	38.68	0.00	XXX	9		80.09	
82488		Chromatography, qualitative; paper, 2-dimensional, analyte not elsewhere specified	0.86	51.17	0.00	XXX	9		107.40	
82489		Chromatography, qualitative; thin layer, analyte not elsewhere specified	0.75	44.63	0.00	XXX	9		80.09	
82491		Chromatography, quantitative, column (eg, gas liquid or HPLC); single analyte not elsewhere specified, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		76.46	
82492		Chromatography, quantitative, column (eg, gas liquid or HPLC); multiple analytes, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		87.41	
82495		Chromium	0.82	48.79	0.00	XXX	9		91.04	
82507		Citrate	1.12	66.64	0.00	XXX	9		132.92	
82520		Cocaine or metabolite	0.61	36.30	0.00	XXX	9		87.41	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
82523		Collagen cross links, any method	0.76	45.22	0.00	XXX	9		0.00	
82525		Copper	0.50	29.75	0.00	XXX	9		63.72	
82528		Corticosterone	0.91	54.15	0.00	XXX	9		103.77	
82530		Cortisol; free	0.68	40.46	0.00	XXX	9		96.51	
82533		Cortisol; total	0.66	39.27	0.00	XXX	9		85.56	
82540		Creatine	0.19	11.31	0.00	XXX	9		28.20	
82541		Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; qualitative, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		63.72	
82542		Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		72.83	
82543		Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, single analyte, quantitative, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		72.83	
82544		Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, multiple analytes, quantitative, single stationary and mobile phase	0.73	43.44	0.00	XXX	9		91.04	
82550		Creatine kinase (CK), (CPK); total	0.26	15.47	0.00	XXX	9		23.68	
82552		Creatine kinase (CK), (CPK); isoenzymes	0.54	32.13	0.00	XXX	9		69.20	
82553		Creatine kinase (CK), (CPK); MB fraction only	0.47	27.97	0.00	XXX	9		36.41	
82554		Creatine kinase (CK), (CPK); isoforms	0.48	28.56	0.00	XXX	9		61.88	
82565		Creatinine; blood	0.21	12.50	0.00	XXX	9		20.05	
82570		Creatinine; other source	0.21	12.50	0.00	XXX	9		29.16	
82575		Creatinine; clearance	0.38	22.61	0.00	XXX	9		52.78	
82585		Cryofibrinogen	0.35	20.83	0.00	XXX	9		41.89	
82595		Cryoglobulin, qualitative or semi-quantitative (eg, cryocrit)	0.26	15.47	0.00	XXX	9		38.26	
82600		Cyanide	0.78	46.41	0.00	XXX	9		80.09	
82607		Cyanocobalamin (Vitamin B-12);	0.61	36.30	0.00	XXX	9		72.83	
82608		Cyanocobalamin (Vitamin B-12); unsaturated binding capacity	0.58	34.51	0.00	XXX	9		76.46	
82610		Cystatin C	0.55	32.73	0.00	XXX	9		30.00	
82615		Cystine and homocystine, urine, qualitative	0.33	19.64	0.00	XXX	9		54.62	
82626		Dehydroepiandrosterone (DHEA)	1.02	60.69	0.00	XXX	9		123.82	
82627		Dehydroepiandrosterone-sulfate (DHEA-S)	0.90	53.55	0.00	XXX	9		109.24	
82633		Desoxycorticosterone, 11-	1.25	74.38	0.00	XXX	9		118.35	
82634		Deoxycortisol, 11-	1.18	70.21	0.00	XXX	9		118.35	
82638		Dibucaine number	0.49	29.16	0.00	XXX	9		50.99	
82646		Dihydrocodeinone	0.83	49.39	0.00	XXX	9		98.29	
82649		Dihydromorphinone	1.04	61.88	0.00	XXX	9		91.04	
82651		Dihydrotestosterone (DHT)	1.04	61.88	0.00	XXX	9		109.24	
82652		Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	1.56	92.82	0.00	XXX	9		145.66	
82654		Dimethadione	0.56	33.32	0.00	XXX	9		98.29	
82656		Elastase, pancreatic (EL-1), fecal, qualitative or semi-quantitative	0.47	27.97	0.00	XXX	9		0.00	
82657		Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; nonradioactive substrate, each specimen	0.73	43.44	0.00	XXX	9		0.00	
82658		Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; radioactive substrate, each specimen	0.73	43.44	0.00	XXX	9		109.24	
82664		Electrophoretic technique, not elsewhere specified	1.39	82.71	0.00	XXX	9		83.78	
82666		Epiandrosterone	0.87	51.77	0.00	XXX	9		94.66	
82668		Erythropoietin	0.76	45.22	0.00	XXX	9		118.35	
82670		Estradiol	1.13	67.24	0.00	XXX	9		85.56	
82671		Estrogens; fractionated	1.30	77.35	0.00	XXX	9		160.23	
82672		Estrogens; total	0.88	52.36	0.00	XXX	9		109.24	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
82677		Estriol	0.98	58.31	0.00	XXX	9		78.30	
82679		Estrone	1.01	60.10	0.00	XXX	9		109.24	
82690		Ethchlorvynol	0.70	41.65	0.00	XXX	9		63.72	
82693		Ethylene glycol	0.60	35.70	0.00	XXX	9		85.56	
82696		Etiocholanolone	0.95	56.53	0.00	XXX	9		109.24	
82705		Fat or lipids, feces; qualitative	0.21	12.50	0.00	XXX	9		40.04	
82710		Fat or lipids, feces; quantitative	0.68	40.46	0.00	XXX	9		89.19	
82715		Fat differential, feces, quantitative	0.70	41.65	0.00	XXX	9		43.67	
82725		Fatty acids, nonesterified	0.54	32.13	0.00	XXX	9		36.41	
82726		Very long chain fatty acids	0.73	43.44	0.00	XXX	9		0.00	
82728		Ferritin	0.55	32.73	0.00	XXX	9		67.35	
82731		Fetal fibronectin, cervicovaginal secretions, semi-quantitative	2.60	154.70	0.00	XXX	9		109.24	
82735		Fluoride	0.75	44.63	0.00	XXX	9		74.67	
82742		Flurazepam	0.80	47.60	0.00	XXX	9		89.19	
82746		Folic acid; serum	0.59	35.11	0.00	XXX	9		74.67	
82747		Folic acid; RBC	0.70	41.65	0.00	XXX	9		89.19	
82757		Fructose, semen	0.70	41.65	0.00	XXX	9		54.62	
82759		Galactokinase, RBC	0.87	51.77	0.00	XXX	9		69.20	
82760		Galactose	0.45	26.78	0.00	XXX	9		43.67	
82775		Galactose-1-phosphate uridyl transferase; quantitative	0.85	50.58	0.00	XXX	9		54.62	
82776		Galactose-1-phosphate uridyl transferase; screen	0.34	20.23	0.00	XXX	9		23.68	
82777		Galectin-3	0.52	30.94	0.00	XXX	9		New	
82784		Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each	0.38	22.61	0.00	XXX	9		58.25	
82785		Gammaglobulin (immunoglobulin); IgE	0.67	39.87	0.00	XXX	9		74.67	
82787		Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each	0.32	19.04	0.00	XXX	9		163.86	
82800		Gases, blood, pH only	0.34	20.23	0.00	XXX	9		41.89	
82803		Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)	0.78	46.41	0.00	XXX	9		83.78	
82805		Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry	1.15	68.43	0.00	XXX	9		85.56	
82810		Gases, blood, O2 saturation only, by direct measurement, except pulse oximetry	0.35	20.83	0.00	XXX	9		45.52	
82820		Hemoglobin-oxygen affinity (pO2 for 50% hemoglobin saturation with oxygen	0.40	23.80	0.00	XXX	9		61.88	
82930		Gastric acid analysis, includes pH if performed, each specimen	0.22	13.09	0.00	XXX	9		New	
82938		Gastrin after secretin stimulation	0.71	42.25	0.00	XXX	9		96.51	
82941		Gastrin	0.71	42.25	0.00	XXX	9		85.56	
82943		Glucagon	0.58	34.51	0.00	XXX	9		103.77	
82945		Glucose, body fluid, other than blood	0.16	9.52	0.00	XXX	9		69.20	
82946		Glucagon tolerance test	0.61	36.30	0.00	XXX	9		56.47	
82947		Glucose; quantitative, blood (except reagent strip)	0.16	9.52	0.00	XXX	9		23.68	
82948		Glucose; blood, reagent strip	0.13	7.74	0.00	XXX	9		18.21	
82950		Glucose; post glucose dose (includes glucose)	0.19	11.31	0.00	XXX	9		30.94	
82951		Glucose; tolerance test (GTT), 3 specimens (includes glucose)	0.52	30.94	0.00	XXX	9		65.57	
82952		Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	0.16	9.52	0.00	XXX	9		20.05	
82953		Glucose; tolbutamide tolerance test	0.61	36.30	0.00	XXX	9		81.93	
82955		Glucose-6-phosphate dehydrogenase (G6PD); quantitative	0.39	23.21	0.00	XXX	9		65.57	
82960		Glucose-6-phosphate dehydrogenase (G6PD); screen	0.24	14.28	0.00	XXX	9		34.57	
82962		Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	0.09	5.36	0.00	XXX	9		18.21	
82963		Glucosidase, beta	0.87	51.77	0.00	XXX	9		81.93	
82965		Glutamate dehydrogenase	0.31	18.45	0.00	XXX	9		25.47	
82975		Glutamine (glutamic acid amide)	0.64	38.08	0.00	XXX	9		61.88	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
82977		Glutamyltransferase, gamma (GGT)	0.29	17.26	0.00	XXX	9		20.05	
82978		Glutathione	0.58	34.51	0.00	XXX	9		60.10	
82979		Glutathione reductase, RBC	0.28	16.66	0.00	XXX	9		52.78	
82980		Glutethimide	0.74	44.03	0.00	XXX	9		87.41	
82985		Glycated protein	0.61	36.30	0.00	XXX	9		36.41	
83001		Gonadotropin; follicle stimulating hormone (FSH)	0.75	44.63	0.00	XXX	9		91.04	
83002		Gonadotropin; luteinizing hormone (LH)	0.75	44.63	0.00	XXX	9		91.04	
83003		Growth hormone, human (HGH) (somatotropin)	0.67	39.87	0.00	XXX	9		87.41	
83008		Guanosine monophosphate (GMP), cyclic	0.68	40.46	0.00	XXX	9		91.04	
83009		Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (eg, C-13	2.72	161.84	0.00	XXX	9		0.00	
83010		Haptoglobin; quantitative	0.51	30.35	0.00	XXX	9		67.35	
83012		Haptoglobin; phenotypes	0.69	41.06	0.00	XXX	9		81.93	
83013		Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (eg, C-13	2.72	161.84	0.00	XXX	9		0.00	
83014		Helicobacter pylori; drug administration	0.32	19.04	0.00	XXX	9		0.00	
83015		Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); screer	0.76	45.22	0.00	XXX	9		105.61	
83018		Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, eacl	0.89	52.96	0.00	XXX	9		105.61	
83020		Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F	1.11	66.05	35.11	XXX	9		63.72	
83021		Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F	0.73	43.44	0.00	XXX	9		81.93	
83026		Hemoglobin; by copper sulfate method, non-automatec	0.10	5.95	0.00	XXX	9		12.73	
83030		Hemoglobin; F (fetal), chemical	0.33	19.64	0.00	XXX	9		40.04	
83033		Hemoglobin; F (fetal), qualitative	0.24	14.28	0.00	XXX	9		29.16	
83036		Hemoglobin; glycosylated (A1C)	0.39	23.21	0.00	XXX	9		49.15	
83037		Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use	0.39	23.21	0.00	XXX	9		43.67	
83045		Hemoglobin; methemoglobin, qualitative	0.20	11.90	0.00	XXX	9		23.68	
83050		Hemoglobin; methemoglobin, quantitative	0.30	17.85	0.00	XXX	9		30.94	
83051		Hemoglobin; plasma	0.30	17.85	0.00	XXX	9		30.94	
83055		Hemoglobin; sulfhemoglobin, qualitative	0.20	11.90	0.00	XXX	9		30.94	
83060		Hemoglobin; sulfhemoglobin, quantitative	0.33	19.64	0.00	XXX	9		45.52	
83065		Hemoglobin; thermolabile	0.28	16.66	0.00	XXX	9		36.41	
83068		Hemoglobin; unstable, screen	0.34	20.23	0.00	XXX	9		30.94	
83069		Hemoglobin; urine	0.16	9.52	0.00	XXX	9		21.84	
83070		Hemosiderin; qualitative	0.19	11.31	0.00	XXX	9		25.47	
83071		Hemosiderin; quantitative	0.28	16.66	0.00	XXX	9		25.47	
83080		b-Hexosaminidase, each assay	0.68	40.46	0.00	XXX	9		61.88	
83088		Histamine	1.19	70.81	0.00	XXX	9		123.82	
83090		Homocysteine	0.68	40.46	0.00	XXX	9		69.20	
83150		Homovanillic acid (HVA)	0.78	46.41	0.00	XXX	9		72.83	
83491		Hydroxycorticosteroids, 17- (17-OHCS)	0.71	42.25	0.00	XXX	9		100.14	
83497		Hydroxyindolacetic acid, 5-(HIAA)	0.52	30.94	0.00	XXX	9		80.09	
83498		Hydroxyprogesterone, 17-d	1.10	65.45	0.00	XXX	9		116.50	
83499		Hydroxyprogesterone, 20-	1.02	60.69	0.00	XXX	9		97.40	
83500		Hydroxyproline; free	0.91	54.15	0.00	XXX	9		89.19	
83505		Hydroxyproline; total	0.98	58.31	0.00	XXX	9		118.35	
83516		Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method	0.47	27.97	0.00	XXX	9		54.62	
83518		Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)	0.34	20.23	0.00	XXX	9		36.41	
83519		Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (eg, RIA)	0.55	32.73	0.00	XXX	9		81.93	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
83520		Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	0.52	30.94	0.00	XXX	9		61.88	
83525		Insulin; total	0.46	27.37	0.00	XXX	9		69.20	
83527		Insulin; free	0.52	30.94	0.00	XXX	9		78.30	
83528		Intrinsic factor	0.64	38.08	0.00	XXX	9		91.04	
83540		Iron	0.26	15.47	0.00	XXX	9		20.05	
83550		Iron binding capacity	0.35	20.83	0.00	XXX	9		30.94	
83570		Isocitric dehydrogenase (IDH)	0.36	21.42	0.00	XXX	9		47.36	
83582		Ketogenic steroids, fractionation	0.57	33.92	0.00	XXX	9		72.83	
83586		Ketosteroids, 17- (17-KS); total	0.52	30.94	0.00	XXX	9		72.83	
83593		Ketosteroids, 17- (17-KS); fractionation	1.06	63.07	0.00	XXX	9		142.03	
83605		Lactate (lactic acid)	0.43	25.59	0.00	XXX	9		54.62	
83615		Lactate dehydrogenase (LD), (LDH);	0.24	14.28	0.00	XXX	9		20.05	
83625		Lactate dehydrogenase (LD), (LDH); isoenzymes, separation and quantitation	0.52	30.94	0.00	XXX	9		67.35	
83630		Lactoferrin, fecal; qualitative	0.79	47.01	0.00	XXX	9		54.62	
83631		Lactoferrin, fecal; quantitative	0.79	47.01	0.00	XXX	9		54.62	
83632		Lactogen, human placental (HPL) human chorionic somatomammotropin	0.82	48.79	0.00	XXX	9		116.50	
83633		Lactose, urine; qualitative	0.22	13.09	0.00	XXX	9		27.31	
83634		Lactose, urine; quantitative	0.47	27.97	0.00	XXX	9		43.67	
83655		Lead	0.49	29.16	0.00	XXX	9		45.52	
83661		Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio	0.89	52.96	0.00	XXX	9		156.60	
83662		Fetal lung maturity assessment; foam stability test	0.76	45.22	0.00	XXX	9		50.99	
83663		Fetal lung maturity assessment; fluorescence polarization	0.76	45.22	0.00	XXX	9		54.62	
83664		Fetal lung maturity assessment; lamellar body density	0.76	45.22	0.00	XXX	9		47.36	
83670		Leucine aminopeptidase (LAP)	0.37	22.02	0.00	XXX	9		70.98	
83690		Lipase	0.28	16.66	0.00	XXX	9		40.04	
83695		Lipoprotein (a)	0.52	30.94	0.00	XXX	9		41.89	
83698		Lipoprotein-associated phospholipase A2 (Lp-PLA2)	1.37	81.52	0.00	XXX	9		63.72	
83700		Lipoprotein, blood; electrophoretic separation and quantitation	0.45	26.78	0.00	XXX	9		56.47	
83701		Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	1.00	59.50	0.00	XXX	9		76.46	
83704		Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy)	1.27	75.57	0.00	XXX	9		85.56	
83718		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	0.33	19.64	0.00	XXX	9		34.57	
83719		Lipoprotein, direct measurement; VLDL cholesterol	0.47	27.97	0.00	XXX	9		41.89	
83721		Lipoprotein, direct measurement; LDL cholesterol	0.39	23.21	0.00	XXX	9		36.41	
83727		Luteinizing releasing factor (LRH)	0.69	41.06	0.00	XXX	9		100.14	
83735		Magnesium	0.27	16.07	0.00	XXX	9		27.31	
83775		Malate dehydrogenase	0.30	17.85	0.00	XXX	9		41.89	
83785		Manganese	0.99	58.91	0.00	XXX	9		91.04	
83788		Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; qualitative, each specimen	0.73	43.44	0.00	XXX	9		0.00	
83789		Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative each specimen	0.73	43.44	0.00	XXX	9		0.00	
83805		Meprobamate	0.71	42.25	0.00	XXX	9		91.04	
83825		Mercury, quantitative	0.66	39.27	0.00	XXX	9		81.93	
83835		Metanephrines	0.68	40.46	0.00	XXX	9		105.61	
83840		Methadone	0.66	39.27	0.00	XXX	9		85.56	
83857		Methemalbumin	0.43	25.59	0.00	XXX	9		43.67	
83858		Methsuximide	0.60	35.70	0.00	XXX	9		98.29	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
83861		Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	0.67	39.87	0.00	XXX	9		New	
83864		Mucopolysaccharides, acid; quantitative	0.80	47.60	0.00	XXX	9		69.20	
83866		Mucopolysaccharides, acid; screen	0.40	23.80	0.00	XXX	9		45.52	
83872		Mucin, synovial fluid (Ropes test)	0.24	14.28	0.00	XXX	9		29.16	
83873		Myelin basic protein, cerebrospinal fluid	0.70	41.65	0.00	XXX	9		100.14	
83874		Myoglobin	0.52	30.94	0.00	XXX	9		76.46	
83876		Myeloperoxidase (MPO)	1.37	81.52	0.00	XXX	9		91.04	
83880		Natriuretic peptide	1.37	81.52	0.00	XXX	9		109.24	
83883		Nephelometry, each analyte not elsewhere specified	0.55	32.73	0.00	XXX	9		70.98	
83885		Nickel	0.99	58.91	0.00	XXX	9		76.46	
83887		Nicotine	0.96	57.12	0.00	XXX	9		87.41	
83915		Nucleotidase 5'-	0.45	26.78	0.00	XXX	9		58.25	
83916		Oligoclonal immune (oligoclonal bands)	0.81	48.20	0.00	XXX	9		94.66	
83918		Organic acids; total, quantitative, each specimen	0.66	39.27	0.00	XXX	9		123.82	
83919		Organic acids; qualitative, each specimen	0.66	39.27	0.00	XXX	9		91.04	
83921		Organic acid, single, quantitative	0.66	39.27	0.00	XXX	9		78.30	
83925		Opiate(s), drug and metabolites, each procedure	0.79	47.01	0.00	XXX	9		91.04	
83930		Osmolality; blood	0.27	16.07	0.00	XXX	9		34.57	
83935		Osmolality; urine	0.28	16.66	0.00	XXX	9		45.52	
83937		Osteocalcin (bone g1a protein)	1.21	72.00	0.00	XXX	9		136.55	
83945		Oxalate	0.52	30.94	0.00	XXX	9		65.57	
83950		Oncoprotein; HER-2/neu	2.60	154.70	0.00	XXX	9		105.61	
83951		Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	2.60	154.70	0.00	XXX	9		363.55	
83970		Parathormone (parathyroid hormone)	1.67	99.37	0.00	XXX	9		154.76	
83986		pH; body fluid, not otherwise specified	0.14	8.33	0.00	XXX	9		20.05	
83987		pH; exhaled breath condensate	0.64	38.08	0.00	XXX	9		22.61	
83992		Phencyclidine (PCP)	0.59	35.11	0.00	XXX	9		91.04	
83993		Calprotectin, fecal	0.79	47.01	0.00	XXX	9		43.20	
84022		Phenothiazine	0.63	37.49	0.00	XXX	9		74.67	
84030		Phenylalanine (PKU), blood	0.22	13.09	0.00	XXX	9		25.47	
84035		Phenylketones, qualitative	0.15	8.93	0.00	XXX	9		20.05	
84060		Phosphatase, acid; total	0.30	17.85	0.00	XXX	9		50.99	
84061		Phosphatase, acid; forensic examination	0.32	19.04	0.00	XXX	9		54.62	
84066		Phosphatase, acid; prostatic	0.39	23.21	0.00	XXX	9		60.10	
84075		Phosphatase, alkaline;	0.21	12.50	0.00	XXX	9		20.05	
84078		Phosphatase, alkaline; heat stable (total not included)	0.29	17.26	0.00	XXX	9		47.36	
84080		Phosphatase, alkaline; isoenzymes	0.60	35.70	0.00	XXX	9		78.30	
84081		Phosphatidylglycerol	0.67	39.87	0.00	XXX	9		112.87	
84085		Phosphogluconate, 6-, dehydrogenase, RBC	0.27	16.07	0.00	XXX	9		45.52	
84087		Phosphohexose isomerase	0.42	24.99	0.00	XXX	9		72.83	
84100		Phosphorus inorganic (phosphate);	0.19	11.31	0.00	XXX	9		18.21	
84105		Phosphorus inorganic (phosphate); urine	0.21	12.50	0.00	XXX	9		29.16	
84106		Porphobilinogen, urine; qualitative	0.17	10.12	0.00	XXX	9		40.04	
84110		Porphobilinogen, urine; quantitative	0.34	20.23	0.00	XXX	9		49.15	
84112		Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	2.60	154.70	0.00	XXX	9		New	
84119		Porphyrins, urine; qualitative	0.35	20.83	0.00	XXX	9		47.36	
84120		Porphyrins, urine; quantitation and fractionation	0.59	35.11	0.00	XXX	9		92.88	
84126		Porphyrins, feces; quantitative	1.03	61.29	0.00	XXX	9		92.88	
84127		Porphyrins, feces; qualitative	0.47	27.97	0.00	XXX	9		23.68	
84132		Potassium; serum, plasma or whole blood	0.19	11.31	0.00	XXX	9		21.84	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
84133		Potassium; urine	0.17	10.12	0.00	XXX	9		25.47	
84134		Prealbumin	0.59	35.11	0.00	XXX	9		61.88	
84135		Pregnanediol	0.77	45.82	0.00	XXX	9		76.46	
84138		Pregnanetriol	0.77	45.82	0.00	XXX	9		81.93	
84140		Pregnenolone	0.84	49.98	0.00	XXX	9		112.87	
84143		17-hydroxypregnenolone	0.92	54.74	0.00	XXX	9		112.87	
84144		Progesterone	0.84	49.98	0.00	XXX	9		94.66	
84145		Procalcitonin (PCT)	1.08	64.26	0.00	XXX	9		0.00	
84146		Prolactin	0.78	46.41	0.00	XXX	9		94.66	
84150		Prostaglandin, each	1.01	60.10	0.00	XXX	9		72.83	
84152		Prostate specific antigen (PSA); complexed (direct measurement)	0.74	44.03	0.00	XXX	9		72.83	
84153		Prostate specific antigen (PSA); total	0.74	44.03	0.00	XXX	9		94.66	
84154		Prostate specific antigen (PSA); free	0.74	44.03	0.00	XXX	9		87.41	
84155		Protein, total, except by refractometry; serum, plasma or whole blood	0.15	8.93	0.00	XXX	9		20.05	
84156		Protein, total, except by refractometry; urine	0.15	8.93	0.00	XXX	9		25.47	
84157		Protein, total, except by refractometry; other source (eg, synovial fluid, cerebrospinal fluid	0.15	8.93	0.00	XXX	9		23.68	
84160		Protein, total, by refractometry, any source	0.21	12.50	0.00	XXX	9		14.58	
84163		Pregnancy-associated plasma protein-A (PAPP-A)	0.61	36.30	0.00	XXX	9		0.00	
84165		Protein; electrophoretic fractionation and quantitation, serum	1.02	60.69	35.11	XXX	9		65.57	
84166		Protein; electrophoretic fractionation and quantitation, other fluids with concentration (eg, urine, CSF)	1.31	77.95	35.11	XXX	9		69.20	
84181		Protein; Western Blot, with interpretation and report, blood or other body fluid	1.28	76.16	35.11	XXX	9		94.66	
84182		Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each	1.27	75.57	32.13	XXX	9		152.92	
84202		Protoporphyrin, RBC; quantitative	0.58	34.51	0.00	XXX	9		63.72	
84203		Protoporphyrin, RBC; screen	0.35	20.83	0.00	XXX	9		34.57	
84206		Proinsulin	0.72	42.84	0.00	XXX	9		140.18	
84207		Pyridoxal phosphate (Vitamin B-6)	1.14	67.83	0.00	XXX	9		136.55	
84210		Pyruvate	0.44	26.18	0.00	XXX	9		60.10	
84220		Pyruvate kinase	0.38	22.61	0.00	XXX	9		47.36	
84228		Quinine	0.47	27.97	0.00	XXX	9		72.83	
84233		Receptor assay; estrogen	2.60	154.70	0.00	XXX	9		136.55	
84234		Receptor assay; progesterone	2.62	155.89	0.00	XXX	9		136.55	
84235		Receptor assay; endocrine, other than estrogen or progesterone (specify hormone	2.11	125.55	0.00	XXX	9		136.55	
84238		Receptor assay; non-endocrine (specify receptor)	1.48	88.06	0.00	XXX	9		200.28	
84244		Renin	0.89	52.96	0.00	XXX	9		125.60	
84252		Riboflavin (Vitamin B-2)	0.82	48.79	0.00	XXX	9		81.93	
84255		Selenium	1.03	61.29	0.00	XXX	9		81.93	
84260		Serotonin	1.25	74.38	0.00	XXX	9		154.76	
84270		Sex hormone binding globulin (SHBG)	0.88	52.36	0.00	XXX	9		105.61	
84275		Sialic acid	0.54	32.13	0.00	XXX	9		63.72	
84285		Silica	0.95	56.53	0.00	XXX	9		100.14	
84295		Sodium; serum, plasma or whole blood	0.19	11.31	0.00	XXX	9		18.21	
84300		Sodium; urine	0.20	11.90	0.00	XXX	9		25.47	
84302		Sodium; other source	0.20	11.90	0.00	XXX	9		25.47	
84305		Somatomedin	0.86	51.17	0.00	XXX	9		145.66	
84307		Somatostatin	0.74	44.03	0.00	XXX	9		112.87	
84311		Spectrophotometry, analyte not elsewhere specified	0.28	16.66	0.00	XXX	9		38.26	
84315		Specific gravity (except urine)	0.10	5.95	0.00	XXX	9		16.36	
84375		Sugars, chromatographic, TLC or paper chromatography	0.79	47.01	0.00	XXX	9		69.20	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
84376		Sugars (mono-, di-, and oligosaccharides); single qualitative, each specimer	0.22	13.09	0.00	XXX	9		0.00	
84377		Sugars (mono-, di-, and oligosaccharides); multiple qualitative, each specimer	0.22	13.09	0.00	XXX	9		0.00	
84378		Sugars (mono-, di-, and oligosaccharides); single quantitative, each specimer	0.47	27.97	0.00	XXX	9		0.00	
84379		Sugars (mono-, di-, and oligosaccharides); multiple quantitative, each specimer	0.47	27.97	0.00	XXX	9		0.00	
84392		Sulfate, urine	0.19	11.31	0.00	XXX	9		0.00	
84402		Testosterone; free	1.03	61.29	0.00	XXX	9		103.77	
84403		Testosterone; total	1.04	61.88	0.00	XXX	9		85.56	
84425		Thiamine (Vitamin B-1)	0.86	51.17	0.00	XXX	9		98.29	
84430		Thiocyanate	0.47	27.97	0.00	XXX	9		60.10	
84431		Thromboxane metabolite(s), including thromboxane if performed, urine	0.68	40.46	0.00	XXX	9		0.00	
84432		Thyroglobulin	0.65	38.68	0.00	XXX	9		87.41	
84436		Thyroxine; total	0.28	16.66	0.00	XXX	9		32.78	
84437		Thyroxine; requiring elution (eg, neonatal)	0.26	15.47	0.00	XXX	9		32.78	
84439		Thyroxine; free	0.36	21.42	0.00	XXX	9		54.62	
84442		Thyroxine binding globulin (TBG)	0.60	35.70	0.00	XXX	9		63.72	
84443		Thyroid stimulating hormone (TSH)	0.68	40.46	0.00	XXX	9		76.46	
84445		Thyroid stimulating immune globulins (TSI)	2.05	121.98	0.00	XXX	9		227.59	
84446		Tocopherol alpha (Vitamin E)	0.57	33.92	0.00	XXX	9		69.20	
84449		Transcortin (cortisol binding globulin)	0.73	43.44	0.00	XXX	9		91.04	
84450		Transferase; aspartate amino (AST) (SGOT)	0.21	12.50	0.00	XXX	9		20.05	
84460		Transferase; alanine amino (ALT) (SGPT)	0.21	12.50	0.00	XXX	9		20.05	
84466		Transferrin	0.52	30.94	0.00	XXX	9		69.20	
84478		Triglycerides	0.23	13.69	0.00	XXX	9		20.05	
84479		Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	0.26	15.47	0.00	XXX	9		32.78	
84480		Triiodothyronine T3; total (TT-3)	0.57	33.92	0.00	XXX	9		72.83	
84481		Triiodothyronine T3; free	0.68	40.46	0.00	XXX	9		96.51	
84482		Triiodothyronine T3; reverse	0.64	38.08	0.00	XXX	9		91.04	
84484		Troponin, quantitative	0.40	23.80	0.00	XXX	9		0.00	
84485		Trypsin; duodenal fluid	0.30	17.85	0.00	XXX	9		54.62	
84488		Trypsin; feces, qualitative	0.29	17.26	0.00	XXX	9		54.62	
84490		Trypsin; feces, quantitative, 24-hour collection	0.31	18.45	0.00	XXX	9		32.78	
84510		Tyrosine	0.42	24.99	0.00	XXX	9		36.41	
84512		Troponin, qualitative	0.31	18.45	0.00	XXX	9		0.00	
84520		Urea nitrogen; quantitative	0.16	9.52	0.00	XXX	9		20.05	
84525		Urea nitrogen; semiquantitative (eg, reagent strip test)	0.15	8.93	0.00	XXX	9		21.84	
84540		Urea nitrogen, urine	0.19	11.31	0.00	XXX	9		30.94	
84545		Urea nitrogen, clearance	0.27	16.07	0.00	XXX	9		38.26	
84550		Uric acid; blood	0.18	10.71	0.00	XXX	9		20.05	
84560		Uric acid; other source	0.19	11.31	0.00	XXX	9		29.16	
84577		Urobilinogen, feces, quantitative	0.50	29.75	0.00	XXX	9		32.78	
84578		Urobilinogen, urine; qualitative	0.13	7.74	0.00	XXX	9		21.84	
84580		Urobilinogen, urine; quantitative, timed specimen	0.29	17.26	0.00	XXX	9		32.78	
84583		Urobilinogen, urine; semiquantitative	0.20	11.90	0.00	XXX	9		21.84	
84585		Vanillylmandelic acid (VMA), urine	0.63	37.49	0.00	XXX	9		81.93	
84586		Vasoactive intestinal peptide (VIP)	1.43	85.09	0.00	XXX	9		140.18	
84588		Vasopressin (antidiuretic hormone, ADH)	1.37	81.52	0.00	XXX	9		145.66	
84590		Vitamin A	0.47	27.97	0.00	XXX	9		81.93	
84591		Vitamin, not otherwise specified	0.47	27.97	0.00	XXX	9		78.30	
84597		Vitamin K	0.55	32.73	0.00	XXX	9		105.61	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
84600		Volatiles (eg, acetic anhydride, carbon tetrachloride, dichloroethane, dichloromethane, diethylether, isopropyl alcohol, methanol)	0.65	38.68	0.00	XXX	9		56.47	
84620		Xylose absorption test, blood and/or urine	0.48	28.56	0.00	XXX	9		74.67	
84630		Zinc	0.46	27.37	0.00	XXX	9		69.20	
84681		C-peptide	0.84	49.98	0.00	XXX	9		103.77	
84702		Gonadotropin, chorionic (hCG); quantitative	0.61	36.30	0.00	XXX	9		69.20	
84703		Gonadotropin, chorionic (hCG); qualitative	0.30	17.85	0.00	XXX	9		41.89	
84704		Gonadotropin, chorionic (hCG); free beta chain	0.61	36.30	0.00	XXX	9		33.00	
84830		Ovulation tests, by visual color comparison methods for human luteinizing hormone	0.41	24.40	0.00	XXX	9		36.41	
84999		Unlisted chemistry procedure	0.00	BR	BR	XXX	9		BR	
85002		Bleeding time	0.18	10.71	0.00	XXX	9		36.41	
85004		Blood count; automated differential WBC count	0.26	15.47	0.00	XXX	9		23.68	
85007		Blood count; blood smear, microscopic examination with manual differential WBC count	0.14	8.33	0.00	XXX	9		21.84	
85008		Blood count; blood smear, microscopic examination without manual differential WBC count	0.14	8.33	0.00	XXX	9		18.21	
85009		Blood count; manual differential WBC count, buffy coat	0.15	8.93	0.00	XXX	9		21.84	
85013		Blood count; spun microhematocrit	0.10	5.95	0.00	XXX	9		16.36	
85014		Blood count; hematocrit (Hct)	0.10	5.95	0.00	XXX	9		16.36	
85018		Blood count; hemoglobin (Hgb)	0.10	5.95	0.00	XXX	9		16.36	
85025		Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	0.31	18.45	0.00	XXX	9		33.68	
85027		Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	0.26	15.47	0.00	XXX	9		31.89	
85032		Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each	0.17	10.12	0.00	XXX	9		25.47	
85041		Blood count; red blood cell (RBC), automated	0.12	7.14	0.00	XXX	9		21.84	
85044		Blood count; reticulocyte, manual	0.17	10.12	0.00	XXX	9		25.47	
85045		Blood count; reticulocyte, automated	0.16	9.52	0.00	XXX	9		27.31	
85046		Blood count; reticulocytes, automated, including 1 or more cellular parameters (eg, reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement	0.23	13.69	0.00	XXX	9		0.00	
85048		Blood count; leukocyte (WBC), automated	0.10	5.95	0.00	XXX	9		21.84	
85049		Blood count; platelet, automated	0.18	10.71	0.00	XXX	9		21.84	
85055		Reticulated platelet assay	1.08	64.26	0.00	XXX	9		0.00	
85060		Blood smear, peripheral, interpretation by physician with written report	0.71	42.25		XXX	0		35.11	
85097		Bone marrow, smear interpretation	2.53	150.54		XXX	0	49.15	157.68	48.34
85130		Chromogenic substrate assay	0.48	28.56	0.00	XXX	9		69.20	
85170		Clot retraction	0.15	8.93	0.00	XXX	9		21.84	
85175		Clot lysis time, whole blood dilution	0.18	10.71	0.00	XXX	9		40.04	
85210		Clotting; factor II, prothrombin, specific	0.52	30.94	0.00	XXX	9		50.99	
85220		Clotting; factor V (AcG or proaccelerin), labile factor	0.71	42.25	0.00	XXX	9		109.24	
85230		Clotting; factor VII (proconvertin, stable factor)	0.72	42.84	0.00	XXX	9		109.24	
85240		Clotting; factor VIII (AHG), 1-stage	0.72	42.84	0.00	XXX	9		118.35	
85244		Clotting; factor VIII related antigen	0.82	48.79	0.00	XXX	9		136.55	
85245		Clotting; factor VIII, VW factor, ristocetin cofactor	0.93	55.34	0.00	XXX	9		98.29	
85246		Clotting; factor VIII, VW factor antigen	0.93	55.34	0.00	XXX	9		145.66	
85247		Clotting; factor VIII, von Willebrand factor, multimetric analysis	0.93	55.34	0.00	XXX	9		149.29	
85250		Clotting; factor IX (PTC or Christmas)	0.77	45.82	0.00	XXX	9		118.35	
85260		Clotting; factor X (Stuart-Prower)	0.72	42.84	0.00	XXX	9		118.35	
85270		Clotting; factor XI (PTA)	0.72	42.84	0.00	XXX	9		116.50	
85280		Clotting; factor XII (Hageman)	0.78	46.41	0.00	XXX	9		118.35	
85290		Clotting; factor XIII (fibrin stabilizing)	0.66	39.27	0.00	XXX	9		109.24	
85291		Clotting; factor XIII (fibrin stabilizing), screen solubility	0.36	21.42	0.00	XXX	9		72.83	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
85292		Clotting; prekallikrein assay (Fletcher factor assay)	0.77	45.82	0.00	XXX	9		112.87	
85293		Clotting; high molecular weight kininogen assay (Fitzgerald factor assay	0.77	45.82	0.00	XXX	9		109.24	
85300		Clotting inhibitors or anticoagulants; antithrombin III, activity	0.48	28.56	0.00	XXX	9		96.51	
85301		Clotting inhibitors or anticoagulants; antithrombin III, antigen assay	0.44	26.18	0.00	XXX	9		94.66	
85302		Clotting inhibitors or anticoagulants; protein C, antigen	0.49	29.16	0.00	XXX	9		100.14	
85303		Clotting inhibitors or anticoagulants; protein C, activity	0.56	33.32	0.00	XXX	9		112.87	
85305		Clotting inhibitors or anticoagulants; protein S, total	0.47	27.97	0.00	XXX	9		114.72	
85306		Clotting inhibitors or anticoagulants; protein S, free	0.62	36.89	0.00	XXX	9		118.35	
85307		Activated Protein C (APC) resistance assay	0.62	36.89	0.00	XXX	9		103.77	
85335		Factor inhibitor test	0.52	30.94	0.00	XXX	9		72.83	
85337		Thrombomodulin	0.42	24.99	0.00	XXX	9		87.41	
85345		Coagulation time; Lee and White	0.17	10.12	0.00	XXX	9		45.52	
85347		Coagulation time; activated	0.17	10.12	0.00	XXX	9		27.31	
85348		Coagulation time; other methods	0.15	8.93	0.00	XXX	9		29.16	
85360		Euglobulin lysis	0.34	20.23	0.00	XXX	9		61.88	
85362		Fibrin(ogen) degradation (split) products (FDP) (FSP); agglutination slide, semiquantitative	0.28	16.66	0.00	XXX	9		40.04	
85366		Fibrin(ogen) degradation (split) products (FDP) (FSP); paracoagulation	0.35	20.83	0.00	XXX	9		60.10	
85370		Fibrin(ogen) degradation (split) products (FDP) (FSP); quantitative	0.46	27.37	0.00	XXX	9		61.88	
85378		Fibrin degradation products, D-dimer; qualitative or semiquantitative	0.29	17.26	0.00	XXX	9		47.36	
85379		Fibrin degradation products, D-dimer; quantitative	0.41	24.40	0.00	XXX	9		60.10	
85380		Fibrin degradation products, D-dimer; ultrasensitive (eg, for evaluation for venous thromboembolism), qualitative or semiquantitative	0.41	24.40	0.00	XXX	9		60.10	
85384		Fibrinogen; activity	0.34	20.23	0.00	XXX	9		43.67	
85385		Fibrinogen; antigen	0.34	20.23	0.00	XXX	9		52.78	
85390		Fibrinolysins or coagulopathy screen, interpretation and report	0.80	47.60	35.11	XXX	9		43.67	
85396		Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	0.59	35.11		XXX	0		29.75	
85397		Coagulation and fibrinolysis, functional activity, not otherwise specified (eg, ADAMTS-13), each analyte	0.93	55.34	0.00	XXX	9		91.04	
85400		Fibrinolytic factors and inhibitors; plasmin	0.36	21.42	0.00	XXX	9		81.93	
85410		Fibrinolytic factors and inhibitors; alpha-2 antiplasmin	0.31	18.45	0.00	XXX	9		100.14	
85415		Fibrinolytic factors and inhibitors; plasminogen activator	0.69	41.06	0.00	XXX	9		81.93	
85420		Fibrinolytic factors and inhibitors; plasminogen, except antigenic assay	0.26	15.47	0.00	XXX	9		91.04	
85421		Fibrinolytic factors and inhibitors; plasminogen, antigenic assay	0.41	24.40	0.00	XXX	9		109.24	
85441		Heinz bodies; direct	0.17	10.12	0.00	XXX	9		36.41	
85445		Heinz bodies; induced, acetyl phenylhydrazine	0.28	16.66	0.00	XXX	9		30.94	
85460		Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke)	0.31	18.45	0.00	XXX	9		52.78	
85461		Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; rosette	0.27	16.07	0.00	XXX	9		43.67	
85475		Hemolysin, acid	0.36	21.42	0.00	XXX	9		65.57	
85520		Heparin assay	0.53	31.54	0.00	XXX	9		83.78	
85525		Heparin neutralization	0.48	28.56	0.00	XXX	9		67.35	
85530		Heparin-protamine tolerance test	0.57	33.92	0.00	XXX	9		63.72	
85536		Iron stain, peripheral blood	0.26	15.47	0.00	XXX	9		34.57	
85540		Leukocyte alkaline phosphatase with count	0.35	20.83	0.00	XXX	9		49.15	
85547		Mechanical fragility, RBC	0.35	20.83	0.00	XXX	9		38.26	
85549		Muramidase	0.76	45.22	0.00	XXX	9		81.93	
85555		Osmotic fragility, RBC; unincubated	0.27	16.07	0.00	XXX	9		63.72	
85557		Osmotic fragility, RBC; incubated	0.54	32.13	0.00	XXX	9		87.41	
85576		Platelet, aggregation (in vitro), each agent	1.46	86.87	35.11	XXX	9		91.04	
85597		Phospholipid neutralization; platelet	0.73	43.44	0.00	XXX	9		70.98	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
85598		Phospholipid neutralization; hexagonal phospholipic	0.73	43.44	0.00	XXX	9		New	
85610		Prothrombin time;	0.16	9.52	0.00	XXX	9		23.68	
85611		Prothrombin time; substitution, plasma fractions, each	0.16	9.52	0.00	XXX	9		29.16	
85612		Russell viper venom time (includes venom); undiluted	0.39	23.21	0.00	XXX	9		49.15	
85613		Russell viper venom time (includes venom); diluted	0.39	23.21	0.00	XXX	9		60.10	
85635		Reptilase test	0.40	23.80	0.00	XXX	9		54.62	
85651		Sedimentation rate, erythrocyte; non-automatec	0.14	8.33	0.00	XXX	9		22.79	
85652		Sedimentation rate, erythrocyte; automatec	0.11	6.55	0.00	XXX	9		22.79	
85660		Sickling of RBC, reduction	0.22	13.09	0.00	XXX	9		30.94	
85670		Thrombin time; plasma	0.23	13.69	0.00	XXX	9		38.26	
85675		Thrombin time; titer	0.28	16.66	0.00	XXX	9		41.89	
85705		Thromboplastin inhibition, tissue	0.39	23.21	0.00	XXX	9		72.83	
85730		Thromboplastin time, partial (PTT); plasma or whole blooc	0.24	14.28	0.00	XXX	9		30.94	
85732		Thromboplastin time, partial (PTT); substitution, plasma fractions, each	0.26	15.47	0.00	XXX	9		40.04	
85810		Viscosity	0.47	27.97	0.00	XXX	9		45.52	
85999		Unlisted hematology and coagulation procedure	0.00	BR	BR	XXX	9		BR	
86000		Agglutinins, febrile (eg, Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus), each antigen	0.28	16.66	0.00	XXX	9		38.26	
86001		Allergen specific IgG quantitative or semiquantitative, each allerger	0.21	12.50	0.00	XXX	9		20.05	
86003		Allergen specific IgE; quantitative or semiquantitative, each allerger	0.21	12.50	0.00	XXX	9		20.05	
86005		Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle, or disk)	0.32	19.04	0.00	XXX	9		72.83	
86021		Antibody identification; leukocyte antibodies	0.61	36.30	0.00	XXX	9		109.24	
86022		Antibody identification; platelet antibodies	0.74	44.03	0.00	XXX	9		154.76	
86023		Antibody identification; platelet associated immunoglobulin assay	0.50	29.75	0.00	XXX	9		100.14	
86038		Antinuclear antibodies (ANA);	0.49	29.16	0.00	XXX	9		63.72	
86039		Antinuclear antibodies (ANA); titer	0.45	26.78	0.00	XXX	9		63.72	
86060		Antistreptolysin 0; titer	0.29	17.26	0.00	XXX	9		43.67	
86063		Antistreptolysin 0; screen	0.23	13.69	0.00	XXX	9		30.94	
86077		Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report	1.57	93.42		XXX	0	16.39	75.57	22.63
86078		Blood bank physician services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report	1.58	94.01		XXX	0	30.22	78.54	48.34
86079		Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report	1.57	93.42		XXX	0	30.22	77.95	22.63
86140		C-reactive protein;	0.21	12.50	0.00	XXX	9		36.41	
86141		C-reactive protein; high sensitivity (hsCRP)	0.52	30.94	0.00	XXX	9		47.36	
86146		Beta 2 Glycoprotein I antibody, each	1.03	61.29	0.00	XXX	9		118.35	
86147		Cardiolipin (phospholipid) antibody, each Ig class	1.03	61.29	0.00	XXX	9		118.35	
86148		Anti-phosphatidylserine (phospholipid) antibody	0.65	38.68	0.00	XXX	9		0.00	
86152		Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	0.00	BR		XXX	9	16.39	New	
86153		Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	0.00	0.00	58.91	XXX	0	16.39	New	
86155		Chemotaxis assay, specify methoc	0.65	38.68	0.00	XXX	9		56.47	
86156		Cold agglutinin; screen	0.27	16.07	0.00	XXX	9		34.57	
86157		Cold agglutinin; titer	0.33	19.64	0.00	XXX	9		41.89	
86160		Complement; antigen, each component	0.48	28.56	0.00	XXX	9		74.67	
86161		Complement; functional activity, each component	0.48	28.56	0.00	XXX	9		83.78	
86162		Complement; total hemolytic (CH50)	0.82	48.79	0.00	XXX	9		112.87	
86171		Complement fixation tests, each antigen	0.40	23.80	0.00	XXX	9		52.78	

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86185		Counterimmunoelectrophoresis, each antigen	0.36	21.42	0.00	XXX	9		45.52	
86200		Cyclic citrullinated peptide (CCP), antibody	0.52	30.94	0.00	XXX	9		76.46	
86215		Deoxyribonuclease, antibody	0.54	32.13	0.00	XXX	9		70.98	
86225		Deoxyribonucleic acid (DNA) antibody; native or double strandec	0.55	32.73	0.00	XXX	9		78.30	
86226		Deoxyribonucleic acid (DNA) antibody; single strandec	0.49	29.16	0.00	XXX	9		69.20	
86235		Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A, SS-B, Sm, RNP, Sc170, J01), each antibody	0.72	42.84	0.00	XXX	9		69.20	
86243		Fc receptor	0.83	49.39	0.00	XXX	9		72.83	
86255		Fluorescent noninfectious agent antibody; screen, each antibody	1.08	64.26	35.11	XXX	9		63.72	
86256		Fluorescent noninfectious agent antibody; titer, each antibody	1.05	62.48	33.32	XXX	9		58.25	
86277		Growth hormone, human (HGH), antibody	0.64	38.08	0.00	XXX	9		67.35	
86280		Hemagglutination inhibition test (HAI)	0.33	19.64	0.00	XXX	9		52.78	
86294		Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen	0.79	47.01	0.00	XXX	9		94.66	
86300		Immunoassay for tumor antigen, quantitative; CA 15-3 (27.29)	0.84	49.98	0.00	XXX	9		94.66	
86301		Immunoassay for tumor antigen, quantitative; CA 19-9	0.84	49.98	0.00	XXX	9		94.66	
86304		Immunoassay for tumor antigen, quantitative; CA 125	0.84	49.98	0.00	XXX	9		94.66	
86305		Human epididymis protein 4 (HE4)	0.84	49.98	0.00	XXX	9		0.00	
86308		Heterophile antibodies; screening	0.21	12.50	0.00	XXX	9		32.78	
86309		Heterophile antibodies; titer	0.26	15.47	0.00	XXX	9		45.52	
86310		Heterophile antibodies; titers after absorption with beef cells and guinea pig kidney	0.30	17.85	0.00	XXX	9		45.52	
86316		Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each	0.84	49.98	0.00	XXX	9		94.66	
86317		Immunoassay for infectious agent antibody, quantitative, not otherwise specifiec	0.61	36.30	0.00	XXX	9		43.67	
86318		Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)	0.52	30.94	0.00	XXX	9		43.67	
86320		Immunoelectrophoresis; serum	1.45	86.28	32.13	XXX	9		111.09	
86325		Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentratior	1.45	86.28	32.73	XXX	9		118.35	
86327		Immunoelectrophoresis; crossed (2-dimensional assay)	1.59	94.61	39.87	XXX	9		91.04	
86329		Immunodiffusion; not elsewhere specified	0.57	33.92	0.00	XXX	9		74.67	
86331		Immunodiffusion; gel diffusion, qualitative (Ouchterlony), each antigen or antibody	0.48	28.56	0.00	XXX	9		74.67	
86332		Immune complex assay	0.98	58.31	0.00	XXX	9		100.14	
86334		Immunofixation electrophoresis; serum	1.48	88.06	34.51	XXX	9		98.29	
86335		Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)	1.78	105.91	35.11	XXX	9		98.29	
86336		Inhibin A	0.63	37.49	0.00	XXX	9		91.04	
86337		Insulin antibodies	0.87	51.77	0.00	XXX	9		114.72	
86340		Intrinsic factor antibodies	0.61	36.30	0.00	XXX	9		80.09	
86341		Islet cell antibody	0.80	47.60	0.00	XXX	9		63.72	
86343		Leukocyte histamine release test (LHR)	0.50	29.75	0.00	XXX	9		81.93	
86344		Leukocyte phagocytosis	0.32	19.04	0.00	XXX	9		72.83	
86352		Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)	5.49	326.66	0.00	XXX	9		0.00	
86353		Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	1.98	117.81	0.00	XXX	9		227.59	
86355		B cells, total count	1.52	90.44	0.00	XXX	9		114.72	
86356		Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antige	1.08	64.26	0.00	XXX	9		58.80	
86357		Natural killer (NK) cells, total count	1.52	90.44	0.00	XXX	9		114.72	
86359		T cells; total count	1.52	90.44	0.00	XXX	9		114.72	
86360		T cells; absolute CD4 and CD8 count, including ratic	1.90	113.05	0.00	XXX	9		149.29	
86361		T cells; absolute CD4 count	1.08	64.26	0.00	XXX	9		114.72	
86367		Stem cells (ie, CD34), total count	1.52	90.44	0.00	XXX	9		114.72	
86376		Microsomal antibodies (eg, thyroid or liver-kidney), each	0.59	35.11	0.00	XXX	9		76.46	
86378		Migration inhibitory factor test (MIF)	0.80	47.60	0.00	XXX	9		76.46	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
86382		Neutralization test, viral	0.68	40.46	0.00	XXX	9		91.04	
86384		Nitroblue tetrazolium dye test (NTD)	0.46	27.37	0.00	XXX	9		63.72	
86386		Nuclear Matrix Protein 22 (NMP22), qualitative	0.65	38.68	0.00	XXX	9		New	
86403		Particle agglutination; screen, each antibody	0.41	24.40	0.00	XXX	9		29.16	
86406		Particle agglutination; titer, each antibody	0.43	25.59	0.00	XXX	9		36.41	
86430		Rheumatoid factor; qualitative	0.23	13.69	0.00	XXX	9		34.57	
86431		Rheumatoid factor; quantitative	0.23	13.69	0.00	XXX	9		36.41	
86480		Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon	2.50	148.75	0.00	XXX	9		32.78	
86481		Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	3.03	180.29	0.00	XXX	9		New	
86485		Skin test; candida	0.40	23.80	0.00	XXX	0	8.80	29.16	7.29
86486		Skin test; unlisted antigen, each	0.17	10.12	0.00	XXX	0	8.80	9.00	7.29
86490		Skin test; coccidioidomycosis	0.15	8.93	0.00	XXX	0	8.80	16.07	7.29
86510		Skin test; histoplasmosis	0.19	11.31	0.00	XXX	0	8.80	17.85	7.29
86580		Skin test; tuberculosis, intradermal	0.24	14.28	0.00	XXX	0	8.80	14.88	7.29
86590		Streptokinase, antibody	0.45	26.78	0.00	XXX	9		32.78	
86592		Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART	0.17	10.12	0.00	XXX	9		23.68	
86593		Syphilis test, non-treponemal antibody; quantitative	0.18	10.71	0.00	XXX	9		25.47	
86602		Antibody; actinomyces	0.41	24.40	0.00	XXX	9		63.72	
86603		Antibody; adenovirus	0.52	30.94	0.00	XXX	9		63.72	
86606		Antibody; Aspergillus	0.61	36.30	0.00	XXX	9		63.72	
86609		Antibody; bacterium, not elsewhere specified	0.52	30.94	0.00	XXX	9		81.93	
86611		Antibody; Bartonella	0.41	24.40	0.00	XXX	9		81.93	
86612		Antibody; Blastomyces	0.52	30.94	0.00	XXX	9		80.09	
86615		Antibody; Bordetella	0.53	31.54	0.00	XXX	9		91.04	
86617		Antibody; Borrelia burgdorferi (Lyme disease) confirmatory test (eg, Western Blot or immunoblot)	0.63	37.49	0.00	XXX	9		96.51	
86618		Antibody; Borrelia burgdorferi (Lyme disease)	0.69	41.06	0.00	XXX	9		91.04	
86619		Antibody; Borrelia (relapsing fever)	0.54	32.13	0.00	XXX	9		72.83	
86622		Antibody; Brucella	0.36	21.42	0.00	XXX	9		54.62	
86625		Antibody; Campylobacter	0.53	31.54	0.00	XXX	9		85.56	
86628		Antibody; Candida	0.48	28.56	0.00	XXX	9		81.93	
86631		Antibody; Chlamydia	0.48	28.56	0.00	XXX	9		56.47	
86632		Antibody; Chlamydia, IgM	0.51	30.35	0.00	XXX	9		63.72	
86635		Antibody; Coccidioides	0.46	27.37	0.00	XXX	9		81.93	
86638		Antibody; Coxiella burnetii (Q fever)	0.49	29.16	0.00	XXX	9		69.20	
86641		Antibody; Cryptococcus	0.58	34.51	0.00	XXX	9		54.62	
86644		Antibody; cytomegalovirus (CMV)	0.58	34.51	0.00	XXX	9		83.78	
86645		Antibody; cytomegalovirus (CMV), IgM	0.68	40.46	0.00	XXX	9		87.41	
86648		Antibody; Diphtheria	0.61	36.30	0.00	XXX	9		76.46	
86651		Antibody; encephalitis, California (La Crosse)	0.53	31.54	0.00	XXX	9		65.57	
86652		Antibody; encephalitis, Eastern equine	0.53	31.54	0.00	XXX	9		65.57	
86653		Antibody; encephalitis, St. Louis	0.53	31.54	0.00	XXX	9		65.57	
86654		Antibody; encephalitis, Western equine	0.53	31.54	0.00	XXX	9		65.57	
86658		Antibody; enterovirus (eg, coxsackie, echo, polio)	0.53	31.54	0.00	XXX	9		65.57	
86663		Antibody; Epstein-Barr (EB) virus, early antigen (EA)	0.53	31.54	0.00	XXX	9		83.78	
86664		Antibody; Epstein-Barr (EB) virus, nuclear antigen (EBNA)	0.62	36.89	0.00	XXX	9		83.78	
86665		Antibody; Epstein-Barr (EB) virus, viral capsid (VCA)	0.73	43.44	0.00	XXX	9		94.66	
86666		Antibody; Ehrlichia	0.41	24.40	0.00	XXX	9		83.78	
86668		Antibody; Francisella tularensis	0.42	24.99	0.00	XXX	9		65.57	
86671		Antibody; fungus, not elsewhere specified	0.50	29.75	0.00	XXX	9		91.04	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
86674		Antibody; Giardia lamblia	0.59	35.11	0.00	XXX	9		72.83	
86677		Antibody; Helicobacter pylori	0.59	35.11	0.00	XXX	9		91.04	
86682		Antibody; helminth, not elsewhere specifiec	0.53	31.54	0.00	XXX	9		91.04	
86684		Antibody; Haemophilus influenza	0.64	38.08	0.00	XXX	9		91.04	
86687		Antibody; HTLV-I	0.34	20.23	0.00	XXX	9		72.83	
86688		Antibody; HTLV-II	0.57	33.92	0.00	XXX	9		69.20	
86689		Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)	0.78	46.41	0.00	XXX	9		96.51	
86692		Antibody; hepatitis, delta agent	0.69	41.06	0.00	XXX	9		96.51	
86694		Antibody; herpes simplex, non-specific type test	0.58	34.51	0.00	XXX	9		80.09	
86695		Antibody; herpes simplex, type 1	0.53	31.54	0.00	XXX	9		80.09	
86696		Antibody; herpes simplex, type 2	0.78	46.41	0.00	XXX	9		80.09	
86698		Antibody; histoplasma	0.50	29.75	0.00	XXX	9		72.83	
86701		Antibody; HIV-1	0.36	21.42	0.00	XXX	9		61.88	
86702		Antibody; HIV-2	0.55	32.73	0.00	XXX	9		83.78	
86703		Antibody; HIV-1 and HIV-2, single result	0.55	32.73	0.00	XXX	9		72.83	
86704		Hepatitis B core antibody (HBcAb); total	0.49	29.16	0.00	XXX	9		63.72	
86705		Hepatitis B core antibody (HBcAb); IgM antibody	0.48	28.56	0.00	XXX	9		69.20	
86706		Hepatitis B surface antibody (HBsAb)	0.43	25.59	0.00	XXX	9		56.47	
86707		Hepatitis Be antibody (HBeAb)	0.47	27.97	0.00	XXX	9		61.88	
86708		Hepatitis A antibody (HAAb); total	0.50	29.75	0.00	XXX	9		67.35	
86709		Hepatitis A antibody (HAAb); IgM antibody	0.45	26.78	0.00	XXX	9		63.72	
86710		Antibody; influenza virus	0.55	32.73	0.00	XXX	9		60.10	
86711		Antibody; JC (John Cunningham) virus	0.58	34.51	0.00	XXX	9		New	
86713		Antibody; Legionella	0.62	36.89	0.00	XXX	9		72.83	
86717		Antibody; Leishmania	0.49	29.16	0.00	XXX	9		60.10	
86720		Antibody; Leptospira	0.53	31.54	0.00	XXX	9		60.10	
86723		Antibody; Listeria monocytogenes	0.53	31.54	0.00	XXX	9		60.10	
86727		Antibody; lymphocytic choriomeningitis	0.52	30.94	0.00	XXX	9		60.10	
86729		Antibody; lymphogranuloma venereum	0.48	28.56	0.00	XXX	9		60.10	
86732		Antibody; mucormycosis	0.53	31.54	0.00	XXX	9		80.09	
86735		Antibody; mumps	0.53	31.54	0.00	XXX	9		72.83	
86738		Antibody; mycoplasma	0.53	31.54	0.00	XXX	9		72.83	
86741		Antibody; Neisseria meningitidis	0.53	31.54	0.00	XXX	9		72.83	
86744		Antibody; Nocardia	0.53	31.54	0.00	XXX	9		72.83	
86747		Antibody; parvovirus	0.61	36.30	0.00	XXX	9		85.56	
86750		Antibody; Plasmodium (malaria)	0.53	31.54	0.00	XXX	9		80.09	
86753		Antibody; protozoa, not elsewhere specifiec	0.50	29.75	0.00	XXX	9		91.04	
86756		Antibody; respiratory syncytial virus	0.52	30.94	0.00	XXX	9		72.83	
86757		Antibody; Rickettsia	0.78	46.41	0.00	XXX	9		72.83	
86759		Antibody; rotavirus	0.53	31.54	0.00	XXX	9		72.83	
86762		Antibody; rubella	0.58	34.51	0.00	XXX	9		49.15	
86765		Antibody; rubeola	0.52	30.94	0.00	XXX	9		87.41	
86768		Antibody; Salmonella	0.53	31.54	0.00	XXX	9		63.72	
86771		Antibody; Shigella	0.53	31.54	0.00	XXX	9		63.72	
86774		Antibody; tetanus	0.60	35.70	0.00	XXX	9		81.93	
86777		Antibody; Toxoplasma	0.58	34.51	0.00	XXX	9		65.57	
86778		Antibody; Toxoplasma, IgM	0.58	34.51	0.00	XXX	9		81.93	
86780		Antibody; Treponema pallidum	0.53	31.54	0.00	XXX	9		77.35	
86784		Antibody; Trichinella	0.51	30.35	0.00	XXX	9		61.88	
86787		Antibody; varicella-zoster	0.52	30.94	0.00	XXX	9		80.09	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
86788		Antibody; West Nile virus, IgM	0.68	40.46	0.00	XXX	9		81.93	
86789		Antibody; West Nile virus	0.58	34.51	0.00	XXX	9		81.93	
86790		Antibody; virus, not elsewhere specifiec	0.52	30.94	0.00	XXX	9		91.04	
86793		Antibody; Yersinia	0.53	31.54	0.00	XXX	9		65.57	
86800		Thyroglobulin antibody	0.64	38.08	0.00	XXX	9		78.30	
86803		Hepatitis C antibody;	0.58	34.51	0.00	XXX	9		89.19	
86804		Hepatitis C antibody; confirmatory test (eg, immunoblot)	0.63	37.49	0.00	XXX	9		142.03	
86805		Lymphocytotoxicity assay, visual crossmatch; with titratior	2.11	125.55	0.00	XXX	9		218.48	
86806		Lymphocytotoxicity assay, visual crossmatch; without titratior	1.92	114.24	0.00	XXX	9		218.48	
86807		Serum screening for cytotoxic percent reactive antibody (PRA); standard methoc	1.60	95.20	0.00	XXX	9		105.61	
86808		Serum screening for cytotoxic percent reactive antibody (PRA); quick methoc	1.20	71.40	0.00	XXX	9		100.14	
86812		HLA typing; A, B, or C (eg, A10, B7, B27), single antiger	1.04	61.88	0.00	XXX	9		127.45	
86813		HLA typing; A, B, or C, multiple antigens	2.34	139.23	0.00	XXX	9		172.97	
86816		HLA typing; DR/DQ, single antigen	1.13	67.24	0.00	XXX	9		172.97	
86817		HLA typing; DR/DQ, multiple antigens	2.60	154.70	0.00	XXX	9		455.18	
86821		HLA typing; lymphocyte culture, mixed (MLC)	2.28	135.66	0.00	XXX	9		345.93	
86822		HLA typing; lymphocyte culture, primed (PLC)	1.48	88.06	0.00	XXX	9		127.45	
86825		Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); first serum sample or dilution	3.24	192.78	0.00	XXX	9		0.00	
86826		Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); each additional serum sample or sample dilution (List separately in addition to primary procedure)	1.08	64.26	0.00	XXX	9		0.00	
86828		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens	1.60	95.20	0.00	XXX	9		New	
86829		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens	1.20	71.40	0.00	XXX	9		New	
86830		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I	3.26	193.97	0.00	XXX	9		New	
86831		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II	2.80	166.60	0.00	XXX	9		New	
86832		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class I	5.13	305.24	0.00	XXX	9		New	
86833		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class II	4.66	277.27	0.00	XXX	9		New	
86834		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class I	14.45	859.78	0.00	XXX	9		New	
86835		Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class II	13.05	776.48	0.00	XXX	9		New	
86849		Unlisted immunology procedure	0.00	BR	BR	XXX	9		BR	
86850		Antibody screen, RBC, each serum technique	0.50	29.75	0.00	XXX	9	23.17	36.41	20.02
86860		Antibody elution (RBC), each elution	0.64	38.08	0.00	XXX	9	32.24	43.67	34.05
86870		Antibody identification, RBC antibodies, each panel for each serum technique	0.88	52.36	0.00	XXX	9	44.25	67.35	34.05
86880		Antihuman globulin test (Coombs test); direct, each antiserum	0.22	13.09	0.00	XXX	9	12.48	25.47	10.59
86885		Antihuman globulin test (Coombs test); indirect, qualitative, each reagent red cel	0.23	13.69	0.00	XXX	9	12.48	25.47	10.59
86886		Antihuman globulin test (Coombs test); indirect, each antibody titer	0.21	12.50	0.00	XXX	9	12.48	36.41	10.59

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
86890		Autologous blood or component, collection processing and storage; predeposited	2.02	120.19	0.00	XXX	9	44.25	145.66	67.33
86891		Autologous blood or component, collection processing and storage; intra- or postoperative salvage	2.86	170.17	0.00	XXX	9	23.17	227.59	20.02
86900		Blood typing; ABO	0.12	7.14	0.00	XXX	9	12.48	20.05	10.59
86901		Blood typing; Rh (D)	0.12	7.14	0.00	XXX	9	12.48	20.05	10.59
86902		Blood typing; antigen testing of donor blood using reagent serum, each antigen tes	0.15	8.93	0.00	XXX	9	23.17	New	
86904		Blood typing; antigen screening for compatible unit using patient serum, per unit screened	0.38	22.61	0.00	XXX	9	23.17	34.57	20.02
86905		Blood typing; RBC antigens, other than ABO or Rh (D), each	0.15	8.93	0.00	XXX	9	23.17	34.57	20.02
86906		Blood typing; Rh phenotyping, complete	0.31	18.45	0.00	XXX	9	23.17	30.94	20.02
86910		Blood typing, for paternity testing, per individual; ABO, Rh and MN	0.52	30.94	0.00	XXX	9		40.04	2097.37**
86911		Blood typing, for paternity testing, per individual; each additional antigen system	0.45	26.78	0.00	XXX	9		34.57	2097.37**
86920		Compatibility test each unit; immediate spin technique	0.71	42.25	0.00	XXX	9	23.17	60.10	20.02
86921		Compatibility test each unit; incubation technique	0.64	38.08	0.00	XXX	9	23.17	49.15	20.02
86922		Compatibility test each unit; antiglobulin technique	0.76	45.22	0.00	XXX	9	32.24	54.62	34.05
86923		Compatibility test each unit; electronic	0.57	33.92	0.00	XXX	9	23.17	43.67	20.02
86927		Fresh frozen plasma, thawing, each unit	0.40	23.80	0.00	XXX	9	23.17	23.68	20.02
86930		Frozen blood, each unit; freezing (includes preparation)	2.38	141.61	0.00	XXX	9	44.25	182.07	67.33
86931		Frozen blood, each unit; thawing	1.79	106.51	0.00	XXX	9	44.25	136.55	67.33
86932		Frozen blood, each unit; freezing (includes preparation) and thawing	2.02	120.19	0.00	XXX	9	44.25	182.07	67.33
86940		Hemolysins and agglutinins; auto, screen, each	0.33	19.64	0.00	XXX	9		38.26	
86941		Hemolysins and agglutinins; incubated	0.49	29.16	0.00	XXX	9		43.67	
86945		Irradiation of blood product, each unit	0.60	35.70	0.00	XXX	9	23.17	50.99	20.02
86950		Leukocyte transfusion	1.55	92.23	0.00	XXX	9	23.17	112.87	20.02
86960		Volume reduction of blood or blood product (eg, red blood cells or platelets), each uni	0.67	39.87	0.00	XXX	9	23.17	50.99	20.02
86965		Pooling of platelets or other blood products	0.67	39.87	0.00	XXX	9	32.24	45.52	34.05
86970		Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each	0.60	35.70	0.00	XXX	9	23.17	36.41	20.02
86971		Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with enzymes, each	0.48	28.56	0.00	XXX	9	23.17	36.41	20.02
86972		Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; by density gradient separation	0.83	49.39	0.00	XXX	9	23.17	58.25	20.02
86975		Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each	0.64	38.08	0.00	XXX	9	44.25	49.15	34.05
86976		Pretreatment of serum for use in RBC antibody identification; by dilution	0.71	42.25	0.00	XXX	9	23.17	54.62	20.02
86977		Pretreatment of serum for use in RBC antibody identification; incubation with inhibitors, each	0.71	42.25	0.00	XXX	9	44.25	49.15	67.33
86978		Pretreatment of serum for use in RBC antibody identification; by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption	0.71	42.25	0.00	XXX	9	32.24	49.15	34.05
86985		Splitting of blood or blood products, each unit	0.52	30.94	0.00	XXX	9	23.17	36.41	20.02
86999		Unlisted transfusion medicine procedure	0.00	BR	BR	XXX	9	23.17	BR	20.02
87001		Animal inoculation, small animal; with observation	0.53	31.54	0.00	XXX	9		58.25	
87003		Animal inoculation, small animal; with observation and dissection	0.68	40.46	0.00	XXX	9		63.72	
87015		Concentration (any type), for infectious agents	0.27	16.07	0.00	XXX	9		38.26	
87040		Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)	0.42	24.99	0.00	XXX	9		50.99	
87045		Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species	0.38	22.61	0.00	XXX	9		50.99	
87046		Culture, bacterial; stool, aerobic, additional pathogens, isolation and presumptive identification of isolates, each plate	0.38	22.61	0.00	XXX	9		50.99	
87070		Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	0.35	20.83	0.00	XXX	9		49.15	
87071		Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool	0.38	22.61	0.00	XXX	9		50.99	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
87073		Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool	0.38	22.61	0.00	XXX	9		54.62	
87075		Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates	0.38	22.61	0.00	XXX	9		54.62	
87076		Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate	0.33	19.64	0.00	XXX	9		54.62	
87077		Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate	0.33	19.64	0.00	XXX	9		54.62	
87081		Culture, presumptive, pathogenic organisms, screening only	0.27	16.07	0.00	XXX	9		32.78	
87084		Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart	0.35	20.83	0.00	XXX	9		36.41	
87086		Culture, bacterial; quantitative colony count, urine	0.33	19.64	0.00	XXX	9		45.52	
87088		Culture, bacterial; with isolation and presumptive identification of each isolate, urine	0.33	19.64	0.00	XXX	9		43.67	
87101		Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nai	0.31	18.45	0.00	XXX	9		45.52	
87102		Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)	0.34	20.23	0.00	XXX	9		47.36	
87103		Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; blooc	0.36	21.42	0.00	XXX	9		47.36	
87106		Culture, fungi, definitive identification, each organism; yeas	0.42	24.99	0.00	XXX	9		49.15	
87107		Culture, fungi, definitive identification, each organism; mold	0.42	24.99	0.00	XXX	9		49.15	
87109		Culture, mycoplasma, any source	0.62	36.89	0.00	XXX	9		100.14	
87110		Culture, chlamydia, any source	0.79	47.01	0.00	XXX	9		69.20	
87116		Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates	0.44	26.18	0.00	XXX	9		54.62	
87118		Culture, mycobacterial, definitive identification, each isolate	0.44	26.18	0.00	XXX	9		50.99	
87140		Culture, typing; immunofluorescent method, each antiserum	0.23	13.69	0.00	XXX	9		34.57	
87143		Culture, typing; gas liquid chromatography (GLC) or high pressure liquid chromatography (HPLC) method	0.51	30.35	0.00	XXX	9		67.35	
87147		Culture, typing; immunologic method, other than immunofluoresence (eg, agglutination grouping), per antiserum	0.21	12.50	0.00	XXX	9		25.47	
87149		Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed	0.81	48.20	0.00	XXX	9		72.83	
87150		Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed	1.42	84.49	0.00	XXX	9		91.04	
87152		Culture, typing; identification by pulse field gel typing	0.21	12.50	0.00	XXX	9		0.00	
87153		Culture, typing; identification by nucleic acid sequencing method, each isolate (eg, sequencing of the 16S rRNA gene)	4.66	277.27	0.00	XXX	9		95.20	
87158		Culture, typing; other methods	0.21	12.50	0.00	XXX	9		29.16	
87164		Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collectior	0.99	58.91	33.32	XXX	9		54.62	
87166		Dark field examination, any source (eg, penile, vaginal, oral, skin); without collectior	0.46	27.37	0.00	XXX	9		50.99	
87168		Macroscopic examination; arthropod	0.17	10.12	0.00	XXX	9		27.31	
87169		Macroscopic examination; parasite	0.17	10.12	0.00	XXX	9		27.31	
87172		Pinworm exam (eg, cellophane tape prep)	0.17	10.12	0.00	XXX	9		27.31	
87176		Homogenization, tissue, for culture	0.24	14.28	0.00	XXX	9		32.78	
87177		Ova and parasites, direct smears, concentration and identificatior	0.36	21.42	0.00	XXX	9		49.15	
87181		Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	0.19	11.31	0.00	XXX	9		27.31	
87184		Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents	0.28	16.66	0.00	XXX	9		36.41	
87185		Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzym	0.19	11.31	0.00	XXX	9		30.94	
87186		Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate	0.35	20.83	0.00	XXX	9		41.89	

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87187		Susceptibility studies, antimicrobial agent; microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure)	0.42	24.99	0.00	XXX	9		41.89	
87188		Susceptibility studies, antimicrobial agent; macrobroth dilution method, each agen	0.27	16.07	0.00	XXX	9		41.89	
87190		Susceptibility studies, antimicrobial agent; mycobacteria, proportion method, each agen	0.23	13.69	0.00	XXX	9		29.16	
87197		Serum bactericidal titer (Schlicter test)	0.61	36.30	0.00	XXX	9		58.25	
87205		Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	0.17	10.12	0.00	XXX	9		27.31	
87206		Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	0.22	13.09	0.00	XXX	9		32.78	
87207		Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	0.83	49.39	35.11	XXX	9		50.99	
87209		Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites	0.73	43.44	0.00	XXX	9		32.78	
87210		Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)	0.17	10.12	0.00	XXX	9		23.68	
87220		Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)	0.17	10.12	0.00	XXX	9		27.31	
87230		Toxin or antitoxin assay, tissue culture (eg, Clostridium difficile toxin)	0.80	47.60	0.00	XXX	9		81.93	
87250		Virus isolation; inoculation of embryonated eggs, or small animal, includes observation and dissection	0.79	47.01	0.00	XXX	9		91.04	
87252		Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect	1.05	62.48	0.00	XXX	9		91.04	
87253		Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluoresence stain), each isolate	0.82	48.79	0.00	XXX	9		91.04	
87254		Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus	0.79	47.01	0.00	XXX	9		91.04	
87255		Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity)	1.37	81.52	0.00	XXX	9		91.04	
87260		Infectious agent antigen detection by immunofluorescent technique; adenovirus	0.48	28.56	0.00	XXX	9		72.83	
87265		Infectious agent antigen detection by immunofluorescent technique; Bordetella pertussis/parapertussis	0.48	28.56	0.00	XXX	9		72.83	
87267		Infectious agent antigen detection by immunofluorescent technique; Enterovirus, direct fluorescent antibody (DFA)	0.48	28.56	0.00	XXX	9		72.83	
87269		Infectious agent antigen detection by immunofluorescent technique; giardia	0.48	28.56	0.00	XXX	9		72.83	
87270		Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	0.48	28.56	0.00	XXX	9		72.83	
87271		Infectious agent antigen detection by immunofluorescent technique; Cytomegalovirus, direct fluorescent antibody (DFA)	0.48	28.56	0.00	XXX	9		87.41	
87272		Infectious agent antigen detection by immunofluorescent technique; cryptosporidium	0.48	28.56	0.00	XXX	9		72.83	
87273		Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2	0.48	28.56	0.00	XXX	9		72.83	
87274		Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1	0.48	28.56	0.00	XXX	9		72.83	
87275		Infectious agent antigen detection by immunofluorescent technique; influenza B virus	0.48	28.56	0.00	XXX	9		72.83	
87276		Infectious agent antigen detection by immunofluorescent technique; influenza A virus	0.48	28.56	0.00	XXX	9		72.83	
87277		Infectious agent antigen detection by immunofluorescent technique; Legionella micdade	0.48	28.56	0.00	XXX	9		63.72	
87278		Infectious agent antigen detection by immunofluorescent technique; Legionella pneumophila	0.48	28.56	0.00	XXX	9		72.83	
87279		Infectious agent antigen detection by immunofluorescent technique; Parainfluenza virus, each type	0.48	28.56	0.00	XXX	9		72.83	
87280		Infectious agent antigen detection by immunofluorescent technique; respiratory syncytial virus	0.48	28.56	0.00	XXX	9		72.83	
87281		Infectious agent antigen detection by immunofluorescent technique; Pneumocystis carinii	0.48	28.56	0.00	XXX	9		72.83	
87283		Infectious agent antigen detection by immunofluorescent technique; Rubeola	0.48	28.56	0.00	XXX	9		72.83	
87285		Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum	0.48	28.56	0.00	XXX	9		81.93	
87290		Infectious agent antigen detection by immunofluorescent technique; Varicella zoster virus	0.48	28.56	0.00	XXX	9		72.83	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
87299		Infectious agent antigen detection by immunofluorescent technique; not otherwise specified, each organism	0.48	28.56	0.00	XXX	9		80.09	
87300		Infectious agent antigen detection by immunofluorescent technique, polyvalent for multiple organisms, each polyvalent antiserum	0.48	28.56	0.00	XXX	9		58.25	
87301		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; adenovirus enteric types 40/41	0.48	28.56	0.00	XXX	9		58.25	
87305		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Aspergillus	0.48	28.56	0.00	XXX	9		58.25	
87320		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis	0.48	28.56	0.00	XXX	9		58.25	
87324		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Clostridium difficile toxin(s)	0.48	28.56	0.00	XXX	9		58.25	
87327		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Cryptococcus neoformans	0.48	28.56	0.00	XXX	9		58.25	
87328		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; cryptosporidium	0.48	28.56	0.00	XXX	9		58.25	
87329		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; giardia	0.48	28.56	0.00	XXX	9		58.25	
87332		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; cytomegalovirus	0.48	28.56	0.00	XXX	9		58.25	
87335		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Escherichia coli 0157	0.48	28.56	0.00	XXX	9		58.25	
87336		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Entamoeba histolytica dispar group	0.48	28.56	0.00	XXX	9		58.25	
87337		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Entamoeba histolytica group	0.48	28.56	0.00	XXX	9		58.25	
87338		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool	0.58	34.51	0.00	XXX	9		58.25	
87339		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori	0.48	28.56	0.00	XXX	9		58.25	
87340		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)	0.42	24.99	0.00	XXX	9		58.25	
87341		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization	0.42	24.99	0.00	XXX	9		58.25	
87350		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg)	0.47	27.97	0.00	XXX	9		61.88	
87380		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis, delta agent	0.66	39.27	0.00	XXX	9		81.93	
87385		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Histoplasma capsulatum	0.48	28.56	0.00	XXX	9		58.25	
87389		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	0.97	57.72	0.00	XXX	9		New	
87390		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1	0.71	42.25	0.00	XXX	9		91.04	
87391		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2	0.71	42.25	0.00	XXX	9		85.56	
87400		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Influenza, A or B, each	0.48	28.56	0.00	XXX	9		58.25	

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87420		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; respiratory syncytial virus	0.48	28.56	0.00	XXX	9		58.25	
87425		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; rotavirus	0.48	28.56	0.00	XXX	9		58.25	
87427		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Shiga-like toxin	0.48	28.56	0.00	XXX	9		58.25	
87430		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Streptococcus, group A	0.48	28.56	0.00	XXX	9		43.67	
87449		Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	0.48	28.56	0.00	XXX	9		58.25	
87450		Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; single step method, not otherwise specified, each organism	0.39	23.21	0.00	XXX	9		58.25	
87451		Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, polyvalent for multiple organisms, each polyvalent antiserum	0.39	23.21	0.00	XXX	9		58.25	
87470		Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87471		Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87472		Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, quantification	1.73	102.94	0.00	XXX	9		145.66	
87475		Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87476		Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87477		Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, quantificatior	1.73	102.94	0.00	XXX	9		146.55	
87480		Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique	0.81	48.20	0.00	XXX	9		89.19	
87481		Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87482		Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantificatior	1.69	100.56	0.00	XXX	9		146.55	
87485		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87486		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87487		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantificatior	1.73	102.94	0.00	XXX	9		146.55	
87490		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87491		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87492		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantificatior	1.41	83.90	0.00	XXX	9		136.55	
87493		Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique	1.42	84.49	0.00	XXX	9		163.63	
87495		Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87496		Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87497		Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantificatior	1.73	102.94	0.00	XXX	9		163.86	
87498		Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, reverse transcription and amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87500		Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique	1.42	84.49	0.00	XXX	9		77.40	

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87501		Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype	2.07	123.17	0.00	XXX	9		New	
87502		Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, first 2 types or sub-types	3.44	204.68	0.00	XXX	9		New	
87503		Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in additio	0.84	49.98	0.00	XXX	9		New	
87510		Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87511		Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87512		Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantificatior	1.69	100.56	0.00	XXX	9		136.55	
87515		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87516		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87517		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantificatior	1.73	102.94	0.00	XXX	9		163.86	
87520		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87521		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, reverse transcription and amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87522		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, reverse transcription and quantification	1.73	102.94	0.00	XXX	9		163.86	
87525		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87526		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87527		Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantificatior	1.69	100.56	0.00	XXX	9		163.86	
87528		Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87529		Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87530		Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantificatior	1.73	102.94	0.00	XXX	9		163.86	
87531		Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87532		Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87533		Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantificatior	1.69	100.56	0.00	XXX	9		163.86	
87534		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87535		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, reverse transcription and amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87536		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, reverse transcription and quantification	3.44	204.68	0.00	XXX	9		163.86	
87537		Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87538		Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, reverse transcription and amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87539		Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, reverse transcription and quantification	1.73	102.94	0.00	XXX	9		163.86	
87540		Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87541		Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87542		Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantificatior	1.69	100.56	0.00	XXX	9		145.66	
87550		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	

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87551		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87552		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, quantificatior	1.73	102.94	0.00	XXX	9		163.86	
87555		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87556		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87557		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, quantificatior	1.73	102.94	0.00	XXX	9		146.55	
87560		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87561		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87562		Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, quantification	1.73	102.94	0.00	XXX	9		163.86	
87580		Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87581		Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique	1.42	84.49	0.00	XXX	9		163.86	
87582		Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantificatior	1.69	100.56	0.00	XXX	9		145.66	
87590		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87591		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87592		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantificatior	1.73	102.94	0.00	XXX	9		146.55	
87620		Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique	0.81	48.20	0.00	XXX	9		91.04	
87621		Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87622		Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantificatior	1.69	100.56	0.00	XXX	9		146.55	
87631		Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe t	5.18	308.21	0.00	XXX	9		New	
87632		Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe t	8.62	512.89	0.00	XXX	9		New	
87633		Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe t	16.84	1001.98	0.00	XXX	9		New	
87640		Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87641		Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87650		Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87651		Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	
87652		Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantificatior	1.69	100.56	0.00	XXX	9		146.55	
87653		Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique	1.42	84.49	0.00	XXX	9		145.66	

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87660		Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique	0.81	48.20	0.00	XXX	9		72.83	
87797		Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	0.81	48.20	0.00	XXX	9		72.83	
87798		Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism	1.42	84.49	0.00	XXX	9		145.66	
87799		Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism	1.73	102.94	0.00	XXX	9		163.86	
87800		Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique	1.62	96.39	0.00	XXX	9		0.00	
87801		Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique	2.84	168.98	0.00	XXX	9		0.00	
87802		Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B	0.48	28.56	0.00	XXX	9		63.72	
87803		Infectious agent antigen detection by immunoassay with direct optical observation; Clostridium difficile toxin A	0.48	28.56	0.00	XXX	9		63.72	
87804		Infectious agent antigen detection by immunoassay with direct optical observation; Influenza	0.48	28.56	0.00	XXX	9		63.72	
87807		Infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus	0.48	28.56	0.00	XXX	9		63.72	
87808		Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis	0.48	28.56	0.00	XXX	9		63.72	
87809		Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus	0.48	28.56	0.00	XXX	9		26.40	
87810		Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis	0.48	28.56	0.00	XXX	9		63.72	
87850		Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae	0.48	28.56	0.00	XXX	9		63.72	
87880		Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A	0.48	28.56	0.00	XXX	9		63.72	
87899		Infectious agent antigen detection by immunoassay with direct optical observation; not otherwise specified	0.48	28.56	0.00	XXX	9		63.72	
87900		Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics	5.27	313.57	0.00	XXX	9		0.00	
87901		Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions	10.40	618.80	0.00	XXX	9		808.37	
87902		Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus	10.40	618.80	0.00	XXX	9		808.37	
87903		Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested	19.74	1174.53	0.00	XXX	9		1533.02	
87904		Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested (List separately in addition to code for primary procedure)	1.05	62.48	0.00	XXX	9		407.81	
87905		Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid	0.49	29.16	0.00	XXX	9		0.00	
87906		Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (eg, integrase, fusion)	5.20	309.40	0.00	XXX	9		New	
87910		Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus	10.40	618.80	0.00	XXX	9		New	
87912		Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus	10.40	618.80	0.00	XXX	9		New	
87999		Unlisted microbiology procedure	0.00	BR	BR	XXX	9		BR	
88000		Necropsy (autopsy), gross examination only; without CNS	6.82	405.79		XXX	9		364.14	2097.37**
88005		Necropsy (autopsy), gross examination only; with brain	7.96	473.62		XXX	9		418.76	2097.37**
88007		Necropsy (autopsy), gross examination only; with brain and spinal cord	8.34	496.23		XXX	9		455.18	2097.37**
88012		Necropsy (autopsy), gross examination only; infant with brain	6.82	405.79		XXX	9		327.73	2097.37**

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88014		Necropsy (autopsy), gross examination only; stillborn or newborn with brai	6.25	371.88		XXX	9		327.73	2097.37**
88016		Necropsy (autopsy), gross examination only; macerated stillborr	8.72	518.84		XXX	9		418.76	2097.37**
88020		Necropsy (autopsy), gross and microscopic; without CNS	11.75	699.13		XXX	9		564.42	2097.37**
88025		Necropsy (autopsy), gross and microscopic; with brair	11.37	676.52		XXX	9		619.04	2097.37**
88027		Necropsy (autopsy), gross and microscopic; with brain and spinal cor	12.13	721.74		XXX	9		673.66	2097.37**
88028		Necropsy (autopsy), gross and microscopic; infant with brair	6.82	405.79		XXX	9		327.73	2097.37**
88029		Necropsy (autopsy), gross and microscopic; stillborn or newborn with brair	6.82	405.79		XXX	9		327.73	2097.37**
88036		Necropsy (autopsy), limited, gross and/or microscopic; regiona	3.41	202.90		XXX	9		182.07	2097.37**
88037		Necropsy (autopsy), limited, gross and/or microscopic; single orgar	3.03	180.29		XXX	9		145.66	2097.37**
88040		Necropsy (autopsy); forensic examination	18.95	1127.53		XXX	9		910.35	2097.37**
88045		Necropsy (autopsy); coroner's call	1.90	113.05		XXX	9		91.04	2097.37**
88099		Unlisted necropsy (autopsy) procedure	0.00	BR		XXX	9		BR	2097.37**
88104		Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretatio	2.24	133.28	49.98	XXX	0	30.22	87.47	22.63
88106		Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation	2.51	149.35	33.32	XXX	0	30.22	114.84	22.63
88108		Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique	2.32	138.04	38.68	XXX	0	30.22	107.70	22.63
88112		Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	3.22	191.59	101.75	XXX	0	30.22	175.53	48.34
88120		Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual	18.25	1085.88	98.77	XXX	0	202.61	New	
88121		Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology	16.40	975.80	86.28	XXX	0	202.61	New	
88125		Cytopathology, forensic (eg, sperm)	0.66	39.27	22.61	XXX	0	30.22	30.94	22.63
88130		Sex chromatin identification; Barr bodies	0.61	36.30	0.00	XXX	9		45.52	
88140		Sex chromatin identification; peripheral blood smear, polymorphonuclear drumsticks	0.32	19.04	0.00	XXX	9		27.31	
88141		Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physicia	0.93	55.34		XXX	0		36.30	
88142		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	0.82	48.79	0.00	XXX	9		30.94	
88143		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	0.82	48.79	0.00	XXX	9		33.68	
88147		Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	0.46	27.37	0.00	XXX	9		32.31	
88148		Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision	0.61	36.30	0.00	XXX	9		34.15	
88150		Cytopathology, slides, cervical or vaginal; manual screening under physician supervisio	0.43	25.59	0.00	XXX	9		29.16	
88152		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision	0.43	25.59	0.00	XXX	9		34.57	
88153		Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	0.43	25.59	0.00	XXX	9		34.57	
88154		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	0.43	25.59	0.00	XXX	9		35.52	
88155		Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)	0.24	14.28	0.00	XXX	9		21.84	
88160		Cytopathology, smears, any other source; screening and interpretatio	1.87	111.27	44.63	XXX	0	16.39	79.73	22.63
88161		Cytopathology, smears, any other source; preparation, screening and interpretatio	1.78	105.91	42.84	XXX	0	16.39	88.06	22.63
88162		Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains	2.83	168.39	68.43	XXX	0	30.22	105.91	48.34
88164		Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	0.43	25.59	0.00	XXX	9		30.94	

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88165		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision	0.43	25.59	0.00	XXX	9		34.15	
88166		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision	0.43	25.59	0.00	XXX	9		30.94	
88167		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	0.43	25.59	0.00	XXX	9		40.04	
88172		Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site	1.61	95.80	61.88	XXX	0	30.22	79.73	48.34
88173		Cytopathology, evaluation of fine needle aspirate; interpretation and repor	4.41	262.40	122.57	XXX	0	49.15	208.25	48.34
88174		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	0.86	51.17	0.00	XXX	9		34.57	
88175		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	1.07	63.67	0.00	XXX	9		35.52	
88177		Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	0.87	51.77	38.08	ZZZ	0	16.39	New	
88182		Flow cytometry, cell cycle or DNA analysis	3.21	191.00	61.29	XXX	0	49.15	162.44	48.34
88184		Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marke	2.61	155.30	0.00	XXX	0	30.22	96.39	22.63
88185		Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)	1.59	94.61	0.00	ZZZ	0	16.39	51.77	22.63
88187		Flow cytometry, interpretation; 2 to 8 markers	2.02	120.19		XXX	0	30.22	99.37	14.10
88188		Flow cytometry, interpretation; 9 to 15 markers	2.58	153.51		XXX	0	30.22	123.17	48.34
88189		Flow cytometry, interpretation; 16 or more markers	3.13	186.24		XXX	0	30.22	160.65	48.34
88199		Unlisted cytopathology procedure	0.00	BR	BR	XXX	0	16.39	BR	14.10
88230		Tissue culture for non-neoplastic disorders; lymphocyte	4.71	280.25	0.00	XXX	9		209.38	
88233		Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy	5.69	338.56	0.00	XXX	9		209.38	
88235		Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells	5.95	354.03	0.00	XXX	9		364.14	
88237		Tissue culture for neoplastic disorders; bone marrow, blood cells	5.10	303.45	0.00	XXX	9		327.73	
88239		Tissue culture for neoplastic disorders; solid tumor	5.96	354.62	0.00	XXX	9		209.38	
88240		Cryopreservation, freezing and storage of cells, each cell line	0.41	24.40	0.00	XXX	9		182.07	
88241		Thawing and expansion of frozen cells, each aliquot	0.41	24.40	0.00	XXX	9		136.55	
88245		Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	6.01	357.60	0.00	XXX	9		245.79	
88248		Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)	7.00	416.50	0.00	XXX	9		436.97	
88249		Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	7.00	416.50	0.00	XXX	9		491.59	
88261		Chromosome analysis; count 5 cells, 1 karyotype, with banding	7.14	424.83	0.00	XXX	9		427.86	
88262		Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	5.04	299.88	0.00	XXX	9		573.52	
88263		Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	6.07	361.17	0.00	XXX	9		589.88	
88264		Chromosome analysis; analyze 20-25 cells	5.04	299.88	0.00	XXX	9		546.21	
88267		Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding	7.26	431.97	0.00	XXX	9		646.35	
88269		Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding	6.72	399.84	0.00	XXX	9		568.05	
88271		Molecular cytogenetics; DNA probe, each (eg, FISH)	0.87	51.77	0.00	XXX	9		0.00	
88272		Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)	1.08	64.26	0.00	XXX	9		0.00	
88273		Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)	1.30	77.35	0.00	XXX	9		0.00	

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88274		Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells	1.41	83.90	0.00	XXX	9		0.00	
88275		Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells	1.62	96.39	0.00	XXX	9		0.00	
88280		Chromosome analysis; additional karyotypes, each study	1.01	60.10	0.00	XXX	9		187.54	
88283		Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding	2.77	164.82	0.00	XXX	9		163.86	
88285		Chromosome analysis; additional cells counted, each study	0.77	45.82	0.00	XXX	9		163.86	
88289		Chromosome analysis; additional high resolution study	1.39	82.71	0.00	XXX	9		136.55	
88291		Cytogenetics and molecular cytogenetics, interpretation and repor	0.90	53.55		XXX	0		41.06	
88299		Unlisted cytogenetic study	0.00	BR		XXX	0	16.39	BR	14.10
88300		Level I - Surgical pathology, gross examination only	0.43	25.59	7.74	XXX	0	16.39	34.51	22.63
88302		Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic	0.91	54.15	11.90	XXX	0	30.22	74.38	22.63
88304		Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pa	1.31	77.95	19.64	XXX	0	30.22	95.20	48.34
88305		Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of su	2.06	122.57	64.26	XXX	0	49.15	161.25	48.34
88307		Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of	8.74	520.03	143.40	XXX	0	77.99	299.29	73.21
88309		Level VI - Surgical pathology, gross and microscopic examination Bone resection, Breast, mastectomy - with regional lymph nodes, Colon, segmental resection for tumor, Colon, total resection, Esophagus, partial/total resection, Extremity, disarticulation,	13.21	786.00	253.47	XXX	0	202.61	447.44	73.21
88311		Decalcification procedure (List separately in addition to code for surgical pathology examination	0.60	35.70	21.42	XXX	0	16.39	27.97	14.10
88312		Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)	2.87	170.77	46.41	XXX	0	30.22	135.66	22.63
88313		Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry	1.99	118.41	20.83	XXX	0	30.22	98.77	22.63
88314		Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	2.38	141.61	39.27	XXX	0	30.22	147.56	22.63
88319		Special stain including interpretation and report; Group III, for enzyme constituents	2.57	152.92	47.60	XXX	0	30.22	230.86	73.21
88321		Consultation and report on referred slides prepared elsewhere	2.74	163.03		XXX	0	16.39	136.85	22.63
88323		Consultation and report on referred material requiring preparation of slides	4.16	247.52	145.18	XXX	0	49.15	214.20	48.34
88325		Consultation, comprehensive, with review of records and specimens, with report on referred material	6.18	367.71		XXX	0	77.99	302.26	73.21
88329		Pathology consultation during surgery	1.69	100.56		XXX	0	16.39	76.16	22.63
88331		Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	2.93	174.34	107.10	XXX	0	30.22	136.26	48.34
88332		Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	1.28	76.16	52.96	XXX	0	16.39	61.29	22.63
88333		Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site	3.09	183.86	108.89	XXX	0	30.22	137.45	22.63
88334		Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)	1.93	114.84	67.24	XXX	0	16.39	80.33	22.63
88342		Immunohistochemistry (including tissue immunoperoxidase), each antibody	3.39	201.71	73.78	XXX	0	49.15	143.40	48.34
88346		Immunofluorescent study, each antibody; direct method	3.21	191.00	73.19	XXX	0	49.15	148.16	48.34
88347		Immunofluorescent study, each antibody; indirect method	2.33	138.64	66.64	XXX	0	30.22	124.95	48.34
88348		Electron microscopy; diagnostic	21.32	1268.54	129.71	XXX	0	202.61	771.72	222.96
88349		Electron microscopy; scanning	12.86	765.17	70.21	XXX	0	202.61	336.18	222.96

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
88355		Morphometric analysis; skeletal muscle	5.37	319.52	144.59	XXX	0	49.15	547.40	48.34
88356		Morphometric analysis; nerve	8.16	485.52	223.72	XXX	0	49.15	458.15	73.21
88358		Morphometric analysis; tumor (eg, DNA ploidy)	2.41	143.40	76.16	XXX	0	49.15	114.84	48.34
88360		Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual	3.74	222.53	91.63	XXX	0	49.15	174.93	48.34
88361		Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology	4.60	273.70	99.96	XXX	0	49.15	248.12	73.21
88362		Nerve teasing preparations	9.17	545.62	191.00	XXX	0	77.99	412.34	73.21
88363		Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	1.67	99.37		XXX	0	16.39	New	
88365		In situ hybridization (eg, FISH), each probe	5.25	312.38	101.75	XXX	0	49.15	205.28	73.21
88367		Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology	7.59	451.61	104.72	XXX	0	49.15	333.20	73.21
88368		Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manua	6.82	405.79	107.70	XXX	0	77.99	258.23	73.21
88371		Protein analysis of tissue by Western Blot, with interpretation and report	1.47	87.47	33.92	XXX	9		158.39	
88372		Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each	1.39	82.71	27.97	XXX	9		154.76	
88375		Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	0.00	BR		YYY	0	16.39	New	
88380		Microdissection (ie, sample preparation of microscopically identified target); laser capture	4.64	276.08	125.55	XXX	0		0.00	
88381		Microdissection (ie, sample preparation of microscopically identified target); manua	4.50	267.75	89.25	XXX	0		335.40	
88387		Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	0.99	58.91	48.20	XXX	0		64.86	
88388		Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation	0.97	57.72	41.06	XXX	0		38.68	
88399		Unlisted surgical pathology procedure	0.00	BR	BR	XXX	0	16.39	BR	14.10
88720		Bilirubin, total, transcutaneous	0.20	11.90	0.00	XXX	9		22.61	
88738		Hemoglobin (Hgb), quantitative, transcutaneous	0.20	11.90	0.00	XXX	9		22.61	
88740		Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobir	0.20	11.90	0.00	XXX	9		22.61	
88741		Hemoglobin, quantitative, transcutaneous, per day; methemoglobir	0.20	11.90	0.00	XXX	9		22.61	
88749		Unlisted in vivo (eg, transcutaneous) laboratory service	0.00	BR		XXX	9		New	
89049		Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report	8.12	483.14		XXX	0	16.39	292.15	14.10
89050		Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood	0.19	11.31	0.00	XXX	9		32.78	
89051		Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count	0.22	13.09	0.00	XXX	9		34.57	
89055		Leukocyte assessment, fecal, qualitative or semiquantitative	0.17	10.12	0.00	XXX	9		29.16	
89060		Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)	0.87	51.77	34.51	XXX	9		36.41	
89125		Fat stain, feces, urine, or respiratory secretions	0.17	10.12	0.00	XXX	9		32.78	
89160		Meat fibers, feces	0.15	8.93	0.00	XXX	9		21.84	
89190		Nasal smear for eosinophils	0.19	11.31	0.00	XXX	9		25.47	
89220		Sputum, obtaining specimen, aerosol induced technique (separate procedure	0.52	30.94	0.00	XXX	0	30.22	25.59	22.63
89230		Sweat collection by iontophoresis	0.07	4.17	0.00	XXX	0	49.15	7.14	48.34
89240		Unlisted miscellaneous pathology test	0.00	BR		XXX	0	16.39	BR	14.10
89250		Culture of oocyte(s)/embryo(s), less than 4 days	31.16	1854.02	0.00	XXX	9	77.99	1225.34	73.21
89251		Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	32.41	1928.40	0.00	XXX	9	77.99	1274.49	73.21

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
89253		Assisted embryo hatching, microtechniques (any method)	0.00	BR		XXX	9	77.99	BR	73.21
89254		Oocyte identification from follicular fluid	0.00	BR		XXX	9	77.99	BR	73.21
89255		Preparation of embryo for transfer (any method)	0.00	BR		XXX	9	77.99	BR	73.21
89257		Sperm identification from aspiration (other than seminal fluid)	0.00	BR		XXX	9	30.22	BR	73.21
89258		Cryopreservation; embryo(s)	0.00	BR		XXX	9	77.99	BR	73.21
89259		Cryopreservation; sperm	0.00	BR		XXX	9	30.22	BR	73.21
89260		Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	0.00	BR		XXX	9	49.15	BR	73.21
89261		Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	0.00	BR		XXX	9	49.15	BR	73.21
89264		Sperm identification from testis tissue, fresh or cryopreserved	0.00	BR		XXX	9	77.99	BR	73.21
89268		Insemination of oocytes	0.00	BR		XXX	9	77.99	BR	73.21
89272		Extended culture of oocyte(s)/embryo(s), 4-7 days	0.00	BR		XXX	9	77.99	BR	73.21
89280		Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	0.00	BR		XXX	9	49.15	BR	73.21
89281		Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	0.00	BR		XXX	9	77.99	BR	73.21
89290		Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	0.00	BR		XXX	9	77.99	BR	73.21
89291		Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	0.00	BR		XXX	9	77.99	BR	73.21
89300		Semen analysis; presence and/or motility of sperm including Huhner test (post coital	0.36	21.42	0.00	XXX	9		63.72	
89310		Semen analysis; motility and count (not including Huhner test)	0.35	20.83	0.00	XXX	9		65.57	
89320		Semen analysis; volume, count, motility, and differentia	0.49	29.16	0.00	XXX	9		91.04	
89321		Semen analysis; sperm presence and motility of sperm, if performed	0.49	29.16	0.00	XXX	9		54.62	
89322		Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	0.63	37.49	0.00	XXX	9		34.20	
89325		Sperm antibodies	0.43	25.59	0.00	XXX	9		145.66	
89329		Sperm evaluation; hamster penetration test	0.85	50.58	0.00	XXX	9		364.14	
89330		Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit tes	0.40	23.80	0.00	XXX	9		100.14	
89331		Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	0.79	47.01	0.00	XXX	9		43.20	
89335		Cryopreservation, reproductive tissue, testicular	0.00	BR		XXX	9	77.99	BR	73.21
89342		Storage (per year); embryo(s)	0.00	BR		XXX	9	77.99	BR	73.21
89343		Storage (per year); sperm/semen	0.00	BR		XXX	9	77.99	BR	73.21
89344		Storage (per year); reproductive tissue, testicular/ovarian	0.00	BR		XXX	9	77.99	BR	73.21
89346		Storage (per year); oocyte(s)	0.00	BR		XXX	9	77.99	BR	73.21
89352		Thawing of cryopreserved; embryo(s)	0.00	BR		XXX	9	77.99	BR	73.21
89353		Thawing of cryopreserved; sperm/semen, each aliquot	0.00	BR		XXX	9	77.99	BR	73.21
89354		Thawing of cryopreserved; reproductive tissue, testicular/ovarian	0.00	BR		XXX	9	77.99	BR	73.21
89356		Thawing of cryopreserved; oocytes, each aliquot	0.00	BR		XXX	9	77.99	BR	73.21
89398		Unlisted reproductive medicine laboratory procedure	0.00	BR		XXX	9	16.39	BR	14.10
90281		Immune globulin (Ig), human, for intramuscular use	0.00	BR		XXX	9		BR	2097.37**
90283		Immune globulin (IgIV), human, for intravenous use	0.00	BR		XXX	9		BR	2097.37**
90284		Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	0.00	BR		XXX	9		BR	2097.37**
90287		Botulinum antitoxin, equine, any route	0.00	BR		XXX	9		BR	2097.37**
90288		Botulism immune globulin, human, for intravenous use	0.00	BR		XXX	9		BR	2097.37**
90291		Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	0.00	BR		XXX	9		BR	2097.37**
90296		Diphtheria antitoxin, equine, any route	0.00	BR		XXX	9		BR	2097.37**
90371		Hepatitis B immune globulin (HBIg), human, for intramuscular use	3.30	194.70		XXX	9		105.55	
90375		Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use	6.07	358.13		XXX	9		120.36	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90376		Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use	5.96	351.64		XXX	9		127.79	
90378		Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, eacl	0.00	BR		XXX	9		BR	
90384		Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	3.54	208.86		XXX	9		86.26	2097.37**
90385		Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	0.72	42.48		XXX	9		26.96	
90386		Rho(D) immune globulin (RhIgIV), human, for intravenous use	3.80	224.20		XXX	9		100.83	2097.37**
90389		Tetanus immune globulin (TIg), human, for intramuscular use	3.29	194.11		XXX	9		93.40	2097.37**
90393		Vaccinia immune globulin, human, for intramuscular use	0.00	BR		XXX	9		BR	2097.37**
90396		Varicella-zoster immune globulin, human, for intramuscular use	3.64	214.76		XXX	9		112.69	
90399		Unlisted immune globulin	0.00	BR		XXX	9		BR	2097.37**
90460		Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	0.76	44.84		XXX	0		New	
90461		Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code fo	0.37	21.83		ZZZ	0		New	
90471		Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	0.76	44.84		XXX	0	50.48	30.09	34.73
90472		Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	0.37	21.83		ZZZ	0	34.85	15.93	34.73
90473		Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	0.76	44.84		XXX	0	34.85	20.06	34.73
90474		Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	0.37	21.83		ZZZ	0	34.85	13.57	34.73
90476		Adenovirus vaccine, type 4, live, for oral use	0.00	BR		XXX	9		BR	
90477		Adenovirus vaccine, type 7, live, for oral use	0.00	BR		XXX	9		BR	2097.37**
90581		Anthrax vaccine, for subcutaneous or intramuscular use	4.21	248.39		XXX	9		98.71	2097.37**
90585		Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use	3.45	203.55		XXX	9		125.14	
90586		Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	3.45	203.55		XXX	9		136.41	
90632		Hepatitis A vaccine, adult dosage, for intramuscular use	1.48	87.32		XXX	9		52.16	
90633		Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use	1.01	59.59		XXX	9		25.78	
90634		Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use	1.06	62.54		XXX	9		25.78	
90636		Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	2.78	164.02		XXX	9		68.79	
90644		Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	0.81	47.79		XXX	9		0.00	2097.37**
90645		Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use	0.81	47.79		XXX	9		20.18	
90646		Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use	0.81	47.79		XXX	9		0.00	
90647		Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	0.86	50.74		XXX	9		20.77	
90648		Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use	0.81	47.79		XXX	9		20.18	
90649		Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use	3.85	227.15		XXX	9		0.00	
90650		Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use	0.00	BR		XXX	9		BR	
90653		Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use	0.00	BR		XXX	9		New	
90654		Influenza virus vaccine, split virus, preservative-free, for intradermal use	0.56	33.04		XXX	9		New	
90655		Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	0.48	28.32		XXX	9		0.00	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90656		Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use	0.36	21.24		XXX	9		0.00	
90657		Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use	0.18	10.62		XXX	9		10.97	
90658		Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use	0.47	27.73		XXX	9		10.97	
90660		Influenza virus vaccine, trivalent, live, for intranasal use	0.69	40.71		XXX	9		0.00	
90661		Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	0.00	BR		XXX	9		BR	2097.37**
90662		Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	0.91	53.69		XXX	9		0.00	2097.37**
90664		Influenza virus vaccine, pandemic formulation, live, for intranasal use	0.00	BR		XXX	9		New	
90666		Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	0.00	BR		XXX	9		New	
90667		Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	0.00	BR		XXX	9		New	
90668		Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	0.00	BR		XXX	9		New	
90669		Pneumococcal conjugate vaccine, 7 valent, for intramuscular use	2.81	165.79		XXX	9		61.36	
90670		Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	4.29	253.11		XXX	9		0.00	2097.37**
90672		Influenza virus vaccine, quadrivalent, live, for intranasal use	0.00	BR		XXX	9		New	
90675		Rabies vaccine, for intramuscular use	6.52	384.68		XXX	9		135.17	
90676		Rabies vaccine, for intradermal use	0.00	BR		XXX	9		BR	
90680		Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	2.28	134.52		XXX	9		57.82	
90681		Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	2.28	134.52		XXX	9		86.14	
90685		Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	0.00	BR		XXX	9		New	
90686		Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use	0.00	BR		XXX	9		New	
90687		Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use	0.00	BR		XXX	9		New	
90688		Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use	0.00	BR		XXX	9		New	
90690		Typhoid vaccine, live, oral	1.16	68.44		XXX	9		28.73	
90691		Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	1.79	105.61		XXX	9		38.82	
90692		Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use	0.00	BR		XXX	9		BR	
90693		Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (U.S. military)	0.00	BR		XXX	9		BR	
90696		Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	0.00	BR		XXX	9		BR	
90698		Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use	2.28	134.52		XXX	9		64.02	
90700		Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use	0.76	44.84		XXX	9		19.00	
90702		Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use	0.62	36.58		XXX	9		14.51	
90703		Tetanus toxoid adsorbed, for intramuscular use	1.07	63.13		XXX	9		16.28	
90704		Mumps virus vaccine, live, for subcutaneous use	0.78	46.02		XXX	9		17.17	
90705		Measles virus vaccine, live, for subcutaneous use	0.81	47.79		XXX	9		13.33	
90706		Rubella virus vaccine, live, for subcutaneous use	0.81	47.79		XXX	9		14.81	
90707		Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	1.52	89.68		XXX	9		38.82	
90708		Measles and rubella virus vaccine, live, for subcutaneous use	0.00	BR		XXX	9		BR	
90710		Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	4.05	238.95		XXX	9		106.73	
90712		Poliovirus vaccine, (any type[s]) (OPV), live, for oral use	0.00	BR		XXX	9		BR	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90713		Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	0.86	50.74		XXX	9		21.95	
90714		Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	0.60	35.40		XXX	9		0.00	
90715		Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	1.02	60.18		XXX	9		0.00	
90716		Varicella virus vaccine, live, for subcutaneous use	2.23	131.57		XXX	9		59.30	
90717		Yellow fever vaccine, live, for subcutaneous use	2.21	130.39		XXX	9		60.48	
90719		Diphtheria toxoid, for intramuscular use	0.00	BR		XXX	9		BR	
90720		Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	0.00	BR		XXX	9		BR	
90721		Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use	0.00	BR		XXX	9		BR	
90723		Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use	2.23	131.57		XXX	9		0.00	2097.37**
90725		Cholera vaccine for injectable use	0.00	BR		XXX	9		BR	
90727		Plague vaccine, for intramuscular use	0.00	BR		XXX	9		BR	2097.37**
90732		Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	2.13	125.67		XXX	9		22.24	
90733		Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use	3.13	184.67		XXX	9		75.87	
90734		Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	2.88	169.92		XXX	9		72.92	
90735		Japanese encephalitis virus vaccine, for subcutaneous use	3.00	177.00		XXX	9		80.65	
90736		Zoster (shingles) vaccine, live, for subcutaneous injection	4.86	286.74		XXX	9		0.00	
90738		Japanese encephalitis virus vaccine, inactivated, for intramuscular use	2.01	118.59		XXX	9		50.74	
90739		Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	0.00	BR		XXX	9		New	
90740		Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	3.51	207.09		XXX	9		153.58	
90743		Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	0.71	41.89		XXX	9		24.60	
90744		Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	0.71	41.89		XXX	9		24.60	
90746		Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use	1.75	103.25		XXX	9		48.03	
90747		Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	3.51	207.09		XXX	9		153.58	
90748		Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	1.70	100.30		XXX	9		39.71	2097.37**
90749		Unlisted vaccine/toxoid	0.00	BR		XXX	9		BR	
90785		Interactive complexity (List separately in addition to the code for primary procedure	0.14	8.26		ZZZ	9		New	
90791		Psychiatric diagnostic evaluation	4.43	261.37		XXX	9	142.12	New	
90792		Psychiatric diagnostic evaluation with medical services	3.65	215.35		XXX	9	142.12	New	
90832		Psychotherapy, 30 minutes with patient and/or family membe	1.84	108.56		XXX	9	106.89	New	
90833		Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	1.22	71.98		ZZZ	9		New	
90834		Psychotherapy, 45 minutes with patient and/or family membe	2.37	139.83		XXX	9	142.12	New	
90836		Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	1.98	116.82		ZZZ	9		New	
90837		Psychotherapy, 60 minutes with patient and/or family membe	3.47	204.73		XXX	9	142.12	New	
90838		Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	3.20	188.80		ZZZ	9		New	
90839		Psychotherapy for crisis; first 60 minutes	0.00	BR		XXX	0	142.12	New	
90840		Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	0.00	BR		XXX	0		New	
90845		Psychoanalysis	2.21	130.39		XXX	0	142.12	128.62	152.20

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90846		Family psychotherapy (without the patient present	2.17	128.03		XXX	0	165.41	136.29	201.56
90847		Family psychotherapy (conjoint psychotherapy) (with patient present	2.60	153.40		XXX	0	165.41	167.56	201.56
90849		Multiple-family group psychotherapy	1.00	59.00		XXX	0	78.26	48.97	81.20
90853		Group psychotherapy (other than of a multiple-family group)	0.72	42.48		XXX	0	78.26	47.20	81.20
90863		Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)	0.00	138.09		XXX	9		New	
90865		Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)	4.94	291.46		XXX	0	142.12	235.41	152.20
90867		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	0.00	BR		000	1	237.41	New	
90868		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	0.00	BR		000	1	237.41	New	
90869		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	0.00	876.07		000	1	237.41	New	
90870		Electroconvulsive therapy (includes necessary monitoring)	5.26	310.34		000	0	565.90	215.94	534.56
90875		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	2.12	125.08		XXX	9		113.87	2097.37**
90876		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	3.12	184.08		XXX	9		165.20	2097.37**
90880		Hypnotherapy	2.82	166.38		XXX	0	142.12	173.46	152.20
90882		Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	2.36	139.24		XXX	9		93.69	2097.37**
90885		Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	1.43	84.37		XXX	9		71.98	
90887		Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	2.57	151.63		XXX	9		126.26	
90889		Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	2.00	118.00		XXX	9		80.65	
90899		Unlisted psychiatric service or procedure	0.00	BR		XXX	0	106.89	BR	109.05
90901		Biofeedback training by any modality	1.17	69.03		000	0		59.00	
90911		Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	2.50	147.50		000	0	105.77	139.83	99.93
90935		Hemodialysis procedure with single evaluation by a physician or other qualified health care professional	2.09	123.31		000	0	640.29	105.02	622.03
90937		Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.99	176.41		000	0		171.10	
90940		Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method	1.69	99.71	39.53	XXX	9		65.25	
90945		Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	2.49	146.91		000	0	226.78	109.15	226.63
90947		Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluation by a physician or other qualified health care professional, with or without substantial rev	3.58	211.22		000	0		174.05	
90951		End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a	26.87	1585.33		XXX	0		1611.29	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90952		End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physi	21.12	1246.08		XXX	0		771.72	
90953		End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physicia	14.07	830.13		XXX	0		514.48	
90954		End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician	23.37	1378.83		XXX	0		1327.50	
90955		End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or ot	13.19	778.21		XXX	0		747.53	
90956		End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other	9.18	541.62		XXX	0		503.86	
90957		End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physicia	18.62	1098.58		XXX	0		1066.13	
90958		End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or o	12.66	746.94		XXX	0		716.26	
90959		End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or othe	8.59	506.81		XXX	0		467.28	
90960		End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	8.28	488.52		XXX	0		471.41	
90961		End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	6.98	411.82		XXX	0		379.37	
90962		End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	5.41	319.19		XXX	0		273.17	
90963		End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	15.79	931.61		XXX	0		901.52	
90964		End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	13.77	812.43		XXX	0		758.74	
90965		End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	13.09	772.31		XXX	0		723.34	
90966		End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	6.97	411.23		XXX	0		377.60	
90967		End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	0.51	30.09		XXX	0		33.04	
90968		End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age	0.44	25.96		XXX	0		25.96	
90969		End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	0.43	25.37		XXX	0		24.78	
90970		End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.23	13.57		XXX	0		12.98	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
90989		Dialysis training, patient, including helper where applicable, any mode, completed course	10.56	623.04		XXX	9		444.74	
90993		Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session	2.29	135.11		XXX	9		77.11	
90997		Hemoperfusion (eg, with activated charcoal or resin)	2.60	153.40		000	0		137.47	
90999		Unlisted dialysis procedure, inpatient or outpatient	0.00	BR		XXX	0		BR	
91010		Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;	5.52	325.68	118.00	000	0	390.38	322.14	372.41
91013		Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedu	0.74	43.66	16.52	ZZZ	0	390.38	New	
91020		Gastric motility (manometric) studies	7.42	437.78	133.34	000	0	390.38	354.59	372.41
91022		Duodenal motility (manometric) study	5.34	315.06	132.75	000	0	390.38	325.09	372.41
91030		Esophagus, acid perfusion (Bernstein) test for esophagitis	4.37	257.83	84.37	000	0	390.38	202.37	372.41
91034		Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	5.93	349.87	87.91	000	0	390.38	351.05	372.41
91035		Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	15.45	911.55	145.14	000	0	390.38	735.73	372.41
91037		Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	5.07	299.13	90.27	000	0	177.09	237.77	372.41
91038		Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	14.50	855.50	100.89	000	0	390.38	204.73	372.41
91040		Esophageal balloon distension provocation study	9.01	531.59	79.65	000	0	177.09	687.94	138.64
91065		Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	2.95	174.05	18.29	000	0	177.09	96.17	138.64
91110		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	28.52	1682.68	336.30	XXX	0	968.45	1486.80	898.25
91111		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	23.83	1405.97	92.04	XXX	0	1195.63	1156.40	797.57
91112		Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	34.89	2058.51	194.11	XXX	0	390.38	New	
91117		Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	4.72	278.48		000	0	299.71	New	
91120		Rectal sensation, tone, and compliance test (ie, response to graded balloon distention	12.57	741.63	87.32	XXX	0	105.77	676.73	99.93
91122		Anorectal manometry	6.72	396.48	153.40	000	0	299.71	387.04	275.52
91132		Electrogastrography, diagnostic, transcutaneous	4.97	293.23	48.38	XXX	0	177.09	35.58	138.64
91133		Electrogastrography, diagnostic, transcutaneous; with provocative testing	5.73	338.07	61.95	XXX	0	177.09	41.54	138.64
91299		Unlisted diagnostic gastroenterology procedure	0.00	BR	BR	XXX	0	177.09	BR	138.64
92002		Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	2.44	143.96		XXX	0	125.08	105.02	120.57
92004		Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	4.45	262.55		XXX	0	125.08	189.39	120.57
92012		Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	2.57	151.63		XXX	0	95.05	96.17	78.36
92014		Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	3.71	218.89		XXX	0	95.05	142.19	94.26
92015		Determination of refractive state	0.58	34.22		XXX	9		87.91	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92018		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	4.22	248.98		XXX	0	1459.88	198.24	1417.16
92019		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; limited	2.05	120.95		XXX	0	1459.88	102.66	1417.16
92020		Gonioscopy (separate procedure)	0.81	47.79		XXX	0	62.45	38.94	54.21
92025		Computerized corneal topography, unilateral or bilateral, with interpretation and repor	1.13	66.67	34.22	XXX	0	62.45	45.43	87.11
92060		Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	1.96	115.64	66.67	XXX	0	62.45	82.60	87.11
92065		Orthoptic and/or pleoptic training, with continuing medical direction and evaluatior	1.63	96.17	30.68	XXX	0	62.45	57.23	87.11
92071		Fitting of contact lens for treatment of ocular surface disease	1.00	59.00		XXX	0		New	
92072		Fitting of contact lens for management of keratoconus, initial fitting	3.76	221.84		XXX	0		New	
92081		Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	1.03	60.77	28.91	XXX	0	62.45	76.11	54.21
92082		Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic	1.48	87.32	38.94	XXX	0	62.45	99.12	87.11
92083		Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshol	1.96	115.64	48.97	XXX	0	95.55	113.87	87.11
92100		Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation o intraocular pressure)	2.41	142.19		XXX	0		128.62	
92132		Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	1.07	63.13	34.22	XXX	0	62.45	New	
92133		Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	1.33	78.47	48.97	XXX	0	62.45	New	
92134		Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	1.36	80.24	50.15	XXX	0	62.45	New	
92136		Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculatior	2.74	161.66	53.69	XXX	0	95.55	128.03	87.11
92140		Provocative tests for glaucoma, with interpretation and report, without tonography	1.91	112.69		XXX	0	62.45	84.37	54.21
92225		Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	0.81	47.79		XXX	0	62.45	34.22	54.21
92226		Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent	0.73	43.07		XXX	0	62.45	31.27	87.11
92227		Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	0.41	24.19		XXX	0	30.23	New	
92228		Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	1.06	62.54	37.17	XXX	0	30.23	New	
92230		Fluorescein angioscopy with interpretation and repor	1.76	103.84		XXX	0	95.55	111.51	178.50
92235		Fluorescein angiography (includes multiframe imaging) with interpretation and repor	3.33	196.47	81.42	XXX	0	186.92	197.65	178.50
92240		Indocyanine-green angiography (includes multiframe imaging) with interpretation and repor	7.82	461.38	110.33	XXX	0	186.92	400.02	178.50
92250		Fundus photography with interpretation and repor	2.39	141.01	40.71	XXX	0	62.45	112.10	87.11
92260		Ophthalmodynamometry	0.57	33.63		XXX	0	62.45	25.96	54.21
92265		Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	2.39	141.01	73.75	XXX	0	62.45	127.44	87.11
92270		Electro-oculography with interpretation and repor	2.76	162.84	70.80	XXX	0	62.45	134.52	54.21
92275		Electroretinography with interpretation and repor	4.86	286.74	101.48	XXX	0	186.92	179.36	178.50

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92283		Color vision examination, extended, eg, anomaloscope or equivalen	1.69	99.71	15.93	XXX	0	62.45	62.54	54.21
92284		Dark adaptation examination with interpretation and repor	1.88	110.92	21.24	XXX	0	62.45	115.64	87.11
92285		External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	0.63	37.17	5.31	XXX	0	62.45	67.85	87.11
92286		Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	1.14	67.26	37.76	XXX	0	95.55	204.14	178.50
92287		Anterior segment imaging with interpretation and report; with fluorescein angiography	4.21	248.39	81.42	XXX	0	95.55	178.77	178.50
92310		Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	2.83	166.97		XXX	9		129.21	2097.37**
92311		Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, 1 eye	3.10	182.90		XXX	0	95.55	126.26	87.11
92312		Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	3.48	205.32		XXX	0	62.45	138.65	87.11
92313		Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	3.06	180.54		XXX	0	95.55	119.18	54.21
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	2.37	139.83		XXX	9		95.58	2097.37**
92315		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, 1 eye	2.49	146.91		XXX	0	95.55	81.42	54.21
92316		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	3.29	194.11		XXX	0	95.55	102.07	87.11
92317		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	2.31	136.29		XXX	0	62.45	87.32	54.21
92325		Modification of contact lens (separate procedure), with medical supervision of adaptatior	1.27	74.93		XXX	0	95.55	30.68	54.21
92326		Replacement of contact lens	1.08	63.72		XXX	0	62.45	86.73	87.11
92340		Fitting of spectacles, except for aphakia; monofocal	1.06	62.54		XXX	9		57.82	2097.37**
92341		Fitting of spectacles, except for aphakia; bifocal	1.20	70.80		XXX	9		64.90	2097.37**
92342		Fitting of spectacles, except for aphakia; multifocal, other than bifoca	1.29	76.11		XXX	9		69.62	2097.37**
92352		Fitting of spectacle prosthesis for aphakia; monofocal	1.21	71.39		XXX	9	95.55	58.41	87.11
92353		Fitting of spectacle prosthesis for aphakia; multifocal	1.40	82.60		XXX	9	95.55	69.03	54.21
92354		Fitting of spectacle mounted low vision aid; single element system	0.42	24.78		XXX	9	62.45	402.38	54.21
92355		Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	0.65	38.35		XXX	9	62.45	198.83	54.21
92358		Prosthesis service for aphakia, temporary (disposable or loan, including materials)	0.35	20.65		XXX	9	62.45	49.56	54.21
92370		Repair and refitting spectacles; except for aphakia	0.92	54.28		XXX	9		48.38	2097.37**
92371		Repair and refitting spectacles; spectacle prosthesis for aphakia	0.36	21.24		XXX	9	95.55	32.45	54.21
92499		Unlisted ophthalmological service or procedure	0.00	BR	BR	XXX	0	62.45	BR	54.21
92502		Otolaryngologic examination under general anesthesia	2.86	168.74		000	0	296.47	143.96	312.33
92504		Binocular microscopy (separate diagnostic procedure)	0.93	54.87		XXX	0		40.12	
92506		Evaluation of speech, language, voice, communication, and/or auditory processing	6.39	377.01		XXX	0		210.04	
92507		Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	2.09	123.31		XXX	0		95.58	
92508		Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	0.61	35.99		XXX	0		44.25	
92511		Nasopharyngoscopy with endoscope (separate procedure	4.23	249.57		000	0	99.72	236.00	73.02
92512		Nasal function studies (eg, rhinomanometry)	1.85	109.15		XXX	0	84.24	94.40	82.63
92516		Facial nerve function studies (eg, electroneuronography)	2.13	125.67		XXX	0	84.24	93.81	136.96
92520		Laryngeal function studies (ie, aerodynamic testing and acoustic testing	2.21	130.39		XXX	0	170.37	76.70	136.96
92526		Treatment of swallowing dysfunction and/or oral function for feeding	2.27	133.93		XXX	0		127.44	
92531		Spontaneous nystagmus, including gaze	0.49	28.91		XXX	9		35.58	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92532		Positional nystagmus test	0.55	32.45		XXX	9		32.04	
92533		Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)	0.79	46.61		XXX	9		50.98	
92534		Optokinetic nystagmus test	0.60	35.40		XXX	9		27.26	
92540		Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral sti	2.96	174.64	135.11	XXX	0	170.37	155.17	136.96
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recordin	0.89	52.51	35.40	XXX	0	84.24	85.55	82.63
92542		Positional nystagmus test, minimum of 4 positions, with recordinç	0.79	46.61	29.50	XXX	0	84.24	87.91	82.63
92543		Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording	0.48	28.32	9.44	XXX	0	170.37	41.30	136.96
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recordinç	0.69	40.71	23.60	XXX	0	84.24	70.21	82.63
92545		Oscillating tracking test, with recording	0.62	36.58	20.65	XXX	0	84.24	64.31	82.63
92546		Sinusoidal vertical axis rotational testing	3.14	185.26	25.37	XXX	0	170.37	131.57	136.96
92547		Use of vertical electrodes (List separately in addition to code for primary procedure)	0.19	11.21	2.36	ZZZ	0		8.85	
92548		Computerized dynamic posturography	3.14	185.26	43.66	XXX	0	170.37	159.30	136.96
92550		Tympanometry and reflex threshold measurements	0.61	35.99		XXX	0	46.29	33.63	42.86
92551		Screening test, pure tone, air only	0.37	21.83		XXX	9		15.34	2097.37**
92552		Pure tone audiometry (threshold); air only	0.95	56.05		XXX	0	46.29	30.09	42.86
92553		Pure tone audiometry (threshold); air and bone	1.15	67.85		XXX	0	114.30	43.07	115.58
92555		Speech audiometry threshold;	0.72	42.48		XXX	0	46.29	24.78	42.86
92556		Speech audiometry threshold; with speech recognitior	1.13	66.67		XXX	0	46.29	36.58	42.86
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	1.10	64.90		XXX	0	114.30	78.47	115.58
92558		Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	0.29	17.11	0.00	XXX	9		New	
92559		Audiometric testing of groups	0.85	50.15		XXX	9		35.58	2097.37**
92560		Bekesy audiometry; screening	0.60	35.40		XXX	9		21.36	2097.37**
92561		Bekesy audiometry; diagnostic	1.16	68.44		XXX	0	114.30	45.43	42.86
92562		Loudness balance test, alternate binaural or monaura	1.44	84.96		XXX	0	46.29	30.68	42.86
92563		Tone decay test	0.97	57.23		XXX	0	46.29	26.55	42.86
92564		Short increment sensitivity index (SISI)	0.88	51.92		XXX	0	46.29	30.09	42.86
92565		Stenger test, pure tone	0.52	30.68		XXX	0	46.29	23.60	42.86
92567		Tympanometry (impedance testing)	0.42	24.78		XXX	0	46.29	33.63	42.86
92568		Acoustic reflex testing, threshold	0.45	26.55		XXX	0	46.29	21.24	42.86
92570		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	0.94	55.46		XXX	0	114.30	51.33	42.86
92571		Filtered speech test	0.84	49.56		XXX	0	46.29	25.37	42.86
92572		Staggered spondaic word test	1.62	95.58		XXX	0	150.89	13.57	148.12
92575		Sensorineural acuity level test	2.33	137.47		XXX	0	46.29	30.68	42.86
92576		Synthetic sentence identification test	1.05	61.95		XXX	0	46.29	30.68	42.86
92577		Stenger test, speech	0.57	33.63		XXX	0	150.89	39.53	148.12
92579		Visual reinforcement audiometry (VRA)	1.22	71.98		XXX	0	114.30	48.38	115.58
92582		Conditioning play audiometry	2.21	130.39		XXX	0	114.30	51.92	115.58
92583		Select picture audiometry	1.59	93.81		XXX	0	46.29	54.28	42.86
92584		Electrocochleography	2.15	126.85		XXX	0	237.41	138.65	244.67
92585		Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	3.85	227.15	44.84	XXX	0	237.41	155.76	244.67
92586		Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	2.63	155.17		XXX	0	102.99	110.92	109.11

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92587		Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	0.64	37.76	32.45	XXX	0	84.24	84.37	82.63
92588		Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	0.97	57.23	50.15	XXX	0	84.24	114.46	82.63
92590		Hearing aid examination and selection; monaura	1.58	93.22		XXX	9		65.25	2097.37**
92591		Hearing aid examination and selection; binaura	2.01	118.59		XXX	9		83.01	2097.37**
92592		Hearing aid check; monaural	0.63	37.17		XXX	9		26.08	2097.37**
92593		Hearing aid check; binaural	1.05	61.95		XXX	9		42.72	2097.37**
92594		Electroacoustic evaluation for hearing aid; monaura	0.60	35.40		XXX	9		24.90	2097.37**
92595		Electroacoustic evaluation for hearing aid; binaura	1.30	76.70		XXX	9		53.40	2097.37**
92596		Ear protector attenuation measurements	1.33	78.47		XXX	0	46.29	43.66	42.86
92597		Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	2.04	120.36		XXX	0		146.91	
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	3.90	230.10		XXX	0	150.89	230.69	148.12
92602		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	2.64	155.76		XXX	0	150.89	158.71	148.12
92603		Diagnostic analysis of cochlear implant, age 7 years or older; with programming	4.32	254.88		XXX	0	150.89	145.73	148.12
92604		Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	2.60	153.40		XXX	0	150.89	94.99	148.12
92605		Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	2.67	157.53		XXX	9		0.00	
92606		Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	2.40	141.60		XXX	9		0.00	
92607		Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	3.51	207.09		XXX	0		202.37	
92608		Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	1.41	83.19		ZZZ	0		40.12	
92609		Therapeutic services for the use of speech-generating device, including programming and modification	2.89	170.51		XXX	0		106.79	
92610		Evaluation of oral and pharyngeal swallowing function	2.29	135.11		XXX	0		180.54	
92611		Motion fluoroscopic evaluation of swallowing function by cine or video recording	2.57	151.63		XXX	0		184.08	
92612		Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording	5.29	312.11		XXX	0		231.28	
92613		Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; interpretation and report only	1.12	66.08		XXX	0		61.95	
92614		Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording	4.55	268.45		XXX	0		213.58	
92615		Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only	0.98	57.82		XXX	0		54.87	2097.37**
92616		Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	6.24	368.16		XXX	0		296.18	
92617		Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording interpretation and report only	1.22	71.98		XXX	0		67.85	2097.37**
92618		Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	0.96	56.64		ZZZ	9		New	
92620		Evaluation of central auditory function, with report; initial 60 minutes	2.72	160.48		XXX	0	114.30	81.42	115.58
92621		Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	0.65	38.35		ZZZ	0		20.65	
92625		Assessment of tinnitus (includes pitch, loudness matching, and masking)	2.02	119.18		XXX	0	114.30	80.24	115.58
92626		Evaluation of auditory rehabilitation status; first hour	2.63	155.17		XXX	0	150.89	128.03	148.12

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92627		Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)	0.63	37.17		ZZZ	0		31.86	
92630		Auditory rehabilitation; prelingual hearing loss	0.00	BR		XXX	9		BR	2097.37**
92633		Auditory rehabilitation; postlingual hearing loss	0.00	BR		XXX	9		BR	2097.37**
92640		Diagnostic analysis with programming of auditory brainstem implant, per hou	3.62	213.58		XXX	0	114.30	83.19	115.58
92700		Unlisted otorhinolaryngological service or procedure	0.00	BR		XXX	0	46.29	BR	42.86
92920		Percutaneous transluminal coronary angioplasty; single major coronary artery or brancl	15.99	943.41		000	0	5190.09	New	
92921		Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	0.00	552.19		ZZZ	9	5190.09	New	
92924		Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	19.01	1121.59		000	0	9896.50	New	
92925		Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	0.00	702.74		ZZZ	9	9896.50	New	
92928		Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	17.76	1047.84		000	0	7883.00	New	
92929		Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	0.00	624.02		ZZZ	9	7883.00	New	
92933		Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	19.86	1171.74		000	0	7883.00	New	
92934		Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	0.00	773.01		ZZZ	9	7883.00	New	
92937		Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vesse	17.74	1046.66		000	0	7883.00	New	
92938		Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additio	0.00	843.29		ZZZ	9	7883.00	New	
92941		Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration th	19.90	1174.10		000	0	7883.00	New	
92943		Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	19.90	1174.10		000	0	7883.00	New	
92944		Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronar	0.00	843.29		ZZZ	9	7883.00	New	
92950		Cardiopulmonary resuscitation (eg, in cardiac arrest)	9.05	533.95		000	0	207.48	451.35	223.90
92953		Temporary transcutaneous pacing	0.31	18.29		000	0	207.48	17.70	223.90
92960		Cardioversion, elective, electrical conversion of arrhythmia; externa	6.04	356.36		000	0	515.63	467.28	501.97
92961		Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)	7.03	414.77		000	9	515.63	389.99	501.97
92970		Cardioassist-method of circulatory assist; internal	5.14	303.26		000	0		266.68	2097.37**
92971		Cardioassist-method of circulatory assist; external	2.69	158.71		000	0		151.04	2097.37**
92973		Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	5.19	306.21		ZZZ	0	3999.56	271.40	3729.70
92974		Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)	4.74	279.66		ZZZ	0	1491.99	248.98	1627.16
92975		Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiograph	11.47	676.73		000	0		595.90	2097.37**

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
92977		Thrombolysis, coronary; by intravenous infusior	1.67	98.53		XXX	0	222.75	408.28	218.44
92978		Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	7.37	434.83	152.22	ZZZ	0		830.13	
92979		Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	4.50	265.50	122.13	ZZZ	0		443.50	
92986		Percutaneous balloon valvuloplasty; aortic valve	39.33	2320.47		090	0	5190.09	2051.43	4621.59
92987		Percutaneous balloon valvuloplasty; mitral valve	40.70	2401.30		090	0	5190.09	2121.05	4621.59
92990		Percutaneous balloon valvuloplasty; pulmonary valve	31.92	1883.28		090	0	5190.09	1632.53	4621.59
92992		Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)	31.67	1868.53		090	2		2761.97	2097.37**
92993		Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)	25.05	1477.95		090	2		2184.42	2097.37**
92997		Percutaneous transluminal pulmonary artery balloon angioplasty; single vesse	19.14	1129.26		000	0	5190.09	949.90	4621.59
92998		Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	9.47	558.73		ZZZ	0	5190.09	473.18	4621.59
93000		Electrocardiogram, routine ECG with at least 12 leads; with interpretation and repor	0.54	31.86		XXX	0		38.35	
93005		Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and repor	0.30	17.70	0.00	XXX	0	34.41	25.37	35.93
93010		Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	0.24	14.16		XXX	0		12.98	
93015		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	2.34	138.06		XXX	0		162.84	
93016		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	0.63	37.17		XXX	0		35.99	
93017		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	1.29	76.11	0.00	XXX	0	228.11	103.25	238.33
93018		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	0.42	24.78		XXX	0		23.60	
93024		Ergonovine provocation test	3.31	195.29	96.76	XXX	0	228.11	174.64	238.33
93025		Microvolt T-wave alternans for assessment of ventricular arrhythmias	5.03	296.77	63.13	XXX	0	228.11	441.32	238.33
93040		Rhythm ECG, 1-3 leads; with interpretation and repor	0.39	23.01		XXX	0		21.24	
93041		Rhythm ECG, 1-3 leads; tracing only without interpretation and repor	0.18	10.62	0.00	XXX	0	30.23	9.44	21.16
93042		Rhythm ECG, 1-3 leads; interpretation and report only	0.21	12.39		XXX	0		11.80	
93224		External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	2.76	162.84		XXX	0		236.00	
93225		External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)	0.83	48.97	0.00	XXX	0	85.82	75.52	89.80
93226		External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report	1.17	69.03	0.00	XXX	0	85.82	119.18	89.80
93227		External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional	0.76	44.84		XXX	0		41.30	
93228		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	0.74	43.66		XXX	0		43.07	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93229		External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events	21.63	1276.17		XXX	0	222.68	0.00	1042.44
93268		External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpr	6.50	383.50		XXX	0		458.43	
93270		External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording	0.28	16.52	0.00	XXX	0	85.82	63.72	89.80
93271		External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	5.51	325.09	0.00	XXX	0	143.81	354.00	145.90
93272		External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician	0.71	41.89		XXX	0		40.71	
93278		Signal-averaged electrocardiography (SAECG), with or without ECG	0.91	53.69	21.24	XXX	0	30.23	84.37	21.16
93279		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	1.46	86.14	54.87	XXX	0	43.80	87.32	31.97
93280		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	1.68	99.12	64.31	XXX	0	43.80	103.25	31.97
93281		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	1.96	115.64	74.93	XXX	0	43.80	120.36	31.97
93282		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	1.82	107.38	71.39	XXX	0	43.80	110.33	51.80
93283		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	2.34	138.06	96.17	XXX	0	43.80	141.60	51.80
93284		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	2.58	152.22	104.43	XXX	0	43.80	159.30	51.80
93285		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care	1.20	70.80	43.07	XXX	0	43.80	73.75	31.97
93286		Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple	0.78	46.02	25.37	XXX	0		43.66	
93287		Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple	1.02	60.18	37.17	XXX	0		57.82	
93288		Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker syste	1.08	63.72	35.40	XXX	0	43.80	66.08	31.97
93289		Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable car	1.89	111.51	76.70	XXX	0	43.80	112.69	51.80

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93290		Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, inc	0.89	52.51	35.40	XXX	0	30.23	50.74	31.97
93291		Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including he	1.04	61.36	35.40	XXX	0	43.80	63.72	31.97
93292		Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	0.94	55.46	35.40	XXX	0	43.80	57.23	51.80
93293		Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up	1.56	92.04	25.96	XXX	0	43.80	89.68	51.80
93294		Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	0.96	56.64		XXX	0		58.41	
93295		Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	1.89	111.51		XXX	0		114.46	
93296		Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and	0.77	45.43		XXX	0	43.80	56.05	51.80
93297		Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report	0.75	44.25		XXX	0		43.07	
93298		Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	0.75	44.25		XXX	0		47.79	
93299		Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of re	0.00	BR		XXX	0	43.80	BR	51.80
93303		Transthoracic echocardiography for congenital cardiac anomalies; complete	5.81	342.79	107.97	XXX	0	720.72	345.15	806.35
93304		Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	3.86	227.74	62.54	XXX	0	503.76	193.52	610.09
93306		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	5.57	328.63	107.38	XXX	0	503.76	390.58	610.09
93307		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	3.36	198.24	76.70	XXX	0	503.76	306.21	357.67
93308		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	2.95	174.05	43.07	XXX	0	274.34	170.51	357.67
93312		Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	8.99	530.41	177.00	XXX	0	720.72	451.94	806.35
93313		Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	1.21	71.39		XXX	0	503.76	64.90	610.09
93314		Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	8.38	494.42	101.48	XXX	0		379.96	
93315		Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	7.98	470.82	235.41	XXX	0	503.76	498.08	806.35
93316		Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	1.23	72.57		XXX	0	720.72	67.85	806.35

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93317		Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	5.38	317.42	158.71	XXX	0		343.91	
93318		Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to t	6.44	379.96	189.98	XXX	0	720.72	379.49	806.35
93320		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	1.32	77.88	31.27	ZZZ	0		135.11	
93321		Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	0.70	41.30	12.39	ZZZ	0		74.34	
93325		Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	0.59	34.81	6.49	ZZZ	0		155.76	
93350		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	5.89	347.51	120.95	XXX	0	503.76	267.86	610.09
93351		Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	6.89	406.51	144.55	XXX	9	720.72	397.07	806.35
93352		Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	1.02	60.18		ZZZ	0		59.00	
93451		Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	24.06	1419.54	254.29	000	0	3418.11	New	
93452		Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	26.64	1571.76	445.45	000	0	3418.11	New	
93453		Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	34.74	2049.66	584.69	000	0	3418.11	New	
93454		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	27.28	1609.52	448.40	000	0	3418.11	New	
93455		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, ven	31.70	1870.30	517.43	000	0	3418.11	New	
93456		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	34.19	2017.21	574.07	000	0	3418.11	New	
93457		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, ven	38.59	2276.81	643.69	000	0	3418.11	New	
93458		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	32.67	1927.53	547.52	000	0	3418.11	New	
93459		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	36.07	2128.13	615.96	000	0	3418.11	New	
93460		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	38.65	2280.35	686.17	000	0	3418.11	New	
93461		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	44.28	2612.52	757.56	000	0	3418.11	New	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93462		Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	6.00	354.00		ZZZ	0	3418.11	New	
93463		Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, w	3.11	183.49		ZZZ	0		New	
93464		Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	8.56	505.04	165.79	ZZZ	0		New	
93503		Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	3.78	223.02		000	0	1491.99	130.45	1627.16
93505		Endomyocardial biopsy	23.03	1358.77	400.61	000	0	1491.99	266.86	1627.16
93530		Right heart catheterization, for congenital cardiac anomalies	25.65	1513.35	393.53	000	0	3418.11	766.12	3630.26
93531		Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	52.80	3115.20	778.80	000	0	3418.11	2004.17	3630.26
93532		Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	63.20	3728.80	932.20	000	0	3418.11	2134.62	3630.26
93533		Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	52.95	3124.05	624.81	000	0	3418.11	2016.03	3630.26
93561		Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	1.30	76.70	41.30	000	0		59.30	
93562		Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output	0.58	34.22	12.98	000	0		28.44	
93563		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	1.61	94.99		ZZZ	0		New	
93564		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free ma	1.65	97.35		ZZZ	0		New	
93565		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	1.25	73.75		ZZZ	0		New	
93566		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	5.20	306.80		ZZZ	0		New	
93567		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)	4.26	251.34		ZZZ	0		New	
93568		Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	4.65	274.35		ZZZ	0		New	
93571		Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary pro	7.34	433.06	151.63	ZZZ	0		230.04	
93572		Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for pri	4.43	261.37	122.72	ZZZ	0		141.13	
93580		Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	28.90	1705.10		000	0	15448.36	1497.42	13438.93
93581		Percutaneous transcatheter closure of a congenital ventricular septal defect with implan	38.98	2299.82		000	0	15448.36	2008.95	13438.93
93600		Bundle of His recording	5.68	335.12	201.19	000	0	909.98	445.92	985.86
93602		Intra-atrial recording	4.72	278.48	200.60	000	0	909.98	296.48	985.86
93603		Right ventricular recording	5.38	317.42	200.01	000	0	909.98	288.16	985.86

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93609		Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)	11.15	657.85	473.77	ZZZ	0		1002.12	
93610		Intra-atrial pacing	6.44	379.96	284.97	000	0	909.98	474.36	985.86
93612		Intraventricular pacing	6.67	393.53	283.20	000	0	909.98	375.95	985.86
93613		Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	11.28	665.52	478.49	ZZZ	0		578.79	
93615		Esophageal recording of atrial electrogram with or without ventricular electrogram(s)	1.77	104.43	82.60	000	0	909.98	110.27	985.86
93616		Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	2.52	148.68	111.51	000	0	909.98	189.74	985.86
93618		Induction of arrhythmia by electrical pacing	11.40	672.60	403.56	000	0	909.98	1067.31	985.86
93619		Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted inducti	20.61	1215.99	693.25	000	0	5060.12	1738.55	4777.28
93620		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bund	24.84	1465.56	1099.17	000	0	5060.12	2055.15	4777.28
93621		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separatel	4.51	266.09	199.42	ZZZ	0		505.22	
93622		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for prim	6.65	392.35	294.41	ZZZ	0		434.06	
93623		Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)	6.13	361.67	271.40	ZZZ	0		426.92	
93624		Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	9.83	579.97	452.53	000	0	5060.12	948.72	4777.28
93631		Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	15.84	934.56	700.92	000	0		1501.37	
93640		Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implant	14.00	826.00	330.40	000	0		1263.01	
93641		Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implant	17.92	1057.28	560.50	000	0		1452.76	
93642		Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming	11.49	677.91	411.23	000	0	909.98	817.74	985.86
93650		Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	17.21	1015.39		000	0	5060.12	885.00	4777.28
93653		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His re	24.18	1426.62		000	0	14378.96	New	
93654		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His re	32.27	1903.93		000	0	14378.96	New	
93655		Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary	12.09	713.31		ZZZ	0		New	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93656		Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right v	32.28	1904.52		000	0	14378.96	New	
93657		Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	12.10	713.90		ZZZ	0		New	
93660		Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	4.59	270.81	158.71	000	0	391.57	257.24	398.55
93662		Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	5.47	322.73	241.90	ZZZ	0		632.07	
93668		Peripheral arterial disease (PAD) rehabilitation, per session	0.59	34.81	0.00	XXX	9		24.19	2097.37**
93701		Bioimpedance-derived physiologic cardiovascular analysis	0.74	43.66	11.80	XXX	0	34.41	63.72	35.93
93724		Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	7.77	458.43	408.28	000	0	43.80	594.13	31.97
93740		Temperature gradient studies	0.25	14.75	11.80	XXX	9	81.11	18.29	77.47
93745		Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient	0.00	BR	BR	XXX	0	43.80	BR	51.80
93750		Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum sta	1.58	93.22		XXX	0	143.81	84.96	145.90
93770		Determination of venous pressure	0.25	14.75	14.16	XXX	9		13.57	
93784		Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report	1.64	96.76		XXX	0		112.69	2097.37**
93786		Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	0.93	54.87	0.00	XXX	0	85.82	53.69	89.80
93788		Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report	0.17	10.03	0.00	XXX	0	85.82	30.68	89.80
93790		Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report	0.54	31.86		XXX	0		28.32	
93797		Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	0.49	28.91		000	0	103.10	28.32	51.90
93798		Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	0.73	43.07		000	0	103.10	42.48	51.90
93799		Unlisted cardiovascular service or procedure	0.00	BR	BR	XXX	0	85.82	BR	89.80
93880		Duplex scan of extracranial arteries; complete bilateral study	7.18	423.62	50.15	XXX	0	199.63	389.40	209.78
93882		Duplex scan of extracranial arteries; unilateral or limited study	5.17	305.03	34.22	XXX	0	199.63	250.75	209.78
93886		Transcranial Doppler study of the intracranial arteries; complete study	11.19	660.21	82.01	XXX	0	199.63	476.13	209.78
93888		Transcranial Doppler study of the intracranial arteries; limited study	6.50	383.50	53.69	XXX	0	83.30	309.16	84.51
93890		Transcranial Doppler study of the intracranial arteries; vasoreactivity study	8.80	519.20	85.55	XXX	0	128.14	386.45	131.62
93892		Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection	9.94	586.46	99.12	XXX	0	128.14	413.00	131.62
93893		Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection	10.61	625.99	100.30	XXX	0	128.14	402.38	131.62
93922		Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording	2.77	163.43	20.65	XXX	0	85.82	185.85	89.80

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
93923		Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure	4.30	253.70	37.76	XXX	0	140.12	285.56	146.59
93924		Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at	5.39	318.01	41.89	XXX	0	140.12	342.20	146.59
93925		Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	7.55	445.45	67.26	XXX	0	199.63	469.64	209.78
93926		Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	4.34	256.06	42.48	XXX	0	128.14	290.87	131.62
93930		Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	7.21	425.39	38.94	XXX	0	199.63	375.24	209.78
93931		Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	4.83	284.97	25.96	XXX	0	128.14	247.21	131.62
93965		Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)	3.70	218.30	29.50	XXX	0	140.12	193.52	146.59
93970		Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	5.69	335.71	59.59	XXX	0	199.63	384.09	209.78
93971		Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	3.44	202.96	37.76	XXX	0	128.14	257.83	131.62
93975		Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	10.86	640.74	151.63	XXX	0	199.63	587.64	209.78
93976		Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	6.30	371.70	101.48	XXX	0	199.63	340.43	209.78
93978		Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	6.97	411.23	55.46	XXX	0	199.63	345.74	209.78
93979		Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	4.82	284.38	36.58	XXX	0	128.14	243.67	131.62
93980		Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	4.83	284.97	104.43	XXX	0	199.63	269.04	209.78
93981		Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	3.31	195.29	36.58	XXX	0	199.63	211.22	209.78
93982		Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	1.30	76.70		XXX	0	85.82	63.13	89.80
93990		Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow	6.17	364.03	21.24	XXX	0	128.14	280.84	131.62
93998		Unlisted noninvasive vascular diagnostic study	0.00	BR		XXX	0	30.23	New	
94002		Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	2.69	158.71		XXX	0	319.18	130.98	281.46
94003		Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	1.95	115.05		XXX	0	319.18	95.58	281.46
94004		Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day	1.43	84.37		XXX	0		69.62	
94005		Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan	2.71	159.89		XXX	9		123.90	
94010		Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	1.10	64.90	14.16	XXX	0	81.11	51.33	77.47
94011		Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	2.91	171.69		XXX	0	58.13	158.12	77.47
94012		Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	4.59	270.81		XXX	0	58.13	243.08	77.47
94013		Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	1.03	60.77		XXX	0	232.03	51.33	239.17
94014		Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other	1.46	86.14	34.81	XXX	0	81.11	74.93	54.42

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
94015		Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	0.75	44.25	0.00	XXX	0	81.11	36.58	54.42
94016		Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	0.71	41.89		XXX	0		38.35	
94060		Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	1.89	111.51	22.42	XXX	0	130.23	87.32	128.96
94070		Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)	1.80	106.20	49.56	XXX	0	232.03	90.27	239.17
94150		Vital capacity, total (separate procedure)	0.77	45.43	6.49	XXX	9	58.13	33.04	54.42
94200		Maximum breathing capacity, maximal voluntary ventilatior	0.77	45.43	9.44	XXX	0	58.13	34.22	54.42
94250		Expired gas collection, quantitative, single procedure (separate procedure)	0.78	46.02	9.44	XXX	0	58.13	43.07	77.47
94375		Respiratory flow volume loop	1.19	70.21	25.37	XXX	0	58.13	55.46	77.47
94400		Breathing response to CO2 (CO2 response curve)	1.76	103.84	32.45	XXX	0	58.13	79.06	54.42
94450		Breathing response to hypoxia (hypoxia response curve	2.07	122.13	33.63	XXX	0	81.11	76.11	77.47
94452		High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	1.81	106.79	25.37	XXX	0	81.11	80.83	77.47
94453		High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	2.54	149.86	32.45	XXX	0	81.11	113.87	77.47
94610		Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube	1.76	103.84		XXX	0	45.26	97.35	37.00
94620		Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)	1.68	99.12	52.51	XXX	0	81.11	163.43	77.47
94621		Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)	4.92	290.28	117.41	XXX	0	232.03	229.51	239.17
94640		Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	0.57	33.63		XXX	0	45.26	20.06	37.00
94642		Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis	1.33	78.47		XXX	0	130.23	83.01	128.96
94644		Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hou	1.38	81.42		XXX	0	64.04	55.46	61.03
94645		Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour (List separately in addition to code for primary procedure)	0.44	25.96		XXX	0	64.04	21.24	61.03
94660		Continuous positive airway pressure ventilation (CPAP), initiation and managemen	1.88	110.92		XXX	0	130.23	83.19	128.96
94662		Continuous negative pressure ventilation (CNP), initiation and managemen	1.05	61.95		XXX	0	319.18	54.87	281.46
94664		Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	0.55	32.45		XXX	0	45.26	21.83	37.00
94667		Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	0.77	45.43		XXX	0	45.26	34.22	37.00
94668		Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent	0.80	47.20		XXX	0	45.26	28.32	37.00
94680		Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	1.80	106.20	21.83	XXX	0	232.03	116.23	239.17
94681		Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracte	1.62	95.58	17.11	XXX	0	232.03	145.73	77.47
94690		Oxygen uptake, expired gas analysis; rest, indirect (separate procedure	1.52	89.68	6.49	XXX	0	58.13	109.74	54.42
94726		Plethysmography for determination of lung volumes and, when performed, airway resistance	1.79	105.61	22.42	XXX	0	58.13	New	
94727		Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes	1.40	82.60	22.42	XXX	0	58.13	New	
94728		Airway resistance by impulse oscillometry	1.35	79.65	22.42	XXX	0	58.13	New	
94729		Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)	1.84	108.56	16.52	ZZZ	0	81.11	New	
94750		Pulmonary compliance study (eg, plethysmography, volume and pressure measurements	2.56	151.04	18.88	XXX	0	58.13	99.71	54.42
94760		Noninvasive ear or pulse oximetry for oxygen saturation; single determinatior	0.10	5.90	0.00	XXX	0		4.13	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
94761		Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)	0.15	8.85	0.00	XXX	0		8.26	
94762		Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	0.74	43.66	0.00	XXX	0	85.82	38.94	89.80
94770		Carbon dioxide, expired gas determination by infrared analyze	0.24	14.16	2.95	XXX	0	232.03	57.23	54.42
94772		Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant	0.00	BR	BR	XXX	0	232.03	BR	239.17
94774		Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, review, interpretation, and preparation of a repor by a physician or other qualif	0.00	BR		YYY	0		BR	
94775		Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection)	0.00	BR		YYY	0	85.82	BR	89.80
94776		Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only	0.00	BR		YYY	0	85.82	BR	89.80
94777		Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; review, interpretation and preparation of report only by a physician or other qualified health care professional	0.00	BR		YYY	0		BR	
94780		Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes	1.54	90.86		XXX	1	64.04	New	
94781		Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in additio	0.61	35.99		ZZZ	1	64.04	New	
94799		Unlisted pulmonary service or procedure	0.00	BR	BR	XXX	0	58.13	BR	54.42
95004		Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.20	11.80		XXX	0	32.00	7.67	39.32
95012		Nitric oxide expired gas determination	0.61	35.99		XXX	0	58.13	28.91	54.42
95017		Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	0.26	15.34		XXX	0	32.00	New	
95018		Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	0.64	37.76		XXX	0	32.00	New	
95024		Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.24	14.16		XXX	0	32.00	10.62	39.32
95027		Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	0.15	8.85		XXX	0	32.00	10.62	39.32
95028		Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	0.43	25.37		XXX	0	32.00	15.34	39.32
95044		Patch or application test(s) (specify number of tests)	0.17	10.03		XXX	0	32.00	11.80	39.32
95052		Photo patch test(s) (specify number of tests)	0.21	12.39		XXX	0	32.00	14.16	39.32
95056		Photo tests	1.39	82.01		XXX	0	122.79	25.96	133.12
95060		Ophthalmic mucous membrane tests	1.04	61.36		XXX	0	122.79	27.73	133.12
95065		Direct nasal mucous membrane test	0.81	47.79		XXX	0	32.00	19.47	39.32
95070		Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds	0.93	54.87		XXX	0	232.03	113.87	239.17
95071		Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify	1.06	62.54		XXX	0	81.11	143.37	239.17

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
95076		Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	3.44	202.96		XXX	0	390.38	New	
95079		Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure)	2.42	142.78		ZZZ	0	177.09	New	
95115		Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	0.28	16.52		XXX	0	34.85	21.83	34.73
95117		Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	0.32	18.88		XXX	0	34.85	27.14	34.73
95120		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single injection	0.32	18.88		XXX	9		13.04	2097.37**
95125		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 or more injections	0.41	24.19		XXX	9		15.99	2097.37**
95130		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single stinging insect venom	0.57	33.63		XXX	9		22.54	2097.37**
95131		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 stinging insect venoms	0.72	42.48		XXX	9		28.44	2097.37**
95132		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 3 stinging insect venoms	0.87	51.33		XXX	9		34.40	2097.37**
95133		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 4 stinging insect venoms	1.05	61.95		XXX	9		41.54	2097.37**
95134		Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 5 stinging insect venoms	1.27	74.93		XXX	9		49.80	2097.37**
95144		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)	0.38	22.42		XXX	0	50.48	15.93	50.66
95145		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom	0.67	39.53		XXX	0	34.85	23.01	50.66
95146		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms	1.19	70.21		XXX	0	96.35	32.45	102.40
95147		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms	1.08	63.72		XXX	0	96.35	31.86	102.40
95148		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms	1.61	94.99		XXX	0	50.48	43.07	50.66
95149		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms	2.17	128.03		XXX	0	50.48	57.23	50.66
95165		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)	0.39	23.01		XXX	0	34.85	15.93	34.73
95170		Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)	0.29	17.11		XXX	0	50.48	12.39	50.66
95180		Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum	3.91	230.69		XXX	0	122.79	222.43	133.12
95199		Unlisted allergy/clinical immunologic service or procedure	0.00	BR		XXX	0	32.00	BR	39.32

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
95250		Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	4.89	288.51	0.00	XXX	0	125.08	233.64	153.47
95251		Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report	1.25	73.75		XXX	0		58.41	
95782		Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	30.72	1812.48	221.25	XXX	0	1039.98	New	
95783		Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	32.79	1934.61	241.90	XXX	0	1039.98	New	
95800		Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	5.36	316.24	88.50	XXX	0	222.68	New	
95801		Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	2.80	165.20	82.60	XXX	0	222.68	New	
95803		Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	4.48	264.32	76.11	XXX	0	102.99	192.93	109.11
95805		Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	12.62	744.58	99.71	XXX	0	1039.98	992.38	1042.44
95806		Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	5.39	318.01	105.61	XXX	0	222.68	315.06	219.25
95807		Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	14.69	866.71	105.61	XXX	0	1039.98	814.79	1042.44
95808		Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	19.24	1135.16	147.50	XXX	0	1039.98	986.48	1042.44
95810		Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	18.98	1119.82	207.68	XXX	0	1039.98	1256.70	1042.44
95811		Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	19.91	1174.69	215.94	XXX	0	1039.98	1377.06	1042.44
95812		Electroencephalogram (EEG) extended monitoring; 41-60 minutes	13.32	785.88	96.76	XXX	0	222.68	332.17	219.25
95813		Electroencephalogram (EEG) extended monitoring; greater than 1 hou	15.31	903.29	155.17	XXX	0	222.68	422.44	219.25
95816		Electroencephalogram (EEG); including recording awake and drowsy	12.22	720.98	97.94	XXX	0	222.68	308.57	219.25
95819		Electroencephalogram (EEG); including recording awake and asleep	14.04	828.36	97.35	XXX	0	222.68	288.51	219.25
95822		Electroencephalogram (EEG); recording in coma or sleep only	12.55	740.45	97.35	XXX	0	222.68	352.82	219.25
95824		Electroencephalogram (EEG); cerebral death evaluation only	2.95	174.05	67.85	XXX	0	237.41	160.13	244.67
95827		Electroencephalogram (EEG); all night recording	23.88	1408.92	97.35	XXX	0	222.68	356.95	219.25
95829		Electrocorticogram at surgery (separate procedure)	57.98	3420.82	552.83	XXX	0		2102.76	
95830		Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	7.90	466.10		XXX	0		286.15	
95831		Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	0.85	50.15		XXX	0		41.30	
95832		Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	0.81	47.79		XXX	0		36.58	
95833		Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	1.10	64.90		XXX	0		58.41	
95834		Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	1.53	90.27		XXX	0		69.62	
95851		Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	0.54	31.86		XXX	0		28.91	
95852		Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	0.50	29.50		XXX	0		21.24	
95857		Cholinesterase inhibitor challenge test for myasthenia gravis	1.58	93.22		XXX	0	102.99	64.90	109.11
95860		Needle electromyography; 1 extremity with or without related paraspinal areas	3.74	220.66	87.91	XXX	0	102.99	135.11	109.11

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
95861		Needle electromyography; 2 extremities with or without related paraspinal areas	5.13	302.67	140.42	XXX	0	102.99	177.00	109.11
95863		Needle electromyography; 3 extremities with or without related paraspinal areas	6.27	369.93	169.33	XXX	0	102.99	213.58	109.11
95864		Needle electromyography; 4 extremities with or without related paraspinal areas	7.19	424.21	180.54	XXX	0	102.99	267.27	109.11
95865		Needle electromyography; larynx	4.01	236.59	139.83	XXX	0	102.99	174.05	109.11
95866		Needle electromyography; hemidiaphragm	4.10	241.90	114.46	XXX	0	102.99	125.08	109.11
95867		Needle electromyography; cranial nerve supplied muscle(s), unilatera	3.39	200.01	71.39	XXX	0	102.99	103.84	109.11
95868		Needle electromyography; cranial nerve supplied muscles, bilatera	4.25	250.75	106.20	XXX	0	102.99	142.78	109.11
95869		Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12	2.56	151.04	33.04	XXX	0	55.61	53.10	55.95
95870		Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	2.69	158.71	33.63	XXX	0	55.61	53.10	55.95
95872		Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	5.97	352.23	260.78	XXX	0	102.99	240.13	109.11
95873		Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	2.30	135.70	34.81	ZZZ	0		51.92	
95874		Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	2.21	130.39	33.63	ZZZ	0		52.51	
95875		Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	3.77	222.43	99.71	XXX	0	102.99	148.09	55.95
95885		Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	1.80	110.00	33.00	ZZZ	0	102.99	New	
95886		Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, 5 or more muscles studied, innervated by 3 or more nerves or 4 or more spinal levels (List	2.49	170.00	73.73	ZZZ	0	102.99	New	
95887		Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction amplitude and latency/velocity study (List separately in addition to code for primary procedure)	2.10	134.40	46.08	ZZZ	0	55.61	New	
95905		Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	0.00	0.00	0.00	XXX	0	0.00	124.49	55.95
95907		Nerve conduction studies; 1-2 studies	2.78	177.92	97.28	XXX	0	55.61	New	
95908		Nerve conduction studies; 3-4 studies	3.43	280.00	155.92	XXX	0	55.61	New	
95909		Nerve conduction studies; 5-6 studies	4.11	440.00	244.09	XXX	0	55.61	New	
95910		Nerve conduction studies; 7-8 studies	5.41	600.00	338.26	XXX	0	55.61	New	
95911		Nerve conduction studies; 9-10 studies	6.55	760.00	442.08	XXX	0	102.99	New	
95912		Nerve conduction studies; 11-12 studies	7.67	920.00	548.16	XXX	0	102.99	New	
95913		Nerve conduction studies; 13 or more studies	8.89	1080.00	658.45	XXX	0	102.99	New	
95921		Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	2.66	156.94	77.88	XXX	0	102.99	99.71	109.11
95922		Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	3.20	188.80	83.78	XXX	0	102.99	113.87	55.95
95923		Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	7.73	456.07	80.83	XXX	0	102.99	169.33	109.11
95924		Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	4.34	256.06	150.45	XXX	0	102.99	New	
95925		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	5.79	341.61	47.79	XXX	0	237.41	130.98	244.67

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
95926		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	5.60	330.40	48.97	XXX	0	237.41	128.03	244.67
95927		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	5.08	299.72	47.20	XXX	0	237.41	130.98	244.67
95928		Central motor evoked potential study (transcranial motor stimulation); upper limbs	8.71	513.89	135.70	XXX	0	102.99	276.71	109.11
95929		Central motor evoked potential study (transcranial motor stimulation); lower limbs	8.76	516.84	135.70	XXX	0	102.99	290.28	109.11
95930		Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	4.83	284.97	31.27	XXX	0	237.41	158.12	244.67
95933		Orbicularis oculi (blink) reflex, by electrodiagnostic testing	2.71	159.89	53.69	XXX	0	55.61	98.53	55.95
95937		Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	2.33	137.47	58.41	XXX	0	102.99	80.24	109.11
95938		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	9.81	578.79	77.88	XXX	0	237.41	New	
95939		Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs	14.99	884.41	204.14	XXX	0	102.99	New	
95940		Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	0.94	55.46		XXX	0		New	
95941		Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	0.00	49.24		XXX	9		New	
95943		Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean he	0.00	BR	BR	XXX	0	55.61	New	
95950		Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	10.28	606.52	136.29	XXX	0	1039.98	356.95	1042.44
95951		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours	23.53	1388.27	555.19	XXX	0	1039.98	1037.69	1042.44
95953		Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended	13.03	768.77	277.89	XXX	0	1039.98	654.31	1042.44
95954		Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	14.08	830.72	210.63	XXX	0	102.99	399.43	109.11
95955		Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery	7.03	414.77	91.45	XXX	0		210.04	
95956		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse	51.17	3019.03	324.50	XXX	0	1039.98	1110.97	1042.44
95957		Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	13.69	807.71	178.77	XXX	0		317.42	
95958		Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	17.25	1017.75	379.37	XXX	0	222.68	495.60	219.25
95961		Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health	8.45	498.55	267.86	XXX	0	237.41	352.23	244.67
95962		Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualifie	7.32	431.88	288.51	ZZZ	0	237.41	346.33	244.67
95965		Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	62.85	3708.15	741.63	XXX	0	3037.89	0.00	4832.08
95966		Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	28.75	1696.25	339.25	XXX	0	1262.03	0.00	1302.27
95967		Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	25.25	1489.75	297.95	ZZZ	0	1262.03	0.00	1302.27

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
95970		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	2.11	124.49		XXX	0	102.99	76.11	109.11
95971		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	1.77	104.43		XXX	0	143.81	84.37	145.90
95972		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	3.23	190.57		XXX	0	143.81	159.30	145.90
95973		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	1.86	109.74		ZZZ	0	102.99	89.09	145.90
95974		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	6.05	356.95		XXX	0	143.81	266.09	145.90
95975		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measureme	3.23	190.57		ZZZ	0	102.99	148.09	145.90
95978		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse	7.35	433.65		XXX	0	143.81	309.16	145.90
95979		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse	3.15	185.85		ZZZ	0	143.81	141.60	145.90
95980		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric n	1.36	80.24		XXX	0		60.18	
95981		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric n	0.99	58.41		XXX	0	102.99	42.48	109.11
95982		Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric n	1.56	92.04		XXX	0	143.81	64.31	145.90
95990		Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;	2.84	167.56		XXX	0	188.66	93.81	171.51
95991		Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care p	3.77	222.43		XXX	0	188.66	134.52	171.51
95992		Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day	1.27	74.93		XXX	0		68.44	2097.37**
95999		Unlisted neurological or neuromuscular diagnostic procedure	0.00	BR		XXX	0	55.61	BR	55.95
96000		Comprehensive computer-based motion analysis by video-taping and 3D kinematics	2.87	169.33	0.00	XXX	0	237.41	133.93	244.67
96001		Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	2.83	166.97	0.00	XXX	0	237.41	156.94	244.67
96002		Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	0.63	37.17	0.00	XXX	0	102.99	31.27	109.11
96003		Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	0.49	28.91	0.00	XXX	0	102.99	28.32	55.95
96004		Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and	3.29	194.11		XXX	0		169.33	

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
96020		Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	0.00	BR	BR	XXX	0		BR	
96040		Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	1.45	85.55		XXX	9		57.82	
96101		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering test	2.43	143.37		XXX	0	228.74	135.70	243.32
96102		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per ho	2.54	149.86		XXX	0	111.58	74.34	243.32
96103		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	2.06	121.54		XXX	0	111.58	57.23	88.98
96105		Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and repor	2.77	163.43		XXX	0		118.59	
96110		Developmental screening, with interpretation and report, per standardized instrument form	0.27	15.93		XXX	9		21.24	88.98
96111		Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	3.73	220.07		XXX	0	111.58	205.32	88.98
96116		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, bot	2.62	154.58		XXX	0	228.74	153.99	243.32
96118		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time int	2.70	159.30		XXX	0	228.74	182.90	243.32
96119		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time	2.18	128.62		XXX	0	228.74	107.38	243.32
96120		Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	3.02	178.18		XXX	0	111.58	89.68	243.32
96125		Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and prepari	3.17	187.03		XXX	0		142.78	
96150		Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	0.59	34.81		XXX	0	57.87	36.58	54.83
96151		Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	0.57	33.63		XXX	0	57.87	35.40	54.83
96152		Health and behavior intervention, each 15 minutes, face-to-face; individua	0.54	31.86		XXX	0	57.87	33.63	54.83
96153		Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients	0.13	7.67		XXX	0	28.84	8.26	54.83
96154		Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present	0.53	31.27		XXX	0	57.87	33.04	54.83
96155		Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present	0.65	38.35		XXX	9		34.22	2097.37**
96360		Intravenous infusion, hydration; initial, 31 minutes to 1 hou	1.72	101.48		XXX	0	96.35	87.91	102.40
96361		Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	0.45	26.55		ZZZ	0	34.85	24.78	34.73
96365		Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	2.22	130.98		XXX	0	188.66	109.15	171.51
96366		Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	0.64	37.76		ZZZ	0	34.85	33.63	34.73

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
96367		Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)	0.94	55.46		ZZZ	0	50.48	53.10	50.66
96368		Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	0.55	32.45		ZZZ	0		31.27	
96369		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	6.24	368.16		XXX	0	188.66	238.36	171.51
96370		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	0.51	30.09		ZZZ	0	50.48	24.19	50.66
96371		Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	2.98	175.82		ZZZ	0	50.48	123.31	34.73
96372		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	0.76	44.84		XXX	0	50.48	34.81	34.73
96373		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arteria	0.59	34.81		XXX	0	50.48	29.50	50.66
96374		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	1.69	99.71		XXX	0	50.48	86.14	50.66
96375		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	0.66	38.94		ZZZ	0	50.48	35.99	50.66
96376		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	0.43	25.37		ZZZ	9		15.34	
96379		Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusior	0.00	BR		XXX	0	34.85	BR	34.73
96401		Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	2.23	131.57		XXX	0	50.48	90.86	50.66
96402		Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	0.96	56.64		XXX	0	50.48	66.08	50.66
96405		Chemotherapy administration; intralesional, up to and including 7 lesions	2.47	145.73		000	1	50.48	189.39	50.66
96406		Chemotherapy administration; intralesional, more than 7 lesions	3.48	205.32		000	1	188.66	225.97	171.51
96409		Chemotherapy administration; intravenous, push technique, single or initial substance/drug	3.29	194.11		XXX	0	188.66	186.44	171.51
96411		Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	1.84	108.56		ZZZ	0	96.35	107.38	102.40
96413		Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	4.21	248.39		XXX	0	297.36	258.42	297.57
96415		Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	0.90	53.10		ZZZ	0	50.48	57.82	50.66
96416		Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	4.19	247.21		XXX	0	297.36	279.66	297.57
96417		Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	2.09	123.31		ZZZ	0	96.35	126.85	102.40
96420		Chemotherapy administration, intra-arterial; push technique	3.16	186.44		XXX	0	96.35	171.10	102.40
96422		Chemotherapy administration, intra-arterial; infusion technique, up to 1 hou	5.07	299.13		XXX	0	297.36	283.20	297.57
96423		Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	2.34	138.06		ZZZ	0	96.35	121.54	102.40
96425		Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	5.45	321.55		XXX	0	297.36	277.89	297.57
96440		Chemotherapy administration into pleural cavity, requiring and including thoracentesis	26.61	1569.99		000	0	188.66	577.02	171.51
96446		Chemotherapy administration into the peritoneal cavity via indwelling port or cathete	5.88	346.92		XXX	0	188.66	New	
96450		Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	5.31	313.29		000	0	297.36	467.28	297.57
96521		Refilling and maintenance of portable pump	4.14	244.26		XXX	0	188.66	227.15	171.51

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
96522		Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	3.36	198.24		XXX	0	188.66	171.69	171.51
96523		Irrigation of implanted venous access device for drug delivery systems	0.74	43.66		XXX	0	63.38	43.07	55.92
96542		Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	3.58	211.22		XXX	0	96.35	283.79	102.40
96549		Unlisted chemotherapy procedure	0.00	BR		XXX	0	34.85	BR	34.73
96567		Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session	4.23	249.57		XXX	0	137.98	143.96	255.17
96570		Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	1.67	98.53		ZZZ	1	137.98	87.32	140.54
96571		Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestin	0.77	45.43		ZZZ	1	137.98	41.89	140.54
96900		Actinotherapy (ultraviolet light)	0.65	38.35		XXX	0	47.93	28.91	48.35
96902		Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	0.63	37.17		XXX	9		31.86	
96904		Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	2.14	126.26		XXX	0		109.15	
96910		Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet E	2.24	132.16		XXX	0	47.93	75.52	48.35
96912		Photochemotherapy; psoralens and ultraviolet A (PUVA)	2.87	169.33		XXX	0	47.93	96.76	48.35
96913		Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	4.04	238.36		XXX	0	222.28	133.93	244.30
96920		Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	4.66	274.94		000	1	137.98	227.15	140.54
96921		Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	5.13	302.67		000	1	137.98	230.10	140.54
96922		Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	7.11	419.49		000	1	137.98	336.30	140.54
96999		Unlisted special dermatological service or procedure	0.00	BR		XXX	0	36.63	BR	40.45
97001		Physical therapy evaluation	2.20	129.80		XXX	0		119.04	
97002		Physical therapy re-evaluation	1.24	73.16		XXX	0		63.36	
97003		Occupational therapy evaluation	2.49	146.91		XXX	0		128.00	
97004		Occupational therapy re-evaluation	1.57	92.63		XXX	0		76.80	
97005		Athletic training evaluation	1.88	110.92		XXX	9		46.34	2097.37**
97006		Athletic training re-evaluation	0.94	55.46		XXX	9		23.17	2097.37**
97010		Application of a modality to 1 or more areas; hot or cold packs	0.00	0.00		XXX	9		0.00	
97012		Application of a modality to 1 or more areas; traction, mechanica	0.47	27.73		XXX	0		23.04	
97014		Application of a modality to 1 or more areas; electrical stimulation (unattended)	0.47	27.73		XXX	9		23.04	2097.37**
97016		Application of a modality to 1 or more areas; vasopneumatic devices	0.58	34.22		XXX	0		23.68	
97018		Application of a modality to 1 or more areas; paraffin bath	0.33	19.47		XXX	0		11.52	
97022		Application of a modality to 1 or more areas; whirlpoo	0.70	41.30		XXX	0		25.60	
97024		Application of a modality to 1 or more areas; diathermy (eg, microwave)	0.19	11.21		XXX	0		8.32	
97026		Application of a modality to 1 or more areas; infrared	0.18	10.62		XXX	0		7.68	
97028		Application of a modality to 1 or more areas; ultraviolet	0.22	12.98		XXX	0		9.60	
97032		Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	0.56	33.04		XXX	0		25.60	
97033		Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	0.97	57.23		XXX	0		35.20	
97034		Application of a modality to 1 or more areas; contrast baths, each 15 minutes	0.53	31.27		XXX	0		23.04	
97035		Application of a modality to 1 or more areas; ultrasound, each 15 minutes	0.37	21.83		XXX	0		19.20	
97036		Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	0.98	57.82		XXX	0		39.04	
97039		Unlisted modality (specify type and time if constant attendance)	0.00	0.00		XXX	0		BR	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
97110		Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	0.94	55.46		XXX	0		44.80	
97112		Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	0.98	57.82		XXX	0		46.72	
97113		Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	1.28	75.52		XXX	0		53.76	
97116		Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing	0.83	48.97		XXX	0		39.68	
97124		Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	0.77	45.43		XXX	0		35.84	
97139		Unlisted therapeutic procedure (specify)	0.00	0.00		XXX	0		BR	
97140		Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	0.88	51.92		XXX	0		42.24	
97150		Therapeutic procedure(s), group (2 or more individuals)	0.51	30.09		XXX	0		28.16	
97530		Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	1.03	60.77		XXX	0		48.00	
97532		Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	0.77	45.43		XXX	0		39.68	
97533		Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	0.85	50.15		XXX	0		42.24	
97535		Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	1.02	60.18		XXX	0		48.00	
97537		Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one cont	0.88	51.92		XXX	0		43.52	
97542		Wheelchair management (eg, assessment, fitting, training), each 15 minutes	0.89	52.51		XXX	0		44.16	
97545		Work hardening/conditioning; initial 2 hours	3.91	230.69		XXX	0		108.03	
97546		Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	1.56	92.04		ZZZ	0		43.07	
97597		Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpe and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound	2.30	135.70		000	0	137.98	85.76	140.54
97598		Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpe and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound	0.75	44.25		ZZZ	0	137.98	107.52	140.54
97602		Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	1.10	64.90		XXX	9	92.29	32.19	80.15
97605		Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	1.25	73.75		XXX	0	92.29	55.68	80.15
97606		Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	1.33	78.47		XXX	0	137.98	60.16	140.54
97750		Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	0.98	57.82		XXX	0		47.36	
97755		Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	1.05	61.95		XXX	0		55.04	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
97760		Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	1.13	66.67		XXX	0		50.56	
97761		Prosthetic training, upper and/or lower extremity(s), each 15 minutes	0.98	57.82		XXX	0		45.44	
97762		Checkout for orthotic/prosthetic use, established patient, each 15 minutes	1.44	84.96		XXX	0		47.36	
97799		Unlisted physical medicine/rehabilitation service or procedure	0.00	0.00		XXX	0		BR	
97802		Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1.04	61.36		XXX	0		51.20	
97803		Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	0.90	53.10		XXX	0		46.08	
97804		Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	0.46	27.14		XXX	0		24.32	
97810		Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1.05	61.95		XXX	9		58.88	2097.37**
97811		Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	0.79	46.61		ZZZ	9		45.44	2097.37**
97813		Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1.12	66.08		XXX	9		62.72	2097.37**
97814		Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	0.90	53.10		ZZZ	9		50.56	2097.37**
98925		Osteopathic manipulative treatment (OMT); 1-2 body regions involved	0.92	54.28		000	0	25.19	46.72	34.73
98926		Osteopathic manipulative treatment (OMT); 3-4 body regions involved	1.31	77.29		000	0	25.19	64.64	34.73
98927		Osteopathic manipulative treatment (OMT); 5-6 body regions involved	1.72	101.48		000	0	25.19	83.20	34.73
98928		Osteopathic manipulative treatment (OMT); 7-8 body regions involved	2.12	125.08		000	0	25.19	98.56	34.73
98929		Osteopathic manipulative treatment (OMT); 9-10 body regions involved	2.53	149.27		000	0	25.19	113.28	34.73
98940		Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	0.77	45.43		000	0	25.19	40.96	34.73
98941		Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	1.07	63.13		000	0	25.19	56.32	34.73
98942		Chiropractic manipulative treatment (CMT); spinal, 5 regions	1.37	80.83		000	0	25.19	74.24	34.73
98943		Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	0.71	41.89		XXX	9		37.76	2097.37**
98960		Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	0.85	50.15		XXX	9		31.36	2097.37**
98961		Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	0.41	24.19		XXX	9		15.36	2097.37**
98962		Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	0.30	17.70		XXX	9		11.52	2097.37**
98966		Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days n	0.40	23.60		XXX	9		18.88	2097.37**
98967		Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days n	0.77	45.43		XXX	9		35.40	2097.37**
98968		Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days n	1.15	67.85		XXX	9		52.51	2097.37**
98969		Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the I	0.64	37.76		XXX	9		0.00	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99000		Handling and/or conveyance of specimen for transfer from the office to a laboratory	0.19	11.21		XXX	9		7.14	2097.37**
99001		Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	0.22	12.98		XXX	9		8.32	2097.37**
99002		Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated b	0.25	14.75		XXX	9		9.50	
99024		Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure	0.00	0.00		XXX	9		BR	
99026		Hospital mandated on call service; in-hospital, each hour	0.00	0.00		XXX	9		BR	2097.37**
99027		Hospital mandated on call service; out-of-hospital, each hour	0.00	0.00		XXX	9		BR	2097.37**
99050		Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	0.66	38.94		XXX	9		24.90	
99051		Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	0.00	0.00		XXX	9		BR	
99053		Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	0.00	0.00		XXX	9		BR	
99056		Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	0.62	36.58		XXX	9		23.72	
99058		Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	0.78	46.02		XXX	9		29.68	
99060		Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	0.87	51.33		XXX	9		33.22	
99070		Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	0.00	BR		XXX	9		BR	
99071		Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	0.00	0.00		XXX	9		BR	
99075		Medical testimony	0.00	BR		XXX	9		BR	2097.37**
99078		Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	0.00	0.00		XXX	9		BR	
99080		Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	0.00	0.00		XXX	9		BR	
99082		Unusual travel (eg, transportation and escort of patient)	0.00	BR		XXX	0		BR	
99090		Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data	0.00	0.00		XXX	9		BR	
99091		Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, train	1.62	95.58		XXX	9		75.52	
99143		Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the pre	1.87	110.33		XXX	0		71.39	
99144		Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the pre	1.56	92.04		XXX	0		59.59	
99145		Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the pre	0.62	36.58		ZZZ	0		23.60	
99148		Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the se	1.72	101.48		XXX	0		65.25	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99149		Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the se	1.40	82.60		XXX	0		53.40	
99150		Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the se	0.62	36.58		ZZZ	0		23.72	
99170		Anogenital examination with colposcopic magnification in childhood for suspected traum	3.70	218.30		000	1	10.64	197.65	12.04
99172		Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for c	0.62	36.58	7.08	XXX	9		26.08	2097.37**
99173		Screening test of visual acuity, quantitative, bilatera	0.09	5.31		XXX	9		4.13	2097.37**
99174		Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilatera	0.90	53.10		XXX	9		21.24	2097.37**
99175		Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	0.50	29.50		XXX	0		72.57	
99183		Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	6.41	378.19		XXX	0		315.06	
99190		Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour	15.60	920.40	0.00	XXX	9		592.95	2097.37**
99191		Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 45 minutes	10.92	644.28	0.00	XXX	9		415.07	2097.37**
99192		Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 30 minutes	7.80	460.20	0.00	XXX	9		296.48	2097.37**
99195		Phlebotomy, therapeutic (separate procedure)	3.02	178.18		XXX	0	63.38	59.00	55.92
99199		Unlisted special service, procedure or report	0.00	BR		XXX	0		BR	
99201		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination o	0.94	47.47		XXX	0	73.23	47.47	78.36
99202		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling a	1.64	82.82		XXX	0	95.05	82.82	94.26
99203		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with	2.43	122.72		XXX	0	125.08	122.72	120.57
99204		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordinatio	3.69	186.35		XXX	0	165.76	186.35	153.47
99205		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of	4.63	233.82		XXX	0	226.78	233.82	226.63
99211		Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minute	0.53	26.77		XXX	0	73.23	26.77	78.36
99212		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counselin	0.97	48.99		XXX	0	95.05	48.99	94.26
99213		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low	1.57	79.29		XXX	0	95.05	79.29	94.26

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99214		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/o	2.38	120.19		XXX	0	125.08	120.19	120.57
99215		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling	3.22	162.61		XXX	0	165.76	162.61	153.47
99217		Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from observation status if the discharge is on other than the initial date of observation status. To report services to a	1.74	87.87		XXX	0		87.87	
99218		Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or o	1.64	82.82		XXX	0		82.82	
99219		Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordinat	2.71	136.86		XXX	0		136.86	
99220		Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination	3.82	192.91		XXX	0		192.91	
99221		Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of	2.24	113.12		XXX	0		113.12	
99222		Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination	3.14	158.57		XXX	0		158.57	
99223		Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of	4.58	231.29		XXX	0		231.29	
99224		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of	1.14	57.57		XXX	0		New	
99225		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of mo	2.06	104.03		XXX	0		New	
99226		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or c	2.98	150.49		XXX	0		New	
99231		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or o	0.94	47.47		XXX	0		47.47	
99232		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moder	1.68	84.84		XXX	0		84.84	
99233		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coor	2.40	121.20		XXX	0		121.20	
99234		Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination;	3.30	166.65		XXX	0		166.65	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99235		Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision ma	4.35	219.68		XXX	0		219.68	
99236		Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision ma	5.42	273.71		XXX	0		273.71	
99238		Hospital discharge day management; 30 minutes or less	1.73	87.37		XXX	0		87.37	
99239		Hospital discharge day management; more than 30 minutes	2.50	126.25		XXX	0		126.25	
99241		Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physician	1.28	64.64		XXX	9		64.64	2097.37**
99242		Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care	2.36	119.18		XXX	9		119.18	2097.37**
99243		Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qua	3.23	163.12		XXX	9		163.12	2097.37**
99244		Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physic	4.74	239.37		XXX	9		239.37	2097.37**
99245		Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians	5.88	296.94		XXX	9		296.94	2097.37**
99251		Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physic	1.21	61.11		XXX	9		61.11	2097.37**
99252		Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of ca	1.94	97.97		XXX	9		97.97	2097.37**
99253		Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other	2.87	144.94		XXX	9		144.94	2097.37**
99254		Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other phy	4.13	208.57		XXX	9		208.57	2097.37**
99255		Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physici	5.15	260.08		XXX	9		260.08	2097.37**
99281		Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care	0.51	25.76		XXX	0	133.70	25.76	71.91
99282		Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/o	0.98	49.49		XXX	0	237.78	49.49	118.85
99283		Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling	1.60	80.80		XXX	0	369.90	80.80	189.64
99284		Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o	2.91	146.96		XXX	0	591.82	146.96	301.92

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CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99285		Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensi	4.36	220.18		XXX	0	889.42	220.18	446.07
99288		Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support	0.00	BR		XXX	9		BR	
99291		Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	6.76	341.38		XXX	0	691.31	341.38	670.17
99292		Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	3.02	152.51		ZZZ	0		152.51	
99304		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforwar	1.61	81.31		XXX	0		81.31	
99305		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coor	2.14	108.07		XXX	0		108.07	
99306		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordina	2.63	132.82		XXX	0		132.82	
99307		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Cou	0.84	42.42		XXX	0		42.42	
99308		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making	1.39	70.20		XXX	0		70.20	
99309		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling	1.95	98.48		XXX	0		98.48	
99310		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Coun	2.44	123.22		XXX	0		123.22	
99315		Nursing facility discharge day management; 30 minutes or less	1.51	76.26		XXX	0		76.26	
99316		Nursing facility discharge day management; more than 30 minutes	1.98	99.99		XXX	0		99.99	
99318		Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Cou	1.61	81.31		XXX	0		81.31	
99324		Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination	1.44	72.72		XXX	0		72.72	
99325		Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseli	2.10	106.05		XXX	0		106.05	
99326		Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of car	3.02	152.51		XXX	0		152.51	
99327		Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordinat	3.97	200.49		XXX	0		200.49	
99328		Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination	4.91	247.96		XXX	0		247.96	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99334		Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Co	1.11	56.06		XXX	0		56.06	
99335		Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making	1.75	88.38		XXX	0		88.38	
99336		Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counselin	2.69	135.85		XXX	0		135.85	
99337		Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high com	3.95	199.48		XXX	0		199.48	
99339		Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care pl	1.76	88.88		XXX	9		88.88	
99340		Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care pl	2.45	123.73		XXX	9		123.73	
99341		Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other	1.43	72.22		XXX	0		72.22	
99342		Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordinati	2.10	106.05		XXX	0		106.05	
99343		Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physici	3.04	153.52		XXX	0		153.52	
99344		Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with oth	3.98	200.99		XXX	0		200.99	
99345		Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other p	4.91	247.96		XXX	0		247.96	
99347		Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coor	1.11	56.06		XXX	0		56.06	
99348		Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	1.75	88.38		XXX	0		88.38	
99349		Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordinatio	2.70	136.35		XXX	0		136.35	
99350		Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling	3.98	200.99		XXX	0		200.99	
99354		Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)	2.41	121.71		ZZZ	0		121.71	
99355		Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	2.39	120.70		ZZZ	0		120.70	

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99356		Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)	2.21	111.61		ZZZ	0		111.61	2097.37**
99357		Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	2.22	112.11		ZZZ	0		112.11	2097.37**
99358		Prolonged evaluation and management service before and/or after direct patient care; first hou	2.49	125.75		XXX	9		125.75	
99359		Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)	1.20	60.60		ZZZ	9		60.60	
99360		Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	1.13	57.07		XXX	9		57.07	
99363		Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of ther	2.84	143.42		XXX	9		143.42	
99364		Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days	0.99	50.00		XXX	9		50.00	
99366		Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional	0.98	49.98		XXX	9		49.98	
99367		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	1.27	64.77		XXX	9		64.77	
99368		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	0.82	41.82		XXX	9		41.82	
9936M		Medical Conference by a physician or qualified health care professional with interdisciplinary team case manager to coordinate activities of patient care.	1.91	96.40		XXX	9		New	
99374		Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision	1.70	85.85		XXX	9		85.85	
99375		Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision	2.98	150.49		XXX	9		150.49	2097.37**
99377		Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of relate	1.70	85.85		XXX	9		85.85	
99378		Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of relate	3.27	165.14		XXX	9		165.14	2097.37**
99379		Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review	1.69	85.35		XXX	9		85.35	
99380		Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review	2.55	128.78		XXX	9		128.78	
99381		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	2.49	125.75		XXX	9		125.75	2097.37**
99382		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	2.68	135.34		XXX	9		135.34	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99383		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	2.64	133.32		XXX	9		133.32	2097.37**
99384		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	2.87	144.94		XXX	9		144.94	2097.37**
99385		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	2.87	144.94		XXX	9		144.94	2097.37**
99386		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	3.35	169.18		XXX	9		169.18	2097.37**
99387		Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnos	3.64	183.82		XXX	9		183.82	2097.37**
99391		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	1.94	97.97		XXX	9		97.97	2097.37**
99392		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.16	109.08		XXX	9		109.08	2097.37**
99393		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.14	108.07		XXX	9		108.07	2097.37**
99394		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.35	118.68		XXX	9		118.68	2097.37**
99395		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.37	119.69		XXX	9		119.69	2097.37**
99396		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.62	132.31		XXX	9		132.31	2097.37**
99397		Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag	2.90	146.45		XXX	9		146.45	2097.37**
99401		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	1.00	50.50		XXX	9		50.50	2097.37**
99402		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	1.67	84.34		XXX	9		84.34	2097.37**
99403		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	2.31	116.66		XXX	9		116.66	2097.37**
99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	2.97	149.99		XXX	9		149.99	2097.37**
99406		Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	0.32	16.32		XXX	0	28.84	16.32	31.44
99407		Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	0.63	32.13		XXX	0	28.84	32.13	31.44
99408		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	0.77	39.27		XXX	9		39.27	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99409		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	1.51	77.01		XXX	9		77.01	2097.37**
99411		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	0.33	16.67		XXX	9		16.67	2097.37**
99412		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes	0.48	24.24		XXX	9		24.24	2097.37**
99420		Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)	0.23	11.62		XXX	9		11.62	2097.37**
99429		Unlisted preventive medicine service	0.00	BR		XXX	9		BR	2097.37**
99441		Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service pro	0.33	16.83		XXX	9		16.83	2097.37**
99442		Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service pro	0.60	30.60		XXX	9		30.60	2097.37**
99443		Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service pro	0.89	45.39		XXX	9		45.39	2097.37**
99444		Online evaluation and management service provided by a physician or other qualified health care professional who may report an evaluation and management services provided to an established patient or guardian, not originating from a related E/M service pr	0.00	BR		XXX	9		0.00	2097.37**
99450		Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody	0.00	BR		XXX	9		BR	2097.37**
99455		Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a di	0.00	250.00		XXX	0		250.00	
99456		Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulat	0.00	BR		XXX	0		BR	
99460		Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	1.60	80.80		XXX	0	95.05	80.80	94.26
99461		Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center	2.40	121.20		XXX	0		121.20	
99462		Subsequent hospital care, per day, for evaluation and management of normal newborr	0.85	42.93		XXX	0		42.93	2097.37**
99463		Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date	2.16	109.08		XXX	0	95.05	109.08	94.26
99464		Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn	2.01	101.51		XXX	0		101.51	
99465		Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	4.09	206.55		XXX	0	207.48	206.55	223.90
99466		Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport	6.55	330.78		XXX	0		330.78	
99467		Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes (List separately in addition to code for primary service)	3.29	166.15		ZZZ	0		166.15	
99468		Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	24.61	1242.81		XXX	0		1242.81	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99469		Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	10.75	542.88		XXX	0		542.88	2097.37**
99471		Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	21.55	1088.28		XXX	0		1088.28	2097.37**
99472		Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	10.78	544.39		XXX	0		544.39	2097.37**
99475		Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	14.85	749.93		XXX	0		749.93	2097.37**
99476		Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	8.91	449.96		XXX	0		449.96	2097.37**
99477		Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services	8.46	431.46		XXX	0		431.46	2097.37**
99478		Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	3.86	194.93		XXX	0		194.93	2097.37**
99479		Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infan (present body weight of 1500-2500 grams)	3.42	172.71		XXX	0		172.71	2097.37**
99480		Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	3.28	165.64		XXX	0		165.64	2097.37**
99485		Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility a	2.19	110.60		XXX	9		New	
99486		Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility a	1.91	96.46		XXX	9		New	
99487		Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month	2.41	121.71		XXX	9		New	
99488		Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month	5.40	272.70		XXX	9		New	
99489		Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	1.21	61.11		ZZZ	9		New	
99495		Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity	4.82	243.41		XXX	0	95.05	New	
99496		Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the s	6.80	343.40		XXX	0	125.08	New	
99499		Unlisted evaluation and management service	0.00	BR		XXX	0		BR	
99500		Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring	0.00	BR		XXX	9		BR	2097.37**
99501		Home visit for postnatal assessment and follow-up care	0.00	BR		XXX	9		BR	2097.37**
99502		Home visit for newborn care and assessment	0.00	BR		XXX	9		BR	2097.37**
99503		Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)	0.00	BR		XXX	9		BR	2097.37**
99504		Home visit for mechanical ventilation care	0.00	BR		XXX	9		BR	2097.37**
99505		Home visit for stoma care and maintenance including colostomy and cystostomy	0.00	BR		XXX	9		BR	2097.37**
99506		Home visit for intramuscular injections	0.00	BR		XXX	9		BR	2097.37**
99507		Home visit for care and maintenance of catheter(s) (eg, urinary, drainage, and enteral	0.00	BR		XXX	9		BR	2097.37**
99509		Home visit for assistance with activities of daily living and personal care	0.00	BR		XXX	9		BR	2097.37**

Medical Fees

CODE	MOD	DESCRIPTION	RVU	Amount	PC AMOUNT	FUD	Assist Surg	APC Amount	2010 Amount	2010 APC Amount
99510		Home visit for individual, family, or marriage counseling	0.00	BR		XXX	9		BR	2097.37**
99511		Home visit for fecal impaction management and enema administration	0.00	BR		XXX	9		BR	2097.37**
99512		Home visit for hemodialysis	0.00	BR		XXX	9		BR	2097.37**
99600		Unlisted home visit service or procedure	0.00	BR		XXX	9		BR	2097.37**
99601		Home infusion/specialty drug administration, per visit (up to 2 hours)	0.00	BR		XXX	9		BR	2097.37**
99602		Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)	0.00	BR		XXX	9		BR	2097.37**
99605		Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	0.00	BR		XXX	9		BR	2097.37**
99606		Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	0.00	BR		XXX	9		BR	2097.37**
99607		Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	0.00	BR		XXX	9		BR	2097.37**

* APC Amount changed in November 2011 per Mississippi Website Fee Schedule Update November 2011.
** CMS APC error

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A0021		Ambulance service, outside state per mile, transport (Medicaid only)	13.78		13.78	2097.37**
A0080		Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	BR		BR	2097.37**
A0090		Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	BR		BR	2097.37**
A0100		Nonemergency transportation; taxi	BR		BR	2097.37**
A0110		Nonemergency transportation and bus, intra- or interstate carrier	BR		BR	2097.37**
A0120		Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	BR		BR	2097.37**
A0130		Nonemergency transportation: wheelchair van	BR		BR	2097.37**
A0140		Nonemergency transportation and air travel (private or commercial) intra- or interstate	BR		BR	2097.37**
A0160		Nonemergency transportation: per mile - caseworker or social worker	0.46		0.46	2097.37**
A0170		Transportation ancillary: parking fees, tolls, other	BR		BR	2097.37**
A0180		Nonemergency transportation: ancillary: lodging-recipient	BR		BR	2097.37**
A0190		Nonemergency transportation: ancillary: meals, recipient	BR		BR	2097.37**
A0200		Nonemergency transportation: ancillary: lodging, escort	BR		BR	2097.37**
A0210		Nonemergency transportation: ancillary: meals, escort	BR		BR	2097.37**
A0225		Ambulance service, neonatal transport, base rate, emergency transport, one way	663.80		663.80	2097.37**
A0380		BLS mileage (per mile)	11.48		11.48	2097.37**
A0382		BLS routine disposable supplies	21.81		21.81	
A0384		BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	109.05		109.05	
A0390		ALS mileage (per mile)	11.48		11.48	2097.37**
A0392		ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)	109.05		109.05	
A0394		ALS specialized service disposable supplies; IV drug therapy	52.34		52.34	
A0396		ALS specialized service disposable supplies; esophageal intubation	87.24		87.24	
A0398		ALS routine disposable supplies	21.81		21.81	
A0420		Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	BR		BR	
A0422		Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	BR		80.70	
A0424		Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	BR		BR	
A0425		Ground mileage, per statute mile	11.48		11.48	
A0426		Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	503.66		503.66	
A0427		Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	529.38		529.38	
A0428		Ambulance service, basic life support, nonemergency transport, (BLS)	443.09		443.09	
A0429		Ambulance service, basic life support, emergency transport (BLS, emergency)	459.68		459.68	
A0430		Ambulance service, conventional air services, transport, one way (fixed wing)	8807.17		0.00	
A0431		Ambulance service, conventional air services, transport, one way (rotary wing)	10134.80		0.00	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A0432		Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers	BR		BR	
A0433		Advanced life support, level 2 (ALS 2)	BR		BR	
A0434		Specialty care transport (SCT)	BR		BR	
A0435		Fixed wing air mileage, per statute mile	26.49		0.00	
A0436		Rotary wing air mileage, per statute mile	70.74		0.00	
A0888		Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)	BR		BR	2097.37**
A0998		Ambulance response and treatment, no transport	BR		BR	2097.37**
A0999		Unlisted ambulance service	BR		BR	
A4206		Syringe with needle, sterile, 1 cc or less, each	0.00		0.24	2097.37**
A4207		Syringe with needle, sterile 2 cc, each	0.00		0.00	2097.37**
A4208		Syringe with needle, sterile 3 cc, each	0.00		0.22	2097.37**
A4209		Syringe with needle, sterile 5 cc or greater, each	0.00		0.35	2097.37**
A4210		Needle-free injection device, each	0.00		1155.15	2097.37**
A4211		Supplies for self-administered injections	0.00		0.00	2097.37**
A4212		Noncoring needle or stylet with or without catheter	0.00		11.23	
A4213		Syringe, sterile, 20 cc or greater, each	0.00		1.20	2097.37**
A4215		Needle, sterile, any size, each	0.00		0.00	2097.37**
A4216		Sterile water, saline and/or dextrose, diluent/flush, 10 ml	0.45		0.54	
A4217		Sterile water/saline, 500 ml	3.18		3.81	
A4218		Sterile saline or water, metered dose dispenser, 10 ml	0.00		0.00	
A4220		Refill kit for implantable infusion pump	0.00		0.00	
A4221		Supplies for maintenance of drug infusion catheter, per week (list drug separately)	22.91		27.45	
A4222		Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)	47.31		56.68	
A4223		Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately)	0.00		0.00	2097.37**
A4230		Infusion set for external insulin pump, nonneedle cannula type	0.00		0.00	
A4231		Infusion set for external insulin pump, needle type	0.00		0.00	
A4232		Syringe with needle for external insulin pump, sterile, 3 cc	0.00		0.00	2097.37**
A4233	NU	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	0.81		0.96	
A4233	RR	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	0.70		0.10	
A4234	NU	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	3.68		4.40	
A4234	RR	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	0.36		0.43	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4234	UE	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	3.30		3.30	
A4235	NU	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	2.38		2.84	
A4235	RR	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	0.24		0.29	
A4235	UE	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	2.13		2.13	
A4236	NU	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	1.69		2.04	
A4236	RR	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	0.16		0.20	
A4236	UE	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	1.54		1.54	
A4244		Alcohol or peroxide, per pint	1.22		1.22	2097.37**
A4245		Alcohol wipes, per box	3.75		3.75	2097.37**
A4246		Betadine or pHisoHex solution, per pint	4.14		4.14	2097.37**
A4247		Betadine or iodine swabs/wipes, per box	6.32		6.32	2097.37**
A4248		Chlorhexidine containing antiseptic, 1 ml	0.00		0.00	
A4250		Urine test or reagent strips or tablets (100 tablets or strips)	23.37		23.37	2097.37**
A4252		Blood ketone test or reagent strip, each	0.89		0.00	2097.37**
A4253		Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips	44.49		44.49	
A4255		Platforms for home blood glucose monitor, 50 per box	4.17		4.99	
A4256		Normal, low, and high calibrator solution/chips	11.58		13.88	
A4257		Replacement lens shield cartridge for use with laser skin piercing device, each	12.91		15.47	
A4258		Spring-powered device for lancet, each	18.27		21.89	
A4259		Lancets, per box of 100	0.00		0.00	
A4261		Cervical cap for contraceptive use	BR		BR	2097.37**
A4262		Temporary, absorbable lacrimal duct implant, each	0.68		0.68	
A4263		Permanent, long-term, nondissolvable lacrimal duct implant, each	53.45		53.45	
A4264		Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	BR		BR	2097.37**
A4265		Paraffin, per pound	3.44		4.12	
A4266		Diaphragm for contraceptive use	BR		BR	2097.37**
A4267		Contraceptive supply, condom, male, each	BR		0.43	2097.37**
A4268		Contraceptive supply, condom, female, each	BR		BR	2097.37**
A4269		Contraceptive supply, spermicide (e.g., foam, gel), each	BR		1.36	2097.37**
A4270		Disposable endoscope sheath, each	BR		BR	
A4280		Adhesive skin support attachment for use with external breast prosthesis, each	5.69		6.81	
A4281		Tubing for breast pump, replacement	BR		BR	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4282		Adapter for breast pump, replacement	BR		BR	2097.37**
A4283		Cap for breast pump bottle, replacement	BR		BR	2097.37**
A4284		Breast shield and splash protector for use with breast pump, replacement	BR		23.76	2097.37**
A4285		Polycarbonate bottle for use with breast pump, replacement	BR		BR	2097.37**
A4286		Locking ring for breast pump, replacement	BR		BR	2097.37**
A4290		Sacral nerve stimulation test lead, each	0.00		0.00	
A4300		Implantable access catheter, (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.) external access	BR		BR	
A4301		Implantable access total catheter, port/reservoir (e.g., venous, arterial, epidural, subarachnoid, peritoneal, etc.)	BR		BR	
A4305		Disposable drug delivery system, flow rate of 50 ml or greater per hour	17.60		17.60	
A4306		Disposable drug delivery system, flow rate of less than 50 ml per hour	24.14		24.14	
A4310		Insertion tray without drainage bag and without catheter (accessories only)	7.82		9.36	
A4311		Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)	15.01		17.99	
A4312		Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way, all silicone	18.25		21.88	
A4313		Insertion tray without drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation	18.75		22.46	
A4314		Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)	25.60		30.67	
A4315		Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way, all silicone	26.71		32.00	
A4316		Insertion tray with drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation	28.74		34.45	
A4320		Irrigation tray with bulb or piston syringe, any purpose	5.39		6.47	
A4321		Therapeutic agent for urinary catheter irrigation	BR		BR	
A4322		Irrigation syringe, bulb or piston, each	3.09		3.68	
A4326		Male external catheter with integral collection chamber, any type, each	10.92		13.09	
A4327		Female external urinary collection device; meatal cup, each	45.17		54.12	
A4328		Female external urinary collection device; pouch, each	10.57		12.67	
A4330		Perianal fecal collection pouch with adhesive, each	7.24		8.67	
A4331		Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each	3.22		3.86	
A4332		Lubricant, individual sterile packet, each	0.12		0.15	
A4333		Urinary catheter anchoring device, adhesive skin attachment, each	2.23		2.66	
A4334		Urinary catheter anchoring device, leg strap, each	4.98		5.98	
A4335		Incontinence supply; miscellaneous	BR		BR	
A4336		Incontinence supply, urethral insert, any type, each	1.46		0.00	
A4338		Indwelling catheter; Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	12.42		14.87	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4340		Indwelling catheter; specialty type, (e.g., Coude, mushroom, wing, etc.), each	32.14		38.51	
A4344		Indwelling catheter, Foley type, 2-way, all silicone, each	16.21		19.43	
A4346		Indwelling catheter; Foley type, 3-way for continuous irrigation, each	19.83		23.76	
A4349		Male external catheter, with or without adhesive, disposable, each	2.05		2.45	
A4351		Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	1.84		2.20	
A4352		Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each	6.50		7.79	
A4353		Intermittent urinary catheter, with insertion supplies	7.08		8.49	
A4354		Insertion tray with drainage bag but without catheter	11.95		14.31	
A4355		Irrigation tubing set for continuous bladder irrigation through a 3-way indwelling Foley catheter, each	9.02		10.82	
A4356		External urethral clamp or compression device (not to be used for catheter clamp), each	46.19		55.34	
A4357		Bedside drainage bag, day or night, with or without antireflux device, with or without tube, each	9.82		11.77	
A4358		Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each	6.71		8.05	
A4360		Disposable external urethral clamp or compression device, with pad and/or pouch, each	0.48		0.00	
A4361		Ostomy faceplate, each	18.60		22.29	
A4362		Skin barrier; solid, 4 x 4 or equivalent; each	3.51		4.20	
A4363		Ostomy clamp, any type, replacement only, each	2.40		2.87	
A4364		Adhesive, liquid or equal, any type, per oz	2.97		3.56	
A4366		Ostomy vent, any type, each	1.32		1.58	
A4367		Ostomy belt, each	7.45		8.92	
A4368		Ostomy filter, any type, each	0.26		0.31	
A4369		Ostomy skin barrier, liquid (spray, brush, etc.), per oz	2.45		2.94	
A4371		Ostomy skin barrier, powder, per oz	3.70		4.43	
A4372		Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear, with built-in convexity, each	4.25		5.07	
A4373		Ostomy skin barrier, with flange (solid, flexible or accordian), with built-in convexity, any size, each	6.35		7.61	
A4375		Ostomy pouch, drainable, with faceplate attached, plastic, each	17.39		20.83	
A4376		Ostomy pouch, drainable, with faceplate attached, rubber, each	48.17		57.72	
A4377		Ostomy pouch, drainable, for use on faceplate, plastic, each	4.35		5.20	
A4378		Ostomy pouch, drainable, for use on faceplate, rubber, each	31.13		37.30	
A4379		Ostomy pouch, urinary, with faceplate attached, plastic, each	15.20		18.21	
A4380		Ostomy pouch, urinary, with faceplate attached, rubber, each	37.80		45.28	
A4381		Ostomy pouch, urinary, for use on faceplate, plastic, each	4.68		5.59	
A4382		Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	24.91		29.86	
A4383		Ostomy pouch, urinary, for use on faceplate, rubber, each	28.53		34.19	
A4384		Ostomy faceplate equivalent, silicone ring, each	9.74		11.67	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4385		Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each	5.16		6.20	
A4387		Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each	BR		BR	
A4388		Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each	4.42		5.29	
A4389		Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each	6.29		7.54	
A4390		Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	9.72		11.66	
A4391		Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each	7.15		8.58	
A4392		Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	8.28		9.92	
A4393		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	9.15		10.97	
A4394		Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fl oz	2.62		3.13	
A4395		Ostomy deodorant for use in ostomy pouch, solid, per tablet	0.04		0.05	
A4396		Ostomy belt with peristomal hernia support	40.99		49.10	
A4397		Irrigation supply; sleeve, each	4.84		5.82	
A4398		Ostomy irrigation supply; bag, each	13.99		16.76	
A4399		Ostomy irrigation supply; cone/catheter, with or without brush	12.42		14.87	
A4400		Ostomy irrigation set	49.47		59.27	
A4402		Lubricant, per oz	1.62		1.94	
A4404		Ostomy ring, each	1.70		2.04	
A4405		Ostomy skin barrier, nonpectin-based, paste, per oz	3.45		4.12	
A4406		Ostomy skin barrier, pectin-based, paste, per oz	5.81		6.97	
A4407		Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 in or smaller, each	8.88		10.63	
A4408		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 in, each	9.99		11.97	
A4409		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 in or smaller, each	6.29		7.54	
A4410		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 in, each	9.15		10.97	
A4411		Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, with built-in convexity, each	5.16		6.20	
A4412		Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each	2.74		3.28	
A4413		Ostomy pouch, drainable, high output, for use on a barrier with flange (2-piece system), with filter, each	5.58		6.67	
A4414		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 in or smaller, each	4.98		5.98	
A4415		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 in, each	6.07		7.28	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4416		Ostomy pouch, closed, with barrier attached, with filter (1 piece), each	2.78		3.34	
A4417		Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each	3.77		4.51	
A4418		Ostomy pouch, closed; without barrier attached, with filter (1 piece), each	1.84		2.20	
A4419		Ostomy pouch, closed; for use on barrier with nonlocking flange, with filter (2 piece), each	1.76		2.12	
A4420		Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each	BR		BR	
A4421		Ostomy supply; miscellaneous	BR		BR	2097.37**
A4422		Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	0.12		0.15	
A4423		Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each	1.89		2.26	
A4424		Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each	4.82		5.76	
A4425		Ostomy pouch, drainable; for use on barrier with nonlocking flange, with filter (2-piece system), each	3.63		4.35	
A4426		Ostomy pouch, drainable; for use on barrier with locking flange (2-piece system), each	2.77		3.32	
A4427		Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2-piece system), each	2.82		3.37	
A4428		Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each	6.59		7.90	
A4429		Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	8.35		10.00	
A4430		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	8.62		10.34	
A4431		Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each	6.29		7.54	
A4432		Ostomy pouch, urinary; for use on barrier with nonlocking flange, with faucet-type tap with valve (2 piece), each	3.64		4.35	
A4433		Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each	3.39		4.05	
A4434		Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each	3.81		4.57	
A4435		Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each	5.85		New	
A4450		Tape, nonwaterproof, per 18 sq in	0.11		0.11	
A4452		Tape, waterproof, per 18 sq in	0.41		0.43	
A4455		Adhesive remover or solvent (for tape, cement or other adhesive), per oz	1.45		1.74	
A4456		Adhesive remover, wipes, any type, each	0.25		0.00	
A4458		Enema bag with tubing, reusable	5.00		0.00	2097.37**
A4461		Surgical dressing holder, nonreusable, each	3.33		3.98	
A4463		Surgical dressing holder, reusable, each	13.49		16.14	
A4465		Nonelastic binder for extremity	12.35		12.35	
A4466		Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each	BR		BR	2097.37**
A4470		Gravlee jet washer	8.43		8.43	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4480		VABRA aspirator	6.74		6.74	
A4481		Tracheostoma filter, any type, any size, each	0.38		0.46	
A4483		Moisture exchanger, disposable, for use with invasive mechanical ventilation	BR		BR	
A4490		Surgical stockings above knee length, each	9.02		9.02	2097.37**
A4495		Surgical stockings thigh length, each	9.02		9.02	2097.37**
A4500		Surgical stockings below knee length, each	6.73		6.73	2097.37**
A4510		Surgical stockings full-length, each	16.31		16.31	2097.37**
A4520		Incontinence garment, any type, (e.g., brief, diaper), each	BR		BR	2097.37**
A4550		Surgical trays	39.41		39.41	
A4554		Disposable underpads, all sizes	4.08		4.08	2097.37**
A4556		Electrodes (e.g., apnea monitor), per pair	12.30		14.73	
A4557		Lead wires (e.g., apnea monitor), per pair	21.36		25.60	
A4558		Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz	5.52		6.60	
A4559		Coupling gel or paste, for use with ultrasound device, per oz	0.10		0.12	
A4561		Pessary, rubber, any type	21.77		26.08	
A4562		Pessary, nonrubber, any type	54.16		64.89	
A4565		Slings	9.51		9.51	
A4566		Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment	BR		New	
A4570		Splint	23.10		23.10	2097.37**
A4575		Topical hyperbaric oxygen chamber, disposable	BR		BR	2097.37**
A4580		Cast supplies (e.g., plaster)	BR		BR	2097.37**
A4590		Special casting material (e.g., fiberglass)	BR		51.98	2097.37**
A4595		Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	29.17		34.94	
A4600		Sleeve for intermittent limb compression device, replacement only, each	BR		BR	
A4601		Lithium ion battery for nonprosthetic use, replacement	BR		BR	
A4604	NU	Tubing with integrated heating element for use with positive airway pressure device	58.29		69.84	
A4604	RR	Tubing with integrated heating element for use with positive airway pressure device	6.99		6.99	
A4604	UE	Tubing with integrated heating element for use with positive airway pressure device	52.38		52.38	
A4605		Tracheal suction catheter, closed system, each	16.60		19.90	
A4606		Oxygen probe for use with oximeter device, replacement	BR		BR	
A4608		Transtracheal oxygen catheter, each	50.74		60.80	
A4611	NU	Battery, heavy-duty; replacement for patient-owned ventilator	198.88		238.27	
A4611	RR	Battery, heavy-duty; replacement for patient-owned ventilator	20.63		24.71	
A4611	UE	Battery, heavy-duty; replacement for patient-owned ventilator	149.17		178.71	
A4612	NU	Battery cables; replacement for patient-owned ventilator	80.93		96.95	
A4612	RR	Battery cables; replacement for patient-owned ventilator	8.24		9.88	
A4612	UE	Battery cables; replacement for patient-owned ventilator	61.70		73.93	
A4613	NU	Battery charger; replacement for patient-owned ventilator	145.99		174.92	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4613	RR	Battery charger; replacement for patient-owned ventilator	14.60		17.50	
A4613	UE	Battery charger; replacement for patient-owned ventilator	105.58		126.50	
A4614		Peak expiratory flow rate meter, hand held	24.08		28.84	
A4615		Cannula, nasal	0.73		0.87	
A4616		Tubing (oxygen), per foot	0.07		0.08	
A4617		Mouthpiece	3.15		3.75	
A4618	NU	Breathing circuits	9.00		10.78	
A4618	RR	Breathing circuits	1.03		1.24	
A4618	UE	Breathing circuits	6.75		8.09	
A4619		Face tent	1.88		1.47	
A4620		Variable concentration mask	0.64		0.75	
A4623		Tracheostomy, inner cannula	6.63		7.95	
A4624		Tracheal suction catheter, any type other than closed system, each	2.66		3.19	
A4625		Tracheostomy care kit for new tracheostomy	7.02		8.41	
A4626		Tracheostomy cleaning brush, each	3.23		3.87	
A4627		Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	22.46		22.46	2097.37**
A4628		Oropharyngeal suction catheter, each	3.78		4.54	
A4629		Tracheostomy care kit for established tracheostomy	4.70		5.61	
A4630		Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient	6.33		7.58	
A4633		Replacement bulb/lamp for ultraviolet light therapy system, each	41.55		49.78	
A4634		Replacement bulb for therapeutic light box, tabletop model	BR		BR	
A4635	NU	Underarm pad, crutch, replacement, each	5.18		6.21	
A4635	RR	Underarm pad, crutch, replacement, each	0.70		0.83	
A4635	UE	Underarm pad, crutch, replacement, each	3.44		4.12	
A4636	NU	Replacement, handgrip, cane, crutch, or walker, each	3.67		4.40	
A4636	RR	Replacement, handgrip, cane, crutch, or walker, each	0.37		0.45	
A4636	UE	Replacement, handgrip, cane, crutch, or walker, each	2.68		3.21	
A4637	NU	Replacement, tip, cane, crutch, walker, each	1.87		2.23	
A4637	RR	Replacement, tip, cane, crutch, walker, each	0.26		0.31	
A4637	UE	Replacement, tip, cane, crutch, walker, each	1.41		1.69	
A4638		Replacement battery for patient-owned ear pulse generator, each	0.00		0.00	
A4639		Replacement pad for infrared heating pad system, each	290.75		348.35	
A4640	NU	Replacement pad for use with medically necessary alternating pressure pad owned by patient	64.10		76.81	
A4640	RR	Replacement pad for use with medically necessary alternating pressure pad owned by patient	6.52		7.81	
A4640	UE	Replacement pad for use with medically necessary alternating pressure pad owned by patient	45.41		54.41	
A4641		Radiopharmaceutical, diagnostic, not otherwise classified	BR		BR	
A4642		Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries	BR		BR	
A4648		Tissue marker, implantable, any type, each	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4649		Surgical supply; miscellaneous	BR		BR	
A4650		Implantable radiation dosimeter, each	BR		BR	
A4651		Calibrated microcapillary tube, each	BR		BR	
A4652		Microcapillary tube sealant	BR		BR	
A4653		Peritoneal dialysis catheter anchoring device, belt, each	BR		BR	
A4657		Syringe, with or without needle, each	0.00		0.00	
A4660		Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	17.73		17.73	
A4663		Blood pressure cuff only	50.92		33.98	
A4670		Automatic blood pressure monitor	86.98		86.98	2097.37**
A4671		Disposable cycler set used with cycler dialysis machine, each	BR		BR	
A4672		Drainage extension line, sterile, for dialysis, each	BR		BR	
A4673		Extension line with easy lock connectors, used with dialysis	BR		BR	
A4674		Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz	BR		BR	
A4680		Activated carbon filter for hemodialysis, each	88.34		88.34	
A4690		Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each	875.92		875.92	
A4706		Bicarbonate concentrate, solution, for hemodialysis, per gallon	BR		BR	
A4707		Bicarbonate concentrate, powder, for hemodialysis, per packet	BR		BR	
A4708		Acetate concentrate solution, for hemodialysis, per gallon	BR		BR	
A4709		Acid concentrate, solution, for hemodialysis, per gallon	BR		BR	
A4714		Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon	BR		BR	
A4719		Y set tubing for peritoneal dialysis	BR		BR	
A4720		Dialysate solution, any concentration of dextrose, fluid volume greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis	BR		BR	
A4721		Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc but less than or equal to 1999 cc, for peritoneal dialysis	BR		BR	
A4722		Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc but less than or equal to 2999 cc, for peritoneal dialysis	BR		BR	
A4723		Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc but less than or equal to 3999 cc, for peritoneal dialysis	BR		BR	
A4724		Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc but less than or equal to 4999 cc, for peritoneal dialysis	BR		BR	
A4725		Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc but less than or equal to 5999 cc, for peritoneal dialysis	BR		BR	
A4726		Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis	BR		BR	
A4728		Dialysate solution, nondextrose containing, 500 ml	BR		BR	
A4730		Fistula cannulation set for hemodialysis, each	BR		BR	
A4736		Topical anesthetic, for dialysis, per g	BR		BR	
A4737		Injectable anesthetic, for dialysis, per 10 ml	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A4740		Shunt accessory, for hemodialysis, any type, each	BR		BR	
A4750		Blood tubing, arterial or venous, for hemodialysis, each	16.85		16.85	
A4755		Blood tubing, arterial and venous combined, for hemodialysis, each	BR		BR	
A4760		Dialysate solution test kit, for peritoneal dialysis, any type, each	BR		BR	
A4765		Dialysate concentrate, powder, additive for peritoneal dialysis, per packet	BR		BR	
A4766		Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml	BR		BR	
A4770		Blood collection tube, vacuum, for dialysis, per 50	BR		BR	
A4771		Serum clotting time tube, for dialysis, per 50	BR		BR	
A4772		Blood glucose test strips, for dialysis, per 50	35.33		35.33	
A4773		Occult blood test strips, for dialysis, per 50	22.41		22.41	
A4774		Ammonia test strips, for dialysis, per 50	BR		BR	
A4802		Protamine sulfate, for hemodialysis, per 50 mg	6.37		6.37	
A4860		Disposable catheter tips for peritoneal dialysis, per 10	BR		BR	
A4870		Plumbing and/or electrical work for home hemodialysis equipment	BR		BR	
A4890		Contracts, repair and maintenance, for hemodialysis equipment	BR		BR	
A4911		Drain bag/bottle, for dialysis, each	BR		BR	
A4913		Miscellaneous dialysis supplies, not otherwise specified	BR		BR	
A4918		Venous pressure clamp, for hemodialysis, each	BR		BR	
A4927		Gloves, nonsterile, per 100	5.44		5.44	
A4928		Surgical mask, per 20	0.00		0.00	
A4929		Tourniquet for dialysis, each	0.19		0.19	
A4930		Gloves, sterile, per pair	1.14		1.14	
A4931		Oral thermometer, reusable, any type, each	0.00		0.00	
A4932		Rectal thermometer, reusable, any type, each	0.00		0.00	2097.37**
A5051		Ostomy pouch, closed; with barrier attached (1 piece), each	2.09		2.50	
A5052		Ostomy pouch, closed; without barrier attached (1 piece), each	1.51		1.81	
A5053		Ostomy pouch, closed; for use on faceplate, each	1.76		2.12	
A5054		Ostomy pouch, closed; for use on barrier with flange (2 piece), each	1.83		2.17	
A5055		Stoma cap	1.46		1.74	
A5056		Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	4.72		New	
A5057		Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each	9.72		New	
A5061		Ostomy pouch, drainable; with barrier attached, (1 piece), each	3.58		4.28	
A5062		Ostomy pouch, drainable; without barrier attached (1 piece), each	2.25		2.69	
A5063		Ostomy pouch, drainable; for use on barrier with flange (2-piece system), each	2.74		3.28	
A5071		Ostomy pouch, urinary; with barrier attached (1 piece), each	6.08		7.28	
A5072		Ostomy pouch, urinary; without barrier attached (1 piece), each	3.58		4.28	
A5073		Ostomy pouch, urinary; for use on barrier with flange (2 piece), each	3.22		3.86	
A5081		Continent device; plug for continent stoma	3.34		4.01	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A5082		Continent device; catheter for continent stoma	12.03		14.42	
A5083		Continent device, stoma absorptive cover for continent stoma	0.65		0.76	
A5093		Ostomy accessory; convex insert	1.98		2.36	
A5102		Bedside drainage bottle with or without tubing, rigid or expandable, each	22.86		27.38	
A5105		Urinary suspensory with leg bag, with or without tube, each	41.27		49.44	
A5112		Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each	35.05		41.99	
A5113		Leg strap; latex, replacement only, per set	4.77		5.71	
A5114		Leg strap; foam or fabric, replacement only, per set	9.06		10.84	
A5120		Skin barrier, wipes or swabs, each	0.25		0.30	
A5121		Skin barrier; solid, 6 x 6 or equivalent, each	7.55		9.05	
A5122		Skin barrier; solid, 8 x 8 or equivalent, each	13.00		15.59	
A5126		Adhesive or nonadhesive; disk or foam pad	1.34		1.60	
A5131		Appliance cleaner, incontinence and ostomy appliances, per 16 oz	16.05		19.23	
A5200		Percutaneous catheter/tube anchoring device, adhesive skin attachment	11.44		13.71	
A5500		For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multidensity insert(s), per shoe	68.16		81.65	
A5501		For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe	204.42		244.93	
A5503		For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe	33.21		36.31	
A5504		For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe	33.21		36.31	
A5505		For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe	33.21		36.31	
A5506		For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with off-set heel(s), per shoe	33.21		36.31	
A5507		For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe	33.21		36.31	
A5508		For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe	BR		BR	
A5510		For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe	BR		BR	2097.37**
A5512		For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer o	27.80		33.32	
A5513		For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher), includes arch filler and other shaping	41.49		49.73	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A6000		Noncontact wound-warming wound cover for use with the noncontact wound-warming device and warming card	31.35		0.00	2097.37**
A6010		Collagen based wound filler, dry form, sterile, per g of collagen	37.55		37.55	
A6011		Collagen based wound filler, gel/paste, per g of collagen	2.31		2.76	
A6021		Collagen dressing, sterile, size 16 sq in or less, each	21.29		25.49	
A6022		Collagen dressing, sterile, size more than 16 sq in but less than or equal to 48 sq in, each	21.29		25.49	
A6023		Collagen dressing, sterile, size more than 48 sq in, each	192.65		230.83	
A6024		Collagen dressing wound filler, sterile, per 6 in	6.27		7.52	
A6025		Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each	32.62		32.62	2097.37**
A6154		Wound pouch, each	14.55		17.45	
A6196		Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq in or less, each dressing	7.45		8.92	
A6197		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, each dressing	16.63		19.94	
A6198		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq in, each dressing	BR		BR	
A6199		Alginate or other fiber gelling dressing, wound filler, sterile, per 6 in	5.35		6.41	
A6203		Composite dressing, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	3.40		4.06	
A6204		Composite dressing, sterile, pad size more than 16 sq in, but less than or equal to 48 sq in, with any size adhesive border, each dressing	6.30		7.56	
A6205		Composite dressing, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	BR		BR	
A6206		Contact layer, sterile, 16 sq in or less, each dressing	5.30		5.95	
A6207		Contact layer, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing	7.43		8.90	
A6208		Contact layer, sterile, more than 48 sq in, each dressing	BR		BR	
A6209		Foam dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	7.57		9.06	
A6210		Foam dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	20.16		24.16	
A6211		Foam dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	29.73		35.62	
A6212		Foam dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	9.82		11.77	
A6213		Foam dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	10.42		28.54	
A6214		Foam dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	12.48		12.48	
A6215		Foam dressing, wound filler, sterile, per g	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A6216		Gauze, nonimpregnated, nonsterile, pad size 16 sq in or less, without adhesive border, each dressing	0.04		0.05	
A6217		Gauze, nonimpregnated, nonsterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	BR		BR	
A6218		Gauze, nonimpregnated, nonsterile, pad size more than 48 sq in, without adhesive border, each dressing	0.97		0.54	
A6219		Gauze, nonimpregnated, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	1.16		1.16	
A6220		Gauze, nonimpregnated, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	2.62		3.13	
A6221		Gauze, nonimpregnated, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	BR		BR	
A6222		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq in or less, without adhesive border, each dressing	2.16		2.58	
A6223		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq in, but less than or equal to 48 sq in, without adhesive border, each dressing	2.45		2.94	
A6224		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq in, without adhesive border, each dressing	3.65		4.38	
A6228		Gauze, impregnated, water or normal saline, sterile, pad size 16 sq in or less, without adhesive border, each dressing	2.55		2.55	
A6229		Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	3.65		4.38	
A6230		Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq in, without adhesive border, each dressing	4.21		4.21	
A6231		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq in or less, each dressing	4.74		5.67	
A6232		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq in, but less than or equal to 48 sq in, each dressing	6.95		8.34	
A6233		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq in, each dressing	19.41		23.28	
A6234		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	6.72		7.94	
A6235		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	17.02		20.40	
A6236		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	27.59		33.05	
A6237		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	8.01		9.59	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A6238		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	23.08		27.64	
A6239		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	BR		BR	
A6240		Hydrocolloid dressing, wound filler, paste, sterile, per oz	12.40		14.84	
A6241		Hydrocolloid dressing, wound filler, dry form, sterile, per g	2.60		3.13	
A6242		Hydrogel dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	6.14		7.35	
A6243		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	12.47		14.94	
A6244		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	39.77		47.63	
A6245		Hydrogel dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	7.35		8.82	
A6246		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	10.05		12.04	
A6247		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	24.08		28.84	
A6248		Hydrogel dressing, wound filler, gel, per fl oz	16.43		19.69	
A6250		Skin sealants, protectants, moisturizers, ointments, any type, any size	BR		BR	
A6251		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing	2.02		2.42	
A6252		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	3.29		3.94	
A6253		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing	6.41		7.69	
A6254		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing	1.22		1.47	
A6255		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing	3.08		3.67	
A6256		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing	BR		BR	
A6257		Transparent film, sterile, 16 sq in or less, each dressing	1.55		1.86	
A6258		Transparent film, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing	4.37		5.22	
A6259		Transparent film, sterile, more than 48 sq in, each dressing	11.08		13.28	
A6260		Wound cleansers, any type, any size	1.43		1.43	
A6261		Wound filler, gel/paste, per fl oz, not otherwise specified	5.41		5.41	
A6262		Wound filler, dry form, per g, not otherwise specified	1.36		1.36	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A6266		Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yd	1.96		2.34	
A6402		Gauze, nonimpregnated, sterile, pad size 16 sq in or less, without adhesive border, each dressing	0.12		0.15	
A6403		Gauze, nonimpregnated, sterile, pad size more than 16 sq in, less than or equal to 48 sq in, without adhesive border, each dressing	0.43		0.52	
A6404		Gauze, nonimpregnated, sterile, pad size more than 48 sq in, without adhesive border, each dressing	0.71		0.71	
A6407		Packing strips, nonimpregnated, sterile, up to 2 in in width, per linear yd	1.90		2.27	
A6410		Eye pad, sterile, each	0.40		0.48	
A6411		Eye pad, nonsterile, each	0.30		0.00	
A6412		Eye patch, occlusive, each	0.34		0.34	2097.37**
A6413		Adhesive bandage, first aid type, any size, each	BR		BR	2097.37**
A6441		Padding bandage, nonelastic, nonwoven/nonknitted, width greater than or equal to 3 in and less than 5 in, per yd	0.68		0.82	
A6442		Conforming bandage, nonelastic, knitted/woven, nonsterile, width less than 3 in, per yd	0.17		0.20	
A6443		Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 3 in and less than 5 in, per yd	0.29		0.35	
A6444		Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 5 in, per yd	0.56		0.68	
A6445		Conforming bandage, nonelastic, knitted/woven, sterile, width less than 3 in, per yd	0.33		0.39	
A6446		Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 3 in and less than 5 in, per yd	0.41		0.50	
A6447		Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 5 in, per yd	0.68		0.82	
A6448		Light compression bandage, elastic, knitted/woven, width less than 3 in, per yd	1.18		1.41	
A6449		Light compression bandage, elastic, knitted/woven, width greater than or equal to 3 in and less than 5 in, per yd	1.78		2.12	
A6450		Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 in, per yd	BR		BR	
A6451		Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 ft lbs at 50% maximum stretch, width greater than or equal to 3 in and less than 5 in, per yd	BR		BR	
A6452		High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 ft lbs at 50% maximum stretch, width greater than or equal to 3 in and less than 5 in, per yd	5.98		7.18	
A6453		Self-adherent bandage, elastic, nonknitted/nonwoven, width less than 3 in, per yd	0.63		0.73	
A6454		Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 3 in and less than 5 in, per yd	0.78		0.94	
A6455		Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 5 in, per yd	1.41		1.69	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A6456		Zinc paste impregnated bandage, nonelastic, knitted/woven, width greater than or equal to 3 in and less than 5 in, per yd	1.29		1.55	
A6457		Tubular dressing with or without elastic, any width, per linear yd	1.15		1.39	
A6501		Compression burn garment, bodysuit (head to foot), custom fabricated	BR		BR	
A6502		Compression burn garment, chin strap, custom fabricated	BR		BR	
A6503		Compression burn garment, facial hood, custom fabricated	BR		BR	
A6504		Compression burn garment, glove to wrist, custom fabricated	BR		BR	
A6505		Compression burn garment, glove to elbow, custom fabricated	BR		BR	
A6506		Compression burn garment, glove to axilla, custom fabricated	BR		BR	
A6507		Compression burn garment, foot to knee length, custom fabricated	BR		BR	
A6508		Compression burn garment, foot to thigh length, custom fabricated	BR		BR	
A6509		Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated	BR		BR	
A6510		Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated	BR		BR	
A6511		Compression burn garment, lower trunk including leg openings (panty), custom fabricated	BR		BR	
A6512		Compression burn garment, not otherwise classified	BR		BR	
A6513		Compression burn mask, face and/or neck, plastic or equal, custom fabricated	BR		BR	
A6530		Gradient compression stocking, below knee, 18-30 mm Hg, each	BR		BR	2097.37**
A6531		Gradient compression stocking, below knee, 30-40 mm Hg, each	89.13		52.48	
A6532		Gradient compression stocking, below knee, 40-50 mm Hg, each	125.38		73.94	
A6533		Gradient compression stocking, thigh length, 18-30 mm Hg, each	BR		BR	2097.37**
A6534		Gradient compression stocking, thigh length, 30-40 mm Hg, each	BR		BR	2097.37**
A6535		Gradient compression stocking, thigh length, 40-50 mm Hg, each	BR		BR	2097.37**
A6536		Gradient compression stocking, full-length/chap style, 18-30 mm Hg, each	BR		BR	2097.37**
A6537		Gradient compression stocking, full-length/chap style, 30-40 mm Hg, each	BR		BR	2097.37**
A6538		Gradient compression stocking, full-length/chap style, 40-50 mm Hg, each	BR		BR	2097.37**
A6539		Gradient compression stocking, waist length, 18-30 mm Hg, each	BR		BR	2097.37**
A6540		Gradient compression stocking, waist length, 30-40 mm Hg, each	BR		BR	2097.37**
A6541		Gradient compression stocking, waist length, 40-50 mm Hg, each	BR		BR	2097.37**
A6544		Gradient compression stocking, garter belt	BR		BR	2097.37**
A6545		Gradient compression wrap, nonelastic, below knee, 30-50 mm Hg, each	BR		BR	
A6549		Gradient compression stocking/sleeve, not otherwise specified	BR		BR	2097.37**
A6550		Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	23.94		28.67	
A7000		Canister, disposable, used with suction pump, each	8.33		9.98	
A7001		Canister, nondisposable, used with suction pump, each	33.48		40.12	
A7002		Tubing, used with suction pump, each	3.88		4.65	
A7003		Administration set, with small volume nonfiltered pneumatic nebulizer, disposable	2.77		3.33	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A7004		Small volume nonfiltered pneumatic nebulizer, disposable	1.84		2.19	
A7005		Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable	31.21		37.39	
A7006		Administration set, with small volume filtered pneumatic nebulizer	9.66		11.58	
A7007		Large volume nebulizer, disposable, unfilled, used with aerosol compressor	4.68		5.59	
A7008		Large volume nebulizer, disposable, prefilled, used with aerosol compressor	11.13		13.35	
A7009		Reservoir bottle, nondisposable, used with large volume ultrasonic nebulizer	42.56		50.99	
A7010		Corrugated tubing, disposable, used with large volume nebulizer, 100 ft	23.88		28.61	
A7011		Corrugated tubing, nondisposable, used with large volume nebulizer, 10 ft	27.15		27.15	
A7012		Water collection device, used with large volume nebulizer	3.84		4.58	
A7013		Filter, disposable, used with aerosol compressor or ultrasonic generator	0.85		1.01	
A7014		Filter, nondisposable, used with aerosol compressor or ultrasonic generator	4.54		5.44	
A7015		Aerosol mask, used with DME nebulizer	1.90		2.27	
A7016		Dome and mouthpiece, used with small volume ultrasonic nebulizer	7.33		8.79	
A7017	NU	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	135.68		162.58	
A7017	RR	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	13.57		16.25	
A7017	UE	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	101.76		121.93	
A7018		Water, distilled, used with large volume nebulizer, 1000 ml	0.38		0.46	
A7020		Interface for cough stimulating device, includes all components, replacement only	14.65		New	
A7025		High frequency chest wall oscillation system vest, replacement for use with patient-owned equipment, each	440.31		527.55	
A7026		High frequency chest wall oscillation system hose, replacement for use with patient-owned equipment, each	29.11		34.87	
A7027		Combination oral/nasal mask, used with continuous positive airway pressure device, each	188.83		226.23	
A7028		Oral cushion for combination oral/nasal mask, replacement only, each	50.16		60.09	
A7029		Nasal pillows for combination oral/nasal mask, replacement only, pair	20.48		24.54	
A7030		Full face mask used with positive airway pressure device, each	164.59		197.20	
A7031		Face mask interface, replacement for full face mask, each	60.87		72.94	
A7032		Cushion for use on nasal mask interface, replacement only, each	35.37		42.37	
A7033		Pillow for use on nasal cannula type interface, replacement only, pair	24.78		29.69	
A7034		Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	102.68		122.98	
A7035		Headgear used with positive airway pressure device	34.67		41.54	
A7036		Chinstrap used with positive airway pressure device	15.86		19.03	
A7037		Tubing used with positive airway pressure device	35.78		42.88	
A7038		Filter, disposable, used with positive airway pressure device	4.71		5.64	
A7039		Filter, nondisposable, used with positive airway pressure device	13.38		16.02	
A7040		One way chest drain valve	43.05		51.57	
A7041		Water seal drainage container and tubing for use with implanted chest tube	80.89		96.92	
A7042		Implanted pleural catheter, each	195.28		233.97	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A7043		Vacuum drainage bottle and tubing for use with implanted catheter	30.65		36.71	
A7044		Oral interface used with positive airway pressure device, each	105.50		126.40	
A7045	NU	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	16.98		20.36	
A7045	RR	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	1.69		2.04	
A7045	UE	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	12.75		15.26	
A7046		Water chamber for humidifier, used with positive airway pressure device, replacement, each	17.02		20.40	
A7501		Tracheostoma valve, including diaphragm, each	106.32		127.39	
A7502		Replacement diaphragm/faceplate for tracheostoma valve, each	50.53		60.54	
A7503		Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each	11.48		13.75	
A7504		Filter for use in a tracheostoma heat and moisture exchange system, each	0.68		0.82	
A7505		Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each	4.74		5.67	
A7506		Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type each	0.34		0.41	
A7507		Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each	2.52		3.02	
A7508		Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each	2.90		3.48	
A7509		Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each	1.43		1.71	
A7520		Tracheostomy/laryngectomy tube, noncuffed, polyvinylchloride (PVC), silicone or equal, each	48.07		57.58	
A7521		Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each	47.62		57.06	
A7522		Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	45.73		54.78	
A7523		Tracheostomy shower protector, each	BR		BR	
A7524		Tracheostoma stent/stud/button, each	78.36		93.88	
A7525		Tracheostomy mask, each	2.09		2.50	
A7526		Tracheostomy tube collar/holder, each	3.41		4.09	
A7527		Tracheostomy/laryngectomy tube plug/stop, each	3.63		4.35	
A8000	NU	Helmet, protective, soft, prefabricated, includes all components and accessories	155.24		186.01	
A8000	RR	Helmet, protective, soft, prefabricated, includes all components and accessories	15.52		18.60	
A8000	UE	Helmet, protective, soft, prefabricated, includes all components and accessories	116.46		139.51	
A8001	NU	Helmet, protective, hard, prefabricated, includes all components and accessories	155.24		186.01	
A8001	RR	Helmet, protective, hard, prefabricated, includes all components and accessories	15.52		18.60	
A8001	UE	Helmet, protective, hard, prefabricated, includes all components and accessories	116.46		139.51	
A8002		Helmet, protective, soft, custom fabricated, includes all components and accessories	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A8003		Helmet, protective, hard, custom fabricated, includes all components and accessories	BR		BR	
A8004		Soft interface for helmet, replacement only	BR		BR	
A9150		Nonprescription drugs	BR		BR	
A9152		Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	BR		BR	2097.37**
A9153		Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified	BR		BR	2097.37**
A9155		Artificial saliva, 30 ml	BR		BR	
A9180		Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker	BR		BR	2097.37**
A9270		Noncovered item or service	BR		BR	2097.37**
A9272		Mechanical wound suction, disposable, includes dressing, all accessories and components, each	BR		New	
A9273		Hot water bottle, ice cap or collar, heat and/or cold wrap, any type	BR		New	
A9274		External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories	BR		BR	2097.37**
A9275		Home glucose disposable monitor, includes test strips	BR		BR	2097.37**
A9276		Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply	BR		BR	2097.37**
A9277		Transmitter; external, for use with interstitial continuous glucose monitoring system	BR		BR	2097.37**
A9278		Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	BR		BR	2097.37**
A9279		Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	BR		BR	2097.37**
A9280		Alert or alarm device, not otherwise classified	BR		BR	2097.37**
A9281		Reaching/grabbing device, any type, any length, each	BR		BR	2097.37**
A9282		Wig, any type, each	BR		BR	2097.37**
A9283		Foot pressure off loading/supportive device, any type, each	BR		BR	2097.37**
A9284		Spirometer, nonelectronic, includes all accessories	BR		BR	
A9300		Exercise equipment	BR		BR	2097.37**
A9500		Technetium tc-99m sestamibi, diagnostic, per study dose	BR		BR	
A9501		Technetium Tc-99m teboroxime, diagnostic, per study dose	BR		BR	
A9502		Technetium Tc-99m tetrofosmin, diagnostic, per study dose	BR		BR	
A9503		Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries	BR		BR	
A9504		Technetium Tc-99m apcitide, diagnostic, per study dose, up to 20 millicuries	BR		BR	
A9505		Thallium Tl-201 thallous chloride, diagnostic, per millicurie	BR		BR	
A9507		Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	BR		BR	
A9508		Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie	BR		BR	
A9509		Iodine I-123 sodium iodide, diagnostic, per millicurie	BR		BR	
A9510		Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries	BR		BR	
A9512		Technetium Tc-99m pertechnetate, diagnostic, per millicurie	BR		BR	
A9516		Iodine I-123 sodium iodide, diagnostic, per 100 microcuries, up to 999 microcuries	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A9517		Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	BR		BR	
A9521		Technetium Tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries	BR		BR	
A9524		Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries	BR		BR	
A9526		Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries	BR		BR	
A9527		Iodine I-125, sodium iodide solution, therapeutic, per millicurie	BR	27.13	BR	51.30
A9528		Iodine I-131 sodium iodide capsule(s), diagnostic, per millicurie	195.67		195.67	
A9529		Iodine I-131 sodium iodide solution, diagnostic, per millicurie	BR		BR	
A9530		Iodine I-131 sodium iodide solution, therapeutic, per millicurie	BR		BR	
A9531		Iodine I-131 sodium iodide, diagnostic, per microcurie (up to 100 microcuries)	BR		BR	
A9532		Iodine I-125 serum albumin, diagnostic, per 5 microcuries	424.12		424.12	
A9536		Technetium Tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries	BR		BR	
A9537		Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries	BR		BR	
A9538		Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries	BR		BR	
A9539		Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries	BR		BR	
A9540		Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 millicuries	BR		BR	
A9541		Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries	BR		BR	
A9542		Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	BR		BR	
A9543		Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	BR		BR	
A9544		Iodine I-131 tositumomab, diagnostic, per study dose	BR		BR	
A9545		Iodine I-131 tositumomab, therapeutic, per treatment dose	BR		BR	
A9546		Cobalt Co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie	BR		BR	
A9547		Indium In-111 oxyquinoline, diagnostic, per 0.5 millicurie	611.55		611.55	
A9548		Indium In-111 pentetate, diagnostic, per 0.5 millicurie	366.93		366.93	
A9550		Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie	BR		BR	
A9551		Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 millicuries	BR		BR	
A9552		Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries	BR		BR	
A9553		Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	BR		BR	
A9554		Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries	BR		BR	
A9555		Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries	BR		BR	
A9556		Gallium Ga-67 citrate, diagnostic, per millicurie	45.84		45.84	
A9557		Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries	BR		BR	
A9558		Xenon Xe-133 gas, diagnostic, per 10 millicuries	BR		BR	
A9559		Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie	BR		BR	
A9560		Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries	BR		BR	
A9561		Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries	BR		BR	
A9562		Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries	BR		BR	
A9563		Sodium phosphate P-32, therapeutic, per millicurie	BR		BR	
A9564		Chromic phosphate P-32 suspension, therapeutic, per millicurie	313.11		313.11	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
A9566		Technetium Tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries	BR		BR	
A9567		Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries	BR		BR	
A9568		Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 millicuries	BR		BR	
A9569		Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose	BR		BR	
A9570		Indium In-111 labeled autologous white blood cells, diagnostic, per study dose	BR		BR	
A9571		Indium In-111 labeled autologous platelets, diagnostic, per study dose	BR		BR	
A9572		Indium In-111 pentetreotide, diagnostic, per study dose, up to 6 millicuries	BR		BR	
A9576		Injection, gadoteridol, (ProHance multipack), per ml	BR		BR	
A9577		Injection, gadobenate dimeglumine (MultiHance), per ml	BR		BR	
A9578		Injection, gadobenate dimeglumine (MultiHance multipack), per ml	BR		BR	
A9579		Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml	BR		BR	
A9580		Sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries	BR		BR	
A9581		Injection, gadoxetate disodium, 1 ml	BR		BR	
A9582		Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	2.12		2.12	
A9583		Injection, gadofosveset trisodium, 1 ml	BR		4484.70	
A9584		Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	BR		New	
A9585		Injection, gadobutrol, 0.1 ml	BR		New	
A9586		Florbetapir F18, diagnostic, per study dose, up to 10 millicuries	BR		New	
A9600		Strontium Sr-89 chloride, therapeutic, per millicurie	BR		791.35	
A9604		Samarium sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	BR		7410.93	
A9698		Nonradioactive contrast imaging material, not otherwise classified, per study	BR		BR	
A9699		Radiopharmaceutical, therapeutic, not otherwise classified	BR		BR	
A9700		Supply of injectable contrast material for use in echocardiography, per study	BR		BR	
A9900		Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	BR		BR	
A9901		DME delivery, set up, and/or dispensing service component of another HCPCS code	BR		BR	
A9999		Miscellaneous DME supply or accessory, not otherwise specified	BR		BR	
B4034		Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	6.72		8.06	
B4035		Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	12.82		15.36	
B4036		Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	8.80		10.55	
B4081		Nasogastric tubing with stylet	23.77		28.48	
B4082		Nasogastric tubing without stylet	17.68		21.19	
B4083		Stomach tube - Levine type	2.72		3.25	
B4087		Gastrostomy/jejunostomy tube, standard, any material, any type, each	39.24		47.01	
B4088		Gastrostomy/jejunostomy tube, low-profile, any material, any type, each	39.24		47.01	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
B4100		Food thickener, administered orally, per oz	BR		BR	2097.37**
B4102		Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	BR		BR	
B4103		Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	BR		BR	
B4104		Additive for enteral formula (e.g., fiber)	BR		BR	2097.37**
B4149		Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1.73		2.07	
B4150		Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	0.75		0.88	
B4152		Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 ca	0.61		0.73	
B4153		Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	2.10		2.51	
B4154		Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral fee	1124.20		1.60	
B4155		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through	1.05		1.25	
B4157		Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	BR		BR	
B4158		Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	BR		BR	
B4159		Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	BR		BR	
B4160		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feedi	BR		BR	
B4161		Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
B4162		Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	BR		BR	
B4164		Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit), home mix	21.01		25.18	
B4168		Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix	30.64		36.71	
B4172		Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix	BR		86.60	
B4176		Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix	59.28		71.02	
B4178		Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit), home mix	71.16		85.26	
B4180		Parenteral nutrition solution: carbohydrates (dextrose), greater than 50% (500 ml = 1 unit), home mix	30.16		36.14	
B4185		Parenteral nutrition solution, per 10 grams lipids	13.89		16.65	
B4189		Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 g of protein, premix	219.84		263.37	
B4193		Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 g of protein, premix	284.06		340.35	
B4197		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix	345.84		414.35	
B4199		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix	395.18		473.48	
B4216		Parenteral nutrition; additives (vitamins, trace elements, Heparin, electrolytes), home mix, per day	9.55		11.44	
B4220		Parenteral nutrition supply kit; premix, per day	9.90		11.86	
B4222		Parenteral nutrition supply kit; home mix, per day	12.21		14.62	
B4224		Parenteral nutrition administration kit, per day	30.92		37.06	
B5000		Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - Amirosyn RF, NephrAmine, RenAmine - premix	14.71		17.61	
B5100		Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - FreAmine HBC, HepatAmine - premix	5.74		6.89	
B5200		Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix	BR		BR	
B9000	NU	Enteral nutrition infusion pump - without alarm	1348.36		1615.50	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
B9000	RR	Enteral nutrition infusion pump - without alarm	123.89		148.44	
B9000	UE	Enteral nutrition infusion pump - without alarm	1011.27		1211.62	
B9002	NU	Enteral nutrition infusion pump - with alarm	1348.36		1615.50	
B9002	RR	Enteral nutrition infusion pump - with alarm	130.58		156.46	
B9002	UE	Enteral nutrition infusion pump - with alarm	1011.27		1211.62	
B9004	NU	Parenteral nutrition infusion pump, portable	3120.51		3738.76	
B9004	RR	Parenteral nutrition infusion pump, portable	493.99		591.87	
B9004	UE	Parenteral nutrition infusion pump, portable	2340.38		2804.05	
B9006	NU	Parenteral nutrition infusion pump, stationary	3120.51		3738.76	
B9006	RR	Parenteral nutrition infusion pump, stationary	493.99		591.87	
B9006	UE	Parenteral nutrition infusion pump, stationary	2340.38		2804.05	
B9998		NOC for enteral supplies	BR		BR	
B9999		NOC for parenteral supplies	BR		BR	
C1300		Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	BR	139.00	BR	144.81
C1713		Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	BR		BR	
C1714		Catheter, transluminal atherectomy, directional	BR		BR	
C1715		Brachytherapy needle	BR		BR	
C1716		Brachytherapy source, nonstranded, gold-198, per source	BR	141.13	BR	57.97
C1717		Brachytherapy source, nonstranded, high dose rate iridium-192, per source	BR	321.33	BR	313.02
C1719		Brachytherapy source, nonstranded, nonhigh dose rate iridium-192, per source	BR	47.89	BR	86.60
C1721		Cardioverter-defibrillator, dual chamber (implantable)	BR		BR	
C1722		Cardioverter-defibrillator, single chamber (implantable)	BR		BR	
C1724		Catheter, transluminal atherectomy, rotational	BR		BR	
C1725		Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability)	BR		BR	
C1726		Catheter, balloon dilatation, nonvascular	BR		BR	
C1727		Catheter, balloon tissue dissector, nonvascular (insertable)	BR		BR	
C1728		Catheter, brachytherapy seed administration	BR		BR	
C1729		Catheter, drainage	BR		BR	
C1730		Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	BR		BR	
C1731		Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	BR		BR	
C1732		Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	BR		BR	
C1733		Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	BR		BR	
C1749		Endoscope, retrograde imaging/illumination colonoscope device (implantable)	BR		New	
C1750		Catheter, hemodialysis/peritoneal, long-term	BR		BR	
C1751		Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	BR		BR	
C1752		Catheter, hemodialysis/peritoneal, short-term	BR		BR	
C1753		Catheter, intravascular ultrasound	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C1754		Catheter, intradiscal	BR		BR	
C1755		Catheter, intraspinal	BR		BR	
C1756		Catheter, pacing, transesophageal	BR		BR	
C1757		Catheter, thrombectomy/embolectomy	BR		BR	
C1758		Catheter, ureteral	BR		BR	
C1759		Catheter, intracardiac echocardiography	BR		BR	
C1760		Closure device, vascular (implantable/insertable)	BR		BR	
C1762		Connective tissue, human (includes fascia lata)	BR		BR	
C1763		Connective tissue, nonhuman (includes synthetic)	BR		BR	
C1764		Event recorder, cardiac (implantable)	BR		BR	
C1765		Adhesion barrier	BR		BR	
C1766		Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	BR		BR	
C1767		Generator, neurostimulator (implantable), nonrechargeable	BR		BR	
C1768		Graft, vascular	BR		BR	
C1769		Guide wire	BR		BR	
C1770		Imaging coil, magnetic resonance (insertable)	BR		BR	
C1771		Repair device, urinary, incontinence, with sling graft	BR		BR	
C1772		Infusion pump, programmable (implantable)	BR		BR	
C1773		Retrieval device, insertable (used to retrieve fractured medical devices)	BR		BR	
C1776		Joint device (implantable)	BR		BR	
C1777		Lead, cardioverter-defibrillator, endocardial single coil (implantable)	BR		BR	
C1778		Lead, neurostimulator (implantable)	BR		BR	
C1779		Lead, pacemaker, transvenous VDD single pass	BR		BR	
C1780		Lens, intraocular (new technology)	BR		BR	
C1781		Mesh (implantable)	BR		BR	
C1782		Morcellator	BR		BR	
C1783		Ocular implant, aqueous drainage assist device	BR		BR	
C1784		Ocular device, intraoperative, detached retina	BR		BR	
C1785		Pacemaker, dual chamber, rate-responsive (implantable)	BR		BR	
C1786		Pacemaker, single chamber, rate-responsive (implantable)	BR		BR	
C1787		Patient programmer, neurostimulator	BR		BR	
C1788		Port, indwelling (implantable)	BR		BR	
C1789		Prosthesis, breast (implantable)	BR		BR	
C1813		Prosthesis, penile, inflatable	BR		BR	
C1814		Retinal tamponade device, silicone oil	BR		BR	
C1815		Prosthesis, urinary sphincter (implantable)	BR		BR	
C1816		Receiver and/or transmitter, neurostimulator (implantable)	BR		BR	
C1817		Septal defect implant system, intracardiac	BR		BR	
C1818		Integrated keratoprosthesis	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C1819		Surgical tissue localization and excision device (implantable)	BR		BR	
C1820		Generator, neurostimulator (implantable), with rechargeable battery and charging system	BR		BR	
C1821		Interspinous process distraction device (implantable)	BR		BR	
C1830		Powered bone marrow biopsy needle	BR		New	
C1840		Lens, intraocular (telescopic)	BR		New	
C1874		Stent, coated/covered, with delivery system	BR		BR	
C1875		Stent, coated/covered, without delivery system	BR		BR	
C1876		Stent, noncoated/noncovered, with delivery system	BR		BR	
C1877		Stent, noncoated/noncovered, without delivery system	BR		BR	
C1878		Material for vocal cord medialization, synthetic (implantable)	BR		BR	
C1879		Tissue marker (implantable)	BR		BR	
C1880		Vena cava filter	BR		BR	
C1881		Dialysis access system (implantable)	BR		BR	
C1882		Cardioverter-defibrillator, other than single or dual chamber (implantable)	BR		BR	
C1883		Adaptor/extension, pacing lead or neurostimulator lead (implantable)	BR		BR	
C1884		Embolization protective system	BR		BR	
C1885		Catheter, transluminal angioplasty, laser	BR		BR	
C1886		Catheter, extravascular tissue ablation, any modality (insertable)	BR		New	
C1887		Catheter, guiding (may include infusion/perfusion capability)	BR		BR	
C1888		Catheter, ablation, noncardiac, endovascular (implantable)	BR		BR	
C1891		Infusion pump, nonprogrammable, permanent (implantable)	BR		BR	
C1892		Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	BR		BR	
C1893		Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	BR		BR	
C1894		Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser	BR		BR	
C1895		Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	BR		BR	
C1896		Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	BR		BR	
C1897		Lead, neurostimulator test kit (implantable)	BR		BR	
C1898		Lead, pacemaker, other than transvenous VDD single pass	BR		BR	
C1899		Lead, pacemaker/cardioverter-defibrillator combination (implantable)	BR		BR	
C1900		Lead, left ventricular coronary venous system	BR		BR	
C2614		Probe, percutaneous lumbar discectomy	BR		BR	
C2615		Sealant, pulmonary, liquid	BR		BR	
C2616		Brachytherapy source, nonstranded, yttrium-90, per source	BR	20214.62	BR	21347.05
C2617		Stent, noncoronary, temporary, without delivery system	BR		BR	
C2618		Probe, cryoablation	BR		BR	
C2619		Pacemaker, dual chamber, nonrate-responsive (implantable)	BR		BR	
C2620		Pacemaker, single chamber, nonrate-responsive (implantable)	BR		BR	
C2621		Pacemaker, other than single or dual chamber (implantable)	BR		BR	
C2622		Prosthesis, penile, noninflatable	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C2625		Stent, noncoronary, temporary, with delivery system	BR		BR	
C2626		Infusion pump, nonprogrammable, temporary (implantable)	BR		BR	
C2627		Catheter, suprapubic/cystoscopic	BR		BR	
C2628		Catheter, occlusion	BR		BR	
C2629		Introducer/sheath, other than guiding, intracardiac electrophysiological, laser	BR		BR	
C2630		Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	BR		BR	
C2631		Repair device, urinary, incontinence, without sling graft	BR		BR	
C2634		Brachytherapy source, nonstranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source	BR	84.91	BR	80.89
C2635		Brachytherapy source, nonstranded, high activity, palladium-103, greater than 2.2 mCi (NIST), per source	BR	39.42	BR	38.68
C2636		Brachytherapy linear source, nonstranded, palladium-103, per 1 mm	BR	45.94	BR	26.20
C2637		Brachytherapy source, nonstranded, ytterbium-169, per source	BR		BR	
C2638		Brachytherapy source, stranded, iodine-125, per source	BR	60.24	BR	57.47
C2639		Brachytherapy source, nonstranded, iodine-125, per source	BR	46.05	BR	48.95
C2640		Brachytherapy source, stranded, palladium-103, per source	BR	97.32	BR	81.66
C2641		Brachytherapy source, nonstranded, palladium-103, per source	BR	78.03	BR	77.27
C2642		Brachytherapy source, stranded, cesium-131, per source	BR	142.24	BR	148.59
C2643		Brachytherapy source, nonstranded, cesium-131, per source	BR	85.18	BR	89.41
C2698		Brachytherapy source, stranded, not otherwise specified, per source	BR	60.24	BR	57.47
C2699		Brachytherapy source, nonstranded, not otherwise specified, per source	BR	39.42	BR	38.68
C8900		Magnetic resonance angiography with contrast, abdomen	BR	586.42	BR	573.59
C8901		Magnetic resonance angiography without contrast, abdomen	BR	436.69	BR	472.87
C8902		Magnetic resonance angiography without contrast followed by with contrast, abdomen	BR	708.87	BR	724.34
C8903		Magnetic resonance imaging with contrast, breast; unilateral	BR	586.42	BR	573.59
C8904		Magnetic resonance imaging without contrast, breast; unilateral	BR	436.69	BR	472.87
C8905		Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral	BR	708.87	BR	724.34
C8906		Magnetic resonance imaging with contrast, breast; bilateral	BR	586.42	BR	573.59
C8907		Magnetic resonance imaging without contrast, breast; bilateral	BR	436.69	BR	472.87
C8908		Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral	BR	708.87	BR	724.34
C8909		Magnetic resonance angiography with contrast, chest (excluding myocardium)	BR	586.42	BR	573.59
C8910		Magnetic resonance angiography without contrast, chest (excluding myocardium)	BR	436.69	BR	472.87
C8911		Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium)	BR	708.87	BR	724.34
C8912		Magnetic resonance angiography with contrast, lower extremity	BR	586.42	BR	573.59
C8913		Magnetic resonance angiography without contrast, lower extremity	BR	436.69	BR	472.87
C8914		Magnetic resonance angiography without contrast followed by with contrast, lower extremity	BR	708.87	BR	724.34
C8918		Magnetic resonance angiography with contrast, pelvis	BR	586.42	BR	573.59
C8919		Magnetic resonance angiography without contrast, pelvis	BR	436.69	BR	472.87

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C8920		Magnetic resonance angiography without contrast followed by with contrast, pelvis	BR	708.87	BR	724.34
C8921		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete	BR	746.13	BR	880.93
C8922		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	BR	559.80	BR	880.93
C8923		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color doppler echocardiography	BR	559.80	BR	880.93
C8924		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording when performed, follow-up or limited study	BR	559.80	BR	880.93
C8925		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	BR	746.13	BR	880.93
C8926		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	BR	746.13	BR	880.93
C8927		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessmen	BR	559.80	BR	880.93
C8928		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise a	BR	746.13	BR	880.93
C8929		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler	BR	746.13	BR	880.93
C8930		Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise	BR	746.13	BR	880.93
C8931		Magnetic resonance angiography with contrast, spinal canal and contents	BR	586.42	New	
C8932		Magnetic resonance angiography without contrast, spinal canal and contents	BR	436.69	New	
C8933		Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents	BR	708.87	New	
C8934		Magnetic resonance angiography with contrast, upper extremity	BR	586.42	New	
C8935		Magnetic resonance angiography without contrast, upper extremity	BR	436.69	New	
C8936		Magnetic resonance angiography without contrast followed by with contrast, upper extremity	BR	708.87	New	
C8957		Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	BR	297.36	BR	297.57
C9113		Injection, pantoprazole sodium, per vial	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C9121		Injection, argatroban, per 5 mg	BR		BR	
C9130		Injection, immune globulin (Bivigam), 500 mg	BR		New	
C9248		Injection, clevidipine butyrate, 1 mg	BR		BR	
C9250		Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2 ml	BR		BR	
C9254		Injection, lacosamide, 1 mg	BR		BR	
C9257		Injection, bevacizumab, 0.25 mg	BR		BR	
C9275		Injection, hexaminolevulinate HCl, 100 mg, per study dose	BR		New	
C9285		Lidocaine 70 mg/tetracaine 70 mg, per patch	BR		New	
C9290		Injection, bupivacaine liposome, 1 mg	BR		New	
C9292		Injection, pertuzumab, 10 mg	BR		New	
C9293		Injection, glucarpidase, 10 units	BR		New	
C9294		Injection, taliglucerase alfa, 10 units	BR		New	
C9295		Injection, carfilzomib, 1 mg	BR		New	
C9296		Injection, ziv-aflibercept, 1 mg	BR		New	
C9297		Injection, omacetaxine mepesuccinate, 0.01 mg	BR		New	
C9298		Injection, ocriplasmin, 0.125 mg	BR		New	
C9352		Microporous collagen implantable tube (NeuraGen Nerve Guide), per cm length	BR		BR	
C9353		Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per cm length	BR		BR	
C9354		Acellular pericardial tissue matrix of nonhuman origin (Veritas), per sq cm	BR		BR	
C9355		Collagen nerve cuff (NeuroMatrix), per 0.5 cm length	BR		BR	
C9356		Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per sq cm	BR		BR	
C9358		Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	BR		BR	
C9359		Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	BR		BR	
C9360		Dermal substitute, native, nondenatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	BR		BR	
C9361		Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 cm length	BR		BR	
C9362		Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	BR		BR	
C9363		Skin substitute (Integra Meshed Bilayer Wound Matrix), per square cm	BR		BR	
C9364		Porcine implant, Permacol, per sq cm	BR		BR	
C9399		Unclassified drugs or biologicals	BR		BR	
C9600		Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	BR	10015.18	New	
C9601		Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	BR	10015.18	New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
C9602		Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	BR	10015.18	New	
C9603		Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	BR	10015.18	New	
C9604		Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed;	BR	10015.18	New	
C9605		Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed;	BR	10015.18	New	
C9606		Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including	BR	10015.18	New	
C9607		Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	BR	10015.18	New	
C9608		Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary ar	BR	10015.18	New	
C9724		Endoscopic full-thickness plication of the stomach using endoscopic plication system (EPS); includes endoscopy	BR	2409.04	BR	2213.21
C9725		Placement of endorectal intracavitary applicator for high intensity brachytherapy	BR	566.80	BR	489.23
C9726		Placement and removal (if performed) of applicator into breast for radiation therapy	BR	2403.13	BR	2257.10
C9727		Insertion of implants into the soft palate; minimum of 3 implants	BR	643.20	BR	694.83
C9728		Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple	BR	1270.08	BR	1254.56
C9733		Nonophthalmic fluorescent vascular angiography	BR	426.98	New	
C9734		Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance (MR) guidance	BR	4258.11	New	
C9735		Anoscopy; with directed submucosal injection(s), any substance	BR	3052.30	New	
C9800		Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	BR	507.49	New	
C9898		Radiolabeled product provided during a hospital inpatient stay	BR		BR	
C9899		Implanted prosthetic device, payable only for inpatients who do not have inpatient coverage	BR		BR	
D0120		Periodic oral evaluation - established patient	36.60		33.08	2097.37**
D0140		Limited oral evaluation - problem focused	61.35		55.45	2097.37**
D0145		Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	57.05		51.56	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D0150		Comprehensive oral evaluation - new or established patient	64.58	697.65	58.37	941.33
D0160		Detailed and extensive oral evaluation - problem focused, by report	129.17		116.74	2097.37**
D0170		Re-evaluation, limited, problem-focused (established patient, not postoperative visit)	43.06		38.91	2097.37**
D0180		Comprehensive periodontal evaluation - new or established patient	69.97		63.23	2097.37**
D0190		SCREENING OF A PATIENT	36.60		New	
D0191		ASSESSMENT OF A PATIENT	25.83		New	
D0210		Intraoral, complete series (including bitewings)	96.14		95.00	2097.37**
D0220		Intraoral, periapical, first film	19.23		19.00	2097.37**
D0230		Intraoral, periapical, each additional film	17.31		17.10	2097.37**
D0240		Intraoral - occlusal film	29.80	697.65	29.45	941.33
D0250		Extraoral, first film	36.53	697.65	36.10	941.33
D0260		Extraoral, each additional film	33.68	697.65	33.25	941.33
D0270		Bitewing, single film	20.69	697.65	19.54	941.33
D0272		Bitewings, 2 films	33.10	697.65	31.27	941.33
D0273		Bitewings, 3 films	40.35		38.11	2097.37**
D0274		Bitewings, 4 films	46.55	697.65	43.97	941.33
D0277		Vertical bitewings - 7 to 8 films	70.35	697.65	66.44	941.33
D0290		Posterior-anterior or lateral skull and facial bone survey film	114.38		103.46	2097.37**
D0310		Sialography	285.94		258.66	2097.37**
D0320		Temporomandibular joint arthrogram, including injection	505.16		456.96	2097.37**
D0321		Other temporomandibular joint films, by report	BR		BR	2097.37**
D0322		Tomographic survey	409.85		370.74	2097.37**
D0330		Panoramic film	88.64		80.18	2097.37**
D0340		Cephalometric film	100.08		90.53	2097.37**
D0350		Oral/facial photographic images	47.66		43.11	2097.37**
D0360		Cone beam CT - craniofacial data capture	BR		517.31	2097.37**
D0362		Cone beam, 2-dimensional image reconstruction using existing data, includes multiple images	BR		413.85	2097.37**
D0363		Cone beam, 3-dimensional image reconstruction using existing data, includes multiple images	476.57		431.10	2097.37**
D0364		CONE BEAM CT CAP&INTEPR LTD FD VIEW-<1 WHOLE JAW	768.23		New	
D0365		CONE BEAM CT CAP&INT FD VW 1 FULL DENT ARCH-MAND	768.23		New	
D0366		CONE BM CT CAP&INT FD VIEW 1 FULL DENT ARCH-MAX	768.23		New	
D0367		CONE BEAM CT CAPTURE & INTERP FD VIEW BOTH JAWS	768.23		New	
D0368		CONE BEAM CT CAP&INTEPR TMJ SERIES 2/> EXPOSURES	1124.71		New	
D0369		MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	2011.13		New	
D0370		MAXILLOFACIAL ULTRASOUND CAPTURE&INTERPRETATION	676.73		New	
D0371		SIALOENDOSCOPY CAPTURE AND INTERPRETATION	BR		New	
D0380		CONE BEAM CT IMAG CAP W/LTD FD VIEW-<1 WHOLE JAW	612.87		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D0381		CONE BM CT IMAG CAP FD VW 1 FULL DENT ARCH-MAND	612.87		New	
D0382		CONE BEAM CT IMAG CAP FD VW 1 FULL DENT ARCH-MAX	612.87		New	
D0383		CONE BEAM CT IMAGE CAPTURE FIELD VIEW BOTH JAWS	612.87		New	
D0384		CONE BEAM CT IMAG CAP TMJ SERIES 2/> EXPOSURES	895.95		New	
D0385		MAXILLOFACIAL MRI IMAGE CAPTURE	1463.07		New	
D0386		MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	366.01		New	
D0391		INTEPR DX IMAG PRACTITNER NOT ASSOC CAP IMAG RPT	BR		New	
D0415		Collection of microorganisms for culture and sensitivity	39.44		21.94	2097.37**
D0416		Viral culture	58.47		32.15	
D0417		Collection and preparation of saliva sample for laboratory diagnostic testing	53.03		29.50	2097.37**
D0418		Analysis of saliva sample	54.39		30.26	2097.37**
D0421		Genetic test for susceptibility to oral diseases	39.44		21.94	
D0425		Caries susceptibility tests	34.00		18.91	2097.37**
D0431		Adjunctive prediagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant leAdjunctive prediagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include	54.39		30.26	
D0460		Pulp vitality tests	54.39	697.65	30.26	941.33
D0470		Diagnostic casts	119.67		66.19	2097.37**
D0472		Accession of tissue, gross examination, preparation, and transmission of written report	74.79		41.60	
D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	157.74		87.75	
D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	176.78		98.34	
D0475		Decalcification procedure	95.19		52.95	
D0476		Special stains for microorganisms	92.47		51.44	
D0477		Special stains, not for microorganisms	126.47		70.35	
D0478		Immunohistochemical stains	115.59		64.30	
D0479		Tissue in-situ hybridization, including interpretation	176.78		98.34	
D0480		Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	108.79		60.52	
D0481		Electron microscopy - diagnostic	407.96		226.94	
D0482		Direct immunofluorescence	135.99		75.65	
D0483		Indirect immunofluorescence	135.99		75.65	
D0484		Consultation on slides prepared elsewhere	203.98		113.47	
D0485		Consultation, including preparation of slides from biopsy material supplied by referring source	281.49		156.59	
D0486		Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	130.55		72.62	2097.37**
D0502		Other oral pathology procedures, by report	BR		BR	
D0999		Unspecified diagnostic procedure, by report	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D1110		Prophylaxis, adult	67.80		63.14	2097.37**
D1120		Prophylaxis, child	46.79		43.58	2097.37**
D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	40.99		33.28	2097.37**
D1208		TOPICAL APPLICATION OF FLUORIDE	27.32		New	
D1310		Nutritional counseling for the control of dental disease	39.96		34.18	2097.37**
D1320		Tobacco counseling for the control and prevention of oral disease	43.39		37.11	2097.37**
D1330		Oral hygiene instruction	54.80		46.88	2097.37**
D1351		Sealant, per tooth	44.53		38.09	2097.37**
D1352		Preventive Resin Restoration In A Moderate To High Caries Risk Patient ? Permanent Tooth	57.09		New	
D1510		Space maintainer, fixed unilateral	305.07	697.65	239.84	941.33
D1515		Space maintainer, fixed bilateral	427.09	697.65	335.77	941.33
D1520		Space maintainer, removable unilateral	335.57	697.65	263.82	941.33
D1525		Space maintainer, removable bilateral	518.61	697.65	407.72	941.33
D1550		Recementation of space maintainer	65.89	697.65	51.80	941.33
D1555		Removal of fixed space maintainer	63.45		49.89	2097.37**
D2140		Amalgam-one surface, primary or permanent	104.78		92.88	2097.37**
D2150		Amalgam, 2 surfaces, primary or permanent	135.59		120.20	2097.37**
D2160		Amalgam, 3 surfaces, primary or permanent	163.94		145.33	2097.37**
D2161		Amalgam, 4 or more surfaces, primary or permanent	199.69		177.02	2097.37**
D2330		Resin, one surface, anterior	110.15		99.45	2097.37**
D2331		Resin, 2 surfaces, anterior	140.57		126.92	2097.37**
D2332		Resin, 3 surfaces, anterior	172.04		155.33	2097.37**
D2335		Resin, 4 or more surfaces or involving incisal angle (anterior)	203.51		183.74	2097.37**
D2390		Resin-based composite crown, anterior	225.54		203.63	2097.37**
D2391		Resin-based composite - one surface, posterior	129.03		116.50	2097.37**
D2392		Resin-based composite, 2 surfaces, posterior	168.89		152.49	2097.37**
D2393		Resin-based composite, 3 surfaces, posterior	209.80		189.43	2097.37**
D2394		Resin-based composite, 4 or more surfaces, posterior	257.01		232.05	2097.37**
D2410		Gold foil, one surface	247.25		183.94	2097.37**
D2420		Gold foil, 2 surfaces	412.08		306.57	2097.37**
D2430		Gold foil, 3 surfaces	714.27		531.39	2097.37**
D2510		Inlay, metallic, one surface	653.83		486.42	2097.37**
D2520		Inlay, metallic, 2 surfaces	741.74		551.83	2097.37**
D2530		Inlay, metallic, 3 or more surfaces	854.92		636.03	2097.37**
D2542		Onlay, metallic, 2 surfaces	838.44		623.77	2097.37**
D2543		Onlay, metallic, 3 surfaces	876.90		652.38	2097.37**
D2544		Onlay, metallic, 4 or more surfaces	912.06		678.54	2097.37**
D2610		Inlay, porcelain/ceramic, one surface	769.21		572.26	2097.37**
D2620		Inlay, porcelain/ceramic, 2 surfaces	812.06		604.15	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D2630		Inlay, porcelain/ceramic, 3 or more surfaces	864.81		643.39	2097.37**
D2642		Onlay, porcelain/ceramic, 2 surfaces	840.64		625.40	2097.37**
D2643		Onlay, porcelain/ceramic, 3 surfaces	906.57		674.45	2097.37**
D2644		Onlay, porcelain/ceramic, 4 or more surfaces	961.51		715.33	2097.37**
D2650		Inlay, resin-based composite - one surface	505.48		376.06	2097.37**
D2651		Inlay, resin-based composite, 2 surfaces	602.18		448.00	2097.37**
D2652		Inlay, resin-based composite, 3 or more surfaces	632.95		470.89	2097.37**
D2662		Onlay, resin-based composite, 2 surfaces	549.44		408.76	2097.37**
D2663		Onlay, resin-based composite, 3 surfaces	646.14		480.70	2097.37**
D2664		Onlay, resin-based composite, 4 or more surfaces	692.29		515.04	2097.37**
D2710		Crown - resin-based composite (indirect)	346.23		319.84	2097.37**
D2712		Crown - 3/4 resin-based composite (indirect)	346.23		319.84	2097.37**
D2720		Crown, resin with high noble metal	853.38		788.35	2097.37**
D2721		Crown, resin with predominantly base metal	799.74		738.80	2097.37**
D2722		Crown, resin with noble metal	817.29		755.01	2097.37**
D2740		Crown, porcelain/ceramic substrate	875.81		809.07	2097.37**
D2750		Crown, porcelain fused to high noble metal	864.11		798.26	2097.37**
D2751		Crown - porcelain fused to predominantly base metal	804.61		743.30	2097.37**
D2752		Crown, porcelain fused to noble metal	824.12		761.32	2097.37**
D2780		Crown - 3/4 cast high noble metal	829.00		765.82	2097.37**
D2781		Crown - 3/4 cast predominantly base metal	780.23		720.78	2097.37**
D2782		Crown - 3/4 cast noble metal	805.59		744.20	2097.37**
D2783		Crown - 3/4 porcelain/ceramic	852.40		787.45	2097.37**
D2790		Crown, full cast high noble metal	833.87		770.33	2097.37**
D2791		Crown, full cast predominantly base metal	798.98		729.79	2097.37**
D2792		Crown, full cast noble metal	804.61		743.30	2097.37**
D2794		Crown, titanium	853.38		788.35	2097.37**
D2799		Provisional crown	346.23		319.84	2097.37**
D2910		Recement inlay, onlay or partial coverage restoration	72.86		68.40	2097.37**
D2915		Recement cast or prefabricated post and core	72.86		68.40	2097.37**
D2920		Recement crown	73.88		69.35	2097.37**
D2929		PREFAB PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH	292.47		New	
D2930		Prefabricated stainless steel crown, primary tooth	201.39		189.05	2097.37**
D2931		Prefabricated stainless steel crown, permanent tooth	227.70		213.75	2097.37**
D2932		Prefabricated resin crown	242.88		228.00	2097.37**
D2933		Prefabricated stainless steel crown with resin window	278.30		261.25	2097.37**
D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	278.30		261.25	2097.37**
D2940		Sedative filling	76.91		72.20	2097.37**
D2950		Core buildup, including any pins	192.28		180.50	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D2951		Pin retention, per tooth, in addition to restoration	43.52		40.85	2097.37**
D2952		Post and core in addition to crown, indirectly fabricated	303.60		285.00	2097.37**
D2953		Each additional indirectly fabricated post - same tooth	151.80		142.50	2097.37**
D2954		Prefabricated post and core in addition to crown	242.88		228.00	2097.37**
D2955		Post removal (not in conjunction with endodontic therapy)	187.22		175.75	2097.37**
D2957		Each additional prefabricated post - same tooth	121.44		114.00	2097.37**
D2960		Labial veneer (laminate)-chairside	586.96		551.01	2097.37**
D2961		Labial veneer (resin laminate), laboratory	665.90		625.11	2097.37**
D2962		Labial veneer (porcelain laminate), laboratory	723.58		679.26	2097.37**
D2970		Temporary crown (fractured tooth)	182.16		171.00	2097.37**
D2971		Additional procedures to construct new crown under existing partial denture framework	116.38		109.25	2097.37**
D2975		Coping	354.20		332.50	2097.37**
D2980		Crown repair, by report	BR		BR	2097.37**
D2981		INLAY REPAIR NECESSITATED RESTORATIVE MATL FAIL	BR		New	
D2982		ONLAY REPAIR NECESSITATED RESTORATIVE MATL FAIL	BR		New	
D2983		VENEER REPAIR NECESSITATED RESTORATIVE MATL FAIL	BR		New	
D2990		RESIN INFILTRATION INCIPIENT SMOOTH SURFACE LES	50.60		New	
D2999		Unspecified restorative procedure, by report	BR	697.65	BR	941.33
D3110		Pulp cap, direct (excluding final restoration)	57.18		56.38	2097.37**
D3120		Pulp cap, indirect (excluding final restoration)	45.75		45.10	2097.37**
D3220		Therapeutic pulpotomy (excluding final restoration), removal of pulp coronal to the dentinocemental junction and application of medicament	117.23		115.58	2097.37**
D3221		Pulpal debridement, primary and permanent teeth	128.66		126.85	2097.37**
D3222		Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development	119.13		117.46	2097.37**
D3230		Pulpal therapy (resorbable filling), anterior, primary tooth (excluding final restoration)	152.62		134.50	2097.37**
D3240		Pulpal therapy (resorbable filling), posterior, primary tooth (excluding final restoration)	187.84		165.54	2097.37**
D3310		Endodontic therapy, anterior tooth (excluding final restoration)	598.75		527.66	2097.37**
D3320		Endodontic therapy, bicuspid tooth (excluding final restoration)	733.76		646.64	2097.37**
D3330		Endodontic therapy, molar (excluding final restoration)	909.86		801.84	2097.37**
D3331		Treatment of root canal obstruction; nonsurgical access	234.80		206.93	2097.37**
D3332		Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	446.12		393.16	2097.37**
D3333		Internal root repair of perforation defects	205.45		181.06	2097.37**
D3346		Retreatment of previous root canal therapy, anterior	798.33		703.55	2097.37**
D3347		Retreatment of previous root canal therapy, bicuspid	939.21		827.70	2097.37**
D3348		Retreatment of previous root canal therapy, molar	1162.27		1024.28	2097.37**
D3351		Apexification/recalcification, initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	338.92		245.42	2097.37**
D3352		Apexification/recalcification, interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	151.93		110.01	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D3353		Apexification/recalcification, final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)	467.48		338.50	2097.37**
D3354		Pulpal Regeneration ? (Completion Of Regenerative Treatment In An Immature Permanent Tooth With A Necrotic Pulp); Does Not Include Final Restoration	BR		New	
D3410		Apicoectomy/periradicular surgery, anterior	672.00		486.60	2097.37**
D3421		Apicoectomy/periradicular surgery, bicuspid (first root)	747.97		541.61	2097.37**
D3425		Apicoectomy/periradicular surgery, molar (first root)	847.31		613.54	2097.37**
D3426		Apicoectomy/periradicular surgery (each additional root)	286.33		207.33	2097.37**
D3430		Retrograde filling, per root	210.37		152.33	2097.37**
D3450		Root amputation, per root	438.26		317.35	2097.37**
D3460		Endodontic endosseous implant	1636.18	697.65	1184.76	941.33
D3470		Intentional replantation (including necessary splinting)	835.62		605.08	2097.37**
D3910		Surgical procedure for isolation of tooth with rubber dam	116.87		84.63	2097.37**
D3920		Hemisection (including any root removal), not including root canal therapy	333.08		241.18	2097.37**
D3950		Canal preparation and fitting of preformed dowel or post	151.93		110.01	2097.37**
D3999		Unspecified endodontic procedure, by report	BR	697.65	BR	941.33
D4210		Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant	527.30		423.55	2097.37**
D4211		Gingivectomy or gingivoplasty, 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	234.35		188.24	2097.37**
D4212		GING/GINGIVOPLASTY ALLW ACSS RESTORATV PRO-TOOTH	187.48		New	
D4230		Anatomical crown exposure, 4 or more contiguous teeth per quadrant	738.22		592.97	2097.37**
D4231		Anatomical crown exposure, 1 to 3 teeth per quadrant	351.53		282.37	2097.37**
D4240		Gingival flap procedure, including root planing, 4 or more contiguous teeth or tooth bounded spaces per quadrant	667.91		536.50	2097.37**
D4241		Gingival flap procedure, including root planing, 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	386.68		310.60	2097.37**
D4245		Apically positioned flap	492.14		395.31	2097.37**
D4249		Clinical crown lengthening, hard tissue	732.36		588.26	2097.37**
D4260		Osseous surgery (including flap entry and closure), 4 or more contiguous teeth or tooth bounded spaces per quadrant	1113.18	697.65	894.16	941.33
D4261		Osseous surgery (including flap entry and closure), 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	597.60		480.02	2097.37**
D4263		Bone replacement graft - first site in quadrant	398.40	697.65	320.01	941.33
D4264		Bone replacement graft - each additional site in quadrant	339.81	697.65	272.95	941.33
D4265		Biologic materials to aid in soft and osseous tissue regeneration	BR		BR	2097.37**
D4266		Guided tissue regeneration - resorbable barrier, per site	410.12		329.43	2097.37**
D4267		Guided tissue regeneration, nonresorbable barrier, per site (includes membrane removal)	527.30		423.55	2097.37**
D4268		Surgical revision procedure, per tooth	BR	697.65	BR	941.33
D4270		Pedicle soft tissue graft procedure	790.94	697.65	635.32	941.33

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D4273		Subepithelial connective tissue graft procedures, per tooth	966.71	697.65	776.51	941.33
D4274		Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	548.39		440.49	2097.37**
D4275		Soft tissue allograft	726.50		583.56	2097.37**
D4276		Combined connective tissue and double pedicle graft, per tooth	1083.89		870.63	2097.37**
D4277		FREE SFT TSS GFT PROC 1ST T/EDNTULS T PSTN GFT	820.24		New	
D4278		FREE SFT TSS GFT EA ADD CNTIG T/EDNT T SAME SITE	269.51		New	
D4320		Provisional splinting, intracoronal	291.15		281.63	2097.37**
D4321		Provisional splinting, extracoronal	264.68		256.03	2097.37**
D4341		Periodontal scaling and root planing, 4 or more teeth per quadrant	167.63		162.15	2097.37**
D4342		Periodontal scaling and root planing, 1 to 3 teeth, per quadrant	97.05		93.88	2097.37**
D4355		Full mouth debridement to enable comprehensive evaluation and diagnosis	114.69	697.65	110.95	941.33
D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	BR	697.65	BR	941.33
D4910		Periodontal maintenance	103.22		99.85	2097.37**
D4920		Unscheduled dressing change (by someone other than treating dentist)	74.99		72.54	2097.37**
D4999		Unspecified periodontal procedure, by report	BR		BR	2097.37**
D5110		Complete denture - maxillary	871.69		865.75	2097.37**
D5120		Complete denture - mandibular	871.69		865.75	2097.37**
D5130		Immediate denture - maxillary	950.43		943.95	2097.37**
D5140		Immediate denture - mandibular	950.43		943.95	2097.37**
D5211		Upper partial denture - resin base (including any conventional clasps, rests and teeth)	735.69		730.68	2097.37**
D5212		Lower partial denture - resin base (including any conventional clasps, rests and teeth)	854.99		849.16	2097.37**
D5213		Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	963.16		956.59	2097.37**
D5214		Mandibular partial denture, cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	963.16		956.59	2097.37**
D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	735.69		730.68	2097.37**
D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	854.99		849.16	2097.37**
D5281		Removable unilateral partial denture, 1 piece cast metal (including clasps and teeth)	561.51		557.68	2097.37**
D5410		Adjust complete denture - maxillary	42.57		47.40	2097.37**
D5411		Adjust complete denture - mandibular	42.57		47.40	2097.37**
D5421		Adjust partial denture - maxillary	42.57		47.40	2097.37**
D5422		Adjust partial denture - mandibular	42.57		47.40	2097.37**
D5510		Repair broken complete denture base	95.44		94.79	2097.37**
D5520		Replace missing or broken teeth, complete denture (each tooth)	79.53		78.99	2097.37**
D5610		Repair resin denture base	103.39		102.69	2097.37**
D5620		Repair cast framework	111.35		110.59	2097.37**
D5630		Repair or replace broken clasp	135.21		134.29	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D5640		Replace broken teeth, per tooth	87.49		86.89	2097.37**
D5650		Add tooth to existing partial denture	119.30		118.49	2097.37**
D5660		Add clasp to existing partial denture	143.16		142.19	2097.37**
D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	349.95		347.56	2097.37**
D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	349.95		347.56	2097.37**
D5710		Rebase complete maxillary denture	353.93		351.51	2097.37**
D5711		Rebase complete mandibular denture	338.02		335.72	2097.37**
D5720		Rebase maxillary partial denture	334.04		331.77	2097.37**
D5721		Rebase mandibular partial denture	334.04		331.77	2097.37**
D5730		Reline complete maxillary denture (chairside)	199.63		198.27	2097.37**
D5731		Reline lower complete mandibular denture (chairside)	199.63		198.27	2097.37**
D5740		Reline maxillary partial denture (chairside)	182.93		181.68	2097.37**
D5741		Reline mandibular partial denture (chairside)	182.93		181.68	2097.37**
D5750		Reline complete maxillary denture (laboratory)	266.44		264.62	2097.37**
D5751		Reline complete mandibular denture (laboratory)	266.44		264.62	2097.37**
D5760		Reline maxillary partial denture (laboratory)	262.46		260.67	2097.37**
D5761		Reline mandibular partial denture (laboratory)	262.46		260.67	2097.37**
D5810		Interim complete denture (maxillary)	421.53		418.66	2097.37**
D5811		Interim complete denture (mandibular)	453.34		450.25	2097.37**
D5820		Interim partial denture (maxillary)	326.09		323.87	2097.37**
D5821		Interim partial denture (mandibular)	345.97		343.62	2097.37**
D5850		Tissue conditioning, maxillary	83.51		82.94	2097.37**
D5851		Tissue conditioning, mandibular	83.51		82.94	2097.37**
D5860		Overdenture, complete, by report	BR		BR	2097.37**
D5861		Overdenture, partial, by report	BR		BR	2097.37**
D5862		Precision attachment, by report	BR		BR	2097.37**
D5867		Replacement of replaceable part of semi-precision or precision attachment (male or female component)	BR		BR	2097.37**
D5875		Modification of removable prosthesis following implant surgery	BR		BR	2097.37**
D5899		Unspecified removable prosthodontic procedure, by report	BR		BR	2097.37**
D5911		Facial moulage (sectional)	221.10	697.65	219.60	941.33
D5912		Facial moulage (complete)	221.10	697.65	219.60	941.33
D5913		Nasal prosthesis	4655.92		4624.19	2097.37**
D5914		Auricular prosthesis	4655.92		4624.19	2097.37**
D5915		Orbital prosthesis	6300.68		6257.75	2097.37**
D5916		Ocular prosthesis	1680.55		1669.10	2097.37**
D5919		Facial prosthesis	BR		BR	2097.37**
D5922		Nasal septal prosthesis	BR		BR	2097.37**
D5923		Ocular prosthesis, interim	BR		BR	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D5924		Cranial prosthesis	BR		BR	2097.37**
D5925		Facial augmentation implant prosthesis	BR		BR	2097.37**
D5926		Nasal prosthesis, replacement	BR		BR	2097.37**
D5927		Auricular prosthesis, replacement	BR		BR	2097.37**
D5928		Orbital prosthesis, replacement	BR		BR	2097.37**
D5929		Facial prosthesis, replacement	BR		BR	2097.37**
D5931		Obturator prosthesis, surgical	2506.91		2489.83	2097.37**
D5932		Obturator prosthesis, definitive	4688.53		4656.58	2097.37**
D5933		Obturator prosthesis, modification	BR		BR	2097.37**
D5934		Mandibular resection prosthesis with guide flange	4273.36		4244.24	2097.37**
D5935		Mandibular resection prosthesis without guide flange	3718.21		3692.88	2097.37**
D5936		Obturator/prosthesis, interim	4176.33		4147.87	2097.37**
D5937		Trismus appliance (not for TM treatment)	524.92		521.35	2097.37**
D5951		Feeding aid	682.40		677.75	2097.37**
D5952		Speech aid prosthesis, pediatric	2215.82		2200.72	2097.37**
D5953		Speech aid prosthesis, adult	4208.14		4179.47	2097.37**
D5954		Palatal augmentation prosthesis	3899.55		3872.98	2097.37**
D5955		Palatal lift prosthesis, definitive	3606.87		3582.29	2097.37**
D5958		Palatal lift prosthesis, interim	BR		BR	2097.37**
D5959		Palatal lift prosthesis, modification	BR		BR	2097.37**
D5960		Speech aid prosthesis, modification	BR		BR	2097.37**
D5982		Surgical stent	392.29		351.51	2097.37**
D5983		Radiation carrier	795.34	697.65	789.92	941.33
D5984		Radiation shield	795.34	697.65	789.92	941.33
D5985		Radiation cone locator	795.34	697.65	789.92	941.33
D5986		Fluoride gel carrier	79.53		78.99	2097.37**
D5987		Commissure splint	1193.01	697.65	1184.88	941.33
D5988		Surgical splint	238.60		236.98	2097.37**
D5991		Topical medicament carrier	91.46		90.84	2097.37**
D5992		Adjust Maxillofacial Prosthetic Appliance	BR		New	
D5993		Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra Or Intraoral) Other Than Required Adjustments, By Report	BR		New	
D5999		Unspecified maxillofacial prosthesis, by report	BR		BR	2097.37**
D6010		Surgical placement of implant body: endosteal implant	1456.27		1446.34	2097.37**
D6012		Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1375.94		1366.56	2097.37**
D6040		Surgical placement: eposteal implant	5010.64		4976.50	2097.37**
D6050		Surgical placement: transosteal implant	3738.10		3712.62	2097.37**
D6051		INTERIM ABUTMENT	BR		New	
D6053		Implant/abutment supported removable denture for completely edentulous arch	1087.23		1079.82	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D6054		Implant/abutment supported removable denture for partially edentulous arch	1087.23		1079.82	2097.37**
D6055		Dental implant supported connecting bar	437.44		434.46	2097.37**
D6056		Prefabricated abutment - includes placement	302.23		300.17	2097.37**
D6057		Custom abutment - includes placement	373.81		371.26	2097.37**
D6058		Abutment supported porcelain/ceramic crown	838.29		832.58	2097.37**
D6059		Abutment supported porcelain fused to metal crown (high noble metal)	827.15		821.52	2097.37**
D6060		Abutment supported porcelain fused to metal crown (predominantly base metal)	781.82		776.49	2097.37**
D6061		Abutment supported porcelain fused to metal crown (noble metal)	797.73		792.29	2097.37**
D6062		Abutment supported cast metal crown (high noble metal)	794.54		789.13	2097.37**
D6063		Abutment supported cast metal crown (predominantly base metal)	691.95		687.23	2097.37**
D6064		Abutment supported cast metal crown (noble metal)	723.76		718.83	2097.37**
D6065		Implant supported porcelain/ceramic crown	824.77		819.15	2097.37**
D6066		Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	803.29		797.82	2097.37**
D6067		Implant supported metal crown (titanium, titanium alloy, high noble metal)	779.43		774.12	2097.37**
D6068		Abutment supported retainer for porcelain/ceramic FPD	831.13		825.47	2097.37**
D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	827.15		821.52	2097.37**
D6070		Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	781.82		776.49	2097.37**
D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	797.73		792.29	2097.37**
D6072		Abutment supported retainer for cast metal FPD (high noble metal)	807.27		801.77	2097.37**
D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	737.28		732.26	2097.37**
D6074		Abutment supported retainer for cast metal FPD (noble metal)	783.41		778.07	2097.37**
D6075		Implant supported retainer for ceramic FPD	824.77		819.15	2097.37**
D6076		Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	803.29		797.82	2097.37**
D6077		Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	779.43		774.12	2097.37**
D6078		Implant/abutment supported fixed denture for completely edentulous arch	BR		BR	2097.37**
D6079		Implant/abutment supported fixed denture for partially edentulous arch	BR		BR	2097.37**
D6080		Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis	68.40		67.93	2097.37**
D6090		Repair implant-supported prosthesis, by report	BR		BR	2097.37**
D6091		Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	330.07		327.82	2097.37**
D6092		Recement implant/abutment supported crown	64.42		63.98	2097.37**
D6093		Recement implant/abutment supported fixed partial denture	101.01		100.32	2097.37**
D6094		Abutment supported crown - (titanium)	656.16		651.68	2097.37**
D6095		Repair implant abutment, by report	BR		BR	2097.37**
D6100		Implant removal, by report	BR		BR	2097.37**
D6101		DEBR PERIIMPL DFCT CLN EXPSD IMPL FLP ENTRY CLO	BR		New	
D6102		DEBR&OSS CNTR PERIIMPL DFCT;SURF&FLAP ENTRY&CLOS	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D6103		BN GFT PERIIMPL DFCT-NO FLP/BR MB/BIOL MATL	BR		New	
D6104		BONE GRAFT AT TIME OF IMPLANT PLACEMENT	BR		New	
D6190		Radiographic/surgical implant index, by report	147.14		146.14	2097.37**
D6194		Abutment supported retainer crown for FPD - (titanium)	676.04		671.43	2097.37**
D6199		Unspecified implant procedure, by report	BR		BR	2097.37**
D6205		Pontic - indirect resin based composite	502.78		513.06	2097.37**
D6210		Pontic, cast high noble metal	768.67		784.39	2097.37**
D6211		Pontic, cast predominantly base metal	720.33		735.06	2097.37**
D6212		Pontic, cast noble metal	749.33		764.66	2097.37**
D6214		Pontic - titanium	773.50		789.33	2097.37**
D6240		Pontic, porcelain fused to high noble metal	759.00		774.53	2097.37**
D6241		Pontic, porcelain fused to predominantly base metal	700.99		715.33	2097.37**
D6242		Pontic, porcelain fused to noble metal	739.66		754.79	2097.37**
D6245		Pontic - porcelain/ceramic	783.17		799.19	2097.37**
D6250		Pontic, resin with high noble metal	749.33		764.66	2097.37**
D6251		Pontic, resin with predominantly base metal	691.32		705.46	2097.37**
D6252		Pontic, resin with noble metal	713.56		728.16	2097.37**
D6253		Provisional pontic	322.94		329.54	2097.37**
D6545		Retainer, cast metal for resin bonded fixed prosthesis	286.43		289.84	2097.37**
D6548		Retainer - porcelain/ceramic for resin bonded fixed prosthesis	315.07		318.82	2097.37**
D6600		Inlay, porcelain/ceramic, 2 surfaces	568.52		575.29	2097.37**
D6601		Inlay, porcelain/ceramic, 3 or more surfaces	596.30		603.39	2097.37**
D6602		Inlay, cast high noble metal, 2 surfaces	607.58		614.81	2097.37**
D6603		Inlay, cast high noble metal, 3 or more surfaces	668.34		676.29	2097.37**
D6604		Inlay, cast predominantly base metal, 2 surfaces	595.43		602.51	2097.37**
D6605		Inlay, cast predominantly base metal, 3 or more surfaces	631.01		638.52	2097.37**
D6606		Inlay, cast noble metal, 2 surfaces	585.88		592.85	2097.37**
D6607		Inlay, cast noble metal, 3 or more surfaces	650.11		657.85	2097.37**
D6608		Onlay, porcelain/ceramic, 2 surfaces	617.99		625.35	2097.37**
D6609		Onlay, porcelain/ceramic, 3 or more surfaces	644.90		652.58	2097.37**
D6610		Onlay, cast high noble metal, 2 surfaces	655.32		663.12	2097.37**
D6611		Onlay, cast high noble metal, 3 or more surfaces	716.94		725.48	2097.37**
D6612		Onlay, cast predominantly base metal, 2 surfaces	651.85		659.60	2097.37**
D6613		Onlay, cast predominantly base metal, 3 or more surfaces	681.36		689.47	2097.37**
D6614		Onlay, cast noble metal, 2 surfaces	637.96		645.55	2097.37**
D6615		Onlay, cast noble metal, 3 or more surfaces	663.13		671.02	2097.37**
D6624		Inlay, titanium	607.58		614.81	2097.37**
D6634		Onlay, titanium	637.96		645.55	2097.37**
D6710		Crown - indirect resin based composite	650.98		658.73	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D6720		Crown, resin with high noble metal	759.47		768.51	2097.37**
D6721		Crown, resin with predominantly base metal	720.42		728.99	2097.37**
D6722		Crown, resin with noble metal	733.43		742.16	2097.37**
D6740		Crown - porcelain/ceramic	798.53		808.04	2097.37**
D6750		Crown, porcelain fused to high noble metal	777.70		786.96	2097.37**
D6751		Crown, porcelain fused to predominantly base metal	725.62		734.26	2097.37**
D6752		Crown, porcelain fused to noble metal	742.98		751.82	2097.37**
D6780		Crown, 3/4 cast high noble metal	733.43		742.16	2097.37**
D6781		Crown - 3/4 cast predominantly base metal	733.43		742.16	2097.37**
D6782		Crown - 3/4 cast noble metal	681.36		689.47	2097.37**
D6783		Crown - 3/4 porcelain/ceramic	755.13		764.12	2097.37**
D6790		Crown, full cast high noble metal	750.79		759.73	2097.37**
D6791		Crown, full cast predominantly base metal	711.74		720.21	2097.37**
D6792		Crown, full cast noble metal	737.77		746.56	2097.37**
D6793		Provisional retainer crown	308.13		311.80	2097.37**
D6794		Crown - titanium	737.77		746.56	2097.37**
D6920		Connector bar	172.68	697.65	146.97	941.33
D6930		Recement bridge	100.73		85.73	2097.37**
D6940		Stress breaker	228.32		194.32	2097.37**
D6950		Precision attachment	441.29		375.59	2097.37**
D6975		Coping, metal	489.26		416.41	2097.37**
D6980		Bridge repair, by report	BR		BR	2097.37**
D6985		Pediatric partial denture, fixed	383.73		326.60	2097.37**
D6999		Unspecified fixed prosthodontic procedure, by report	BR		BR	2097.37**
D7111		Extraction, coronal remnants - deciduous tooth	84.13	697.65	73.03	941.33
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	111.83	697.65	97.08	941.33
D7210		Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	211.33	697.65	168.70	941.33
D7220		Removal of impacted tooth, soft tissue	264.99	697.65	211.53	941.33
D7230		Removal of impacted tooth, partially bony	352.59	697.65	281.46	941.33
D7240		Removal of impacted tooth, completely bony	413.91	697.65	330.41	941.33
D7241		Removal of impacted tooth, completely bony, with unusual surgical complications	520.12	697.65	415.20	941.33
D7250		Surgical removal of residual tooth roots (cutting procedure)	223.38	697.65	178.32	941.33
D7251		Coronectomy ? Intentional Partial Tooth Removal	438.00		New	
D7260		Oral antral fistula closure	1214.40	697.65	1051.09	941.33
D7261		Primary closure of a sinus perforation	506.00	697.65	437.96	941.33
D7270		Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	379.50		328.47	2097.37**
D7272		Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	506.00		437.96	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D7280		Surgical access of an unerupted tooth	354.20		306.57	2097.37**
D7282		Mobilization of erupted or malpositioned tooth to aid eruption	177.10		153.28	2097.37**
D7283		Placement of device to facilitate eruption of impacted tooth	151.80		131.39	
D7285		Biopsy of oral tissue - hard (bone, tooth)	708.40		613.14	2097.37**
D7286		Biopsy of oral tissue - soft	303.60		262.77	2097.37**
D7287		Exfoliative cytological sample collection	121.44		105.11	2097.37**
D7288		Brush biopsy - transepithelial sample collection	121.44		105.11	
D7290		Surgical repositioning of teeth	303.60		262.77	2097.37**
D7291		Transseptal fiberotomy/supra crestal fiberotomy, by report	BR	697.65	BR	941.33
D7292		Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap	485.76		420.44	2097.37**
D7293		Surgical placement: temporary anchorage device requiring surgical flap	303.60		262.77	2097.37**
D7294		Surgical placement: temporary anchorage device without surgical flap	253.00		218.98	2097.37**
D7295		Harvest Of Bone For Use In Autogenous Grafting Procedure	BR		New	
D7310		Alveoloplasty in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant	176.28		111.48	2097.37**
D7311		Alveoloplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	154.24		97.55	2097.37**
D7320		Alveoloplasty not in conjunction with extractions, 4 or more teeth or tooth spaces, per quadrant	286.45		181.16	2097.37**
D7321		Alveoloplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant	242.38		153.29	
D7340		Vestibuloplasty, ridge extension (second epithelialization)	1211.91		766.43	2097.37**
D7350		Vestibuloplasty, ridge extension (including soft tissue grafts, muscle re-attachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)	3525.56		2229.60	2097.37**
D7410		Excision of benign lesion up to 1.25 cm	528.83		334.44	2097.37**
D7411		Excision of benign lesion greater than 1.25 cm	837.32		529.53	2097.37**
D7412		Excision of benign lesion, complicated	925.46		585.27	2097.37**
D7413		Excision of malignant lesion up to 1.25 cm	616.97		390.18	2097.37**
D7414		Excision of malignant lesion greater than 1.25 cm	925.46		585.27	2097.37**
D7415		Excision of malignant lesion, complicated	1035.63		654.95	2097.37**
D7440		Excision of malignant tumor, lesion diameter up to 1.25 cm	837.32		529.53	2097.37**
D7441		Excision of malignant tumor, lesion diameter greater than 1.25 cm	1233.95		780.36	2097.37**
D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	528.83		334.44	2097.37**
D7451		Removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	722.74		457.07	2097.37**
D7460		Removal of benign nonodontogenic cyst or tumor, lesion diameter up to 1.25 cm	528.83		334.44	2097.37**
D7461		Removal of benign nonodontogenic cyst or tumor, lesion diameter greater than 1.25 cm	722.74		457.07	2097.37**
D7465		Destruction of lesion(s) by physical or chemical methods, by report	286.45		181.16	2097.37**
D7471		Removal of lateral exostosis (maxilla or mandible)	654.87		414.15	2097.37**
D7472		Removal of torus palatinus	778.27		492.18	2097.37**
D7473		Removal of torus mandibularis	734.20		464.31	2097.37**
D7485		Surgical reduction of osseous tuberosity	654.87		414.15	2097.37**
D7490		Radical resection of maxilla or mandible	5288.34		3344.40	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D7510		Incision and drainage of abscess, intraoral soft tissue	189.50		119.84	2097.37**
D7511		Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	286.45		181.16	
D7520		Incision and drainage of abscess, extraoral soft tissue	902.54		570.78	2097.37**
D7521		Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	991.56		627.08	
D7530		Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	325.23		205.68	2097.37**
D7540		Removal of reaction-producing foreign bodies, musculoskeletal system	360.49		227.98	2097.37**
D7550		Partial ostectomy/sequestrectomy for removal of nonvital bone	224.75		142.14	2097.37**
D7560		Maxillary sinusotomy for removal of tooth fragment or foreign body	1784.81		1128.74	2097.37**
D7610		Maxilla, open reduction (teeth immobilized if present)	2886.55		1825.49	2097.37**
D7620		Maxilla, closed reduction (teeth immobilized if present)	2164.69		1368.97	2097.37**
D7630		Mandible, open reduction (teeth immobilized if present)	3752.96		2373.41	2097.37**
D7640		Mandible, closed reduction (teeth immobilized if present)	2381.52		1506.09	2097.37**
D7650		Malar and/or zygomatic arch, open reduction	1804.21		1141.00	2097.37**
D7660		Malar and/or zygomatic arch, closed reduction	1063.84		672.78	2097.37**
D7670		Alveolus - closed reduction, may include stabilization of teeth	830.27		525.07	2097.37**
D7671		Alveolus - open reduction, may include stabilization of teeth	1564.47		989.39	2097.37**
D7680		Facial bones, complicated reduction with fixation and multiple surgical approaches	5412.62		3422.99	2097.37**
D7710		Maxilla, open reduction	3392.47		2145.43	2097.37**
D7720		Maxilla, closed reduction	2381.52		1506.09	2097.37**
D7730		Mandible, open reduction	4907.58		3103.60	2097.37**
D7740		Mandible, closed reduction	2428.23		1535.64	2097.37**
D7750		Malar and/or zygomatic arch, open reduction	3088.39		1953.13	2097.37**
D7760		Malar and/or zygomatic arch, closed reduction	1239.23		783.70	2097.37**
D7770		Alveolus - open reduction stabilization of teeth	1679.05		1061.85	2097.37**
D7771		Alveolus, closed reduction stabilization of teeth	1295.64		819.38	2097.37**
D7780		Facial bones, complicated reduction with fixation and multiple surgical approaches	7216.82		4563.99	2097.37**
D7810		Open reduction of dislocation	3174.77		2007.75	2097.37**
D7820		Closed reduction of dislocation	520.02		328.87	2097.37**
D7830		Manipulation under anesthesia	297.91		188.40	2097.37**
D7840		Condylectomy	4327.62		2736.83	2097.37**
D7850		Surgical discectomy; with/without implant	3737.09		2363.38	2097.37**
D7852		Disc repair	4279.15		2706.18	2097.37**
D7854		Synovectomy	4415.76		2792.57	2097.37**
D7856		Myotomy	3133.34		1981.56	2097.37**
D7858		Joint reconstruction	8931.12		5648.13	2097.37**
D7860		Arthrotomy	3806.72		2407.41	2097.37**
D7865		Arthroplasty	6134.47		3879.50	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D7870		Arthrocentesis	202.72		128.20	2097.37**
D7871		Nonarthroscopic lysis and lavage	405.44		256.40	2097.37**
D7872		Arthroscopy, diagnosis, with or without biopsy	2163.81		1368.42	2097.37**
D7873		Arthroscopy, surgical: lavage and lysis of adhesions	2605.39		1647.67	2097.37**
D7874		Arthroscopy, surgical: disc repositioning and stabilization	3737.09		2363.38	2097.37**
D7875		Arthroscopy, surgical: synovectomy	4094.06		2589.12	2097.37**
D7876		Arthroscopy, surgical: discectomy	4414.00		2791.46	2097.37**
D7877		Arthroscopy, surgical: debridement	3895.74		2463.71	2097.37**
D7880		Occlusal orthotic appliance	486.53		307.68	2097.37**
D7899		Unspecified TMD therapy, by report	BR		BR	2097.37**
D7910		Suture of recent small wounds up to 5 cm	289.10		182.83	2097.37**
D7911		Complicated suture, up to 5 cm	721.86		456.51	2097.37**
D7912		Complicated suture, greater than 5 cm	1299.17		821.61	2097.37**
D7920		Skin graft (identify defect covered, location, and type of graft)	2128.56		1346.12	2097.37**
D7921		COLLECTION & APPLIC AUTO BLOOD CONCENTRATE PROD	196.55		New	
D7940		Osteoplasty, for orthognathic deformities	BR	697.65	BR	941.33
D7941		Osteotomy - mandibular rami	5420.55		3428.01	2097.37**
D7943		Osteotomy - mandibular rami with bone graft; includes obtaining the graft	4979.85		3149.31	2097.37**
D7944		Osteotomy-segmented or subapical	4437.80		2806.51	2097.37**
D7945		Osteotomy, body of mandible	5905.31		3734.58	2097.37**
D7946		LeFort I (maxilla, total)	7315.54		4626.42	2097.37**
D7947		LeFort I (maxilla, segmented)	6152.10		3890.65	2097.37**
D7948		LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion), without bone graft	7985.39		5050.04	2097.37**
D7949		LeFort II or LeFort III, with bone graft	10400.40		6577.32	2097.37**
D7950		Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or nonautogenous, by report	BR		BR	2097.37**
D7951		Sinus augmentation with bone or bone substitutes	BR		BR	2097.37**
D7952		SINUS AUGMENTATION VIA A VERTICAL APPROACH	BR		New	
D7953		Bone replacement graft for ridge preservation - per site	160.29		94.76	2097.37**
D7955		Repair of maxillofacial soft and/or hard tissue defect	BR		BR	2097.37**
D7960		Frenulectomy (frenectomy or frenotomy), separate procedure	259.29		153.29	2097.37**
D7963		Frenuloplasty	424.29		250.83	2097.37**
D7970		Excision of hyperplastic tissue, per arch	377.14		222.96	2097.37**
D7971		Excision of pericoronal gingiva	141.43		83.61	2097.37**
D7972		Surgical reduction of fibrous tuberosity	528.00		312.14	2097.37**
D7980		Sialolithotomy	594.00		351.16	2097.37**
D7981		Excision of salivary gland, by report	BR		BR	2097.37**
D7982		Sialodochoplasty	1404.86		830.53	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D7983		Closure of salivary fistula	1348.29		797.08	2097.37**
D7990		Emergency tracheotomy	1159.72		685.60	2097.37**
D7991		Coronoidectomy	2828.58		1672.20	2097.37**
D7995		Synthetic graft, mandible or facial bones, by report	BR		BR	2097.37**
D7996		Implant, mandible for augmentation purposes (excluding alveolar ridge), by report	BR		BR	2097.37**
D7997		Appliance removal (not by dentist who placed appliance), includes removal of archbar	216.86		128.20	2097.37**
D7998		Intraoral placement of a fixation device not in conjunction with a fracture	942.86		557.40	2097.37**
D7999		Unspecified oral surgery procedure, by report	BR		BR	2097.37**
D8010		Limited orthodontic treatment of the primary dentition	BR		BR	2097.37**
D8020		Limited orthodontic treatment of the transitional dentition	BR		BR	2097.37**
D8030		Limited orthodontic treatment of the adolescent dentition	BR		BR	2097.37**
D8040		Limited orthodontic treatment of the adult dentition	BR		BR	2097.37**
D8050		Interceptive orthodontic treatment of the primary dentition	BR		BR	2097.37**
D8060		Interceptive orthodontic treatment of the transitional dentition	BR		BR	2097.37**
D8070		Comprehensive orthodontic treatment of the transitional dentition	BR		BR	2097.37**
D8080		Comprehensive orthodontic treatment of the adolescent dentition	BR		BR	2097.37**
D8090		Comprehensive orthodontic treatment of the adult dentition	BR		BR	2097.37**
D8210		Removable appliance therapy	BR		BR	2097.37**
D8220		Fixed appliance therapy	BR		BR	2097.37**
D8660		Preorthodontic visit	BR		BR	2097.37**
D8670		Periodic orthodontic treatment visit (as part of contract)	BR		BR	2097.37**
D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	BR		BR	2097.37**
D8690		Orthodontic treatment (alternative billing to a contract fee)	BR		BR	2097.37**
D8691		Repair of orthodontic appliance	BR		BR	2097.37**
D8692		Replacement of lost or broken retainer	BR		BR	2097.37**
D8693		Rebonding or recementing; and/or repair, as required, of fixed retainers	BR		BR	2097.37**
D8999		Unspecified orthodontic procedure, by report	BR		BR	2097.37**
D9110		Palliative (emergency) treatment of dental pain-minor procedures	45.54		56.48	
D9120		Fixed partial denture sectioning	51.45		63.82	2097.37**
D9210		Local anesthesia not in conjunction with operative or surgical procedures	33.78		21.19	2097.37**
D9211		Regional block anesthesia	37.28		23.39	2097.37**
D9212		Trigeminal division block anesthesia	58.24		36.54	2097.37**
D9215		Local anesthesia	27.96		17.54	2097.37**
D9220		Deep sedation/general anesthesia, first 30 minutes	337.81		211.94	2097.37**
D9221		Deep sedation/general anesthesia, each additional 15 minutes	151.43		95.01	2097.37**
D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	55.91		35.08	
D9241		Intravenous conscious sedation/analgesia - first 30 minutes	262.09		164.44	2097.37**
D9242		Intravenous conscious sedation/analgesia - each additional 15 minutes	128.13		80.39	2097.37**
D9248		Nonintravenous conscious sedation	81.54		51.16	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
D9310		Consultation, diagnostic service provided by dentist or physician other than requesting dentist or physician	88.04		75.64	2097.37**
D9410		House/extended care facility call	100.70		86.52	2097.37**
D9420		Hospital call	162.88		139.94	2097.37**
D9430		Office visit for observation (during regularly scheduled hours), no other services performed	BR		BR	2097.37**
D9440		Office visit, after regularly scheduled hours	55.03		47.28	2097.37**
D9450		Case presentation, detailed and extensive treatment planning	27.51		23.64	2097.37**
D9610		Therapeutic parenteral drug, single administration	BR		BR	2097.37**
D9612		Therapeutic parenteral drugs, 2 or more administrations, different medications	BR		BR	2097.37**
D9630		Other drugs and/or medicaments, by report	BR	697.65	BR	941.33
D9910		Application of desensitizing medicament	18.32		23.19	2097.37**
D9911		Application of desensitizing resin for cervical and/or root surface, per tooth	25.65		32.46	2097.37**
D9920		Behavior management, by report	BR		BR	2097.37**
D9930		Treatment of complications (postsurgical) - unusual circumstances, by report	BR	697.65	BR	941.33
D9940		Occlusal guards, by report	151.80	697.65	192.12	941.33
D9941		Fabrication of athletic mouthguard	52.35		66.25	2097.37**
D9942		Repair and/or reline of occlusal guard	62.81		79.50	2097.37**
D9950		Occlusion analysis, mounted case	99.46	697.65	125.87	941.33
D9951		Occlusal adjustment, limited	44.49	697.65	56.31	941.33
D9952		Occlusal adjustment, complete	209.38	697.65	264.99	941.33
D9970		Enamel microabrasion	23.56		29.81	2097.37**
D9971		Odontoplasty 1-2 teeth; includes removal of enamel projections	30.36		38.42	2097.37**
D9972		External bleaching - per arch	104.69		132.49	2097.37**
D9973		External bleaching - per tooth	17.27		21.86	2097.37**
D9974		Internal bleaching - per tooth	91.60		115.93	2097.37**
D9975		EXT BLEACH HOM APPLIC-ARCH; MATL FAB CSTM TRAYS	104.69		New	
D9999		Unspecified adjunctive procedure, by report	BR		BR	2097.37**
E0100	NU	Cane, includes canes of all materials, adjustable or fixed, with tip	19.39		29.44	
E0100	RR	Cane, includes canes of all materials, adjustable or fixed, with tip	5.47		8.30	
E0100	UE	Cane, includes canes of all materials, adjustable or fixed, with tip	17.31		23.47	
E0105	NU	Cane, quad or 3-prong, includes canes of all materials, adjustable or fixed, with tips	53.18		68.64	
E0105	RR	Cane, quad or 3-prong, includes canes of all materials, adjustable or fixed, with tips	8.15		12.39	
E0105	UE	Cane, quad or 3-prong, includes canes of all materials, adjustable or fixed, with tips	40.99		52.92	
E0110	NU	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	79.63		108.45	
E0110	RR	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	14.71		22.35	
E0110	UE	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	59.72		81.32	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0111	NU	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips	49.01		74.43	
E0111	RR	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips	7.75		11.78	
E0111	UE	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips	37.83		57.46	
E0112	NU	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips	40.06		51.71	
E0112	RR	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips	9.15		13.89	
E0112	UE	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips	30.56		39.45	
E0113	NU	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip	22.88		29.53	
E0113	RR	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip	4.73		7.20	
E0113	UE	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip	17.17		22.16	
E0114	NU	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips	51.10		65.96	
E0114	RR	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips	7.89		11.98	
E0114	UE	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips	38.62		49.85	
E0116	NU	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	28.51		38.77	
E0116	RR	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	4.97		7.55	
E0116	UE	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	22.61		29.17	
E0117	NU	Crutch, underarm, articulating, spring assisted, each	208.66		269.35	
E0117	RR	Crutch, underarm, articulating, spring assisted, each	20.85		26.92	
E0117	UE	Crutch, underarm, articulating, spring assisted, each	156.51		202.03	
E0118		Crutch substitute, lower leg platform, with or without wheels, each	BR		BR	2097.37**
E0130	NU	Walker, rigid (pickup), adjustable or fixed height	55.90		84.61	
E0130	RR	Walker, rigid (pickup), adjustable or fixed height	14.64		20.26	
E0130	UE	Walker, rigid (pickup), adjustable or fixed height	45.70		65.93	
E0135	NU	Walker, folding (pickup), adjustable or fixed height	66.50		101.01	
E0135	RR	Walker, folding (pickup), adjustable or fixed height	14.50		20.80	
E0135	UE	Walker, folding (pickup), adjustable or fixed height	51.03		77.49	
E0140	NU	Walker, with trunk support, adjustable or fixed height, any type	336.61		434.52	
E0140	RR	Walker, with trunk support, adjustable or fixed height, any type	33.67		43.46	
E0140	UE	Walker, with trunk support, adjustable or fixed height, any type	252.47		325.90	
E0141	NU	Walker, rigid, wheeled, adjustable or fixed height	107.55		138.89	
E0141	RR	Walker, rigid, wheeled, adjustable or fixed height	20.88		26.94	
E0141	UE	Walker, rigid, wheeled, adjustable or fixed height	80.68		104.17	
E0143	NU	Walker, folding, wheeled, adjustable or fixed height	102.21		144.84	
E0143	RR	Walker, folding, wheeled, adjustable or fixed height	17.13		26.01	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0143	UE	Walker, folding, wheeled, adjustable or fixed height	76.67		108.40	
E0144	NU	Walker, enclosed, 4 sided framed, rigid or folding, wheeled with posterior seat	297.18		383.62	
E0144	RR	Walker, enclosed, 4 sided framed, rigid or folding, wheeled with posterior seat	29.73		38.38	
E0144	UE	Walker, enclosed, 4 sided framed, rigid or folding, wheeled with posterior seat	222.87		287.71	
E0147	NU	Walker, heavy-duty, multiple braking system, variable wheel resistance	536.41		692.44	
E0147	RR	Walker, heavy-duty, multiple braking system, variable wheel resistance	53.65		69.25	
E0147	UE	Walker, heavy-duty, multiple braking system, variable wheel resistance	402.32		519.35	
E0148	NU	Walker, heavy-duty, without wheels, rigid or folding, any type, each	118.57		153.05	
E0148	RR	Walker, heavy-duty, without wheels, rigid or folding, any type, each	11.87		15.32	
E0148	UE	Walker, heavy-duty, without wheels, rigid or folding, any type, each	88.92		114.79	
E0149	NU	Walker, heavy-duty, wheeled, rigid or folding, any type	208.29		268.88	
E0149	RR	Walker, heavy-duty, wheeled, rigid or folding, any type	20.83		26.89	
E0149	UE	Walker, heavy-duty, wheeled, rigid or folding, any type	156.21		201.65	
E0153	NU	Platform attachment, forearm crutch, each	75.13		96.97	
E0153	RR	Platform attachment, forearm crutch, each	7.92		10.96	
E0153	UE	Platform attachment, forearm crutch, each	56.34		72.73	
E0154	NU	Platform attachment, walker, each	65.80		84.94	
E0154	RR	Platform attachment, walker, each	7.99		10.32	
E0154	UE	Platform attachment, walker, each	49.99		64.53	
E0155	NU	Wheel attachment, rigid pick-up walker, per pair	25.02		38.02	
E0155	RR	Wheel attachment, rigid pick-up walker, per pair	3.05		4.64	
E0155	UE	Wheel attachment, rigid pick-up walker, per pair	19.08		28.97	
E0156	NU	Seat attachment, walker	24.67		31.84	
E0156	RR	Seat attachment, walker	3.16		4.07	
E0156	UE	Seat attachment, walker	18.52		23.91	
E0157	NU	Crutch attachment, walker, each	64.99		98.69	
E0157	RR	Crutch attachment, walker, each	7.14		10.84	
E0157	UE	Crutch attachment, walker, each	48.74		74.02	
E0158	NU	Leg extensions for walker, per set of 4	25.53		38.76	
E0158	RR	Leg extensions for walker, per set of 4	3.32		4.28	
E0158	UE	Leg extensions for walker, per set of 4	19.27		29.25	
E0159	NU	Brake attachment for wheeled walker, replacement, each	16.67		21.52	
E0159	RR	Brake attachment for wheeled walker, replacement, each	1.72		2.22	
E0159	UE	Brake attachment for wheeled walker, replacement, each	12.51		16.15	
E0160	NU	Sitz type bath or equipment, portable, used with or without commode	35.79		46.20	
E0160	RR	Sitz type bath or equipment, portable, used with or without commode	4.00		6.06	
E0160	UE	Sitz type bath or equipment, portable, used with or without commode	26.81		34.62	
E0161	NU	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)	28.40		36.66	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0161	RR	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)	3.87		5.00	
E0161	UE	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)	21.26		27.45	
E0162	NU	Sitz bath chair	157.76		203.64	
E0162	RR	Sitz bath chair	16.52		21.36	
E0162	UE	Sitz bath chair	122.34		157.93	
E0163	NU	Commode chair, mobile or stationary, with fixed arms	107.79		154.14	
E0163	RR	Commode chair, mobile or stationary, with fixed arms	22.47		34.14	
E0163	UE	Commode chair, mobile or stationary, with fixed arms	87.02		118.88	
E0165	NU	Commode chair, mobile or stationary, with detachable arms	171.10		259.64	
E0165	RR	Commode chair, mobile or stationary, with detachable arms	17.10		25.96	
E0165	UE	Commode chair, mobile or stationary, with detachable arms	128.33		194.73	
E0167	NU	Pail or pan for use with commode chair, replacement only	12.99		16.77	
E0167	RR	Pail or pan for use with commode chair, replacement only	1.30		1.75	
E0167	UE	Pail or pan for use with commode chair, replacement only	9.77		12.64	
E0168	NU	Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	163.41		210.94	
E0168	RR	Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	16.42		21.20	
E0168	UE	Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	122.54		158.18	
E0170	RR	Commode chair with integrated seat lift mechanism, electric, any type	174.02		224.64	
E0171	RR	Commode chair with integrated seat lift mechanism, nonelectric, any type	31.32		40.42	
E0172		Seat lift mechanism placed over or on top of toilet, any type	BR		BR	2097.37**
E0175	NU	Footrest, for use with commode chair, each	71.71		92.57	
E0175	RR	Footrest, for use with commode chair, each	7.17		9.26	
E0175	UE	Footrest, for use with commode chair, each	52.78		68.12	
E0181	NU	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty	282.10		364.25	
E0181	RR	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty	28.21		36.43	
E0181	UE	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty	211.58		273.19	
E0182	NU	Pump for alternating pressure pad, for replacement only	240.90		365.97	
E0182	RR	Pump for alternating pressure pad, for replacement only	24.09		36.60	
E0182	UE	Pump for alternating pressure pad, for replacement only	180.68		274.49	
E0184	NU	Dry pressure mattress	210.81		272.12	
E0184	RR	Dry pressure mattress	26.60		34.34	
E0184	UE	Dry pressure mattress	161.67		208.70	
E0185	NU	Gel or gel-like pressure pad for mattress, standard mattress length and width	294.36		447.05	
E0185	RR	Gel or gel-like pressure pad for mattress, standard mattress length and width	41.36		62.81	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0185	UE	Gel or gel-like pressure pad for mattress, standard mattress length and width	225.91		343.09	
E0186	NU	Air pressure mattress	186.80		283.76	
E0186	RR	Air pressure mattress	18.68		28.38	
E0186	UE	Air pressure mattress	140.10		212.82	
E0187	NU	Water pressure mattress	213.60		324.32	
E0187	RR	Water pressure mattress	21.36		32.43	
E0187	UE	Water pressure mattress	160.20		243.25	
E0188	NU	Synthetic sheepskin pad	28.62		36.94	
E0188	RR	Synthetic sheepskin pad	3.37		4.34	
E0188	UE	Synthetic sheepskin pad	21.49		27.73	
E0189	NU	Lambswool sheepskin pad, any size	47.83		72.63	
E0189	RR	Lambswool sheepskin pad, any size	5.18		7.86	
E0189	UE	Lambswool sheepskin pad, any size	35.87		54.48	
E0190	NU	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	BR		BR	2097.37**
E0190	RR	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	BR		BR	2097.37**
E0190	UE	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	BR		BR	2097.37**
E0191	NU	Heel or elbow protector, each	10.40		13.97	
E0191	RR	Heel or elbow protector, each	1.03		1.43	
E0191	UE	Heel or elbow protector, each	7.81		10.43	
E0193	RR	Powered air flotation bed (low air loss therapy)	716.64		1088.35	
E0194	NU	Air fluidized bed	35235.30		45484.47	
E0194	RR	Air fluidized bed	3523.53		4548.45	
E0194	UE	Air fluidized bed	26426.48		34113.35	
E0196	NU	Gel pressure mattress	299.00		453.98	
E0196	RR	Gel pressure mattress	29.90		45.40	
E0196	UE	Gel pressure mattress	20.93		340.50	
E0197	NU	Air pressure pad for mattress, standard mattress length and width	203.92		309.69	
E0197	RR	Air pressure pad for mattress, standard mattress length and width	28.14		42.74	
E0197	UE	Air pressure pad for mattress, standard mattress length and width	179.13		272.03	
E0198	NU	Water pressure pad for mattress, standard mattress length and width	203.92		309.69	
E0198	RR	Water pressure pad for mattress, standard mattress length and width	21.13		32.09	
E0198	UE	Water pressure pad for mattress, standard mattress length and width	154.73		235.01	
E0199	NU	Dry pressure pad for mattress, standard mattress length and width	29.50		44.79	
E0199	RR	Dry pressure pad for mattress, standard mattress length and width	2.94		4.46	
E0199	UE	Dry pressure pad for mattress, standard mattress length and width	22.13		33.59	
E0200	NU	Heat lamp, without stand (table model), includes bulb, or infrared element	72.96		110.79	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0200	RR	Heat lamp, without stand (table model), includes bulb, or infrared element	9.90		15.05	
E0200	UE	Heat lamp, without stand (table model), includes bulb, or infrared element	54.75		83.14	
E0202	RR	Phototherapy (bilirubin) light with photometer	67.79		87.51	
E0203		Therapeutic lightbox, minimum 10,000 lux, table top model	BR		BR	2097.37**
E0205	NU	Heat lamp, with stand, includes bulb, or infrared element	178.60		271.23	
E0205	RR	Heat lamp, with stand, includes bulb, or infrared element	19.64		29.83	
E0205	UE	Heat lamp, with stand, includes bulb, or infrared element	133.94		203.42	
E0210	NU	Electric heat pad, standard	30.29		45.62	
E0210	RR	Electric heat pad, standard	3.02		4.29	
E0210	UE	Electric heat pad, standard	22.73		34.22	
E0215	NU	Electric heat pad, moist	65.20		99.00	
E0215	RR	Electric heat pad, moist	6.82		10.35	
E0215	UE	Electric heat pad, moist	48.91		74.28	
E0217	NU	Water circulating heat pad with pump	534.60		693.89	
E0217	RR	Water circulating heat pad with pump	52.17		77.25	
E0217	UE	Water circulating heat pad with pump	400.94		520.38	
E0218	NU	Water circulating cold pad with pump	1061.78		528.53	
E0218	RR	Water circulating cold pad with pump	106.18		61.07	
E0218	UE	Water circulating cold pad with pump	796.34		396.20	
E0221		Infrared heating pad system	0.00		0.00	
E0225	NU	Hydrocollator unit, includes pads	420.79		543.20	
E0225	RR	Hydrocollator unit, includes pads	41.48		53.56	
E0225	UE	Hydrocollator unit, includes pads	315.58		407.38	
E0231		Noncontact wound-warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover	BR		BR	2097.37**
E0232		Warming card for use with the noncontact wound-warming device and noncontact wound-warming wound cover	BR		BR	2097.37**
E0235	NU	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	186.80		241.16	
E0235	RR	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	18.68		24.12	
E0235	UE	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	140.10		180.87	
E0236	NU	Pump for water circulating pad	479.00		618.41	
E0236	RR	Pump for water circulating pad	47.90		61.84	
E0236	UE	Pump for water circulating pad	359.25		463.82	
E0239	NU	Hydrocollator unit, portable	487.04		628.70	
E0239	RR	Hydrocollator unit, portable	48.71		62.87	
E0239	UE	Hydrocollator unit, portable	365.30		471.55	
E0240	NU	Bath/shower chair, with or without wheels, any size	BR		BR	2097.37**
E0240	RR	Bath/shower chair, with or without wheels, any size	BR		BR	2097.37**
E0240	UE	Bath/shower chair, with or without wheels, any size	BR		BR	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0241		Bathtub wall rail, each	33.63		36.80	2097.37**
E0242		Bathtub rail, floor base	76.20		83.39	2097.37**
E0243		Toilet rail, each	60.46		66.16	2097.37**
E0244		Raised toilet seat	45.79		50.11	2097.37**
E0245		Tub stool or bench	75.49		82.61	2097.37**
E0246		Transfer tub rail attachment	103.03		112.75	2097.37**
E0247	NU	Transfer bench for tub or toilet with or without commode opening	74.41		81.43	2097.37**
E0247	RR	Transfer bench for tub or toilet with or without commode opening	7.44		8.14	2097.37**
E0247	UE	Transfer bench for tub or toilet with or without commode opening	55.81		56.38	2097.37**
E0248	NU	Transfer bench, heavy-duty, for tub or toilet with or without commode opening	BR		BR	2097.37**
E0248	RR	Transfer bench, heavy-duty, for tub or toilet with or without commode opening	BR		BR	2097.37**
E0248	UE	Transfer bench, heavy-duty, for tub or toilet with or without commode opening	BR		BR	2097.37**
E0249	NU	Pad for water circulating heat unit, for replacement only	91.67		139.20	
E0249	RR	Pad for water circulating heat unit, for replacement only	10.08		15.32	
E0249	UE	Pad for water circulating heat unit, for replacement only	68.75		104.41	
E0250	NU	Hospital bed, fixed height, with any type side rails, with mattress	775.40		1177.63	
E0250	RR	Hospital bed, fixed height, with any type side rails, with mattress	77.54		117.76	
E0250	UE	Hospital bed, fixed height, with any type side rails, with mattress	581.55		883.22	
E0251	NU	Hospital bed, fixed height, with any type side rails, without mattress	686.10		892.31	
E0251	RR	Hospital bed, fixed height, with any type side rails, without mattress	68.61		89.23	
E0251	UE	Hospital bed, fixed height, with any type side rails, without mattress	514.58		669.23	
E0255	NU	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	931.90		1415.19	
E0255	RR	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	93.19		141.52	
E0255	UE	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	698.32		1061.40	
E0256	NU	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	661.10		1004.12	
E0256	RR	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	66.11		100.41	
E0256	UE	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	495.83		753.09	
E0260	NU	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	1310.80		0.00	
E0260	RR	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	131.08		0.00	
E0260	UE	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	983.10		0.00	
E0261	NU	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	1086.20		1649.62	
E0261	RR	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	108.62		164.96	
E0261	UE	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	814.65		1237.22	
E0265	NU	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress	1736.20		2407.88	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0265	RR	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress	173.62		240.79	
E0265	UE	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress	1302.15		1805.91	
E0266	NU	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress	1408.70		2139.31	
E0266	RR	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress	140.87		213.93	
E0266	UE	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress	1056.53		1604.49	
E0270	NU	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	BR		BR	2097.37**
E0270	RR	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	BR		BR	2097.37**
E0270	UE	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	BR		BR	2097.37**
E0271	NU	Mattress, innerspring	176.13		267.49	
E0271	RR	Mattress, innerspring	18.29		27.78	
E0271	UE	Mattress, innerspring	150.03		208.95	
E0272	NU	Mattress, foam rubber	160.52		243.78	
E0272	RR	Mattress, foam rubber	16.76		25.45	
E0272	UE	Mattress, foam rubber	119.82		181.97	
E0273	NU	Bed board	42.94		39.93	2097.37**
E0273	RR	Bed board	4.29		15.66	2097.37**
E0273	UE	Bed board	32.21		31.32	2097.37**
E0274	NU	Over-bed table	69.04		64.21	2097.37**
E0274	RR	Over-bed table	6.90		28.19	2097.37**
E0274	UE	Over-bed table	51.78		51.68	2097.37**
E0275	NU	Bed pan, standard, metal or plastic	16.58		21.41	
E0275	RR	Bed pan, standard, metal or plastic	1.73		2.24	
E0275	UE	Bed pan, standard, metal or plastic	12.43		16.04	
E0276	NU	Bed pan, fracture, metal or plastic	14.41		18.59	
E0276	RR	Bed pan, fracture, metal or plastic	1.70		2.19	
E0276	UE	Bed pan, fracture, metal or plastic	11.39		14.70	
E0277	NU	Powered pressure-reducing air mattress	6564.60		0.00	
E0277	RR	Powered pressure-reducing air mattress	656.46		0.00	
E0277	UE	Powered pressure-reducing air mattress	4923.45		0.00	
E0280	NU	Bed cradle, any type	30.30		46.01	
E0280	RR	Bed cradle, any type	3.26		4.95	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0280	UE	Bed cradle, any type	22.72		34.51	
E0290	NU	Hospital bed, fixed height, without side rails, with mattress	592.80		900.29	
E0290	RR	Hospital bed, fixed height, without side rails, with mattress	59.28		90.03	
E0290	UE	Hospital bed, fixed height, without side rails, with mattress	444.60		675.23	
E0291	NU	Hospital bed, fixed height, without side rails, without mattress	488.50		654.12	
E0291	RR	Hospital bed, fixed height, without side rails, without mattress	48.85		65.41	
E0291	UE	Hospital bed, fixed height, without side rails, without mattress	366.38		490.60	
E0292	NU	Hospital bed, variable height, hi-lo, without side rails, with mattress	666.60		1012.42	
E0292	RR	Hospital bed, variable height, hi-lo, without side rails, with mattress	66.66		101.24	
E0292	UE	Hospital bed, variable height, hi-lo, without side rails, with mattress	499.95		759.32	
E0293	NU	Hospital bed, variable height, hi-lo, without side rails, without mattress	610.50		861.46	
E0293	RR	Hospital bed, variable height, hi-lo, without side rails, without mattress	61.05		86.15	
E0293	UE	Hospital bed, variable height, hi-lo, without side rails, without mattress	427.35		646.10	
E0294	NU	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	1036.30		1573.83	
E0294	RR	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	103.63		157.38	
E0294	UE	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	777.23		1180.37	
E0295	NU	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	1010.10		1534.05	
E0295	RR	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	101.01		153.41	
E0295	UE	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	757.58		1150.54	
E0296	NU	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress	1302.50		1978.01	
E0296	RR	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress	130.25		197.80	
E0296	UE	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress	976.88		1483.52	
E0297	NU	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress	1115.80		1694.57	
E0297	RR	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress	111.58		169.46	
E0297	UE	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress	761.85		1270.93	
E0300	NU	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	2648.99		3419.53	
E0300	RR	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	264.89		341.95	
E0300	UE	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	1986.74		2564.64	
E0301	NU	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	2234.70		3261.20	
E0301	RR	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	223.47		326.12	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0301	UE	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	1676.03		2445.90	
E0302	NU	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	6676.40		8618.48	
E0302	RR	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	667.64		861.85	
E0302	UE	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	5007.30		6463.87	
E0303	NU	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	2547.00		3661.93	
E0303	RR	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	254.70		366.19	
E0303	UE	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	1910.25		2746.45	
E0304	NU	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	7191.90		9283.87	
E0304	RR	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	719.19		928.39	
E0304	UE	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	5393.93		6962.91	
E0305	NU	Bedside rails, half-length	166.00		214.39	
E0305	RR	Bedside rails, half-length	16.60		21.44	
E0305	UE	Bedside rails, half-length	124.50		160.80	
E0310	NU	Bedside rails, full-length	163.41		233.88	
E0310	RR	Bedside rails, full-length	19.01		27.42	
E0310	UE	Bedside rails, full-length	122.55		176.97	
E0315		Bed accessory: board, table, or support device, any type	BR		BR	2097.37**
E0316	NU	Safety enclosure frame/canopy for use with hospital bed, any type	1911.90		2545.22	
E0316	RR	Safety enclosure frame/canopy for use with hospital bed, any type	191.19		254.52	
E0316	UE	Safety enclosure frame/canopy for use with hospital bed, any type	1433.93		1908.92	
E0325	NU	Urinal; male, jug-type, any material	10.95		14.14	
E0325	RR	Urinal; male, jug-type, any material	1.39		2.11	
E0325	UE	Urinal; male, jug-type, any material	7.24		9.35	
E0326	NU	Urinal; female, jug-type, any material	11.37		14.69	
E0326	RR	Urinal; female, jug-type, any material	1.15		1.66	
E0326	UE	Urinal; female, jug-type, any material	8.52		10.99	
E0328		Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0329		Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress	BR		BR	
E0350	NU	Control unit for electronic bowel irrigation/evacuation system	BR		BR	2097.37**
E0350	RR	Control unit for electronic bowel irrigation/evacuation system	BR		BR	2097.37**
E0350	UE	Control unit for electronic bowel irrigation/evacuation system	BR		BR	2097.37**
E0352		Disposable pack (water reservoir bag, speculum, valving mechanism, and collection bag/box) for use with the electronic bowel irrigation/evacuation system	BR		BR	2097.37**
E0370		Air pressure elevator for heel	BR		BR	2097.37**
E0371	RR	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	371.68		535.43	
E0372	RR	Powered air overlay for mattress, standard mattress length and width	451.02		649.72	
E0373	RR	Nonpowered advanced pressure reducing mattress	516.62		740.23	
E0424	RR	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	1773.60		0.00	
E0425	NU	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	177.36		4979.88	2097.37**
E0425	UE	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	1330.20		3758.40	2097.37**
E0430	NU	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	2059.20		2255.04	2097.37**
E0430	UE	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	1544.40		1691.28	2097.37**
E0431	RR	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	29.67		0.00	
E0433		Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	51.63		0.00	
E0434	RR	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	29.67		0.00	
E0435	NU	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor	1415.70		1550.34	2097.37**
E0435	UE	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor	1061.78		1162.76	2097.37**
E0439	RR	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing	177.36		0.00	
E0440	NU	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	2874.30		3147.66	2097.37**
E0440	UE	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	2155.73		2360.75	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0441		Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	77.45		0.00	
E0442		Stationary oxygen contents, liquid, 1 month's supply = 1 unit	77.45		0.00	
E0443		Portable oxygen contents, gaseous, 1 month's supply = 1 unit	77.45		0.00	
E0444		Portable oxygen contents, liquid, 1 month's supply = 1 unit	77.45		0.00	
E0445		Oximeter device for measuring blood oxygen levels noninvasively	BR		BR	
E0446		Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	BR		New	
E0450	NU	Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	8784.60		13340.91	
E0450	RR	Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	878.46		1334.09	
E0450	UE	Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	6588.45		10005.69	
E0455	NU	Oxygen tent, excluding croup or pediatric tents	BR		BR	
E0455	RR	Oxygen tent, excluding croup or pediatric tents	BR		BR	
E0455	UE	Oxygen tent, excluding croup or pediatric tents	BR		BR	
E0457	NU	Chest shell (cuirass)	665.34		858.87	
E0457	RR	Chest shell (cuirass)	66.54		85.88	
E0457	UE	Chest shell (cuirass)	498.97		644.11	
E0459	NU	Chest wrap	468.40		711.28	
E0459	RR	Chest wrap	46.84		71.13	
E0459	UE	Chest wrap	351.30		533.46	
E0460	NU	Negative pressure ventilator; portable or stationary	7942.50		10252.76	
E0460	RR	Negative pressure ventilator; portable or stationary	794.25		1025.28	
E0460	UE	Negative pressure ventilator; portable or stationary	5956.88		7689.58	
E0461	RR	Volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface (e.g., mask)	878.46		1334.09	
E0462	NU	Rocking bed, with or without side rails	3155.00		4072.70	
E0462	RR	Rocking bed, with or without side rails	315.50		407.27	
E0462	UE	Rocking bed, with or without side rails	2366.25		3054.53	
E0463	RR	Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	1522.72		1965.64	
E0464	RR	Pressure support ventilator with volume control mode, may include pressure control mode, used with noninvasive interface (e.g., mask)	1522.72		1965.64	
E0470	NU	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	2166.20		3091.13	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0470	RR	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	216.62		309.11	
E0470	UE	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	1624.65		2318.35	
E0471	NU	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	5400.00		7735.88	
E0471	RR	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	540.00		773.59	
E0471	UE	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	4050.00		5801.92	
E0472	NU	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	5400.00		7735.88	
E0472	RR	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	540.00		773.59	
E0472	UE	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	4050.00		5801.92	
E0480	NU	Percussor, electric or pneumatic, home model	404.40		614.19	
E0480	RR	Percussor, electric or pneumatic, home model	40.44		61.42	
E0480	UE	Percussor, electric or pneumatic, home model	303.30		460.64	
E0481		Intrapulmonary percussive ventilation system and related accessories	BR		BR	2097.37**
E0482	RR	Cough stimulating device, alternating positive and negative airway pressure	417.22		601.02	
E0483	NU	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	11510.70		14858.99	
E0483	RR	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	1151.07		1485.90	
E0483	UE	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	8633.03		11144.25	
E0484	NU	Oscillatory positive expiratory pressure device, nonelectric, any type, each	39.98		51.60	
E0484	RR	Oscillatory positive expiratory pressure device, nonelectric, any type, each	3.99		5.15	
E0484	UE	Oscillatory positive expiratory pressure device, nonelectric, any type, each	30.00		38.73	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0485		Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	0.00		0.00	
E0486		Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment	0.00		0.00	
E0487	NU	Spirometer, electronic, includes all accessories	BR		BR	
E0487	RR	Spirometer, electronic, includes all accessories	BR		BR	
E0487	UE	Spirometer, electronic, includes all accessories	BR		BR	
E0500	NU	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	1010.10		1534.21	
E0500	RR	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	101.01		153.42	
E0500	UE	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	757.58		1150.67	
E0550	NU	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	542.80		700.63	
E0550	RR	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	54.28		70.06	
E0550	UE	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	407.10		525.47	
E0555	NU	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	12.10		10.96	
E0555	RR	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	1.21		7.83	
E0555	UE	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	9.08		9.40	
E0560	NU	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery	158.54		206.63	
E0560	RR	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery	15.95		24.21	
E0560	UE	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery	118.89		154.97	
E0561	NU	Humidifier, nonheated, used with positive airway pressure device	99.85		128.90	
E0561	RR	Humidifier, nonheated, used with positive airway pressure device	9.97		12.87	
E0561	UE	Humidifier, nonheated, used with positive airway pressure device	74.88		96.67	
E0562	NU	Humidifier, heated, used with positive airway pressure device	281.10		362.86	
E0562	RR	Humidifier, heated, used with positive airway pressure device	28.09		36.27	
E0562	UE	Humidifier, heated, used with positive airway pressure device	210.82		272.14	
E0565	NU	Compressor, air power source for equipment which is not self-contained or cylinder driven	561.50		852.69	
E0565	RR	Compressor, air power source for equipment which is not self-contained or cylinder driven	56.15		85.27	
E0565	UE	Compressor, air power source for equipment which is not self-contained or cylinder driven	421.13		639.52	
E0570	NU	Nebulizer, with compressor	174.50		0.00	
E0570	RR	Nebulizer, with compressor	17.45		0.00	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0570	UE	Nebulizer, with compressor	130.88		0.00	
E0572	NU	Aerosol compressor, adjustable pressure, light duty for intermittent use	371.40		532.28	
E0572	RR	Aerosol compressor, adjustable pressure, light duty for intermittent use	37.14		53.23	
E0572	UE	Aerosol compressor, adjustable pressure, light duty for intermittent use	278.25		399.22	
E0574	NU	Ultrasonic/electronic aerosol generator with small volume nebulizer	392.50		562.66	
E0574	RR	Ultrasonic/electronic aerosol generator with small volume nebulizer	39.25		56.27	
E0574	UE	Ultrasonic/electronic aerosol generator with small volume nebulizer	294.38		422.01	
E0575	NU	Nebulizer, ultrasonic, large volume	945.90		1436.49	
E0575	RR	Nebulizer, ultrasonic, large volume	94.59		143.65	
E0575	UE	Nebulizer, ultrasonic, large volume	709.43		1077.38	
E0580	NU	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	125.09		161.47	
E0580	RR	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	12.51		16.15	
E0580	UE	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	93.80		121.08	
E0585	NU	Nebulizer, with compressor and heater	322.70		490.16	
E0585	RR	Nebulizer, with compressor and heater	32.27		49.02	
E0585	UE	Nebulizer, with compressor and heater	242.03		367.62	
E0600	NU	Respiratory suction pump, home model, portable or stationary, electric	421.30		640.02	
E0600	RR	Respiratory suction pump, home model, portable or stationary, electric	42.13		64.00	
E0600	UE	Respiratory suction pump, home model, portable or stationary, electric	315.98		480.03	
E0601	NU	Continuous airway pressure (CPAP) device	936.80		1345.82	
E0601	RR	Continuous airway pressure (CPAP) device	93.68		134.58	
E0601	UE	Continuous airway pressure (CPAP) device	702.60		1009.37	
E0602	NU	Breast pump, manual, any type	31.96		41.26	
E0602	RR	Breast pump, manual, any type	3.21		4.13	
E0602	UE	Breast pump, manual, any type	23.98		30.94	
E0603	NU	Breast pump, electric (AC and/or DC), any type	BR		117.45	
E0603	RR	Breast pump, electric (AC and/or DC), any type	BR		39.15	
E0603	UE	Breast pump, electric (AC and/or DC), any type	BR		93.96	
E0604	NU	Breast pump, hospital grade, electric (AC and/or DC), any type	BR		338.26	
E0604	RR	Breast pump, hospital grade, electric (AC and/or DC), any type	BR		129.98	
E0604	UE	Breast pump, hospital grade, electric (AC and/or DC), any type	BR		253.69	
E0605	NU	Vaporizer, room type	28.62		36.94	
E0605	RR	Vaporizer, room type	3.31		4.29	
E0605	UE	Vaporizer, room type	23.58		30.43	
E0606	NU	Postural drainage board	248.50		320.72	
E0606	RR	Postural drainage board	24.85		32.07	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0606	UE	Postural drainage board	186.38		240.54	
E0607	NU	Home blood glucose monitor	72.34		0.00	
E0607	RR	Home blood glucose monitor	7.23		0.00	
E0607	UE	Home blood glucose monitor	54.25		0.00	
E0610	NU	Pacemaker monitor, self-contained, (checks battery depletion, includes audible and visible check systems)	257.53		332.45	
E0610	RR	Pacemaker monitor, self-contained, (checks battery depletion, includes audible and visible check systems)	27.16		35.06	
E0610	UE	Pacemaker monitor, self-contained, (checks battery depletion, includes audible and visible check systems)	193.17		249.37	
E0615	NU	Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems	518.42		669.23	
E0615	RR	Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems	63.34		81.78	
E0615	UE	Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems	388.83		501.93	
E0616		Implantable cardiac event recorder with memory, activator, and programmer	BR		BR	
E0617	RR	External defibrillator with integrated electrocardiogram analysis	329.19		424.95	
E0618	RR	Apnea monitor, without recording feature	303.55		391.83	
E0619	RR	Apnea monitor, with recording feature	0.00		0.00	
E0620	NU	Skin piercing device for collection of capillary blood, laser, each	946.71		1222.09	
E0620	RR	Skin piercing device for collection of capillary blood, laser, each	94.66		122.19	
E0620	UE	Skin piercing device for collection of capillary blood, laser, each	710.04		916.56	
E0621	NU	Sling or seat, patient lift, canvas or nylon	103.93		134.16	
E0621	RR	Sling or seat, patient lift, canvas or nylon	10.01		12.92	
E0621	UE	Sling or seat, patient lift, canvas or nylon	78.34		101.13	
E0625	NU	Patient lift, bathroom or toilet, not otherwise classified	BR		BR	2097.37**
E0625	RR	Patient lift, bathroom or toilet, not otherwise classified	BR		BR	2097.37**
E0625	UE	Patient lift, bathroom or toilet, not otherwise classified	BR		BR	2097.37**
E0627	NU	Seat lift mechanism incorporated into a combination lift-chair mechanism	358.07		471.46	
E0627	RR	Seat lift mechanism incorporated into a combination lift-chair mechanism	35.81		47.17	
E0627	UE	Seat lift mechanism incorporated into a combination lift-chair mechanism	268.52		353.60	
E0628	NU	Separate seat lift mechanism for use with patient-owned furniture, electric	358.07		471.46	
E0628	RR	Separate seat lift mechanism for use with patient-owned furniture, electric	35.81		47.17	
E0628	UE	Separate seat lift mechanism for use with patient-owned furniture, electric	268.52		353.60	
E0629	NU	Separate seat lift mechanism for use with patient-owned furniture, nonelectric	358.07		462.22	
E0629	RR	Separate seat lift mechanism for use with patient-owned furniture, nonelectric	35.81		46.23	
E0629	UE	Separate seat lift mechanism for use with patient-owned furniture, nonelectric	268.52		346.63	
E0630	NU	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	937.60		1423.96	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0630	RR	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	93.76		142.40	
E0630	UE	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	703.20		1067.98	
E0635	NU	Patient lift, electric, with seat or sling	1324.80		1710.23	
E0635	RR	Patient lift, electric, with seat or sling	132.48		171.02	
E0635	UE	Patient lift, electric, with seat or sling	993.60		1282.68	
E0636	NU	Multipositional patient support system, with integrated lift, patient accessible controls	11417.90		14739.19	
E0636	RR	Multipositional patient support system, with integrated lift, patient accessible controls	1141.79		1473.92	
E0636	UE	Multipositional patient support system, with integrated lift, patient accessible controls	8563.43		11054.39	
E0637	NU	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	3013.05		2801.92	2097.37**
E0637	RR	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	301.30		280.19	2097.37**
E0637	UE	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	2259.79		2101.45	2097.37**
E0638	NU	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	BR		BR	2097.37**
E0638	RR	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	BR		BR	2097.37**
E0638	UE	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	BR		BR	2097.37**
E0639		Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	BR		BR	2097.37**
E0640		Patient lift, fixed system, includes all components/accessories	BR		BR	2097.37**
E0641		Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels	BR		BR	2097.37**
E0642		Standing frame/table system, mobile (dynamic stander), any size including pediatric	BR		BR	2097.37**
E0650	NU	Pneumatic compressor, nonsegmental home model	662.82		1006.62	
E0650	RR	Pneumatic compressor, nonsegmental home model	81.79		124.20	
E0650	UE	Pneumatic compressor, nonsegmental home model	497.11		754.95	
E0651	NU	Pneumatic compressor, segmental home model without calibrated gradient pressure	994.39		1283.63	
E0651	RR	Pneumatic compressor, segmental home model without calibrated gradient pressure	101.58		131.12	
E0651	UE	Pneumatic compressor, segmental home model without calibrated gradient pressure	745.80		962.73	
E0652	NU	Pneumatic compressor, segmental home model with calibrated gradient pressure	4878.97		7409.59	
E0652	RR	Pneumatic compressor, segmental home model with calibrated gradient pressure	482.20		732.31	
E0652	UE	Pneumatic compressor, segmental home model with calibrated gradient pressure	3655.97		5552.24	
E0655	NU	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	99.33		150.84	
E0655	RR	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	11.67		17.71	
E0655	UE	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	74.59		113.28	
E0656	NU	Segmental pneumatic appliance for use with pneumatic compressor, trunk	625.49		0.00	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0656	RR	Segmental pneumatic appliance for use with pneumatic compressor, trunk	62.48		0.00	
E0656	UE	Segmental pneumatic appliance for use with pneumatic compressor, trunk	469.18		0.00	
E0657	NU	Segmental pneumatic appliance for use with pneumatic compressor, chest	587.63		0.00	
E0657	RR	Segmental pneumatic appliance for use with pneumatic compressor, chest	58.66		0.00	
E0657	UE	Segmental pneumatic appliance for use with pneumatic compressor, chest	440.76		0.00	
E0660	NU	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	172.96		223.28	
E0660	RR	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	17.46		23.24	
E0660	UE	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	129.71		167.44	
E0665	NU	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	126.08		191.46	
E0665	RR	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	12.95		19.65	
E0665	UE	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	94.67		143.79	
E0666	NU	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	127.08		192.98	
E0666	RR	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	13.10		19.89	
E0666	UE	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	95.34		144.78	
E0667	NU	Segmental pneumatic appliance for use with pneumatic compressor, full leg	297.97		452.53	
E0667	RR	Segmental pneumatic appliance for use with pneumatic compressor, full leg	33.64		51.10	
E0667	UE	Segmental pneumatic appliance for use with pneumatic compressor, full leg	223.48		339.38	
E0668	NU	Segmental pneumatic appliance for use with pneumatic compressor, full arm	406.67		617.58	
E0668	RR	Segmental pneumatic appliance for use with pneumatic compressor, full arm	40.13		60.95	
E0668	UE	Segmental pneumatic appliance for use with pneumatic compressor, full arm	305.01		463.21	
E0669	NU	Segmental pneumatic appliance for use with pneumatic compressor, half leg	198.48		256.21	
E0669	RR	Segmental pneumatic appliance for use with pneumatic compressor, half leg	19.86		25.64	
E0669	UE	Segmental pneumatic appliance for use with pneumatic compressor, half leg	148.89		192.20	
E0670		Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	1199.92		New	
E0671	NU	Segmental gradient pressure pneumatic appliance, full leg	449.71		580.52	
E0671	RR	Segmental gradient pressure pneumatic appliance, full leg	44.99		58.07	
E0671	UE	Segmental gradient pressure pneumatic appliance, full leg	337.27		435.38	
E0672	NU	Segmental gradient pressure pneumatic appliance, full arm	349.42		451.07	
E0672	RR	Segmental gradient pressure pneumatic appliance, full arm	34.95		45.12	
E0672	UE	Segmental gradient pressure pneumatic appliance, full arm	262.08		338.32	
E0673	NU	Segmental gradient pressure pneumatic appliance, half leg	290.35		374.81	
E0673	RR	Segmental gradient pressure pneumatic appliance, half leg	29.04		37.49	
E0673	UE	Segmental gradient pressure pneumatic appliance, half leg	217.79		281.14	
E0675	NU	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	4163.60		5374.67	
E0675	RR	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	416.36		537.47	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0675	UE	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	3122.70		4031.01	
E0676		Intermittent limb compression device (includes all accessories), not otherwise specified	BR		BR	
E0691	NU	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less	972.92		1255.92	
E0691	RR	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less	97.29		125.59	
E0691	UE	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less	729.69		941.93	
E0692	NU	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel	1221.72		1577.07	
E0692	RR	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel	122.16		157.70	
E0692	UE	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel	916.29		1182.82	
E0693	NU	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel	1506.04		1944.11	
E0693	RR	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel	150.61		194.42	
E0693	UE	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel	1129.52		1458.09	
E0694	NU	Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection	4793.56		6187.89	
E0694	RR	Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection	479.36		618.79	
E0694	UE	Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection	3595.19		4640.97	
E0700		Safety equipment, device or accessory, any type	BR		BR	2097.37**
E0705	NU	Transfer device, any type, each	59.68		77.05	
E0705	RR	Transfer device, any type, each	6.07		7.85	
E0705	UE	Transfer device, any type, each	43.71		56.41	
E0710		Restraints, any type (body, chest, wrist, or ankle)	BR		BR	2097.37**
E0720	NU	Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation	397.98		513.76	
E0730	NU	Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation	401.21		517.92	
E0731		Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	386.20		498.52	
E0740	NU	Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and/or trainer	566.11		730.79	
E0740	RR	Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and/or trainer	56.62		73.09	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0740	UE	Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and/or trainer	424.62		548.13	
E0744	NU	Neuromuscular stimulator for scoliosis	842.80		1279.89	
E0744	RR	Neuromuscular stimulator for scoliosis	84.28		127.99	
E0744	UE	Neuromuscular stimulator for scoliosis	632.10		959.93	
E0745	NU	Neuromuscular stimulator, electronic shock unit	823.80		1251.08	
E0745	RR	Neuromuscular stimulator, electronic shock unit	82.38		125.11	
E0745	UE	Neuromuscular stimulator, electronic shock unit	617.85		938.32	
E0746	NU	Electromyography (EMG), biofeedback device	BR		BR	
E0746	RR	Electromyography (EMG), biofeedback device	BR		BR	
E0746	UE	Electromyography (EMG), biofeedback device	BR		BR	
E0747	NU	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	4240.00		5473.31	
E0747	RR	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	421.34		543.90	
E0747	UE	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	3150.24		4066.57	
E0748	NU	Osteogenesis stimulator, electrical, noninvasive, spinal applications	4212.53		5437.86	
E0748	RR	Osteogenesis stimulator, electrical, noninvasive, spinal applications	421.24		543.78	
E0748	UE	Osteogenesis stimulator, electrical, noninvasive, spinal applications	3159.41		4078.41	
E0749	RR	Osteogenesis stimulator, electrical, surgically implanted	307.89		397.45	
E0755		Electronic salivary reflex stimulator (intraoral/noninvasive)	BR		BR	2097.37**
E0760	NU	Osteogenesis stimulator, low intensity ultrasound, noninvasive	3500.54		4518.77	
E0760	RR	Osteogenesis stimulator, low intensity ultrasound, noninvasive	350.07		451.90	
E0760	UE	Osteogenesis stimulator, low intensity ultrasound, noninvasive	2625.40		3389.07	
E0761		Nonthermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	BR		BR	2097.37**
E0762	NU	Transcutaneous electrical joint stimulation device system, includes all accessories	1190.52		1536.81	
E0762	RR	Transcutaneous electrical joint stimulation device system, includes all accessories	119.05		153.69	
E0762	UE	Transcutaneous electrical joint stimulation device system, includes all accessories	892.86		1152.58	
E0764	NU	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	11982.24		15467.60	
E0764	RR	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	1198.21		1546.74	
E0764	UE	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	8986.68		11600.71	
E0765	NU	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting	91.09		117.59	
E0765	RR	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting	9.12		11.78	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0765	UE	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting	68.34		88.23	
E0769		Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	BR		BR	
E0770	NU	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	BR		BR	
E0770	RR	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	BR		BR	
E0770	UE	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	BR		BR	
E0776	NU	IV pole	155.00		200.09	
E0776	RR	IV pole	17.46		26.06	
E0776	UE	IV pole	114.05		147.22	
E0779	RR	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	16.32		23.38	
E0780		Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours	11.23		14.50	
E0781	RR	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	258.63		370.19	
E0782	NU	Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.)	4648.55		6000.71	
E0782	RR	Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.)	464.88		600.11	
E0782	UE	Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.)	3486.42		4500.54	
E0783	NU	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)	8864.11		11442.48	
E0783	RR	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)	886.43		1144.26	
E0783	UE	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)	6648.09		8581.87	
E0784	NU	External ambulatory infusion pump, insulin	4521.10		5836.17	
E0784	RR	External ambulatory infusion pump, insulin	452.11		583.62	
E0784	UE	External ambulatory infusion pump, insulin	3390.83		4377.13	
E0785		Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement	511.59		660.40	
E0786	NU	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)	8646.40		11161.45	
E0786	RR	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)	864.62		1116.14	
E0786	UE	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)	6484.80		8371.07	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0791	NU	Parenteral infusion pump, stationary, single, or multichannel	2910.10		4419.41	
E0791	RR	Parenteral infusion pump, stationary, single, or multichannel	291.01		441.94	
E0791	UE	Parenteral infusion pump, stationary, single, or multichannel	2182.58		3314.56	
E0830		Ambulatory traction device, all types, each	BR		BR	
E0840	NU	Traction frame, attached to headboard, cervical traction	79.33		102.42	
E0840	RR	Traction frame, attached to headboard, cervical traction	17.67		22.82	
E0840	UE	Traction frame, attached to headboard, cervical traction	59.47		76.78	
E0849	NU	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible	557.94		720.23	
E0849	RR	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible	55.80		72.02	
E0849	UE	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible	418.42		540.13	
E0850	NU	Traction stand, freestanding, cervical traction	113.74		146.83	
E0850	RR	Traction stand, freestanding, cervical traction	15.61		20.17	
E0850	UE	Traction stand, freestanding, cervical traction	85.32		110.14	
E0855	NU	Cervical traction equipment not requiring additional stand or frame	544.20		702.51	
E0855	RR	Cervical traction equipment not requiring additional stand or frame	54.42		70.24	
E0855	UE	Cervical traction equipment not requiring additional stand or frame	408.14		526.87	
E0856	NU	Cervical traction device, cervical collar with inflatable air bladder	166.77		215.28	
E0856	RR	Cervical traction device, cervical collar with inflatable air bladder	16.69		21.55	
E0856	UE	Cervical traction device, cervical collar with inflatable air bladder	125.09		161.47	
E0860	NU	Traction equipment, overdoor, cervical	41.72		53.85	
E0860	RR	Traction equipment, overdoor, cervical	6.73		9.10	
E0860	UE	Traction equipment, overdoor, cervical	31.95		41.25	
E0870	NU	Traction frame, attached to footboard, extremity traction (e.g., Buck's)	107.05		162.57	
E0870	RR	Traction frame, attached to footboard, extremity traction (e.g., Buck's)	14.52		18.73	
E0870	UE	Traction frame, attached to footboard, extremity traction (e.g., Buck's)	80.64		122.46	
E0880	NU	Traction stand, freestanding, extremity traction (e.g., Buck's)	115.54		175.47	
E0880	RR	Traction stand, freestanding, extremity traction (e.g., Buck's)	18.15		27.56	
E0880	UE	Traction stand, freestanding, extremity traction (e.g., Buck's)	87.45		132.80	
E0890	NU	Traction frame, attached to footboard, pelvic traction	110.81		168.30	
E0890	RR	Traction frame, attached to footboard, pelvic traction	30.22		45.88	
E0890	UE	Traction frame, attached to footboard, pelvic traction	89.26		135.55	
E0900	NU	Traction stand, freestanding, pelvic traction (e.g., Buck's)	117.92		179.07	
E0900	RR	Traction stand, freestanding, pelvic traction (e.g., Buck's)	25.42		38.60	
E0900	UE	Traction stand, freestanding, pelvic traction (e.g., Buck's)	88.47		134.35	
E0910	NU	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	164.70		241.01	
E0910	RR	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	16.47		24.10	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0910	UE	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	123.53		180.76	
E0911	RR	Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	46.51		60.04	
E0912	RR	Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, freestanding, complete with grab bar	106.83		137.90	
E0920	NU	Fracture frame, attached to bed, includes weights	424.70		644.88	
E0920	RR	Fracture frame, attached to bed, includes weights	42.47		64.49	
E0920	UE	Fracture frame, attached to bed, includes weights	318.53		483.66	
E0930	RR	Fracture frame, freestanding, includes weights	42.04		63.85	
E0935	RR	Continuous passive motion exercise device for use on knee only	20.93		31.77	
E0936		Continuous passive motion exercise device for use other than knee	BR		BR	2097.37**
E0940	NU	Trapeze bar, freestanding, complete with grab bar	275.80		418.91	
E0940	RR	Trapeze bar, freestanding, complete with grab bar	27.58		41.89	
E0940	UE	Trapeze bar, freestanding, complete with grab bar	206.85		314.19	
E0941	RR	Gravity assisted traction device, any type	39.94		60.67	
E0942	NU	Cervical head harness/halter	18.27		27.73	
E0942	RR	Cervical head harness/halter	2.16		3.27	
E0942	UE	Cervical head harness/halter	13.69		20.80	
E0944	NU	Pelvic belt/harness/boot	42.48		64.11	
E0944	RR	Pelvic belt/harness/boot	4.29		6.44	
E0944	UE	Pelvic belt/harness/boot	34.89		48.08	
E0945	NU	Extremity belt/harness	40.79		61.95	
E0945	RR	Extremity belt/harness	4.09		6.20	
E0945	UE	Extremity belt/harness	31.57		47.97	
E0946	RR	Fracture, frame, dual with cross bars, attached to bed, (e.g., Balken, 4 Poster)	54.45		82.68	
E0947	NU	Fracture frame, attachments for complex pelvic traction	558.13		847.61	
E0947	RR	Fracture frame, attachments for complex pelvic traction	57.87		87.90	
E0947	UE	Fracture frame, attachments for complex pelvic traction	418.59		635.70	
E0948	NU	Fracture frame, attachments for complex cervical traction	554.42		819.85	
E0948	RR	Fracture frame, attachments for complex cervical traction	55.80		81.95	
E0948	UE	Fracture frame, attachments for complex cervical traction	415.83		578.21	
E0950	NU	Wheelchair accessory, tray, each	97.01		125.22	
E0950	RR	Wheelchair accessory, tray, each	9.72		12.54	
E0950	UE	Wheelchair accessory, tray, each	72.76		93.93	
E0951	NU	Heel loop/holder, any type, with or without ankle strap, each	15.05		22.86	
E0951	RR	Heel loop/holder, any type, with or without ankle strap, each	1.55		2.35	
E0951	UE	Heel loop/holder, any type, with or without ankle strap, each	11.29		17.13	
E0952	NU	Toe loop/holder, any type, each	17.57		22.68	
E0952	RR	Toe loop/holder, any type, each	1.82		2.35	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0952	UE	Toe loop/holder, any type, each	13.19		17.02	
E0955	NU	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	188.68		243.54	
E0955	RR	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	18.88		24.37	
E0955	UE	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	141.50		182.67	
E0956	NU	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	91.99		118.75	
E0956	RR	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	9.20		11.89	
E0956	UE	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	68.99		89.06	
E0957	NU	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each	128.72		166.17	
E0957	RR	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each	12.87		16.62	
E0957	UE	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each	96.54		124.62	
E0958	NU	Manual wheelchair accessory, one-arm drive attachment, each	426.80		609.80	
E0958	RR	Manual wheelchair accessory, one-arm drive attachment, each	42.68		60.98	
E0958	UE	Manual wheelchair accessory, one-arm drive attachment, each	320.10		457.35	
E0959	NU	Manual wheelchair accessory, adapter for amputee, each	46.99		61.79	
E0959	RR	Manual wheelchair accessory, adapter for amputee, each	4.71		6.22	
E0959	UE	Manual wheelchair accessory, adapter for amputee, each	35.28		46.76	
E0960	NU	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	84.90		109.60	
E0960	RR	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	8.50		10.96	
E0960	UE	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	63.69		82.22	
E0961	NU	Manual wheelchair accessory, wheel lock brake extension (handle), each	27.38		41.58	
E0961	RR	Manual wheelchair accessory, wheel lock brake extension (handle), each	2.86		4.34	
E0961	UE	Manual wheelchair accessory, wheel lock brake extension (handle), each	13.67		20.77	
E0966	NU	Manual wheelchair accessory, headrest extension, each	65.69		99.75	
E0966	RR	Manual wheelchair accessory, headrest extension, each	6.48		9.83	
E0966	UE	Manual wheelchair accessory, headrest extension, each	49.26		74.81	
E0967	NU	Manual wheelchair accessory, hand rim with projections, any type, each	71.11		91.80	
E0967	RR	Manual wheelchair accessory, hand rim with projections, any type, each	7.12		9.19	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0967	UE	Manual wheelchair accessory, hand rim with projections, any type, each	53.32		68.83	
E0968	NU	Commode seat, wheelchair	194.10		250.72	
E0968	RR	Commode seat, wheelchair	19.41		25.07	
E0968	UE	Commode seat, wheelchair	145.58		188.05	
E0969	NU	Narrowing device, wheelchair	169.59		218.91	
E0969	RR	Narrowing device, wheelchair	16.79		21.69	
E0969	UE	Narrowing device, wheelchair	127.20		164.20	
E0970	NU	No. 2 footplates, except for elevating legrest	68.83		79.08	2097.37**
E0970	RR	No. 2 footplates, except for elevating legrest	6.88		7.05	2097.37**
E0970	UE	No. 2 footplates, except for elevating legrest	51.62		59.51	2097.37**
E0971	NU	Manual wheelchair accessory, antitipping device, each	46.97		60.65	
E0971	RR	Manual wheelchair accessory, antitipping device, each	4.71		6.08	
E0971	UE	Manual wheelchair accessory, antitipping device, each	35.26		45.51	
E0973	NU	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	91.20		138.50	
E0973	RR	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	8.69		13.19	
E0973	UE	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	68.40		103.87	
E0974	NU	Manual wheelchair accessory, antirollback device, each	84.89		109.59	
E0974	RR	Manual wheelchair accessory, antirollback device, each	9.00		11.62	
E0974	UE	Manual wheelchair accessory, antirollback device, each	64.15		82.81	
E0978	NU	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	39.85		51.43	
E0978	RR	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	3.99		5.15	
E0978	UE	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	29.54		38.13	
E0980	NU	Safety vest, wheelchair	35.28		46.20	
E0980	RR	Safety vest, wheelchair	3.52		4.62	
E0980	UE	Safety vest, wheelchair	26.47		34.47	
E0981	NU	Wheelchair accessory, seat upholstery, replacement only, each	37.40		56.80	
E0981	RR	Wheelchair accessory, seat upholstery, replacement only, each	3.81		5.78	
E0981	UE	Wheelchair accessory, seat upholstery, replacement only, each	28.31		43.00	
E0982	NU	Wheelchair accessory, back upholstery, replacement only, each	40.87		62.08	
E0982	RR	Wheelchair accessory, back upholstery, replacement only, each	4.09		6.20	
E0982	UE	Wheelchair accessory, back upholstery, replacement only, each	30.66		46.54	
E0983	NU	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	2429.70		3493.28	
E0983	RR	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	242.97		349.33	
E0983	UE	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	1822.28		2619.96	
E0984	NU	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	2068.62		2670.33	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E0984	RR	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	163.44		248.21	
E0984	UE	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	1596.21		2060.51	
E0985	NU	Wheelchair accessory, seat lift mechanism	219.63		283.51	
E0985	RR	Wheelchair accessory, seat lift mechanism	21.98		28.38	
E0985	UE	Wheelchair accessory, seat lift mechanism	164.71		212.62	
E0986	NU	Manual wheelchair accessory, push activated power assist, each	5266.60		6798.52	
E0986	RR	Manual wheelchair accessory, push activated power assist, each	526.67		679.86	
E0986	UE	Manual wheelchair accessory, push activated power assist, each	3949.97		5098.93	
E0988	RR	Manual wheelchair accessory, lever-activated, wheel drive, pair	324.11		New	
E0990	NU	Wheelchair accessory, elevating legrest, complete assembly, each	93.14		141.46	
E0990	RR	Wheelchair accessory, elevating legrest, complete assembly, each	10.49		15.93	
E0990	UE	Wheelchair accessory, elevating legrest, complete assembly, each	72.78		110.53	
E0992	NU	Manual wheelchair accessory, solid seat insert	101.61		132.98	
E0992	RR	Manual wheelchair accessory, solid seat insert	10.01		12.92	
E0992	UE	Manual wheelchair accessory, solid seat insert	76.21		99.75	
E0994	NU	Armrest, each	16.22		24.63	
E0994	RR	Armrest, each	1.64		2.49	
E0994	UE	Armrest, each	12.17		18.49	
E0995	NU	Wheelchair accessory, calf rest/pad, each	24.11		36.61	
E0995	RR	Wheelchair accessory, calf rest/pad, each	2.42		3.68	
E0995	UE	Wheelchair accessory, calf rest/pad, each	18.07		27.45	
E1002	NU	Wheelchair accessory, power seating system, tilt only	3782.46		4882.69	
E1002	RR	Wheelchair accessory, power seating system, tilt only	378.23		488.26	
E1002	UE	Wheelchair accessory, power seating system, tilt only	2836.83		3662.00	
E1003	NU	Wheelchair accessory, power seating system, recline only, without shear reduction	4097.96		5289.96	
E1003	RR	Wheelchair accessory, power seating system, recline only, without shear reduction	409.80		529.01	
E1003	UE	Wheelchair accessory, power seating system, recline only, without shear reduction	3073.47		3967.48	
E1004	NU	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	4543.79		5865.48	
E1004	RR	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	454.37		586.53	
E1004	UE	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	3407.84		4399.08	
E1005	NU	Wheelchair accessory, power seating system, recline only, with power shear reduction	4918.30		6348.92	
E1005	RR	Wheelchair accessory, power seating system, recline only, with power shear reduction	491.82		634.89	
E1005	UE	Wheelchair accessory, power seating system, recline only, with power shear reduction	3688.74		4761.70	
E1006	NU	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	6024.46		7776.83	
E1006	RR	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	602.43		777.66	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1006	UE	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	4518.35		5832.63	
E1007	NU	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	8157.35		10530.13	
E1007	RR	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	815.74		1053.03	
E1007	UE	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	6118.01		7897.59	
E1008	NU	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	8158.09		10531.08	
E1008	RR	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	815.80		1053.10	
E1008	UE	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	6118.58		7898.32	
E1009	NU	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and legrest, each	BR		BR	
E1009	RR	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and legrest, each	BR		BR	
E1009	UE	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and legrest, each	BR		BR	
E1010	NU	Wheelchair accessory, addition to power seating system, power leg elevation system, including legrest, pair	1067.38		1377.86	
E1010	RR	Wheelchair accessory, addition to power seating system, power leg elevation system, including legrest, pair	106.74		137.78	
E1010	UE	Wheelchair accessory, addition to power seating system, power leg elevation system, including legrest, pair	800.54		1033.42	
E1011	NU	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	BR		BR	
E1011	RR	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	BR		BR	
E1011	UE	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	BR		BR	
E1014	NU	Reclining back, addition to pediatric size wheelchair	395.35		510.34	
E1014	RR	Reclining back, addition to pediatric size wheelchair	39.54		51.05	
E1014	UE	Reclining back, addition to pediatric size wheelchair	296.49		382.75	
E1015	NU	Shock absorber for manual wheelchair, each	124.20		160.31	
E1015	RR	Shock absorber for manual wheelchair, each	12.41		16.02	
E1015	UE	Shock absorber for manual wheelchair, each	93.14		120.22	
E1016	NU	Shock absorber for power wheelchair, each	122.54		158.18	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1016	RR	Shock absorber for power wheelchair, each	12.27		15.83	
E1016	UE	Shock absorber for power wheelchair, each	91.90		118.62	
E1017	NU	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	0.00		0.00	
E1017	RR	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	0.00		0.00	
E1017	UE	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	0.00		0.00	
E1018	NU	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair, each	0.00		0.00	
E1018	RR	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair, each	0.00		0.00	
E1018	UE	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair, each	0.00		0.00	
E1020	NU	Residual limb support system for wheelchair, any type	227.15		293.23	
E1020	RR	Residual limb support system for wheelchair, any type	22.70		29.30	
E1020	UE	Residual limb support system for wheelchair, any type	170.35		219.91	
E1028	NU	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	192.74		248.81	
E1028	RR	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	19.27		24.88	
E1028	UE	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	144.55		186.59	
E1029	NU	Wheelchair accessory, ventilator tray, fixed	344.86		445.17	
E1029	RR	Wheelchair accessory, ventilator tray, fixed	34.48		44.51	
E1029	UE	Wheelchair accessory, ventilator tray, fixed	258.63		333.87	
E1030	NU	Wheelchair accessory, ventilator tray, gimbaled	1087.43		1403.73	
E1030	RR	Wheelchair accessory, ventilator tray, gimbaled	108.74		140.38	
E1030	UE	Wheelchair accessory, ventilator tray, gimbaled	815.57		1052.81	
E1031	NU	Rollabout chair, any and all types with castors 5 in or greater	464.90		705.95	
E1031	RR	Rollabout chair, any and all types with castors 5 in or greater	46.49		70.60	
E1031	UE	Rollabout chair, any and all types with castors 5 in or greater	348.68		529.46	
E1035	RR	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs	663.93		857.04	
E1036		Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs	930.76		0.00	
E1037	NU	Transport chair, pediatric size	1174.60		1516.20	
E1037	RR	Transport chair, pediatric size	117.46		151.62	
E1037	UE	Transport chair, pediatric size	880.95		1137.15	
E1038	NU	Transport chair, adult size, patient weight capacity up to and including 300 pounds	195.10		251.97	
E1038	RR	Transport chair, adult size, patient weight capacity up to and including 300 pounds	19.51		25.20	
E1038	UE	Transport chair, adult size, patient weight capacity up to and including 300 pounds	146.33		188.98	
E1039	NU	Transport chair, adult size, heavy-duty, patient weight capacity greater than 300 pounds	370.20		477.94	
E1039	RR	Transport chair, adult size, heavy-duty, patient weight capacity greater than 300 pounds	37.02		47.79	
E1039	UE	Transport chair, adult size, heavy-duty, patient weight capacity greater than 300 pounds	277.65		358.46	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1050	NU	Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	937.20		1423.34	
E1050	RR	Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	93.72		142.33	
E1050	UE	Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	702.90		1067.51	
E1060	NU	Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating legrests	1160.20		1761.91	
E1060	RR	Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating legrests	116.02		176.19	
E1060	UE	Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating legrests	870.15		1321.44	
E1070	NU	Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	1008.00		1530.92	
E1070	RR	Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	100.80		153.09	
E1070	UE	Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	756.00		1148.19	
E1083	NU	Hemi-wheelchair, fixed full-length arms, swing-away detachable elevating legrest	724.70		1100.58	
E1083	RR	Hemi-wheelchair, fixed full-length arms, swing-away detachable elevating legrest	72.47		110.06	
E1083	UE	Hemi-wheelchair, fixed full-length arms, swing-away detachable elevating legrest	543.53		825.44	
E1084	NU	Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating legrests	902.90		1371.19	
E1084	RR	Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating legrests	90.29		137.12	
E1084	UE	Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating legrests	677.18		1028.39	
E1085	NU	Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests	1063.14		1221.48	2097.37**
E1085	RR	Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests	106.31		122.15	2097.37**
E1085	UE	Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests	797.36		876.96	2097.37**
E1086	NU	Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	1294.85		1487.70	2097.37**
E1086	RR	Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	129.49		135.46	2097.37**
E1086	UE	Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	971.14		1080.54	2097.37**
E1087	NU	High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	1164.40		1768.17	
E1087	RR	High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	116.44		176.82	
E1087	UE	High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	873.30		1326.14	
E1088	NU	High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating legrests	1387.60		2107.21	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1088	RR	High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating legrests	138.76		210.72	
E1088	UE	High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating legrests	1040.70		1580.41	
E1089	NU	High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest	1718.74		1974.73	2097.37**
E1089	RR	High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest	171.87		197.32	2097.37**
E1089	UE	High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest	1289.06		1481.04	2097.37**
E1090	NU	High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	1771.90		2035.80	2097.37**
E1090	RR	High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	177.19		197.32	2097.37**
E1090	UE	High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	1328.93		1487.70	2097.37**
E1092	NU	Wide heavy-duty wheel chair, detachable arms (desk or full-length), swing-away detachable elevating legrests	1361.90		1796.20	
E1092	RR	Wide heavy-duty wheel chair, detachable arms (desk or full-length), swing-away detachable elevating legrests	136.19		179.62	
E1092	UE	Wide heavy-duty wheel chair, detachable arms (desk or full-length), swing-away detachable elevating legrests	1021.43		1347.15	
E1093	NU	Wide heavy-duty wheelchair, detachable arms, desk or full-length arms, swing-away detachable footrests	1167.50		1544.70	
E1093	RR	Wide heavy-duty wheelchair, detachable arms, desk or full-length arms, swing-away detachable footrests	116.75		154.47	
E1093	UE	Wide heavy-duty wheelchair, detachable arms, desk or full-length arms, swing-away detachable footrests	875.63		1158.53	
E1100	NU	Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	955.30		1450.90	
E1100	RR	Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	95.53		145.09	
E1100	UE	Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	716.48		1088.18	
E1110	NU	Semi-reclining wheelchair, detachable arms (desk or full-length) elevating legrest	935.50		1420.83	
E1110	RR	Semi-reclining wheelchair, detachable arms (desk or full-length) elevating legrest	93.55		142.08	
E1110	UE	Semi-reclining wheelchair, detachable arms (desk or full-length) elevating legrest	701.63		1065.63	
E1130	NU	Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests	681.50		783.00	2097.37**
E1130	RR	Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests	68.15		78.30	2097.37**
E1130	UE	Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests	340.75		595.08	2097.37**
E1140	NU	Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	981.36		1127.52	2097.37**
E1140	RR	Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	98.14		112.75	2097.37**
E1140	UE	Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	736.02		798.66	2097.37**
E1150	NU	Wheelchair, detachable arms, desk or full-length swing-away detachable elevating legrests	750.70		1140.20	
E1150	RR	Wheelchair, detachable arms, desk or full-length swing-away detachable elevating legrests	75.07		114.02	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1150	UE	Wheelchair, detachable arms, desk or full-length swing-away detachable elevating legrests	563.03		855.16	
E1160	NU	Wheelchair, fixed full-length arms, swing-away detachable elevating legrests	575.20		873.67	
E1160	RR	Wheelchair, fixed full-length arms, swing-away detachable elevating legrests	57.52		87.37	
E1160	UE	Wheelchair, fixed full-length arms, swing-away detachable elevating legrests	431.40		655.26	
E1161	NU	Manual adult size wheelchair, includes tilt in space	2561.81		3306.97	
E1161	RR	Manual adult size wheelchair, includes tilt in space	256.18		330.69	
E1161	UE	Manual adult size wheelchair, includes tilt in space	1921.39		2480.26	
E1170	NU	Amputee wheelchair, fixed full-length arms, swing-away detachable elevating legrests	822.00		1248.26	
E1170	RR	Amputee wheelchair, fixed full-length arms, swing-away detachable elevating legrests	82.20		124.83	
E1170	UE	Amputee wheelchair, fixed full-length arms, swing-away detachable elevating legrests	616.50		936.20	
E1171	NU	Amputee wheelchair, fixed full-length arms, without footrests or legrest	737.70		1120.32	
E1171	RR	Amputee wheelchair, fixed full-length arms, without footrests or legrest	73.77		112.03	
E1171	UE	Amputee wheelchair, fixed full-length arms, without footrests or legrest	5536.28		840.24	
E1172	NU	Amputee wheelchair, detachable arms (desk or full-length) without footrests or legrest	901.50		1369.00	
E1172	RR	Amputee wheelchair, detachable arms (desk or full-length) without footrests or legrest	90.15		136.90	
E1172	UE	Amputee wheelchair, detachable arms (desk or full-length) without footrests or legrest	676.13		1026.75	
E1180	NU	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests	932.60		1416.45	
E1180	RR	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests	93.26		141.64	
E1180	UE	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests	699.45		1062.34	
E1190	NU	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating legrests	1077.50		1636.16	
E1190	RR	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating legrests	107.75		163.62	
E1190	UE	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating legrests	808.13		1227.12	
E1195	NU	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating legrests	1156.20		1755.80	
E1195	RR	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating legrests	115.62		175.58	
E1195	UE	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating legrests	867.15		1316.85	
E1200	NU	Amputee wheelchair, fixed full-length arms, swing-away detachable footrest	800.80		1216.16	
E1200	RR	Amputee wheelchair, fixed full-length arms, swing-away detachable footrest	80.08		121.62	
E1200	UE	Amputee wheelchair, fixed full-length arms, swing-away detachable footrest	600.60		912.12	
E1220		Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification	BR		BR	
E1221	NU	Wheelchair with fixed arm, footrests	514.50		664.14	
E1221	RR	Wheelchair with fixed arm, footrests	51.45		66.41	
E1221	UE	Wheelchair with fixed arm, footrests	385.88		498.11	
E1222	NU	Wheelchair with fixed arm, elevating legrests	734.00		947.43	
E1222	RR	Wheelchair with fixed arm, elevating legrests	73.40		94.74	
E1222	UE	Wheelchair with fixed arm, elevating legrests	550.50		710.57	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1223	NU	Wheelchair with detachable arms, footrests	801.40		1034.50	
E1223	RR	Wheelchair with detachable arms, footrests	80.14		103.45	
E1223	UE	Wheelchair with detachable arms, footrests	601.05		775.87	
E1224	NU	Wheelchair with detachable arms, elevating legrests	878.60		1134.25	
E1224	RR	Wheelchair with detachable arms, elevating legrests	87.86		113.43	
E1224	UE	Wheelchair with detachable arms, elevating legrests	615.02		850.70	
E1225	NU	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	439.00		631.72	
E1225	RR	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	43.90		63.17	
E1225	UE	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	329.25		473.79	
E1226	NU	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	590.79		762.63	
E1226	RR	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	60.80		78.49	
E1226	UE	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	443.05		571.92	
E1227	NU	Special height arms for wheelchair	300.46		387.85	
E1227	RR	Special height arms for wheelchair	30.05		38.79	
E1227	UE	Special height arms for wheelchair	225.37		290.93	
E1228	NU	Special back height for wheelchair	257.90		391.66	
E1228	RR	Special back height for wheelchair	25.79		39.17	
E1228	UE	Special back height for wheelchair	193.43		293.75	
E1229		Wheelchair, pediatric size, not otherwise specified	BR		BR	
E1230	NU	Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number	2081.56		3161.21	
E1230	RR	Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number	204.72		310.90	
E1230	UE	Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number	1646.25		2500.13	
E1231	NU	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	0.00		0.00	
E1231	RR	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	0.00		0.00	
E1231	UE	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	0.00		0.00	
E1232	NU	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	2315.29		2988.76	
E1232	RR	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	231.54		298.89	
E1232	UE	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	1736.49		2241.59	
E1233	NU	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	2399.01		3096.83	
E1233	RR	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	239.90		309.68	
E1233	UE	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	1799.26		2322.61	
E1234	NU	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	2088.51		2696.01	
E1234	RR	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	208.88		269.63	
E1234	UE	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	1566.37		2021.99	
E1235	NU	Wheelchair, pediatric size, rigid, adjustable, with seating system	2011.07		2596.05	
E1235	RR	Wheelchair, pediatric size, rigid, adjustable, with seating system	201.12		259.61	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1235	UE	Wheelchair, pediatric size, rigid, adjustable, with seating system	1508.30		1947.02	
E1236	NU	Wheelchair, pediatric size, folding, adjustable, with seating system	1774.28		2290.38	
E1236	RR	Wheelchair, pediatric size, folding, adjustable, with seating system	177.43		229.03	
E1236	UE	Wheelchair, pediatric size, folding, adjustable, with seating system	1330.71		1717.79	
E1237	NU	Wheelchair, pediatric size, rigid, adjustable, without seating system	1789.78		2310.40	
E1237	RR	Wheelchair, pediatric size, rigid, adjustable, without seating system	178.98		231.03	
E1237	UE	Wheelchair, pediatric size, rigid, adjustable, without seating system	1342.35		1732.81	
E1238	NU	Wheelchair, pediatric size, folding, adjustable, without seating system	1774.28		2290.38	
E1238	RR	Wheelchair, pediatric size, folding, adjustable, without seating system	177.43		229.03	
E1238	UE	Wheelchair, pediatric size, folding, adjustable, without seating system	1330.71		1717.79	
E1239		Power wheelchair, pediatric size, not otherwise specified	BR		BR	
E1240	NU	Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating legrest	948.10		1439.78	
E1240	RR	Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating legrest	94.81		143.98	
E1240	UE	Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating legrest	711.08		1079.84	
E1250	NU	Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest	1049.51		1205.82	2097.37**
E1250	RR	Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest	104.95		109.62	2097.37**
E1250	UE	Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest	787.13		955.26	2097.37**
E1260	NU	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	1226.70		1409.40	2097.37**
E1260	RR	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	122.67		140.94	2097.37**
E1260	UE	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	920.03		1111.86	2097.37**
E1270	NU	Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	726.60		1103.40	
E1270	RR	Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	72.66		110.34	
E1270	UE	Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	544.95		827.55	
E1280	NU	Heavy-duty wheelchair, detachable arms (desk or full-length) elevating legrests	1207.90		1834.57	
E1280	RR	Heavy-duty wheelchair, detachable arms (desk or full-length) elevating legrests	120.79		183.46	
E1280	UE	Heavy-duty wheelchair, detachable arms (desk or full-length) elevating legrests	905.93		1375.93	
E1285	NU	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest	1581.08		1816.56	2097.37**
E1285	RR	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest	158.11		181.66	2097.37**
E1285	UE	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest	1185.81		1331.10	2097.37**
E1290	NU	Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	1635.60		1879.20	2097.37**
E1290	RR	Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	163.56		187.92	2097.37**
E1290	UE	Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	1226.70		1370.25	2097.37**
E1295	NU	Heavy-duty wheelchair, fixed full-length arms, elevating legrest	1117.80		1697.70	
E1295	RR	Heavy-duty wheelchair, fixed full-length arms, elevating legrest	111.78		169.77	
E1295	UE	Heavy-duty wheelchair, fixed full-length arms, elevating legrest	838.35		1273.28	
E1296	NU	Special wheelchair seat height from floor	532.33		687.18	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1296	RR	Special wheelchair seat height from floor	53.25		69.80	
E1296	UE	Special wheelchair seat height from floor	399.25		515.39	
E1297	NU	Special wheelchair seat depth, by upholstery	113.26		146.20	
E1297	RR	Special wheelchair seat depth, by upholstery	11.32		16.24	
E1297	UE	Special wheelchair seat depth, by upholstery	84.93		109.64	
E1298	NU	Special wheelchair seat depth and/or width, by construction	458.70		592.12	
E1298	RR	Special wheelchair seat depth and/or width, by construction	46.93		60.59	
E1298	UE	Special wheelchair seat depth and/or width, by construction	344.02		444.09	
E1300	NU	Whirlpool, portable (overtub type)	BR		BR	2097.37**
E1300	RR	Whirlpool, portable (overtub type)	BR		BR	2097.37**
E1300	UE	Whirlpool, portable (overtub type)	BR		BR	2097.37**
E1310	NU	Whirlpool, nonportable (built-in type)	2325.03		3001.32	
E1310	RR	Whirlpool, nonportable (built-in type)	198.86		256.70	
E1310	UE	Whirlpool, nonportable (built-in type)	1743.78		2251.00	
E1353	NU	Regulator	30.67		39.60	
E1353	RR	Regulator	3.06		3.96	
E1353	UE	Regulator	23.00		29.70	
E1354		Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each	BR		BR	
E1355	NU	Stand/rack	23.10		29.82	
E1355	RR	Stand/rack	2.31		2.98	
E1355	UE	Stand/rack	17.33		22.36	
E1356		Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each	BR		BR	
E1357		Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each	BR		BR	
E1358		Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each	BR		BR	
E1372	NU	Immersion external heater for nebulizer	150.03		227.85	
E1372	RR	Immersion external heater for nebulizer	21.80		33.11	
E1372	UE	Immersion external heater for nebulizer	111.06		168.66	
E1390	NU	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	1773.60		0.00	
E1390	RR	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	177.36		0.00	
E1390	UE	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	1330.20		0.00	
E1391	RR	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each	177.36		0.00	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1392	RR	Portable oxygen concentrator, rental	51.63		0.00	
E1399		Durable medical equipment, miscellaneous	BR		BR	
E1405	NU	Oxygen and water vapor enriching system with heated delivery	2096.30		0.00	
E1405	RR	Oxygen and water vapor enriching system with heated delivery	209.63		0.00	
E1405	UE	Oxygen and water vapor enriching system with heated delivery	1572.23		0.00	
E1406	NU	Oxygen and water vapor enriching system without heated delivery	1948.10		0.00	
E1406	RR	Oxygen and water vapor enriching system without heated delivery	194.81		0.00	
E1406	UE	Oxygen and water vapor enriching system without heated delivery	1461.08		0.00	
E1500		Centrifuge, for dialysis	BR		BR	
E1510	NU	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container	BR		BR	
E1510	RR	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container	BR		BR	
E1510	UE	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container	BR		BR	
E1520	NU	Heparin infusion pump for hemodialysis	BR		BR	
E1520	RR	Heparin infusion pump for hemodialysis	BR		BR	
E1520	UE	Heparin infusion pump for hemodialysis	BR		BR	
E1530	NU	Air bubble detector for hemodialysis, each, replacement	BR		BR	
E1530	RR	Air bubble detector for hemodialysis, each, replacement	BR		BR	
E1530	UE	Air bubble detector for hemodialysis, each, replacement	BR		BR	
E1540	NU	Pressure alarm for hemodialysis, each, replacement	BR		BR	
E1540	RR	Pressure alarm for hemodialysis, each, replacement	BR		BR	
E1540	UE	Pressure alarm for hemodialysis, each, replacement	BR		BR	
E1550	NU	Bath conductivity meter for hemodialysis, each	BR		BR	
E1550	RR	Bath conductivity meter for hemodialysis, each	BR		BR	
E1550	UE	Bath conductivity meter for hemodialysis, each	BR		BR	
E1560	NU	Blood leak detector for hemodialysis, each, replacement	BR		BR	
E1560	RR	Blood leak detector for hemodialysis, each, replacement	BR		BR	
E1560	UE	Blood leak detector for hemodialysis, each, replacement	BR		BR	
E1570	NU	Adjustable chair, for ESRD patients	BR		BR	
E1570	RR	Adjustable chair, for ESRD patients	BR		BR	
E1570	UE	Adjustable chair, for ESRD patients	BR		BR	
E1575	NU	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10	BR		BR	
E1575	RR	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10	BR		BR	
E1575	UE	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1580	NU	Unipuncture control system for hemodialysis	BR		BR	
E1580	RR	Unipuncture control system for hemodialysis	BR		BR	
E1580	UE	Unipuncture control system for hemodialysis	BR		BR	
E1590	NU	Hemodialysis machine	BR		BR	
E1590	RR	Hemodialysis machine	BR		BR	
E1590	UE	Hemodialysis machine	BR		BR	
E1592	NU	Automatic intermittent peritoneal dialysis system	BR		BR	
E1592	RR	Automatic intermittent peritoneal dialysis system	BR		BR	
E1592	UE	Automatic intermittent peritoneal dialysis system	BR		BR	
E1594	NU	Cycler dialysis machine for peritoneal dialysis	BR		BR	
E1594	RR	Cycler dialysis machine for peritoneal dialysis	BR		BR	
E1594	UE	Cycler dialysis machine for peritoneal dialysis	BR		BR	
E1600	NU	Delivery and/or installation charges for hemodialysis equipment	BR		BR	
E1600	RR	Delivery and/or installation charges for hemodialysis equipment	BR		BR	
E1600	UE	Delivery and/or installation charges for hemodialysis equipment	BR		BR	
E1610	NU	Reverse osmosis water purification system, for hemodialysis	BR		BR	
E1610	RR	Reverse osmosis water purification system, for hemodialysis	BR		BR	
E1610	UE	Reverse osmosis water purification system, for hemodialysis	BR		BR	
E1615	NU	Deionizer water purification system, for hemodialysis	BR		BR	
E1615	RR	Deionizer water purification system, for hemodialysis	BR		BR	
E1615	UE	Deionizer water purification system, for hemodialysis	BR		BR	
E1620	NU	Blood pump for hemodialysis, replacement	BR		BR	
E1620	RR	Blood pump for hemodialysis, replacement	BR		BR	
E1620	UE	Blood pump for hemodialysis, replacement	BR		BR	
E1625	NU	Water softening system, for hemodialysis	BR		BR	
E1625	RR	Water softening system, for hemodialysis	BR		BR	
E1625	UE	Water softening system, for hemodialysis	BR		BR	
E1630	NU	Reciprocating peritoneal dialysis system	BR		BR	
E1630	RR	Reciprocating peritoneal dialysis system	BR		BR	
E1630	UE	Reciprocating peritoneal dialysis system	BR		BR	
E1632	NU	Wearable artificial kidney, each	BR		BR	
E1632	RR	Wearable artificial kidney, each	BR		BR	
E1632	UE	Wearable artificial kidney, each	BR		BR	
E1634		Peritoneal dialysis clamps, each	BR		BR	
E1635	NU	Compact (portable) travel hemodialyzer system	BR		BR	
E1635	RR	Compact (portable) travel hemodialyzer system	BR		BR	
E1635	UE	Compact (portable) travel hemodialyzer system	BR		BR	
E1636	NU	Sorbent cartridges, for hemodialysis, per 10	BR		BR	
E1636	RR	Sorbent cartridges, for hemodialysis, per 10	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1636	UE	Sorbent cartridges, for hemodialysis, per 10	BR		BR	
E1637		Hemostats, each	BR		BR	
E1639		Scale, each	BR		BR	
E1699		Dialysis equipment, not otherwise specified	BR		BR	
E1700	NU	Jaw motion rehabilitation system	373.36		481.97	
E1700	RR	Jaw motion rehabilitation system	36.61		47.26	
E1700	UE	Jaw motion rehabilitation system	280.02		361.48	
E1701		Replacement cushions for jaw motion rehabilitation system, package of 6	9.77		14.83	
E1702		Replacement measuring scales for jaw motion rehabilitation system, package of 200	20.77		31.55	
E1800	RR	Dynamic adjustable elbow extension/flexion device, includes soft interface material	112.74		171.23	
E1801	RR	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories	125.17		180.29	
E1802	RR	Dynamic adjustable forearm pronation/supination device, includes soft interface material	353.84		456.76	
E1805	RR	Dynamic adjustable wrist extension/flexion device, includes soft interface material	116.28		176.58	
E1806	RR	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories	102.72		148.03	
E1810	RR	Dynamic adjustable knee extension/flexion device, includes soft interface material	114.66		174.12	
E1811	RR	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories	130.14		187.47	
E1812	NU	Dynamic knee, extension/flexion device with active resistance control	931.00		1201.91	
E1812	RR	Dynamic knee, extension/flexion device with active resistance control	93.10		120.19	
E1812	UE	Dynamic knee, extension/flexion device with active resistance control	698.25		901.44	
E1815	RR	Dynamic adjustable ankle extension/flexion device, includes soft interface material	116.28		176.58	
E1816	RR	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories	132.16		190.41	
E1818	RR	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories	134.95		194.39	
E1820	NU	Replacement soft interface material, dynamic adjustable extension/flexion device	88.50		114.26	
E1820	RR	Replacement soft interface material, dynamic adjustable extension/flexion device	8.85		11.42	
E1820	UE	Replacement soft interface material, dynamic adjustable extension/flexion device	66.39		85.69	
E1821	NU	Replacement soft interface material/cuffs for bi-directional static progressive stretch device	113.95		147.09	
E1821	RR	Replacement soft interface material/cuffs for bi-directional static progressive stretch device	11.38		14.69	
E1821	UE	Replacement soft interface material/cuffs for bi-directional static progressive stretch device	85.49		110.36	
E1825	RR	Dynamic adjustable finger extension/flexion device, includes soft interface material	116.28		176.58	
E1830	RR	Dynamic adjustable toe extension/flexion device, includes soft interface material	116.28		176.58	
E1831		Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories	71.54		New	
E1840	RR	Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material	363.16		534.90	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E1841	RR	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories	490.46		633.13	
E1902		Communication board, nonelectronic augmentative or alternative communication device	BR		BR	
E2000	RR	Gastric suction pump, home model, portable or stationary, electric	50.28		72.44	
E2100	NU	Blood glucose monitor with integrated voice synthesizer	696.39		898.96	
E2100	RR	Blood glucose monitor with integrated voice synthesizer	69.64		89.90	
E2100	UE	Blood glucose monitor with integrated voice synthesizer	522.30		674.23	
E2101	NU	Blood glucose monitor with integrated lancing/blood sample	204.16		263.54	
E2101	RR	Blood glucose monitor with integrated lancing/blood sample	20.41		26.36	
E2101	UE	Blood glucose monitor with integrated lancing/blood sample	153.12		197.66	
E2120	RR	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	306.98		396.28	
E2201	NU	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 in and less than 24 in	403.97		521.48	
E2201	RR	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 in and less than 24 in	40.40		52.15	
E2201	UE	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 in and less than 24 in	302.97		391.11	
E2202	NU	Manual wheelchair accessory, nonstandard seat frame width, 24-27 in	513.18		662.46	
E2202	RR	Manual wheelchair accessory, nonstandard seat frame width, 24-27 in	51.32		66.24	
E2202	UE	Manual wheelchair accessory, nonstandard seat frame width, 24-27 in	384.91		496.88	
E2203	NU	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 in	518.68		669.54	
E2203	RR	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 in	51.85		66.93	
E2203	UE	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 in	388.99		502.14	
E2204	NU	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 in	880.69		1136.85	
E2204	RR	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 in	88.08		113.71	
E2204	UE	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 in	660.51		852.64	
E2205	NU	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each	35.37		45.66	
E2205	RR	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each	3.52		4.54	
E2205	UE	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each	26.55		34.28	
E2206	NU	Manual wheelchair accessory, wheel Lock assembly, complete, each	44.04		56.85	
E2206	RR	Manual wheelchair accessory, wheel Lock assembly, complete, each	4.39		5.67	
E2206	UE	Manual wheelchair accessory, wheel Lock assembly, complete, each	33.03		42.64	
E2207	NU	Wheelchair accessory, crutch and cane holder, each	46.93		60.59	
E2207	RR	Wheelchair accessory, crutch and cane holder, each	4.71		6.08	
E2207	UE	Wheelchair accessory, crutch and cane holder, each	35.21		45.45	
E2208	NU	Wheelchair accessory, cylinder tank carrier, each	110.85		143.10	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2208	RR	Wheelchair accessory, cylinder tank carrier, each	11.08		14.30	
E2208	UE	Wheelchair accessory, cylinder tank carrier, each	83.14		107.33	
E2209	NU	Accessory, arm trough, with or without hand support, each	100.00		129.09	
E2209	RR	Accessory, arm trough, with or without hand support, each	10.02		12.94	
E2209	UE	Accessory, arm trough, with or without hand support, each	75.01		96.83	
E2210	NU	Wheelchair accessory, bearings, any type, replacement only, each	6.11		7.89	
E2210	RR	Wheelchair accessory, bearings, any type, replacement only, each	0.61		0.80	
E2210	UE	Wheelchair accessory, bearings, any type, replacement only, each	4.60		5.92	
E2211	NU	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	37.66		57.19	
E2211	RR	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	3.69		5.61	
E2211	UE	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	26.97		40.95	
E2212	NU	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	6.36		8.21	
E2212	RR	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	0.67		0.85	
E2212	UE	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	4.79		6.17	
E2213	NU	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	32.93		42.50	
E2213	RR	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	3.31		4.26	
E2213	UE	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	24.68		31.85	
E2214	NU	Manual wheelchair accessory, pneumatic caster tire, any size, each	33.13		50.32	
E2214	RR	Manual wheelchair accessory, pneumatic caster tire, any size, each	3.65		5.54	
E2214	UE	Manual wheelchair accessory, pneumatic caster tire, any size, each	24.84		37.72	
E2215	NU	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	10.39		13.42	
E2215	RR	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	1.03		1.33	
E2215	UE	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	7.77		10.04	
E2216	NU	Manual wheelchair accessory, foam filled propulsion tire, any size, each	0.00		0.00	
E2216	RR	Manual wheelchair accessory, foam filled propulsion tire, any size, each	0.00		0.00	
E2216	UE	Manual wheelchair accessory, foam filled propulsion tire, any size, each	0.00		0.00	
E2217	NU	Manual wheelchair accessory, foam filled caster tire, any size, each	0.00		0.00	
E2217	RR	Manual wheelchair accessory, foam filled caster tire, any size, each	0.00		0.00	
E2217	UE	Manual wheelchair accessory, foam filled caster tire, any size, each	0.00		0.00	
E2218	NU	Manual wheelchair accessory, foam propulsion tire, any size, each	0.00		0.00	
E2218	RR	Manual wheelchair accessory, foam propulsion tire, any size, each	0.00		0.00	
E2218	UE	Manual wheelchair accessory, foam propulsion tire, any size, each	0.00		0.00	
E2219	NU	Manual wheelchair accessory, foam caster tire, any size, each	38.51		58.49	
E2219	RR	Manual wheelchair accessory, foam caster tire, any size, each	4.35		6.61	
E2219	UE	Manual wheelchair accessory, foam caster tire, any size, each	28.89		43.88	
E2220	NU	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	30.89		39.87	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2220	RR	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	2.98		3.85	
E2220	UE	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	23.62		30.49	
E2221	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	27.66		35.72	
E2221	RR	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	2.80		3.60	
E2221	UE	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	20.76		26.81	
E2222	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	22.80		29.43	
E2222	RR	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	2.26		2.91	
E2222	UE	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	17.12		22.10	
E2224	NU	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	96.24		137.06	
E2224	RR	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	9.62		14.38	
E2224	UE	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	72.19		102.81	
E2225	NU	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	18.84		24.32	
E2225	RR	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1.88		2.44	
E2225	UE	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	14.12		18.23	
E2226	NU	Manual wheelchair accessory, caster fork, any size, replacement only, each	41.09		53.02	
E2226	RR	Manual wheelchair accessory, caster fork, any size, replacement only, each	4.11		5.29	
E2226	UE	Manual wheelchair accessory, caster fork, any size, replacement only, each	30.81		39.78	
E2227	NU	Manual wheelchair accessory, gear reduction drive wheel, each	2025.38		2193.10	
E2227	RR	Manual wheelchair accessory, gear reduction drive wheel, each	202.55		219.33	
E2227	UE	Manual wheelchair accessory, gear reduction drive wheel, each	1519.06		1644.79	
E2228	NU	Manual wheelchair accessory, wheel braking system and lock, complete, each	1013.71		1308.57	
E2228	RR	Manual wheelchair accessory, wheel braking system and lock, complete, each	101.36		130.85	
E2228	UE	Manual wheelchair accessory, wheel braking system and lock, complete, each	760.30		981.46	
E2230		Manual wheelchair accessory, manual standing system	BR		BR	2097.37**
E2231	NU	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	166.39		214.79	
E2231	RR	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	16.64		21.49	
E2231	UE	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	124.78		161.08	
E2291		Back, planar, for pediatric size wheelchair including fixed attaching hardware	BR		BR	
E2292		Seat, planar, for pediatric size wheelchair including fixed attaching hardware	BR		BR	
E2293		Back, contoured, for pediatric size wheelchair including fixed attaching hardware	BR		BR	
E2294		Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	BR		BR	
E2295		Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2300		Power wheelchair accessory, power seat elevation system	BR		BR	
E2301		Power wheelchair accessory, power standing system	BR		BR	
E2310	NU	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	1092.07		1409.73	
E2310	RR	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	109.20		140.97	
E2310	UE	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	819.05		1057.30	
E2311	NU	Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	2210.95		2854.05	
E2311	RR	Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	221.10		285.42	
E2311	UE	Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	1658.20		2140.53	
E2312	NU	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	2183.53		2818.67	
E2312	RR	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	218.35		281.86	
E2312	UE	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	1637.68		2114.04	
E2313	NU	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	346.74		447.61	
E2313	RR	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	34.69		44.77	
E2313	UE	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	260.06		335.70	
E2321	NU	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	1720.56		1914.31	
E2321	RR	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	172.07		191.44	
E2321	UE	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	1290.42		1435.76	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2322	NU	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	1527.03		1698.98	
E2322	RR	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	152.69		169.90	
E2322	UE	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	1145.28		1274.25	
E2323	NU	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	74.88		83.31	
E2323	RR	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	7.49		8.33	
E2323	UE	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	56.17		62.48	
E2324	NU	Power wheelchair accessory, chin cup for chin control interface	47.44		52.79	
E2324	RR	Power wheelchair accessory, chin cup for chin control interface	4.74		5.26	
E2324	UE	Power wheelchair accessory, chin cup for chin control interface	35.59		39.60	
E2325	NU	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	1458.24		1622.45	
E2325	RR	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	145.85		162.27	
E2325	UE	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	1093.69		1216.84	
E2326	NU	Power wheelchair accessory, breath tube kit for sip and puff interface	375.86		418.18	
E2326	RR	Power wheelchair accessory, breath tube kit for sip and puff interface	37.60		41.84	
E2326	UE	Power wheelchair accessory, breath tube kit for sip and puff interface	281.88		313.62	
E2327	NU	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	2828.48		3146.99	
E2327	RR	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	282.85		314.70	
E2327	UE	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	2121.34		2360.24	
E2328	NU	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	5365.22		5969.40	
E2328	RR	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	536.51		596.93	
E2328	UE	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	4023.93		4477.07	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2329	NU	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	1912.23		2127.57	
E2329	RR	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	191.22		212.76	
E2329	UE	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	1434.17		1595.68	
E2330	NU	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	3705.16		4122.40	
E2330	RR	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	370.50		412.23	
E2330	UE	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	2778.88		3091.82	
E2331		Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	BR		BR	
E2340	NU	Power wheelchair accessory, nonstandard seat frame width, 20-23 in	388.00		500.87	
E2340	RR	Power wheelchair accessory, nonstandard seat frame width, 20-23 in	38.81		50.10	
E2340	UE	Power wheelchair accessory, nonstandard seat frame width, 20-23 in	291.03		375.68	
E2341	NU	Power wheelchair accessory, nonstandard seat frame width, 24-27 in	582.05		751.35	
E2341	RR	Power wheelchair accessory, nonstandard seat frame width, 24-27 in	58.20		75.14	
E2341	UE	Power wheelchair accessory, nonstandard seat frame width, 24-27 in	436.54		563.53	
E2342	NU	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in	485.04		626.12	
E2342	RR	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in	48.50		62.61	
E2342	UE	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 in	363.79		469.60	
E2343	NU	Power wheelchair accessory, nonstandard seat frame depth, 22-25 in	776.07		1001.82	
E2343	RR	Power wheelchair accessory, nonstandard seat frame depth, 22-25 in	77.59		100.16	
E2343	UE	Power wheelchair accessory, nonstandard seat frame depth, 22-25 in	582.05		751.35	
E2351	NU	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	756.42		841.60	
E2351	RR	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	75.66		84.17	
E2351	UE	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	567.30		631.18	
E2358		Power wheelchair accessory, group 34 nonsealed lead acid battery, each	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2359	NU	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	188.54		New	
E2359	RR	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	18.86		New	
E2359	UE	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	141.40		New	
E2360	NU	Power wheelchair accessory, 22 NF nonsealed lead acid battery, each	103.39		157.02	
E2360	RR	Power wheelchair accessory, 22 NF nonsealed lead acid battery, each	10.39		15.77	
E2360	UE	Power wheelchair accessory, 22 NF nonsealed lead acid battery, each	77.54		117.76	
E2361	NU	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	151.00		168.02	
E2361	RR	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	15.11		16.80	
E2361	UE	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	113.27		126.03	
E2362	NU	Power wheelchair accessory, group 24 nonsealed lead acid battery, each	99.59		128.55	
E2362	RR	Power wheelchair accessory, group 24 nonsealed lead acid battery, each	9.96		12.86	
E2362	UE	Power wheelchair accessory, group 24 nonsealed lead acid battery, each	74.69		96.42	
E2363	NU	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	201.38		224.06	
E2363	RR	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	20.15		22.41	
E2363	UE	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	151.04		168.05	
E2364	NU	Power wheelchair accessory, U-1 nonsealed lead acid battery, each	103.39		157.02	
E2364	RR	Power wheelchair accessory, U-1 nonsealed lead acid battery, each	10.39		15.77	
E2364	UE	Power wheelchair accessory, U-1 nonsealed lead acid battery, each	77.54		117.76	
E2365	NU	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	121.44		135.11	
E2365	RR	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	12.15		13.51	
E2365	UE	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	91.11		101.38	
E2366	NU	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each	285.43		317.57	
E2366	RR	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each	28.62		31.84	
E2366	UE	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each	214.08		238.19	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2367	NU	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each	453.74		504.85	
E2367	RR	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each	45.39		50.49	
E2367	UE	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each	340.31		378.63	
E2368	NU	Power wheelchair component, drive wheel motor, replacement only	559.30		622.30	
E2368	RR	Power wheelchair component, drive wheel motor, replacement only	55.94		62.25	
E2368	UE	Power wheelchair component, drive wheel motor, replacement only	419.48		466.73	
E2369	NU	Power wheelchair component, drive wheel gear box, replacement only	487.17		542.02	
E2369	RR	Power wheelchair component, drive wheel gear box, replacement only	48.72		54.21	
E2369	UE	Power wheelchair component, drive wheel gear box, replacement only	365.37		406.50	
E2370	NU	Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only	869.25		967.13	
E2370	RR	Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only	86.93		96.72	
E2370	UE	Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only	651.93		725.34	
E2371	NU	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each	163.21		181.59	
E2371	RR	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each	16.32		18.17	
E2371	UE	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each	122.41		136.20	
E2372	NU	Power wheelchair accessory, group 27 nonsealed lead acid battery, each	0.00		0.00	
E2372	RR	Power wheelchair accessory, group 27 nonsealed lead acid battery, each	0.00		0.00	
E2372	UE	Power wheelchair accessory, group 27 nonsealed lead acid battery, each	0.00		0.00	
E2373	NU	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	761.13		982.52	
E2373	RR	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	76.10		98.24	
E2373	UE	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	570.85		736.90	
E2374	NU	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	578.19		643.31	
E2374	RR	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	57.81		64.33	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2374	UE	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	433.66		482.50	
E2375	NU	Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	927.41		1031.85	
E2375	RR	Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	92.74		103.17	
E2375	UE	Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	695.54		773.85	
E2376	NU	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	1453.29		1616.96	
E2376	RR	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	145.33		161.71	
E2376	UE	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	1089.99		1212.74	
E2377	NU	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	525.89		585.10	
E2377	RR	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	52.58		58.51	
E2377	UE	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	394.44		438.86	
E2378	NU	Power wheelchair component, actuator, replacement only	0.00		New	
E2378	RR	Power wheelchair component, actuator, replacement only	0.00		New	
E2378	UE	Power wheelchair component, actuator, replacement only	0.00		New	
E2381	NU	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	82.48		91.77	
E2381	RR	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	8.26		9.19	
E2381	UE	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	61.87		68.83	
E2382	NU	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	22.49		25.02	
E2382	RR	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	2.24		2.49	
E2382	UE	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	16.85		18.76	
E2383	NU	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	164.44		182.96	
E2383	RR	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	16.44		18.31	
E2383	UE	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	123.34		137.23	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2384	NU	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	87.62		97.47	
E2384	RR	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	8.78		9.77	
E2384	UE	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	65.70		73.10	
E2385	NU	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	53.61		59.63	
E2385	RR	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	5.36		5.98	
E2385	UE	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	40.18		44.69	
E2386	NU	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	162.96		181.31	
E2386	RR	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	16.29		18.13	
E2386	UE	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	122.20		135.98	
E2387	NU	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	73.07		81.31	
E2387	RR	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	7.31		8.13	
E2387	UE	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	54.85		61.01	
E2388	NU	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	54.56		60.70	
E2388	RR	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	5.45		6.08	
E2388	UE	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	40.92		45.54	
E2389	NU	Power wheelchair accessory, foam caster tire, any size, replacement only, each	29.63		32.96	
E2389	RR	Power wheelchair accessory, foam caster tire, any size, replacement only, each	2.97		3.30	
E2389	UE	Power wheelchair accessory, foam caster tire, any size, replacement only, each	22.22		24.71	
E2390	NU	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each	46.34		51.54	
E2390	RR	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each	4.64		5.15	
E2390	UE	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each	34.73		38.63	
E2391	NU	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	22.21		24.70	
E2391	RR	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	2.22		2.47	
E2391	UE	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	16.65		18.53	
E2392	NU	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	58.33		64.91	
E2392	RR	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	5.85		6.51	
E2392	UE	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	43.76		48.67	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2394	NU	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	83.10		92.46	
E2394	RR	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	8.32		9.27	
E2394	UE	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	62.33		69.36	
E2395	NU	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	59.06		65.71	
E2395	RR	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	5.91		6.58	
E2395	UE	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	44.32		49.30	
E2396	NU	Power wheelchair accessory, caster fork, any size, replacement only, each	72.01		80.12	
E2396	RR	Power wheelchair accessory, caster fork, any size, replacement only, each	7.72		8.58	
E2396	UE	Power wheelchair accessory, caster fork, any size, replacement only, each	54.02		60.10	
E2397	NU	Power wheelchair accessory, lithium-based battery, each	448.40		578.81	
E2397	RR	Power wheelchair accessory, lithium-based battery, each	44.84		57.88	
E2397	UE	Power wheelchair accessory, lithium-based battery, each	336.28		434.10	
E2402	RR	Negative pressure wound therapy electrical pump, stationary or portable	1601.80		2067.73	
E2500	NU	Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time	423.40		546.57	
E2500	RR	Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time	42.35		54.67	
E2500	UE	Speech generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time	317.54		409.92	
E2502	NU	Speech generating device, digitized speech, using prerecorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	1294.71		1671.31	
E2502	RR	Speech generating device, digitized speech, using prerecorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	129.48		167.14	
E2502	UE	Speech generating device, digitized speech, using prerecorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	971.05		1253.50	
E2504	NU	Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	1707.89		2204.69	
E2504	RR	Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	170.81		220.49	
E2504	UE	Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	1280.91		1653.49	
E2506	NU	Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time	2504.29		3232.73	
E2506	RR	Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time	250.42		323.25	
E2506	UE	Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time	1878.18		2424.50	
E2508	NU	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	3872.45		4998.86	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2508	RR	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	387.24		499.90	
E2508	UE	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	2904.35		3749.16	
E2510	NU	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	7328.10		9459.67	
E2510	RR	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	732.81		945.96	
E2510	UE	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	5496.07		7094.75	
E2511	NU	Speech generating software program, for personal computer or personal digital assistant	BR		BR	
E2511	RR	Speech generating software program, for personal computer or personal digital assistant	BR		BR	
E2511	UE	Speech generating software program, for personal computer or personal digital assistant	BR		BR	
E2512	NU	Accessory for speech generating device, mounting system	BR		BR	
E2512	RR	Accessory for speech generating device, mounting system	BR		BR	
E2512	UE	Accessory for speech generating device, mounting system	BR		BR	
E2599		Accessory for speech generating device, not otherwise classified	BR		BR	
E2601	NU	General use wheelchair seat cushion, width less than 22 in, any depth	66.23		73.68	
E2601	RR	General use wheelchair seat cushion, width less than 22 in, any depth	6.63		7.39	
E2601	UE	General use wheelchair seat cushion, width less than 22 in, any depth	49.65		55.25	
E2602	NU	General use wheelchair seat cushion, width 22 in or greater, any depth	129.28		143.84	
E2602	RR	General use wheelchair seat cushion, width 22 in or greater, any depth	12.93		14.39	
E2602	UE	General use wheelchair seat cushion, width 22 in or greater, any depth	96.96		107.87	
E2603	NU	Skin protection wheelchair seat cushion, width less than 22 in, any depth	164.13		182.61	
E2603	RR	Skin protection wheelchair seat cushion, width less than 22 in, any depth	16.42		18.28	
E2603	UE	Skin protection wheelchair seat cushion, width less than 22 in, any depth	123.09		136.96	
E2604	NU	Skin protection wheelchair seat cushion, width 22 in or greater, any depth	203.99		226.96	
E2604	RR	Skin protection wheelchair seat cushion, width 22 in or greater, any depth	20.38		22.68	
E2604	UE	Skin protection wheelchair seat cushion, width 22 in or greater, any depth	153.02		170.26	
E2605	NU	Positioning wheelchair seat cushion, width less than 22 in, any depth	291.44		324.26	
E2605	RR	Positioning wheelchair seat cushion, width less than 22 in, any depth	29.16		32.43	
E2605	UE	Positioning wheelchair seat cushion, width less than 22 in, any depth	218.62		243.23	
E2606	NU	Positioning wheelchair seat cushion, width 22 in or greater, any depth	454.67		505.86	
E2606	RR	Positioning wheelchair seat cushion, width 22 in or greater, any depth	45.49		50.61	
E2606	UE	Positioning wheelchair seat cushion, width 22 in or greater, any depth	341.00		379.39	
E2607	NU	Skin protection and positioning wheelchair seat cushion, width less than 22 in, any depth	313.83		349.16	
E2607	RR	Skin protection and positioning wheelchair seat cushion, width less than 22 in, any depth	31.39		34.92	
E2607	UE	Skin protection and positioning wheelchair seat cushion, width less than 22 in, any depth	235.37		261.88	
E2608	NU	Skin protection and positioning wheelchair seat cushion, width 22 in or greater, any depth	376.87		419.33	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2608	RR	Skin protection and positioning wheelchair seat cushion, width 22 in or greater, any depth	37.68		41.92	
E2608	UE	Skin protection and positioning wheelchair seat cushion, width 22 in or greater, any depth	282.66		314.50	
E2609		Custom fabricated wheelchair seat cushion, any size	BR		BR	
E2610		Wheelchair seat cushion, powered	BR		BR	
E2611	NU	General use wheelchair back cushion, width less than 22 in, any height, including any type mounting hardware	338.18		376.28	
E2611	RR	General use wheelchair back cushion, width less than 22 in, any height, including any type mounting hardware	33.82		37.62	
E2611	UE	General use wheelchair back cushion, width less than 22 in, any height, including any type mounting hardware	253.66		282.24	
E2612	NU	General use wheelchair back cushion, width 22 in or greater, any height, including any type mounting hardware	457.50		509.01	
E2612	RR	General use wheelchair back cushion, width 22 in or greater, any height, including any type mounting hardware	45.74		50.90	
E2612	UE	General use wheelchair back cushion, width 22 in or greater, any height, including any type mounting hardware	343.10		381.74	
E2613	NU	Positioning wheelchair back cushion, posterior, width less than 22 in, any height, including any type mounting hardware	425.55		473.48	
E2613	RR	Positioning wheelchair back cushion, posterior, width less than 22 in, any height, including any type mounting hardware	42.57		47.36	
E2613	UE	Positioning wheelchair back cushion, posterior, width less than 22 in, any height, including any type mounting hardware	319.16		355.11	
E2614	NU	Positioning wheelchair back cushion, posterior, width 22 in or greater, any height, including any type mounting hardware	588.92		655.25	
E2614	RR	Positioning wheelchair back cushion, posterior, width 22 in or greater, any height, including any type mounting hardware	58.90		65.54	
E2614	UE	Positioning wheelchair back cushion, posterior, width 22 in or greater, any height, including any type mounting hardware	441.72		491.46	
E2615	NU	Positioning wheelchair back cushion, posterior-lateral, width less than 22 in, any height, including any type mounting hardware	489.75		544.89	
E2615	RR	Positioning wheelchair back cushion, posterior-lateral, width less than 22 in, any height, including any type mounting hardware	48.98		54.50	
E2615	UE	Positioning wheelchair back cushion, posterior-lateral, width less than 22 in, any height, including any type mounting hardware	367.28		408.65	
E2616	NU	Positioning wheelchair back cushion, posterior-lateral, width 22 in or greater, any height, including any type mounting hardware	658.92		733.12	
E2616	RR	Positioning wheelchair back cushion, posterior-lateral, width 22 in or greater, any height, including any type mounting hardware	65.89		73.32	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2616	UE	Positioning wheelchair back cushion, posterior-lateral, width 22 in or greater, any height, including any type mounting hardware	494.20		549.87	
E2617		Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	BR		BR	
E2619	NU	Replacement cover for wheelchair seat cushion or back cushion, each	55.57		61.81	
E2619	RR	Replacement cover for wheelchair seat cushion or back cushion, each	5.55		6.17	
E2619	UE	Replacement cover for wheelchair seat cushion or back cushion, each	41.70		46.38	
E2620	NU	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in, any height, including any type mounting hardware	593.01		659.79	
E2620	RR	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in, any height, including any type mounting hardware	59.30		65.98	
E2620	UE	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in, any height, including any type mounting hardware	444.77		494.86	
E2621	NU	Positioning wheelchair back cushion, planar back with lateral supports, width 22 in or greater, any height, including any type mounting hardware	622.31		692.39	
E2621	RR	Positioning wheelchair back cushion, planar back with lateral supports, width 22 in or greater, any height, including any type mounting hardware	62.22		69.23	
E2621	UE	Positioning wheelchair back cushion, planar back with lateral supports, width 22 in or greater, any height, including any type mounting hardware	466.73		519.30	
E2622	NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 in, any depth	358.88		New	
E2622	RR	Skin protection wheelchair seat cushion, adjustable, width less than 22 in, any depth	35.89		New	
E2622	UE	Skin protection wheelchair seat cushion, adjustable, width less than 22 in, any depth	269.17		New	
E2623	NU	Skin protection wheelchair seat cushion, adjustable, width 22 in or greater, any depth	456.67		New	
E2623	RR	Skin protection wheelchair seat cushion, adjustable, width 22 in or greater, any depth	45.68		New	
E2623	UE	Skin protection wheelchair seat cushion, adjustable, width 22 in or greater, any depth	342.50		New	
E2624	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 in, any depth	361.83		New	
E2624	RR	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 in, any depth	36.18		New	
E2624	UE	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 in, any depth	271.39		New	
E2625	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 in or greater, any depth	458.06		New	
E2625	RR	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 in or greater, any depth	45.81		New	
E2625	UE	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 in or greater, any depth	343.54		New	
E2626	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	672.50		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2626	RR	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	67.23		New	
E2626	UE	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	504.33		New	
E2627	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	912.14		New	
E2627	RR	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	91.24		New	
E2627	UE	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	684.10		New	
E2628	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	808.41		New	
E2628	RR	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	80.84		New	
E2628	UE	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	606.30		New	
E2629	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	1023.02		New	
E2629	RR	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	102.29		New	
E2629	UE	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	767.27		New	
E2630	NU	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	715.40		New	
E2630	RR	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	71.54		New	
E2630	UE	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	536.54		New	
E2631	NU	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	243.24		New	
E2631	RR	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	24.33		New	
E2631	UE	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	182.43		New	
E2632	NU	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	167.15		New	
E2632	RR	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	16.73		New	
E2632	UE	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	125.35		New	
E2633	NU	Wheelchair accessory, addition to mobile arm support, supinator	131.19		New	
E2633	RR	Wheelchair accessory, addition to mobile arm support, supinator	13.13		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
E2633	UE	Wheelchair accessory, addition to mobile arm support, supinator	98.40		New	
E8000		Gait trainer, pediatric size, posterior support, includes all accessories and components	BR		BR	2097.37**
E8001		Gait trainer, pediatric size, upright support, includes all accessories and components	BR		BR	2097.37**
E8002		Gait trainer, pediatric size, anterior support, includes all accessories and components	BR		BR	2097.37**
G0008		Administration of influenza virus vaccine	20.10	34.85	12.23	34.73
G0009		Administration of pneumococcal vaccine	10.29	34.85	12.23	34.73
G0010		Administration of hepatitis B vaccine	10.29	34.85	12.23	
G0027		Semen analysis; presence and/or motility of sperm excluding Huhner	30.31		27.52	
G0101		Cervical or vaginal cancer screening; pelvic and clinical breast examination	55.30	73.23	65.75	78.36
G0102		Prostate cancer screening; digital rectal examination	BR		BR	
G0103		Prostate cancer screening; prostate specific antigen test (PSA)	64.30		76.45	
G0104		Colorectal cancer screening; flexible sigmoidoscopy	182.61	535.50	217.12	339.47
G0105		Colorectal cancer screening; colonoscopy on individual at high risk	664.86	789.24	790.49	737.84
G0106		Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	272.63	237.65	324.15	114.09
G0108		Diabetes outpatient self-management training services, individual, per 30 minutes	BR		BR	
G0109		Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	BR		BR	
G0117		Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	BR	95.55	BR	87.11
G0118		Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist	BR	62.45	BR	54.21
G0120		Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema	272.63	237.65	324.15	114.09
G0121		Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	664.86	789.24	790.49	737.84
G0122		Colorectal cancer screening; barium enema	272.63		324.15	2097.37**
G0123		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	21.47		19.49	
G0124		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	5.47		4.97	
G0127		Trimming of dystrophic nails, any number	25.72	36.63	30.58	40.45
G0128		Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes	BR		BR	
G0129		Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)	BR		BR	
G0130		Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	BR	91.38	BR	60.74
G0141		Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0143		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	29.89		27.14	
G0144		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	28.63		25.99	
G0145		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	31.15		28.29	
G0147		Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	28.63		25.99	
G0148		Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	29.89		27.14	
G0151		Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	BR		BR	
G0152		Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	BR		BR	
G0153		Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	BR		BR	
G0154		Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes	BR		BR	
G0155		Services of clinical social worker in home health or hospice settings, each 15 minutes	BR		BR	
G0156		Services of home health/hospice aide in home health or hospice settings, each 15 minutes	BR		BR	
G0157		Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes	BR		New	
G0158		Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes	BR		New	
G0159		Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes	BR		New	
G0160		Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	BR		New	
G0161		Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes	BR		New	
G0162		Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home hea	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0163		Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possi	BR		New	
G0164		Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	BR		New	
G0166		External counterpulsation, per treatment session	BR	128.35	BR	141.01
G0168		Wound closure utilizing tissue adhesive(s) only	BR		BR	
G0173		Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	BR	4258.11	BR	4832.08
G0175		Scheduled interdisciplinary team conference (minimum of 3 exclusive of patient care nursing staff) with patient present	BR	226.78	BR	153.47
G0176		Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	BR		BR	
G0177		Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	BR		BR	
G0179		Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial im	BR		BR	
G0180		Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial imple	BR		BR	
G0181		Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of	BR		BR	
G0182		Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patie	BR		BR	
G0186		Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)	BR	537.18	BR	533.44
G0202		Screening mammography, producing direct digital image, bilateral, all views	BR		BR	
G0204		Diagnostic mammography, producing direct digital image, bilateral, all views	BR		BR	
G0206		Diagnostic mammography, producing direct digital image, unilateral, all views	BR		BR	
G0219		PET imaging whole body; melanoma for noncovered indications	BR		BR	2097.37**
G0235		PET imaging, any site, not otherwise specified	BR		BR	2097.37**
G0237		Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)	BR	45.26	BR	37.00
G0238		Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)	BR	45.26	BR	37.00

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0239		Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, 2 or more individuals (includes monitoring)	BR	45.26	BR	37.00
G0245		Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that con	BR	73.23	BR	78.36
G0246		Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a)	BR	73.23	BR	94.26
G0247		Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following,	BR	92.29	BR	80.15
G0248		Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-t	BR	165.76	BR	153.47
G0249		Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in th	BR	165.76	BR	153.47
G0250		Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequen	BR		BR	
G0251		Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment	BR	1262.03	BR	1302.27
G0252		PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes)	BR		BR	2097.37**
G0255		Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve	BR		BR	2097.37**
G0257		Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility	BR	640.29	BR	622.03
G0259		Injection procedure for sacroiliac joint; arthrography	BR		BR	
G0260		Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography	BR	729.86	BR	656.59
G0268		Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing	BR		BR	
G0269		Placement of occlusive device into either a venous or arterial access site, postsurgical or interventional procedure (e.g., angioseal plug, vascular plug)	BR		BR	
G0270		Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face w	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0271		Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individu	BR		BR	
G0275		Renal angiography, nonselective, one or both kidneys, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta at or near the origins (ostia) of the renal a	BR		BR	
G0278		Iliac and/or femoral artery angiography, nonselective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta	BR		BR	
G0281		Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as	BR		BR	
G0282		Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	BR		BR	2097.37**
G0283		Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	BR		BR	
G0288		Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery	BR		BR	
G0289		Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee	BR		BR	
G0293		Noncovered surgical procedure(s) using conscious sedation, regional, general, or spinal anesthesia in a Medicare qualifying clinical trial, per day	BR	64.04	BR	61.03
G0294		Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day	BR	64.04	BR	61.03
G0295		Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses	BR		BR	2097.37**
G0302		Preoperative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services	BR	1039.98	BR	1042.44
G0303		Preoperative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services	BR	1039.98	BR	1042.44
G0304		Preoperative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services	BR	222.68	BR	219.25
G0305		Postdischarge pulmonary surgery services after LVRS, minimum of 6 days of services	BR	222.68	BR	219.25
G0306		Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count	BR		BR	
G0307		Complete (CBC), automated (HgB, Hct, RBC, WBC; without platelet count)	BR		BR	
G0328		Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0329		Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a thera	BR		BR	
G0333		Pharmacy dispensing fee for inhalation drug(s); initial 30-day supply as a beneficiary	BR		BR	
G0337		Hospice evaluation and counseling services, preelection	BR		BR	
G0339		Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment	BR	4258.11	BR	4832.08
G0340		Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment	BR	3037.89	BR	3366.00
G0341		Percutaneous islet cell transplant, includes portal vein catheterization and infusion	BR		BR	2097.37**
G0342		Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	BR		BR	2097.37**
G0343		Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	BR		BR	2097.37**
G0364		Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service	BR	64.04	BR	61.03
G0365		Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	BR	199.63	BR	209.78
G0372		Physician service required to establish and document the need for a power mobility device	BR		BR	
G0378		Hospital observation service, per hour	BR		BR	
G0379		Direct admission of patient for hospital observation care	BR	226.78	BR	78.36
G0380		Level 1 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or	BR	87.44	BR	61.97
G0381		Level 2 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or	BR	69.82	BR	84.16
G0382		Level 3 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or	BR	115.97	BR	132.88
G0383		Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or	BR	175.84	BR	191.87
G0384		Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or	BR	267.44	BR	314.30
G0389		Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening	BR	128.14	BR	131.62
G0390		Trauma response team associated with hospital critical care service	BR	1179.74	BR	1128.18

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0396		Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	BR	57.87	BR	54.83
G0397		Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	BR	57.87	BR	54.83
G0398		Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	BR	222.68	BR	219.25
G0399		Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	BR	222.68	BR	219.25
G0400		Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	BR	222.68	BR	219.25
G0402		Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	BR	125.08	BR	153.47
G0403		Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	BR		BR	
G0404		Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	BR	34.41	BR	35.93
G0405		Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	BR		BR	
G0406		Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	BR		BR	2097.37**
G0407		Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	BR		BR	2097.37**
G0408		Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	BR		BR	2097.37**
G0409		Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF qualified social worker or psychologist in a CORF)	BR		BR	
G0410		Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	BR		BR	
G0411		Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes	BR		BR	
G0412		Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed	BR		BR	2097.37**
G0413		Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum)	BR	2975.93	BR	2897.26
G0414		Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami)	BR		BR	2097.37**

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0415		Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)	BR		BR	2097.37**
G0416		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 10-20 specimens	BR	202.61	BR	
G0417		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens	BR	202.61	BR	
G0418		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens	BR	202.61	BR	
G0419		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens	BR	202.61	BR	
G0420		Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour	BR		BR	
G0421		Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour	BR		BR	
G0422		Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	BR	103.10	BR	51.90
G0423		Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session	BR	103.10	BR	51.90
G0424		Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to 2 sessions per day	BR	50.71	BR	68.26
G0425		Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	BR		BR	2097.37**
G0426		Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	BR		BR	2097.37**
G0427		Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	BR		BR	2097.37**
G0428		Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	BR		New	
G0429		Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	BR		New	
G0431		Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter	276.56		New	
G0432		Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	37.71		New	
G0433		Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV 1 and/or HIV-2, screening	37.71		New	
G0434		Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter	63.85		New	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0435		Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening	37.71		New	
G0436		Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	BR	28.84	New	
G0437		Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	BR	57.87	New	
G0438		Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	BR		New	
G0439		Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	BR		New	
G0442		Annual alcohol misuse screening, 15 minutes	BR	57.87	New	
G0443		Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	BR	57.87	New	
G0444		Annual depression screening, 15 minutes	BR	57.87	New	
G0445		Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior	BR	57.87	New	
G0446		Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	BR	57.87	New	
G0447		Face-to-face behavioral counseling for obesity, 15 minutes	BR	57.87	New	
G0448		Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing	BR		New	
G0451		Development testing, with interpretation and report, per standardized instrument form	BR	57.87	New	
G0452		Molecular pathology procedure; physician interpretation and report	BR		New	
G0453		Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	BR		New	
G0454		Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist	BR		New	
G0455		Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen	BR	64.04	New	
G0456		Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions fo	BR	270.47	New	
G0457		Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions fo	BR	270.47	New	
G0458		Low dose rate (LDR) prostate brachytherapy services, composite rate	BR		New	
G0459		Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	BR		New	
G0908		Most recent hemoglobin (HgB) level > 12.0 g/dl	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G0909		Hemoglobin level measurement not documented, reason not given	BR		New	
G0910		Most recent hemoglobin level <= 12.0 g/dl	BR		New	
G0913		Improvement in visual function achieved within 90 days following cataract surgery	BR		New	
G0914		Patient care survey was not completed by patient	BR		New	
G0915		Improvement in visual function not achieved within 90 days following cataract surgery	BR		New	
G0916		Satisfaction with care achieved within 90 days following cataract surgery	BR		New	
G0917		Patient satisfaction survey was not completed by patient	BR		New	
G0918		Satisfaction with care not achieved within 90 days following cataract surgery	BR		New	
G0919		Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit	BR		New	
G0920		Type, anatomic location, and activity all documented	BR		New	
G0921		Documentation of patient reason(s) for not being able to assess (e.g., patient refuses endoscopic and/or radiologic assessment)	BR		New	
G0922		No documentation of disease type, anatomic location, and activity, reason not given	BR		New	
G3001		Administration and supply of tositumomab, 450 mg	BR	2531.79	BR	2349.73
G8126		Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase	BR		BR	
G8127		Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase	BR		BR	
G8128		Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure	BR		BR	
G8395		Left ventricular ejection fraction (LVEF) >= 40% or documentation as normal or mildly depressed left ventricular systolic function	BR		BR	
G8396		Left ventricular ejection fraction (LVEF) not performed or documented	BR		BR	
G8397		Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy	BR		BR	
G8398		Dilated macular or fundus exam not performed	BR		BR	
G8399		Patient with central dual-energy x-ray absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	BR		BR	
G8400		Patient with central dual-energy x-ray absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed, reason not given	BR		BR	
G8401		Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure	BR		BR	
G8404		Lower extremity neurological exam performed and documented	BR		BR	
G8405		Lower extremity neurological exam not performed	BR		BR	
G8406		Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure	BR		BR	
G8410		Footwear evaluation performed and documented	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8415		Footwear evaluation was not performed	BR		BR	
G8416		Clinician documented that patient was not an eligible candidate for footwear evaluation measure	BR		BR	
G8417		Calculated BMI above normal parameters and a follow-up plan was documented	BR		BR	
G8418		Calculated BMI below the lower parameter and a follow-up plan was documented	BR		BR	
G8419		Calculated BMI outside normal parameters, no follow-up plan was documented	BR		BR	
G8420		Calculated BMI within normal parameters and documented	BR		BR	
G8421		BMI not calculated	BR		BR	
G8422		Patient not eligible for BMI calculation	BR		BR	
G8427		Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	BR		BR	
G8428		Current medication and route not documented by eligible professional, reason not specified	BR		BR	
G8430		Eligible professional attests the patient is not eligible for medication documentation	BR		BR	
G8431		Positive screen for clinical depression with a documented follow-up plan	BR		BR	
G8432		Clinical depression screening not documented, reason not given	BR		BR	
G8433		Screening for clinical depression not documented, patient not eligible/appropriate	BR		BR	
G8442		Documentation that patient is not eligible for pain assessment	BR		BR	
G8450		Beta-blocker therapy prescribed	BR		BR	
G8451		Clinician documented patient with left ventricular ejection fraction (LVEF) < 40% or documentation as moderately or severely depressed left ventricular systolic function was not eligible candidate for beta-blocker therapy	BR		BR	
G8452		Beta-blocker therapy not prescribed	BR		BR	
G8458		Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for hepatitis C	BR		BR	
G8459		Clinician documented that patient is receiving antiviral treatment for hepatitis C	BR		BR	
G8460		Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for hepatitis C	BR		BR	
G8461		Patient receiving antiviral treatment for hepatitis C	BR		BR	
G8462		Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for hepatitis C	BR		BR	
G8463		Patient receiving antiviral treatment for hepatitis C documented	BR		BR	
G8464		Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; low or intermediate risk of recurrence or risk of recurrence not determined	BR		BR	
G8465		High risk of recurrence of prostate cancer	BR		BR	
G8473		Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed	BR		BR	
G8474		Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8475		Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not given	BR		BR	
G8476		Most recent blood pressure has a systolic measurement of < 130 mm Hg and a diastolic measurement of < 80 mm Hg	BR		BR	
G8477		Most recent blood pressure has a systolic measurement of >= 130 mm Hg and/or a diastolic measurement of >= 80 mm Hg	BR		BR	
G8478		Blood pressure measurement not performed or documented, reason not given	BR		BR	
G8482		Influenza immunization administered or previously received	BR		BR	
G8483		Influenza immunization was not ordered or administered for reasons documented by clinician (e.g., patient allergy or other medical reason, patient declined or other patient reasons, or other system reasons)	BR		BR	
G8484		Influenza immunization was not ordered or administered, reason not given	BR		BR	
G8485		I intend to report the diabetes mellitus (DM) measures group	BR		BR	
G8486		I intend to report the preventive care measures group	BR		BR	
G8487		I intend to report the chronic kidney disease (CKD) measures group	BR		BR	
G8489		I intend to report the coronary artery disease (CAD) measures group	BR		BR	
G8490		I intend to report the rheumatoid arthritis (RA) measures group	BR		BR	
G8491		I intend to report the HIV/AIDS measures group	BR		BR	
G8492		I intend to report the perioperative care measures group	BR		BR	
G8493		I intend to report the back pain measures group	BR		BR	
G8494		All quality actions for the applicable measures in the diabetes mellitus (DM) measures group have been performed for this patient	BR		BR	
G8495		All quality actions for the applicable measures in the chronic kidney disease (CKD) measures group have been performed for this patient	BR		BR	
G8496		All quality actions for the applicable measures in the preventive care measures group have been performed for this patient	BR		BR	
G8497		All quality actions for the applicable measures in the coronary artery bypass graft (CABG) measures group have been performed for this patient	BR		BR	
G8498		All quality actions for the applicable measures in the coronary artery disease (CAD) measures group have been performed for this patient	BR		BR	
G8499		All quality actions for the applicable measures in the rheumatoid arthritis (RA) measures group have been performed for this patient	BR		BR	
G8500		All quality actions for the applicable measures in the HIV/AIDS measures group have been performed for this patient	BR		BR	
G8501		All quality actions for the applicable measures in the perioperative care measures group have been performed for this patient	BR		BR	
G8502		All quality actions for the applicable measures in the back pain measures group have been performed for this patient	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8506		Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy	BR		BR	
G8509		Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given	BR		BR	
G8510		Negative screen for clinical depression, follow-up not required	BR		BR	
G8511		Positive screen for clinical depression documented, follow up plan not documented, reason not given	BR		BR	
G8530		Autogenous AV fistula received	BR		BR	
G8531		Clinician documented that patient was not an eligible candidate for autogenous AV fistula	BR		BR	
G8532		Clinician documented that patient received vascular access other than autogenous AV fistula, reason not given	BR		BR	
G8535		No documentation of an elder maltreatment screen, patient not eligible	BR		BR	
G8536		No documentation of an elder maltreatment screen, reason not given	BR		BR	
G8539		Documentation of a functional outcome assessment using a standardized tool and documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment	BR		BR	
G8540		Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool	BR		BR	
G8541		Functional outcome assessment using a standardized tool, not documented, reason not given	BR		BR	
G8542		Documentation of a functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required	BR		BR	
G8543		Documentation of a functional outcome assessment using a standardized tool; care plan not documented, reason not given	BR		BR	
G8544		I intend to report the coronary artery bypass graft (CABG) measures group	BR		BR	
G8545		I intend to report the hepatitis C measures group	BR		BR	
G8547		I intend to report the ischemic vascular disease (IVD) measures group	BR		BR	
G8548		I intend to report the heart failure (HF) measures group	BR		BR	
G8549		All quality actions for the applicable measures in the hepatitis C measures group have been performed for this patient	BR		BR	
G8551		All quality actions for the applicable measures in the heart failure (HF) measures group have been performed for this patient	BR		BR	
G8552		All quality actions for the applicable measures in the ischemic vascular disease (IVD) measures group have been performed for this patient	BR		BR	
G8553		Prescription(s) generated and transmitted via a qualified ERX system	BR		BR	
G8556		Referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation	BR		BR	
G8557		Patient is not eligible for the referral for otologic evaluation measure	BR		BR	
G8558		Not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8559		Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation	BR		BR	
G8560		Patient has a history of active drainage from the ear within the previous 90 days	BR		BR	
G8561		Patient is not eligible for the referral for otologic evaluation for patients with a history of active drainage measure	BR		BR	
G8562		Patient does not have a history of active drainage from the ear within the previous 90 days	BR		BR	
G8563		Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	BR		BR	
G8564		Patient was referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified)	BR		BR	
G8565		Verification and documentation of sudden or rapidly progressive hearing loss	BR		BR	
G8566		Patient is not eligible for the "referral for otologic evaluation for sudden or rapidly progressive hearing loss" measure	BR		BR	
G8567		Patient does not have verification and documentation of sudden or rapidly progressive hearing loss	BR		BR	
G8568		Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	BR		BR	
G8569		Prolonged intubation (> 24 hrs) required	BR		BR	
G8570		Prolonged intubation (> 24 hrs) not required	BR		BR	
G8571		Development of deep sternal wound infection within 30 days postoperatively	BR		BR	
G8572		No deep sternal wound infection	BR		BR	
G8573		Stroke following isolated CABG surgery	BR		BR	
G8574		No stroke following isolated CABG surgery	BR		BR	
G8575		Developed postoperative renal failure or required dialysis	BR		BR	
G8576		No postoperative renal failure/dialysis not required	BR		BR	
G8577		Re-exploration required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction or other cardiac reason	BR		BR	
G8578		Re-exploration not required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction or other cardiac reason	BR		BR	
G8579		Antiplatelet medication at discharge	BR		BR	
G8580		Antiplatelet medication contraindicated	BR		BR	
G8581		No antiplatelet medication at discharge	BR		BR	
G8582		Beta-blocker at discharge	BR		BR	
G8583		Beta-blocker contraindicated	BR		BR	
G8584		No beta-blocker at discharge	BR		BR	
G8585		Antilipid treatment at discharge	BR		BR	
G8586		Antilipid treatment contraindicated	BR		BR	
G8587		No antilipid treatment at discharge	BR		BR	
G8588		Most recent systolic blood pressure < 140 mm Hg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8589		Most recent systolic blood pressure >= 140 mm Hg	BR		BR	
G8590		Most recent diastolic blood pressure < 90 mm Hg	BR		BR	
G8591		Most recent diastolic blood pressure >= 90 mm Hg	BR		BR	
G8592		No documentation of blood pressure measurement, reason not given	BR		BR	
G8593		Lipid profile results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)	BR		BR	
G8594		Lipid profile not performed, reason not given	BR		BR	
G8595		Most recent LDL-C < 100 mg/dL	BR		BR	
G8596		LDL-C was not performed	BR		BR	
G8597		Most recent LDL-C >= 100 mg/dL	BR		BR	
G8598		Aspirin or another antithrombotic therapy used	BR		BR	
G8599		Aspirin or another antithrombotic therapy not used, reason not given	BR		BR	
G8600		IV tPA initiated within 3 hours (<= 180 minutes) of time last known well	BR		BR	
G8601		IV tPA not initiated within 3 hours (<= 180 minutes) of time last known well for reasons documented by clinician	BR		BR	
G8602		IV tPA not initiated within 3 hours (<= 180 minutes) of time last known well, reason not given	BR		BR	
G8603		Score on the spoken language comprehension functional communication measure at discharge was higher than at admission	BR		BR	
G8604		Score on the spoken language comprehension functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8605		Patient treated for spoken language comprehension but not scored on the spoken language comprehension functional communication measure either at admission or at discharge	BR		BR	
G8606		Score on the attention functional communication measure at discharge was higher than at admission	BR		BR	
G8607		Score on the attention functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8608		Patient treated for attention but not scored on the attention functional communication measure either at admission or at discharge	BR		BR	
G8609		Score on the memory functional communication measure at discharge was higher than at admission	BR		BR	
G8610		Score on the memory functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8611		Patient treated for memory but not scored on the memory functional communication measure either at admission or at discharge	BR		BR	
G8612		Score on the motor speech functional communication measure at discharge was higher than at admission	BR		BR	
G8613		Score on the motor speech functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8614		Patient treated for motor speech but not scored on the motor speech comprehension functional communication measure either at admission or at discharge	BR		BR	
G8615		Score on the reading functional communication measure at discharge was higher than at admission	BR		BR	
G8616		Score on the reading functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8617		Patient treated for reading but not scored on the reading functional communication measure either at admission or at discharge	BR		BR	
G8618		Score on the spoken language expression functional communication measure at discharge was higher than at admission	BR		BR	
G8619		Score on the spoken language expression functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8620		Patient treated for spoken language expression but not scored on the spoken language expression functional communication measure either at admission or at discharge	BR		BR	
G8621		Score on the writing functional communication measure at discharge was higher than at admission	BR		BR	
G8622		Score on the writing functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8623		Patient treated for writing but not scored on the writing functional communication measure either at admission or at discharge	BR		BR	
G8624		Score on the swallowing functional communication measure at discharge was higher than at admission	BR		BR	
G8625		Score on the swallowing functional communication measure at discharge was not higher than at admission, reason not given	BR		BR	
G8626		Patient treated for swallowing but not scored on the swallowing functional communication measure at admission or at discharge	BR		BR	
G8627		Surgical procedure performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power iol, retinal detachment, or wound dehiscence)	BR		BR	
G8628		Surgical procedure not performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power iol, retinal detachment, or wound dehiscence)	BR		BR	
G8629		Documentation of order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required)	BR		New	
G8630		Documentation that administration of prophylactic parenteral antibiotics was initiated within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required), as ordered	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8631		Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is	BR		New	
G8632		Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to the surgical incision (or start of procedure when no incision is required), reason not given	BR		New	
G8633		Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	BR		New	
G8634		Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis	BR		New	
G8635		Pharmacologic therapy for osteoporosis was not prescribed, reason not given	BR		New	
G8642		The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5) (a) of the Social Security Act	BR		New	
G8643		The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption for the application of the payment adjustment under section 1848(a)(5) (a) of the Social Security Act	BR		New	
G8644		Eligible professional does not have prescribing privileges	BR		New	
G8645		I intend to report the asthma measures group	BR		New	
G8646		All quality actions for the applicable measures in the asthma measures group have been performed for this patient	BR		New	
G8647		Risk-adjusted functional status change residual score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8648		Risk-adjusted functional status change residual score for the knee successfully calculated and the score was less than zero (< 0)	BR		New	
G8649		Risk-adjusted functional status change residual scores for the knee not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate	BR		New	
G8650		Risk-adjusted functional status change residual scores for the knee not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8651		Risk-adjusted functional status change residual score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8652		Risk-adjusted functional status change residual score for the hip successfully calculated and the score was less than zero (< 0)	BR		New	
G8653		Risk-adjusted functional status change residual scores for the hip not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8654		Risk-adjusted functional status change residual scores for the hip not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8655		Risk-adjusted functional status change residual score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8656		Risk-adjusted functional status change residual score for the lower leg, foot or ankle successfully calculated and the score was less than zero (< 0)	BR		New	
G8657		Risk-adjusted functional status change residual scores for the lower leg, foot or ankle not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropr	BR		New	
G8658		Risk-adjusted functional status change residual scores for the lower leg, foot or ankle not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8659		Risk-adjusted functional status change residual score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8660		Risk-adjusted functional status change residual score for the lumbar spine successfully calculated and the score was less than zero (< 0)	BR		New	
G8661		Risk-adjusted functional status change residual scores for the lumbar spine not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate	BR		New	
G8662		Risk-adjusted functional status change residual scores for the lumbar spine not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8663		Risk-adjusted functional status change residual score for the shoulder successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8664		Risk-adjusted functional status change residual score for the shoulder successfully calculated and the score was less than zero (< 0)	BR		New	
G8665		Risk-adjusted functional status change residual scores for the shoulder not measured because the patient did not complete FOTO's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate	BR		New	
G8666		Risk-adjusted functional status change residual scores for the shoulder not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8667		Risk-adjusted functional status change residual score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8668		Risk-adjusted functional status change residual score for the elbow, wrist or hand successfully calculated and the score was less than zero (< 0)	BR		New	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8669		Risk-adjusted functional status change residual scores for the elbow, wrist or hand not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate	BR		New	
G8670		Risk-adjusted functional status change residual scores for the elbow, wrist or hand not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not given	BR		New	
G8671		Risk-adjusted functional status change residual score for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	BR		New	
G8672		Risk-adjusted functional status change residual score for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment successfully calculated and the score was less than zero (< 0)	BR		New	
G8673		Risk-adjusted functional status change residual scores for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment not measured because the patient did not complete foto's functional intake on admission and/or follow up s	BR		New	
G8674		Risk-adjusted functional status change residual scores for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment not measured because the patient did not complete foto's functional intake on admission and/or follow up s	BR		New	
G8682		LVF testing performed during the measurement period	BR		New	
G8683		LVF testing not performed, patient not eligible	BR		New	
G8685		LVF testing not performed, reason not given	BR		New	
G8694		Left ventriucular ejection fraction (LVEF) < 40%	BR		New	
G8696		Antithrombotic therapy prescribed at discharge	BR		New	
G8697		Antithrombotic therapy not prescribed for documented reasons (e.g., patient admitted for performance of elective carotidintervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (e.g., patient	BR		New	
G8698		Antithrombotic therapy was not prescribed at discharge, reason not given	BR		New	
G8699		Rehabilitation services (occupational, physical or speech) ordered at or prior to discharge	BR		New	
G8700		Rehabilitation services (occupational, physical or speech) not indicated at or prior to discharge	BR		New	
G8701		Rehabilitation services were not ordered, reason not otherwise specified	BR		New	
G8702		Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively	BR		New	
G8703		Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor intraoperatively	BR		New	
G8704		12-lead electrocardiogram (ECG) performed	BR		New	
G8705		Documentation of medical reason(s) for not performing a 12-lead electrocardiogram (ECG)	BR		New	
G8706		Documentation of patient reason(s) for not performing a 12-lead electrocardiogram (ECG)	BR		New	
G8707		12-lead electrocardiogram (ECG) not performed, reason not given	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8708		Patient not prescribed or dispensed antibiotic	BR		New	
G8709		Patient prescribed or dispensed antibiotic for documented medical reason(s)	BR		New	
G8710		Patient prescribed or dispensed antibiotic	BR		New	
G8711		Prescribed or dispensed antibiotic	BR		New	
G8712		Antibiotic not prescribed or dispensed	BR		New	
G8713		SpKt/V greater than or equal to 1.2 (single-pool clearance of urea [Kt] / volume V])	BR		New	
G8714		Hemodialysis treatment performed exactly 3 times per week > 90 days	BR		New	
G8717		SpKt/V less than 1.2 (single-pool clearance of urea [Kt] / volume V), reason not given	BR		New	
G8718		Total Kt/V greater than or equal to 1.7 per week (total clearance of urea [Kt] / volume V])	BR		New	
G8720		Total Kt/V less than 1.7 per week (total clearance of urea [Kt] / volume V), reason not given	BR		New	
G8721		PT category (primary tumor), pN category (regional lymph nodes), and histologic grade were documented in pathology report	BR		New	
G8722		Medical reason(s) documented for not including pT category, pN category and histologic grade in the pathology report (e.g., anal canal)	BR		New	
G8723		Specimen site is other than anatomic location of primary tumor	BR		New	
G8724		PT category, pN category and histologic grade were not documented in the pathology report, reason not given	BR		New	
G8725		Fasting lipid profile performed (triglycerides, LDL-C, HDL-C and total cholesterol)	BR		New	
G8726		Clinician has documented reason for not performing fasting lipid profile (e.g., patient declined, other patient reasons)	BR		New	
G8728		Fasting lipid profile not performed, reason not given	BR		New	
G8730		Pain assessment documented as positive utilizing a standardized tool and a follow-up plan is documented	BR		New	
G8731		Pain assessment documented as negative, no follow-up plan is required	BR		New	
G8732		No documentation of pain assessment, reason not given	BR		New	
G8733		Documentation of a positive elder maltreatment screen and documented follow-up plan at the time of the postive screen	BR		New	
G8734		Elder maltreatment screen documented as negative, no follow-up required	BR		New	
G8735		Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given	BR		New	
G8736		Most current LDL-C < 100 mg/dL	BR		New	
G8737		Most current LDL-C >= 100 mg/dL	BR		New	
G8738		Left ventricular ejection fraction (LVEF) < 40% or documentation of severely or moderately depressed left ventricular systolic function	BR		New	
G8739		Left ventricular ejection fraction (LVEF) >= 40% or documentation as normal or mildly depressed left ventricular systolic function	BR		New	
G8740		Left ventricular ejection fraction (LVEF) not performed or assessed, reason not given	BR		New	
G8741		Patient not treated for spoken language comprehension disorder	BR		New	
G8742		Patient not treated for attention disorder	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8743		Patient not treated for memory disorder	BR		New	
G8744		Patient not treated for motor speech disorder	BR		New	
G8745		Patient not treated for reading disorder	BR		New	
G8746		Patient not treated for spoken language expression disorder	BR		New	
G8747		Patient not treated for writing disorder	BR		New	
G8748		Patient not treated for swallowing disorder	BR		New	
G8749		Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possib	BR		New	
G8751		Smoking status and exposure to secondhand smoke in the home not assessed, reason not given	BR		New	
G8752		Most recent systolic blood pressure < 140 mm Hg	BR		New	
G8753		Most recent systolic blood pressure >= 140 mm Hg	BR		New	
G8754		Most recent diastolic blood pressure < 90 mm Hg	BR		New	
G8755		Most recent diastolic blood pressure >= 90 mm Hg	BR		New	
G8756		No documentation of blood pressure measurement, reason not given	BR		New	
G8757		All quality actions for the applicable measures in the chronic obstructive pulmonary disease (COPD) measures group have been performed for this patient	BR		New	
G8758		All quality actions for the applicable measures in the inflammatory bowel disease (IBD) measures group have been performed for this patient	BR		New	
G8759		All quality actions for the applicable measures in the sleep apnea measures group have been performed for this patient	BR		New	
G8761		All quality actions for the applicable measures in the dementia measures group have been performed for this patient	BR		New	
G8762		All quality actions for the applicable measures in the Parkinson's disease measures group have been performed for this patient	BR		New	
G8763		All quality actions for the applicable measures in the hypertension (HTN) measures group have been performed for this patient	BR		New	
G8764		All quality actions for the applicable measures in the cardiovascular prevention measures group have been performed for this patient	BR		New	
G8765		All quality actions for the applicable measures in the cataract measures group have been performed for this patient	BR		New	
G8767		Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)	BR		New	
G8768		Documentation of medical reason(s) for not performing lipid profile (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	
G8769		Lipid profile not performed, reason not given	BR		New	
G8770		Urine protein test result documented and reviewed	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8771		Documentation of diagnosis of chronic kidney disease	BR		New	
G8772		Documentation of medical reason(s) for not performing urine protein test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not cllinically appropriate)	BR		New	
G8773		Urine protein test was not performed, reason not given	BR		New	
G8774		Serum creatinine test result documented and reviewed	BR		New	
G8775		Documentation of medical reason(s) for not performing serum creatinine test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	
G8776		Serum creatinine test not performed, reason not gvien	BR		New	
G8777		Diabetes screening test performed	BR		New	
G8778		Documentation of medical reason(s) for not performing diabetes screening test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate, or patients with a diagnosis of di	BR		New	
G8779		Diabetes screening test not performed, reason not given	BR		New	
G8780		Counseling for diet and physical activity performed	BR		New	
G8781		Documentation of medical reason(s) for patient not receiving counseling for diet and physical activity (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	
G8782		Counseling for diet and physical activity not performed, reason not given	BR		New	
G8783		Normal blood pressure reading documented, follow-up not required	BR		New	
G8784		Blood pressure not documented, patient not eligible/not appropriate	BR		New	
G8785		Blood pressure reading not documented, reason not given	BR		New	
G8790		Most recent office visit systolic blood pressure < 130 mm Hg	BR		New	
G8791		Most recent office visit systolic blood pressure, 130-139 mm Hg	BR		New	
G8792		Most recent office visit systolic blood pressure >= 140 mm Hg	BR		New	
G8793		Most recent office visit diastolic blood pressure, < 80 mm Hg	BR		New	
G8794		Most recent office visit diastolic blood pressure, 80-89 mm Hg	BR		New	
G8795		Most recent office visit diastolic blood pressure >= 90 mm Hg	BR		New	
G8796		Blood pressure measurement not documented, reason not given	BR		New	
G8797		Specimen site other than anatomic location of esophagus	BR		New	
G8798		Specimen site other than anatomic location of prostate	BR		New	
G8799		Anticoagulation ordered	BR		New	
G8800		Anticoagulation not ordered for reasons documented by clinician	BR		New	
G8801		Anticoagulation was not ordered, reason not given	BR		New	
G8806		Performance of transabdominal or transvaginal ultrasound	BR		New	
G8807		Transabdominal or transvaginal ultrasound not performed for reasons documented by clinician (e.g., patient has visited the ED multiple times within 72 hours, patient has a documented intrauterine pregnancy (IUP)	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8808		Performance of transabdominal or transvaginal ultrasound not ordered, reason not given	BR		New	
G8809		Rh immune globulin (RhoGam) ordered	BR		New	
G8810		Rh-immunoglobulin (RhoGam) not ordered for reasons documented by clinician (e.g, patient had prior documented receipt of RhoGram within 12 weeks)	BR		New	
G8811		Documentation Rh immunoglobulin (Rhogam) was not ordered, reason not specified	BR		New	
G8812		Patient is not eligible for follow-up CTA, duplex, or MRA (e.g., patient death, failure to return for scheduled follow-up study which will meet numerator criteria has not yet occurred at the time of reporting)	BR		New	
G8813		Follow-up CTA, duplex, or MRA of the abdomen and pelvis performed	BR		New	
G8814		Follow-up CTA, duplex, or MRA of the abdomen and pelvis not performed	BR		New	
G8815		Statin therapy not prescribed for documented reasons (e.g., medical intolerance to statin, dealth of patient prior to discharge, transfer to care of another acute care or federal hospital, hospice admission, left against medical advice)	BR		New	
G8816		Statin medication prescribed at discharge	BR		New	
G8817		Statin therapy not prescribed at discharge, reason not given	BR		New	
G8818		Patient discharge to home no later than postoperative day #7	BR		New	
G8825		Patient not discharged to home by postoperative day #7	BR		New	
G8826		Patient discharged to home no later than postoperative day #2 following EVAR	BR		New	
G8827		Aneurysm minor diameter <= 5.5 cm for women	BR		New	
G8833		Patient not discharged to home by postoperative day #2 following EVAR	BR		New	
G8834		Patient discharged to home no later than postoperative day #2 following CEA	BR		New	
G8835		Asymptomatic patient with no history of any transient ischemic attack or stroke in any carotid or vertebrobasilar territory	BR		New	
G8838		Patient not discharged to home by postoperative day #2 following CEA	BR		New	
G8839		Sleep apnea symptoms assessed, including presence or absence of snoring and daytime sleepiness	BR		New	
G8840		Documentation of reason(s) for not performing an assessment of sleep symptoms (e.g., patient didn't have initial daytime sleepiness, patient visits between initial testing and initiation of therapy)	BR		New	
G8841		Sleep apnea symptoms not assessed, reason not given	BR		New	
G8842		Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) measured at the time of initial diagnosis	BR		New	
G8843		Documentation of reason(s) for not measuring an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) at the time of initial diagnosis (e.g., abnormal anatomy, patient declined, financial, insurance coverage)	BR		New	
G8844		Apnea hypopna index (AHI) or respiratory disturbance index (RDI) not measured at the time of initial diagnosis, reason not given	BR		New	
G8845		Positive airway pressure therapy prescribed	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8846		Moderate or severe obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of 15 or greater)	BR		New	
G8848		Mild obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of less than 15)	BR		New	
G8849		Documentation of reason(s) for not prescribing positive airway pressure therapy (e.g., patient unable to tolerate, alternative therapies use, patient declined, financial, insurance coverage)	BR		New	
G8850		Positive airway pressure therapy not prescribed, reason not given	BR		New	
G8851		Objective measurement of adherence to positive airway pressure therapy, documented	BR		New	
G8852		Positive airway pressure therapy prescribed	BR		New	
G8853		Positive airway pressure therapy not prescribed	BR		New	
G8854		Documentation of reason(s) for not objectively measuring adherence to positive airway pressure therapy (e.g., patient did not bring data from continuous positive airway pressure (CPAP), therapy not yet initiated, not available on machine)	BR		New	
G8855		Objective measurement of adherence to positive airway pressure therapy not performed, reason not given	BR		New	
G8856		Referral to a physician for an otologic evaluation performed	BR		New	
G8857		Patient is not eligible for the referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness)	BR		New	
G8858		Referral to a physician for an otologic evaluation not performed, reason not given	BR		New	
G8859		Patient receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	BR		New	
G8860		Patients who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	BR		New	
G8861		Central dual-energy x-ray absorptiometry (DXA) ordered or documented, review of systems and medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	BR		New	
G8862		Patients not receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	BR		New	
G8863		Patients not assessed for risk of bone loss, reason not given	BR		New	
G8864		Pneumococcal vaccine administered or previously received	BR		New	
G8865		Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient allergic reaction, potential adverse drug reaction)	BR		New	
G8866		Documentation of patient reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient refusal)	BR		New	
G8867		Pneumococcal vaccine not administered or previously received, reason not given	BR		New	
G8868		Patients receiving a first course of anti-TNF therapy	BR		New	
G8869		Patient has documented immunity to hepatitis B and is receiving a first course of anti-TNF therapy	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8870		Hepatitis B vaccine injection administered or previously received and is receiving a first course of anti-TNF therapy	BR		New	
G8871		Patient not receiving a first course of anti-TNF therapy	BR		New	
G8872		Excised tissue evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion	BR		New	
G8873		Patients with needle localization specimens which are not amenable to intraoperative imaging such as MRI needle wire localization, or targets which are tentatively identified on mammogram or ultrasound which do not contain a biopsy marker but which can be	BR		New	
G8874		Excised tissue not evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion	BR		New	
G8875		Clinician diagnosed breast cancer preoperatively by a minimally invasive biopsy method	BR		New	
G8876		Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer preoperatively (e.g., clinical and imaging findings consistent with a benign lesion, lesion too close to skin, implant, chest wall, etc., lesion could not be	BR		New	
G8877		Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given	BR		New	
G8878		Sentinel lymph node biopsy procedure performed	BR		New	
G8879		Clinically node negative (T1N0M0 or T2N0M0) invasive breast cancer	BR		New	
G8880		Documentation of reason(s) sentinel lymph node biopsy not performed (e.g., cancer diagnosed at prophylactic mastectomy, non-invasive cancer, incidentaldiscovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reductio	BR		New	
G8881		Stage of breast cancer is greater than T1N0M0 or T2N0M0	BR		New	
G8882		Sentinel lymph node biopsy procedure not performed	BR		New	
G8883		Biopsy results reviewed, communicated, tracked and documented	BR		New	
G8884		Clinician documented reason that patient's biopsy results were not reviewed	BR		New	
G8885		Biopsy results not reviewed, communicated, tracked or documented	BR		New	
G8886		Most recent blood pressure under control	BR		New	
G8887		Documentation of medical reason(s) for most recent blood pressure not being under control (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	
G8888		Most recent blood pressure not under control, results documented and reviewed	BR		New	
G8889		No documentation of blood pressure measurement, reason not given	BR		New	
G8890		Most recent LDL-C under control, results documented and reviewed	BR		New	
G8891		Documentation of medical reason(s) for most recent LDL-C not under control (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	
G8892		Documentation of medical reason(s) for not performing LDL-C test (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8893		Most recent LDL-C not under control, results documented and reviewed	BR		New	
G8894		LDL-C not performed, reason not given	BR		New	
G8895		Oral aspirin or other antithrombotic therapy prescribed	BR		New	
G8896		Documentation of medical reason(s) for not prescribing oral aspirin or other antithrombotic therapy (e.g., patient documented to be low risk or patient with terminal illness or treatment of hypertension with standard treatment goals is not clinically appr	BR		New	
G8897		Oral aspirin or other antithrombotic therapy was not prescribed, reason not given	BR		New	
G8898		I intend to report the chronic obstructive pulmonary disease (COPD) measures group	BR		New	
G8899		I intend to report the inflammatory bowel disease (IBD) measures group	BR		New	
G8900		I intend to report the sleep apnea measures group	BR		New	
G8902		I intend to report the dementia measures group	BR		New	
G8903		I intend to report the Parkinson's disease measures group	BR		New	
G8904		I intend to report the hypertension (HTN) measures group	BR		New	
G8905		I intend to report the cardiovascular prevention measures group	BR		New	
G8906		I intend to report the cataract measures group	BR		New	
G8907		Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site/side/patient/procedure/implant event; or a hospital transfer or hospital admission upon discharge from the facility	BR		New	
G8908		Patient documented to have received a burn prior to discharge	BR		New	
G8909		Patient documented not to have received a burn prior to discharge	BR		New	
G8910		Patient documented to have experienced a fall within ASC	BR		New	
G8911		Patient documented not to have experienced a fall within ambulatory surgery center	BR		New	
G8912		Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	BR		New	
G8913		Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	BR		New	
G8914		Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC	BR		New	
G8915		Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC	BR		New	
G8916		Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time	BR		New	
G8917		Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time	BR		New	
G8918		Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis	BR		New	
G8919		Most recent systolic blood pressure < 140 mm Hg	BR		New	
G8920		Most recent systolic blood pressure >= 140 mm Hg	BR		New	
G8921		Most recent diastolic blood pressure < 90 mm Hg	BR		New	
G8922		Most recent diastolic blood pressure >= 90 mm Hg	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8923		Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function	BR		New	
G8924		Spirometry test results demonstrate FEV1/FVC < 60% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)	BR		New	
G8925		Spirometry test results demonstrate FEV1/FVC >= 60% or patient does not have COPD symptoms	BR		New	
G8926		Spirometry test not performed or documented, reason not given	BR		New	
G8927		Adjuvant chemotherapy referred, prescribed or previously received for AJCC stage III, colon cancer	BR		New	
G8928		Adjuvant chemotherapy not prescribed or previously received, reason given	BR		New	
G8929		Adjuvant chemotherapy not prescribed or previously received, reason not given	BR		New	
G8930		Assessment of depression severity not documented, reason not given	BR		New	
G8931		Assessment of depression severity not documented, reason not given	BR		New	
G8932		Suicide risk assessed at the initial evaluation	BR		New	
G8933		Suicide risk not assessed at the initial evaluation, reason not given	BR		New	
G8934		Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function	BR		New	
G8935		Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy	BR		New	
G8936		Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy	BR		New	
G8937		Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not given	BR		New	
G8938		BMI is calculated, but patient not eligible for follow-up plan	BR		New	
G8939		Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate	BR		New	
G8940		Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate	BR		New	
G8941		Elder maltreatment screen documented, patient not eligible for follow-up	BR		New	
G8942		Documented functional outcomes assessment and care plan within the previous 30 days	BR		New	
G8943		LDL-C result not present or not within 12 months prior	BR		New	
G8944		AJCC melanoma cancer stage 0 through IIC melanoma	BR		New	
G8945		Aneurysm minor diameter <= 6 cm for men	BR		New	
G8946		Minimally invasive biopsy method attempted but not diagnostic of breast cancer (e.g., high risk lesion of breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular carcinoma in situ, atypical columnar hyperplasica, flat epithelial at	BR		New	
G8947		One or more neuropsychiatric symptoms	BR		New	
G8948		No neuropsychiatric symptoms	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8949		Documentation of patient reason(s) for patient not receiving counseling for diet and physical activity (e.g., patient is not willing to discuss diet or exercise interventions to help control blood pressure, or the patient said he/she refused to make these	BR		New	
G8950		Prehypertensive or hypertensive blood pressure reading documented, indicated follow-up documented	BR		New	
G8951		Prehypertensive or hypertensive blood pressure reading documented, indicated follow-up not documented, patient not eligible/not appropriate	BR		New	
G8952		Prehypertensive or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given	BR		New	
G8953		All quality actions for the applicable measures in the oncology measures group have been performed for this patient	BR		New	
G8954		Complete and appropriate patient data were reported to a qualified clinical database registry	BR		New	
G8955		Most recent assessment of adequacy of volume management	BR		New	
G8956		Patient receiving maintenance hemodialysis in an outpatient dialysis facility	BR		New	
G8957		Patient not receiving maintenance hemodialysis in an outpatient dialysis facility	BR		New	
G8958		Assessment of adequacy of volume management not documented, reason not given	BR		New	
G8959		Clinician treating major depressive disorder communicates to clinician treating comorbid condition	BR		New	
G8960		Clinician treating major depressive disorder did not communicate to clinician treating comorbid condition, reason not given	BR		New	
G8961		Cardiac stress imaging test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery	BR		New	
G8962		Cardiac stress imaging test performed on patient for any reason including those who did not have low risk surgery or test that was performed more than 30 days preceding low risk surgery	BR		New	
G8963		Cardiac stress imaging performed primarily for monitoring of asymptomatic patient who had PCI wihin 2 years	BR		New	
G8964		Cardiac stress imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had PCI wthin 2 years (e.g., symptomatic patient, patient greater than 2 years since PCI, initial evaluation, etc.)	BR		New	
G8965		Cardiac stress imaging test primarily performed on low CHD risk patient for initial detection and risk assessment	BR		New	
G8966		Cardiac stress imaging test performed on symptomatic or higher than low CHD risk patient or for any reason other than initial detection and risk assessment	BR		New	
G8967		Warfarin or another oral anticoagulant that is FDA approved prescribed	BR		New	
G8968		Documentation of medical reason(s) for not prescribing warfarin or another oral anticoagulant that is FDA approved not prescribed (e.g., allergy, risk of bleeding, transient or reversible causes of atrial fibrillation, other medical reasons including, but	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8969		Documentation of patient reason(s) for not prescribing warfarin or another oral anticoagulant that is FDA approved (e.g., economic, social, and/or religious impediments, noncompliance or patient refusal, other patient reasons)	BR		New	
G8970		No risk factors or one moderate risk factor for thromboembolism	BR		New	
G8971		Warfarin or another oral anticoagulant that is FDA approved not prescribed, reason not given	BR		New	
G8972		One or more high risk factors for thromboembolism or more than one moderate risk factor for thromboembolism	BR		New	
G8973		Most recent hemoglobin (HgB) level < 10 g/dl	BR		New	
G8974		Hemoglobin level measurement not documented, reason not given	BR		New	
G8975		Documentation of medical reason(s) for patient having a hemoglobin level < 10 g/dl (e.g., patients who have nonrenal etiologies of anemia [e.g., sickle cell anemia or other hemoglobinopathies, hypersplenism, primary bone marrow disease, anemia related to	BR		New	
G8976		Most recent hemoglobin (HgB) level >= 10 g/dl	BR		New	
G8977		I intend to report the oncology measures group	BR		New	
G8978		Mobility: walking and moving around functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8979		Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	BR		New	
G8980		Mobility: walking and moving around functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8981		Changing and maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8982		Changing and maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	BR		New	
G8983		Changing and maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8984		Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8985		Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8986		Carrying, moving and handling objects functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8987		Self care functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8988		Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	BR		New	
G8989		Self care functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8990		Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G8991		Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	BR		New	
G8992		Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8993		Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals	BR		New	
G8994		Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	BR		New	
G8995		Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting	BR		New	
G8996		Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G8997		Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy	BR		New	
G8998		Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation	BR		New	
G8999		Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9001		Coordinated care fee, initial rate	BR		BR	
G9002		Coordinated care fee (Level 1)	BR		BR	
G9003		Coordinated care fee, risk adjusted high, initial	BR		BR	
G9004		Coordinated care fee, risk adjusted low, initial	BR		BR	
G9005		Coordinated care fee risk adjusted maintenance	BR		BR	
G9006		Coordinated care fee, home monitoring	BR		BR	
G9007		Coordinated care fee, scheduled team conference	BR		BR	
G9008		Coordinated care fee, physician coordinated care oversight services	BR		BR	
G9009		Coordinated care fee, risk adjusted maintenance, level 3	BR		BR	
G9010		Coordinated care fee, risk adjusted maintenance, level 4	BR		BR	
G9011		Coordinated care fee, risk adjusted maintenance, Level 5	BR		BR	
G9012		Other specified case management service not elsewhere classified	BR		BR	
G9013		ESRD demo basic bundle Level I	BR		BR	
G9014		ESRD demo expanded bundle including venous access and related services	BR		BR	
G9016		Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes) [demo project code only]	BR		BR	
G9017		Amantadine HCl, oral, per 100 mg (for use in a Medicare-approved demonstration project)	BR		1.35	
G9018		Zanamivir, inhalation powder, administered through inhaler, per 10 mg (for use in a Medicare-approved demonstration project)	BR		7.78	
G9019		Oseltamivir phosphate, oral, per 75 mg (for use in a Medicare-approved demonstration project)	BR		8.24	
G9020		Rimantadine HCl, oral, per 100 mg (for use in a Medicare-approved demonstration project)	BR		2.34	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9033		Amantadine HCl, oral brand, per 100 mg (for use in a Medicare-approved demonstration project)	BR		BR	
G9034		Zanamivir, inhalation powder, administered through inhaler, brand, per 10 mg (for use in a Medicare approved demonstration project)	BR		BR	
G9035		Oseltamivir phosphate, oral, brand, per 75 mg (for use in a Medicare-approved demonstration project)	BR		BR	
G9036		Rimantadine HCl, oral, brand, per 100 mg (for use in a Medicare-approved demonstration project)	BR		BR	
G9050		Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a Medicare-approved demonstration project)	BR		BR	
G9051		Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer-directed therapy or managing consequences of cancer-directed therapy (for use in a Med	BR		BR	
G9052		Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer-directed therapy might be considered in the future (for use in	BR		BR	
G9053		Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer-directed therapy is being administered or arranged at present; cancer-directed therapy might be considered in the future (for use in a Medicare-ap	BR		BR	
G9054		Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliat	BR		BR	
G9055		Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9056		Oncology; practice guidelines; management adheres to guidelines (for use in a Medicare-approved demonstration project)	BR		BR	
G9057		Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board-approved clinical trial (for use in a Medicare-approved demonstration project)	BR		BR	
G9058		Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a Medicare-approved demonstration project)	BR		BR	
G9059		Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a Medicare-approved demo	BR		BR	
G9060		Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a Medicare-approved demonstration project)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9061		Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a Medicare-approved demonstration project)	BR		BR	
G9062		Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9063		Oncology; disease status; limited to nonsmall cell lung cancer; extent of disease initially established as Stage I (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved de	BR		BR	
G9064		Oncology; disease status; limited to nonsmall cell lung cancer; extent of disease initially established as Stage II (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved d	BR		BR	
G9065		Oncology; disease status; limited to nonsmall cell lung cancer; extent of disease initially established as Stage III a (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approve	BR		BR	
G9066		Oncology; disease status; limited to nonsmall cell lung cancer; Stage III B-IV at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	
G9067		Oncology; disease status; limited to nonsmall cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9068		Oncology; disease status; limited to small cell and combined small cell/nonsmall cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration proj	BR		BR	
G9069		Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/nonsmall cell; extensive Stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	
G9070		Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/nonsmall; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9071		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage I or stage IIA-IIB; or T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recu	BR		BR	
G9072		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage I, or stage IIA-IIB; or T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurr	BR		BR	
G9073		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage IIIA-IIIB; and not T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurren	BR		BR	
G9074		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage IIIA-IIIB; and not T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence,	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9075		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration proj	BR		BR	
G9077		Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T1-T2C and Gleason 2-7 and PSA < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved	BR		BR	
G9078		Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T2 or T3a Gleason 8-10 or PSA > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration	BR		BR	
G9079		Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T3B-T4, any N; any T, N1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9080		Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising PSA or failure of PSA decline (for use in a Medicare-approved demonstration project)	BR		BR	
G9083		Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9084		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N0, M0 with no evidence of disease progression, recurrence or metastases (for use in a Medicare-a	BR		BR	
G9085		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, N0, M0 with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-ap	BR		BR	
G9086		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-4, N1-2, M0 with no evidence of disease progression, recurrence, or metastases (for use in a Medicar	BR		BR	
G9087		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a	BR		BR	
G9088		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use i	BR		BR	
G9089		Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9090		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-2, N0, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrenc	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9091		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T3, N0, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence,	BR		BR	
G9092		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N1-2, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurre	BR		BR	
G9093		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurren	BR		BR	
G9094		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	
G9095		Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9096		Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T1-T3, N0-N1 or NX (prior to neoadjuvant therapy, if any) with no evidence of disease pr	BR		BR	
G9097		Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progres	BR		BR	
G9098		Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	
G9099		Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9100		Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a Medicare-approved demons	BR		BR	
G9101		Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R1 or R2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstratio	BR		BR	
G9102		Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M0, unresectable with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9103		Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9104		Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9105		Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post R0 resection without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9106		Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post R1 or R2 resection with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9107		Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	BR		BR	
G9108		Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9109		Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T1-T2 and N0, M0 (prior to neoadjuvant therapy, if any) with no e	BR		BR	
G9110		Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T3-4 and/or N1-3, M0 (prior to neoadjuvant therapy, if any) with	BR		BR	
G9111		Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration	BR		BR	
G9112		Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration	BR		BR	
G9113		Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage 1A-B (Grade 1) without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9114		Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage IA-B (grade 2-3); or stage IC (all grades); or stage II; without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstrat	BR		BR	
G9115		Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage III-IV; without evidence of progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9116		Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a Medicare-approved demonstration project)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9117		Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9123		Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project)	BR		BR	
G9124		Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and /or BCR-ABL positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project)	BR		BR	
G9125		Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project)	BR		BR	
G9126		Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project)	BR		BR	
G9128		Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage I (for use in a Medicare-approved demonstration project)	BR		BR	
G9129		Oncology; disease status; limited to multiple myeloma, systemic disease; stage II or higher (for use in a Medicare-approved demonstration project)	BR		BR	
G9130		Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9131		Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration proje	BR		BR	
G9132		Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-refractory/androgen-independent (e.g., rising PSA on antiandrogen therapy or postorchiectomy); clinical metastases (for use in a Medicare-approved demonstration project)	BR		BR	
G9133		Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-responsive; clinical metastases or M1 at diagnosis (for use in a Medicare-approved demonstration project)	BR		BR	
G9134		Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; Stage I, II at diagnosis, not relapsed, not refractory (for use in a Medicare-approved demonstration project)	BR		BR	
G9135		Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; Stage III, IV, not relapsed, not refractory (for use in a Medicare-approved demonstration project)	BR		BR	
G9136		Oncology; disease status; non-Hodgkin's lymphoma, transformed from original cellular diagnosis to a second cellular classification (for use in a medicare-approved demonstration project)	BR		BR	
G9137		Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; relapsed/refractory (for use in a medicare-approved demonstration project)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9138		Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; diagnostic evaluation, stage not determined, evaluation of possible relapse or nonresponse to therapy, or not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9139		Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; extent of disease unknown, staging in progress, not listed (for use in a Medicare-approved demonstration project)	BR		BR	
G9140		Frontier extended stay clinic demonstration; for a patient stay in a clinic approved for the CMS demonstration project; the following measures should be present: the stay must be equal to or greater than 4 hours; weather or other conditions must prevent t	BR		BR	
G9143		Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	BR		BR	
G9147		Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potass	BR		New	
G9148		National Committee for Quality Assurance-Level 1 medical home	BR		New	
G9149		National Committee for Quality Assurance-Level 2 medical home	BR		New	
G9150		National Committee for Quality Assurance-Level 3 medical home	BR		New	
G9151		MAPCP Demonstration-state provided services	BR		New	
G9152		MAPCP Demonstration-Community Health Teams	BR		New	
G9153		MAPCP Demonstration-Physician Incentive Pool	BR		New	
G9156		Evaluation for wheelchair requiring face-to-face visit with physician	BR		New	
G9157		Transesophageal Doppler used for cardiac monitoring	BR		New	
G9158		Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9159		Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9160		Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9161		Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9162		Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9163		Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9164		Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9165		Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
G9166		Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9167		Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9168		Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9169		Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9170		Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9171		Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9172		Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9173		Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9174		Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals	BR		New	
G9175		Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
G9176		Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation	BR		New	
G9186		Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy	BR		New	
J0120		Injection, tetracycline, up to 250 mg	BR		BR	
J0129		Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	33.09		33.09	
J0130		Injection abciximab, 10 mg	1125.65		1125.65	
J0131		Injection, acetaminophen, 10 mg	BR		New	
J0132		Injection, acetylcysteine, 100 mg	4.44		4.44	
J0133		Injection, acyclovir, 5 mg	BR		BR	
J0135		Injection, adalimumab, 20 mg	514.89		514.89	
J0150		Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)	53.56		53.56	
J0152		Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270)	BR		BR	
J0171		Injection, Adrenalin, epinephrine, 0.1 mg	0.17		New	
J0178		Injection, aflibercept, 1 mg	1642.32		New	
J0180		Injection, agalsidase beta, 1 mg	220.61		220.61	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J0190		Injection, biperiden lactate, per 5 mg	BR		BR	
J0200		Injection, alatrofloxacin mesylate, 100 mg	BR		BR	
J0205		Injection, alglucerase, per 10 units	60.51		60.51	
J0207		Injection, amifostine, 500 mg	854.92		854.92	
J0210		Injection, methyldopate HCl, up to 250 mg	19.15		19.15	
J0215		Injection, alefacept, 0.5 mg	50.82		50.82	
J0220		Injection, alglucosidase alfa, 10 mg, not otherwise specified	BR		BR	
J0221		Injection, alglucosidase alfa, (Lumizyme), 10 mg	BR		New	
J0256		Injection, alpha 1-proteinase inhibitor (human), not otherwise specified, 10 mg	BR		BR	
J0257		Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg	BR		New	
J0270		Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	4.52		4.52	
J0275		Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	BR		BR	
J0278		Injection, amikacin sulfate, 100 mg	3.26		3.26	
J0280		Injection, aminophyllin, up to 250 mg	3.22		3.22	
J0282		Injection, amiodarone HCl, 30 mg	1.27		1.27	
J0285		Injection, amphotericin B, 50 mg	44.15		44.15	
J0287		Injection, amphotericin B lipid complex, 10 mg	36.77		36.77	
J0288		Injection, amphotericin B cholesteryl sulfate complex, 10 mg	142.98		142.98	
J0289		Injection, amphotericin B liposome, 10 mg	57.73		57.73	
J0290		Injection, ampicillin sodium, 500 mg	6.88		6.88	
J0295		Injection, ampicillin sodium/sulbactam sodium, per 1.5 g	15.00		15.00	
J0300		Injection, amobarbital, up to 125 mg	22.87		22.87	
J0330		Injection, succinylcholine chloride, up to 20 mg	1.27		1.27	
J0348		Injection, anidulafungin, 1 mg	3.31		3.31	
J0350		Injection, anistreplase, per 30 units	BR		BR	2097.37**
J0360		Injection, hydralazine HCl, up to 20 mg	25.86		25.86	
J0364		Injection, apomorphine HCl, 1 mg	5.70		5.70	
J0365		Injection, aprotinin, 10,000 kiu	4.99		4.99	
J0380		Injection, metaraminol bitartrate, per 10 mg	2.19		2.19	
J0390		Injection, chloroquine HCl, up to 250 mg	BR		BR	
J0395		Injection, arbutamine HCl, 1 mg	BR		BR	2097.37**
J0400		Injection, aripiprazole, intramuscular, 0.25 mg	0.52		0.52	
J0456		Injection, azithromycin, 500 mg	31.13		31.13	
J0461		Injection, atropine sulfate, 0.01 mg	0.03		0.03	
J0470		Injection, dimercaprol, per 100 mg	BR		BR	
J0475		Injection, baclofen, 10 mg	BR		BR	
J0476		Injection, baclofen, 50 mcg for intrathecal trial	128.69		128.69	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J0480		Injection, basiliximab, 20 mg	2951.29		2951.29	
J0485		Injection, belatacept, 1 mg	BR		New	
J0490		Injection, belimumab, 10 mg	6.37		New	
J0500		Injection, dicyclomine HCl, up to 20 mg	21.26		21.26	
J0515		Injection, benztropine mesylate, per 1 mg	26.26		26.26	
J0520		Injection, bethanechol chloride, Myotonachol or Urecholine, up to 5 mg	BR		BR	
J0558		Injection, penicillin G benzathine and penicillin G procaine, 100,000 units	BR		New	
J0561		Injection, penicillin G benzathine, 100,000 units	2.65		New	
J0583		Injection, bivalirudin, 1 mg	4.23		4.23	
J0585		Injection, onabotulinumtoxinA, 1 unit	9.18		9.18	
J0586		Injection, abobotulinumtoxinA, 5 units	BR		BR	
J0587		Injection, rimabotulinumtoxinB, 100 units	15.29		15.29	
J0588		Injection, incobotulinumtoxinA, 1 unit	BR		New	
J0592		Injection, buprenorphine HCl, 0.1 mg	1.59		1.59	
J0594		Injection, busulfan, 1 mg	25.57		25.57	
J0595		Injection, butorphanol tartrate, 1 mg	7.77		7.77	
J0597		Injection, C-1 esterase inhibitor (human), Berinert, 10 units	86.53		New	
J0598		Injection, C-1 esterase inhibitor (human), Cinryze, 10 units	71.70		71.70	
J0600		Injection, edetate calcium disodium, up to 1,000 mg	92.66		92.66	
J0610		Injection, calcium gluconate, per 10 ml	1.92		1.92	
J0620		Injection, calcium glycerophosphate and calcium lactate, per 10 ml	22.03		22.03	
J0630		Injection, calcitonin salmon, up to 400 units	88.83		88.83	
J0636		Injection, calcitriol, 0.1 mcg	2.36		2.36	
J0637		Injection, caspofungin acetate, 5 mg	60.58		60.58	
J0638		Injection, canakinumab, 1 mg	BR		New	
J0640		Injection, leucovorin calcium, per 50 mg	3.68		3.68	
J0641		Injection, levoleucovorin calcium, 0.5 mg	BR		BR	
J0670		Injection, mepivacaine HCl, per 10 ml	BR		BR	
J0690		Injection, cefazolin sodium, 500 mg	5.19		5.19	
J0692		Injection, cefepime HCl, 500 mg	24.40		24.40	
J0694		Injection, cefoxitin sodium, 1 g	14.46		14.46	
J0696		Injection, ceftriaxone sodium, per 250 mg	14.11		14.11	
J0697		Injection, sterile cefuroxime sodium, per 750 mg	11.63		11.63	
J0698		Injection, cefotaxime sodium, per g	14.46		14.46	
J0702		Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	9.67		9.67	
J0706		Injection, caffeine citrate, 5 mg	5.82		5.82	
J0710		Injection, cephapirin sodium, up to 1 g	BR		BR	
J0712		Injection, ceftaroline fosamil, 10 mg	BR		New	
J0713		Injection, ceftazidime, per 500 mg	10.91		10.91	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J0715		Injection, ceftizoxime sodium, per 500 mg	BR		BR	
J0716		Injection, Centruroides immune f(ab)2, up to 120 mg	6089.90		New	
J0718		Injection, certolizumab pegol, 1 mg	12.68		12.68	
J0720		Injection, chloramphenicol sodium succinate, up to 1 g	45.78		45.78	
J0725		Injection, chorionic gonadotropin, per 1,000 USP units	6.69		6.69	
J0735		Injection, clonidine HCl, 1 mg	118.64		118.64	
J0740		Injection, cidofovir, 375 mg	1433.14		1433.14	
J0743		Injection, cilastatin sodium; imipenem, per 250 mg	33.12		33.12	
J0744		Injection, ciprofloxacin for intravenous infusion, 200 mg	22.98		22.98	
J0745		Injection, codeine phosphate, per 30 mg	1.79		1.79	
J0760		Injection, colchicine, per 1 mg	11.40		11.40	
J0770		Injection, colistimethate sodium, up to 150 mg	87.32		87.32	
J0775		Injection, collagenase, clostridium histolyticum, 0.01 mg	BR		New	
J0780		Injection, prochlorperazine, up to 10 mg	BR		BR	
J0795		Injection, corticorelin ovine triflutate, 1 mcg	8.32		8.32	
J0800		Injection, corticotropin, up to 40 units	BR		BR	
J0833		Injection, cosyntropin, not otherwise specified, 0.25 mg	183.70		183.70	
J0834		Injection, cosyntropin (Cortrosyn), 0.25 mg	195.94		195.94	
J0840		Injection, crotalidae polyvalent immune fab (ovine), up to 1 g	5823.73		New	
J0850		Injection, cytomegalovirus immune globulin intravenous (human), per vial	1620.11		1620.11	
J0878		Injection, daptomycin, 1 mg	0.63		0.63	
J0881		Injection, darbepoetin alfa, 1 mcg (non-ESRD use)	8.41		8.41	
J0882		Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)	8.41		8.41	
J0885		Injection, epoetin alfa, (for non-ESRD use), 1000 units	22.54		22.54	
J0886		Injection, epoetin alfa, 1000 units (for ESRD on dialysis)	22.54		22.54	
J0890		Injection, peginesatide, 0.1 mg (for ESRD on dialysis)	BR		New	
J0894		Injection, decitabine, 1 mg	45.96		45.96	
J0895		Injection, deferoxamine mesylate, 500 mg	29.43		29.43	
J0897		Injection, denosumab, 1 mg	BR		New	
J0900		Injection, testosterone enanthate and estradiol valerate, up to 1 cc	BR		BR	
J0945		Injection, brompheniramine maleate, per 10 mg	0.03		0.03	
J1000		Injection, depo-estradiol cypionate, up to 5 mg	12.38		12.38	
J1020		Injection, methylprednisolone acetate, 20 mg	5.27		5.27	
J1030		Injection, methylprednisolone acetate, 40 mg	11.05		11.05	
J1040		Injection, methylprednisolone acetate, 80 mg	17.54		17.54	
J1050		Injection, medroxyprogesterone acetate, 1 mg	BR		New	
J1051		Injection, medroxyprogesterone acetate, 50 mg	20.61		20.61	
J1055		Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	102.32		102.32	2097.37**
J1056		Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg	48.99		48.99	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J1060		Injection, testosterone cypionate and estradiol cypionate, up to 1 ml	BR		BR	
J1070		Injection, testosterone cypionate, up to 100 mg	11.52		11.52	
J1080		Injection, testosterone cypionate, 1 cc, 200 mg	28.48		28.48	
J1094		Injection, dexamethasone acetate, 1 mg	0.89		0.89	
J1100		Injection, dexamethasone sodium phosphate, 1 mg	0.89		0.89	
J1110		Injection, dihydroergotamine mesylate, per 1 mg	64.74		64.74	
J1120		Injection, acetazolamide sodium, up to 500 mg	66.18		66.18	
J1160		Injection, digoxin, up to 0.5 mg	4.14		4.14	
J1162		Injection, digoxin immune fab (ovine), per vial	1017.17		1017.17	
J1165		Injection, phenytoin sodium, per 50 mg	2.42		2.42	
J1170		Injection, hydromorphone, up to 4 mg	2.33		2.33	
J1180		Injection, dyphylline, up to 500 mg	BR		BR	
J1190		Injection, dexrazoxane HCl, per 250 mg	634.43		634.43	
J1200		Injection, diphenhydramine HCl, up to 50 mg	2.96		2.96	
J1205		Injection, chlorothiazide sodium, per 500 mg	330.79		330.79	
J1212		Injection, DMSO, dimethyl sulfoxide, 50%, 50 ml	91.92		91.92	
J1230		Injection, methadone HCl, up to 10 mg	BR		BR	
J1240		Injection, dimenhydrinate, up to 50 mg	3.32		3.32	
J1245		Injection, dipyridamole, per 10 mg	52.56		52.56	
J1250		Injection, Dobutamine HCl, per 250 mg	5.47		5.47	
J1260		Injection, dolasetron mesylate, 10 mg	7.17		7.17	
J1265		Injection, dopamine HCl, 40 mg	0.63		0.63	
J1267		Injection, doripenem, 10 mg	1.41		1.41	
J1270		Injection, doxercalciferol, 1 mcg	573.12		573.12	
J1290		Injection, ecallantide, 1 mg	664.62		New	
J1300		Injection, eculizumab, 10 mg	BR		BR	
J1320		Injection, amitriptyline HCl, up to 20 mg	BR		BR	
J1324		Injection, enfuvirtide, 1 mg	0.67		0.67	
J1325		Injection, epoprostenol, 0.5 mg	BR		BR	
J1327		Injection, eptifibatide, 5 mg	41.06		41.06	
J1330		Injection, ergonovine maleate, up to 0.2 mg	BR		BR	
J1335		Injection, ertapenem sodium, 500 mg	103.38		103.38	
J1364		Injection, erythromycin lactobionate, per 500 mg	18.41		18.41	
J1380		Injection, estradiol valerate, up to 10 mg	12.98		12.98	
J1410		Injection, estrogen conjugated, per 25 mg	146.64		146.64	
J1430		Injection, ethanolamine oleate, 100 mg	141.54		141.54	
J1435		Injection, estrone, per 1 mg	0.61		0.61	
J1436		Injection, etidronate disodium, per 300 mg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J1438		Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	283.39		283.39	
J1440		Injection, filgrastim (G-CSF), 300 mcg	398.24		398.24	
J1441		Injection, filgrastim (G-CSF), 480 mcg	580.20		580.20	
J1450		Injection, fluconazole, 200 mg	61.65		61.65	
J1451		Injection, fomepizole, 15 mg	13.67		13.67	
J1452		Injection, fomivirsen sodium, intraocular, 1.65 mg	BR		BR	2097.37**
J1453		Injection, fosaprepitant, 1 mg	2.80		2.80	
J1455		Injection, foscarnet sodium, per 1,000 mg	38.36		38.36	
J1457		Injection, gallium nitrate, 1 mg	2.86		2.86	
J1458		Injection, galsulfase, 1 mg	599.32		599.32	
J1459		Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	BR		BR	
J1460		Injection, gamma globulin, intramuscular, 1 cc	BR		BR	
J1557		Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	BR		New	
J1559		Injection, immune globulin (Hizentra), 100 mg	BR		New	
J1560		Injection, gamma globulin, intramuscular, over 10 cc	BR		BR	
J1561		Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg	75.57		75.57	
J1562		Injection, immune globulin (Vivaglobin), 100 mg	18.38		18.38	
J1566		Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	109.20		109.20	
J1568		Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg	82.73		82.73	
J1569		Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg	93.45		93.45	
J1570		Injection, ganciclovir sodium, 500 mg	107.99		107.99	
J1571		Injection, hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml	140.02		140.02	
J1572		Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg	74.15		74.15	
J1573		Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5 ml	BR		BR	
J1580		Injection, garamycin, gentamicin, up to 80 mg	3.36		3.36	
J1590		Injection, gatifloxacin, 10 mg	BR		BR	
J1595		Injection, glatiramer acetate, 20 mg	3128.93		3128.93	
J1599		Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg	BR		New	
J1600		Injection, gold sodium thiomalate, up to 50 mg	26.49		26.49	
J1610		Injection, glucagon HCl, per 1 mg	144.61		144.61	
J1620		Injection, gonadorelin HCl, per 100 mcg	BR		BR	
J1626		Injection, granisetron HCl, 100 mcg	17.68		17.68	
J1630		Injection, haloperidol, up to 5 mg	17.62		17.62	
J1631		Injection, haloperidol decanoate, per 50 mg	23.85		23.85	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J1640		Injection, hemin, 1 mg	12.64		12.64	
J1642		Injection, heparin sodium, (heparin lock flush), per 10 units	1.26		1.26	
J1644		Injection, Heparin sodium, per 1000 units	1.99		1.99	
J1645		Injection, dalteparin sodium, per 2500 IU	29.37		29.37	
J1650		Injection, enoxaparin sodium, 10 mg	11.95		11.95	
J1652		Injection, fondaparinux sodium, 0.5 mg	14.06		14.06	
J1655		Injection, tinzaparin sodium, 1000 IU	6.96		6.96	
J1670		Injection, tetanus immune globulin, human, up to 250 units	410.51		410.51	
J1675		Injection, histrelin acetate, 10 mcg	1.84		1.84	
J1680		Injection, human fibrinogen concentrate, 100 mg	BR		BR	
J1700		Injection, hydrocortisone acetate, up to 25 mg	BR		BR	
J1710		Injection, hydrocortisone sodium phosphate, up to 50 mg	BR		BR	
J1720		Injection, hydrocortisone sodium succinate, up to 100 mg	3.55		3.55	
J1725		Injection, hydroxyprogesterone caproate, 1 mg	BR		New	
J1730		Injection, diazoxide, up to 300 mg	198.27		198.27	
J1740		Injection, ibandronate sodium, 1 mg	789.16		789.16	
J1741		Injection, ibuprofen, 100 mg	BR		New	
J1742		Injection, ibutilide fumarate, 1 mg	519.35		519.35	
J1743		Injection, idursulfase, 1 mg	805.22		805.22	
J1744		Injection, icatibant, 1 mg	393.71		New	
J1745		Injection infliximab, 10 mg	102.80		102.80	
J1750		Injection, iron dextran, 50 mg	28.88		28.88	
J1756		Injection, iron sucrose, 1 mg	1.04		1.04	
J1786		Injection, imiglucerase, 10 units	99.44		New	
J1790		Injection, droperidol, up to 5 mg	5.79		5.79	
J1800		Injection, propranolol HCl, up to 1 mg	17.53		17.53	
J1810		Injection, droperidol and fentanyl citrate, up to 2 ml ampule	BR		BR	2097.37**
J1815		Injection, insulin, per 5 units	BR		BR	
J1817		Insulin for administration through DME (i.e., insulin pump) per 50 units	BR		BR	
J1826		Injection, interferon beta-1a, 30 mcg	1548.69		New	
J1830		Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	BR		BR	
J1835		Injection, itraconazole, 50 mg	1833.27		1833.27	
J1840		Injection, kanamycin sulfate, up to 500 mg	10.05		10.05	
J1850		Injection, kanamycin sulfate, up to 75 mg	0.98		0.98	
J1885		Injection, ketorolac tromethamine, per 15 mg	6.66		6.66	
J1890		Injection, cephalothin sodium, up to 1 g	BR		BR	
J1930		Injection, lanreotide, 1 mg	52.39		52.39	
J1931		Injection, laronidase, 0.1 mg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J1940		Injection, furosemide, up to 20 mg	2.28		2.28	
J1945		Injection, lepirudin, 50 mg	292.67		292.67	
J1950		Injection, leuprolide acetate (for depot suspension), per 3.75 mg	933.77		933.77	
J1953		Injection, levetiracetam, 10 mg	1.10		1.10	
J1955		Injection, levocarnitine, per 1 g	53.02		53.02	
J1956		Injection, levofloxacin, 250 mg	35.40		35.40	
J1960		Injection, levorphanol tartrate, up to 2 mg	6.07		6.07	
J1980		Injection, hyoscyamine sulfate, up to 0.25 mg	18.12		18.12	
J1990		Injection, chlordiazepoxide HCl, up to 100 mg	40.31		40.31	
J2001		Injection, lidocaine HCl for intravenous infusion, 10 mg	BR		BR	
J2010		Injection, lincomycin HCl, up to 300 mg	8.96		8.96	
J2020		Injection, linezolid, 200 mg	BR		BR	
J2060		Injection, lorazepam, 2 mg	2.41		2.41	
J2150		Injection, mannitol, 25% in 50 ml	5.45		5.45	
J2170		Injection, mecasermin, 1 mg	13.80		13.80	
J2175		Injection, meperidine HCl, per 100 mg	1.87		1.87	
J2180		Injection, meperidine and promethazine HCl, up to 50 mg	15.23		15.23	
J2185		Injection, meropenem, 100 mg	11.63		11.63	
J2210		Injection, methylergonovine maleate, up to 0.2 mg	9.02		9.02	
J2212		Injection, methylnaltrexone, 0.1 mg	0.63		New	
J2248		Injection, micafungin sodium, 1 mg	3.43		3.43	
J2250		Injection, midazolam HCl, per 1 mg	1.06		1.06	
J2260		Injection, milrinone lactate, 5 mg	82.35		82.35	
J2265		Injection, minocycline HCl, 1 mg	0.96		New	
J2270		Injection, morphine sulfate, up to 10 mg	6.24		6.24	
J2271		Injection, morphine sulfate, 100 mg	11.84		11.84	
J2275		Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	11.75		11.75	
J2278		Injection, ziconotide, 1 mcg	14.69		14.69	
J2280		Injection, moxifloxacin, 100 mg	16.09		16.09	
J2300		Injection, nalbuphine HCl, per 10 mg	6.60		6.60	
J2310		Injection, naloxone HCl, per 1 mg	11.52		11.52	
J2315		Injection, naltrexone, depot form, 1 mg	BR		BR	
J2320		Injection, nandrolone decanoate, up to 50 mg	7.57		7.57	
J2323		Injection, natalizumab, 1 mg	13.33		13.33	
J2325		Injection, nesiritide, 0.1 mg	58.37		58.37	
J2353		Injection, octreotide, depot form for intramuscular injection, 1 mg	285.92		285.92	
J2354		Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg	8.73		8.73	
J2355		Injection, oprelvekin, 5 mg	482.56		482.56	
J2357		Injection, omalizumab, 5 mg	31.71		31.71	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J2358		Injection, olanzapine, long-acting, 1 mg	BR		New	
J2360		Injection, orphenadrine citrate, up to 60 mg	22.66		22.66	
J2370		Injection, phenylephrine HCl, up to 1 ml	3.52		3.52	
J2400		Injection, chloroprocaine HCl, per 30 ml	10.54		10.54	
J2405		Injection, ondansetron HCl, per 1 mg	11.37		11.37	
J2410		Injection, oxymorphone HCl, up to 1 mg	4.80		4.80	
J2425		Injection, palifermin, 50 mcg	20.22		20.22	
J2426		Injection, paliperidone palmitate extended release, 1 mg	BR		New	
J2430		Injection, pamidronate disodium, per 30 mg	415.00		415.00	
J2440		Injection, papaverine HCl, up to 60 mg	5.21		5.21	
J2460		Injection, oxytetracycline HCl, up to 50 mg	BR		BR	2097.37**
J2469		Injection, palonosetron HCl, 25 mcg	59.75		59.75	
J2501		Injection, paricalcitol, 1 mcg	8.59		8.59	
J2503		Injection, pegaptanib sodium, 0.3 mg	1829.21		1829.21	
J2504		Injection, pegademase bovine, 25 IU	311.50		311.50	
J2505		Injection, pegfilgrastim, 6 mg	5232.09		5232.09	
J2507		Injection, pegloticase, 1 mg	BR		New	
J2510		Injection, penicillin G procaine, aqueous, up to 600,000 units	19.27		19.27	
J2513		Injection, pentastarch, 10% solution, 100 ml	BR		BR	
J2515		Injection, pentobarbital sodium, per 50 mg	13.41		13.41	
J2540		Injection, penicillin G potassium, up to 600,000 units	4.20		4.20	
J2543		Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	BR		BR	
J2545		Pentamidine isethionate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 300 mg	116.59		116.59	
J2550		Injection, promethazine HCl, up to 50 mg	5.64		5.64	
J2560		Injection, phenobarbital sodium, up to 120 mg	5.33		5.33	
J2562		Injection, plerixafor, 1 mg	478.75		478.75	
J2590		Injection, oxytocin, up to 10 units	6.94		6.94	
J2597		Injection, desmopressin acetate, per 1 mcg	15.18		15.18	
J2650		Injection, prednisolone acetate, up to 1 ml	BR		BR	
J2670		Injection, tolazoline HCl, up to 25 mg	BR		BR	
J2675		Injection, progesterone, per 50 mg	5.94		5.94	
J2680		Injection, fluphenazine decanoate, up to 25 mg	11.11		11.11	
J2690		Injection, procainamide HCl, up to 1 g	6.79		6.79	
J2700		Injection, oxacillin sodium, up to 250 mg	4.44		4.44	
J2710		Injection, neostigmine methylsulfate, up to 0.5 mg	0.92		0.92	
J2720		Injection, protamine sulfate, per 10 mg	2.04		2.04	
J2724		Injection, protein C concentrate, intravenous, human, 10 IU	BR		BR	
J2725		Injection, protirelin, per 250 mcg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J2730		Injection, pralidoxime chloride, up to 1 g	159.39		159.39	
J2760		Injection, phentolamine mesylate, up to 5 mg	99.27		99.27	
J2765		Injection, metoclopramide HCl, up to 10 mg	3.39		3.39	
J2770		Injection, quinupristin/dalfopristin, 500 mg (150/350)	230.27		230.27	
J2778		Injection, ranibizumab, 0.1 mg	746.85		746.85	
J2780		Injection, ranitidine HCl, 25 mg	3.06		3.06	
J2783		Injection, rasburicase, 0.5 mg	256.15		256.15	
J2785		Injection, regadenoson, 0.1 mg	BR		BR	
J2788		Injection, Rho D immune globulin, human, minidose, 50 mcg (250 i.u.)	125.35		125.35	
J2790		Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 i.u.)	205.90		205.90	
J2791		Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU	19.66		19.66	
J2792		Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU	BR		BR	
J2793		Injection, rilonacept, 1 mg	41.78		41.78	
J2794		Injection, risperidone, long acting, 0.5 mg	3.63		3.63	
J2795		Injection, ropivacaine HCl, 1 mg	0.32		0.32	
J2796		Injection, romiplostim, 10 mcg	78.13		78.13	
J2800		Injection, methocarbamol, up to 10 ml	29.23		29.23	
J2805		Injection, sincalide, 5 mcg	107.24		107.24	
J2810		Injection, theophylline, per 40 mg	BR		BR	
J2820		Injection, sargramostim (GM-CSF), 50 mcg	52.85		52.85	
J2850		Injection, secretin, synthetic, human, 1 mcg	37.35		37.35	
J2910		Injection, aurothioglucose, up to 50 mg	BR		BR	
J2916		Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	13.18		13.18	
J2920		Injection, methylprednisolone sodium succinate, up to 40 mg	5.53		5.53	
J2930		Injection, methylprednisolone sodium succinate, up to 125 mg	12.23		12.23	
J2940		Injection, somatrem, 1 mg	BR		BR	
J2941		Injection, somatropin, 1 mg	87.32		87.32	
J2950		Injection, promazine HCl, up to 25 mg	BR		BR	
J2993		Injection, reteplase, 18.1 mg	2216.10		2216.10	
J2995		Injection, streptokinase, per 250,000 IU	143.63		143.63	
J2997		Injection, alteplase recombinant, 1 mg	62.75		62.75	
J3000		Injection, streptomycin, up to 1 g	13.94		13.94	
J3010		Injection, fentanyl citrate, 0.1 mg	0.25		0.25	
J3030		Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	104.25		104.25	
J3070		Injection, pentazocine, 30 mg	53.48		53.48	
J3095		Injection, telavancin, 10 mg	BR		New	
J3101		Injection, tenecteplase, 1 mg	89.39		89.39	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J3105		Injection, terbutaline sulfate, up to 1 mg	45.24		45.24	
J3110		Injection, teriparatide, 10 mcg	15.47		15.47	
J3120		Injection, testosterone enanthate, up to 100 mg	17.40		17.40	
J3130		Injection, testosterone enanthate, up to 200 mg	34.79		34.79	
J3140		Injection, testosterone suspension, up to 50 mg	BR		BR	
J3150		Injection, testosterone propionate, up to 100 mg	1.29		1.29	
J3230		Injection, chlorpromazine HCl, up to 50 mg	4.95		4.95	
J3240		Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial	1332.84		1332.84	
J3243		Injection, tigecycline, 1 mg	1.85		1.85	
J3246		Injection, tirofiban HCl, 0.25 mg	16.27		16.27	
J3250		Injection, trimethobenzamide HCl, up to 200 mg	9.77		9.77	
J3260		Injection, tobramycin sulfate, up to 80 mg	6.13		6.13	
J3262		Injection, tocilizumab, 1 mg	1.00		New	
J3265		Injection, torsemide, 10 mg/ml	BR		BR	
J3280		Injection, thiethylperazine maleate, up to 10 mg	9.12		9.12	
J3285		Injection, treprostinil, 1 mg	103.03		103.03	
J3300		Injection, triamcinolone acetonide, preservative free, 1 mg	BR		BR	
J3301		Injection, triamcinolone acetonide, not otherwise specified, 10 mg	3.45		3.45	
J3302		Injection, triamcinolone diacetate, per 5 mg	0.43		0.43	
J3303		Injection, triamcinolone hexacetonide, per 5 mg	4.35		4.35	
J3305		Injection, trimetrexate glucuronate, per 25 mg	BR		BR	
J3310		Injection, perphenazine, up to 5 mg	BR		BR	
J3315		Injection, triptorelin pamoate, 3.75 mg	891.62		891.62	
J3320		Injection, spectinomycin dihydrochloride, up to 2 g	BR		BR	
J3350		Injection, urea, up to 40 g	BR		BR	
J3355		Injection, urofollitropin, 75 IU	119.50		119.50	
J3357		Injection, ustekinumab, 1 mg	BR		New	
J3360		Injection, diazepam, up to 5 mg	2.14		2.14	
J3364		Injection, urokinase, 5,000 IU vial	BR		BR	
J3365		Injection, IV, urokinase, 250,000 IU vial	BR		BR	
J3370		Injection, vancomycin HCl, 500 mg	10.16		10.16	
J3385		Injection, velaglucerase alfa, 100 units	BR		New	
J3396		Injection, verteporfin, 0.1 mg	16.88		16.88	
J3400		Injection, triflupromazine HCl, up to 20 mg	BR		BR	
J3410		Injection, hydroxyzine HCl, up to 25 mg	1.36		1.36	
J3411		Injection, thiamine HCl, 100 mg	2.34		2.34	
J3415		Injection, pyridoxine HCl, 100 mg	4.67		4.67	
J3420		Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg	0.12		0.12	
J3430		Injection, phytonadione (vitamin K), per 1 mg	8.15		8.15	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J3465		Injection, voriconazole, 10 mg	9.31		9.31	
J3470		Injection, hyaluronidase, up to 150 units	45.96		45.96	
J3471		Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)	0.26		0.26	
J3472		Injection, hyaluronidase, ovine, preservative free, per 1,000 USP units	214.48		214.48	
J3473		Injection, hyaluronidase, recombinant, 1 USP unit	0.70		0.70	
J3475		Injection, magnesium sulfate, per 500 mg	1.33		1.33	
J3480		Injection, potassium chloride, per 2 mEq	0.77		0.77	
J3485		Injection, zidovudine, 10 mg	2.19		2.19	
J3486		Injection, ziprasidone mesylate, 10 mg	9.01		9.01	
J3487		Injection, zoledronic acid (Zometa), 1 mg	376.90		376.90	
J3488		Injection, zoledronic acid (Reclast), 1 mg	376.87		376.87	
J3490		Unclassified drugs	BR		BR	
J3520		Edetate disodium, per 150 mg	0.77		0.77	2097.37**
J3530		Nasal vaccine inhalation	BR		BR	
J3535		Drug administered through a metered dose inhaler	BR		BR	2097.37**
J3570		Laetrile, amygdalin, vitamin B-17	BR		BR	2097.37**
J3590		Unclassified biologics	BR		BR	
J7030		Infusion, normal saline solution, 1,000 cc	18.71		18.71	
J7040		Infusion, normal saline solution, sterile (500 ml=1 unit)	9.77		9.77	
J7042		5% dextrose/normal saline (500 ml = 1 unit)	7.58		7.58	
J7050		Infusion, normal saline solution, 250 cc	8.46		8.46	
J7060		5% dextrose/water (500 ml = 1 unit)	10.42		10.42	
J7070		Infusion, D-5-W, 1,000 cc	14.69		14.69	
J7100		Infusion, dextran 40, 500 ml	152.33		152.33	
J7110		Infusion, dextran 75, 500 ml	BR		BR	
J7120		Ringers lactate infusion, up to 1,000 cc	BR		BR	
J7131		Hypertonic saline solution, 1 ml	BR		New	
J7178		Injection, human fibrinogen concentrate, 1 mg	0.56		New	
J7180		Injection, factor XIII (antihemophilic factor, human), 1 IU	3.96		New	
J7183		Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCo	0.54		New	
J7185		Injection, factor VIII (antihemophilic factor, recombinant) (XYNTHA), per IU	2.54		2.54	
J7186		Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u.	2.18		2.18	
J7187		Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCO	BR		BR	
J7189		Factor VIIa (antihemophilic factor, recombinant), per 1 mcg	BR		BR	
J7190		Factor VIII (antihemophilic factor, human) per IU	1.53		1.53	
J7191		Factor VIII (antihemophilic factor (porcine)), per IU	BR		BR	
J7192		Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	2.31		2.31	
J7193		Factor IX (antihemophilic factor, purified, nonrecombinant) per IU	1.81		1.81	
J7194		Factor IX complex, per IU	1.39		1.39	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J7195		Factor IX (antihemophilic factor, recombinant) per IU	1.23		1.23	
J7196		Injection, antithrombin recombinant, 50 IU	BR		New	
J7197		Antithrombin III (human), per IU	3.48		3.48	
J7198		Antiinhibitor, per IU	2.53		2.53	
J7199		Hemophilia clotting factor, not otherwise classified	BR		BR	
J7300		Intrauterine copper contraceptive	727.70		727.70	2097.37**
J7302		Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	757.85		757.85	2097.37**
J7303		Contraceptive supply, hormone containing vaginal ring, each	70.58		70.58	2097.37**
J7304		Contraceptive supply, hormone containing patch, each	BR		BR	2097.37**
J7306		Levonorgestrel (contraceptive) implant system, including implants and supplies	757.85		757.85	2097.37**
J7307		Etonogestrel (contraceptive) implant system, including implant and supplies	BR		BR	2097.37**
J7308		Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)	262.97		262.97	
J7309		Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g	BR		New	
J7310		Ganciclovir, 4.5 mg, long-acting implant	8272.80		8272.80	
J7311		Fluocinolone acetonide, intravitreal implant	BR		BR	
J7312		Injection, dexamethasone, intravitreal implant, 0.1 mg	BR		New	
J7315		Mitomycin, opthalmic, 0.2 mg	BR		New	
J7321		Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose	223.67		223.67	
J7323		Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	222.14		222.14	
J7324		Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	BR		BR	
J7325		Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	545.85		545.85	
J7326		Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	1489.97		New	
J7330		Autologous cultured chondrocytes, implant	BR		BR	
J7335		Capsaicin 8% patch, per 10 sq cm	BR		New	
J7500		Azathioprine, oral, 50 mg	2.37		2.37	
J7501		Azathioprine, parenteral, 100 mg	125.01		125.01	
J7502		Cyclosporine, oral, 100 mg	9.50		9.50	
J7504		Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg	617.46		617.46	
J7505		Muromonab-CD3, parenteral, 5 mg	1750.49		1750.49	
J7506		Prednisone, oral, per 5 mg	0.37		0.37	
J7507		Tacrolimus, oral, per 1 mg	6.68		6.68	
J7509		Methylprednisolone, oral, per 4 mg	1.13		1.13	
J7510		Prednisolone, oral, per 5 mg	0.23		0.23	
J7511		Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg	716.98		716.98	
J7513		Daclizumab, parenteral, 25 mg	755.80		755.80	
J7515		Cyclosporine, oral, 25 mg	2.30		2.30	
J7516		Cyclosporine, parenteral, 250 mg	23.79		23.79	
J7517		Mycophenolate mofetil, oral, 250 mg	4.99		4.99	
J7518		Mycophenolic acid, oral, 180 mg	4.14		4.14	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J7520		Sirolimus, oral, 1 mg	13.41		13.41	
J7525		Tacrolimus, parenteral, 5 mg	251.16		251.16	
J7527		Everolimus, oral, 0.25 mg	5.46		New	
J7599		Immunosuppressive drug, not otherwise classified	BR		BR	
J7604		Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per g	BR		BR	
J7605		Arformoterol, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, 15 mcg	BR		BR	
J7606		Formoterol fumarate, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, 20 mcg	8.55		8.55	
J7607		Levalbuterol, inhalation solution, compounded product, administered through DME, concentrated form, 0.5 mg	BR		BR	
J7608		Acetylcysteine, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per g	BR		BR	
J7609		Albuterol, inhalation solution, compounded product, administered through DME, unit dose, 1 mg	BR		BR	
J7610		Albuterol, inhalation solution, compounded product, administered through DME, concentrated form, 1 mg	BR		BR	
J7611		Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg	BR		BR	
J7612		Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5 mg	3.80		3.80	
J7613		Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg	0.77		0.77	
J7614		Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg	3.80		3.80	
J7615		Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg	3.80		3.80	
J7620		Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, noncompounded, administered through DME	BR		BR	
J7622		Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7624		Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7626		Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 0.5 mg	9.25		9.25	
J7627		Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg	9.25		9.25	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J7628		Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7629		Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7631		Cromolyn sodium, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 10 mg	0.63		0.63	
J7632		Cromolyn sodium, inhalation solution, compounded product, administered through DME, unit dose form, per 10 mg	0.60		0.60	
J7633		Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 0.25 mg	BR		BR	
J7634		Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 mg	BR		BR	
J7635		Atropine, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7636		Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7637		Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7638		Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7639		Dornase alfa, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg	38.61		38.61	
J7640		Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 mcg	BR		BR	2097.37**
J7641		Flunisolide, inhalation solution, compounded product, administered through DME, unit dose, per mg	20.44		20.44	
J7642		Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7643		Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7644		Ipratropium bromide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg	BR		BR	
J7645		Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7647		Isoetharine HCl, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7648		Isoetharine HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per mg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J7649		Isoetharine HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg	BR		BR	
J7650		Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7657		Isoproterenol HCl, inhalation solution, compounded product, administered through DME, concentrated form, per mg	BR		BR	
J7658		Isoproterenol HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per mg	BR		BR	
J7659		Isoproterenol HCl, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg	BR		BR	
J7660		Isoproterenol HCl, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7665		Mannitol, administered through an inhaler, 5 mg	BR		New	
J7667		Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 mg	BR		BR	
J7668		Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 10 mg	BR		BR	
J7669		Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 10 mg	BR		BR	
J7670		Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 mg	BR		BR	
J7674		Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg	0.67		0.67	
J7676		Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg	BR		BR	
J7680		Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per mg	25.11		25.11	
J7681		Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per mg	25.11		25.11	
J7682		Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg	119.99		119.99	
J7683		Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per mg	9.01		9.01	
J7684		Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per mg	BR		BR	
J7685		Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg	116.43		116.43	
J7686		Treprostinil, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, 1.74 mg	BR		New	
J7699		NOC drugs, inhalation solution administered through DME	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J7799		NOC drugs, other than inhalation drugs, administered through DME	BR		BR	
J8498		Antiemetic drug, rectal/suppository, not otherwise specified	BR		BR	
J8499		Prescription drug, oral, nonchemotherapeutic, NOS	BR		BR	2097.37**
J8501		Aprepitant, oral, 5 mg	9.96		9.96	
J8510		Busulfan; oral, 2 mg	4.35		4.35	
J8515		Cabergoline, oral, 0.25 mg	27.65		27.65	2097.37**
J8520		Capecitabine, oral, 150 mg	8.87		8.87	
J8521		Capecitabine, oral, 500 mg	25.81		25.81	
J8530		Cyclophosphamide; oral, 25 mg	5.16		5.16	
J8540		Dexamethasone, oral, 0.25 mg	BR		BR	
J8560		Etoposide; oral, 50 mg	84.72		84.72	
J8562		Fludarabine phosphate, oral, 10 mg	BR		New	
J8565		Gefitinib, oral, 250 mg	104.30		104.30	2097.37**
J8597		Antiemetic drug, oral, not otherwise specified	BR		BR	
J8600		Melphalan; oral, 2 mg	9.02		9.02	
J8610		Methotrexate; oral, 2.5 mg	4.93		4.93	
J8650		Nabilone, oral, 1 mg	30.64		30.64	
J8700		Temozolomide, oral, 5 mg	14.45		14.45	
J8705		Topotecan, oral, 0.25 mg	BR		BR	
J8999		Prescription drug, oral, chemotherapeutic, NOS	BR		BR	
J9000		Injection, doxorubicin HCl, 10 mg	25.66		25.66	
J9001		Injection, doxorubicin HCl, all lipid formulations, 10 mg	781.14		781.14	
J9002		Injection, doxorubicin hydrochloride, liposomal, Doxil, 10 mg	396.22		New	
J9010		Injection, alemtuzumab, 10 mg	983.96		983.96	
J9015		Injection, aldesleukin, per single use vial	1450.21		1450.21	
J9017		Injection, arsenic trioxide, 1 mg	61.82		61.82	
J9019		Injection, asparaginase (Erwinaze), 1,000 IU	248.98		New	
J9020		Injection, asparaginase, not otherwise specified, 10,000 units	102.75		102.75	
J9025		Injection, azacitidine, 1 mg	7.91		7.91	
J9027		Injection, clofarabine, 1 mg	206.82		206.82	
J9031		BCG (intravesical) per instillation	274.58		274.58	
J9033		Injection, bendamustine HCl, 1 mg	BR		BR	
J9035		Injection, bevacizumab, 10 mg	105.33		105.33	
J9040		Injection, bleomycin sulfate, 15 units	96.27		96.27	
J9041		Injection, bortezomib, 0.1 mg	44.03		44.03	
J9042		Injection, brentuximab vedotin, 1 mg	71.05		New	
J9043		Injection, cabazitaxel, 1 mg	BR		New	
J9045		Injection, carboplatin, 50 mg	39.95		39.95	
J9050		Injection, carmustine, 100 mg	294.51		294.51	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J9055		Injection, cetuximab, 10 mg	88.24		88.24	
J9060		Injection, cisplatin, powder or solution, 10 mg	6.74		6.74	
J9065		Injection, cladribine, per 1 mg	101.71		101.71	
J9070		Cyclophosphamide, 100 mg	13.96		13.96	
J9098		Injection, cytarabine liposome, 10 mg	824.22		824.22	
J9100		Injection, cytarabine, 100 mg	20.45		20.45	
J9120		Injection, dactinomycin, 0.5 mg	873.24		873.24	
J9130		Dacarbazine, 100 mg	31.18		31.18	
J9150		Injection, daunorubicin, 10 mg	98.77		98.77	
J9151		Injection, daunorubicin citrate, liposomal formulation, 10 mg	104.18		104.18	
J9155		Injection, degarelix, 1 mg	BR		BR	
J9160		Injection, denileukin diftitox, 300 mcg	2536.99		2536.99	
J9165		Injection, diethylstilbestrol diphosphate, 250 mg	BR		BR	
J9171		Injection, docetaxel, 1 mg	67.56		67.56	
J9175		Injection, Elliotts' B solution, 1 ml	7.22		7.22	
J9178		Injection, epirubicin HCl, 2 mg	44.08		44.08	
J9179		Injection, eribulin mesylate, 0.1 mg	BR		New	
J9181		Injection, etoposide, 10 mg	8.87		8.87	
J9185		Injection, fludarabine phosphate, 50 mg	532.91		532.91	
J9190		Injection, fluorouracil, 500 mg	5.39		5.39	
J9200		Injection, floxuridine, 500 mg	209.70		209.70	
J9201		Injection, gemcitabine HCl, 200 mg	241.38		241.38	
J9202		Goserelin acetate implant, per 3.6 mg	720.02		720.02	
J9206		Injection, irinotecan, 20 mg	230.34		230.34	
J9207		Injection, ixabepilone, 1 mg	112.99		112.99	
J9208		Injection, ifosfamide, 1 g	142.71		142.71	
J9209		Injection, mesna, 200 mg	99.83		99.83	
J9211		Injection, idarubicin HCl, 5 mg	659.33		659.33	
J9212		Injection, interferon alfacon-1, recombinant, 1 mcg	12.53		12.53	
J9213		Injection, interferon, alfa-2a, recombinant, 3 million units	68.16		68.16	
J9214		Injection, interferon, alfa-2b, recombinant, 1 million units	25.69		25.69	
J9215		Injection, interferon, alfa-N3, (human leukocyte derived), 250,000 IU	32.94		32.94	
J9216		Injection, interferon, gamma 1-b, 3 million units	583.74		583.74	
J9217		Leuprolide acetate (for depot suspension), 7.5 mg	907.82		907.82	
J9218		Leuprolide acetate, per 1 mg	BR		BR	
J9219		Leuprolide acetate implant, 65 mg	BR		BR	
J9225		Histrelin implant (Vantas), 50 mg	9192.00		9192.00	
J9226		Histrelin implant (Supprelin LA), 50 mg	BR		BR	
J9228		Injection, ipilimumab, 1 mg	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
J9230		Injection, mechlorethamine HCl, (nitrogen mustard), 10 mg	255.63		255.63	
J9245		Injection, melphalan HCl, 50 mg	2767.19		2767.19	
J9250		Methotrexate sodium, 5 mg	1.59		1.59	
J9260		Methotrexate sodium, 50 mg	15.90		15.90	
J9261		Injection, nelarabine, 50 mg	151.48		151.48	
J9263		Injection, oxaliplatin, 0.5 mg	16.45		16.45	
J9264		Injection, paclitaxel protein-bound particles, 1 mg	15.81		15.81	
J9265		Injection, paclitaxel, 30 mg	142.22		142.22	
J9266		Injection, pegaspargase, per single dose vial	5024.96		5024.96	
J9268		Injection, pentostatin, 10 mg	3492.96		3492.96	
J9270		Injection, plicamycin, 2.5 mg	BR		BR	
J9280		Injection, mitomycin, 5 mg	144.80		144.80	
J9293		Injection, mitoxantrone HCl, per 5 mg	502.17		502.17	
J9300		Injection, gemtuzumab ozogamicin, 5 mg	4527.37		4527.37	
J9302		Injection, ofatumumab, 10 mg	441.67		New	
J9303		Injection, panitumumab, 10 mg	147.07		147.07	
J9305		Injection, pemetrexed, 10 mg	83.39		83.39	
J9307		Injection, pralatrexate, 1 mg	313.69		New	
J9310		Injection, rituximab, 100 mg	955.81		955.81	
J9315		Injection, romidepsin, 1 mg	BR		New	
J9320		Injection, streptozocin, 1 g	342.40		342.40	
J9328		Injection, temozolomide, 1 mg	BR		BR	
J9330		Injection, temsirolimus, 1 mg	84.77		84.77	
J9340		Injection, thiotepa, 15 mg	181.08		181.08	
J9351		Injection, topotecan, 0.1 mg	BR		New	
J9355		Injection, trastuzumab, 10 mg	110.38		110.38	
J9357		Injection, valrubicin, intravesical, 200 mg	1139.53		1139.53	
J9360		Injection, vinblastine sulfate, 1 mg	4.20		4.20	
J9370		Vincristine sulfate, 1 mg	21.19		21.19	
J9390		Injection, vinorelbine tartrate, 10 mg	105.65		105.65	
J9395		Injection, fulvestrant, 25 mg	146.12		146.12	
J9600		Injection, porfimer sodium, 75 mg	4433.88		4433.88	
J9999		Not otherwise classified, antineoplastic drugs	BR		BR	
K0001	NU	Standard wheelchair	502.70		0.00	
K0001	RR	Standard wheelchair	50.27		0.00	
K0001	UE	Standard wheelchair	37.70		0.00	
K0002	NU	Standard hemi (low seat) wheelchair	753.00		972.03	
K0002	RR	Standard hemi (low seat) wheelchair	75.30		97.20	
K0002	UE	Standard hemi (low seat) wheelchair	488.35		729.03	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0003	NU	Lightweight wheelchair	824.60		1064.27	
K0003	RR	Lightweight wheelchair	82.46		106.43	
K0003	UE	Lightweight wheelchair	618.45		798.20	
K0004	NU	High strength, lightweight wheelchair	1229.90		1587.48	
K0004	RR	High strength, lightweight wheelchair	122.99		158.75	
K0004	UE	High strength, lightweight wheelchair	922.43		1190.62	
K0005	NU	Ultralightweight wheelchair	2001.69		2196.18	
K0005	RR	Ultralightweight wheelchair	200.15		219.60	
K0005	UE	Ultralightweight wheelchair	1501.24		1647.11	
K0006	NU	Heavy-duty wheelchair	1154.20		1489.79	
K0006	RR	Heavy-duty wheelchair	115.42		148.98	
K0006	UE	Heavy-duty wheelchair	863.40		1117.35	
K0007	NU	Extra heavy-duty wheelchair	1755.50		2120.55	
K0007	RR	Extra heavy-duty wheelchair	175.55		212.05	
K0007	UE	Extra heavy-duty wheelchair	1316.63		1590.41	
K0009		Other manual wheelchair/base	BR		BR	
K0010	NU	Standard-weight frame motorized/power wheelchair	3920.40		5060.46	
K0010	RR	Standard-weight frame motorized/power wheelchair	392.04		506.05	
K0010	UE	Standard-weight frame motorized/power wheelchair	2940.30		3795.35	
K0011	NU	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	5138.80		0.00	
K0011	RR	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	513.88		0.00	
K0011	UE	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	5854.10		0.00	
K0012	NU	Lightweight portable motorized/power wheelchair	3152.40		3859.77	
K0012	RR	Lightweight portable motorized/power wheelchair	315.24		385.98	
K0012	UE	Lightweight portable motorized/power wheelchair	2364.30		2894.83	
K0014		Other motorized/power wheelchair base	BR		BR	
K0015	NU	Detachable, nonadjustable height armrest, each	196.73		186.03	
K0015	RR	Detachable, nonadjustable height armrest, each	19.69		18.61	
K0015	UE	Detachable, nonadjustable height armrest, each	147.54		139.52	
K0017	NU	Detachable, adjustable height armrest, base, each	55.35		52.32	
K0017	RR	Detachable, adjustable height armrest, base, each	5.53		5.23	
K0017	UE	Detachable, adjustable height armrest, base, each	41.51		39.25	
K0018	NU	Detachable, adjustable height armrest, upper portion, each	30.92		29.23	
K0018	RR	Detachable, adjustable height armrest, upper portion, each	3.07		2.90	
K0018	UE	Detachable, adjustable height armrest, upper portion, each	23.20		21.93	
K0019	NU	Arm pad, each	18.66		17.65	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0019	RR	Arm pad, each	1.86		1.77	
K0019	UE	Arm pad, each	14.01		13.24	
K0020	NU	Fixed, adjustable height armrest, pair	50.30		47.57	
K0020	RR	Fixed, adjustable height armrest, pair	5.04		4.76	
K0020	UE	Fixed, adjustable height armrest, pair	37.71		35.66	
K0037	NU	High mount flip-up footrest, each	44.32		49.30	
K0037	RR	High mount flip-up footrest, each	3.97		4.41	
K0037	UE	High mount flip-up footrest, each	33.25		37.00	
K0038	NU	Leg strap, each	26.26		24.85	
K0038	RR	Leg strap, each	2.63		2.49	
K0038	UE	Leg strap, each	19.71		18.63	
K0039	NU	Leg strap, H style, each	58.33		55.17	
K0039	RR	Leg strap, H style, each	5.85		5.54	
K0039	UE	Leg strap, H style, each	43.76		41.37	
K0040	NU	Adjustable angle footplate, each	80.84		76.45	
K0040	RR	Adjustable angle footplate, each	8.06		7.63	
K0040	UE	Adjustable angle footplate, each	60.62		57.33	
K0041	NU	Large size footplate, each	57.29		54.19	
K0041	RR	Large size footplate, each	5.75		5.44	
K0041	UE	Large size footplate, each	42.97		40.64	
K0042	NU	Standard size footplate, each	33.52		37.29	
K0042	RR	Standard size footplate, each	3.34		3.73	
K0042	UE	Standard size footplate, each	25.14		27.96	
K0043	NU	Footrest, lower extension tube, each	21.15		19.99	
K0043	RR	Footrest, lower extension tube, each	2.12		2.00	
K0043	UE	Footrest, lower extension tube, each	15.87		15.01	
K0044	NU	Footrest, upper hanger bracket, each	18.01		17.04	
K0044	RR	Footrest, upper hanger bracket, each	1.80		1.70	
K0044	UE	Footrest, upper hanger bracket, each	13.51		12.78	
K0045	NU	Footrest, complete assembly	61.31		57.97	
K0045	RR	Footrest, complete assembly	6.32		5.99	
K0045	UE	Footrest, complete assembly	45.98		43.48	
K0046	NU	Elevating legrest, lower extension tube, each	21.15		19.99	
K0046	RR	Elevating legrest, lower extension tube, each	2.12		2.00	
K0046	UE	Elevating legrest, lower extension tube, each	15.87		15.01	
K0047	NU	Elevating legrest, upper hanger bracket, each	82.81		78.30	
K0047	RR	Elevating legrest, upper hanger bracket, each	8.30		7.85	
K0047	UE	Elevating legrest, upper hanger bracket, each	62.08		58.71	
K0050	NU	Ratchet assembly	35.20		33.28	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0050	RR	Ratchet assembly	3.51		3.31	
K0050	UE	Ratchet assembly	26.40		24.97	
K0051	NU	Cam release assembly, footrest or legrest, each	56.95		53.87	
K0051	RR	Cam release assembly, footrest or legrest, each	5.72		5.42	
K0051	UE	Cam release assembly, footrest or legrest, each	42.70		40.38	
K0052	NU	Swingaway, detachable footrests, each	100.08		94.65	
K0052	RR	Swingaway, detachable footrests, each	10.00		9.46	
K0052	UE	Swingaway, detachable footrests, each	75.07		70.97	
K0053	NU	Elevating footrests, articulating (telescoping), each	110.45		104.44	
K0053	RR	Elevating footrests, articulating (telescoping), each	11.04		10.44	
K0053	UE	Elevating footrests, articulating (telescoping), each	82.85		78.33	
K0056	NU	Seat height less than 17 in or equal to or greater than 21 in for a high-strength, lightweight, or ultralightweight wheelchair	102.97		112.98	
K0056	RR	Seat height less than 17 in or equal to or greater than 21 in for a high-strength, lightweight, or ultralightweight wheelchair	10.30		11.30	
K0056	UE	Seat height less than 17 in or equal to or greater than 21 in for a high-strength, lightweight, or ultralightweight wheelchair	77.25		84.74	
K0065	NU	Spoke protectors, each	48.13		52.81	
K0065	RR	Spoke protectors, each	4.82		5.28	
K0065	UE	Spoke protectors, each	36.10		39.61	
K0069	NU	Rear wheel assembly, complete, with solid tire, spokes or molded, each	108.20		118.70	
K0069	RR	Rear wheel assembly, complete, with solid tire, spokes or molded, each	11.27		12.36	
K0069	UE	Rear wheel assembly, complete, with solid tire, spokes or molded, each	81.14		89.03	
K0070	NU	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	198.31		217.58	
K0070	RR	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	19.85		21.78	
K0070	UE	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	148.74		163.18	
K0071	NU	Front caster assembly, complete, with pneumatic tire, each	118.29		129.77	
K0071	RR	Front caster assembly, complete, with pneumatic tire, each	11.84		12.99	
K0071	UE	Front caster assembly, complete, with pneumatic tire, each	88.69		97.32	
K0072	NU	Front caster assembly, complete, with semipneumatic tire, each	71.21		78.12	
K0072	RR	Front caster assembly, complete, with semipneumatic tire, each	7.12		7.81	
K0072	UE	Front caster assembly, complete, with semipneumatic tire, each	53.40		58.59	
K0073	NU	Caster pin lock, each	37.68		41.34	
K0073	RR	Caster pin lock, each	3.77		4.13	
K0073	UE	Caster pin lock, each	28.26		31.01	
K0077	NU	Front caster assembly, complete, with solid tire, each	63.72		69.90	
K0077	RR	Front caster assembly, complete, with solid tire, each	6.36		6.97	
K0077	UE	Front caster assembly, complete, with solid tire, each	47.78		52.43	
K0098	NU	Drive belt for power wheelchair	29.45		27.87	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0098	RR	Drive belt for power wheelchair	2.95		2.78	
K0098	UE	Drive belt for power wheelchair	22.08		20.87	
K0105	NU	IV hanger, each	107.65		118.11	
K0105	RR	IV hanger, each	10.76		11.81	
K0105	UE	IV hanger, each	80.74		88.59	
K0108		Wheelchair component or accessory, not otherwise specified	BR		BR	
K0195	RR	Elevating legrests, pair (for use with capped rental wheelchair base)	20.92		21.58	
K0455	RR	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)	258.63		314.64	
K0462		Temporary replacement for patient-owned equipment being repaired, any type	BR		BR	
K0552		Supplies for external drug infusion pump, syringe type cartridge, sterile, each	2.87		3.14	
K0601	NU	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	1.20	Modifier Change		
K0602	NU	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	6.88	Modifier Change		
K0603	NU	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	0.61	Modifier Change		
K0604	NU	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	6.58	Modifier Change		
K0605	NU	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	15.81	Modifier Change		
K0606	RR	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	2726.58		2694.44	
K0607	NU	Replacement battery for automated external defibrillator, garment type only, each	233.47		230.73	
K0607	RR	Replacement battery for automated external defibrillator, garment type only, each	23.36		23.08	
K0607	UE	Replacement battery for automated external defibrillator, garment type only, each	175.11		173.04	
K0608	NU	Replacement garment for use with automated external defibrillator, each	145.72		143.99	
K0608	RR	Replacement garment for use with automated external defibrillator, each	14.59		14.43	
K0608	UE	Replacement garment for use with automated external defibrillator, each	109.28		108.00	
K0609		Replacement electrodes for use with automated external defibrillator, garment type only, each	872.76		957.56	
K0669		Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC	BR		BR	
K0672		Addition to lower extremity orthotic, removable soft interface, all components, replacement only, each	79.60		91.51	
K0730	NU	Controlled dose inhalation drug delivery system	1866.62		2048.00	
K0730	RR	Controlled dose inhalation drug delivery system	186.66		204.80	
K0730	UE	Controlled dose inhalation drug delivery system	1399.96		1535.99	
K0733	NU	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	32.71		30.93	
K0733	RR	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	3.30		3.11	
K0733	UE	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	24.54		23.21	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0738	NU	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	516.30		Modifier Change	
K0738	RR	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	51.63		Modifier Change	
K0738	UE	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	687.23		Modifier Change	
K0739		Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	BR		BR	
K0740		Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	BR		BR	2097.37**
K0743		Suction pump, home model, portable, for use on wounds	BR		New	
K0744		Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 sq in or less	BR		New	
K0745		Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 sq in but less than or equal to 48 sq in	BR		New	
K0746		Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 sq in	BR		New	
K0800	NU	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	1206.41		1323.64	
K0800	RR	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	120.65		132.37	
K0800	UE	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	904.81		992.73	
K0801	NU	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds	1944.99		2133.98	
K0801	RR	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds	194.47		213.37	
K0801	UE	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds	1458.74		1600.46	
K0802	NU	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds	2201.11		2414.97	
K0802	RR	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds	220.11		241.48	
K0802	UE	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds	1650.83		1811.24	
K0806	NU	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	1459.43		1601.25	
K0806	RR	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	145.94		160.12	
K0806	UE	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	1094.58		1200.93	
K0807	NU	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds	2214.53		2429.70	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0807	RR	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds	221.46		242.97	
K0807	UE	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds	1660.91		1822.29	
K0808	NU	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds	3426.34		3759.25	
K0808	RR	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds	342.63		375.91	
K0808	UE	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds	2569.74		2819.43	
K0812		Power operated vehicle, not otherwise classified	BR		BR	
K0813	RR	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	337.68		246.99	
K0814	RR	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	432.27		316.15	
K0815	RR	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	492.19		360.04	
K0816	RR	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds	471.38		344.78	
K0820	RR	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	360.69		263.80	
K0821	RR	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	463.01		338.67	
K0822	RR	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	559.57		409.28	
K0823	RR	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	563.26		411.97	
K0824	RR	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	677.87		495.82	
K0825	RR	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds	620.59		453.90	
K0826	RR	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	877.60		641.89	
K0827	RR	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	746.21		545.82	
K0828	RR	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	967.01		707.31	
K0829	RR	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more	888.01		649.51	
K0830		Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	BR		BR	
K0831		Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0835	RR	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	567.96		415.42	
K0836	RR	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	589.00		430.79	
K0837	RR	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	677.87		495.82	
K0838	RR	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	606.42		443.57	
K0839	RR	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds	877.60		641.89	
K0840	RR	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	1329.54		972.51	
K0841	RR	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	604.53		442.17	
K0842	RR	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	604.53		442.17	
K0843	RR	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	727.84		532.37	
K0848	RR	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	739.70		541.05	
K0849	RR	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	711.20		520.19	
K0850	RR	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	858.04		627.62	
K0851	RR	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds	825.00		603.44	
K0852	RR	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	991.41		725.17	
K0853	RR	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	1018.43		744.92	
K0854	RR	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	1349.19		986.87	
K0855	RR	Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more	1274.51		932.25	
K0856	RR	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	794.00		580.77	
K0857	RR	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	809.91		592.41	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0858	RR	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	985.13		720.56	
K0859	RR	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	939.50		687.20	
K0860	RR	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	1407.37		1029.42	
K0861	RR	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	795.27		581.70	
K0862	RR	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	985.13		720.56	
K0863	RR	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	1407.37		1029.42	
K0864	RR	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	1674.78		1225.01	
K0868		Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	BR		BR	
K0869		Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds	BR		BR	
K0870		Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	BR		BR	
K0871		Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	BR		BR	
K0877		Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	BR		BR	
K0878		Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	BR		BR	
K0879		Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	BR		BR	
K0880		Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	BR		BR	
K0884		Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	BR		BR	
K0885		Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	BR		BR	
K0886		Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	BR		BR	
K0890		Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
K0891		Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	BR		BR	
K0898		Power wheelchair, not otherwise classified	BR		BR	
K0899		Power mobility device, not coded by DME PDAC or does not meet criteria	BR		BR	
K0900		Customized durable medical equipment, other than wheelchair	BR		New	
L0112		Cranial cervical orthotic, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated	1506.84		1506.84	
L0113		Cranial cervical orthotic, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment	723.22		0.00	
L0120		Cervical, flexible, nonadjustable (foam collar)	29.89		29.89	
L0130		Cervical, flexible, thermoplastic collar, molded to patient	183.85		183.85	
L0140		Cervical, semi-rigid, adjustable (plastic collar)	72.14		72.14	
L0150		Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)	121.77		121.77	
L0160		Cervical, semi-rigid, wire frame occipital/mandibular support	176.49		176.49	
L0170		Cervical, collar, molded to patient model	726.74		726.74	
L0172		Cervical, collar, semi-rigid thermoplastic foam, 2 piece	143.07		143.07	
L0174		Cervical, collar, semi-rigid, thermoplastic foam, 2 piece with thoracic extension	309.56		309.56	
L0180		Cervical, multiple post collar, occipital/mandibular supports, adjustable	417.53		417.53	
L0190		Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types)	441.88		558.21	
L0200		Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension	405.75		581.93	
L0220		Thoracic, rib belt, custom fabricated	96.23		138.01	
L0430		Spinal orthotic, anterior-posterior-lateral control, with interface material, custom fitted (DeWall Posture Protector only)	1175.18		1509.94	
L0450		Thoracic-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated,	158.86		195.84	
L0452		Thoracic-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabrica	BR		BR	
L0454		Thoracic-lumbar-sacral orthotic (TLSO) flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral d	293.01		373.40	
L0456		Thoracic-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk mo	840.29		1070.78	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L0458		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis	753.48		960.16	
L0460		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis	848.11		1080.73	
L0462		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 3 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis	1054.89		1344.24	
L0464		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 4 rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the	1255.83		1600.30	
L0466		Thoracic-lumbar-sacral orthotic (TLSO), sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervert	322.92		421.01	
L0468		Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic,	404.86		516.53	
L0470		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral	576.42		718.45	
L0472		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with 2 anterior components (one pubic and one sternal), posterior and lateral pads with straps and cl	361.82		455.64	
L0480		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 1 piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior exte	1118.82		1604.60	
L0482		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 1 piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from	1282.57		1747.47	
L0484		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 2 piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior exte	1495.45		2002.61	
L0486		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 2 piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from	1481.43		2124.66	
L0488		Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 1 piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from	848.11		1080.73	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L0490		Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, 1 piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vert	238.99		304.55	
L0491		Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the sym	648.84		826.84	
L0492		Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, modular segmented spinal system, 3 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the sym	420.52		536.89	
L0621		Sacroiliac orthotic, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment	75.33		103.91	
L0622		Sacroiliac orthotic, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated	204.27		291.12	
L0623		Sacroiliac orthotic, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting a	BR		BR	
L0624		Sacroiliac orthotic, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated	BR		BR	
L0625		Lumbar orthotic, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder str	46.56		59.32	
L0626		Lumbar orthotic, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder	65.86		83.93	
L0627		Lumbar orthotic, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shou	347.29		442.65	
L0628		Lumbar-sacral orthotic, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shou	70.86		90.33	
L0629		Lumbar-sacral orthotic, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shou	BR		BR	
L0630		Lumbar-sacral orthotic, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pad	136.81		174.40	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L0631		Lumbar-sacral orthotic (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures	867.31		1105.50	
L0632		Lumbar-sacral orthotic (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures	BR		BR	
L0633		Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce	242.27		308.81	
L0634		Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to redu	BR		BR	
L0635		Lumbar-sacral orthotic (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigi	898.40		1078.64	
L0636		Lumbar-sacral orthotic (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid	1325.64		1596.79	
L0637		Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressur	1150.16		1263.65	
L0638		Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressur	1114.30		1419.95	
L0639		Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the interv	1150.16		1263.65	
L0640		Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the interv	884.07		1126.56	
L0700		Cervical-thoracic-lumbar-sacral orthotic (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type)	1819.01		2278.21	
L0710		Cervical-thoracic-lumbar-sacral orthotic (CTLSO), anterior-posterior-lateral-control, molded to patient model, with interface material, (Minerva type)	1985.57		2353.49	
L0810		Halo procedure, cervical halo incorporated into jacket vest	2109.37		2906.68	
L0820		Halo procedure, cervical halo incorporated into plaster body jacket	1706.39		2434.15	
L0830		Halo procedure, cervical halo incorporated into Milwaukee type orthotic	2463.84		3533.65	
L0859		Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material	957.19		1372.79	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L0861		Addition to halo procedure, replacement liner/interface material	182.10		232.05	
L0970		Thoracic-lumbar-sacral orthotic (TLSO), corset front	89.80		128.79	
L0972		Lumbar-sacral orthotic (LSO), corset front	91.79		115.97	
L0974		Thoracic-lumbar-sacral orthotic (TLSO), full corset	187.56		201.75	
L0976		Lumbar-sacral orthotic (LSO), full corset	167.52		180.19	
L0978		Axillary crutch extension	151.25		216.91	
L0980		Peroneal straps, pair	13.73		19.67	
L0982		Stocking supporter grips, set of 4	14.95		18.34	
L0984		Protective body sock, each	47.71		67.47	
L0999		Addition to spinal orthotic, not otherwise specified	BR		BR	
L1000		Cervical-thoracic-lumbar-sacral orthotic (CTLSO) (Milwaukee), inclusive of furnishing initial orthotic, including model	1595.19		2287.83	
L1001		Cervical-thoracic-lumbar-sacral orthotic (CTLSO), immobilizer, infant size, prefabricated, includes fitting and adjustment	BR		BR	
L1005		Tension based scoliosis orthotic and accessory pads, includes fitting and adjustment	2704.11		3445.84	
L1010		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, axilla sling	64.24		75.63	
L1020		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, kyphosis pad	87.77		97.40	
L1025		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, kyphosis pad, floating	99.76		140.51	
L1030		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar bolster pad	66.65		71.69	
L1040		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar or lumbar rib pad	80.22		87.91	
L1050		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, sternal pad	69.45		93.82	
L1060		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, thoracic pad	78.35		107.77	
L1070		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, trapezius sling	80.09		101.40	
L1080		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, outrigger	55.50		62.37	
L1085		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, outrigger, bilateral with vertical extensions	154.18		173.46	
L1090		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar sling	72.02		103.29	
L1100		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, ring flange, plastic or leather	127.13		179.21	
L1110		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, ring flange, plastic or leather, molded to patient model	215.34		287.80	
L1120		Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO), scoliosis orthotic, cover for upright, each	34.31		44.75	
L1200		Thoracic-lumbar-sacral orthotic (TLSO), inclusive of furnishing initial orthotic only	1365.48		1765.62	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L1210		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), lateral thoracic extension	205.59		294.86	
L1220		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), anterior thoracic extension	174.07		249.64	
L1230		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), Milwaukee type superstructure	446.64		640.57	
L1240		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), lumbar derotation pad	76.87		87.50	
L1250		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), anterior ASIS pad	75.69		81.42	
L1260		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), anterior thoracic derotation pad	77.78		85.25	
L1270		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), abdominal pad	77.69		87.31	
L1280		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), rib gusset (elastic), each	69.25		97.20	
L1290		Addition to thoracic-lumbar-sacral orthotic (TLSO), (low profile), lateral trochanteric pad	78.52		88.56	
L1300		Other scoliosis procedure, body jacket molded to patient model	1312.49		1882.37	
L1310		Other scoliosis procedure, postoperative body jacket	1350.55		1936.96	
L1499		Spinal orthotic, not otherwise specified	BR		BR	
L1600		Hip orthotic (HO), abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment	101.25		145.21	
L1610		Hip orthotic (HO), abduction control of hip joints, flexible, (Frejka cover only), prefabricated, includes fitting and adjustment	34.49		49.47	
L1620		Hip orthotic (HO), abduction control of hip joints, flexible, (Pavlik harness), prefabricated, includes fitting and adjustment	113.59		150.98	
L1630		Hip orthotic (HO), abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated	135.55		190.95	
L1640		Hip orthotic (HO), abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated	362.56		519.97	
L1650		Hip orthotic (HO), abduction control of hip joints, static, adjustable, (Ilfled type), prefabricated, includes fitting and adjustment	192.27		260.90	
L1652		Hip orthotic, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type	301.18		383.78	
L1660		Hip orthotic (HO), abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment	134.47		192.85	
L1680		Hip orthotic (HO), abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated	1105.50		1373.02	
L1685		Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type, custom fabricated	1166.48		1340.40	
L1686		Hip orthotic (HO), abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustment	782.56		1027.93	
L1690		Combination, bilateral, lumbo-sacral, hip, femur orthotic providing adduction and internal rotation control, prefabricated, includes fitting and adjustment	1633.76		2081.88	
L1700		Legg Perthes orthotic, (Toronto type), custom fabricated	1359.18		1720.86	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L1710		Legg Perthes orthotic, (Newington type), custom fabricated	1597.64		2014.47	
L1720		Legg Perthes orthotic, trilateral, (Tachdijan type), custom fabricated	1180.18		1484.90	
L1730		Legg Perthes orthotic, (Scottish Rite type), custom fabricated	890.41		1275.39	
L1755		Legg Perthes orthotic, (Patten bottom type), custom fabricated	1296.01		1784.11	
L1810		Knee orthotic (KO), elastic with joints, prefabricated, includes fitting and adjustment	102.29		110.98	
L1820		Knee orthotic, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment	101.88		146.12	
L1830		Knee orthotic (KO), immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	85.22		98.57	
L1831		Knee orthotic, locking knee joint(s), positional orthotic, prefabricated, includes fitting and adjustment	248.64		316.87	
L1832		Knee orthotic, adjustable knee joints (unicentric or polycentric), positional orthotic, rigid support, prefabricated, includes fitting and adjustment	636.92		685.11	
L1834		Knee orthotic (KO), without knee joint, rigid, custom fabricated	749.32		874.75	
L1836		Knee orthotic, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment	112.72		143.65	
L1840		Knee orthotic (KO), derotation, medial-lateral, anterior cruciate ligament, custom fabricated	787.67		1036.14	
L1843		Knee orthotic (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment	758.05		966.00	
L1844		Knee orthotic (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	1313.54		1791.81	
L1845		Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment	791.35		921.05	
L1846		Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	1004.08		1258.87	
L1847		Knee orthotic (KO), double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment	485.95		619.23	
L1850		Knee orthotic (KO), Swedish type, prefabricated, includes fitting and adjustment	226.16		324.36	
L1860		Knee orthotic (KO), modification of supracondylar prosthetic socket, custom fabricated (SK)	877.19		1209.20	
L1900		Ankle-foot orthotic (AFO), spring wire, dorsiflexion assist calf band, custom fabricated	237.64		304.00	
L1902		Ankle-foot orthotic (AFO), ankle gauntlet, prefabricated, includes fitting and adjustment	64.54		89.96	
L1904		Ankle-foot orthotic (AFO), molded ankle gauntlet, custom fabricated	369.48		529.91	
L1906		Ankle-foot orthotic (AFO), multiligamentus ankle support, prefabricated, includes fitting and adjustment	107.96		135.52	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L1907		Ankle-foot orthotic (AFO), supramalleolar with straps, with or without interface/pads, custom fabricated	475.40		605.79	
L1910		Ankle-foot orthotic (AFO), posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment	210.12		301.35	
L1920		Ankle-foot orthotic (AFO), single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated	274.69		393.95	
L1930		Ankle-foot orthotic (AFO), plastic or other material, prefabricated, includes fitting and adjustment	185.88		266.57	
L1932		Ankle-foot orthotic (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment	753.91		960.72	
L1940		Ankle-foot orthotic (AFO), plastic or other material, custom fabricated	420.04		557.29	
L1945		Ankle-foot orthotic (AFO), plastic, rigid anterior tibial section (floor reaction), custom fabricated	771.38		1043.14	
L1950		Ankle-foot orthotic (AFO), spiral, (Institute of Rehabilitative Medicine type), plastic, custom fabricated	585.23		839.34	
L1951		Ankle-foot orthotic (AFO), spiral, (Institute of rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment	709.54		904.17	
L1960		Ankle-foot orthotic (AFO), posterior solid ankle, plastic, custom fabricated	435.51		624.61	
L1970		Ankle-foot orthotic (AFO), plastic with ankle joint, custom fabricated	644.15		801.85	
L1971		Ankle-foot orthotic (AFO), plastic or other material with ankle joint, prefabricated, includes fitting and adjustment	396.00		504.64	
L1980		Ankle-foot orthotic (AFO), single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar 'BK' orthotic), custom fabricated	288.36		413.57	
L1990		Ankle-foot orthotic (AFO), double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar 'BK' orthotic), custom fabricated	370.50		502.31	
L2000		Knee-ankle-foot orthotic (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'AK' orthotic), custom fabricated	796.94		1142.98	
L2005		Knee-ankle-foot orthotic (KAFO), any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated	3462.01		4412.74	
L2010		Knee-ankle-foot orthotic (KAFO), single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'AK' orthotic), without knee joint, custom fabricated	726.49		1041.93	
L2020		Knee-ankle-foot orthotic (KAFO), double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar 'AK' orthotic), custom fabricated	917.44		1315.80	
L2030		Knee-ankle-foot orthotic (KAFO), double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar 'AK' orthotic), without knee joint, custom fabricated	795.97		1141.57	
L2034		Knee-ankle-foot orthotic (KAFO), full plastic, single upright, with or without free motion knee, medial-lateral rotation control, with or without free motion ankle, custom fabricated	1734.76		2206.12	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L2035		Knee-ankle-foot orthotic (KAFO), full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment	146.36		187.67	
L2036		Knee-ankle-foot orthotic (KAFO), full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated	1457.76		2090.72	
L2037		Knee-ankle-foot orthotic (KAFO), full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated	1343.41		1876.92	
L2038		Knee-ankle-foot orthotic (KAFO), full plastic, with or without free motion knee, multi-axis ankle, custom fabricated	1123.37		1611.14	
L2040		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated	143.50		200.06	
L2050		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated	382.14		536.81	
L2060		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom fabricated	490.45		654.25	
L2070		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated	140.89		151.55	
L2080		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated	300.46		405.32	
L2090		Hip-knee-ankle-foot orthotic (HKAFO), torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/ belt, custom fabricated	370.35		494.12	
L2106		Ankle-foot orthotic (AFO), fracture orthotic, tibial fracture cast orthotic, thermoplastic type casting material, custom fabricated	534.22		766.18	
L2108		Ankle-foot orthotic (AFO), fracture orthotic, tibial fracture cast orthotic, custom fabricated	839.50		1204.02	
L2112		Ankle-foot orthotic (AFO), fracture orthotic, tibial fracture orthotic, soft, prefabricated, includes fitting and adjustment	398.61		525.75	
L2114		Ankle-foot orthotic (AFO), fracture orthotic, tibial fracture orthotic, semi-rigid, prefabricated, includes fitting and adjustment	456.06		654.08	
L2116		Ankle-foot orthotic (AFO), fracture orthotic, tibial fracture orthotic, rigid, prefabricated, includes fitting and adjustment	600.87		802.22	
L2126		Knee-ankle-foot orthotic (KAFO), fracture orthotic, femoral fracture cast orthotic, thermoplastic type casting material, custom fabricated	1069.09		1349.38	
L2128		Knee-ankle-foot orthotic (KAFO), fracture orthotic, femoral fracture cast orthotic, custom fabricated	1347.30		1932.29	
L2132		Knee-ankle-foot orthotic (KAFO), fracture orthotic, femoral fracture cast orthotic, soft, prefabricated, includes fitting and adjustment	633.83		909.03	
L2134		Knee-ankle-foot orthotic (KAFO), fracture orthotic, femoral fracture cast orthotic, semi-rigid, prefabricated, includes fitting and adjustment	759.93		1089.89	
L2136		Knee-ankle-foot orthotic (KAFO), fracture orthotic, femoral fracture cast orthotic, rigid, prefabricated, includes fitting and adjustment	929.20		1332.65	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L2180		Addition to lower extremity fracture orthotic, plastic shoe insert with ankle joints	92.02		131.97	
L2182		Addition to lower extremity fracture orthotic, drop lock knee joint	72.02		103.29	
L2184		Addition to lower extremity fracture orthotic, limited motion knee joint	129.78		139.60	
L2186		Addition to lower extremity fracture orthotic, adjustable motion knee joint, Lerman type	143.81		169.65	
L2188		Addition to lower extremity fracture orthotic, quadrilateral brim	313.75		337.49	
L2190		Addition to lower extremity fracture orthotic, waist belt	81.50		98.41	
L2192		Addition to lower extremity fracture orthotic, hip joint, pelvic band, thigh flange, and pelvic belt	280.15		401.79	
L2200		Addition to lower extremity, limited ankle motion, each joint	37.36		53.57	
L2210		Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint	60.62		75.75	
L2220		Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint	69.61		92.29	
L2230		Addition to lower extremity, split flat caliper stirrups and plate attachment	60.29		86.46	
L2232		Addition to lower extremity orthotic, rocker bottom for total contact ankle-foot orthotic (AFO), for custom fabricated orthotic only	81.62		105.36	
L2240		Addition to lower extremity, round caliper and plate attachment	65.71		94.23	
L2250		Addition to lower extremity, foot plate, molded to patient model, stirrup attachment	279.19		400.42	
L2260		Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)	157.51		225.90	
L2265		Addition to lower extremity, long tongue stirrup	92.53		132.70	
L2270		Addition to lower extremity, varus/valgus correction (T) strap, padded/lined or malleolus pad	42.20		60.52	
L2275		Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined	102.67		141.34	
L2280		Addition to lower extremity, molded inner boot	381.42		510.27	
L2300		Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable	215.31		303.40	
L2310		Addition to lower extremity, abduction bar, straight	96.66		138.62	
L2320		Addition to lower extremity, nonmolded lacer, for custom fabricated orthotic only	161.67		231.86	
L2330		Addition to lower extremity, lacer molded to patient model, for custom fabricated orthotic only	308.52		442.48	
L2335		Addition to lower extremity, anterior swing band	181.49		255.99	
L2340		Addition to lower extremity, pretibial shell, molded to patient model	428.28		503.64	
L2350		Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for PTB, AFO orthoses)	700.12		1004.11	
L2360		Addition to lower extremity, extended steel shank	40.65		58.30	
L2370		Addition to lower extremity, Patten bottom	201.70		289.28	
L2375		Addition to lower extremity, torsion control, ankle joint and half solid stirrup	88.78		127.32	
L2380		Addition to lower extremity, torsion control, straight knee joint, each joint	96.73		138.73	
L2385		Addition to lower extremity, straight knee joint, heavy-duty, each joint	105.25		150.94	
L2387		Addition to lower extremity, polycentric knee joint, for custom fabricated knee-ankle-foot orthotic (KAFO), each joint	142.83		186.50	
L2390		Addition to lower extremity, offset knee joint, each joint	86.01		123.36	
L2395		Addition to lower extremity, offset knee joint, heavy-duty, each joint	131.32		176.30	
L2397		Addition to lower extremity orthotic, suspension sleeve	92.09		126.64	
L2405		Addition to knee joint, drop lock, each	73.66		93.86	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L2415		Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint	102.64		130.77	
L2425		Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint	121.10		154.32	
L2430		Addition to knee joint, ratchet lock for active and progressive knee extension, each joint	121.10		154.32	
L2492		Addition to knee joint, lift loop for drop lock ring	80.12		114.91	
L2500		Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring	247.88		355.50	
L2510		Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model	663.66		818.54	
L2520		Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted	361.96		519.13	
L2525		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model	1241.82		1373.66	
L2526		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted	669.35		771.85	
L2530		Addition to lower extremity, thigh/weight bearing, lacer, nonmolded	184.61		264.78	
L2540		Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model	332.19		476.42	
L2550		Addition to lower extremity, thigh/weight bearing, high roll cuff	225.67		323.65	
L2570		Addition to lower extremity, pelvic control, hip joint, Clevis type 2 position joint, each	499.00		536.74	
L2580		Addition to lower extremity, pelvic control, pelvic sling	473.01		522.99	
L2600		Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each	161.37		231.43	
L2610		Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each	190.81		273.67	
L2620		Addition to lower extremity, pelvic control, hip joint, heavy-duty, each	210.09		301.30	
L2622		Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each	240.95		345.57	
L2624		Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each	327.56		373.16	
L2627		Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables	1349.54		1931.80	
L2628		Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables	1585.28		1887.96	
L2630		Addition to lower extremity, pelvic control, band and belt, unilateral	194.56		279.04	
L2640		Addition to lower extremity, pelvic control, band and belt, bilateral	264.04		378.70	
L2650		Addition to lower extremity, pelvic and thoracic control, gluteal pad, each	94.29		135.23	
L2660		Addition to lower extremity, thoracic control, thoracic band	146.45		210.03	
L2670		Addition to lower extremity, thoracic control, paraspinal uprights	134.03		192.22	
L2680		Addition to lower extremity, thoracic control, lateral support uprights	122.96		176.34	
L2750		Addition to lower extremity orthotic, plating chrome or nickel, per bar	65.67		94.19	
L2755		Addition to lower extremity orthotic, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthotic only	110.41		140.67	
L2760		Addition to lower extremity orthotic, extension, per extension, per bar (for lineal adjustment for growth)	47.74		68.47	
L2768		Orthotic side bar disconnect device, per bar	110.10		140.27	
L2780		Addition to lower extremity orthotic, noncorrosive finish, per bar	56.48		76.27	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L2785		Addition to lower extremity orthotic, drop lock retainer, each	33.20		35.71	
L2795		Addition to lower extremity orthotic, knee control, full kneecap	66.76		95.75	
L2800		Addition to lower extremity orthotic, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthotic only	83.81		120.20	
L2810		Addition to lower extremity orthotic, knee control, condylar pad	61.37		88.02	
L2820		Addition to lower extremity orthotic, soft interface for molded plastic, below knee section	68.24		97.86	
L2830		Addition to lower extremity orthotic, soft interface for molded plastic, above knee section	76.73		105.87	
L2840		Addition to lower extremity orthotic, tibial length sock, fracture or equal, each	42.82		49.23	
L2850		Addition to lower extremity orthotic, femoral length sock, fracture or equal, each	48.64		69.77	
L2861		Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	BR		BR	2097.37**
L2999		Lower extremity orthotic, not otherwise specified	BR		BR	
L3000		Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each	265.40		338.19	
L3001		Foot, insert, removable, molded to patient model, Spenco, each	111.74		142.39	
L3002		Foot insert, removable, molded to patient model, Plastazote or equal, each	136.45		173.88	
L3003		Foot insert, removable, molded to patient model, silicone gel, each	147.20		187.59	
L3010		Foot insert, removable, molded to patient model, longitudinal arch support, each	147.20		187.59	
L3020		Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each	167.63		213.60	
L3030		Foot insert, removable, formed to patient foot, each	64.48		82.16	
L3031		Foot, insert/plate, removable, addition to lower extremity orthotic, high strength, lightweight material, all hybrid lamination/prepreg composite, each	BR		BR	
L3040		Foot, arch support, removable, premolded, longitudinal, each	39.76		50.66	
L3050		Foot, arch support, removable, premolded, metatarsal, each	39.76		50.66	
L3060		Foot, arch support, removable, premolded, longitudinal/metatarsal, each	62.32		79.41	
L3070		Foot, arch support, nonremovable, attached to shoe, longitudinal, each	26.87		34.22	
L3080		Foot, arch support, nonremovable, attached to shoe, metatarsal, each	26.87		34.22	
L3090		Foot, arch support, nonremovable, attached to shoe, longitudinal/metatarsal, each	34.40		43.83	
L3100		Hallus-valgus night dynamic splint	36.51		46.55	
L3140		Foot, abduction rotation bar, including shoes	75.21		95.86	
L3150		Foot, abduction rotation bar, without shoes	68.78		87.63	
L3160		Foot, adjustable shoe-styled positioning device	19.97		19.97	
L3170		Foot, plastic, silicone or equal, heel stabilizer, each	42.99		54.78	
L3201		Orthopedic shoe, Oxford with supinator or pronator, infant	76.53		76.53	
L3202		Orthopedic shoe, Oxford with supinator or pronator, child	75.20		75.20	
L3203		Orthopedic shoe, Oxford with supinator or pronator, junior	83.21		73.21	
L3204		Orthopedic shoe, hightop with supinator or pronator, infant	83.21		73.21	
L3206		Orthopedic shoe, hightop with supinator or pronator, child	76.20		76.20	
L3207		Orthopedic shoe, hightop with supinator or pronator, junior	77.53		77.53	
L3208		Surgical boot, each, infant	40.60		40.60	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L3209		Surgical boot, each, child	57.57		57.57	
L3211		Surgical boot, each, junior	61.23		61.23	
L3212		Benesch boot, pair, infant	85.52		85.52	
L3213		Benesch boot, pair, child	103.15		103.15	
L3214		Benesch boot, pair, junior	109.81		109.81	
L3215		Orthopedic footwear, ladies shoe, oxford, each	139.76		139.76	2097.37**
L3216		Orthopedic footwear, ladies shoe, depth inlay, each	169.04		169.04	2097.37**
L3217		Orthopedic footwear, ladies shoe, hightop, depth inlay, each	183.35		183.35	2097.37**
L3219		Orthopedic footwear, mens shoe, oxford, each	157.06		157.06	2097.37**
L3221		Orthopedic footwear, mens shoe, depth inlay, each	188.34		188.34	2097.37**
L3222		Orthopedic footwear, mens shoe, hightop, depth inlay, each	207.97		207.97	2097.37**
L3224		Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthotic)	46.21		66.27	
L3225		Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthotic)	53.15		76.23	
L3230		Orthopedic footwear, custom shoe, depth inlay, each	244.90		244.90	
L3250		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	476.50		476.50	
L3251		Foot, shoe molded to patient model, silicone shoe, each	65.55		65.55	
L3252		Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each	260.88		260.88	
L3253		Foot, molded shoe, Plastazote (or similar), custom fitted, each	65.22		65.22	
L3254		Nonstandard size or width	BR		BR	
L3255		Nonstandard size or length	BR		BR	
L3257		Orthopedic footwear, additional charge for split size	47.25		47.25	
L3260		Surgical boot/shoe, each	26.62		26.62	2097.37**
L3265		Plastazote sandal, each	28.95		28.95	
L3300		Lift, elevation, heel, tapered to metatarsals, per in	44.05		56.13	
L3310		Lift, elevation, heel and sole, neoprene, per in	68.78		87.63	
L3320		Lift, elevation, heel and sole, cork, per in	176.36		176.36	
L3330		Lift, elevation, metal extension (skate)	478.13		609.29	
L3332		Lift, elevation, inside shoe, tapered, up to one-half in	62.32		79.41	
L3334		Lift, elevation, heel, per in	32.23		41.07	
L3340		Heel wedge, SACH	72.02		91.76	
L3350		Heel wedge	19.32		24.64	
L3360		Sole wedge, outside sole	30.09		38.33	
L3370		Sole wedge, between sole	41.90		53.39	
L3380		Clubfoot wedge	41.90		53.39	
L3390		Outflare wedge	41.90		53.39	
L3400		Metatarsal bar wedge, rocker	34.40		43.83	
L3410		Metatarsal bar wedge, between sole	78.46		99.96	
L3420		Full sole and heel wedge, between sole	46.19		58.87	
L3430		Heel, counter, plastic reinforced	135.39		172.52	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L3440		Heel, counter, leather reinforced	64.48		82.16	
L3450		Heel, SACH cushion type	89.16		113.64	
L3455		Heel, new leather, standard	34.40		43.83	
L3460		Heel, new rubber, standard	29.00		36.96	
L3465		Heel, Thomas with wedge	49.43		63.00	
L3470		Heel, Thomas extended to ball	52.63		67.10	
L3480		Heel, pad and depression for spur	52.63		67.10	
L3485		Heel, pad, removable for spur	26.62		26.62	
L3500		Orthopedic shoe addition, insole, leather	24.73		31.49	
L3510		Orthopedic shoe addition, insole, rubber	24.73		31.49	
L3520		Orthopedic shoe addition, insole, felt covered with leather	26.87		34.22	
L3530		Orthopedic shoe addition, sole, half	26.87		34.22	
L3540		Orthopedic shoe addition, sole, full	42.99		54.78	
L3550		Orthopedic shoe addition, toe tap, standard	7.53		9.58	
L3560		Orthopedic shoe addition, toe tap, horseshoe	19.32		24.64	
L3570		Orthopedic shoe addition, special extension to instep (leather with eyelets)	72.02		91.76	
L3580		Orthopedic shoe addition, convert instep to Velcro closure	54.79		69.82	
L3590		Orthopedic shoe addition, convert firm shoe counter to soft counter	45.14		57.51	
L3595		Orthopedic shoe addition, March bar	35.45		45.17	
L3600		Transfer of an orthotic from one shoe to another, caliper plate, existing	64.48		82.16	
L3610		Transfer of an orthotic from one shoe to another, caliper plate, new	84.89		108.17	
L3620		Transfer of an orthotic from one shoe to another, solid stirrup, existing	64.48		82.16	
L3630		Transfer of an orthotic from one shoe to another, solid stirrup, new	84.89		108.17	
L3640		Transfer of an orthotic from one shoe to another, Dennis Browne splint (Riveton), both shoes	36.51		46.55	
L3649		Orthopedic shoe, modification, addition or transfer, not otherwise specified	BR		BR	
L3650		Shoulder orthotic (SO), figure of eight design abduction restrainer, prefabricated, includes fitting and adjustment	46.03		65.39	
L3660		Shoulder orthotic (SO), figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment	79.02		113.33	
L3670		Shoulder orthotic (SO), acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment	110.15		124.70	
L3671		Shoulder orthotic (SO), shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	692.81		882.87	
L3674		Shoulder orthotic, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment	908.86		New	
L3675		Shoulder orthotic (SO), vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment	134.94		171.94	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L3677		Shoulder orthotic, shoulder joint design, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment	193.00		193.00	2097.37**
L3702		Elbow orthotic (EO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	197.64		282.93	
L3710		Elbow orthotic (EO), elastic with metal joints, prefabricated, includes fitting and adjustment	111.47		136.32	
L3720		Elbow orthotic (EO), double upright with forearm/arm cuffs, free motion, custom fabricated	556.17		721.26	
L3730		Elbow orthotic (EO), double upright with forearm/arm cuffs, extension/ flexion assist, custom fabricated	732.14		994.03	
L3740		Elbow orthotic (EO), double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated	822.81		1178.51	
L3760		Elbow orthotic (EO), with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type	384.52		489.99	
L3762		Elbow orthotic (EO), rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment	82.68		105.36	
L3763		Elbow-wrist-hand orthotic (EWHO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	610.46		721.32	
L3764		Elbow-wrist-hand orthotic (EWHO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	608.81		814.68	
L3765		Elbow-wrist-hand-finger orthotic (EWHFO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	985.91		1256.36	
L3766		Elbow-wrist-hand-finger orthotic (EWHFO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1044.03		1330.39	
L3806		Wrist-hand-finger orthotic (WHFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment	349.26		445.07	
L3807		Wrist-hand-finger orthotic (WHFO), without joint(s), prefabricated, includes fitting and adjustments, any type	192.27		245.00	
L3808		Wrist-hand-finger orthotic (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	256.82		365.16	
L3891		Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	BR		BR	2097.37**
L3900		Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated	1201.15		1426.85	
L3901		Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, cable driven, custom fabricated	1346.81		1772.07	
L3904		Wrist-hand-finger orthotic (WHFO), external powered, electric, custom fabricated	2741.73		3229.22	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L3905		Wrist-hand orthotic (WHO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	762.51		971.68	
L3906		Wrist-hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	324.36		435.72	
L3908		Wrist-hand orthotic (WHO), wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment	46.07		66.07	
L3912		Hand-finger orthotic (HFO), flexion glove with elastic finger control, prefabricated, includes fitting and adjustment	73.90		104.58	
L3913		Hand finger orthotic (HFO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	208.26		265.37	
L3915		Wrist hand orthotic (WHO), includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment	408.73		520.85	
L3917		Hand orthotic (HO), metacarpal fracture orthotic, prefabricated, includes fitting and adjustment	81.23		103.50	
L3919		Hand orthotic (HO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	208.26		265.37	
L3921		Hand finger orthotic (HFO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	246.96		314.71	
L3923		Hand finger orthotic (HFO), without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment	66.88		95.93	
L3925		Finger orthotic (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment	40.63		54.42	
L3927		Finger orthotic (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment	26.91		34.27	
L3929		Hand-finger orthotic (HFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	64.73		86.20	
L3931		Wrist-hand-finger orthotic (WHFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	156.58		201.07	
L3933		Finger orthotic (FO), without joints, may include soft interface, custom fabricated, includes fitting and adjustment	164.07		209.06	
L3935		Finger orthotic, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment	169.88		216.47	
L3956		Addition of joint to upper extremity orthotic, any material; per joint	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L3960		Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning, airplane design, prefabricated, includes fitting and adjustment	633.79		810.41	
L3961		Shoulder elbow wrist hand orthotic (SEWHO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1291.84		1646.21	
L3962		Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment	659.92		791.19	
L3967		Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1525.22		1943.61	
L3971		Shoulder-elbow-wrist-hand orthotic (SEWHO), shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1447.77		1844.91	
L3973		Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fi	1525.22		1943.61	
L3975		Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1291.84		1646.21	
L3976		Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1291.84		1646.21	
L3977		Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	1447.77		1844.91	
L3978		Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, incl	1525.22		1943.61	
L3980		Upper extremity fracture orthotic, humeral, prefabricated, includes fitting and adjustment	237.69		340.90	
L3982		Upper extremity fracture orthotic, radius/ulnar, prefabricated, includes fitting and adjustment	293.67		411.65	
L3984		Upper extremity fracture orthotic, wrist, prefabricated, includes fitting and adjustment	313.46		379.53	
L3995		Addition to upper extremity orthotic, sock, fracture or equal, each	26.31		36.06	
L3999		Upper limb orthotic, not otherwise specified	BR		BR	
L4000		Replace girdle for spinal orthotic (cervical-thoracic-lumbar-sacral orthotic (CTLSO) or spinal orthotic SO)	1025.00		1436.81	
L4002		Replacement strap, any orthotic, includes all components, any length, any type	BR		BR	
L4010		Replace trilateral socket brim	576.81		756.27	
L4020		Replace quadrilateral socket brim, molded to patient model	720.48		970.61	
L4030		Replace quadrilateral socket brim, custom fitted	396.70		568.95	
L4040		Replace molded thigh lacer, for custom fabricated orthotic only	320.72		459.99	
L4045		Replace nonmolded thigh lacer, for custom fabricated orthotic only	257.74		369.65	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L4050		Replace molded calf lacer, for custom fabricated orthotic only	324.38		465.22	
L4055		Replace nonmolded calf lacer, for custom fabricated orthotic only	210.04		301.25	
L4060		Replace high roll cuff	249.71		358.12	
L4070		Replace proximal and distal upright for KAFO	238.23		317.14	
L4080		Replace metal bands KAFO, proximal thigh	83.99		113.97	
L4090		Replace metal bands KAFO-AFO, calf or distal thigh	74.34		101.77	
L4100		Replace leather cuff KAFO, proximal thigh	83.84		117.54	
L4110		Replace leather cuff KAFO-AFO, calf or distal thigh	66.63		95.57	
L4130		Replace pretibial shell	458.59		559.09	
L4205		Repair of orthotic device, labor component, per 15 minutes	BR		BR	
L4210		Repair of orthotic device, repair or replace minor parts	BR		BR	
L4350		Ankle control orthotic, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment	82.62		100.73	
L4360		Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment	231.15		312.01	
L4370		Pneumatic full leg splint, prefabricated, includes fitting and adjustment	148.33		212.73	
L4386		Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment	133.96		170.70	
L4392		Replacement, soft interface material, static AFO	19.90		25.29	
L4394		Replace soft interface material, foot drop splint	14.53		18.46	
L4396		Static or dynamic ankle-foot orthotic (AFO), including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, includes fitting and adjustment	141.80		180.35	
L4398		Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment	65.26		83.03	
L4631		Ankle-foot orthotic, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated	1260.80		New	
L5000		Partial foot, shoe insert with longitudinal arch, toe filler	443.00		606.59	
L5010		Partial foot, molded socket, ankle height, with toe filler	1069.95		1461.60	
L5020		Partial foot, molded socket, tibial tubercle height, with toe filler	1817.02		2379.19	
L5050		Ankle, Symes, molded socket, SACH foot	2009.96		2755.21	
L5060		Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot	2312.04		3315.92	
L5100		Below knee, molded socket, shin, SACH foot	2014.40		2790.27	
L5105		Below knee, plastic socket, joints and thigh lacer, SACH foot	2908.00		4170.65	
L5150		Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot	2939.58		4215.94	
L5160		Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot	3197.32		4585.60	
L5200		Above knee, molded socket, single axis constant friction knee, shin, SACH foot	3061.89		3965.98	
L5210		Above knee, short prosthesis, no knee joint (stubbies), with foot blocks, no ankle joints, each	2031.25		2913.23	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5220		Above knee, short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each	2308.90		3311.41	
L5230		Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot	3184.42		4567.09	
L5250		Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	4343.27		6229.11	
L5270		Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot	4323.99		6174.54	
L5280		Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	4290.88		6112.79	
L5301		Below knee, molded socket, shin, SACH foot, endoskeletal system	2302.58		2756.50	
L5312		Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system	3295.99		New	
L5321		Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee	3337.65		3945.84	
L5331		Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	4252.84		5583.52	
L5341		Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	4427.23		6067.52	
L5400		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee	1139.97		1444.91	
L5410		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment	349.75		501.61	
L5420		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change AK or knee disarticulation	1397.00		1824.85	
L5430		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, AK or knee disarticulation, each additional cast change and realignment	421.23		604.13	
L5450		Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, below knee	342.68		489.12	
L5460		Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, above knee	456.57		654.64	
L5500		Initial, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed	1075.10		1541.90	
L5505		Initial, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed	1486.88		2088.14	
L5510		Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model	1218.69		1747.84	
L5520		Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed	1203.78		1726.45	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5530		Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	1445.85		2073.63	
L5535		Preparatory, below knee PTB type socket, nonalignable system, no cover, SACH foot, prefabricated, adjustable open end socket	1419.53		2035.90	
L5540		Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model	1515.10		2172.94	
L5560		Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model	1626.95		2333.36	
L5570		Preparatory, above knee - knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed	1691.44		2425.87	
L5580		Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	1974.65		2832.04	
L5585		Preparatory, above knee - knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket	2430.12		3071.68	
L5590		Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model	2012.30		2886.03	
L5595		Preparatory, hip disarticulation/hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model	3555.00		4834.01	
L5600		Preparatory, hip disarticulation/hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model	3821.45		5338.19	
L5610		Addition to lower extremity, endoskeletal system, above knee, hydracadence system	1733.09		2485.60	
L5611		Addition to lower extremity, endoskeletal system, above knee, knee disarticulation, 4-bar linkage, with friction swing phase control	1348.69		1934.29	
L5613		Addition to lower extremity, endoskeletal system, above knee, knee disarticulation, 4-bar linkage, with hydraulic swing phase control	2108.63		2942.18	
L5614		Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control	1428.45		1820.28	
L5616		Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control	1139.49		1630.53	
L5617		Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each	473.63		607.42	
L5618		Addition to lower extremity, test socket, Symes	250.56		337.63	
L5620		Addition to lower extremity, test socket, below knee	232.72		333.77	
L5622		Addition to lower extremity, test socket, knee disarticulation	303.46		435.22	
L5624		Addition to lower extremity, test socket, above knee	304.33		436.47	
L5626		Addition to lower extremity, test socket, hip disarticulation	399.11		572.41	
L5628		Addition to lower extremity, test socket, hemipelvectomy	426.75		579.65	
L5629		Addition to lower extremity, below knee, acrylic socket	266.02		381.53	
L5630		Addition to lower extremity, Symes type, expandable wall socket	375.68		538.79	
L5631		Addition to lower extremity, above knee or knee disarticulation, acrylic socket	367.79		527.49	

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Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5632		Addition to lower extremity, Symes type, PTB brim design socket	205.27		266.57	
L5634		Addition to lower extremity, Symes type, posterior opening (Canadian) socket	254.63		365.20	
L5636		Addition to lower extremity, Symes type, medial opening socket	213.29		305.90	
L5637		Addition to lower extremity, below knee, total contact	241.82		346.82	
L5638		Addition to lower extremity, below knee, leather socket	421.25		584.27	
L5639		Addition to lower extremity, below knee, wood socket	938.53		1346.03	
L5640		Addition to lower extremity, knee disarticulation, leather socket	535.26		767.67	
L5642		Addition to lower extremity, above knee, leather socket	518.63		743.82	
L5643		Addition to lower extremity, hip disarticulation, flexible inner socket, external frame	1302.88		1868.58	
L5644		Addition to lower extremity, above knee, wood socket	494.41		709.09	
L5645		Addition to lower extremity, below knee, flexible inner socket, external frame	667.91		957.91	
L5646		Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	458.65		657.79	
L5647		Addition to lower extremity, below knee, suction socket	665.86		954.98	
L5648		Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	551.11		790.41	
L5649		Addition to lower extremity, ischial containment/narrow M-L socket	1997.00		2285.77	
L5650		Additions to lower extremity, total contact, above knee or knee disarticulation socket	408.65		586.08	
L5651		Addition to lower extremity, above knee, flexible inner socket, external frame	1005.27		1441.75	
L5652		Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	364.95		523.42	
L5653		Addition to lower extremity, knee disarticulation, expandable wall socket	487.18		698.71	
L5654		Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)	277.61		398.16	
L5655		Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	235.26		318.44	
L5656		Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	315.59		445.34	
L5658		Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	304.36		436.51	
L5661		Addition to lower extremity, socket insert, multidurometer Symes	509.41		730.59	
L5665		Addition to lower extremity, socket insert, multidurometer, below knee	428.61		614.71	
L5666		Addition to lower extremity, below knee, cuff suspension	58.60		84.04	
L5668		Addition to lower extremity, below knee, molded distal cushion	94.51		121.23	
L5670		Addition to lower extremity, below knee, molded supracondylar suspension (PTS or similar)	227.14		325.76	
L5671		Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard, or equal), excludes socket insert	481.34		597.17	
L5672		Addition to lower extremity, below knee, removable medial brim suspension	249.62		357.99	
L5673		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	595.21		802.22	
L5676		Additions to lower extremity, below knee, knee joints, single axis, pair	303.34		435.04	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5677		Additions to lower extremity, below knee, knee joints, polycentric, pair	412.73		591.94	
L5678		Additions to lower extremity, below knee, joint covers, pair	33.24		47.66	
L5679		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	495.99		668.49	
L5680		Addition to lower extremity, below knee, thigh lacer, nonmolded	277.45		365.41	
L5681		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code	1113.51		1419.29	
L5682		Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded	523.50		750.80	
L5683		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initia	1113.51		1419.29	
L5684		Addition to lower extremity, below knee, fork strap	40.28		57.78	
L5685		Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each	108.42		138.16	
L5686		Addition to lower extremity, below knee, back check (extension control)	42.77		61.33	
L5688		Addition to lower extremity, below knee, waist belt, webbing	51.13		73.34	
L5690		Addition to lower extremity, below knee, waist belt, padded and lined	81.91		117.47	
L5692		Addition to lower extremity, above knee, pelvic control belt, light	111.23		159.53	
L5694		Addition to lower extremity, above knee, pelvic control belt, padded and lined	151.86		217.79	
L5695		Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each	140.19		195.79	
L5696		Addition to lower extremity, above knee or knee disarticulation, pelvic joint	154.88		222.13	
L5697		Addition to lower extremity, above knee or knee disarticulation, pelvic band	67.20		96.38	
L5698		Addition to lower extremity, above knee or knee disarticulation, Silesian bandage	109.89		125.22	
L5699		All lower extremity prostheses, shoulder harness	197.95		223.85	
L5700		Replacement, socket, below knee, molded to patient model	2398.41		3287.76	
L5701		Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model	2880.31		4082.02	
L5702		Replacement, socket, hip disarticulation, including hip joint, molded to patient model	3644.01		5215.96	
L5703		Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only	1885.82		2511.38	
L5704		Custom shaped protective cover, below knee	448.69		632.15	
L5705		Custom shaped protective cover, above knee	801.72		1115.22	
L5706		Custom shaped protective cover, knee disarticulation	785.90		1094.11	
L5707		Custom shaped protective cover, hip disarticulation	1036.09		1485.13	
L5710		Addition, exoskeletal knee-shin system, single axis, manual lock	313.06		431.79	
L5711		Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material	437.53		626.87	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5712		Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	366.61		517.31	
L5714		Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	376.57		502.16	
L5716		Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	610.10		875.01	
L5718		Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	762.56		1093.67	
L5722		Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	805.62		1083.94	
L5724		Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	1263.51		1812.12	
L5726		Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control	1456.16		2088.43	
L5728		Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	1991.84		2856.70	
L5780		Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	958.38		1374.51	
L5781		Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system	3387.03		4316.11	
L5782		Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy-duty	3570.71		4550.16	
L5785		Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	538.72		623.75	
L5790		Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	601.88		863.22	
L5795		Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	1198.36		1289.02	
L5810		Addition, endoskeletal knee-shin system, single axis, manual lock	407.55		584.51	
L5811		Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	610.50		875.57	
L5812		Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	473.20		678.66	
L5814		Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	3143.83		4006.19	
L5816		Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	716.18		1021.00	
L5818		Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control	803.87		1152.91	
L5822		Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	1425.47		2044.42	
L5824		Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	1283.72		1841.12	
L5826		Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	2643.55		3389.83	
L5828		Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	2363.88		3390.27	
L5830		Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control	1588.40		2278.07	
L5840		Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	2936.96		4069.13	
L5845		Addition, endoskeletal knee-shin system, stance flexion feature, adjustable	1517.27		1933.45	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5848		Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability	910.26		1159.95	
L5850		Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist	107.08		153.58	
L5855		Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist	287.74		370.76	
L5856		Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type	20321.21		25932.87	
L5857		Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type	7210.70		9226.15	
L5858		Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type	15732.57		20048.07	
L5859		Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	BR		New	
L5910		Addition, endoskeletal system, below knee, alignable system	303.17		434.81	
L5920		Addition, endoskeletal system, above knee or hip disarticulation, alignable system	444.15		636.99	
L5925		Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock	375.02		403.39	
L5930		Addition, endoskeletal system, high activity knee control frame	2849.26		3654.11	
L5940		Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	419.89		602.21	
L5950		Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	656.53		934.04	
L5960		Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	806.99		1157.38	
L5961		Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control	3848.02		New	
L5962		Addition, endoskeletal system, below knee, flexible protective outer surface covering system	531.08		705.67	
L5964		Addition, endoskeletal system, above knee, flexible protective outer surface covering system	783.95		1124.35	
L5966		Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	998.95		1432.69	
L5968		Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	3076.16		3919.95	
L5970		All lower extremity prostheses, foot, external keel, SACH foot	170.01		243.83	
L5971		All lower extremity prostheses, solid ankle cushion heel (SACH) foot, replacement only	170.01		243.83	
L5972		All lower extremity prostheses, foot, flexible keel	317.55		423.11	
L5973		Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source	14563.94		0.00	
L5974		All lower extremity prostheses, foot, single axis ankle/foot	195.07		279.76	
L5975		All lower extremity prostheses, combination single axis ankle and flexible keel foot	392.45		500.10	
L5976		All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)	468.78		672.34	
L5978		All lower extremity prostheses, foot, multiaxial ankle/foot	244.29		350.36	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L5979		All lower extremity prostheses, multiaxial ankle, dynamic response foot, one piece system	1910.03		2739.36	
L5980		All lower extremity prostheses, flex-foot system	3103.67		4451.28	
L5981		All lower extremity prostheses, flex-walk system or equal	2507.34		3457.78	
L5982		All exoskeletal lower extremity prostheses, axial rotation unit	483.93		694.05	
L5984		All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability	476.86		683.92	
L5985		All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	239.04		306.56	
L5986		All lower extremity prostheses, multiaxial rotation unit (MCP or equal)	530.45		760.77	
L5987		All lower extremity prostheses, shank foot system with vertical loading pylon	6089.58		7759.97	
L5988		Addition to lower limb prosthesis, vertical shock reducing pylon feature	1691.06		2154.94	
L5990		Addition to lower extremity prosthesis, user adjustable heel height	1535.75		1957.00	
L5999		Lower extremity prosthesis, not otherwise specified	BR		BR	
L6000		Partial hand, thumb remaining	1112.23		1595.15	
L6010		Partial hand, little and/or ring finger remaining	1237.73		1775.14	
L6020		Partial hand, no finger remaining	1153.99		1655.05	
L6025		Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, 2 batteries, charger, myoelectric control of terminal device	6774.09		8632.25	
L6050		Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad	1590.15		2280.59	
L6055		Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad	2216.25		3178.55	
L6100		Below elbow, molded socket, flexible elbow hinge, triceps pad	1611.06		2310.59	
L6110		Below elbow, molded socket (Muenster or Northwestern suspension types)	1708.80		2450.76	
L6120		Below elbow, molded double wall split socket, step-up hinges, half cuff	1991.37		2856.02	
L6130		Below elbow, molded double wall split socket, stump activated locking hinge, half cuff	2166.98		3107.87	
L6200		Elbow disarticulation, molded socket, outside locking hinge, forearm	2283.64		3275.19	
L6205		Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm	3048.30		4371.87	
L6250		Above elbow, molded double wall socket, internal locking elbow, forearm	2392.72		3223.88	
L6300		Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	3118.67		4472.79	
L6310		Shoulder disarticulation, passive restoration (complete prosthesis)	2692.83		3643.19	
L6320		Shoulder disarticulation, passive restoration (shoulder cap only)	1471.03		2051.66	
L6350		Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	3278.80		4702.46	
L6360		Interscapular thoracic, passive restoration (complete prosthesis)	2948.77		3823.96	
L6370		Interscapular thoracic, passive restoration (shoulder cap only)	1764.45		2438.41	
L6380		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow	1022.46		1380.95	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L6382		Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow	1538.24		1777.62	
L6384		Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic	2127.99		2288.97	
L6386		Immediate postsurgical or early fitting, each additional cast change and realignment	336.16		482.13	
L6388		Immediate postsurgical or early fitting, application of rigid dressing only	368.00		527.79	
L6400		Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	1942.37		2785.74	
L6450		Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	2594.95		3701.39	
L6500		Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	2714.86		3704.43	
L6550		Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	3263.31		4577.99	
L6570		Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping	3663.82		5254.64	
L6580		Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model	1398.76		1876.64	
L6582		Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed	1266.90		1652.32	
L6584		Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	1986.83		2457.29	
L6586		Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed	1859.36		2261.14	
L6588		Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	2443.16		3393.37	
L6590		Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed	2320.62		3158.53	
L6600		Upper extremity additions, polycentric hinge, pair	157.01		225.19	
L6605		Upper extremity additions, single pivot hinge, pair	155.04		222.36	
L6610		Upper extremity additions, flexible metal hinge, pair	148.89		199.88	
L6611		Addition to upper extremity prosthesis, external powered, additional switch, any type	348.51		444.13	
L6615		Upper extremity addition, disconnect locking wrist unit	160.43		208.55	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L6616		Upper extremity addition, additional disconnect insert for locking wrist unit, each	59.45		77.86	
L6620		Upper extremity addition, flexion/extension wrist unit, with or without friction	256.66		364.02	
L6621		Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device	1936.20		2467.34	
L6623		Upper extremity addition, spring assisted rotational wrist unit with latch release	715.95		770.10	
L6624		Upper extremity addition, flexion/extension and rotation wrist unit	3188.02		4062.53	
L6625		Upper extremity addition, rotation wrist unit with cable lock	508.70		638.52	
L6628		Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal	401.00		575.13	
L6629		Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal	122.47		175.65	
L6630		Upper extremity addition, stainless steel, any wrist	180.40		258.75	
L6632		Upper extremity addition, latex suspension sleeve, each	62.66		78.00	
L6635		Upper extremity addition, lift assist for elbow	147.44		211.46	
L6637		Upper extremity addition, nudge control elbow lock	314.48		440.83	
L6638		Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow	2116.90		2697.58	
L6640		Upper extremity additions, shoulder abduction joint, pair	279.38		336.29	
L6641		Upper extremity addition, excursion amplifier, pulley type	134.29		192.60	
L6642		Upper extremity addition, excursion amplifier, lever type	182.03		261.06	
L6645		Upper extremity addition, shoulder flexion-abduction joint, each	335.98		383.25	
L6646		Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system	2669.89		3402.25	
L6647		Upper extremity addition, shoulder lock mechanism, body powered actuator	439.54		560.11	
L6648		Upper extremity addition, shoulder lock mechanism, external powered actuator	2753.60		3508.93	
L6650		Upper extremity addition, shoulder universal joint, each	348.83		406.37	
L6655		Upper extremity addition, standard control cable, extra	68.56		90.19	
L6660		Upper extremity addition, heavy-duty control cable	76.83		110.19	
L6665		Upper extremity addition, Teflon, or equal, cable lining	38.56		55.29	
L6670		Upper extremity addition, hook to hand, cable adapter	42.62		57.58	
L6672		Upper extremity addition, harness, chest or shoulder, saddle type	169.15		202.43	
L6675		Upper extremity addition, harness, (e.g., figure of eight type), single cable design	100.53		144.17	
L6676		Upper extremity addition, harness, (e.g., figure of eight type), dual cable design	116.20		145.60	
L6677		Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow	251.14		320.00	
L6680		Upper extremity addition, test socket, wrist disarticulation or below elbow	194.21		278.54	
L6682		Upper extremity addition, test socket, elbow disarticulation or above elbow	214.72		307.95	
L6684		Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic	291.78		418.48	
L6686		Upper extremity addition, suction socket	658.92		708.76	
L6687		Upper extremity addition, frame type socket, below elbow or wrist disarticulation	482.84		692.49	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L6688		Upper extremity addition, frame type socket, above elbow or elbow disarticulation	479.93		635.98	
L6689		Upper extremity addition, frame type socket, shoulder disarticulation	575.01		808.93	
L6690		Upper extremity addition, frame type socket, interscapular-thoracic	626.60		825.51	
L6691		Upper extremity addition, removable insert, each	290.03		414.42	
L6692		Upper extremity addition, silicone gel insert or equal, each	468.13		671.38	
L6693		Upper extremity addition, locking elbow, forearm counterbalance	2403.23		3062.46	
L6694		Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	595.21		802.22	
L6695		Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	495.99		668.49	
L6696		Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than init	1113.51		1419.29	
L6697		Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for othe	1113.51		1419.29	
L6698		Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert	481.34		597.17	
L6703		Terminal device, passive hand/mitt, any material, any size	304.32		390.29	
L6704		Terminal device, sport/recreational/work attachment, any material, any size	490.23		703.09	
L6706		Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined	292.08		418.91	
L6707		Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined	1076.54		1543.99	
L6708		Terminal device, hand, mechanical, voluntary opening, any material, any size	703.77		1004.21	
L6709		Terminal device, hand, mechanical, voluntary closing, any material, any size	1014.16		1454.50	
L6711		Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	569.11		725.24	
L6712		Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	1047.87		1335.30	
L6713		Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	1322.50		1685.27	
L6714		Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	1120.16		1427.42	
L6715		Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement	2672.56		New	
L6721		Terminal device, hook or hand, heavy-duty, mechanical, voluntary opening, any material, any size, lined or unlined	1990.98		2537.10	
L6722		Terminal device, hook or hand, heavy-duty, mechanical, voluntary closing, any material, any size, lined or unlined	1716.35		2187.17	
L6805		Addition to terminal device, modifier wrist unit	284.81		408.47	
L6810		Addition to terminal device, precision pinch device	161.43		223.94	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L6880		Electric hand, switch or myolelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)	20225.25		New	
L6881		Automatic grasp feature, addition to upper limb electric prosthetic terminal device	3460.73		4410.03	
L6882		Microprocessor control feature, addition to upper limb prosthetic terminal device	2625.15		3345.23	
L6883		Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power	1328.35		1905.13	
L6884		Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power	1971.55		2680.23	
L6885		Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power	2948.77		3823.96	
L6890		Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment	142.38		204.20	
L6895		Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated	523.77		670.37	
L6900		Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining	1494.71		1813.38	
L6905		Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining	1486.21		1762.66	
L6910		Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining	1270.86		1717.19	
L6915		Hand restoration (shading and measurements included), replacement glove for above	640.75		751.58	
L6920		Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and 1 charger, switch control of terminal device	5586.48		8012.13	
L6925		Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	7520.37		9249.89	
L6930		Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device	5621.12		8061.81	
L6935		Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	7637.08		9423.05	
L6940		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device	7344.36		10533.28	
L6945		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	8973.94		12254.25	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L6950		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device	8347.90		11972.56	
L6955		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	9997.75		14338.77	
L6960		Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device	11324.96		14461.73	
L6965		Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal d	12078.48		17014.91	
L6970		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device	12585.98		17509.90	
L6975		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal dev	13765.01		19185.30	
L7007		Electric hand, switch or myoelectric controlled, adult	2880.47		4131.17	
L7008		Electric hand, switch or myoelectric, controlled, pediatric	4533.55		6502.01	
L7009		Electric hook, switch or myoelectric controlled, adult	2938.99		4215.09	
L7040		Prehensile actuator, switch controlled	2359.89		3384.56	
L7045		Electric hook, switch or myoelectric controlled, pediatric	1353.01		1940.49	
L7170		Electronic elbow, Hosmer or equal, switch controlled	6229.76		7039.42	
L7180		Electronic elbow, microprocessor sequential control of elbow and terminal device	27345.16		39218.41	
L7181		Electronic elbow, microprocessor simultaneous control of elbow and terminal device	33917.99		43221.88	
L7185		Electronic elbow, adolescent, Variety Village or equal, switch controlled	6151.96		7128.36	
L7186		Electronic elbow, child, Variety Village or equal, switch controlled	7404.48		10619.50	
L7190		Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	6461.66		9069.49	
L7191		Electronic elbow, child, Variety Village or equal, myoelectronically controlled	7737.26		11096.76	
L7260		Electronic wrist rotator, Otto Bock or equal	1647.40		2362.71	
L7261		Electronic wrist rotator, for Utah arm	2998.91		4301.03	
L7360		Six volt battery, each	199.74		273.00	
L7362		Battery charger, 6 volt, each	209.73		300.78	
L7364		Twelve volt battery, each	333.56		478.39	
L7366		Battery charger, twelve volt, each	449.32		644.40	
L7367		Lithium ion battery, replacement	329.55		419.97	
L7368		Lithium ion battery charger, replacement only	427.23		544.42	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L7400		Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal)	259.45		330.62	
L7401		Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)	290.45		370.11	
L7402		Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal)	313.64		399.70	
L7403		Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material	311.75		397.25	
L7404		Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material	470.48		599.56	
L7405		Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material	615.33		784.13	
L7499		Upper extremity prosthesis, not otherwise specified	BR		BR	
L7510		Repair of prosthetic device, repair or replace minor parts	BR		BR	
L7520		Repair prosthetic device, labor component, per 15 minutes	BR		BR	
L7600		Prosthetic donning sleeve, any material, each	BR		BR	2097.37**
L7900		Male vacuum erection system	458.14		578.51	
L7902		Tension ring, for vacuum erection device, any type, replacement only, each	BR		New	
L8000		Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type	36.82		43.83	
L8001		Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type	106.17		135.30	
L8002		Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type	139.67		177.97	
L8010		Breast prosthesis, mastectomy sleeve	59.90		59.90	
L8015		External breast prosthesis garment, with mastectomy form, post mastectomy	50.74		64.81	
L8020		Breast prosthesis, mastectomy form	190.84		240.84	
L8030		Breast prosthesis, silicone or equal, without integral adhesive	276.04		378.75	
L8031		Breast prosthesis, silicone or equal, with integral adhesive	276.04		0.00	
L8032		Nipple prosthesis, reusable, any type, each	33.16		0.00	
L8035		Custom breast prosthesis, post mastectomy, molded to patient model	3101.29		3951.99	
L8039		Breast prosthesis, not otherwise specified	2046.16		0.00	
L8040		Nasal prosthesis, provided by a nonphysician	1943.86		2671.70	
L8041		Midfacial prosthesis, provided by a nonphysician	2466.26		3220.31	
L8042		Orbital prosthesis, provided by a nonphysician	2771.06		3618.32	
L8043		Upper facial prosthesis, provided by a nonphysician	3103.60		4052.52	
L8044		Hemi-facial prosthesis, provided by a nonphysician	3436.12		4486.71	
L8045		Auricular prosthesis, provided by a nonphysician	2151.79		2952.26	
L8046		Partial facial prosthesis, provided by a nonphysician	2216.85		2894.66	
L8047		Nasal septal prosthesis, provided by a nonphysician	1136.13		1483.51	
L8048		Unspecified maxillofacial prosthesis, by report, provided by a nonphysician	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L8049		Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a nonphysician	BR		BR	
L8300		Truss, single with standard pad	81.52		101.26	
L8310		Truss, double with standard pads	125.35		159.89	
L8320		Truss, addition to standard pad, water pad	54.76		64.18	
L8330		Truss, addition to standard pad, scrotal pad	54.28		59.27	
L8400		Prosthetic sheath, below knee, each	15.86		18.90	
L8410		Prosthetic sheath, above knee, each	18.05		24.88	
L8415		Prosthetic sheath, upper limb, each	17.95		25.74	
L8417		Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each	63.65		81.08	
L8420		Prosthetic sock, multiple ply, below knee, each	20.99		23.35	
L8430		Prosthetic sock, multiple ply, above knee, each	23.07		26.57	
L8435		Prosthetic sock, multiple ply, upper limb, each	20.70		25.25	
L8440		Prosthetic shrinker, below knee, each	43.88		50.21	
L8460		Prosthetic shrinker, above knee, each	61.07		80.02	
L8465		Prosthetic shrinker, upper limb, each	54.44		58.56	
L8470		Prosthetic sock, single ply, fitting, below knee, each	5.59		8.01	
L8480		Prosthetic sock, single ply, fitting, above knee, each	7.70		11.05	
L8485		Prosthetic sock, single ply, fitting, upper limb, each	9.31		13.35	
L8499		Unlisted procedure for miscellaneous prosthetic services	BR		BR	
L8500		Artificial larynx, any type	552.44		792.32	
L8501		Tracheostomy speaking valve	122.70		145.03	
L8505		Artificial larynx replacement battery/accessory, any type	BR		BR	
L8507		Tracheo-esophageal voice prosthesis, patient inserted, any type, each	35.46		45.19	
L8509		Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type	92.46		117.81	
L8510		Voice amplifier	213.92		272.58	
L8511		Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each	61.57		78.46	
L8512		Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10	1.86		2.34	
L8513		Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each	4.41		5.60	
L8514		Tracheoesophageal puncture dilator, replacement only, each	79.83		101.73	
L8515		Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each	53.42		68.09	
L8600		Implantable breast prosthesis, silicone or equal	522.71		749.67	
L8603		Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies	367.10		473.41	
L8604		Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L8605		Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	606.29		New	
L8606		Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	192.71		237.40	
L8609		Artificial cornea	5515.40		7030.04	
L8610		Ocular implant	536.18		702.70	
L8612		Aqueous shunt	565.51		729.97	
L8613		Ossicula implant	253.19		308.70	
L8614		Cochlear device, includes all internal and external components	16025.78		20864.80	
L8615		Headset/headpiece for use with cochlear implant device, replacement	381.79		486.64	
L8616		Microphone for use with cochlear implant device, replacement	88.92		113.35	
L8617		Transmitting coil for use with cochlear implant device, replacement	77.69		99.00	
L8618		Transmitter cable for use with cochlear implant device, replacement	22.18		28.28	
L8619		Cochlear implant, external speech processor and controller, integrated system, replacement	6874.46		8955.99	
L8621		Zinc air battery for use with cochlear implant device, replacement, each	0.51		0.67	
L8622		Alkaline battery for use with cochlear implant device, any size, replacement, each	0.28		0.36	
L8623		Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	54.76		69.80	
L8624		Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	136.48		173.99	
L8627		Cochlear implant, external speech processor, component, replacement	5827.26		0.00	
L8628		Cochlear implant, external controller component, replacement	1047.20		0.00	
L8629		Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	151.58		0.00	
L8630		Metacarpophalangeal joint implant	282.02		404.46	
L8631		Metacarpal phalangeal joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system)	1892.65		2373.85	
L8641		Metatarsal joint implant	306.09		420.25	
L8642		Hallux implant	251.25		340.87	
L8658		Interphalangeal joint spacer, silicone or equal, each	262.58		366.41	
L8659		Interphalangeal finger joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size	1633.48		2082.10	
L8670		Vascular graft material, synthetic, implant	465.97		601.45	
L8680		Implantable neurostimulator electrode, each	501.24		501.24	
L8681		Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	956.11		1295.14	
L8682		Implantable neurostimulator radiofrequency receiver	6505.36		6505.36	
L8683		Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	5726.20		5726.20	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
L8684		Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	817.50		817.50	
L8685		Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	14269.36		14269.36	
L8686		Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension	9105.00		9105.00	
L8687		Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	18570.15		18570.15	
L8688		Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	11849.25		11849.25	
L8689		External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	1460.17		1861.18	
L8690		Auditory osseointegrated device, includes all internal and external components	4026.99		5132.88	
L8691		Auditory osseointegrated device, external sound processor, replacement	2257.26		2877.16	
L8692		Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment	BR		BR	2097.37**
L8693		Auditory osseointegrated device abutment, any length, replacement only	1283.59		New	
L8695		External recharging system for battery (external) for use with implantable neurostimulator, replacement only	14.09		17.98	
L8699		Prosthetic implant, not otherwise specified	BR		BR	
L9900		Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code	BR		BR	
M0064		Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders	29.75	125.08	29.75	153.47
M0075		Cellular therapy	BR		BR	2097.37**
M0076		Prolotherapy	BR		BR	2097.37**
M0100		Intragastric hypothermia using gastric freezing	BR		BR	2097.37**
M0300		IV chelation therapy (chemical endarterectomy)	BR		BR	2097.37**
M0301		Fabric wrapping of abdominal aneurysm	BR		BR	2097.37**
P2028		Cephalin floculation, blood	BR		BR	
P2029		Congo red, blood	BR		BR	
P2031		Hair analysis (excluding arsenic)	BR		BR	2097.37**
P2033		Thymol turbidity, blood	BR		BR	
P2038		Mucoprotein, blood (seromucoid) (medical necessity procedure)	8.84		8.84	
P3000		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision	11.26		11.26	
P3001		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician	9.65		9.65	
P7001		Culture, bacterial, urine; quantitative, sensitivity study	21.71		21.71	2097.37**
P9010		Blood (whole), for transfusion, per unit	51.26	219.10	51.26	279.02
P9011		Blood, split unit	73.16	175.91	73.16	118.23
P9012		Cryoprecipitate, each unit	BR	101.46	BR	63.01

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
P9016		Red blood cells, leukocytes reduced, each unit	BR	249.29	BR	252.62
P9017		Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit	BR	101.54	BR	102.84
P9019		Platelets, each unit	BR	118.18	BR	90.11
P9020		Platelet rich plasma, each unit	BR	226.56	BR	185.06
P9021		Red blood cells, each unit	BR	195.82	BR	191.75
P9022		Red blood cells, washed, each unit	BR	382.37	BR	332.80
P9023		Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	BR	93.19	BR	69.20
P9031		Platelets, leukocytes reduced, each unit	BR	152.67	BR	141.72
P9032		Platelets, irradiated, each unit	BR	173.16	BR	203.54
P9033		Platelets, leukocytes reduced, irradiated, each unit	BR	201.84	BR	178.51
P9034		Platelets, pheresis, each unit	BR	557.31	BR	634.63
P9035		Platelets, pheresis, leukocytes reduced, each unit	BR	659.58	BR	692.81
P9036		Platelets, pheresis, irradiated, each unit	BR	871.80	BR	484.26
P9037		Platelets, pheresis, leukocytes reduced, irradiated, each unit	BR	869.73	BR	915.30
P9038		Red blood cells, irradiated, each unit	BR	260.53	BR	305.48
P9039		Red blood cells, deglycerolized, each unit	BR	618.91	BR	492.32
P9040		Red blood cells, leukocytes reduced, irradiated, each unit	BR	352.44	BR	331.48
P9041		Infusion, albumin (human), 5%, 50 ml	17.29		17.29	
P9043		Infusion, plasma protein fraction (human), 5%, 50 ml	16.98	26.20	16.98	88.95
P9044		Plasma, cryoprecipitate reduced, each unit	BR	87.69	BR	127.99
P9045		Infusion, albumin (human), 5%, 250 ml	86.46		86.46	
P9046		Infusion, albumin (human), 25%, 20 ml	28.22		28.22	
P9047		Infusion, albumin (human), 25%, 50 ml	70.55		70.55	
P9048		Infusion, plasma protein fraction (human), 5%, 250 ml	33.96	60.84	33.96	146.06
P9050		Granulocytes, pheresis, each unit	BR	2087.48	BR	60.77
P9051		Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit	BR	239.03	BR	183.07
P9052		Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit	BR	1000.40	BR	996.62
P9053		Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit	BR	852.06	BR	888.45
P9054		Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit	BR	157.95	BR	140.19
P9055		Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit	BR	434.17	BR	567.16
P9056		Whole blood, leukocytes reduced, irradiated, each unit	BR	226.94	BR	223.43
P9057		Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit	BR	475.64	BR	491.13
P9058		Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit	BR	369.68	BR	397.62
P9059		Fresh frozen plasma between 8-24 hours of collection, each unit	BR	97.44	BR	104.79
P9060		Fresh frozen plasma, donor retested, each unit	BR	73.30	BR	97.25
P9603		Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
P9604		Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge	4.02		4.02	
P9612		Catheterization for collection of specimen, single patient, all places of service	26.53		26.53	
P9615		Catheterization for collection of specimen(s) (multiple patients)	BR		BR	
Q0035		Cardiokymography	10.05	228.11	10.05	238.33
Q0081		Infusion therapy, using other than chemotherapeutic drugs, per visit	BR		BR	
Q0083		Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit	BR		BR	
Q0084		Chemotherapy administration by infusion technique only, per visit	113.77		113.77	
Q0085		Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit	BR		BR	
Q0090		Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	BR		New	
Q0091		Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	BR	10.64	BR	12.04
Q0092		Set-up portable x-ray equipment	8.04		8.04	
Q0111		Wet mounts, including preparations of vaginal, cervical or skin specimens	8.04		8.04	
Q0112		All potassium hydroxide (KOH) preparations	9.25		9.25	
Q0113		Pinworm examinations	BR		BR	
Q0114		Fern test	BR		BR	
Q0115		Postcoital direct, qualitative examinations of vaginal or cervical mucous	BR		BR	
Q0138		Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)	BR		BR	
Q0139		Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)	BR		BR	
Q0144		Azithromycin dihydrate, oral, capsules/powder, 1 g	15.70		15.70	2097.37**
Q0162		Ondansetron 1 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	BR		New	
Q0163		Diphenhydramine HCl, 50 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen	0.40		0.40	
Q0164		Prochlorperazine maleate, 5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.59		0.59	
Q0165		Prochlorperazine maleate, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	1.22		1.22	
Q0166		Granisetron HCl, 1 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen	46.09		46.09	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q0167		Dronabinol, 2.5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	4.86		4.86	
Q0168		Dronabinol, 5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	9.17		9.17	
Q0169		Promethazine HCl, 12.5 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.88		0.88	
Q0170		Promethazine HCl, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	1.06		1.06	
Q0171		Chlorpromazine HCl, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.22		0.22	
Q0172		Chlorpromazine HCl, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.27		0.27	
Q0173		Trimethobenzamide HCl, 250 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.84		0.84	
Q0174		Thiethylperazine maleate, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.67		0.67	
Q0175		Perphenazine, 4 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	0.65		0.65	
Q0176		Perphenazine, 8 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	0.81		0.81	
Q0177		Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	2.47		2.47	
Q0178		Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	0.79		0.79	
Q0180		Dolasetron mesylate, 100 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen	68.48		68.48	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q0181		Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	BR		BR	2097.37**
Q0478		Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type	BR		New	
Q0479		Power module for use with electric or electric/pneumatic ventricular assist device, replacement only	BR		New	
Q0480		Driver for use with pneumatic ventricular assist device, replacement only	58701.00		58701.00	
Q0481		Microprocessor control unit for use with electric ventricular assist device, replacement only	9470.73		9470.73	
Q0482		Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	2966.41		2966.41	
Q0483		Monitor/display module for use with electric ventricular assist device, replacement only	12220.27		12220.27	
Q0484		Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only	2373.13		2373.13	
Q0485		Monitor control cable for use with electric ventricular assist device, replacement only	229.12		229.12	
Q0486		Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	190.70		190.70	
Q0487		Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	222.48		222.48	
Q0488		Power pack base for use with electric ventricular assist device, replacement only	BR		BR	
Q0489		Power pack base for use with electric/pneumatic ventricular assist device, replacement only	10594.32		10594.32	
Q0490		Emergency power source for use with electric ventricular assist device, replacement only	458.26		458.26	
Q0491		Emergency power source for use with electric/pneumatic ventricular assist device, replacement only	720.43		720.43	
Q0492		Emergency power supply cable for use with electric ventricular assist device, replacement only	58.04		58.04	
Q0493		Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only	165.26		165.26	
Q0494		Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	139.85		139.85	
Q0495		Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	2722.47		2722.47	
Q0496		Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	977.14		977.14	
Q0497		Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only	305.12		305.12	
Q0498		Holster for use with electric or electric/pneumatic ventricular assist device, replacement only	334.79		334.79	
Q0499		Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only	108.77		108.77	
Q0500		Filters for use with electric or electric/pneumatic ventricular assist device, replacement only	19.90		19.90	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q0501		Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only	332.86		332.86	
Q0502		Mobility cart for pneumatic ventricular assist device, replacement only	423.76		423.76	
Q0503		Battery for pneumatic ventricular assist device, replacement only, each	847.54		847.54	
Q0504		Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	447.23		447.23	
Q0505		Miscellaneous supply or accessory for use with ventricular assist device	BR		BR	
Q0506		Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	BR		BR	
Q0507		Miscellaneous supply or accessory for use with an external ventricular assist device	BR		New	
Q0508		Miscellaneous supply or accessory for use with an implanted ventricular assist device	BR		New	
Q0509		Miscellaneous supply or accessory for use any implanted ventricular assist device for which payment was not made under Medicare Part A	BR		New	
Q0510		Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant	BR		BR	
Q0511		Pharmacy supply fee for oral anticancer, oral antiemetic, or immunosuppressive drug(s); for the first prescription in a 30-day period	BR		BR	
Q0512		Pharmacy supply fee for oral anticancer, oral antiemetic, or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	BR		BR	
Q0513		Pharmacy dispensing fee for inhalation drug(s); per 30 days	BR		BR	
Q0514		Pharmacy dispensing fee for inhalation drug(s); per 90 days	BR		BR	
Q0515		Injection, sermorelin acetate, 1 mcg	1.64		1.64	
Q1004		New technology, intraocular lens, category 4 as defined in Federal Register notice	BR		BR	2097.37**
Q1005		New technology, intraocular lens, category 5 as defined in Federal Register notice	BR		BR	2097.37**
Q2004		Irrigation solution for treatment of bladder calculi, for example renacidin, per 500 ml	17.35		17.35	
Q2009		Injection, fosphenytoin, 50 mg phenytoin equivalent	3.04		3.04	
Q2017		Injection, teniposide, 50 mg	264.68		264.68	
Q2026		Injection, Radiesse, 0.1 ml	BR		New	
Q2027		Injection, Sculptra, 0.1 ml	BR		New	
Q2033		Influenza vaccine, recombinant hemagglutinin antigens, for intramuscular use (Flublok)	BR		New	
Q2034		Influenza virus vaccine, split virus, for intramuscular use (Agriflu)	BR		New	
Q2035		Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)	14.25		New	
Q2036		Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)	BR		New	
Q2037		Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)	15.07		New	
Q2038		Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)	12.92		New	
Q2039		Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)	BR		New	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q2043		Sipuleucel-T, minimum of 50 million autologous cd54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion	BR		New	
Q2049		Injection, doxorubicin hydrochloride, liposomal, imported Lipodox, 10 mg	472.79		New	
Q3001		Radioelements for brachytherapy, any type, each	BR		BR	
Q3014		Telehealth originating site facility fee	BR		BR	
Q3025		Injection, interferon beta-1a, 11 mcg for intramuscular use	112.04		112.04	
Q3026		Injection, interferon beta-1a, 11 mcg for subcutaneous use	BR		BR	2097.37**
Q3031		Collagen skin test	BR		BR	
Q4001		Casting supplies, body cast adult, with or without head, plaster	110.55		110.55	
Q4002		Cast supplies, body cast adult, with or without head, fiberglass	235.17		235.17	
Q4003		Cast supplies, shoulder cast, adult (11 years +), plaster	59.90		59.90	
Q4004		Cast supplies, shoulder cast, adult (11 years +), fiberglass	127.43		127.43	
Q4005		Cast supplies, long arm cast, adult (11 years +), plaster	32.96		32.96	
Q4006		Cast supplies, long arm cast, adult (11 years +), fiberglass	70.15		70.15	
Q4007		Cast supplies, long arm cast, pediatric (0-10 years), plaster	16.48		16.48	
Q4008		Cast supplies, long arm cast, pediatric (0-10 years), fiberglass	34.97		34.97	
Q4009		Cast supplies, short arm cast, adult (11 years +), plaster	25.33		25.33	
Q4010		Cast supplies, short arm cast, adult (11 years +), fiberglass	54.27		54.27	
Q4011		Cast supplies, short arm cast, pediatric (0-10 years), plaster	12.66		12.66	
Q4012		Cast supplies, short arm cast, pediatric (0-10 years), fiberglass	27.14		27.14	
Q4013		Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster	23.92		23.92	
Q4014		Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass	51.05		51.05	
Q4015		Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0-10 years), plaster	12.06		12.06	
Q4016		Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0-10 years), fiberglass	25.53		25.53	
Q4017		Cast supplies, long arm splint, adult (11 years +), plaster	20.90		20.90	
Q4018		Cast supplies, long arm splint, adult (11 years +), fiberglass	44.62		44.62	
Q4019		Cast supplies, long arm splint, pediatric (0-10 years), plaster	10.45		10.45	
Q4020		Cast supplies, long arm splint, pediatric (0-10 years), fiberglass	22.31		22.31	
Q4021		Cast supplies, short arm splint, adult (11 years +), plaster	20.90		20.90	
Q4022		Cast supplies, short arm splint, adult (11 years +), fiberglass	44.62		44.62	
Q4023		Cast supplies, short arm splint, pediatric (0-10 years), plaster	10.45		10.45	
Q4024		Cast supplies, short arm splint, pediatric (0-10 years), fiberglass	22.31		22.31	
Q4025		Cast supplies, hip spica (one or both legs), adult (11 years +), plaster	92.86		92.86	
Q4026		Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass	197.58		197.58	
Q4027		Cast supplies, hip spica (one or both legs), pediatric (0-10 years), plaster	46.43		46.43	
Q4028		Cast supplies, hip spica (one or both legs), pediatric (0-10 years), fiberglass	98.89		98.89	
Q4029		Cast supplies, long leg cast, adult (11 years +), plaster	45.83		45.83	
Q4030		Cast supplies, long leg cast, adult (11 years +), fiberglass	97.28		97.28	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q4031		Cast supplies, long leg cast, pediatric (0-10 years), plaster	22.91		22.91	
Q4032		Cast supplies, long leg cast, pediatric (0-10 years), fiberglass	48.64		48.64	
Q4033		Cast supplies, long leg cylinder cast, adult (11 years +), plaster	38.99		38.99	
Q4034		Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass	82.81		82.81	
Q4035		Cast supplies, long leg cylinder cast, pediatric (0-10 years), plaster	19.50		19.50	
Q4036		Cast supplies, long leg cylinder cast, pediatric (0-10 years), fiberglass	41.41		41.41	
Q4037		Cast supplies, short leg cast, adult (11 years +), plaster	52.46		52.46	
Q4038		Cast supplies, short leg cast, adult (11 years +), fiberglass	111.56		111.56	
Q4039		Cast supplies, short leg cast, pediatric (0-10 years), plaster	26.13		26.13	
Q4040		Cast supplies, short leg cast, pediatric (0-10 years), fiberglass	55.88		55.88	
Q4041		Cast supplies, long leg splint, adult (11 years +), plaster	29.95		29.95	
Q4042		Cast supplies, long leg splint, adult (11 years +), fiberglass	63.72		63.72	
Q4043		Cast supplies, long leg splint, pediatric (0-10 years), plaster	15.08		15.08	
Q4044		Cast supplies, long leg splint, pediatric (0-10 years), fiberglass	31.96		31.96	
Q4045		Cast supplies, short leg splint, adult (11 years +), plaster	19.50		19.50	
Q4046		Cast supplies, short leg splint, adult (11 years +), fiberglass	41.41		41.41	
Q4047		Cast supplies, short leg splint, pediatric (0-10 years), plaster	9.65		9.65	
Q4048		Cast supplies, short leg splint, pediatric (0-10 years), fiberglass	20.70		20.70	
Q4049		Finger splint, static	BR		BR	
Q4050		Cast supplies, for unlisted types and materials of casts	BR		BR	
Q4051		Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	BR		BR	
Q4074		Iloprost, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg	52.10		52.10	
Q4081		Injection, epoetin alfa, 100 units (for ESRD on dialysis)	1.19		1.19	
Q4082		Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)	BR		BR	
Q4100		Skin substitute, not otherwise specified	BR		BR	
Q4101		Apligraf, per sq cm	24.89		24.89	
Q4102		Oasis wound matrix, per sq cm	BR		BR	
Q4103		Oasis burn matrix, per sq cm	BR		BR	
Q4104		Integra bilayer matrix wound dressing (BMWD), per sq cm	42.21		42.21	
Q4105		Integra dermal regeneration template (DRT), per sq cm	42.21		42.21	
Q4106		Dermagraft, per sq cm	34.31		34.31	
Q4107		GRAFTJACKET, per sq cm	87.09		87.09	
Q4108		Integra matrix, per sq cm	42.21		42.21	
Q4110		PriMatrix, per sq cm	33.77		33.77	
Q4111		GammaGraft, per sq cm	BR		BR	
Q4112		Cymetra, injectable, 1 cc	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q4113		GRAFTJACKET XPRESS, injectable, 1cc	BR		BR	
Q4114		Integra flowable wound matrix, injectable, 1 cc	BR		BR	
Q4115		AlloSkin, per sq cm	BR		BR	
Q4116		AlloDerm, per sq cm	BR		BR	
Q4117		HYALOMATRIX, per sq cm	BR		New	
Q4118		MatriStem micromatrix, 1 mg	BR		New	
Q4119		MatriStem Wound Matrix, PSMX, RS, or PSM, per sq cm	BR		New	
Q4120		MatriStem burn matrix, per sq cm	BR		New	
Q4121		TheraSkin, per sq cm	BR		New	
Q4122		DermACELL, per sq cm	BR		New	
Q4123		AlloSkin RT, per sq cm	BR		New	
Q4124		OASIS ultra tri-layer wound matrix, per sq cm	BR		New	
Q4125		Arthroflex, per sq cm	BR		New	
Q4126		MemoDerm, DermaSpan, TranZgraft or InteguPly, per sq cm	BR		New	
Q4127		Talymed, per sq cm	BR		New	
Q4128		FlexHD, AllopatchHD, or Matrix HD, per sq cm	BR		New	
Q4129		Unite biomatrix, per sq cm	BR		New	
Q4130		Strattice TM, per sq cm	BR		New	
Q4131		EpiFix, per sq cm	BR		New	
Q4132		Grafix core, per sq cm	BR		New	
Q4133		Grafix prime, per sq cm	BR		New	
Q4134		hMatrix, per sq cm	BR		New	
Q4135		Mediskin, per sq cm	BR		New	
Q4136		E-Z Derm, per sq cm	BR		New	
Q5001		Hospice care provided in patient's home/residence	BR		BR	
Q5002		Hospice care provided in assisted living facility	BR		BR	
Q5003		Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)	BR		BR	
Q5004		Hospice care provided in skilled nursing facility (SNF)	BR		BR	
Q5005		Hospice care provided in inpatient hospital	BR		BR	
Q5006		Hospice care provided in inpatient hospice facility	BR		BR	
Q5007		Hospice care provided in long-term care facility	BR		BR	
Q5008		Hospice care provided in inpatient psychiatric facility	BR		BR	
Q5009		Hospice care provided in place not otherwise specified (NOS)	BR		BR	
Q5010		Hospice home care provided in a hospice facility	BR		New	
Q9951		Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml	BR		BR	
Q9953		Injection, iron-based magnetic resonance contrast agent, per ml	BR		BR	
Q9954		Oral magnetic resonance contrast agent, per 100 ml	BR		BR	
Q9955		Injection, perflexane lipid microspheres, per ml	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
Q9956		Injection, octafluoropropane microspheres, per ml	BR		BR	
Q9957		Injection, perflutren lipid microspheres, per ml	62.71		62.71	
Q9958		High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml	BR		BR	
Q9959		High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml	BR		BR	
Q9960		High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml	BR		BR	
Q9961		High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml	BR		BR	
Q9962		High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml	BR		BR	
Q9963		High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml	BR		BR	
Q9964		High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml	BR		BR	
Q9965		Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml	BR		BR	
Q9966		Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml	BR		BR	
Q9967		Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	BR		BR	
Q9968		Injection, nonradioactive, noncontrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg	BR		BR	
Q9969		Tc-99m from nonhighly enriched uranium source, full cost recovery add-on, per study dose	BR		New	
R0070		Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen	92.46		92.46	
R0075		Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen	0.00		BR	
R0076		Transportation of portable EKG to facility or location, per patient	36.98		36.98	
S0012		Butorphanol tartrate, nasal spray, 25 mg	68.60		68.60	
S0014		Tacrine HCl, 10 mg	2.35		2.35	
S0017		Injection, aminocaproic acid, 5 g	5.75		5.75	
S0020		Injection, bupivicaine HCl, 30 ml	BR		BR	
S0021		Injection, cefoperazone sodium, 1 g	BR		BR	
S0023		Injection, cimetidine HCl, 300 mg	2.44		2.44	
S0028		Injection, famotidine, 20 mg	1.88		1.88	
S0030		Injection, metronidazole, 500 mg	9.04		9.04	
S0032		Injection, nafcillin sodium, 2 g	19.48		19.48	
S0034		Injection, ofloxacin, 400 mg	BR		BR	
S0039		Injection, sulfamethoxazole and trimethoprim, 10 ml	BR		BR	
S0040		Injection, ticarcillin disodium and clavulanate potassium, 3.1 g	12.99		12.99	
S0073		Injection, aztreonam, 500 mg	16.05		16.05	
S0074		Injection, cefotetan disodium, 500 mg	BR		BR	
S0077		Injection, clindamycin phosphate, 300 mg	3.02		3.02	
S0078		Injection, fosphenytoin sodium, 750 mg	157.39		157.39	
S0080		Injection, pentamidine isethionate, 300 mg	61.18		61.18	
S0081		Injection, piperacillin sodium, 500 mg	1.68		1.68	
S0088		Imatinib, 100 mg	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S0090		Sildenafil citrate, 25 mg	15.19		15.19	
S0091		Granisetron HCl, 1 mg (for circumstances falling under the Medicare statute, use Q0166)	72.67		72.67	
S0092		Injection, hydromorphone HCl, 250 mg (loading dose for infusion pump)	92.30		92.30	
S0093		Injection, morphine sulfate, 500 mg (loading dose for infusion pump)	212.26		212.26	
S0104		Zidovudine, oral, 100 mg	1.62		1.62	
S0106		Bupropion HCl sustained release tablet, 150 mg, per bottle of 60 tablets	97.64		97.64	
S0108		Mercaptopurine, oral, 50 mg	3.37		3.37	
S0109		Methadone, oral, 5 mg	0.25		0.25	
S0117		Tretinoin, topical, 5 g	BR		BR	
S0119		Ondansetron, oral, 4 mg (for circumstances falling under the Medicare statute, use HCPCS Q code)	BR		New	
S0122		Injection, menotropins, 75 IU	62.71		62.71	
S0126		Injection, follitropin alfa, 75 IU	71.59		71.59	
S0128		Injection, follitropin beta, 75 IU	68.11		68.11	
S0132		Injection, ganirelix acetate, 250 mcg	94.32		94.32	
S0136		Clozapine, 25 mg	1.16		1.16	
S0137		Didanosine (ddI), 25 mg	BR		BR	
S0138		Finasteride, 5 mg	2.52		2.52	
S0139		Minoxidil, 10 mg	1.00		1.00	
S0140		Saquinavir, 200 mg	1.68		1.68	
S0142		Colistimethate sodium, inhalation solution administered through DME, concentrated form, per mg	BR		BR	
S0145		Injection, pegylated interferon alfa-2a, 180 mcg per ml	BR		BR	
S0148		Injection, pegylated interferon alfa-2B, 10 mcg	BR		New	
S0155		Sterile dilutant for epoprostenol, 50 ml	BR		BR	
S0156		Exemestane, 25 mg	7.51		7.51	
S0157		Becaplermin gel 0.01%, 0.5 gm	15.70		15.70	
S0160		Dextroamphetamine sulfate, 5 mg	0.35		0.35	
S0164		Injection, pantoprazole sodium, 40 mg	11.58		11.58	
S0166		Injection, olanzapine, 2.5 mg	5.26		5.26	
S0169		Calcitrol, 0.25 mcg	BR		New	
S0170		Anastrozole, oral, 1 mg	7.22		7.22	
S0171		Injection, bumetanide, 0.5 mg	1.06		1.06	
S0172		Chlorambucil, oral, 2 mg	1.98		1.98	
S0174		Dolasetron mesylate, oral 50 mg (for circumstances falling under the Medicare statute, use Q0180)	46.25		46.25	
S0175		Flutamide, oral, 125 mg	1.91		1.91	
S0176		Hydroxyurea, oral, 500 mg	1.02		1.02	
S0177		Levamisole HCl, oral, 50 mg	4.45		4.45	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S0178		Lomustine, oral, 10 mg	22.91		22.91	
S0179		Megestrol acetate, oral, 20 mg	0.51		0.51	
S0182		Procarbazine HCl, oral, 50 mg	46.11		46.11	
S0183		Prochlorperazine maleate, oral, 5 mg (for circumstances falling under the Medicare statute, use Q0164-Q0165)	0.59		0.59	
S0187		Tamoxifen citrate, oral, 10 mg	1.91		1.91	
S0189		Testosterone pellet, 75 mg	BR		BR	
S0190		Mifepristone, oral, 200 mg	72.36		72.36	
S0191		Misoprostol, oral, 200 mcg	1.88		1.88	
S0194		Dialysis/stress vitamin supplement, oral, 100 capsules	BR		BR	
S0195		Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from 5 years to 9 years of age who have not previously received the vaccine	BR		BR	
S0197		Prenatal vitamins, 30-day supply	BR		BR	
S0199		Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm comple	BR		BR	
S0201		Partial hospitalization services, less than 24 hours, per diem	BR		BR	
S0207		Paramedic intercept, nonhospital-based ALS service (nonvoluntary), nontransport	BR		BR	
S0208		Paramedic intercept, hospital-based ALS service (nonvoluntary), nontransport	BR		BR	
S0209		Wheelchair van, mileage, per mile	BR		BR	
S0215		Nonemergency transportation; mileage, per mile	BR		BR	
S0220		Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes	BR		BR	
S0221		Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes	BR		BR	
S0250		Comprehensive geriatric assessment and treatment planning performed by assessment team	BR		BR	
S0255		Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff	BR		BR	
S0257		Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)	BR		BR	
S0260		History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service)	BR		BR	
S0265		Genetic counseling, under physician supervision, each 15 minutes	BR		BR	
S0270		Physician management of patient home care, standard monthly case rate (per 30 days)	BR		BR	
S0271		Physician management of patient home care, hospice monthly case rate (per 30 days)	BR		BR	
S0272		Physician management of patient home care, episodic care monthly case rate (per 30 days)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S0273		Physician visit at member's home, outside of a capitation arrangement	BR		BR	
S0274		Nurse practitioner visit at member's home, outside of a capitation arrangement	BR		BR	
S0280		Medical home program, comprehensive care coordination and planning, initial plan	BR		BR	
S0281		Medical home program, comprehensive care coordination and planning, maintenance of plan	BR		BR	
S0302		Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)	BR		BR	
S0310		Hospitalist services (list separately in addition to code for appropriate evaluation and management service)	BR		BR	
S0315		Disease management program; initial assessment and initiation of the program	BR		BR	
S0316		Disease management program, follow-up/reassessment	BR		BR	
S0317		Disease management program; per diem	BR		BR	
S0320		Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	BR		BR	
S0340		Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter/stage	BR		BR	
S0341		Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter/stage	BR		BR	
S0342		Lifestyle modification program for management of coronary artery disease, including all supportive services; 4th quarter / stage	BR		BR	
S0353		Treatment planning and care coordination management for cancer initial treatment	BR		New	
S0354		Treatment planning and care coordination management for cancer established patient with a change of regimen	BR		New	
S0390		Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit	BR		BR	
S0395		Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic	BR		BR	
S0400		Global fee for extracorporeal shock wave lithotripsy treatment of kidney stone(s)	BR		BR	
S0500		Disposable contact lens, per lens	BR		BR	
S0504		Single vision prescription lens (safety, athletic, or sunglass), per lens	BR		BR	
S0506		Bifocal vision prescription lens (safety, athletic, or sunglass), per lens	BR		BR	
S0508		Trifocal vision prescription lens (safety, athletic, or sunglass), per lens	BR		BR	
S0510		Nonprescription lens (safety, athletic, or sunglass), per lens	BR		BR	
S0512		Daily wear specialty contact lens, per lens	BR		BR	
S0514		Color contact lens, per lens	BR		BR	
S0515		Scleral lens, liquid bandage device, per lens	BR		BR	
S0516		Safety eyeglass frames	BR		BR	
S0518		Sunglasses frames	BR		BR	
S0580		Polycarbonate lens (list this code in addition to the basic code for the lens)	BR		BR	
S0581		Nonstandard lens (list this code in addition to the basic code for the lens)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S0590		Integral lens service, miscellaneous services reported separately	BR		BR	
S0592		Comprehensive contact lens evaluation	BR		BR	
S0595		Dispensing new spectacle lenses for patient supplied frame	BR		BR	
S0596		Phakic intraocular lens for correction of refractive error	BR		New	
S0601		Screening proctoscopy	BR		BR	
S0610		Annual gynecological examination, new patient	BR		BR	
S0612		Annual gynecological examination, established patient	BR		BR	
S0613		Annual gynecological examination; clinical breast examination without pelvic evaluation	BR		BR	
S0618		Audiometry for hearing aid evaluation to determine the level and degree of hearing loss	BR		BR	
S0620		Routine ophthalmological examination including refraction; new patient	BR		BR	
S0621		Routine ophthalmological examination including refraction; established patient	BR		BR	
S0622		Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)	BR		BR	
S0630		Removal of sutures; by a physician other than the physician who originally closed the wound	BR		BR	
S0800		Laser in situ keratomileusis (LASIK)	BR		BR	
S0810		Photorefractive keratectomy (PRK)	BR		BR	
S0812		Phototherapeutic keratectomy (PTK)	BR		BR	
S1001		Deluxe item, patient aware (list in addition to code for basic item)	BR		BR	
S1002		Customized item (list in addition to code for basic item)	BR		BR	
S1015		IV tubing extension set	BR		BR	
S1016		Non-PVC (polyvinyl chloride) intravenous administration set, for use with drugs that are not stable in PVC e.g., Paclitaxel	BR		BR	
S1030		Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use CPT code)	BR		BR	
S1031		Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use CPT code)	BR		BR	
S1040		Cranial remolding orthotic, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)	BR		BR	
S1090		Mometasone furoate sinus implant, 370 micrograms	BR		New	
S2053		Transplantation of small intestine and liver allografts	BR		BR	
S2054		Transplantation of multivisceral organs	BR		BR	
S2055		Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor	BR		BR	
S2060		Lobar lung transplantation	BR		BR	
S2061		Donor lobectomy (lung) for transplantation, living donor	BR		BR	
S2065		Simultaneous pancreas kidney transplantation	BR		BR	
S2066		Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S2067		Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping th	BR		BR	
S2068		Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilatera	BR		BR	
S2070		Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with endoscopic laser treatment of ureteral calculi (includes ureteral catheterization)	BR		BR	
S2079		Laparoscopic esophagomyotomy (Heller type)	BR		BR	
S2080		Laser-assisted uvulopalatoplasty (LAUP)	BR		BR	
S2083		Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	BR		BR	
S2095		Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	BR		BR	
S2102		Islet cell tissue transplant from pancreas; allogeneic	BR		BR	
S2103		Adrenal tissue transplant to brain	BR		BR	
S2107		Adoptive immunotherapy i.e. development of specific antitumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment	BR		BR	
S2112		Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	BR		BR	
S2115		Osteotomy, periacetabular, with internal fixation	BR		BR	
S2117		Arthroereisis, subtalar	BR		BR	
S2118		Metal-on-metal total hip resurfacing, including acetabular and femoral components	BR		BR	
S2120		Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation	BR		BR	
S2140		Cord blood harvesting for transplantation, allogeneic	BR		BR	
S2142		Cord blood-derived stem-cell transplantation, allogeneic	BR		BR	
S2150		Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalizatio	BR		BR	
S2152		Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor (s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, d	BR		BR	
S2202		Echosclerotherapy	BR		BR	
S2205		Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), single coronary arterial graft	BR		BR	
S2206		Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), 2 coronary arterial grafts	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S2207		Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using venous graft only, single coronary venous graft	BR		BR	
S2208		Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using single arterial and venous graft(s), single venous graft	BR		BR	
S2209		Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using 2 arterial grafts and single venous graft	BR		BR	
S2225		Myringotomy, laser-assisted	BR		BR	
S2230		Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	BR		BR	
S2235		Implantation of auditory brain stem implant	BR		BR	
S2260		Induced abortion, 17 to 24 weeks	BR		BR	
S2265		Induced abortion, 25 to 28 weeks	BR		BR	
S2266		Induced abortion, 29 to 31 weeks	BR		BR	
S2267		Induced abortion, 32 weeks or greater	BR		BR	
S2300		Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	BR		BR	
S2325		Hip core decompression	BR		BR	
S2340		Chemodenervation of abductor muscle(s) of vocal cord	BR		BR	
S2341		Chemodenervation of adductor muscle(s) of vocal cord	BR		BR	
S2342		Nasal endoscopy for postoperative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(s), unilateral or bilateral	BR		BR	
S2348		Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar	BR		BR	
S2350		Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace	BR		BR	
S2351		Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)	BR		BR	
S2360		Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; cervical	BR		BR	
S2361		Each additional cervical vertebral body (list separately in addition to code for primary procedure)	BR		BR	
S2400		Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	BR		BR	
S2401		Repair, urinary tract obstruction in the fetus, procedure performed in utero	BR		BR	
S2402		Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	BR		BR	
S2403		Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	BR		BR	
S2404		Repair, myelomeningocele in the fetus, procedure performed in utero	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S2405		Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	BR		BR	
S2409		Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	BR		BR	
S2411		Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	BR		BR	
S2900		Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)	BR		BR	
S3000		Diabetic indicator; retinal eye exam, dilated, bilateral	BR		BR	
S3005		Performance measurement, evaluation of patient self assessment, depression	BR		BR	
S3600		STAT laboratory request (situations other than S3601)	BR		BR	
S3601		Emergency STAT laboratory charge for patient who is homebound or residing in a nursing facility	BR		BR	
S3620		Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-d; phenylanine (PKU); and thyroxine, total)	BR		BR	
S3625		Maternal serum triple marker screen including alpha-fetoprotein (AFP), estriol, and human chorionic gonadotropin (HCG)	BR		BR	
S3626		Maternal serum quadruple marker screen including alpha-fetoprotein (AFP), estriol, human chorionic gonadotropin hCG) and inhibin A	BR		BR	
S3630		Eosinophil count, blood, direct	BR		BR	
S3645		HIV-1 antibody testing of oral mucosal transudate	BR		BR	
S3650		Saliva test, hormone level; during menopause	BR		BR	
S3652		Saliva test, hormone level; to assess preterm labor risk	BR		BR	
S3655		Antisperm antibodies test (immunobead)	BR		BR	
S3708		Gastrointestinal fat absorption study	BR		BR	
S3711		Circulating tumor cell test	BR		BR	
S3713		Kras mutation analysis testing	BR		BR	
S3721		Prostate cancer antigen 3 (PCA3) testing	BR		New	
S3722		Dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil	BR		New	
S3800		Genetic testing for amyotrophic lateral sclerosis (ALS)	BR		BR	
S3818		Complete gene sequence analysis; BRCA1 gene	BR		BR	
S3819		Complete gene sequence analysis; BRCA2 gene	BR		BR	
S3820		Complete BRCA1 and BRCA2 gene sequence analysis for susceptibility to breast and ovarian cancer	BR		BR	
S3822		Single mutation analysis (in individual with a known BRCA1 or BRCA2 mutation in the family) for susceptibility to breast and ovarian cancer	BR		BR	
S3823		Three-mutation BRCA1 and BRCA2 analysis for susceptibility to breast and ovarian cancer in Ashkenazi individuals	BR		BR	
S3828		Complete gene sequence analysis; MLH1 gene	BR		BR	
S3829		Complete gene sequence analysis; MSH2 gene	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S3830		Complete MLH1 and MSH2 gene sequence analysis for hereditary nonpolyposis colorectal cancer (HNPCC) genetic testing	BR		BR	
S3831		Single-mutation analysis (in individual with a known MLH1 and MSH2 mutation in the family) for hereditary nonpolyposis colorectal cancer (HNPCC) genetic testing	BR		BR	
S3833		Complete APC gene sequence analysis for susceptibility to familial adenomatous polyposis (FAP) and attenuated fap	BR		BR	
S3834		Single-mutation analysis (in individual with a known APC mutation in the family) for susceptibility to familial adenomatous polyposis (FAP) and attenuated FAP	BR		BR	
S3835		Complete gene sequence analysis for cystic fibrosis genetic testing	BR		BR	
S3837		Complete gene sequence analysis for hemochromatosis genetic testing	BR		BR	
S3840		DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2	BR		BR	
S3841		Genetic testing for retinoblastoma	BR		BR	
S3842		Genetic testing for Von Hippel-Lindau disease	BR		BR	
S3843		DNA analysis of the F5 gene for susceptibility to factor V Leiden thrombophilia	BR		BR	
S3844		DNA analysis of the connexin 26 gene (GJB2) for susceptibility to congenital, profound deafness	BR		BR	
S3845		Genetic testing for alpha-thalassemia	BR		BR	
S3846		Genetic testing for hemoglobin E beta-thalassemia	BR		BR	
S3847		Genetic testing for Tay-Sachs disease	BR		BR	
S3848		Genetic testing for Gaucher disease	BR		BR	
S3849		Genetic testing for Niemann-Pick disease	BR		BR	
S3850		Genetic testing for sickle cell anemia	BR		BR	
S3851		Genetic testing for Canavan disease	BR		BR	
S3852		DNA analysis for APOE epsilon 4 allele for susceptibility to Alzheimer's disease	BR		BR	
S3853		Genetic testing for myotonic muscular dystrophy	BR		BR	
S3854		Gene expression profiling panel for use in the management of breast cancer treatment	BR		BR	
S3855		Genetic testing for detection of mutations in the presenilin - 1 gene	BR		BR	
S3860		Genetic testing, comprehensive cardiac ion channel analysis, for variants in 5 major cardiac ion channel genes for individuals with high index of suspicion for familial long QT syndrome (LQTS) or related syndromes	BR		BR	
S3861		Genetic testing, sodium channel, voltage-gated, type V, alpha subunit (SCN5A) and variants for suspected Brugada Syndrome	BR		BR	
S3862		Genetic testing, family-specific ion channel analysis, for blood-relatives of individuals (index case) who have previously tested positive for a genetic variant of a cardiac ion channel syndrome using either one of the above test configurations or confirm	BR		BR	
S3865		Comprehensive gene sequence analysis for hypertrophic cardiomyopathy	BR		BR	
S3866		Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S3870		Comparative genomic hybrization (CGH) microarray testing for developmental delay, autism spectrum disorder and/or mental retardation	BR		BR	
S3890		DNA analysis, fecal, for colorectal cancer screening	BR		BR	
S3900		Surface electromyography (EMG)	BR		BR	
S3902		Ballistocardiogram	BR		BR	
S3904		Masters 2 step	BR		BR	
S4005		Interim labor facility global (labor occurring but not resulting in delivery)	BR		BR	
S4011		In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development	BR		BR	
S4013		Complete cycle, gamete intrafallopian transfer (GIFT), case rate	BR		BR	
S4014		Complete cycle, zygote intrafallopian transfer (ZIFT), case rate	BR		BR	
S4015		Complete in vitro fertilization cycle, not otherwise specified, case rate	BR		BR	
S4016		Frozen in vitro fertilization cycle, case rate	BR		BR	
S4017		Incomplete cycle, treatment cancelled prior to stimulation, case rate	BR		BR	
S4018		Frozen embryo transfer procedure cancelled before transfer, case rate	BR		BR	
S4020		In vitro fertilization procedure cancelled before aspiration, case rate	BR		BR	
S4021		In vitro fertilization procedure cancelled after aspiration, case rate	BR		BR	
S4022		Assisted oocyte fertilization, case rate	BR		BR	
S4023		Donor egg cycle, incomplete, case rate	BR		BR	
S4025		Donor services for in vitro fertilization (sperm or embryo), case rate	BR		BR	
S4026		Procurement of donor sperm from sperm bank	BR		BR	
S4027		Storage of previously frozen embryos	BR		BR	
S4028		Microsurgical epididymal sperm aspiration (MESA)	BR		BR	
S4030		Sperm procurement and cryopreservation services; initial visit	BR		BR	
S4031		Sperm procurement and cryopreservation services; subsequent visit	BR		BR	
S4035		Stimulated intrauterine insemination (IUI), case rate	BR		BR	
S4037		Cryopreserved embryo transfer, case rate	BR		BR	
S4040		Monitoring and storage of cryopreserved embryos, per 30 days	BR		BR	
S4042		Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle	BR		BR	
S4981		Insertion of levonorgestrel-releasing intrauterine system	BR		BR	
S4989		Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies	BR		BR	
S4990		Nicotine patches, legend	BR		BR	
S4991		Nicotine patches, nonlegend	BR		BR	
S4993		Contraceptive pills for birth control	BR		BR	
S4995		Smoking cessation gum	BR		BR	
S5000		Prescription drug, generic	BR		BR	
S5001		Prescription drug, brand name	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S5010		5% dextrose and 0.45% normal saline, 1000 ml	BR		BR	
S5011		5% dextrose in lactated ringer's, 1000 ml	BR		BR	
S5012		5% dextrose with potassium chloride, 1000 ml	BR		BR	
S5013		5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1000 ml	BR		BR	
S5014		5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1500 ml	BR		BR	
S5035		Home infusion therapy, routine service of infusion device (e.g., pump maintenance)	BR		BR	
S5036		Home infusion therapy, repair of infusion device (e.g., pump repair)	BR		BR	
S5100		Day care services, adult; per 15 minutes	BR		BR	
S5101		Day care services, adult; per half day	BR		BR	
S5102		Day care services, adult; per diem	BR		BR	
S5105		Day care services, center-based; services not included in program fee, per diem	BR		BR	
S5108		Home care training to home care client, per 15 minutes	BR		BR	
S5109		Home care training to home care client, per session	BR		BR	
S5110		Home care training, family; per 15 minutes	BR		BR	
S5111		Home care training, family; per session	BR		BR	
S5115		Home care training, nonfamily; per 15 minutes	BR		BR	
S5116		Home care training, nonfamily; per session	BR		BR	
S5120		Chore services; per 15 minutes	BR		BR	
S5121		Chore services; per diem	BR		BR	
S5125		Attendant care services; per 15 minutes	BR		BR	
S5126		Attendant care services; per diem	BR		BR	
S5130		Homemaker service, NOS; per 15 minutes	BR		BR	
S5131		Homemaker service, NOS; per diem	BR		BR	
S5135		Companion care, adult (e.g., IADL/ADL); per 15 minutes	BR		BR	
S5136		Companion care, adult (e.g., IADL/ADL); per diem	BR		BR	
S5140		Foster care, adult; per diem	BR		BR	
S5141		Foster care, adult; per month	BR		BR	
S5145		Foster care, therapeutic, child; per diem	BR		BR	
S5146		Foster care, therapeutic, child; per month	BR		BR	
S5150		Unskilled respite care, not hospice; per 15 minutes	BR		BR	
S5151		Unskilled respite care, not hospice; per diem	BR		BR	
S5160		Emergency response system; installation and testing	BR		BR	
S5161		Emergency response system; service fee, per month (excludes installation and testing)	BR		BR	
S5162		Emergency response system; purchase only	BR		BR	
S5165		Home modifications; per service	BR		BR	
S5170		Home delivered meals, including preparation; per meal	BR		BR	
S5175		Laundry service, external, professional; per order	BR		BR	
S5180		Home health respiratory therapy, initial evaluation	BR		BR	
S5181		Home health respiratory therapy, NOS, per diem	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S5185		Medication reminder service, nonface-to-face; per month	BR		BR	
S5190		Wellness assessment, performed by nonphysician	BR		BR	
S5199		Personal care item, NOS, each	BR		BR	
S5497		Home infusion therapy, catheter care/maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S5498		Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem	BR		BR	
S5501		Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S5502		Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (	BR		BR	
S5517		Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting	BR		BR	
S5518		Home infusion therapy, all supplies necessary for catheter repair	BR		BR	
S5520		Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion	BR		BR	
S5521		Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion	BR		BR	
S5522		Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included)	BR		BR	
S5523		Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)	BR		BR	
S5550		Insulin, rapid onset, 5 units	BR		BR	
S5551		Insulin, most rapid onset (Lispro or Aspart); 5 units	BR		BR	
S5552		Insulin, intermediate acting (NPH or LENTE); 5 units	BR		BR	
S5553		Insulin, long acting; 5 units	BR		BR	
S5560		Insulin delivery device, reusable pen; 1.5 ml size	BR		BR	
S5561		Insulin delivery device, reusable pen; 3 ml size	BR		BR	
S5565		Insulin cartridge for use in insulin delivery device other than pump; 150 units	BR		BR	
S5566		Insulin cartridge for use in insulin delivery device other than pump; 300 units	BR		BR	
S5570		Insulin delivery device, disposable pen (including insulin); 1.5 ml size	BR		BR	
S5571		Insulin delivery device, disposable pen (including insulin); 3 ml size	BR		BR	
S8030		Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	BR		BR	
S8035		Magnetic source imaging	BR		BR	
S8037		Magnetic resonance cholangiopancreatography (MRCP)	BR		BR	
S8040		Topographic brain mapping	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S8042		Magnetic resonance imaging (MRI), low-field	BR		BR	
S8049		Intraoperative radiation therapy (single administration)	BR		BR	
S8055		Ultrasound guidance for multifetal pregnancy reduction(s), technical component (only to be used when the physician doing the reduction procedure does not perform the ultrasound, guidance is included in the CPT code for multifetal pregnancy reduction (5986	BR		BR	
S8080		Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical	BR		BR	
S8085		Fluorine-18 fluorodeoxyglucose (F-18 FDG) imaging using dual-head coincidence detection system (nondedicated PET scan)	BR		BR	
S8092		Electron beam computed tomography (also known as ultrafast CT, cine CT)	BR		BR	
S8096		Portable peak flow meter	BR		BR	
S8097		Asthma kit (including but not limited to portable peak expiratory flow meter, instructional video, brochure, and/or spacer)	BR		BR	
S8100		Holding chamber or spacer for use with an inhaler or nebulizer; without mask	BR		BR	
S8101		Holding chamber or spacer for use with an inhaler or nebulizer; with mask	BR		BR	
S8110		Peak expiratory flow rate (physician services)	BR		BR	
S8120		Oxygen contents, gaseous, 1 unit equals 1 cubic foot	BR		BR	
S8121		Oxygen contents, liquid, 1 unit equals 1 pound	BR		BR	
S8130		Interferential current stimulator, 2 channel	BR		New	
S8131		Interferential current stimulator, 4 channel	BR		New	
S8185		Flutter device	BR		BR	
S8186		Swivel adaptor	BR		BR	
S8189		Tracheostomy supply, not otherwise classified	BR		BR	
S8210		Mucus trap	BR		BR	
S8262		Mandibular orthopedic repositioning device, each	BR		BR	
S8265		Haberman feeder for cleft lip/palate	BR		BR	
S8270		Enuresis alarm, using auditory buzzer and/or vibration device	BR		BR	
S8301		Infection control supplies, not otherwise specified	BR		BR	
S8415		Supplies for home delivery of infant	BR		BR	
S8420		Gradient pressure aid (sleeve and glove combination), custom made	BR		BR	
S8421		Gradient pressure aid (sleeve and glove combination), ready made	BR		BR	
S8422		Gradient pressure aid (sleeve), custom made, medium weight	BR		BR	
S8423		Gradient pressure aid (sleeve), custom made, heavy weight	BR		BR	
S8424		Gradient pressure aid (sleeve), ready made	BR		BR	
S8425		Gradient pressure aid (glove), custom made, medium weight	BR		BR	
S8426		Gradient pressure aid (glove), custom made, heavy weight	BR		BR	
S8427		Gradient pressure aid (glove), ready made	BR		BR	
S8428		Gradient pressure aid (gauntlet), ready made	BR		BR	
S8429		Gradient pressure exterior wrap	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S8430		Padding for compression bandage, roll	BR		BR	
S8431		Compression bandage, roll	BR		BR	
S8450		Splint, prefabricated, digit (specify digit by use of modifier)	BR		BR	
S8451		Splint, prefabricated, wrist or ankle	BR		BR	
S8452		Splint, prefabricated, elbow	BR		BR	
S8460		Camisole, postmastectomy	BR		BR	
S8490		Insulin syringes (100 syringes, any size)	BR		BR	
S8930		Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with patient	BR		New	
S8940		Equestrian/hippotherapy, per session	BR		BR	
S8948		Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	BR		BR	
S8950		Complex lymphedema therapy, each 15 minutes	BR		BR	
S8990		Physical or manipulative therapy performed for maintenance rather than restoration	BR		BR	
S8999		Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event)	BR		BR	
S9001		Home uterine monitor with or without associated nursing services	BR		BR	
S9007		Ultrafiltration monitor	BR		BR	
S9015		Automated EEG monitoring	BR		BR	
S9024		Paranasal sinus ultrasound	BR		BR	
S9025		Omnicardiogram/cardiointegram	BR		BR	
S9034		Extracorporeal shockwave lithotripsy for gall stones (if performed with ERCP, use 43265)	BR		BR	
S9055		Procuren or other growth factor preparation to promote wound healing	BR		BR	
S9056		Coma stimulation per diem	BR		BR	
S9061		Home administration of aerosolized drug therapy (e.g., Pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9083		Global fee urgent care centers	BR		BR	
S9088		Services provided in an urgent care center (list in addition to code for service)	BR		BR	
S9090		Vertebral axial decompression, per session	BR		BR	
S9097		Home visit for wound care	BR		BR	
S9098		Home visit, phototherapy services (e.g., Bili-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem	BR		BR	
S9109		Congestive heart failure telemonitoring, equipment rental, including telescale, computer system and software, telephone connections, and maintenance, per month	BR		BR	
S9110		Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month	BR		New	
S9117		Back school, per visit	BR		BR	
S9122		Home health aide or certified nurse assistant, providing care in the home; per hour	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9123		Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)	BR		BR	
S9124		Nursing care, in the home; by licensed practical nurse, per hour	BR		BR	
S9125		Respite care, in the home, per diem	BR		BR	
S9126		Hospice care, in the home, per diem	BR		BR	
S9127		Social work visit, in the home, per diem	BR		BR	
S9128		Speech therapy, in the home, per diem	BR		BR	
S9129		Occupational therapy, in the home, per diem	BR		BR	
S9131		Physical therapy; in the home, per diem	BR		BR	
S9140		Diabetic management program, follow-up visit to non-MD provider	BR		BR	
S9141		Diabetic management program, follow-up visit to MD provider	BR		BR	
S9145		Insulin pump initiation, instruction in initial use of pump (pump not included)	BR		BR	
S9150		Evaluation by ocularist	BR		BR	
S9152		Speech therapy, re-evaluation	BR		BR	
S9208		Home management of preterm labor, including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infus	BR		BR	
S9209		Home management of preterm premature rupture of membranes (PPROM), including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not	BR		BR	
S9211		Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any	BR		BR	
S9212		Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any	BR		BR	
S9213		Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately); per diem (do not use this code with any home infu	BR		BR	
S9214		Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any hom	BR		BR	
S9325		Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with S9326,	BR		BR	
S9326		Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9327		Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9328		Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9329		Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9	BR		BR	
S9330		Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9331		Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9335		Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem	BR		BR	
S9336		Home infusion therapy, continuous anticoagulant infusion therapy (e.g., Heparin), administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9338		Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9339		Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9340		Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	BR		BR	
S9341		Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	BR		BR	
S9342		Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	BR		BR	
S9343		Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9345		Home infusion therapy, antihemophilic agent infusion therapy (e.g., factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9346		Home infusion therapy, alpha-1-proteinase inhibitor (e.g., Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9347		Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs	BR		BR	
S9348		Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per d	BR		BR	
S9349		Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9351		Home infusion therapy, continuous or intermittent antiemetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem	BR		BR	
S9353		Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9355		Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9357		Home infusion therapy, enzyme replacement intravenous therapy; (e.g., Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9359		Home infusion therapy, antitumor necrosis factor intravenous therapy; (e.g., Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S9361		Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9363		Home infusion therapy, antispasmotic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9364		Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs othe	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9365		Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid for	BR		BR	
S9366		Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formu	BR		BR	
S9367		Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN form	BR		BR	
S9368		Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty ami	BR		BR	
S9370		Home therapy, intermittent antiemetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9372		Home therapy; intermittent anticoagulant injection therapy (e.g., Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not	BR		BR	
S9373		Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes S	BR		BR	
S9374		Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9375		Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately)	BR		BR	
S9376		Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately	BR		BR	
S9377		Home infusion therapy, hydration therapy; more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem	BR		BR	
S9379		Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9381		Delivery or service to high risk areas requiring escort or extra protection, per visit	BR		BR	
S9401		Anticoagulation clinic, inclusive of all services except laboratory tests, per session	BR		BR	
S9430		Pharmacy compounding and dispensing services	see page		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9433		Medical food nutritionally complete, administered orally, providing 100% of nutritional intake	BR		BR	
S9434		Modified solid food supplements for inborn errors of metabolism	BR		BR	
S9435		Medical foods for inborn errors of metabolism	BR		BR	
S9436		Childbirth preparation/Lamaze classes, nonphysician provider, per session	BR		BR	
S9437		Childbirth refresher classes, nonphysician provider, per session	BR		BR	
S9438		Cesarean birth classes, nonphysician provider, per session	BR		BR	
S9439		VBAC (vaginal birth after cesarean) classes, nonphysician provider, per session	BR		BR	
S9441		Asthma education, nonphysician provider, per session	BR		BR	
S9442		Birthing classes, nonphysician provider, per session	BR		BR	
S9443		Lactation classes, nonphysician provider, per session	BR		BR	
S9444		Parenting classes, nonphysician provider, per session	BR		BR	
S9445		Patient education, not otherwise classified, nonphysician provider, individual, per session	BR		BR	
S9446		Patient education, not otherwise classified, nonphysician provider, group, per session	BR		BR	
S9447		Infant safety (including CPR) classes, nonphysician provider, per session	BR		BR	
S9449		Weight management classes, nonphysician provider, per session	BR		BR	
S9451		Exercise classes, nonphysician provider, per session	BR		BR	
S9452		Nutrition classes, nonphysician provider, per session	BR		BR	
S9453		Smoking cessation classes, nonphysician provider, per session	BR		BR	
S9454		Stress management classes, nonphysician provider, per session	BR		BR	
S9455		Diabetic management program, group session	BR		BR	
S9460		Diabetic management program, nurse visit	BR		BR	
S9465		Diabetic management program, dietitian visit	BR		BR	
S9470		Nutritional counseling, dietitian visit	BR		BR	
S9472		Cardiac rehabilitation program, nonphysician provider, per diem	BR		BR	
S9473		Pulmonary rehabilitation program, nonphysician provider, per diem	BR		BR	
S9474		Enterostomal therapy by a registered nurse certified in enterostomal therapy, per diem	BR		BR	
S9475		Ambulatory setting substance abuse treatment or detoxification services, per diem	BR		BR	
S9476		Vestibular rehabilitation program, nonphysician provider, per diem	BR		BR	
S9480		Intensive outpatient psychiatric services, per diem	BR		BR	
S9482		Family stabilization services, per 15 minutes	BR		BR	
S9484		Crisis intervention mental health services, per hour	BR		BR	
S9485		Crisis intervention mental health services, per diem	BR		BR	
S9490		Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9494		Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use thi	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9497		Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S9500		Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S9501		Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S9502		Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per	BR		BR	
S9503		Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9504		Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9529		Routine venipuncture for collection of specimen(s), single homebound, nursing home, or skilled nursing facility patient	BR		BR	
S9537		Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately),	BR		BR	
S9538		Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem	BR		BR	
S9542		Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9558		Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9559		Home injectable therapy, interferon, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9560		Home injectable therapy; hormonal therapy (e.g., leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
S9562		Home injectable therapy, palivizumab, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	BR		BR	
S9590		Home therapy, irrigation therapy (e.g., sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded se	BR		BR	
S9810		Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	BR		BR	
S9900		Services by a Journal-listed Christian Science practitioner for the purpose of healing, per diem	BR		BR	
S9970		Health club membership, annual	BR		BR	
S9975		Transplant related lodging, meals and transportation, per diem	BR		BR	
S9976		Lodging, per diem, not otherwise classified	BR		BR	
S9977		Meals, per diem, not otherwise specified	BR		BR	
S9981		Medical records copying fee, administrative	BR		BR	
S9982		Medical records copying fee, per page	BR		BR	
S9986		Not medically necessary service (patient is aware that service not medically necessary)	BR		BR	
S9988		Services provided as part of a Phase I clinical trial	BR		BR	
S9989		Services provided outside of the United States of America (list in addition to code(s) for services(s))	BR		BR	
S9990		Services provided as part of a Phase II clinical trial	BR		BR	
S9991		Services provided as part of a Phase III clinical trial	BR		BR	
S9992		Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion	BR		BR	
S9994		Lodging costs (e.g., hotel charges) for clinical trial participant and one caregiver/companion	BR		BR	
S9996		Meals for clinical trial participant and one caregiver/companion	BR		BR	
S9999		Sales tax	BR		BR	
V2020		Frames, purchases	61.41		59.09	
V2025		Deluxe frame	BR		BR	2097.37**
V2100		Sphere, single vision, plano to plus or minus 4.00, per lens	36.92		36.92	
V2101		Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	38.91		38.91	
V2102		Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	54.73		54.73	
V2103		Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	32.06		32.06	
V2104		Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	35.50		35.50	
V2105		Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	38.65		38.65	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V2106		Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	42.90		42.90	
V2107		Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	40.80		40.80	
V2108		Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	42.24		42.24	
V2109		Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	46.73		46.73	
V2110		Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	46.12		46.12	
V2111		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	48.07		48.07	
V2112		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	52.48		52.48	
V2113		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	59.14		59.14	
V2114		Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	64.07		64.07	
V2115		Lenticular (myodisc), per lens, single vision	69.73		69.73	
V2118		Aniseikonic lens, single vision	69.13		69.13	
V2121		Lenticular lens, per lens, single	71.36		71.36	
V2199		Not otherwise classified, single vision lens	BR		BR	
V2200		Sphere, bifocal, plano to plus or minus 4.00d, per lens	48.32		48.32	
V2201		Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	52.67		52.67	
V2202		Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	61.98		61.98	
V2203		Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	48.75		48.75	
V2204		Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	50.96		50.96	
V2205		Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	55.10		55.10	
V2206		Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	59.20		59.20	
V2207		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	53.86		53.86	
V2208		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	56.52		56.52	
V2209		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	60.86		60.86	
V2210		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	67.12		67.12	
V2211		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	69.61		69.61	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V2212		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	71.89		71.89	
V2213		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	72.61		72.61	
V2214		Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	78.93		78.93	
V2215		Lenticular (myodisc), per lens, bifocal	80.12		80.12	
V2218		Aniseikonic, per lens, bifocal	95.35		95.35	
V2219		Bifocal seg width over 28mm	41.97		41.97	
V2220		Bifocal add over 3.25d	34.04		34.04	
V2221		Lenticular lens, per lens, bifocal	83.26		83.26	
V2299		Specialty bifocal (by report)	BR		BR	
V2300		Sphere, trifocal, plano to plus or minus 4.00d, per lens	61.51		61.51	
V2301		Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens	72.51		72.51	
V2302		Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	77.30		77.30	
V2303		Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	60.54		60.54	
V2304		Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens	63.34		63.34	
V2305		Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens	73.39		73.39	
V2306		Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	75.56		75.56	
V2307		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	71.54		71.54	
V2308		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	74.98		74.98	
V2309		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	81.68		81.68	
V2310		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	80.71		80.71	
V2311		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	83.98		83.98	
V2312		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	84.47		84.47	
V2313		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	94.33		94.33	
V2314		Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens	101.30		101.30	
V2315		Lenticular, (myodisc), per lens, trifocal	112.47		112.47	
V2318		Aniseikonic lens, trifocal	138.26		138.26	
V2319		Trifocal seg width over 28 mm	46.81		46.81	
V2320		Trifocal add over 3.25d	49.38		49.38	
V2321		Lenticular lens, per lens, trifocal	110.86		110.86	
V2399		Specialty trifocal (by report)	BR		BR	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V2410		Variable asphericity lens, single vision, full field, glass or plastic, per lens	84.52		84.52	
V2430		Variable asphericity lens, bifocal, full field, glass or plastic, per lens	101.86		101.86	
V2499		Variable sphericity lens, other type	BR		BR	
V2500		Contact lens, PMMA, spherical, per lens	76.61		76.61	
V2501		Contact lens, PMMA, toric or prism ballast, per lens	116.70		116.70	
V2502		Contact lens PMMA, bifocal, per lens	143.76		143.76	
V2503		Contact lens, PMMA, color vision deficiency, per lens	132.40		132.40	
V2510		Contact lens, gas permeable, spherical, per lens	104.58		104.58	
V2511		Contact lens, gas permeable, toric, prism ballast, per lens	150.27		150.27	
V2512		Contact lens, gas permeable, bifocal, per lens	177.57		177.57	
V2513		Contact lens, gas permeable, extended wear, per lens	149.07		149.07	
V2520		Contact lens, hydrophilic, spherical, per lens	98.30		98.30	
V2521		Contact lens, hydrophilic, toric, or prism ballast, per lens	171.15		171.15	
V2522		Contact lens, hydrophilic, bifocal, per lens	166.55		166.55	
V2523		Contact lens, hydrophilic, extended wear, per lens	141.93		141.93	
V2530		Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	210.22		210.22	
V2531		Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)	461.51		461.51	
V2599		Contact lens, other type	BR		BR	
V2600		Hand held low vision aids and other nonspectacle mounted aids	BR		BR	
V2610		Single lens spectacle mounted low vision aids	BR		BR	
V2615		Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	BR		BR	
V2623		Prosthetic eye, plastic, custom	846.09		846.09	
V2624		Polishing/resurfacing of ocular prosthesis	57.38		57.38	
V2625		Enlargement of ocular prosthesis	348.87		348.87	
V2626		Reduction of ocular prosthesis	188.06		188.06	
V2627		Scleral cover shell	1214.54		1214.54	
V2628		Fabrication and fitting of ocular conformer	286.78		286.78	
V2629		Prosthetic eye, other type	BR		BR	
V2630		Anterior chamber intraocular lens	BR		BR	
V2631		Iris supported intraocular lens	BR		BR	
V2632		Posterior chamber intraocular lens	BR		BR	
V2700		Balance lens, per lens	41.30		41.30	
V2702		Deluxe lens feature	BR		BR	2097.37**
V2710		Slab off prism, glass or plastic, per lens	60.43		60.43	
V2715		Prism, per lens	10.95		10.95	
V2718		Press-on lens, Fresnel prism, per lens	26.91		26.91	
V2730		Special base curve, glass or plastic, per lens	19.88		19.88	
V2744		Tint, photochromatic, per lens	15.47		15.47	

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V2745		Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	9.68		9.68	
V2750		Antireflective coating, per lens	17.99		17.99	
V2755		U-V lens, per lens	15.66		15.66	
V2756		Eye glass case	BR		BR	2097.37**
V2760		Scratch resistant coating, per lens	15.10		15.10	
V2761		Mirror coating, any type, solid, gradient or equal, any lens material, per lens	13.59		13.59	
V2762		Polarization, any lens material, per lens	50.48		50.48	
V2770		Occluder lens, per lens	18.39		18.39	
V2780		Oversize lens, per lens	11.81		11.81	
V2781		Progressive lens, per lens	BR		BR	
V2782		Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	54.52		54.52	
V2783		Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	61.48		61.48	
V2784		Lens, polycarbonate or equal, any index, per lens	39.98		39.98	
V2785		Processing, preserving and transporting corneal tissue	BR		BR	
V2786		Specialty occupational multifocal lens, per lens	BR		BR	
V2787		Astigmatism correcting function of intraocular lens	BR		BR	2097.37**
V2788		Presbyopia correcting function of intraocular lens	BR		BR	2097.37**
V2790		Amniotic membrane for surgical reconstruction, per procedure	BR		BR	
V2797		Vision supply, accessory and/or service component of another HCPCS vision code	BR		BR	
V2799		Vision service, miscellaneous	BR		BR	
V5008		Hearing screening	47.03		47.03	2097.37**
V5010		Assessment for hearing aid	61.66		61.66	2097.37**
V5011		Fitting/orientation/checking of hearing aid	96.14		96.14	2097.37**
V5014		Repair/modification of a hearing aid	116.00		116.00	2097.37**
V5020		Conformity evaluation	54.08		54.08	2097.37**
V5030		Hearing aid, monaural, body worn, air conduction	853.77		853.77	2097.37**
V5040		Hearing aid, monaural, body worn, bone conduction	648.95		648.95	2097.37**
V5050		Hearing aid, monaural, in the ear	750.31		750.31	2097.37**
V5060		Hearing aid, monaural, behind the ear	627.00		627.00	2097.37**
V5070		Glasses, air conduction	348.51		348.51	2097.37**
V5080		Glasses, bone conduction	875.71		875.71	2097.37**
V5090		Dispensing fee, unspecified hearing aid	311.41		311.41	2097.37**
V5095		Semi-implantable middle ear hearing prosthesis	BR		BR	2097.37**
V5100		Hearing aid, bilateral, body worn	1404.74		1404.74	2097.37**
V5110		Dispensing fee, bilateral	316.64		316.64	2097.37**
V5120		Binaural, body	1227.88		1227.88	2097.37**
V5130		Binaural, in the ear	1306.25		1306.25	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V5140		Binaural, behind the ear	1358.50		1358.50	2097.37**
V5150		Binaural, glasses	1450.46		1450.46	2097.37**
V5160		Dispensing fee, binaural	379.07		379.07	2097.37**
V5170		Hearing aid, CROS, in the ear	1008.95		1008.95	2097.37**
V5180		Hearing aid, CROS, behind the ear	853.77		853.77	2097.37**
V5190		Hearing aid, CROS, glasses	997.98		997.98	2097.37**
V5200		Dispensing fee, CROS	314.02		314.02	2097.37**
V5210		Hearing aid, BICROS, in the ear	1096.21		1096.21	2097.37**
V5220		Hearing aid, BICROS, behind the ear	1053.36		1053.36	2097.37**
V5230		Hearing aid, BICROS, glasses	1088.89		1088.89	2097.37**
V5240		Dispensing fee, BICROS	325.00		325.00	2097.37**
V5241		Dispensing fee, monaural hearing aid, any type	BR		BR	2097.37**
V5242		Hearing aid, analog, monaural, CIC (completely in the ear canal)	BR		BR	2097.37**
V5243		Hearing aid, analog, monaural, ITC (in the canal)	BR		BR	2097.37**
V5244		Hearing aid, digitally programmable analog, monaural, CIC	BR		BR	2097.37**
V5245		Hearing aid, digitally programmable, analog, monaural, ITC	BR		BR	2097.37**
V5246		Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	BR		BR	2097.37**
V5247		Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	BR		BR	2097.37**
V5248		Hearing aid, analog, binaural, CIC	BR		BR	2097.37**
V5249		Hearing aid, analog, binaural, ITC	BR		BR	2097.37**
V5250		Hearing aid, digitally programmable analog, binaural, CIC	BR		BR	2097.37**
V5251		Hearing aid, digitally programmable analog, binaural, ITC	BR		BR	2097.37**
V5252		Hearing aid, digitally programmable, binaural, ITE	BR		BR	2097.37**
V5253		Hearing aid, digitally programmable, binaural, BTE	BR		BR	2097.37**
V5254		Hearing aid, digital, monaural, CIC	BR		BR	2097.37**
V5255		Hearing aid, digital, monaural, ITC	BR		BR	2097.37**
V5256		Hearing aid, digital, monaural, ITE	BR		BR	2097.37**
V5257		Hearing aid, digital, monaural, BTE	BR		BR	2097.37**
V5258		Hearing aid, digital, binaural, CIC	BR		BR	2097.37**
V5259		Hearing aid, digital, binaural, ITC	BR		BR	2097.37**
V5260		Hearing aid, digital, binaural, ITE	BR		BR	2097.37**
V5261		Hearing aid, digital, binaural, BTE	BR		BR	2097.37**
V5262		Hearing aid, disposable, any type, monaural	BR		BR	2097.37**
V5263		Hearing aid, disposable, any type, binaural	BR		BR	2097.37**
V5264		Ear mold/insert, not disposable, any type	BR		BR	2097.37**
V5265		Ear mold/insert, disposable, any type	BR		BR	2097.37**
V5266		Battery for use in hearing device	BR		BR	2097.37**
V5267		Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	BR		BR	2097.37**
V5268		Assistive listening device, telephone amplifier, any type	BR		BR	2097.37**

DME Fees

Code	Mod	Description	2013 Amount	2013 APC Amount	2010 Amount	2010 APC Amount
V5269		Assistive listening device, alerting, any type	BR		BR	2097.37**
V5270		Assistive listening device, television amplifier, any type	BR		BR	2097.37**
V5271		Assistive listening device, television caption decoder	BR		BR	2097.37**
V5272		Assistive listening device, TDD	BR		BR	2097.37**
V5273		Assistive listening device, for use with cochlear implant	BR		BR	2097.37**
V5274		Assistive listening device, not otherwise specified	BR		BR	2097.37**
V5275		Ear impression, each	BR		BR	2097.37**
V5281		Assistive listening device, personal FM/DM system, monaural (1 receiver, transmitter, microphone), any type	BR		New	
V5282		Assistive listening device, personal FM/DM system, binaural (2 receivers, transmitter, microphone), any type	BR		New	
V5283		Assistive listening device, personal FM/DM neck, loop induction receiver	BR		New	
V5284		Assistive listening device, personal FM/DM, ear level receiver	BR		New	
V5285		Assistive listening device, personal FM/DM, direct audio input receiver	BR		New	
V5286		Assistive listening device, personal blue tooth FM/DM receiver	BR		New	
V5287		Assistive listening device, personal FM/DM receiver, not otherwise specified	BR		New	
V5288		Assistive listening device, personal FM/DM transmitter assistive listening device	BR		New	
V5289		Assistive listening device, personal FM/DM adapter/boot coupling device for receiver, any type	BR		New	
V5290		Assistive listening device, transmitter microphone, any type	BR		New	
V5298		Hearing aid, not otherwise classified	BR		BR	2097.37**
V5299		Hearing service, miscellaneous	BR		BR	
V5336		Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	BR		BR	2097.37**
V5362		Speech screening	BR		BR	2097.37**
V5363		Language screening	BR		BR	2097.37**
V5364		Dysphagia screening	BR		BR	2097.37**

** CMS APC error