

October 2, 1989

SUBJECT: INSURANCE

WITHDRAWN

Circular Letter No. 14 (1989)

TO: AUTOMOBILE SELF-INSURERS AND INSURERS LICENSED TO WRITE AUTOMOBILE INSURANCE IN NEW YORK STATE

RE: NO-FAULT REIMBURSEMENT SCHEDULES FOR HOSPITAL:

(A) INPATIENT SERVICES RENDERED ON AND AFTER JANUARY 1, 1986; AND

(B) INPATIENT SERVICES RENDERED ON AND AFTER JANUARY 1, 1987

Pursuant to Regulation No. 83, 11 NYCRR 68.2; the no-fault rate schedules' for reimbursing hospital services provided under § 5102(a)(1) of the Insurance Law shall be those established, for workers' compensation by the Chair of the Workers' Compensation Board (WCB). These rates have now been established for hospital inpatient services in conformity with Chapter 767 of the Laws of 1977, as amended and § 2807-a of the Public Health Law; as amended.

Attached are two rate schedules duly established by the WCB Chair:

(a) the first revised per diem schedule to reimburse hospitals for inpatient services rendered during the period January 1, 1986 through December 31, 1986.

(b) the second per diem schedule to reimburse hospitals for inpatient services, rendered during the period January 1, 1987 through December 31, 1987.

Please note that the Health Department has determined that inpatient hospital admissions prior to January 1, 1988 shall be reimbursed on a per diem basis, rather than by the Diagnosis-Related Group (DRG) approach, effective January 1, 1988 for inpatient reimbursement as discussed in Circular Letter Nos. 11 and 18 (1988).

Very truly yours,

[SIGNATURE]

James P. Corcoran

Superintendent of Insurance

To: Medical Fee Schedule Users

Subject: Amendments to September 1986 Medical Fee Schedule

Attached are amendments to the September 1986 Workers' Compensation Board Schedule of Medical Fees. The

amendments to the Medical Fee. Schedule, which include changes in Dollar Conversion Factors, apply to Medical, Physical Therapy and Occupational Therapy services rendered on or after September 1, 1989.

For services rendered prior to September 1, 1989, please refer to previously issued material.

NOTE: Effective 1-1-89, the fees listed in this schedule are applicable to services rendered under the Volunteer Ambulance Workers' Benefit Law.

Barbara Patton

Chairwoman

CONVERSION FACTORS

This schedule is divided into seven sections, each containing a coded listing of procedures pertinent to the section, with unit values assigned on a relativity basis to each section therein. The relativity within any one section is applicable to that particular section only. Familiarize yourself with the instructions preceding each section. In submitting reports and bills, list the 5 digit code(s) that identifies the service(s) performed (it is not necessary to describe the service if the 5 digit code is enumerated).

BILLING: The unit values reflect relativity, not fees. To determine the fee for a procedure, it is necessary to multiply the unit value of each procedure by the dollar conversion factor applicable to the particular section in effect on the date the service was rendered.

The Chairman has established four regions within New York State based on the difference in cost of maintaining a medical practice in different localities of the State. The Chairman has defined each such region by use of the U.S. Postal Service Zip Codes for the State of New York, based upon the relative cost factors which are compatible with that region.

The fees payable for medical care and treatment shall be determined by the Region in which the services were rendered.

REGIONAL CONVERSION FACTORS - effective September 1, 1986

SECTIONS	REGION 1	REGION 2	REGION 3	REGION 4
Medicine	\$ 4.88	\$ 5.11	\$ 5.85	\$ 6.36
Physical Therapy	4.30	4.51	5.16	5.61
Anesthesia	16.74	17.52	20.05	21.81
Surgery	123.66	129.42	148.12	161.00
Radiology	31.35	32.82	37.55	40.82
Pathology	.76	.80	.91	1.00

REGIONAL CONVERSION FACTORS - effective September 1, 1987

SECTIONS	REGION 1	REGION 2	REGION 3	REGION 4
Medicine	\$ 5.10	\$ 5.35	\$ 6.12	\$ 6.65
Physical Therapy	4.61	4.83	5.53	6.01
Anesthesia	17.51	18.33	20.97	22.81
Surgery	129.35	135.37	154.93	168.41
Radiology	32.79	3433	39.28	42.70

REGIONAL CONVERSION FACTORS - effective September 1, 1987

SECTIONS	REGION 1	REGION 2	REGION 3	REGION 4
Pathology	.79	.84	.95	1.05

REGIONAL CONVERSION FACTORS - effective September 1, 1988

SECTIONS	REGION 1	REGION 2	REGION 3	REGION 4
Medicine	\$ 5.39	\$ 5.65	\$ 6.46	\$ 7.02
Physical Therapy	4.82	5.05	5.78	6.29
Occupational Therapy	4.82	5.05	5.78	6.29
Anesthesia	18.49	19.36	22.14	24.09
Surgery	136.59	142.95	163.61	177.84
Radiology	34.63	36.25	41.48	45.09
Pathology	.83	.89	1.00	1.11

REGIONAL CONVERSION FACTORS - effective September 1, 1989

SECTIONS	REGION 1	REGION 2	REGION 3
Medicine,	\$ 5.71	\$ 5.98	\$ 6.84
Physical Therapy	5.10	5.35	6.12
Occupational Therapy	5.10	5.35	6.12
Anesthesia	19.58	20.50	23.45
Surgery	144.65	151.38	173.26
Radiology	36.67	38.39	43.93
Pathology	.88	.94	1.06

POSTAL ZIP CODES INCLUDED IN EACH REGION

Region I		Region II		Region IV	
From,	Thru	From	Thru	From	Thru
12007	12099	12180	12183	10001	10099
12106	12177	12201	12257	10301	10314
12184	12199	12301	12345	10401	10475
12401	12498	12501	12594	11001	11050
12701	12792	12601	12614	11101	11111
12801	12887	13201	13260	11201	11252
12901	12998	13440		11301	11390
13020	13094	13501	13503	11401	11460
13101	13167	13901	13905	11501	11598
13301	13368	14201	14265	11601	11697
13401	13439	14601	14692	11701	11798

Region I		Region II		Region IV	
From,	Thru	From	Thru	From	Thru
13441	13495			11801	11819
13601	13698				
13730	13797				
13801	13865				
Region III					
		From	Thru		
14001	14098	10501	10598		
14101	14174	10601	10650		
14301	14305	10701	10710		
14410	14489	10801	10805		
14501	14592	10901	10998		
14701	14788	11901	11980		
14801	14898				
14901	14905				

NUMERICAL LIST OF POSTAL ZIP CODES

From	Thru	Region	From	Thru	Region
10001	10099	IV	12601	12614	II
10301	10314	IV	12701	12792	I
10401	10475	IV	12801	12887	I
10501	10598	III	12901	12998	I
10601	10650	III	13020	13094	I
10701	10710	III	13101	13176	I
10801	10805	III	13201	13260	II
10901	10998	III	13301	13368	I
11001	11050	IV	13401	13439	I
11101	11111	IV	13440		II
11201	11252	IV	13441	13495	I
11301	11390	IV	13501	13503	II
11401	11460	IV	13601	13698	I
11501	11598	IV	13730	13797	I

From	Thru	Region	From	Thru	Region
11601	11697	IV	13801	13865	I
11701	11798	IV	13901	13905	II
11801	11819	IV	14001	14098	I
11901	11980	III	14101	14174	I
12007	12099	I	14201	14265	II
12106	12177	I	14301	14305	I
12180	12183	II	14410	14489	I
12184	12199	I	14501	14592	I
12201	12257	II	14601	14692	II
12301	12345	II	14701	14788	I
12401	12498	I	14801	14898	I
12501	12594	II	14901	14905	I

MEDICINE

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The unit values listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed "unit value" by the current dollar "conversion factor" applicable to this section, subject to the Ground Rules, Instructions and Definitions of the Schedule.

MEDICINE GROUND RULES

General information and Instructions

1. GENERAL: Visits, examinations, consultations and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or injury. The listed relativities apply only when these services are performed by or under the responsible and direct supervision of a physician unless otherwise stated.
2. Specialists rendering services outside their field of specialization as designated by Workers' Compensation Board Coding may charge only general practitioner fees. A specialist shall be paid a specialist's fee only if the injuries sustained or the services rendered are within the scope of his specialty and the services of specialists are indicated or required. (See page 6 for specialist codings and scope restrictions.)
3. Fees indicated for examinations or visits by specialists are payable only to specialists with "C" ratings. Physicians with specialty ratings such as "IM,S" etc., (without the "C" prefix) shall be paid three-quarters of the fee indicated as payable to a specialist with a "C" rating for an office, home or hospital call, but in no event shall the fee for a physician

with such a specialty rating be less than the fee payable to a general practitioner for the same service. (See also comprehensive level of service, page 4.)

4. If a patient is referred by a physician to a specialist for an opinion on diagnosis, prognosis, necessity and type of treatment, and such written opinion is sent to the referring physician, the insurance carrier, and the Workers' Compensation Board, a fee shall be payable for such opinion and examination in accordance with the level of service (see definitions), regardless of whether or not the specialist subsequently operates upon or treats the patient. See Ground Rule 20 below.

5. If a patient consults a specialist directly (non-referred case) and a complete examination is necessary for diagnosis, prognosis, necessity and type of treatment, and the specialist submits a report thereon to the Workers' Compensation Board and to the insurance carrier, in addition to or on the regular C-4/C-48 form, a specialist's fee is payable in accordance with the level of service (see definitions), regardless of whether or not the specialist subsequently operates upon or treats the patient.

6. A fee is payable to a specialist, in accordance with the level of service, for the examination of a patient who seeks the care of a physician either directly or by referral from another physician, in instances of elective surgery or when it is incumbent upon the specialist to examine the patient in order to make a proper diagnosis, prognosis and to decide on the necessity and type of treatment to be rendered. This fee is in addition to the unit fee prescribed for the operation or treatment subsequently rendered by the specialist except that where the therapeutic procedure or treatment is of a minor character and the fee for the procedure or treatment is in excess of the fee for the office visit, the greater fee (not both fees) is payable. Similarly, if the fee for the minor procedure or treatment is less than the fee for the office visit, the fee for the office visit alone is payable.

7. Where a physician renders treatment in the EMERGENCY ROOM of a hospital as an individual or as a member of a group under contract with the hospital, including those physicians who are hospital salaried or employed, all such services shall be paid at the general practice rates.

Where a physician enters into an agreement to cover the emergency room of a hospital on a fee-for-service basis, and is not under contract or salaried by the hospital, such physician shall be paid the fees of a general practitioner for the services rendered under the appropriate office visit category.

The above applies to all physicians regardless of specialty coding except for those physicians coded C-EM (Board Certified in Emergency Medicine) or EM (Board-eligible). C-EM's or EM's practicing under a fee-for-service agreement with a hospital shall be paid fees as set forth in the Specialist Fees section, office visits (see page 17). However, C-EM or EM remuneration shall not be at a level of reimbursement above the intermediate level with the exception of treatment of a substantiated life or limb threatening situation when the comprehensive level of service may be applicable. Consultation fees do not apply to C-EMs.

	Unit
	Value
90620	A comprehensive consultation involves an indepth evaluation of a patient with a problem requiring the development and documentation of medical data (the chief complaints, present illness, family history, past medical history, personal history, system review and physical examination, review of all diagnostic tests and

	Unit Value
procedures that have previously been done), the establishment or verification of a plan for further investigative and/or therapeutic management and the preparation of a report. For example: A young person with fever, arthritis, and anemia; or a comprehensive psychiatric consultation that may include a detailed present illness history, past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members and other informants, and preparation of a report with recommendations; or a neurological evaluation for possible intracranial pathology; or the in-depth evaluation for spinal cord pathology or a chronic back disorder	22.0

SUBSEQUENT CONSULTATIONS

	Unit Value
90640 Brief consultative follow-up visit	3.5
90641 Limited consultative follow-up visit	6.0
90642 Intermediate consultative follow-up visit and evaluation	8.5

IMMUNIZATION AND THERAPEUTIC

INJECTIONS

(For allergy testing, see 95000 et seq) (For skin testing of bacterial, viral, fungal extracts see 86400-86585)

These injections are usually given in conjunction with a medical service. The unit value for the appropriate medical service will be added to the unit values for the type of injection administered. The cost of the medication or material injected is also additional in accordance with Ground Rule 13; specify material.

	Unit Value
90745 Injection, subcutaneous No additional other than the cost of the specified injectant	0.0

		Unit Value
90746	Intramuscular or deep structures	0.83
90747	Intravenous	3.42
90798	Intravenous therapy for severe or intractable allergic disease in physician's office or institution (eg. theophyllines, corticosteroids, antihistamines)	BR
90799	Unlisted therapeutic injection	BR

PSYCHIATRIC SERVICES

Medical services may be described as coded and listed in other segments in the Medicine Section as appropriate. For initial office or hospital visit see 90010-90020; for subsequent office or hospital visit see 90040-90060; for consultations see 90600-90642. For diagnostic services performed in hospital emergency rooms, Hospital care by the attending physician in treating a psychiatric inpatient may be initial or subsequent in nature, and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations, review of activity therapy reports, supervision of nursing and ancillary personnel, and the programming of all hospital resources for diagnosis and treatment. Some patients receive hospital care services only and others receive hospital care services and other procedures. If other procedures such as electroconvulsive therapy or medical psychotherapy are rendered, these should be listed separately.

		Unit Value	Basic Anes:
90803	Psychotherapy, adult or child (verbal and/or play therapy, with or without drug management), 45-50 minutes, office	16.0	
90805	home	17.5	
90806	25 minutes, office	9.7	
90808	home	10.0	
90811	15 minutes, office	6.4	
90813	home	7.3	
90815	Group therapy (maximum 8 persons per group), per person; per session, 45-50 minutes, office	4.0	
90817	90 minutes, office	6.4	
90821	Group therapy (maximum 16 persons per group), per person, per session, 45- 50 minutes, office	3.2	
90823	90 minutes, office	4.8	

		Unit Value	Basic Anes:
90835	Narcosynthesis for psychiatric diagnostic and therapeutic purposes, e.g. sodium amobarbital (Amytal) interview	20.5	
90836	Convulsive therapy, in-patient	14.0	3.0
90838	out-patient	14.0	3.0
90840	Psychologic testing, psychometric and/or projective tests, with written report, given by or under supervision of physician, per hour (identify test(s) used)	18.5	
90860	Marathon therapy	BR	
90870	Crisis intervention	BR	
90875	Hypnotherapy, 45-50 minutes	16.0	
90876	25 minutes	9.7	
90877	15 minutes	6.4	
90880	Sleep therapy, drug induced	BR	
90885	electrically induced	BR	
90899	Unlisted psychiatric procedure	BR	

BIOFEEDBACK

Administration of biofeedback treatment is limited to qualified physicians. Those wishing to administer such treatments to patients covered by the provisions of the Workers' Compensation Law for the conditions listed below should submit evidence of their training and experience to the insurance carrier to expedite processing. Biofeedback treatments may be administered only for the following conditions:

- (a) Idiopathic Raynaud's disease
- (b) Temporomandibular Joint Dysfunction
- (c) Myofascial Pain Dysfunction Syndrome (MPD)
- (d) Tension headaches
- (e) Migraine headaches
- (f) Tinnitus
- (g) Torticollis
- (h) Neuromuscular re-education as result of neurological damage in CVA or spinal cord injury

(i) Inflammatory and/or musculoskeletal disorders usually related to the accepted condition.

Up to twelve Biofeedback treatments in a ninety day period may be allowed for the above conditions when the following is presented and authorization granted:

(a) An evaluation report documenting:

(i) The basis for the claimant's condition;

(ii) The condition's relationship to the industrial injury or illness;

(iii) An evaluation of the claimant's current functional measurable modalities (i.e., range of motion, up time, walking tolerance, medication intake, etc.);

(iv) An outline of the proposed treatment program;

(v) An outline of the expected restoration goals.

(b) No further Biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (i.e., range of motion, up time, walking tolerance, medication intake, etc.). The need for additional treatments will be determined on a case by case review in accordance with Workers' Compensation Board practices. The fees include interpretations and reports of the treatments.

When more than one of the treatments are performed on the same day, the maximum payment will be limited to 8.0 units.

	Value	Unit
90900	Biofeedback training by electromyogram application - separate procedure (one-half hour)	5.0
90901	Biofeedback training, by electromyogram application, including office visit (one-hour)	8.0
90902	In conduction disorder-separate procedure (one-half hour)	5.0
90903	In conduction disorder, including office visit (one hour)	8.0
90904	Regulation of blood pressure-separate procedure (one-half hour)	5.0
90905	Regulation of blood pressure, including office visit (one hour)	8.0
90906	Regulation of skin temperature or peripheral blood flow-separate procedure (one-half hour)	5.0
90907	Regulation of skin temperature or peripheral blood flow, including office visit (one hour)	8.0
90908	By electroencephalogram application - separate	

	Value	Unit
	procedure (one-half hour)	5.0
90909	By electroencephalogram application, including	
	office visit (one hour)	8.0
90910	By electro-oculogram application - separate	
	procedure (one-half. hour)	5.0
90911	By electro-oculogram application, including	
	office visit (.one hour)	8.0

MONITORING SERVICES

(For fetal monitoring during labor, see 59050)

The following values are for physician's services only and do not include charges for use of equipment or supplies where such charges are justified. The values apply only when the physician is engaged solely and is continuously present in the monitoring process.

	Value	Unit
90919	Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring), per hour	19.0
90920	Monitoring ECG, pressures, etc., in intrathoracic or other critical surgery, per hour (independent procedure)	16.0

DIALYSIS

The following descriptors apply only when these services are under the direct supervision of a physician and reflect only the professional component. Supplies, materials, and services of other personnel should be identified separately. If hemodialysis for acute renal failure exceeds six weeks, a further report is required. Detention time may be allowed in addition for highly complicated or unusual or extended hemodialysis if substantiated by report. If other significant, identifiable services are provided in addition to the appropriate hemodialysis procedure, list the appropriate visit for that service.

Peritoneal Dialysis

	Value	unit
90962	Acute renal failure and/or intoxication, including cannula insertion and institution of treatment program, per dialysis	80.0
90963	excluding cannula and/or catheter insertion, per dialysis	30.0

Peritoneal Dialysis

		unit Value
90964	Chronic renal failure, cannula and/or catheter insertion, per dialysis	80.0
90965	excluding cannula and/or catheter insertions with dialysis through a permanent indwelling peritoneal catheter, per dialysis	30.0

Hemodialysis

(Each of the following code numbers (90970-90981) is for a single therapeutic hemodialysis treatment.)

		Unit Value
90970	Acute renal failure and/or intoxication, initial hemodialysis	130.0
90971	second hemodialysis	80.0
90972	third hemodialysis	80.0
90973	fourth hemodialysis through end of second week, per treatment	40.0
90974	third through end of sixth week, per treatment. 20.0	

(For cannula declotting, see 36860-36861)

90980	Chronic renal failure, initial stabilization through sixth treatment, per treatment	80.0
90981	seventh stabilization through end of first month of chronic hemodialysis therapy, per treatment	30.0
90982	Hemodialysis service for a hospitalized chronic renal failure patient who is hospitalized because of an inter-current illness or for a problem related or unrelated to chronic renal failure	30.0
90983	Hemodialysis treatment per month, two treatments per week	120.0
90984	three treatments per week	180.0

PHYSICAL THERAPY

The procedure codes listed in this section apply only to services rendered by a self-employed duly licensed and registered physical therapist (PT) unless otherwise stated. Physicians rendering physical therapy should utilize the appropriate codes in the Medicine Section.

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this Section is not applicable to any other section.

The unit values listed in this section reflect the relativity for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed "unit value" by the current dollar "conversion factor" applicable to this section, subject to the Ground Rules, Instructions and Definitions of the Schedule.

Physical Therapists are advised to familiarize themselves with the appropriate Ground Rules listed in the Medicine and Surgery Sections of this Schedule.

PHYSICAL THERAPY

The fees for physical therapy services listed below are payable only when the services are rendered by a self-employed duly licensed and registered physical therapist (PT) unless otherwise stated.

Referral of patients by a physician for the treatment by a PT must be made by means of a referral which may be directive, indicating treatment plan and duration of such treatment. The Physical Therapist shall be responsible for obtaining initial authorization and reauthorization from the carrier after the twelfth physical therapy treatment or after 45 days, whichever comes first, unless previous authorization was for a longer period of time or number of treatments.

The physical therapist shall submit PT-4 reports as required by regulation.

PT's employed by physicians (i.e. not self-employed) may not bill separately from the physician-employer although the latter's billing must indicate the manner of service as delineated above.

When physical therapy is rendered in a hospital department, the hospital shall be entitled to the listed values whether or not the head of the department is C-PMR or PMR coded.

When physical therapists who are self-employed render physical therapy during the after care periods for fractures, dislocations or other post-operative procedures, fees for such treatments shall be in addition to those payable to the referring physician or physician for the after care period, notwithstanding that one or more physicians are also treating the same patient during said after-care period. The referring physician or the physical therapist must inform the employer or carrier of the need for such additional therapy and obtain authorization for such from the employer or carrier. If such authorization is refused, a determination by the Workers' Compensation Board shall be requested. The refusal of such requested authorization shall be appealable in accordance with the Workers' Compensation Law.

When it is necessary to render physical therapy in a patient's home, add 50% to the listed unit value. An explanation justifying the need for home therapy rather than in an office or out-patient hospital setting shall be submitted along with the bill.

When multiple services or procedures (different code numbers) are rendered or performed on one day, the payments

will be limited to the greatest allowable fee plus one-half of the lesser fee(s) up to a maximum of twice the highest fee.

ELECTROMYOGRAPHY:

		Unit Value
	(See codes 95860-95869 and addendum thereto).	
T95860	Electromyography, one extremity and related paraspinal areas	12.0
T95861	two extremities and related paraspinal areas	21.6
T95863	three extremities and related paraspinal areas	26.4
195864	four extremities and related paraspinal areas	31.2
T95867	cranial nerve supplied muscles, unilateral	15.6
T95868	bilateral	23.4
T95869	Limited study of specific muscles, e.g., external anal sphincter, thoracic spinal muscles, etc	12.0

MODALITIES

Codes 97000 through 97201 apply whether treatment is rendered to one or more areas on any one day. List Modalities used.

		Unit Value
T97000	Office visit with one or more of the following modalities initial 30 minutes	3.0
	a. Hot or cold packs	
	b. Traction, mechanical	
	c. Electrical stimulation	
	d. Vasopneumatic devices	
	e. Paraffin bath	
	f. Microwave	
	g. Whirlpool	
	h. Diathermy	
	i. Infrared	
	j. Ultraviolet	
	k. Other (identify)	

		Unit Value
T97001	maximum additional 1.1	
PHYSICAL THERAPY (T97100-T97799)		
PROCEDURES		
Physical therapist is required to be in constant attendance		
		Unit Value
T97100	Office visit with one or more of the following procedures, initial 30 minutes	3.8
	<ul style="list-style-type: none"> a. Therapeutic exercises b. Neuromuscular re-education c. Functional activities d. Gait training e. Electrical stimulation (manual) f. Iontophoresis g. Traction, manual h. Massage i. Contrast baths j. Isokinetic or Isometric exercises (eg. Cybex) k. Ultrasound l. Laser m. Other (identify) 	
T97101	maximum additional	1.8
T97200	Office visit including combination of any modality (ies) and procedures(s) initial 30 minutes	4.7
T97201	maximum additional	1.7
T97220	Hubbard tank, initial 30 minutes	5.4

		Unit Value
T97221	each additional 15 minutes (maximum allowance, one hour)	1.1
197240	Pool therapy or Hubbard tank with therapeutic exercises initial 30 minutes	6.6
T97241	each additional 15 minutes (maximum allowance, one hour)	1.4
T97500	Orthotics training (dynamic bracing, splinting etc) initial 30 minutes	4.5
T97501	each additional 15 minutes (maximum allowance, one hour)	0.9
197520	Prosthetic training, initial 30 minutes allowance, one hour)	4.5
T97521	each additional 15 minutes (maximum allowance, one hour)	1.7
197540	Activities of daily with adequate report to be submitted (initial and separate procedure)	4.5
T97541	each additional 15 minutes (maximum allowance, one hour) (For subsequent ADL training, use code T97100) (For muscle testing, manual or electrical, joint range of motion, electromyography or nerve velocity determination, use 95842 et seq)	1.3
T97700	Office visit, including one of the following tests or measurements, with adequate report a. Orthotic "check-out" b. Prosthetic "check-out" c. Activities of daily living "check-out" initial 30 minutes	6.8
T97101	each additional 15 minutes	1.9

		Unit Value
197702	maximum allowance	9.8
	machine) initial testing	7.3
T97752	Muscle testing, torque curves during isometric and isokinetic exercise (eg. by use of Cybex	
T97753	subsequent retesting	5.3
	(applicable only after suitable period of therapy	
T97799	Unlisted physical therapy service or procedure.	BR

OCCUPATIONAL THERAPY

The procedure codes listed in this section apply only to services rendered by a self-employed duly licensed and registered Occupational Therapist (OT). Physicians rendering occupational therapy should utilize the appropriate codes in the Medicine Section.

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this Section is not applicable to any other section.

The fee for a particular procedure or service in this section is determined by multiplying the listed "unit value" by the current dollar "conversion factor" applicable to this section, subject to the Ground Rules, Instructions and Definitions of the Schedule.

Occupational Therapists are advised to familiarize themselves with the appropriate Ground Rules listed in the Medicine and Surgery Sections of this Schedule.

AUDITORY SYSTEM EXTERNAL EAR

(For diagnostic services, such as
audiometric, vestibular and
speech tests, see 92551 et seq)

INCISION

		Unit Value	Follow-up Days	Basic Anes:
*69000	Drainage, external ear, abscess or hematoma	*0.25	0	4
*69020	Drainage, external auditory canal, abscess	*0.25	0	4
69350	Otoscopy, under general			

INCISION

Unit Value	Follow-up Days	Basic Anes:
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EXCISION

69100	Biopsy, external ear	0.45	0	4
69105	Biopsy, external auditory canal	0.45	0	4
69110	Excision, external ear, partial	1.9	30	4
69120	complete amputation (For reconstructive of ear, see 15100 et seq., bone and cartilage grafts)	5.1	90	4
69140	Excision, exostosis(es), external auditory canal	7.7	90	4
69145	Excision, soft tissue lesion, external auditory canal	0.35	30	4
69150	Radical excision, external auditory canal lesion, without neck dissection	14.4	90	4
69155	with neck dissection	19.2	90	6

(for resection of temporal bone, see 69535)

(For skin grafts and flaps, see 15000 et seq.)

REMOVAL, FOREIGN BODY

*69200	Removal, foreign body from external auditory canal, without general anesthesia	*0.25	0	
69205	with general anesthesia one or both ears (separate procedure)	1.3	7	4
		0.25	0	4

REPAIR

(For suture of wound or injury of

INCISION

		Unit Value	Follow-up Days	Basic Anes:
	external ear, see 12011-14062)			
	Unit Follow-up Basic Value Days Anes:			
69300	Otoplasty for protruding ear, with or without size reduction, unilateral	5.8	90	4
69301	bilateral	8.3	90	4
69320	Reconstruction, external auditory canal for congenital atresia, single stage (For combination with middle ear reconstruction, see 69631 or 69641) (For other reconstructive procedures with grafts [skin, cartilage, bone], see 13150- 15730, 21230-21235)	BR		4

OTHER PROCEDURES

69350	Otoscopy, under general anesthesia	1.3	7	4
69399	Unlisted Procedure on external ear	BR		4

MIDDLE EAR

INTRODUCTION

69400	Eustachian tube inflation, transnasal, with catheterization	0.2	0	4
69401	without catheterization	0.2	0	4

INCISION

*69420	Myringotomy, including aspiration and/or eustachian tube inflation	*0.35	0	4
*69424	Ventilating tube removal when originally inserted by another			

INCISION

		Unit Value	Follow-up Days	Basic Anes:
	physician, unilateral	*0.35	0	4
*69425	bilateral	*0.45	0	4
*69433	Tympanostomy (requiring insertion of ventilating tube) local or topical, anesthesia,			
	unilateral	*0.65	0	4
*69434	bilateral	*0.9	0	4
69436	general anesthesia, unilateral	2.3	15	4
69437	bilateral	3.2	15	4
69440	Middle ear exploration through post auricular or ear canal incision (For atticotomy, see 69601 et seq)	6.4	30	5

EXCISION

69501	Transmastoid antrotomy	6.4	90	5
69502	Mastoidectomy, complete	10.0	90	5
69505	modified radical	13.0	90	5
69511	radical (For skin graft, see 15100 et seq.)	13.0	90	6
69530	Petrous apicectomy including radical mastoidectomy	20.8	90	5

An error occurred in the processing of a table at this point in the document. Please refer to the table in the online document.

Basic

Anes:

69535

	Basic Anes:
69540	4
69550	
	4
69552	5
69554	5
REPAIR	
69601	
	5
69603	5
69604	5
69605	5
*69610	
	4
69620	
	4
69631	
	5
69632	

Basic
Anes:

69635 5

69636 5

69637 5

69641 5

69642 5

69643 5

69644 5

69645 5

69646

69650 5

Basic
Anes:

	5
69666	5
69667	5
69670	
	5
69675	5
OTHER PROCEDURE	
69700	
	4
69720	
	9
69740	
	5
69745	
	5
69799	5
INNER EAR INCISION	
69801	
	5

RADIOLOGY

Including Nuclear Medicine and Diagnostic Ultrasound

GROUND RULES

1. **GENERAL:** Listed values for radiology procedures apply only when these services are performed by or under the supervision of a physician, with CR ratings. The listed values for Nuclear Medicine also apply to those physicians with C-NUM ratings.

Fees for physicians with R ratings shall be three-fourths of fees indicated. Fees payable to qualified specialists (C-rated but other than C-R) for items listed in this section, and within the scope of their specialty, shall be two-thirds of the indicated fees, except that full fees are payable to those physicians who are certified by the American Board of Neurological Surgery or the American Board of Psychiatry and Neurology as Neurologists, who perform and interpret CT scans for neurological diagnoses. Fees for all other physicians, including those for items outside the scope of their coding, shall be one-half of the indicated values.

Consultations and referrals for diagnostic and therapeutic radiology are to be done only by specialists, with CR & R ratings.

Physicians qualified as general practitioners with the GP ratings, treating patients under their general medical care are permitted to take x-rays, but radiology requiring the use of ingestion or injection of foreign substance, shall be limited to qualified specialists within their specialty and physicians with the R ratings.

2. **DUPLICATION OF X-RAYS:** Every attempt should be made to minimize the number of x-rays taken. The attending doctor or any other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes should make these x-rays available upon request.

No payments shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to re-x-ray.

The use of photographic 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.

3. **MULTIPLE DIAGNOSTIC X-RAY PROCEDURES:** The following adjustments apply:

- a. For two contiguous parts, the charge shall be the greater fee plus 50% of the lesser fee.
- b. For two remote parts, the charge shall be the greater fee plus 75% of the lesser fee.
- c. For three or more parts, whether contiguous or remote, the charge shall be the greatest fee plus 75% of the total of the lesser fees.
- d. Where more than one part is included in a single line item, it shall be charged for as a single line item. Any additional item examined shall be considered under paragraph a, b, or c above, whichever pertains.
- e. No charge shall be made for comparative x-rays except when such x-rays are specifically authorized by the carrier or the chairman. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in this formula (3a-3d).
- f. X-Rays of different areas taken on different but proximate dates and related to the injury or problem necessitating the first x-ray studies, and which could have reasonably been performed at one time, shall be subject to rules a through e above.

4. **XERORADIOGRAPHY:** Imaging performed by this process shall have the identical values listed for conventional x-ray procedures of the same area and views.

5. **MULTIPLE SERVICES OTHER THAN DIAGNOSTIC RADIOLOGY:** When multiple or bilateral procedures or services are provided at the same session, the highest fee procedure will be reported as listed. The other procedure (s) will be billed for in accordance with Surgery ground rule 5.

6. **UNIT VALUES:** The total unit value includes professional services plus expenses of personnel, materials, including usual contrast media and drugs, space, equipment and other facilities. Values for injection procedures include all usual pre and post-injection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media. Supplies and materials provided by the physician (e.g. sterile trays, radioisotopes, etc.) over and above those usually included with or necessitated by the services rendered may be charged for separately; in these instances, list items individually on bill. See Medicine ground rule 13.

The total unit value includes the professional component (see PC unit value below) plus the technical component (TC). This value is applicable in any situation in which a single charge is made to include both professional, services and the technical cost of providing that service. Identification of a procedure by its 5-digit code without modifier -26 or -27 indicates that the charge includes both the "professional" and "technical" components.

The PC unit value (professional component unit value) represents the value of the professional radiological services of the physician. This includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination including images, and consultation with the referring physician. This component is applicable in any situation in which the physician submits a charge for these professional services only. It does not include the cost of personnel, materials, space, equipment or other facilities. To identify a charge for professional component, use the 5-digit procedure code followed by modifier -26. (See modifier -26 and rule 15 for use of modifiers.)

When this section of the Schedule is used in connection with a "conversion factor" to establish fees, it must be emphasized that the conversion factor cannot be applied to both the TOTAL UNIT VALUE and the PROFESSIONAL COMPONENT UNIT VALUE. Physicians who determine their fees by application of conversion factors to the unit values in this section must determine a separate factor for TOTAL UNIT VALUE and for PC UNIT VALUE.

The technical component includes the charges for personnel, materials, including usual contrast media and drugs, film or xerograph, space, equipment and other facilities but excludes the cost of radioisotopes. No unit values are listed for the technical component of radiology procedures, since these are institutional charges not billed separately by physicians. To identify a charge for the technical component, use the 5-digit procedure code followed by modifier -27. (See modifier -27 and Rule 15 for use of modifiers). The total cost of a procedure(s) (PC plus TC) cannot exceed the total unit value cost of the procedure(s).

Fees are for a competent diagnosis by image, expert interpretation and opinion. Size and number of films are not relevant except as indicated by minimum number listed for respective procedures.

7. **NECESSITY OF SERVICES OR PROCEDURES:** When a patient is referred to radiologists or other specialists for services covered in the Radiology Section, they shall evaluate the patient's problem and determine the service(s) or procedure(s) medically necessary. Such evaluations and necessary consultation with the referring physician(s) is an integral part of the professional component unit value and does not merit any additional charges.

8. **REPORTS AND CUSTODY OF X-RAYS AND OTHER RECORDED IMAGES:** C48 and C4 reports are not acceptable. A written report of the findings must be submitted in quadruplicate; mail one to the district office of the

Workers' Compensation Board, one to the attending physician and retain one for your records; the fourth to accompany bill to insurance carrier, if known, or to the employer.

Films or other recorded images shall be preserved for at least six years (but in no case shall they be destroyed without a report of the findings of such images being filed, as a permanent record). They (or satisfactory reproductions) shall be made available to the attending physician, insurance carrier or self-insured employer. When requested, carriers and self-insured employers shall return original films to the physician within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays and satisfactory reproductions are furnished in lieu of the original films, a fee of four dollars (\$ 4.00) may be charged for the first sheet of duplicating film and two dollars (\$ 2.00) for each additional sheet of film. These reproductions are not returnable to the physician. Copies of images produced by copiers (e.g. Xerox) shall not merit any additional payment and shall not be returnable to the physician; such copies should accompany the bill submitted for the particular, imaging procedure. (The use of photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure.)

In cases where the patient transfers from one physician to another the former treating physician will promptly forward all images or copies of such to the new attending physician.

9. MATERIALS SUPPLIED BY PHYSICIAN: Supplies and materials provided by the physician (e.g., sterile trays, drugs, etc.) over and above those usually included with the office visit or other services rendered may be charged for separately. (List drugs, trays, materials or supplies provided.) Radiopharmaceutical or other radionuclide material cost: Listed values in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost (See Medicine ground rule 13.)

10. INJECTION PROCEDURES: Values for injection procedures include all usual pre-and post-injection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter and injection of contrast media.

Vascular injection procedures are listed in the cardiovascular section, under procedure codes 36000-36299. Other injection procedures are listed in appropriate sections.

11. "BR" (BY REPORT) ITEMS: "BR" in the value column (s) indicates that the value of that service is to be determined by report because the service is too unusual, variable or new to be assigned a unit value (s).

Submit a special report describing 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 which may be helpful might include:
Complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

12. UNLISTED SERVICE OR PROCEDURE: A service or procedure may be provided that is not listed in this Fee Schedule. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, identifying it by report ("BR"). See 11. above.

13. SUBSECTION INFORMATION: Several of the subheadings or subsections have special needs or instructions unique to that section. Where these are indicated, e.g. "Therapeutic Radiology," special "NOTES" will be presented preceding those procedural terminology listings, referring to that subsection specifically. If there is an "Unlisted Procedure" code number (see item 12) for the individual subsection it will be shown. Those subsections with "NOTES" are as follows.

Subsection	Code Numbers
Diagnostic Ultrasound	76500-76999
Therapeutic Radiology	77261-77999
Nuclear Medicine	78000-79999

14. MISCELLANEOUS:

a.) Emergency services rendered between 10 p.m. and 8 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. Submit report (See 11 above and Medicine ground rules 7 & 8).

b.) Values for office, home and hospital visits, consultation and other medical services, anesthesia, surgical and laboratory procedures are listed in the sections entitled "Medicine," "Anesthesia," "Surgery," and "Pathology."

15. UNIT VALUE MODIFIERS:

-26 Professional Component: When the professional component unit value only is applicable, identify by adding this modifier (-26) to the usual procedure number(s). Charges shall be in accordance with the "PC Unit Value" for that procedure(s).

-27 Technical Component: When the professional component is charged for separately from the total unit value, the technical component will also be charged for separately. The technical component unit value will be the total value, less the professional component value. Identify by adding this modifier (-27) to the usual procedure(s) code number(s).

See item 6 above for correct conversion factor applicable to -26 and -27.

16. CT SCAN RECONSTRUCTION: (effective September 1, 1989)

An additional fee up to a maximum of \$ 100 may be permitted for CT scan reconstruction. This additional fee shall be payable only when the reconstruction is requested by the primary care physician. The request must follow a review of the regular CT scan film and only if there is a specifically stated need for clarification via reconstruction.

The fee for reconstruction must be submitted on a separate bill with a separate report and a copy of the primary care physician's request.

17. MAGNETIC RESONANCE IMAGING: (effective September 1, 1989)

The fees for Magnetic Resonance Imaging shall be as follows: Professional component: 4 Radiology units for an MRI of any one part of the body Technical component: see chart below

Region I	Region II	Region III	Region IV	
Technical component	\$ 611	\$ 635	\$ 654	\$ 670

The fees payable for an MRI study include both standard and axial views.

The provisions of Radiology Ground Rules 1 and 3 apply to Magnetic Resonance Imaging.

DIAGNOSTIC RADIOLOGY

HEAD AND NECK

		PC Unit Value	Total Unit Value
70002	Pneumoencephalography, supervision and interpretation only	3.3	9.0
70003	complete procedure	9.0	15.0
	(For injection procedure for pneumoencephalography, see 61053, 62286)		
70010	Myelography, posterior fossa, supervi- sion and interpretation only	3.0	7.5
70011	complete procedure	5.5	10.0
	(For injection procedure only for myelography, see 61052)		
70015	Cisternography, positive contrast supervision and interpretation only	3.0	7.5
70016	complete procedure	5.5	10.0
	(For injection procedure only for cisternography, see 61053)		
70020	Ventriculography, air contrast, supervi- sion and interpretation only	3.0	7.5
70021	positive contrast, supervision and interpretation only	3.0	7.5
	(For injection procedure only for ventriculography, see		

HEAD AND NECK

	PC Unit Value	Total Unit Value
61025, 61120)		
70022 Stereotactic localization, head	4.0	9.0
70030 Eye, for foreign body detection	0.8	2.0
70040 for localization of foreign body (70030 not included)	1.5	3.0
70050 combined 70030 and 70040	2.0	4.0
70100 Mandible, partial, less than four views	0.6	1.5
70110 complete, minimum of four views	0.8	2.0
70120 Mastoids, less than three views per side	0.7	1.7
70130 complete, minimum of three views per side	1.0	2.5
70131 Internal auditory meati, complete	1.0	2.5
70140 Facial bones, less than three views	0.6	1.5
70150 complete, minimum of three views	0.8	2.0
70160 Nasal bones, complete, minimum of three views	0.6	1.5
70170 Dacryocystography, (nasolacrimal duct), supervision and interpretation only	0.8	2.0
70171 complete procedure	2.3	3.5
(For injection procedure only for dacryocystography, see 68850)		
70190 Optic foramina	0.6	1.5
70200 Orbits, complete, minimum of four views	0.8	2.0
70210 Sinuses, paranasal, less than three views	0.6	1.5
70220 complete, minimum of three views,		

HEAD AND NECK

	PC Unit	Total Unit
	Value	Value
	0.8	2.0
70230 without contrast studies		
70230 with contrast studies, in addition to 70220, supervision and interpretation only	0.9	2.5
70231 with contrast studies, in addition to 70220, complete procedure	4.8	6.0
70240 Sella turcica	0.7	1.7
70250 Skull, less than four views, with or without stereo	0.6	1.5
70260 complete, minimum of four views, with or without stereo	1.2	3.0
70300 Teeth, single view	0.2	0.5
70310 partial examination, less than full mouth	0.4	1.0
70320 complete full mouth	0.8	2.0
70328 Temporomandibular joint, open and closed mouth, unilateral	0.6	1.5
70330 bilateral	1.0	2.5
70332 Temporomandibular joint arthrotomography (includes a contrast arthrogram and appropriate laminographic studies); supervision and interpretation only	2.0	4.5
70333 complete procedure	4.0	6.5
(For injection procedure only for arthrotomography, see 21116)		
70350 Cephalogram, orthodontic	0.4	1.0
70355 Orthopantogram	0.4	1.0
70360 Neck, soft tissue	0.4	1.0
70370 pharynx or larynx, including		

HEAD AND NECK

	PC Unit Value	Total Unit Value
fluoroscopy and/or magnification technique	1.0	2.5
70373 Laryngography, contrast, supervision and interpretation only	1.2	3.0
70374 complete procedure	3.0	4.5
(For injection procedure only for laryngography, see 31708)		
70380 Radiologic examination, salivary gland for calculus	0.6	1.5
70390 Sialography, supervision and interpretation only	0.8	2.0
70391 complete procedure	2.3	3.5
(For injection procedure only for sialography, see 42550)		
70400 Orbitography, all or positive contrast, supervision and interpretation only	1.8	4.5
(For injection procedure only for orbitography, see 67510)		
70401 complete procedure	5.7	9.0
70450 Computerized axial tomography, head, without contrast material	4.0	8.5
70460 with contrast material(s)	4.0	10.5
70470 without intravenous contrast material, followed by contrast material(s) and further sections	5.0	12.0
70480 Computerized axial tomography, orbit, sella, or posterior		

HEAD AND NECK

		PC Unit Value	Total Unit Value
	fossa or outer, middle, or inner ear, without contrast material	4.0	8.5
		PC Unit Value	Total Unit Value
75718	by serialography, complete procedure.	10.5	16.5
75722	Angiography, renal, unilateral, selective, supervision and interpretation only	3.0	12.0
75723	complete procedure	9.6	18.0
75724	Angiography, renal, bilateral, selective (including flush aortogram), supervision and interpretation only	4.5	13.5
75725	complete procedure	13.2	21.0
75726	Angiography, visceral, selective or subselective, supervision and interpretation only	3.9	13.5
75727	selective (including flush aortogram), complete procedure	11.1	21.0
75728	subselective, complete procedure	13.2	22.5
	(For selective angiography, additional visceral vessels, studied after basic examination, see 75772, 75773)		
75731	Angiography, adrenal, unilateral, selective, supervision and interpretation only	3.3	12.0
75732	complete procedure	11.1	19.5
75733	Angiography, adrenal, bilateral selective, supervision and interpretation only	4.8	13.5
75734	complete procedure	15.0	22.5
75736	Angiography, pelvic, selective or supraselective, supervision and interpretation only	3.0	9.0

		PC Unit Value	Total Unit Value
75737	selective; complete procedure	7.5	13.5
75738	supraselective, complete procedure	9.6	15.0
75741	Angiography, pulmonary, unilateral, selective, supervision and interpretation only	3.0	9.0
75742	complete procedure	9.6	15.0
75743	Angiography, pulmonary, bilateral, selective, supervision and interpretation only	4.5	10.5
75744	complete procedure	11.1	18.0
75746	Angiography, pulmonary, by nonselective catheter or venous injection, supervision and interpretation only	3.0	9.0
75747	catheter, nonselective, complete procedure	9.0	15.0
75748	venous injection, complete procedure	5.7	12.0
75750	Angiography, coronary, root injection, supervision and interpretation only	3.9	12.0
75751	complete procedure	9.6	16.5
75752	Angiography, coronary, unilateral selective injection, including left ventricular and supra-ventricular angiogram and pressure recording, supervision and interpretation only	3.9	15.0
75753	complete procedure	15.0	27.0
75754	Angiography, coronary, bilateral selective injection, including left ventricular and supra-ventricular angiogram and pressure recording, supervision and interpretation only	5.7	21.0
75755	complete procedure	18.9	34.5
75756	Angiography, internal mammary, supervision and interpretation only	1.8	9.0
75757	complete procedure	9.6	16.5
75762	Angiography, coronary bypass,		

		PC Unit Value	Total Unit Value
	unilateral selective injection, supervision and interpretation only	3.9	15.0
75764	complete procedure	15.0	27.0
75766	Angiography, coronary bypass, multiple selective injection, supervision and interpretation only	5.7	21.0
75767	complete procedure	18.9	34.5
75772	Angiography, visceral, selective, additional vessels studied after basic examination, supervision and interpretation only	3.5	10.5
75773	complete procedure	8.5	10.5

VEINS AND LYMPHATICS

For injection procedure only for venous system, see 36400-36510) For injection procedure only for lymphatic system, see 38790-38794)

		PC Unit Value	Total Unit Value
75801	Lymphangiography, extremity only, unilateral, supervision and interpretation only	1.8	7.5
75802	complete procedure	7.5	13.5
75803	Lymphangiography, extremity only, bilateral, supervision and interpretation only	3.0	9.0
75804	complete procedure	9.6	15.0
75805	Lymphangiography, pelvic/abdominal, unilateral, supervision and interpretation only	2.4	7.5
75806	complete procedure	7.5	13.5
75807	Lymphangiography, pelvic/abdominal, bilateral, supervision and interpretation only	3.3	9.0
75808	complete procedure	10.2	15.0
75810	Splenoportography, supervision and		

		PC Unit Value	Total Unit Value
	interpretation only	1.8	7.5
75811	complete procedure	7.5	13.5
75820	Venography, extremity, unilateral, supervision and interpretation only	1.5	4.5
75821	complete procedure	3.9	6.5
75822	Venography, extremity, bilateral, supervision and interpretation only	1.2	6.0
75823	complete procedure	5.7	9.0
75825	Venography, caval, inferior with serialography, supervision and interpretation only	1.8	6.0
75826	complete procedure	5.7	9.0
75827	Venography, caval, superior, with serialography, supervision and interpretation only	1.8	6.0
75828	complete procedure	5.7	9.0
75831	Venography, renal, unilateral, selective, supervision and interpretation only	2.7	6.5
75832	complete procedure	6.3	10.5
75833	Venography, renal, bilateral, selective, supervision and interpretation only	4.2	7.5
75834	complete procedure	9.6	13.5
75840	Venography, adrenal, unilateral, selective, supervision and interpretation only	2.7	6.5
75841	complete procedure	7.5	12.0
75842	bilateral, selective, supervision and interpretation only	4.2	7.5
75843	complete procedure	13.2	18.0
75845	Venography, azygos, selective or nonselective, supervision and interpretation only	2.4	6.0
		PC Unit Value	Total Unit Value
75846	selective, complete procedure	7.5	12.0

		PC Unit Value	Total Unit Value
75847	non-selective, complete procedure	6.3	10.5
75850	Venography, intraosseous, supervision and interpretation only	2.4	6.0
75851	complete procedure	5.7	9.0
75860	Venography, sinus or jugular, catheter, supervision and interpretation only	3.9	9.0
75861	complete procedure	9.6	14.5
75870	Venography, superior sagittal sinus, supervision and interpretation only	3.0	7.5
75871	direct puncture, complete procedure	7.5	12.0
75880	Venography, orbital, supervision and interpretation only	1.8	6.0
75881	complete procedure	5.7	10.0
75885	Percutaneous transhepatic portography with hemodynamic evaluation, supervision and interpretation only	3.0	8.5
75886	complete procedure	10.5	15.0
75887	Percutaneous transhepatic portography without hemodynamic evaluation, supervision and interpretation only	2.9	8.4
75888	complete procedure	10.0	14.5
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, supervision and interpretation only	3.5	10.4
75890	complete procedure	8.5	10.5
75891	Hepatic venograph, wedged or free without hemodynamic evaluation, supervision and interpretation only	3.4	10.3
75892	complete procedure	8.4	10.4
75893	Venous sampling through catheter without angiography (eg. for parathyroid hormone, renin)	10.	15.0

TRANSCATHETER THERAPY AND BIOPSY

		PC Unit Value	Total Unit Value
75894	Transcatheter therapy, embolization, including angiography, supervision and interpretation only	3.5	18.4
75895	complete procedure	10.5	15.0
75896	Transcatheter therapy, infusion, including angiography, supervision and interpretation only	3.5	10.4
75897	complete procedure	10.5	15.0
75898	Angiogram through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	3.5	10.5
75950	Transcatheter, intravascular occlusion, temporary; supervision and interpretation only	3.5	10.4
75951	complete procedure	10.5	15.0
75955	Transcatheter intravascular occlusion, permanent, supervision and interpretation only	3.5	10.5
75956	complete procedure	10.5	15.0
75961	Transcatheter retrieval, percutaneous, of fractured venous or arterial catheter	10.0	12.0
75970	Transcatheter biopsy, supervision and interpretation only	3.0	7.5
75971	complete procedure (For transcatheter renal and ureteral biopsy, see 52007, 52107) (For percutaneous needle biopsy of pancreas, see 48102; of retroperitoneal lymph node or mass, see 49180)	9.5	12.5
75972	Percutaneous transluminal angioplasty, unilateral, supervision and interpretation only	6.5	13.5
75973	complete procedure	30.0	37.0
75974	Percutaneous transluminal angioplasty, bilateral, single catheter, supervision and interpretation only	8.5	15.0

		PC Unit Value	Total Unit Value
75975	complete procedure	35.0	38.0
75976	Percutaneous transluminal angioplasty, bilateral, dual catheters, supervision and interpretation only	8.5	15.0
75977	complete procedure	35.0	38.0
75980	Percutaneous transhepatic biliary drainage with contrast monitoring, supervision and interpretation only	3.0	7.5
75981	complete procedure	30.0	37.5
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, supervision and interpretation only	4.5	9.5
75983	complete procedure	30.0	37.5
75985	Change of percutaneous drainage catheter with contrast monitoring (ie. biliary tract, urinary tract) complete procedure	3.0	7.5
	(For injection procedure only for percutaneous biliary drainage, see 47510)		
75990	Drainage of abscess, percutaneous, with radiologic guidance (ie. fluoroscopy, ultrasound or computerized tomography) with or without placement of indwelling catheter	8.5	15.0
	(75990 is neither organ nor area specific. For drainage of abscess performed without radiology or fluoroscopy, see under specific anatomic site.)		

MISCELLANEOUS

(For arthrography of shoulder, see 73040, 73041; elbow, see 73085, 73086; wrist, see 73115, 73116; hip, see 73525, 73526, knee, see 73580, 73581; ankle, see 73615, 73616)

		PC Unit Value	Total Unit Value
76000	Fluoroscopy, (separate procedure) other than 71034	1.3	0
76020	Bone age studies	0.6	1.5
76040	Bone length studies (orthoroentgenogram, scanogram)	1.0	2.5
76061	Radiologic examination, osseous survey, limited (eg. for metastases)	2.0	4.5
76062	complete (axial and appendicular. skeleton)	BR	BR
76065	infant	0.8	2.0
76080	Radiologic examination, fistula or sinus tract study, supervision and interpretation only	1.0	2.5
76081	complete procedure	2.5	4.0
		PC Unit Value	Total Unit Value
76086	Mammary ductogram or galactogram, unilateral, supervision and interpretation only	1.0	2.5
76087	complete procedure	1.5	3.5
76088	Mammary ductogram or galactogram, bilateral, supervision and interpretation only	1.0	2.5
76089	complete procedure (For injection procedure only for mammary ductogram or galactogram, see 19030)	1.5	3.5
76090	Mammography, unilateral	1.0	2.5
76091	bilateral	1.5	3.5
76094	Radiologic examination, localization of		

		PC Unit Value	Total Unit Value
	breast nodule or calcification before operation, with marker and confirmation of its position with appropriate imaging	2.4	4.0
76100	Radiologic examination, single plane body section (eg. tomography, planigraphy, body section radiography) (Separate procedure)	2.0	2.8
76120	Cineradiography, except where specifically included	1.1	2.8
76125	Cineradiography, to complement routine examination	0.6	1.5
76400	Magnetic Resonance: bone marrow blood supply....See page 159		
76499	Unlisted diagnostic, radiologic procedure	BR	BR

DIAGNOSTIC ULTRASOUND

NOTES

A-mode implies a one-dimensional ultrasonic measurement procedure. M-mode implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures. B-scan implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display. Real-time scan implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

HEAD AND NECK

		PC Unit Value	Total Unit Value
76500	Echoencephalography, A-mode, diencephalic midline	1.0	2.0
76505	complete (diencephalic midline and ventricular size)	1.5	3.0
76506	Echoencephalography, B-mode, (gray scale) complete (for determination of ventricular size, delineation of cerebral contents and detection of fluid, masses or other intracranial abnormalities), including A-mode encephalography as		

		PC Unit Value	Total Unit Value
	secondary component where indicated	BR	BR
76511	Echography, ophthalmic, spectral analysis with amplitude quantitation, A- mode	1.9	3.8
76512	contract B-scan	1.9	3.8
76515	tomography with or without A or M- mode	2.8	5.6
76516	Echography, ophthalmic, ultrasonic biometry, A-mode	1.3	2.6
76517	B-scan	2.8	5.6
76529	Ophthalmic ultrasonic, foreign body localization	BR	BR
76530	Echography, thyroid, A-mode	1.0	2.0
76535	B-scan	1.5	3.0
76550	Carotid imaging	1.5	3.0

(For Doppler, see 76900)

CHEST

		PC Unit Value	Total Unit Value
76601	Echography, chest, A-mode	1.2	2.5
76604	B-scan (includes mediastinum)	1.5	3.0
76620	Echocardiography, M-mode complete	1.5	4.0
76625	limited (eg. follow-up or limited studies)	1.0	2.0
76627	Echocardiography, real-time scan, complete (includes 76620)	4.0	5.6
76628	limited	3.2	4.5

(For echocardiography as a
cardiovascular procedure, see 76620-
76625)

76640	Echography, breast, A-mode	1.2	2.5
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		PC Unit Value	Total Unit Value
76645	B-scan	2.5	5.0

ABDOMEN AND RETROPERITONEUM

		PC Unit Value	Total Unit Value
76700	Echography, abdominal, B-scan, complete	3.0	6.0
76705	limited (eg. follow-up or limited studies)	2.0	4.0
76770	Echography, retroperitoneal (eg. renal, aorta, nodes), B-scan, complete	2.5	5.0
76775	limited	1.8	3.5

PELVIS

		PC Unit Value	Total Unit Value
76805	Echography, pelvic, B-scan (eg. real- time) in obstetrics, gynecology or transplants, complete	2.0	4.0
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	1.5	3.0

GENITALIA

		PC Unit Value	Total Unit Value
76870	Echography, scrotum and contents	2.0	4.0

EXTREMITIES

		PC Unit Value	Total Unit Value
76880	Echography, extremity, B-scan	1.5	3.0

VASCULAR STUD/ES

		PC Unit Value	Total Unit Value
76900	Peripheral flow study (Doppler), arterial only	1.5	3.0
76910	venous only	1.5	3.0
76920	arterial and venous	2.3	4.5
76925	Peripheral imaging, B-scan, Doppler or real-time scan	1.5	3.0

Magnetic Resonance Imaging

abdomen	74181
bone marrow blood supply	76400
brain, including brain stem	70551
chest	71550
lower extremity	73720
myocardium	75552
orbit, face and neck	70540
pelvis	72196
spinal canal and contents; cervical	72141
spinal canal and contents; lumbar	72144
spinal canal and contents; thoracic	72143
upper extremity	73220