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	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00100	ANES FOR PROCEDURES ON SALIVARY GLANDS, INCLUDING BIOPSY		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00102	ANES FOR PROCEDURES INVOLVING PLASTIC REPAIR OF CLEFT LIP		Instructions	Instructions			6	
			See Billing	See Billing				
			Manual	Manual				
00103	ANES FOR RECONSTRUCTIVE PROCED OF EYELID		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00104	ANES FOR ELECTROCONVULSIVE THERAPY		Instructions	Instructions			4	
00.0.	7 HILL OF CITY CLOTHER CONTROL THE CONTROL OF CONTROL O		See Billing	See Billing			1	+
	ANES FOR PROC ON EXTERNAL, MIDDLE, AND INNER EAR ,INC		Manual	Manual				
00120	BIOPSY		Instructions	Instructions			5	
00120			See Billing	See Billing				
			Manual	Manual				
00124	ANES FOR PROC ON EXTERNAL, MIDDLE, AND INNER EAR, OTOSCOPY		Instructions	Instructions			4	
00124	AND TOTAL TOO ON EXTERIORE, WINDBEE, AND INVIER EAR, OTOGOGIT		See Billing	See Billing			+	+
	ANES FOR PROC ON EXTERNAL, MIDDLE, AND INNER EAR,		Manual	Manual				
00126							4	
00126	TYMPANOTOMY		Instructions See Billing	Instructions See Billing			4	
			_					
00440	ANTEC FOR PROCESN EVE, NOT OTHERWISE ORGANICE		Manual	Manual			_	
00140	ANES FOR PROC ON EYE; NOT OTHERWISE SPECIFIED		Instructions	Instructions			5	1
			See Billing	See Billing				
004:5	14450 FOR RECORDURED ON EVE 1 THE STITLE OF THE		Manual	Manual				
00142	ANES FOR PROCEDURES ON EYE; LENS SURGERY		Instructions	Instructions			6	

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	•		See Billing	See Billing				
			Manual	Manual				
00144	ANES FOR PROCEDURES ON EYE; CORNEAL TRANSPLANT		Instructions	Instructions			6	
	, , , , , , , , , , , , , , , , , , , ,		See Billing	See Billing				
			Manual	Manual				
00145	ANES FOR PROCEDURES ON EYE; VITREORETINAL SURGERY		Instructions	Instructions			6	
001.0	, inter-out rescent of the first transfer of		See Billing	See Billing			+ -	
			Manual	Manual				
00147	ANES FOR PROCEDURES ON EYE; IRIDECTOMY		Instructions	Instructions			6	
00147	THE OT ON THOSE BONES ON ETE, INDEOTOWN		See Billing	See Billing			 	
			Manual	Manual				
00148	ANES FOR PROCEDURES ON EYE; OPHTHALMOSCOPY		Instructions	Instructions			1	
00146	ANES FOR PROCEDURES ON ETE, OFITTIALWOSCOFT		See Billing	See Billing			4	
	ANES FOR PROC ON NOSE AND ACCESS SINUSES; NOT OTHERISE		Manual	Manual				
00460							ļ	
00160	SPEC.	1	Instructions	Instructions			5	
	ANIEG FOR REGO ON NOOF AND ACCESS SINILISES. BARIOAL		See Billing	See Billing				
00400	ANES FOR PROC ON NOSE AND ACCESS SINUSES; RADICAL		Manual	Manual			I_	
00162	SURGERY		Instructions	Instructions			/	
			See Billing	See Billing				
	ANES FOR PROC ON NOSE AND ACCESS SINUSES; BIOPSY SOFT		Manual	Manual				
00164	TISSUE		Instructions	Instructions			4	
			See Billing	See Billing				
	ANES FOR INTRAORAL PROC, INCLUDING BIOPSY; NOT OTHERWISE		Manual	Manual				
00170	SPEC		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00172	ANES FOR INTRAORAL PROC, INCLUDING BIOPSY; REPAIR OF CLEFT		Instructions	Instructions			6	

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	les in Red;							
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	•		See Billing	See Billing	•			
	ANES FOR INTRAORAL PROC, INCLUDING BIOPSY; EXCISION OF		Manual	Manual				
00174	TUMOR		Instructions	Instructions			6	
			See Billing	See Billing				
			Manual	Manual				
00176	ANES FOR INTRAORAL PROC, INCLUDING BIOPSY; RADICAL SURGERY		Instructions	Instructions			7	
			See Billing	See Billing				
	ANES FOR PROC ON FACIAL BONES OR SKULL; NOT OTHERWISE		Manual	Manual				
00190	SPEC		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00192	ANES FOR PROC ON FACIAL BONES OR SKULL; RADICAL SURGERY		Instructions	Instructions			7	
			See Billing	See Billing				
	ANES FOR INTRACRANIAL PROCEDURES; NOT OTHERWISE		Manual	Manual				
00210	SPECIFIED		Instructions	Instructions			11	
			See Billing	See Billing				
			Manual	Manual				
00211	ANESTH, CRAN SURG, HEMOTOMA		Instructions	Instructions			10	
-	,,		See Billing	See Billing				
			Manual	Manual				
00212	ANES FOR INTRACRANIAL PROCEDURES; SUBDURAL TAPS		Instructions	Instructions			5	
		1	See Billing	See Billing	1	1	1	
			Manual	Manual				
00214	ANES FOR INTRACRANIAL PROCEDURES; BURR HOLES		Instructions	Instructions			9	
			See Billing	See Billing		1	-	
			Manual	Manual				
00215	ANES FOR INTRACRANIAL PROCEDURES; CRANIOPLASTY		Instructions	Instructions			9	

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00216	ANES FOR INTRACRANIAL PROCEDURES; VASCULAR PROCEDURES		Instructions	Instructions			15	
			See Billing	See Billing				
			Manual	Manual				
00218	ANES FOR INTRACRANIAL PROCEDURES; PROC IN SITTING POSITION		Instructions	Instructions			13	
			See Billing	See Billing				
			Manual	Manual				
00220	ANES FOR INTRACRANIAL PROC; CEREBROSPINAL FLUID SHUNTING		Instructions	Instructions			10	
			See Billing	See Billing				
	ANES FOR INTRACRANIAL PROC; ELECTROCOAGULATION OF I C		Manual	Manual				
00222	NERVE		Instructions	Instructions			6	
00222			See Billing	See Billing	+		1	
			Manual	Manual				
00300	ANES FOR ALL PROC ON THE INTEGUMENTARY SYSTEM,		Instructions	Instructions			5	
00000	THE OTT OF THE INTEGRAL THE INT		See Billing	See Billing				+
			Manual	Manual				
00320	ANES FOR ALL PROC ON ESOPHAGUS, THYROID, LARYNX, ETC		Instructions	Instructions			6	
00020	ANEOTOR ALET NOO ON EOOTHAGOO, HITKOID, LARTINA, ETO		See Billing	See Billing			-	
	ANES FOR ALL PROC ON ESOPHAGUS, THYROID, AND NEEDLE		Manual	Manual				
00322	BIOPSY		Instructions	Instructions			3	
00322		 	See Billing	See Billing	+		J	+
	ANES FOR ALL PROC ON THE LARYNX , TRACHEA, LESS THAN 1 YR		Manual	Manual				
00326	AGE		Instructions	Instructions			o	
00320	AGE			See Billing	+		8	
			See Billing	_				
00050	ANEC FOR PROCESNA IOR VECCEL C OF NEOK, NOT CREC		Manual	Manual			10	
00350	ANES FOR PROC ON MAJOR VESSELS OF NECK; NOT SPEC	<u> </u>	Instructions	Instructions	1		10	

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00352	ANES FOR PROC ON MAJOR VESSELS OF NECK; SIMPLE LIGATION		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00400	ANES FOR PROC ON THE INTEGUMENTARY SYSTEM		Instructions	Instructions			3	
			See Billing	See Billing				
	ANES FOR PROC ON THE INTEGUMENTARY SYSTEM,		Manual	Manual				
00402	RECONSTRUCTIVE		Instructions	Instructions			5	
			See Billing	See Billing				
	ANES FOR PROC ON THE INTEGUMENTARY SYSTEM, RADICAL		Manual	Manual				
00404	BREAST		Instructions	Instructions			5	
00.10.			See Billing	See Billing				
			Manual	Manual				
00406	ANES FOR PROC ON THE INTEGUMENTARY SYSTEM, AND NODE DIS.		Instructions	Instructions			13	
00.00	7 INCO TOTAL INTERESTINATION OF THE INTERESTI		See Billing	See Billing			1.0	
			Manual	Manual				
00410	ANES FOR PROC ON THE INTEGUMENTARY SYSTEM, WITH CONV.		Instructions	Instructions			4	
33110	7.1.1.2.1. S.C.I. ICO SIT III II	+	See Billing	See Billing		+	1	+
	ANES FOR PROC ON CLAVICLE AND SCAPULA; NOT OTHERWISE		Manual	Manual				
00450	SPEC		Instructions	Instructions			5	
00400		+	See Billing	See Billing		+	3	+
			Manual	Manual				
00454	ANES FOR PROC ON CLAVICLE AND SCAPULA; BIOPSY OF CLAVICLE		Instructions	Instructions			3	
00404	ANLO I OILI NOO ON OLAVIOLE AND SCAFOLA, DIOFST OF CLAVIOLE		See Billing	See Billing			+3	+
			Manual	Manual				
00470	IANIES FOR RARTIAL RIP RESECTION: NOT OTHERWISE SPECIFIED		Instructions	Instructions			6	
00470	ANES FOR PARTIAL RIB RESECTION; NOT OTHERWISE SPECIFIED		instructions	instructions			6	

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00472	ANES FOR PARTIAL RIB RESECTION; THORACOPLASTY (ANY TYPE)		Instructions	Instructions			10	
			See Billing	See Billing				
			Manual	Manual				
00474	ANES FOR PARTIAL RIB RESECTION; RADICAL PROCEDURES		Instructions	Instructions			13	
			See Billing	See Billing				
			Manual	Manual				
00500	ANES FOR ALL PROCEDURES ON ESOPHAGUS		Instructions	Instructions			15	
			See Billing	See Billing				
			Manual	Manual				
00520	ANES FOR CLOSED CHEST PROC; (INCLUDING BRONCHOSCOPY)		Instructions	Instructions			6	
	,,		See Billing	See Billing				
			Manual	Manual				
00522	ANES FOR CLOSED CHEST PROC; NEEDLE BIOPSY OF PLEURA		Instructions	Instructions			4	
00022	7 THE OF THE OFFICE OFF		See Billing	See Billing	+		1	
			Manual	Manual				
00524	ANES FOR CLOSED CHEST PROCEDURES; PNEUMOCENTESIS		Instructions	Instructions			4	
30024	THE STATE OF STATE OF THE STATE		See Billing	See Billing	+		+'	
			Manual	Manual				
00528	ANES FOR CLOSED CHEST PROC; MEDIASTINOSCOPY AND DIAG		Instructions	Instructions			8	
00020	AND DIAG		See Billing	See Billing			U	
			Manual	Manual				
00529	ANES FOR CLOSED CHEST PROC; MEDIAS AND DIAG, LUNG VENT		Instructions	Instructions			11	
00029	ANLO I ON GLOSED GHEST FROG, MEDIAS AND DIAG, LUNG VENT		See Billing	See Billing	-		111	
			Manual	Manual				
00500	ANICO FOD DEDMANIENT TO ANICVENIQUIO DA OFMAVED INICEDTION						1,	
00530	ANES FOR PERMANENT TRANSVENOUS PACEMAKER INSERTION		Instructions	Instructions			4	

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00532	ANES ACCESS TO CENTRAL VENOUS CIRCULATION		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00534	ANES FOR TRANSVENOUS INSERTION OR REPLACEMENT OF PACING		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
00537	ANES FOR CARDIAC ELECTROPHYSIOLOGIC PROCEDURES		Instructions	Instructions			10	
			See Billing	See Billing				
			Manual	Manual				
00539	ANES FOR TRACHEOBRONCHIAL RECONSTRUCTION		Instructions	Instructions			18	
			See Billing	See Billing				
			Manual	Manual				
00540	ANES FOR THORACOTOMY PROC INV LUNGS, PLEURA, ETC		Instructions	Instructions			12	
			See Billing	See Billing				
			Manual	Manual				
00541	ANES FOR THORACOTOMY PROC INV LUNGS, ETC WITH VENT		Instructions	Instructions			15	
			See Billing	See Billing	1		1.5	
			Manual	Manual				
00542	ANES FOR THORACOTOMY PROC, DECORTICATION		Instructions	Instructions			15	
33372	p. 1. 2. 2. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		See Billing	See Billing	+		1.5	+
			Manual	Manual				
00546	ANES FOR THORACOTOMY PROC, THORACOPLASTY		Instructions	Instructions			15	
00040			See Billing	See Billing	+		10	+
			Manual	Manual				
00548	ANES FOR THORACOTOMY PROC, INTRA-THORACIC		Instructions	Instructions			17	
00540	JANES FOR THURACUTURIT FROC, INTRA-THURACIC		mstructions	mstructions			[17	

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Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00550	ANES FOR STERNAL DEBRIDEMENT		Instructions	Instructions			10	
			See Billing	See Billing				
			Manual	Manual				
00560	ANES FOR PROC ON HEART, GREAT VESSELS; W/O OXYGENATOR		Instructions	Instructions			15	
			See Billing	See Billing				
	ANES FOR PROC ON HEART, GREAT VESSELS; WITH OXYG, UNDER		Manual	Manual				
00561	AGE 1		Instructions	Instructions			25	
			See Billing	See Billing			1	
	ANES FOR PROC ON HEART, GREAT VESSELS; WITH OXYG, OVER		Manual	Manual				
00562	AGE 1		Instructions	Instructions			20	
00002	1		See Billing	See Billing			120	
			Manual	Manual				
00563	ANES FOR PROC HEART, GREAT VESSELS; WITH HCA		Instructions	Instructions			25	
00000	THE TOTAL TROUBLE AND THE TRANSPORT OF T		See Billing	See Billing			120	
			Manual	Manual				
00566	ANES FOR DIRECT COR ARTERY BYPASS GRAFTING WITHOUT PUMP		Instructions	Instructions			25	
00000	ANECT OR BINEOT CORVAINTERT BIT AGG GRAFITHO WITHOUT FOR		See Billing	See Billing			20	
			Manual	Manual				
00567	ANESTH, CABG W/PUMP		Instructions	Instructions			18	
00307	ANESTH, CADO W/FUMF		See Billing	See Billing			10	+
			Manual	Manual			1	
00500	ANES FOR HEART TRANSPIANT OR HEART/LLING TRANSPIANT						20	
00580	ANES FOR HEART TRANSPLANT OR HEART/LUNG TRANSPLANT		Instructions	Instructions			20	+
			See Billing	See Billing				
00000	ANEO FOR PROGON OFFINION OFFINE AND CORP. NOT ONLY OFFICE		Manual	Manual				
00600	ANES FOR PROC ON CERVICAL SPINE AND CORD; NOT O/W SPEC		Instructions	Instructions			10	

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Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00604	ANES FOR PROC ON CERVICAL SPINE AND CORD;SIT POSITION		Instructions	Instructions			13	
			See Billing	See Billing				
			Manual	Manual				
00620	ANES FOR PROC ON THORACIC SPINE AND CORD; NOT OTHERWISE		Instructions	Instructions			10	
			See Billing	See Billing				
	ANES FOR PROC ON THORACIC SPINE AND CORD; NOT USING ONE		Manual	Manual				
00625	LUNG VENTILATION		Instructions	Instructions			13	
			See Billing	See Billing				
	ANES FOR PROC ON THORACIC SPINE AND CORD; USING ONE LUNG		Manual	Manual				
00626	VENTILATION		Instructions	Instructions			15	
			See Billing	See Billing				
			Manual	Manual				
00630	ANES FOR PROC IN LUMBAR REGION; NOT OTHERWISE SPECIFIED		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
00632	ANES FOR PROC IN LUMBAR REGION; LUMBAR SYMPATHECTOMY		Instructions	Instructions			7	
			See Billing	See Billing	1			1
			Manual	Manual				
00635	ANES FOR PROC IN LUMBAR REGION; DIAGNOSTIC OR THERAPEUTIC		Instructions	Instructions			4	
			See Billing	See Billing			1	
	ANES FOR MANIPULATION OF THE SPINE OR FOR CLOSED		Manual	Manual				
00640	PROCEDURES		Instructions	Instructions			3	
			See Billing	See Billing				†
			Manual	Manual				
00670	ANES FOR EXTENSIVE SPINE AND SPINAL CORD PROCEDURES		Instructions	Instructions			13	
30070	PARTO LOUIS OF THE WAR OUT INCOME.		mondonona	mondonona			10	

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	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
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						L .	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00700	ANES FOR PROC UPPER ANTERIOR ABDOMINAL WALL		Instructions	Instructions			4	
			See Billing	See Billing				
	ANES FOR PROC ON UPPER ANTERIOR ABD WALL; PERC LIVER		Manual	Manual				
00702	BIOPSY		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00730	ANES FOR PROC ON UPPER POSTERIOR ABDOMINAL WALL		Instructions	Instructions			5	
			See Billing	See Billing				
			Instruction	Instruction				
00731	ANES UPR GI NDSC PX NOS		Manual	Manual			5	Added Effective 1/1/2018
			See Billing	See Billing				
			Instruction	Instruction				
00732	ANES UPR GI NDSC PX ERCP		Manual	Manual			6	Added Effective 1/1/2018
			See Billing	See Billing				
			Manual	Manual				
00750	ANES FOR HERNIA REPAIRS IN UPPER ABDOMEN; NOS		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual		1		
00752	ANES FOR HERNIA REPAIRS IN UPPER ABD; LUMBAR AND VENTRAL		Instructions	Instructions		1	6	
	, in the second		See Billing	See Billing				
			Manual	Manual				
00754	ANES FOR HERNIA REPAIRS IN UPPER ABDOMEN; OMPHALOCELE		Instructions	Instructions		1	7	
			See Billing	See Billing	1	1		
			Manual	Manual		1		
00756	ANES FOR HERNIA REPAIRS IN UPPER ABDOMEN; TRANSABD REPAIR		Instructions	Instructions			7	

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00770	ANES FOR ALL PROC ON MAJOR ABD BLOOD VESSELS		Instructions	Instructions			15	
			See Billing	See Billing				
			Manual	Manual				
00790	ANES FOR INTRAPERITONEAL PROC IN UPPER ABD INC LAP		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
00792	ANES FOR INTRAPERITONEAL PROC; HEPATECTOMY		Instructions	Instructions			13	
			See Billing	See Billing				
			Manual	Manual				
00794	ANES FOR INTRAPERITONEAL PROC IN UPPER ABD INC WHIPPLE		Instructions	Instructions			8	
00.01	A WARD TO SECURITION OF THE SE		See Billing	See Billing			+	+
			Manual	Manual				
00796	ANES FOR INTRAPERITONEAL PROC IN UP ABD INC LIVER TRANS		Instructions	Instructions			30	
00700	THE STORM THE WAR ENTIRE THE STORM OF THE BUTCH THE WAS		See Billing	See Billing			- 00	+
			Manual	Manual				
00797	ANES FOR INTRAPERITONEAL PROC IN UP ABD INC GASTRIC BYPASS		Instructions	Instructions			11	
30131	PRIZE FOR HATTAL ENTITOREMENTAGE IN OF ADD INC GASTING BIFAGS		See Billing	See Billing		+	11	+
			Manual	Manual				
00800	ANES FOR PROC ON LOW ANTE ABD WALL; NOS		Instructions	Instructions		1	4	
00000	ANES FOR FROC ON LOW ANTE ADD WALL, NOS		See Billing	See Billing			4	+
			Manual	Manual				
00000	ANES FOR PROCONLOW ANTE ARD WALL BANKICH FOTOMY					1	5	
00802	ANES FOR PROC ON LOW ANTE ABD WALL; PANNICULECTOMY		Instructions	Instructions		+	5	
			See Billing	See Billing		1		
00044	ANEO LIMB INTOT NIDOO NOO		Instruction	Instruction				A 1 1 1 5 5 5 5 5 6 5 6 5 6 6 6 6 6 6 6 6
00811	ANES LWR INTST NDSC NOS		Manual	Manual			4	Added Effective 1/1/2018

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	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cu	stomary char	ge for the service)				
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	se lab fee schedule for covered codes not listed below in the 80000-8924							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Instruction	Instruction				
00812	ANES LWR INTST SCR COLSC		Manual	Manual			3	Added Effective 1/1/2018
			See Billing	See Billing				
			Instruction	Instruction				
00813	ANES UPR LWR GI NDSC PX		Manual	Manual			3	Added Effective 1/1/2018
			See Billing	See Billing				
			Manual	Manual				
00820	ANES FOR PROC ON LOWER POSTERIOR ABDOMINAL WALL		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00830	ANES FOR HERNIA REPAIRS IN LOWER ABD; NOS		Instructions	Instructions			4	
	,		See Billing	See Billing				
	ANES FOR HERNIA REPAIRS IN LOWER ABD; VENTRAL AND		Manual	Manual				
00832	INCISIONAL		Instructions	Instructions			6	
00002	IN COLOR OF THE CO		See Billing	See Billing			+	
			Manual	Manual				
00834	ANES FOR HERNIA REPAIRS IN THE LOWER ABD;NOS		Instructions	Instructions			5	
3000-	, atto . O. Cheramital rand in the Editerraba, 100		See Billing	See Billing	1		+	+
			Manual	Manual				
00836	ANES FOR HERNIA REPAIRS IN THE LOWER ABD;NOS		Instructions	Instructions			6	
00000	ANLO I OR FILMINA INFAMA IN THE LOWER ADD, 1905	+	See Billing	See Billing		+	0	
			Manual	Manual				
00840	ANES FOR INTRAPERITONEAL PROC IN LOWER ABD INC LAP		Instructions	Instructions			6	
00040	ANES FOR INTRAFERITONEAL FROO IN LOWER ADD INC LAP		See Billing	See Billing			U	
			Manual	Manual				
00040	ANTE FOR AMINOCENTERIS						1	
00842	ANES FOR AMINOCENTESIS		Instructions	Instructions			4	

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00844	ANES FOR ABDOMINOPERINEAL RESECTION		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
00846	ANES FOR RADICAL HYSTERECTOMY		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
00848	ANES FOR PELVIC EXENTERATION		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
00851	ANES FOR TUBAL LIGATION/TRANSECTION		Instructions	Instructions			6	
-	THE TOTAL CONTINUE CO		See Billing	See Billing			 	
			Manual	Manual				
00860	ANES FOR EXTRAPERITONEAL PROCEDURES LOWER ABD		Instructions	Instructions			6	
00000	THE OTHER PROPERTY OF THE PROP		See Billing	See Billing				+
			Manual	Manual				
00862	ANES FOR RENAL PROCEDURES		Instructions	Instructions			7	
00002	ANEOTOR REVAETROOFDORES		See Billing	See Billing			'	+
			Manual	Manual				
00864	ANES FOR TOTAL CYSTECTOMY		Instructions	Instructions				
00004	ANES FOR TOTAL CISTECTOWIT	-	See Billing	See Billing			8	
			Manual	Manual				
00005	ANICS FOR RADICAL PROSTATECTOMY						_	
00865	ANES FOR RADICAL PROSTATECTOMY		Instructions	Instructions		_	1'	
			See Billing	See Billing				
			Manual	Manual			1	
00866	ANES FOR ADRENALECTOMY		Instructions	Instructions			10	

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00868	ANES FOR RENAL TRANSPLANT		Instructions	Instructions			10	
			See Billing	See Billing				
			Manual	Manual				
00870	ANES FOR CYSTOLITHOTOMY		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00872	ANES FOR LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE		Instructions	Instructions			7	
			See Billing	See Billing				
	ANES FOR LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE; W/O		Manual	Manual				
00873	WATER		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00880	ANES FOR PROC MAJOR LOWER ABD VESSELS; NOS		Instructions	Instructions			15	
			See Billing	See Billing				
	ANES FOR PROC ON MAJOR LOW ABD VESSELS; INFERIOR VENA		Manual	Manual				
00882	CAVA		Instructions	Instructions			10	
			See Billing	See Billing		+	1.2	
			Manual	Manual				
00902	ANES FOR; ANORECTAL PROCEDURE		Instructions	Instructions		1	5	
00002	paration, and the paration of		See Billing	See Billing		1	+	+
			Manual	Manual				
00904	ANESTHESIA FOR; RADICAL PERINEAL PROCEDURE		Instructions	Instructions			7	
00007	, we controlled the c		See Billing	See Billing		+	'	
			Manual	Manual				
00906	ANESTHESIA FOR; VULVECTOMY		Instructions	Instructions			1	
00800	INITED THE SIA FOR, VOLVECTOWN		monuclions	III SU UCUONS			J ⁴	

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00908	ANESTHESIA FOR; PERINEAL PROSTATECTOMY		Instructions	Instructions			6	
	, and the second		See Billing	See Billing				
			Manual	Manual				
00910	ANES FOR TRANSU PROC INC URETHROCYSTOSCOPY NOS;		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
00912	ANES FOR TRANSU PROC INC URETHROCYSTOSCOPY; TUMOR		Instructions	Instructions			5	
-			See Billing	See Billing			1	
			Manual	Manual				
00914	ANES FOR TRANSU PROC INC URETHROCYSTOSCOPY; PROSTATE		Instructions	Instructions			5	
00011	THE OTHER PROPERTY OF THE OTHER OTHE		See Billing	See Billing				+
			Manual	Manual				
00916	ANES FOR TRANSU PROC INC URETHROCYSTOSCOPY;BLEEDING		Instructions	Instructions			5	
00010	7 WEST SIX TIVINGS TROS INS SIXETIMOS ISTOSSOT 1,BEEEBING		See Billing	See Billing				
			Manual	Manual				
00918	ANES FOR TRANSU PROC INC URETHROCYSTOSCOPY; UR CAL		Instructions	Instructions			5	
00910		+	See Billing	See Billing	1		-	+
			Manual	Manual				
00920	ANES FOR PROC ON MALE GENITALIA INC OPEN URETHRAL NOS		Instructions	Instructions			2	
00920	ANES FOR PROC ON MALE GENITALIA INCOPEN URETHRAL NOS		See Billing	See Billing			3	
			Manual	Manual				
00004	ANES FOR PROCON MALE CENITALIA . MASCETOMY							
00921	ANES FOR PROC ON MALE GENITALIA ; VASCETOMY		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
00922	ANES PROC ON MALE GENITALIA; SEMINAL VESICLES		Instructions	Instructions			6	

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	les in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	9				
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00924	ANES FOR PROC ON MALE GENITALIA INC UNDECENDED TESTIS		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00926	ANES FOR PROC ON MALE GENITALIA ; ORCHIECTOMY, ING		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00928	ANES FOR PROC ON MALE GENITALIA ; ORCHIECTOMY, ABD		Instructions	Instructions			6	
-			See Billing	See Billing		+	1	
			Manual	Manual				
00930	ANES FOR PROC ON MALE GENITALIA; ORCHIPEXY		Instructions	Instructions			4	
00000	THE OTHER CONTROL CENTRE OF THE CONTROL OF THE CONT		See Billing	See Billing				
			Manual	Manual				
00932	ANES FOR PROC ON MALE GENITALIA ; AMPUTATION OF PENIS		Instructions	Instructions			4	
00932	ANEOTORTROCON MALE GENTALIA, AMI GTATION OF TENIS		See Billing	See Billing		+	-	
			Manual	Manual				
00934	ANES FOR PROC ON MALE GENITALIA ;		Instructions	Instructions			6	
00934	ANES FOR PROC ON MALE GENTIALIA,						O .	
			See Billing Manual	See Billing Manual				
00000	ANICO FOR PROCONIMALE OFNITALIA, AND MUTULINARIUS PROTONIA							
00936	ANES FOR PROC ON MALE GENITALIA; AMP WITH LYMPHADECTOMY		Instructions	Instructions	1	+	8	
			See Billing	See Billing				
00000	ANEO FOR PROGONIMALE OFNITALIA PENIAL PROTUENCE		Manual	Manual				
00938	ANES FOR PROC ON MALE GENITALIA ; PENIAL PROTHESIS		Instructions	Instructions	1		4	
			See Billing	See Billing				
			Manual	Manual				
00940	ANES FOR VAG PROC INC BIOPSY OF LABIA, VAGINA, NOS		Instructions	Instructions			3	

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	se lab fee schedule for covered codes not listed below in the 80000-8924							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
00942	ANES FOR VAGINAL PROC; COLPOTOMY ETC		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00944	ANES FOR VAG HYSTERECTOMY		Instructions	Instructions			6	
			See Billing	See Billing				
			Manual	Manual				
00948	ANES FOR VAG PROC CERVICAL CERLAGE		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
00950	ANES FOR VAG PROC INC; CULDOSCOPY		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
00952	ANES FOR VAG PROC; HYSTEROSCOPY		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01112	ANESFOR BONE MARROW ASPIRATION AND/OR BIOPSY		Instructions	Instructions			5	
			See Billing	See Billing	+			+
			Manual	Manual				
01120	ANESTHESIA FOR PROCEDURES ON BONY PELVIS		Instructions	Instructions			6	
01120	A THE CONTROLL OF THE CONTROLL OF BOTT I LEVIO		See Billing	See Billing				+
			Manual	Manual				
01130	ANESTHESIA BODY CAST APPLICATION OR REVISION		Instructions	Instructions			3	
01130	ANLOTHEDIA BODT GAST AFFEIGATION ON NEVIGION		See Billing	See Billing	+	+	3	+
	ANESTHESIA FOR INTERPELVIABDOMINAL (HINDQUARTER)		Manual	Manual				
01140	,						15	
01140	AMPUTATION		Instructions	Instructions			15	

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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing	•	•		
	ANES FOR RADICAL PROC FOR TUMOR OF PELVIS; EXCEPT		Manual	Manual				
01150	HINDQUAR		Instructions	Instructions			10	
			See Billing	See Billing				
	ANES FOR CLOSED PROC INVOLVING SYMPHYSIS PUBIS OR SACR		Manual	Manual				
01160	JOINT		Instructions	Instructions			4	
			See Billing	See Billing				
	ANES FOR OPEN PROC INVOLVING SYMPHYSIS PUBIS OR SACR		Manual	Manual				
01170	JOINT		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
01173	ANES FOR OPEN REPAIR OF FRACTURE DISRUPTION OF PELVIS		Instructions	Instructions			12	
			See Billing	See Billing				
			Manual	Manual				
01180	ANES FOR OBTURATOR NEURECTOMY; EXTRAPELVIC		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01190	ANES FOR OBTURATOR NEURECTOMY; INTRAPELVIC		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01200	ANES FOR ALL CLOSED PROCEDURES INVOLVING HIP JOINT		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01202	ANES FOR ARTHROSCOPIC PROCEDURES HIP JOINT		Instructions	Instructions			4	
-			See Billing	See Billing				1
			Manual	Manual				
01210	ANES FOR OPEN PROCEDURES INVOLVING HIP JOINT; NOS		Instructions	Instructions			6	

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	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
01212	ANES FOR OPEN PROC INVOLVING HIP JOINT; HIP DISARTICULATION		Instructions	Instructions			10	
			See Billing	See Billing				
	ANES FOR OPEN PROC INVOLVING HIP JOINT; TOTAL HIP		Manual	Manual				
01214	ARTHROPLSTY		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
01215	ANES FOR OPEN PROC INVOLVING HIP JOINT; REVISION OF TOTAL		Instructions	Instructions			10	
			See Billing	See Billing				
			Manual	Manual				
01220	ANES FOR ALL CLOSED PROC INVOLVING UPPER 2/3 OF FEMUR		Instructions	Instructions			4	
0.220	THE STORY RELEGISES THOS INVOLVING STREET STORY		See Billing	See Billing			1	+
			Manual	Manual				
01230	ANES FOR OPEN PROC INVOLVING UPPER 2/3 OF FEMUR; NOS		Instructions	Instructions			6	
01200	THE OTHER THE OTHER PROPERTY OF THE MORE, THE OTHER PROPERTY OF THE OTHER PROPERTY OTH		See Billing	See Billing			 	+
	ANES FOR OPEN PROC INVOLVING UPPER 2/3 OF FEMUR;		Manual	Manual				
01232	AMPUTATION		Instructions	Instructions			5	
01202	AWI OTATION		See Billing	See Billing			9	
			Manual	Manual				
01234	ANES FOR OPEN PROC INVOLVING UPPER 2/3 OF FEMUR; RADICAL		Instructions	Instructions			8	
01234	ANES FOR OFEN FROC INVOLVING OFFER 2/3 OF FEMUR, RADICAL		See Billing	See Billing			0	+
			Manual	Manual				
01250	ANES FOR ALL DROC ON NEDVES MUSCUES TENDONS FASOIA						4	
01250	ANES FOR ALL PROC ON NERVES, MUSCLES, TENDONS, FASCIA		Instructions	Instructions			4	
			See Billing	See Billing				
04000	ANEO FOR ALL BROOKENION (NO MENO OF URBER LEG. INC. EVO		Manual	Manual				
01260	ANES FOR ALL PROC INVOLVING VEINS OF UPPER LEG, INC EXP		Instructions	Instructions			[3	

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
01270	ANES FOR PROC INVOLVING ARTERIES OF UPPER LEG, INC BYPASS		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
01272	ANES FOR PROC INVOLVING ARTERIES FEMORAL ARTERY LIG		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01274	ANES FOR PROC INVOLVING ARTERIES OF UP LEG, INC EMB		Instructions	Instructions			6	
			See Billing	See Billing				
			Manual	Manual				
01320	ANES FOR ALL PROC ON NERVES, MUSCLES, TENDONS, FASCIA		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01340	ANES FOR ALL CLOSED PROC ON LOWER 1/3 FEMUR		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01360	ANES FOR ALL OPEN PROC ON LOWER 1/3 OF FEMUR		Instructions	Instructions			5	
		†	See Billing	See Billing	1		†	1
			Manual	Manual				
01380	ANES FOR ALL CLOSED PROC ON KNEE JOINT		Instructions	Instructions			3	
			See Billing	See Billing			Ť	
			Manual	Manual				
01382	ANES FOR DIAGNOSTIC ARTHROSCOPIC PROC OF KNEE JOINT		Instructions	Instructions			3	
3.002			See Billing	See Billing			 	†
	ANES FOR ALL CLOSED PROC ON UP ENDS OF TIBIA, FIBULA,		Manual	Manual				
01390	PATELLA		Instructions	Instructions			3	
01000			Tillou douono	In iou doublio			<u> </u>	

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cha	rge for the service	9				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
	ANES FOR ALL OPEN PROC ON UPPER ENDS OF TIBIA, FIBULA,		Manual	Manual				
01392	PATELLA		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01400	ANES FOR OPEN OR SURGICAL ARTH PROC ON KNEE JOINT; NOS		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01402	ANES FOR OPEN OR SURG ARTH PROC ON KNEE JOINT; TOT KNEE		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
01404	ANES FOR OPEN OR SURGICAL ARTH PROC ON KNEE JOINT; DISART		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01420	ANES FOR ALL CAST APPLICATIONS, NOS		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01430	ANES FOR PROC ON VEINS OF KNEE AND POPLITEAL AREA; NOS		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01432	ANES FOR PROC ON VEINS OF KNEE AND POPLITEAL AREA; AVS		Instructions	Instructions			6	
			See Billing	See Billing				
			Manual	Manual			1	
01440	ANES FOR PROC ON ARTERIES OF KNEE AND POPLITEAL AREA; NOS		Instructions	Instructions			8	
			See Billing	See Billing				
	ANES FOR PROC ON ARTERIES OF KNEE AND POPL AREA; W/O		Manual	Manual			1	
01442	GRAFT		Instructions	Instructions			8	

ns Auth is required of billed amount not to exceed provider's usual and custo 5.20. Each 15 minute increment=1 time unit. r covered codes not listed below in the 80000-89249 i	omary char						
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dule that begin with a P or Q are currently non-covered for	or physiciai	ns					
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ion	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
		See Billing	See Billing				
		Manual	Manual				
N ARTERIES OF KNEE AND POPL AREA; POPL		Instructions	Instructions			8	
		See Billing	See Billing				
		Manual	Manual				
SED PROC ON LOWER LEG, ANKLE, AND FOOT		Instructions	Instructions			3	
		See Billing	See Billing				
		Manual	Manual				
OSCOPIC PROC OF ANKLE AND/OR FOOT		Instructions	Instructions			3	
		See Billing	See Billing				
N NERVES, MUSCLES, TENDONS, AND FASCIA;		Manual	Manual				
, , , , , , , , , , , , , , , , , , , ,		Instructions	Instructions			3	
		See Billing	See Billing				
		Manual	Manual				
N NERVES. MUSCLES. ETC: ACHILLIES TENDON		Instructions	Instructions			5	
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N NERVES, MUSCLES, TENDONS, AND FASCIA OF L						5	
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	ON ARTERIES OF KNEE AND POPL AREA; POPL OSED PROC ON LOWER LEG, ANKLE, AND FOOT OSCOPIC PROC OF ANKLE AND/OR FOOT ON NERVES, MUSCLES, TENDONS, AND FASCIA; ON NERVES, MUSCLES, ETC; ACHILLIES TENDON	DESCOPIC PROC OF ANKLE AND/OR FOOT ON NERVES, MUSCLES, TENDONS, AND FASCIA; ON NERVES, MUSCLES, TENDONS, AND FASCIA OF L ROC ON BONES OF LOWR LEG, ANKLE, AND FOOT; ROC ON BONES OF LOW LEG, ANKLE, AND FOOT;	See Billing Manual Instructions	Inpat. Rate (Facility) See Billing Manual Instructions See Billing See Billing Manual Instructions Instructions See Billing Manual Instructions See Billing See Billing Manual Instructions See Billing See Billing Manual Instructions See Billing Manual Instructions	Inpat. Rate (Facility) Inpat. Rate (Facility) See Billing Manual Instructions Ins	Inpat. Rate (Facility) (Comp. Comp. See Billing Manual Instructions Instructions See Billing Manual Instructions Instructions Instructions Instructions See Billing Manual Instructions Instructions See Billing Manual Instructions Instructions See Billing Manual Instructions See Billing Manual Instructions Instructions	Inpat. Rate (Facility) Inpat. Rate (Facility) See Billing Manual Instructions Ins

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
01486	ANES FOR OPEN PROC ON BONES; TOTAL ANKLE REPLACEMENT		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
01490	ANES FOR LOWER LEG CAST APPLICATION, REMOVAL, OR REPAIR		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01500	ANES FOR PROC ON ARTERIES OF LOWER LEG, INC BYPASS NOS		Instructions	Instructions			8	
			See Billing	See Billing				1
			Manual	Manual				
01502	ANES FOR PROC ON ARTERIES OF LOWER LEG, INC EMB		Instructions	Instructions			6	
0.002	THE OTT THE CHITTENES OF LOTTENESS, INC. LIND		See Billing	See Billing			1	
			Manual	Manual				
01520	ANES FOR PROC ON VEINS OF LOWER LEG; NOS		Instructions	Instructions			3	
01020	THEO TORT NOO ON VEHICO OF EOWER EEO, NOO		See Billing	See Billing				+
	ANES FOR PROC ON VEINS OF LOWER LEG; VENOUS		Manual	Manual				
01522	THROMBECTOMY,		Instructions	Instructions			5	
01022	THINOMBEOTOMI,		See Billing	See Billing			1	+
			Manual	Manual				
01610	ANTE FOR ALL DROC ON NEDVES MUSCLES FTG. SHOULDED						_	
01610	ANES FOR ALL PROC ON NERVES, MUSCLES, ETC; SHOULDER		Instructions See Billing	Instructions See Billing			5	+
			_	_				
04600	ANICO FOD ALL CLOSED DDGG ON HUMAEDAL HEAD AND NEGY		Manual	Manual			1,	
01620	ANES FOR ALL CLOSED PROC ON HUMERAL HEAD AND NECK,		Instructions	Instructions			4	
			See Billing	See Billing				
0.4000	ANEO 500 DIA O ARTHROGODIO 5500 05 01 01 01 05 05 05 05 05 05 05 05 05 05 05 05 05		Manual	Manual				
01622	ANES FOR DIAG ARTHROSCOPIC PROC OF SHOULDER JOINT		Instructions	Instructions			4	

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	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC ON HUMERAL		Manual	Manual				
01630	HEAD		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01634	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC;SHOULDER		Instructions	Instructions			9	
			See Billing	See Billing				
			Manual	Manual				
01636	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC;AMP		Instructions	Instructions			15	
			See Billing	See Billing				
			Manual	Manual				
01638	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC;REPLACE		Instructions	Instructions			10	
0.000	A WALL OF CIT CIT CONTO IN THE COURT OF THE		See Billing	See Billing	+		1.0	
			Manual	Manual				
01650	ANES FOR PROC ON ARTERIES OF SHOULDER AND AXILLA; NOS		Instructions	Instructions			6	
0.000	THE TOTAL TOO STOTE THE STOTE		See Billing	See Billing				+
			Manual	Manual				
01652	ANES FOR PROC ON ARTERIES OF SHOULDER AND AXILLA;		Instructions	Instructions			10	
01002	PAREST SIXT IXOS SIX ARTERIZO ST SHOOLDER ARD PAREEA,		See Billing	See Billing	+		10	
			Manual	Manual				
01654	ANES FOR PROC ON ARTERIES OF SHOULDER AND AXILLA; BYPASS		Instructions	Instructions			8	
01034	ANLO I OIX FROG ON ARTERIES OF SHOULDER AND AXILLA, DIPASS	-	See Billing	See Billing	+		U	+
	ANES FOR PROC ON ARTERIES OF SHOULDER AND AXILLA; AX		Manual	Manual				
01656	BYPASS						10	
01656	DIFAGG		Instructions	Instructions	1		10	+
			See Billing	See Billing				
04070	ANEO FOR ALL PROGRAMVEING OF CUCUURER AND ANGULA		Manual	Manual				
01670	ANES FOR ALL PROC ON VEINS OF SHOULDER AND AXILLA		Instructions	Instructions			4	

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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomarv cha	rae for the service	<u> </u>				
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing	•	•		
	ANES FOR SHOULDER CAST APPLICATION, REMOVAL OR REPAIR;		Manual	Manual				
01680	NOS		Instructions	Instructions			3	
			See Billing	See Billing				
	ANES FOR SHOULDER CAST APPLICATION, REMOVAL OR REPAIR;		Manual	Manual				
01682	SHOULDER		Instructions	Instructions			4	
			See Billing	See Billing				
			Manual	Manual				
01710	ANES FOR PROC ON NERVES, MUSCLES, TENDONS; ARM NOS		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01712	ANES FOR PROC ON NERVES, MUSCLES, TENDONS,;TENOTOMY		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01714	ANES FOR PROC ON NERVES, MUSCLES, TENDONS; TENOPLASTY		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01716	ANES FOR PROC ON NERVES, MUSCLES, TENDONS; TENODESIS		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01730	ANES FOR ALL CLOSED PROC ON HUMERUS AND ELBOW		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01732	ANES FOR DIAG ARTHROSCOPIC PROC ELBOW JOINT		Instructions	Instructions			3	
			See Billing	See Billing				
	ANES FOR OPEN OR SURG ARTHROSCOPIC PROC OF THE		Manual	Manual				
01740	ELBOW;NOS		Instructions	Instructions			4	

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	n Fee Schedule 2020							
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Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
01742	ANES FOR OPEN OR SURG ARTH PROC OF THE ELBOW; OSTEOTOMY		Instructions	Instructions			5	
	, in the second of the second		See Billing	See Billing				
	ANES FOR OPEN OR SURG ARTHROSCOPIC PROC OF THE ELBOW;		Manual	Manual				
01744	REPAIR		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01756	ANES FOR OPEN OR SURG ARTH PROC OF THE ELBOW;		Instructions	Instructions			6	
• • • • • • • • • • • • • • • • • • • •			See Billing	See Billing				
	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC OF THE		Manual	Manual				
01758	ELBOW;		Instructions	Instructions			5	
01100			See Billing	See Billing			<u> </u>	
	ANES FOR OPEN OR SURGICAL ARTHROSCOPIC PROC OF THE		Manual	Manual				
01760	ELBOW;		Instructions	Instructions			7	
			See Billing	See Billing	1			
			Manual	Manual				
01770	ANES FOR PROC ON ARTERIES OF UPPER ARM AND ELBOW; NOS		Instructions	Instructions			6	
			See Billing	See Billing	+			
	ANES FOR PROC ON ARTERIES OF UPPER ARM AND ELBOW;		Manual	Manual				
01772	EMBOLECT		Instructions	Instructions			6	
01172			See Billing	See Billing	+		 	+
			Manual	Manual				
01780	ANES FOR PROC ON VEINS OF UPPER ARM AND ELBOW; NOS		Instructions	Instructions			3	
31700	, at 20 1 Ort 1 100 Ort Vento Or Or 1 Ert/advi/atablebow, 1000		See Billing	See Billing	+		+	+
			Manual	Manual				
01782	ANES FOR PROC ON VEINS OF UP ARM AND ELBOW; PHLEBORRHAPY		Instructions	Instructions			4	
01702	PRINCE OF THE OF THE ARM AND LEDOW, I HELDORINA FI		การแนบแบกร	การแนบแบกร				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
			Manual	Manual				
01810	ANES ALL PROC ON NERVES, MUSCLES ETC; HAND		Instructions	Instructions			3	
			See Billing	See Billing				
	ANES FOR ALL CLOSED PROCEDURES ON RADIUS, ULNA, WRIST, OR		Manual	Manual				
01820	HAND B		Instructions	Instructions			3	
			See Billing	See Billing				
	ANESTHESIA FOR DIAGNOSTIC ARTHROSCOPIC PROCEDURES ON		Manual	Manual				
01829	THE WRIST		Instructions	Instructions			3	
			See Billing	See Billing				
	ANESTHESIA FOR OPEN OR SURGICAL		Manual	Manual				
01830	ARTHROSCOPIC/ENDOSCOPIC PROCEDURES ON		Instructions	Instructions			3	
			See Billing	See Billing				
	ANESTHESIA FOR OPEN OR SURGICAL		Manual	Manual				
01832	ARTHROSCOPIC/ENDOSCOPIC PROCEDURES ON		Instructions	Instructions			6	
			See Billing	See Billing				
	ANESTHESIA FOR PROCEDURES ON ARTERIES OF FOREARM,		Manual	Manual				
01840	WRIST, AND HAND; NOT		Instructions	Instructions			6	
			See Billing	See Billing	1			
	ANESTHESIA FOR PROCEDURES ON ARTERIES OF FOREARM,		Manual	Manual				
01842	WRIST, AND HAND;		Instructions	Instructions			6	
	,,		See Billing	See Billing	1		<u> </u>	
	ANESTHESIA FOR VASCULAR SHUNT, OR SHUNT REVISION, ANY		Manual	Manual				
01844	TYPE (EG, DIALYS		Instructions	Instructions			6	
	= (==0, ====0		See Billing	See Billing			 	+
	ANESTHESIA FOR PROCEDURES ON VEINS OF FOREARM, WRIST,		Manual	Manual				
01850	AND HAND; NOT		Instructions	Instructions			3	
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary chai	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
	ANESTHESIA FOR PROCEDURES ON VEINS OF FOREARM, WRIST,		Manual	Manual				
01852	AND HAND;		Instructions	Instructions			4	
			See Billing	See Billing				
	ANESTHESIA FOR FOREARM, WRIST, OR HAND CAST APPLICATION,		Manual	Manual				
01860	REMOVAL, OR R		Instructions	Instructions			3	
			See Billing	See Billing				
			Manual	Manual				
01916	ANESTHESIA FOR DIAGNOSTIC ARTERIOGRAPHY/VENOGRAPHY		Instructions	Instructions			5	
			See Billing	See Billing				
	ANESTHESIA FOR CARDIAC CATHETERIZATION INCLUDING		Manual	Manual				
01920	CORONARY ANGIOGRAPHY		Instructions	Instructions			7	
			See Billing	See Billing				
			Manual	Manual				
01922	ANESTHESIA FOR NON-INVASIVE IMAGING OR RADIATION THERAPY		Instructions	Instructions			7	
			See Billing	See Billing				†
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual				
01924	PROCEDURES INVOLV		Instructions	Instructions			6	
0.02.			See Billing	See Billing	1	+	 	+
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual		1		
01925	PROCEDURES INVOLV		Instructions	Instructions			8	
01020	I TOOLDOILES HAVOLV		See Billing	See Billing			+	+
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual		1		
01926	PROCEDURES INVOLV		Instructions	Instructions			10	
01920	I NOOLDONLO IIIVOLV		See Billing	See Billing			110	+
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual		1		
01930	PROCEDURES INVOLV		Instructions	Instructions		1	5	
01930	ILLOCEDOKES INVOLV		instructions	mstructions			5	

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			See Billing	See Billing				
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual				
01931	PROCEDURES INVOLV		Instructions	Instructions			7	
			See Billing	See Billing				
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual				
01932	PROCEDURES INVOLV		Instructions	Instructions			7	
			See Billing	See Billing				
	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGIC		Manual	Manual				
01933	PROCEDURES INVOLV		Instructions	Instructions			8	
			See Billing	See Billing				
			Manual	Manual				
01935	ANESTH, PERC IMG DX SP PROC		Instructions	Instructions			5	
			See Billing	See Billing				
			Manual	Manual				
01936	ANESTH, PERC IMG TX SP PROC		Instructions	Instructions			5	
			See Billing	See Billing				
	ANESTHESIA FOR SECOND AND THIRD DEGREE BURN EXCISION OR		Manual	Manual				
01951	DEBRIDEMENT WI		Instructions	Instructions			3	
			See Billing	See Billing			†	+
	ANESTHESIA FOR SECOND AND THIRD DEGREE BURN EXCISION OR		Manual	Manual		1		
01952	DEBRIDEMENT WI		Instructions	Instructions			5	
01002			See Billing	See Billing			+~	+
	ANESTHESIA FOR SECOND AND THIRD DEGREE BURN EXCISION OR		Manual	Manual		1		
01953	DEBRIDEMENT WI		Instructions	Instructions			1	
01900			See Billing	See Billing			+'	+
			Manual	Manual				
01059	ANESTHESIA FOR EVTERNAL CERHALIC VERSION PROCEDURE						_	
01958	ANESTHESIA FOR EXTERNAL CEPHALIC VERSION PROCEDURE		Instructions	Instructions			5	

Physician	Fee Schedule 2020							
Note:	T ee Ochedule 2020							
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I	T	7				
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ango						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne				+	
Codes list		л риузісіаі І	13					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
01960	ANESTHESIA FOR VAGINAL DELIVERY ONLY	Alliu	\$215.00	\$215.00	Comp.	Comp.	5	Notes
01961	ANESTHESIA FOR CESAREAN DELIVERY ONLY		\$335.00	\$335.00			7	
01301	AND THE OTHER OF GEOAREAN BELIVERY ONE		See Billing	See Billing			+	+
			Manual	Manual				
01962	ANESTHESIA FOR URGENT HYSTERECTOMY FOLLOWING DELIVERY		Instructions	Instructions			8	
01302	AND THE OIR OR OR OED THO TERE OF OWN TO BE EIVER		See Billing	See Billing			-	
	ANESTHESIA FOR CESAREAN HYSTERECTOMY WITHOUT ANY LABOR		Manual	Manual				
01963	ANALGESIA/		Instructions	Instructions			10	
01303	NACOLOIN		See Billing	See Billing			10	
			Manual	Manual				
01965	ANESTHESIA FOR INCOMPLETE OR MISSED ABORTION PROCEDURES		Instructions	Instructions			4	
01303	AND THE OWN ON INCOME LETE ON MICOLD ABOUTHOUT NOOLDONES		See Billing	See Billing			-	
			Manual	Manual				
01966	ANESTHESIA FOR INDUCED ABORTION PROCEDURES		Instructions	Instructions			4	
01000	NEURAXIAL LABOR ANALGESIA/ANESTHESIA FOR PLANNED VAGINAL		motraotions	I I I I I I I I I I I I I I I I I I I			- T	
01967	DELIVERY (THI		\$350.00	\$350.00			5	
01307	ANESTHESIA FOR CESAREAN DELIVERY FOLLOWING NEURAXIAL		Ψ000.00	ψ000.00			+	
01968	LABOR		\$25.00	\$25.00			3	
0.1000	ANESTHESIA FOR CESAREAN HYSTERECTOMY FOLLOWING		Ψ20.00	Ψ20.00			+	+
01969	NEURAXIAL LABOR		\$25.00	\$25.00			5	
01000			See Billing	See Billing			+	
	PHYSIOLOGICAL SUPPORT FOR HARVESTING OF ORGAN(S) FROM		Manual	Manual				
01990	BRAIN-DEAD PATIE		Instructions	Instructions			7	
01000	DIVINE DEAD FAITE	 	See Billing	See Billing	+		+	+
	ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS		Manual	Manual				
01991	AND INJECTIONS (Instructions	Instructions			3	
3 100 1	has accorded (l	in ou douons	i ioti dottorio			<u> </u>	

Physician	Fee Schedule 2020							
Note:	1 66 66164416 2020							
	es in Red;							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	rge for the service					
The Anest	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	linary Criar	T The service	,				
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ange					+	
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>				+	
Oodes list	The lab lee solicatio that begin with a 1- of Q are currently non-covered to	Прпузісіа						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
3040	Trooduir Boothpaon	7	See Billing	See Billing	Comp.	Gomp.	Value	110100
	ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS		Manual	Manual				
01992	AND INJECTIONS (Instructions	Instructions			5	
0.002	/ ## ##CEG 10 10		mon donorio	mod dodono			 	
01996	HOSP MANAGE CONT DRUG ADMIN		\$87.06	\$87.06			3	Updated Effective 01/01/2020
01999	UNLISTED ANESTHESIA PROCEDURE(S)	R	\$0.00	\$0.00			 	
10004	FNA BX W/O IMG GDN EA ADDL		\$35.29	\$41.55				Effective 1/1/2019
10005	FNA BX W/US GDN 1ST LES		\$59.76	\$98.66				Effective 1/1/2019
10006	FNA BX W/US GDN EA ADDL		\$40.72	\$48.03				Effective 1/1/2019
10007	FNA BX W/FLUOR GDN 1ST LES		\$76.60	\$217.33				Effective 1/1/2019
10008	FNA BX W/FLUOR GDN EA ADDL		\$49.94	\$123.04				Effective 1/1/2019
10009	FNA BX W/CT GDN 1ST LES		\$93.03	\$353.34				Effective 1/1/2019
10010	FNA BX W/CT GDN EA ADDL		\$67.99	\$213.94				Effective 1/1/2019
10011	FNA BX W/MR GDN 1ST LES		\$0.00	\$0.00				Effective 1/1/2019
10012	FNA BX W/MR GDN EA ADDL		\$0.00	\$0.00				Effective 1/1/2019
10021	FINE NEEDLE ASPIRATION; WITHOUT IMAGING GUIDANCE		\$65.38	\$65.38	\$12.88	\$52.50		
10030	GUIDE CATHET FLUID DRAINAGE		\$125.74	\$581.61				
	PLACEMENT OF SOFT TISSUE INCLUDING IMAGING GUIDANCE: FIRST							
10035	LESION	R	\$70.75	\$398.81				Added Effective 1/1/2016
10036	EACH ADDITIONAL LESION	R	\$35.62	\$344.28				Added Effective 1/1/2016
	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF							
10040	MULTIPLE MIL		\$44.34	\$48.63				
	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE,							
10060	SUPPURATIVE HIDRADENI		\$39.74	\$45.64				
	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE,							
10061	SUPPURATIVE HIDRADENI		\$82.81	\$91.40			<u> </u>	
10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE		\$55.46	\$62.16				
10081	INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED		\$89.20	\$104.08				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
1,0,00	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS			40.47				
10120	TISSUES; SIMPLE		\$42.30	\$48.47				
40404	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS		400.70	4.07.00				
10121	TISSUES; COMPLICATE	-	\$93.79	\$107.20	_			
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION		¢54.00	¢57.50				
10140	COLLECTION		\$51.08	\$57.52				
10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST		\$40.06	\$45.15				
10100	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND		ψ+0.00	ψ-10.10				+
10180	INFECTION		\$97.09	\$97.09				
10.00	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP		+ + + + + + + + + + + + + + + + + + +	ψοσο				
11000	TO 10% OF BOD		\$33.04	\$38.40				
	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN;							
11001	EACH ADDITIONAL		\$17.18	\$20.66				
	DEBRIDEMENT OF SKIN, SUBCUTANEOUS TISSUE, MUSCLE AND							
11004	FASCIA FOR NECROT		\$422.77	\$422.77				
	DEBRIDEMENT OF SKIN, SUBCUTANEOUS TISSUE, MUSCLE AND							
11005	FASCIA FOR NECROT		\$574.70	\$574.70				
	DEBRIDEMENT OF SKIN, SUBCUTANEOUS TISSUE, MUSCLE AND							
11006	FASCIA FOR NECROT		\$531.05	\$531.05				
	REMOVAL OF PROSTHETIC MATERIAL OR MESH, ABDOMINAL WALL							
11008	FOR NECROTIZING		\$215.69	\$215.69				
	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL							
11010	ASSOCIATED WITH OPEN		\$237.46	\$237.46				
	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL							
11011	ASSOCIATED WITH OPEN		\$283.02	\$283.02				

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Note:	ree Scriedule 2020				+			<u> </u>
	and in Body							
2020 Cod	•							
	PT book for descriptions				_		_	
	olumn indicates Prior Auth is required	<u> </u>	1		_			
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.				_			
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร				4	
							Bass	
D			luurat Data	Outrot Data	T I-	Prof.	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.		Unit	N
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
14040	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL		4000.05	4000.05				
11012	ASSOCIATED WITH OPEN		\$393.35	\$393.35				
11042	DEBRIDEMENT; SKIN, AND SUBCUTANEOUS TISSUE		\$48.18	\$48.18				
11043	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE		\$110.51	\$110.51				
11011	DEDDIDEMENT, CIVIN CUDOLITANICOLIC TICCLIE MUCCI E AND DONE		Φ454 45	Φ454.45				
11044	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, MUSCLE, AND BONE DEB SUBQ TISSUE ADD-ON		\$154.45	\$154.45	_		_	
11045	·		\$15.73	\$27.00				
11010	DEBRIDEMENT, SUBCUTANEOUS TISSUE, EACH ADDTL 20 SQ CM,		# 22.22	¢40.00				
11046	USE IN CONJUCTION W/PROC 11043		\$33.23	\$46.88	_			
44047	DEBRIDEMENT, SUBCUTANEOUS TISSUE, EACH ADDTL 20 SQ CM,		ф г 7 00	ф 77 4 4				
11047	USE IN CONJUCTIONS W/PROC 11044 PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG,		\$57.86	\$77.14	_			
14055			Φ44. 7 4	Φ44. 7 4				
11055	CORN OR CALLUS) PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG,		\$14.74	\$14.74	_		_	
11050	· ·		#00.70	#00.70				
11056	CORN OR CALLUS)		\$20.76	\$20.76	_		_	
11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS)		\$22.12	\$22.12				
11057 11102	TANGNTL BX SKIN SINGLE LES		\$31.95	\$75.29				Effective 1/1/2019
11102	TANGNTL BX SKIN SINGLE LES TANGNTL BX SKIN EA SEP/ADDL		\$18.49	\$40.69				Effective 1/1/2019
				\$94.66	+			
11104 11105	PUNCH BX SKIN SINGLE LESION PUNCH BX SKIN EA SEP/ADDL		\$40.09					Effective 1/1/2019
			\$21.86	\$46.66				Effective 1/1/2019
11106	INCAL BX SKN SINGLE LES		\$48.77	\$114.57	+			Effective 1/1/2019
11107	INCAL BX SKN EA SEP/ADDL		\$26.08	\$55.06				Effective 1/1/2019
11000	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY		¢26.00	620.7 5				
11200	AREA; UP TO AN		\$26.99	\$32.75				
44004	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY		040.40	# 40.00				
11201	AREA; EACH		\$10.40	\$12.68				

Note: Section Core	Physician	Fee Schedule 2020							
Refer to CPT book for descriptions R'm PA column indicates Prival with is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute incremental time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule from covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule from covered codes not listed below in the 80000-89249 range. Proc Code Procedure Description SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SACE, SHAVING OF EPIDERMAL OR DERMAL LESI									
RT in PA column indicates Prior Auth is required (odes listed as 50 00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service (odes listed as 50 00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service (odes listed for covered codes not listed below in the 80000-82249 range.)	2020 Cod	les in Red;							
Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service	Refer to C	CPT book for descriptions							
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Inpat. Rate Code Procedure Description PA Ind (Facility) (NonFacility) (NonFacility) Value Notes	R" in PA	column indicates Prior Auth is required							
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11300 TRUNK, ARMS OR L SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11301 TRUNK, ARMS OR L SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11302 TRUNK, ARMS OR L SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11303 TRUNK, ARMS OR L SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11303 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11304 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11305 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11306 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11307 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11308 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11309 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11300 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11301 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11302 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11303 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11304 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11305 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 11310 SACALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11311 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11312 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11314 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11315 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11316 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11317 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11318 SHAVING	Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians	The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Proc Code Procedure Description PA Ind (Facility) Comp. Comp. Value Notes	Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Proc Procedure Description	Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc Procedure Description									
Code									
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, \$23.29 \$30.40					•				
11300 TRUNK, ARMS OR L \$23.29 \$30.40	Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, 178UNK, ARMS OR L									
11301 TRUNK, ARMS OR L \$35.39 \$44.37	11300			\$23.29	\$30.40				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, \$44.93 \$56.87 \$11302 TRUNK, ARMS OR L \$58.76 \$76.99 \$1303 TRUNK, ARMS OR L \$58.76 \$76.99 \$1305 \$56.87 \$1305 \$56.87 \$1305 \$1801NG OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, \$27.85 \$34.82 \$1306 \$56.4P, NECK, HAN \$40.27 \$49.79 \$1307 \$56.4P, NECK, HAN \$40.27 \$49.79 \$140.00 \$10000 \$10000 \$10000 \$10000 \$10000 \$10000 \$10000 \$10000 \$10000 \$100		· · · · · · · · · · · · · · · · · · ·							
11302 TRUNK, ARMS OR L \$44.93 \$56.87	11301			\$35.39	\$44.37				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, \$58.76 \$76.99	4.4000				4-0.0-				
11303 TRUNK, ARMS OR L \$58.76 \$76.99	11302			\$44.93	\$56.87				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, \$27.85 \$34.82	44000			450.70	470.00				
11305 SCALP, NECK, HAN \$27.85 \$34.82	11303			\$58.76	\$76.99				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERM	44005			407.05	004.00				
11306 SCALP, NECK, HAN \$40.27 \$49.79 \$1307 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SALP, NECK, HAN \$48.49 \$61.09 \$11308 SCALP, NECK, HAN \$64.28 \$83.06 \$64.28 \$83.06 \$64.28 \$83.06 \$64.28 \$	11305			\$27.85	\$34.82				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE	44000			¢40.07	¢40.70				
11307 SCALP, NECK, HAN \$48.49 \$61.09	11306			\$40.27	\$49.79				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, STALE	11207	· · · · · · · · · · · · · · · · · · ·		¢40.40	¢64.00				
11308 SCALP, NECK, HAN SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SING	11307			\$40.49	\$61.09				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL DERMAL DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL DERMAL DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL DERMAL	11209	,		¢64.29	¢83 06				
11310 EARS, EYEL \$32.13 \$41.39 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11311 EARS, EYEL \$44.15 \$55.55 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11312 EARS, EYEL \$52.91 \$67.93 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 EARS, EYEL \$71.16 \$91.15	11300			φ04.20	φου.υο				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11311 EARS, EYEL SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, ST1.16 \$91.15	11310	· · · · · · · · · · · · · · · · · · ·		¢32 13	\$41.30				
11311 EARS, EYEL \$44.15 \$55.55 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11312 EARS, EYEL \$52.91 \$67.93 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 EARS, EYEL \$71.16 \$91.15 EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG	11310	,		ψ02.10	ψ+1.55				
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11312 EARS, EYEL \$52.91 \$67.93 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 EARS, EYEL \$71.16 \$91.15 EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG	11311	· · · · · · · · · · · · · · · · · · ·		\$44.15	\$55.55				
11312 EARS, EYEL \$52.91 \$67.93 SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 EARS, EYEL \$71.16 \$91.15 EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG	11011			ψττ.10	ψ00.00				+
SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, 11313 EARS, EYEL \$71.16 \$91.15 EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG	11312			\$52.91	\$67.93				
11313 EARS, EYEL \$71.16 \$91.15 EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG				732.01	+31.00				
EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG	11313			\$71.16	\$91.15				
				1	1	1	1		
11400 (UNLESS LIS \$33.56 \$40.67	11400	· · · · · · · · · · · · · · · · · · ·		\$33.56	\$40.67				

Physician	Fee Schedule 2020							
Note:	11 00 001104410 2020							
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Ī					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG							
11401	(UNLESS LIS		\$47.71	\$56.69				
	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG							
11402	(UNLESS LIS		\$59.90	\$71.83				
	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG							
11403	(UNLESS LIS		\$73.72	\$89.41				
1	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG							
11404	(UNLESS LIS		\$85.73	\$104.23				
44400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		4.07.00	* 10= 00				
11406	(UNLESS LIS		\$137.96	\$137.96				
44400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		407.00					
11420	(UNLESS LIS		\$37.83	\$44.80				
44404	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		ΦΕ 4. C.E	DC4 47				
11421	(UNLESS LIS EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		\$54.65	\$64.17				
11422	(UNLESS LIS		\$65.21	\$77.82				
11422	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		Φ05.21	\$11.02				
11423	(UNLESS LIS		\$83.42	\$100.99				
11423	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		φ03.42	\$100.99				
11424	(UNLESS LIS		\$97.94	\$116.58				
11727	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG		ψ51.54	ψ110.00				
11426	(UNLESS LIS		\$165.58	\$165.58				
120	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT	†	7.00.00	7.00.00	+			
11440	SKIN TAG (UNLE		\$42.99	\$52.24				
	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT		7 :=: 3	+				
11441	SKIN TAG (UNLE		\$59.12	\$70.52				

Physician	Fee Schedule 2020							
Note:	The content of the co							
	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT							
11442	SKIN TAG (UNLE		\$71.10	\$86.12				
	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT		404.00					
11443	SKIN TAG (UNLE		\$94.69	\$114.13				
	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT		# 400.00	0444.70				
11444	SKIN TAG (UNLE		\$122.00	\$141.72				
11116	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT		Φ4 <i>E</i> 0 <i>E</i> 0	£400.40				
11446	SKIN TAG (UNLE EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS,		\$158.53	\$182.40				
11450	AXILLARY: W		\$158.28	\$158.28				
11430	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS.		φ130.20	φ130.20				
11451	AXILLARY; W		\$200.47	\$200.47				
11401	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS.		Ψ200.+1	Ψ200.41				
11462	INGUINAL; W		\$142.64	\$142.64				
11102	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS,		ψ.12.01	ψ · 12.0 ·				
11463	INGUINAL; W		\$173.41	\$173.41				
	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS,							
11470	PERIANAL,		\$176.46	\$176.46				
	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS,							
11471	PERIANAL,		\$202.65	\$202.65				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,							
11600	OR LEGS; EX		\$57.49	\$72.65				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,							
11601	OR LEGS; EX		\$76.72	\$95.36				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,							
11602	OR LEGS; EX		\$88.16	\$112.56				

Physician	n Fee Schedule 2020							
Note:								
	des in Red;							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Ĭ					
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,							
11603	OR LEGS; EX		\$102.77	\$132.94				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,							
11604	OR LEGS; EX		\$115.29	\$150.03				
44000	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS,		0404.50	040450				
11606	OR LEGS; EX		\$194.50	\$194.50				
44000	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		050.74	#70.74				
11620	HANDS, FEET		\$58.74	\$76.71				
11001	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		#00.70	¢407.47				
11621	HANDS, FEET EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		\$83.70	\$107.17				
11622	HANDS, FEET		\$101.32	\$130.82				
11022	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		\$101.32	\$130.02				
11623	HANDS, FEET		\$125.18	\$159.78				
11023	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		ψ123.10	ψ139.76				
11624	HANDS, FEET		\$150.01	\$193.05				
11024	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK,		Ψ100.01	Ψ100.00				
11626	HANDS, FEET		\$227.10	\$227.10				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS,		V	+==:::0				
11640	EYELIDS, NOS		\$69.20	\$91.33				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS,		, , , ,	, , , , , , , , , , , , , , , , , , , ,				
11641	EYELIDS, NOS		\$102.53	\$130.56				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS,							
11642	EYELIDS, NOS		\$124.56	\$159.03				
	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS,							
11643	EYELIDS, NOS		\$148.41	\$188.77				

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	es in Red;		+			+	+	+
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service)		_	_	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai T	ns T					
							Base	
Duas			lanet Dete	Output Bata	Tech.	Prof.	Unit	
Proc	Durandon Danielation	DA III I	Inpat. Rate	Outpat. Rate				Madaa
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
44044	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS,		0407.44	0004.04				
11644	EYELIDS, NOS		\$187.14	\$234.21				
11646	EXCISION, MALIGNANT LESION INCLUDING MARGIN		\$302.11	\$302.11				
11719	TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER		\$9.61	\$9.61				
11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); ONE TO FIVE		\$18.20	\$18.20				
11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); SIX OR MORE		\$30.70	\$30.70				
11730	AVULUSION OF MAIL DUATE DARTIAL OR COMPLETE SIMPLE, SINCLE		\$40.17	\$46.20				
11730	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SINGLE AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; EACH		\$40.17	\$40.20				
11700	· · · · · · · · · · · · · · · · · · ·		¢44.00	¢40.04				
11732 11740	ADDITIONAL N EVACUATION OF SUBUNGUAL HEMATOMA		\$14.99 \$17.06	\$18.34 \$22.29				
11740			\$17.06	\$22.29				
44750	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG,		CO4 40	¢400.05				
11750	INGROWN OR		\$81.49	\$109.65				
44755	BIOPSY OF NAIL UNIT (EG, PLATE, BED, MATRIX, HYPONYCHIUM,		007.04	007.04				
11755	PROXIMAL AND		\$67.91	\$67.91				
11760	REPAIR OF NAIL BED		\$59.55	\$72.03		_		
11762	RECONSTRUCTION OF NAIL BED WITH GRAFT		\$123.63	\$158.10		_		
44705	WEDGE EXCISION OF SKIN OF NAIL FOLD (EG, FOR INGROWN		000.00	000.07				
11765	TOENAIL)		\$26.83	\$33.67				
11770	EXCISION OF PILONIDAL CYST OR SINUS; SIMPLE		\$157.43	\$157.43				
11771	EXCISION OF PILONIDAL CYST OR SINUS; EXTENSIVE		\$294.71	\$294.71				
11772	EXCISION PILONIDAL CYST OR SINUS; COMPLICATED		\$340.45	\$340.45				
11900	INJECTION, INTRALESIONAL; UP TO AND INCLUDING SEVEN LESIONS		\$19.10	\$22.45				
11901	INJECTION, INTRALESIONAL; MORE THAN SEVEN LESIONS	1	\$29.70	\$35.20		+		+
11001	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN);		Ψ20.10	ψου.20				
11954	OVER 10.0 C	R	\$88.88	\$88.88				

Physiciar	n Fee Schedule 2020							
Note:								
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Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
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The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST,							
11960	INCLUDING SUBSE	R	\$420.53	\$420.53				
	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT							
11970	PROSTHESIS	R	\$462.51	\$462.51				
1	REMOVAL OF TISSUE EXPANDER(S) WITHOUT INSERTION OF							
11971	PROSTHESIS		\$125.92	\$125.92				
11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES		\$93.85	\$93.85				
11980	SUBCUTANEOUS HORMONE PELLET IMPLANTATION		\$51.38	\$74.97				
11981	INSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT		\$61.32	\$86.88				
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT		\$73.80	\$99.36				
44000	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG		A400 70	# 4 0 0 0 F				
11983	DELIVERY IMPLANT		\$136.79	\$162.35				
40004	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		#C4 00	C4.00				
12001	AXILLAE, EXTERNAL SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		\$64.92	\$64.92				
12002			ф 7 С 00	¢76.00				
12002	AXILLAE, EXTERNAL SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		\$76.00	\$76.00				
12004	AXILLAE, EXTERNAL		\$97.27	\$97.27				
12004	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		φ91.21	φ91.21		+		
12005	AXILLAE, EXTERNAL		\$125.29	\$125.29				
12003	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		ψ123.23	ψ123.29				
12006	AXILLAE, EXTERNAL		\$158.58	\$158.58				
12000	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK,		ψ100.00	ψ100.00		+		
12007	AXILLAE, EXTERNAL		\$172.32	\$172.32				
12007			Ψ112.02	ψ112.02		+		+
12011			\$71.48	\$71.48				
12011	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS		\$71.48	\$71.48				

Physician	n Fee Schedule 2020							
Note:	The content of the co							
	des in Red;							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,							
12013	NOSE, LIPS		\$86.50	\$86.50				
	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,							
12014	NOSE, LIPS		\$105.07	\$105.07				
	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,							
12015	NOSE, LIPS		\$138.99	\$138.99				
1,0040	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,		4.70.00	4.70.00				
12016	NOSE, LIPS		\$179.09	\$179.09				
40047	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,		#004.40	#004.40				
12017	NOSE, LIPS SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS,		\$234.40	\$234.40				
10010	NOSE, LIPS		\$310.60	\$310.60				
12018	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; SIMPLE		\$310.00	\$310.00				
12020	CLOSURE		\$111.70	\$111.70				
12020	CLOSURE		φ111.70	φ111.70				
12021	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; WITH PACKING		\$63.51	\$71.83				
12021	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR		Ψ00.01	Ψ7 1.00				
12031	EXTREMITIES		\$72.98	\$82.63				
12001	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR		Ψ12.00	Ψ02.00				
12032	EXTREMITIES		\$87.52	\$101.60				
	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR		+	V.O.1.00				
12034	EXTREMITIES		\$127.29	\$127.29				
	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR							
12035	EXTREMITIES		\$156.27	\$156.27				
	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR							
12036	EXTREMITIES		\$188.59	\$188.59				

Physician	n Fee Schedule 2020		1					
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR		7	, , ,	'			
12037	EXTREMITIES		\$230.11	\$230.11				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12041	EXTERNAL GENITALIA		\$81.29	\$92.55				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12042	EXTERNAL GENITALIA		\$97.54	\$113.23				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12044	EXTERNAL GENITALIA		\$138.25	\$138.25				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12045	EXTERNAL GENITALIA		\$168.06	\$168.06				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12046	EXTERNAL GENITALIA		\$207.87	\$207.87				
	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR							
12047	EXTERNAL GENITALIA		\$256.41	\$256.41				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12051	AND/OR MUCO		\$86.99	\$100.53				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12052	AND/OR MUCO		\$102.93	\$122.64				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12053	AND/OR MUCO		\$141.42	\$141.42				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12054	AND/OR MUCO		\$175.87	\$175.87				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12055	AND/OR MUCO		\$224.42	\$224.42				
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12056	AND/OR MUCO		\$292.06	\$292.06				

Dhysician	Fee Schedule 2020	1		1				
Note:	Tee Scriedule 2020						+	
	│ les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required	<u> </u>						
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS							
12057	AND/OR MUCO		\$334.48	\$334.48				
13100	REPAIR, COMPLEX, TRUNK; 1.1 CM TO 2.5 CM		\$108.53	\$123.82				
13101	REPAIR, COMPLEX, TRUNK; 2.6 CM TO 7.5 CM		\$146.56	\$174.45				
	REPAIR, COMPLEX, TRUNK; EACH ADDITIONAL 5 CM OR LESS (LIST							
13102	SEPARATELY		\$56.01	\$56.01				
13120	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 1.1 CM TO 2.5 CM		\$117.60	\$135.71				
13121	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 2.6 CM TO 7.5 CM		\$169.15	\$204.69				
	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL		Ţ	+ ====================================				
13122	5 CM OR LES		\$65.12	\$65.12				
10122	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK,		ψ00.1 <u>2</u>	ψ00.12				
13131	AXILLAE, GENITAL		\$141.89	\$168.44				
10101	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK,		ψ111.00	Ψ100.11				
13132	AXILLAE, GENITAL		\$195.52	\$256.80				
10102	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK,		ψ133.32	Ψ230.00				
13133	AXILLAE, GENITAL		\$96.50	\$96.50				
13133	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.0 CM OR		ψ90.50	ψ90.50			+	
13150	LESS		\$163.13	\$163.13				
13130	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.1 CM TO		\$103.13	φ103.13				
13151	2.5 CM		\$170.47	\$203.33				
13131	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO		φ1/0.4/	φ ∠ ∪3.33				
12150			¢260.60	t220 40				
13152	7.5 CM	1	\$269.60	\$338.40		_		
40450	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; EACH		# 400.00	0400.00				
13153	ADDITIONAL 5 CM		\$106.06	\$106.06				

Note	Physician	n Fee Schedule 2020							
2020 Codes in Red;		The econedule 2020							
Refer to CPT book for descriptions		des in Red							
R' in PA column indicates Prior Auth is required Codes listed as \$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed as \$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed base Rate is \$15, 20. Each 15 minute increment=1 time unit. Codes listed on the lab fee schedule from covered closely in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the la									
Codes Isled as '\$0.00'' pay 45% of Dilled amount not to exceed provider's usual and ustomary charge for the service									
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.			omany chai	rgo for the convice	,				
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.			T		,			+	
Proc Procedure Description SECONDARY CLOSURE OF SURGICAL WOUND OR DEHISCENCE, 13160 EXTENSIVE OR COMPL. S383.05		•	rango						
Proc Code Procedure Description				ne					
Proc Procedure Description	Codes lis		T priysicia	113					
Proc Procedure Description								Base	
Code	Proc			Innat Rate	Outnat Rate	Tech	Prof		
SECONDARY CLÖSURE OF SURGICAL WOUND OR DEHISCENCE, \$383.05 \$		Procedure Description	DA Ind		•				Notos
13160 EXTENSIVE OR COMPLI \$383.05 \$383.05 \$383.05 \$383.05 \$14000 DEFECT 10 SQ CM OR L \$214.30 \$260.03 \$2	Code		FAIIIU	(i acility)	(Noni acinty)	Comp.	Comp.	Value	Notes
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; \$214.30 \$260.03 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; \$374.16 \$374.16 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DE \$321.74 \$321.74 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, ADJACE	13160	, ,		\$383.05	\$383.05				
14000 DEFECT 10 SQ CM OR L	10100			ψ000.00	ψ000.00				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; \$374.16 \$3	14000	, , ,		\$214 30	\$260.03				
14001 DEFECT 10.1 SQ CM TO	14000		+	Ψ2 14.00	Ψ200.00				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS \$321.74	14001	I ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		\$374 16	\$374 16				
14020 AND/OR LEGS; DE	11001			ψον 1.10	φον 1.10				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS \$464.35 \$464.36 \$464.35	14020			\$321 74	\$321.74				
14021 AND/OR LEGS; DE	11020			Ψ021.71	Ψ021.71				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, 14040 CHEEKS, CHIN, MOU ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, 14041 CHEEKS, CHIN, MOU ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, 14060 NOSE, EARS AND/OR ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, 14061 NOSE, EARS AND/OR ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, 14061 NOSE, EARS AND/OR 4469.36 \$469.36 \$469.36 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, 14301 ADJ TISSUE TRANSFER OR REARRANGEMENTM ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF 14350 RECIPIENT SITE \$453.88 \$453.88 \$15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62	14021			\$464 35	\$464.35				
14040 CHEEKS, CHIN, MOU \$317.27 \$408.06 14041 CHEEKS, CHIN, MOU \$445.61 \$551.29 14061 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR \$469.36 \$469.36 14061 NOSE, EARS AND/OR \$506.64 \$647.32 14301 ADJ TISSUE TRANSFER OR REARRANGEMENT ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15004 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62		,		ψ 10 1.00	ψ101.00				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOU ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR S506.64 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, S506.64 S647.32 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, S506.64 S647.32 S506.64 S647.32 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATELY R S169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE S453.88 S453.88 S453.88 S453.88 S453.88 S453.89 S45	14040	■		\$317.27	\$408.06				
14041 CHEEKS, CHIN, MOU \$445.61 \$551.29 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, \$469.36 \$469.36 14060 NOSE, EARS AND/OR \$506.64 \$647.32 14061 NOSE, EARS AND/OR \$506.64 \$647.32 14301 ADJ TISSUE TRANSFER OR REARRANGEMENTM ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62				V • • • • • • • • • • • • • • • • • • •	V 100100				
ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS,	14041			\$445.61	\$551.29				
14060 NOSE, EARS AND/OR \$469.36 \$469.36 ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, \$506.64 \$647.32 14061 NOSE, EARS AND/OR \$506.64 \$647.32 14301 ADJ TISSUE TRANSFER OR REARRANGEMENTM ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY) R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF \$453.88 \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62				Ų	40020				
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14061 NOSE, EARS AND/OR \$506.64 \$647.32 14301 ADJ TISSUE TRANSFER OR REARRANGEMENTM ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62		I '		,	,				
14301 ADJ TISSUE TRANSFER OR REARRANGEMENTM ANY AREA R \$647.04 \$758.80 14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF 14350 RECIPIENT SITE \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62	14061	· · · · · · · · · · · · · · · · · · ·		\$506.64	\$647.32				
14302 EACH ADD'L 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY R \$169.02 \$169.02 FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF 14350 \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62			R						
FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF									
14350 RECIPIENT SITE \$453.88 \$453.88 15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62									
15002 WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM \$159.39 \$222.05 15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62	14350			\$453.88	\$453.88				
15003 WOUND PREP, CH/INF, ADDITIONAL 100 CM \$32.93 \$49.17 15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62		WOUND PREP, CH/INF, TRK/ARM/LEG FIRST 100 SQ CM		\$159.39	\$222.05				
15004 WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM \$197.59 \$268.62					\$49.17				
15005 WOUND PREP, F/N/HF/G, ADDITIONAL 100 CM \$65.86 \$84.13	15004	WOUND PREP, CH/INF, F/N/HF/G FIRST 100 SQ CM		\$197.59	\$268.62				
	15005	WOUND PREP, F/N/HF/G, ADDITIONAL 100 CM		\$65.86	\$84.13				

Physician	n Fee Schedule 2020							
Note:	11 00 001104410 2020							
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	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	2				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	HARVEST OF SKIN FOR TISSUE CULTURED SKIN AUTOGRAFT, 100 SQ							
15040	CM OR LESS		\$94.39	\$182.17				
	PINCH GRAFT, SINGLE OR MULTIPLE, TO COVER SMALL ULCER, TIP							
15050	OF DIGIT, O		\$169.74	\$169.74				
	SPLIT-THICKNESS AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ							
15100	CM OR LESS,		\$379.61	\$379.61				
1.5404	SPLIT-THICKNESS AUTOGRAFT, TRUNK, ARMS, LEGS; EACH							
15101	ADDITIONAL 100 SQ C		\$101.14	\$101.14				
45440	EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR		# 404.00	# 500.00				
15110	LESS, OR ON		\$494.92	\$588.82				
45444	EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL		04.70	DO 4.54				
15111	100 SQ CM, OR EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK,		\$81.78	\$94.54				
15115	EARS, ORBITS,		\$508.90	\$556.87				
13113	EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK,		\$506.90	\$550.0 <i>1</i>				
15116	EARS, ORBITS,		\$111.30	\$123.04				
13110	SPLIT-THICKNESS AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH,		φ111.50	ψ123.04				
15120	NECK, EARS, OR		\$453.31	\$453.31				
10120	SPLIT-THICKNESS AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH,		ψ+30.01	ψ+00.01				
15121	NECK, EARS, OR		\$169.28	\$169.28				
10121	DERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR		Ψ100.20	Ψ100.20				
15130	LESS, OR ONE		\$485.17	\$295.10				
	DERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100			1	1			
15131	SQ CM, OR EAC		\$66.27	\$77.25				
	DERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS,							
15135	ORBITS,		\$551.35	\$596.00				

Physician	n Fee Schedule 2020							
Note:	The content of the co							
	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS,							
15136	ORBITS,		\$66.78	\$72.39				
	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS;							
15150	FIRST 25 SQ CM		\$439.14	\$490.68				
1	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS;							
15151	ADDITIONAL 1 S		\$88.28	\$100.02				
45450	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS;			4400.05				
15152	EACH ADDITIONA		\$110.29	\$123.05				
45455	TISSUE CULTURED EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS,		ф4 7 0.00	¢404.07				
15155	MOUTH, NECK TISSUE CULTURED EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS,		\$472.33	\$494.27				
15150	MOUTH, NECK		\$122.56	\$130.72				
15156	TISSUE CULTURED EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS,		\$122.50	\$130.72				
15157	MOUTH, NECK		\$133.56	\$144.53				
13137	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF		φ133.30	φ144.55				
15200	DONOR SITE, TR		\$346.44	\$346.44				
10200	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF		ψοτο.ττ	ψοτο.ττ				
15201	DONOR SITE, TR		\$95.94	\$95.94				
10201	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF		Ψοσ.σ ι	Ψ00.01				
15220	DONOR SITE, SC		\$368.20	\$368.20				
	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF		+++++++++++++++++++++++++++++++++++++	 				
15221	DONOR SITE, SC		\$89.72	\$89.72				
	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF							
15240	DONOR SITE,		\$432.19	\$432.19				
	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF							
15241	DONOR SITE,		\$132.51	\$132.51				

Physician	Fee Schedule 2020				1		1	
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	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	Э				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc Code	Dracedure Deceription	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech. Comp.	Prof. Comp.	Base Unit Value	Notes
Code	Procedure Description FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF	PAIIIU	(гаспіту)	(NonFacility)	Comp.	Comp.	value	Notes
15260	DONOR SITE, NO		\$504.67	\$504.67				
13200	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF		ψ304.07	ψ304.07				
15261	DONOR SITE, NO		\$156.46	\$156.46				
10201	BONOR GITE, NO		ψ100.40	ψ100.40				
15271	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		\$70.24	\$113.14				
15272	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		\$14.02	\$21.51				
15273	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		\$167.13	\$233.28				
15274	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		\$35.62	\$55.00				

Physician Fee Schedule 2020 Note: 2020 Codes in Rod; Refer to CPT book for descriptions R° in PA column indicates Prior Auth is required Codes listed as 30.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment** time unit. Phases usua lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from the 180000-89249 range. Codes listed on the lab fee schedule from 180000-89249 range. Codes listed on the lab fee schedule from 180000-89249 range. Codes listed on the lab fee schedule from 180000-89249 range. Force Listed on the lab fee schedule from 180000-89249 range. Codes listed on the lab fee schedule from 180000-89249 range. Codes listed on the lab fee schedule from 180000	Division	F - 0 1 - 1 1 - 0000						1	
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EACH ADDITIONAL 25 SQ CM WOUND SURFACE AREA, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) 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 15277 AREA, OR 1% OF BODY AREA OF EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION 15278 TO CODE FOR PRIMARY PROCEDURE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15570 TRANSFER; TRUNK FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15571 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15575 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; FOREHE S298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; FOREHE S298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; FOREHE S223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT		· ·							
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15276 PROCEDURE \$20.14 \$26.86		, and the second							
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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 15277 AREA, OR 1% OF BODY AREA OF EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION 15278 TO CODE FOR PRIMARY PROCEDURE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15570 TRANSFER; TRUNK S308.10 15572 TRANSFER; TRUNK S308.10 15574 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE S298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15575 TRANSFER; FOREHE S298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; FOREHE S298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT	15276	/		\$20.14	\$26.86				
AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE 15277 AREA, OR 1% OF BODY AREA OF EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION 15278 TO CODE FOR PRIMARY PROCEDURE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15570 TRANSFER; TRUNK FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15572 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT		APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP,							
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THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION 15278 TO CODE FOR PRIMARY PROCEDURE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15570 TRANSFER; TRUNK FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15572 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15575 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT	15277	AREA, OR 1% OF BODY AREA OF		\$173.89	\$236.17				
AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION 15278 TO CODE FOR PRIMARY PROCEDURE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15570 TRANSFER; TRUNK FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15572 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID S298.15 FORMATION OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT		EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART							
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FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15572 TRANSFER; SCALP, FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT		FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT							
15572 TRANSFER; SCALP, \$301.00 \$301.00 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT \$298.15 \$298.15 15574 TRANSFER; FOREHE \$298.15 \$298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT \$223.56 \$223.56 15576 TRANSFER; EYELID \$223.56 \$223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT \$23.56 \$223.56	15570	TRANSFER; TRUNK		\$308.10	\$308.10				
FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE \$298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID \$223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT		FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT							
FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15574 TRANSFER; FOREHE \$298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT 15576 TRANSFER; EYELID \$223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT	15572	TRANSFER; SCALP,		\$301.00	\$301.00				
15574 TRANSFER; FOREHE \$298.15 \$298.15 FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT \$223.56 \$223.56 15576 TRANSFER; EYELID \$223.56 \$223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT \$23.56 \$223.56									
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15576 TRANSFER; EYELID \$223.56 \$223.56 DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT									
DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT	15576	· · · · · · · · · · · · · · · · · · ·		\$223.56	\$223.56				
		DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT							
	15600			\$138.59	\$138.59				

Physician	n Fee Schedule 2020			<u> </u>				
Note:					+			
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary cha	ge for the service	9				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT							
15610	SCALP, AR		\$159.93	\$159.93				
	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT							
15620	FOREHEAD,		\$192.10	\$192.10				
	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT							
15630	EYELIDS,		\$214.02	\$214.02				
	TRANSFER, INTERMEDIATE, OF ANY PEDICLE FLAP (EG, ABDOMEN							
15650	TO WRIST, WAL		\$252.45	\$252.45				
15730	MDFC FLAP W/PRSRV VASC PEDCL		\$724.17	\$1,189.45				Added Effective 1/1/2018
15731	FOREHEAD FLAP W/VASC PEDICLE		\$681.51	\$746.71				
15733	MUSC MYOQ/FSCQ FLP H&N PEDCL		\$827.58	\$827.58				Added Effective 1/1/2018
15734	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; TRUNK		\$1,073.37	\$1,073.37				
13734	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAF, TRONK		φ1,073.37	φ1,073.37	+			
15736	EXTREMITY		\$955.95	\$955.95				
13730	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; LOWER		ψ900.90	ψ933.93				
15738	EXTREMITY		\$721.17	\$721.17				
15740	FLAP; ISLAND PEDICLE		\$595.34	\$595.34				
15750	FLAP; NEUROVASCULAR PEDICLE		\$681.45	\$681.45				
10100	FREE MUSCLE OR MYOCUTANEOUS FLAP WITH MICROVASCULAR		ψοστιτο	ψοστ.το			1	
15756	ANASTOMOSIS		\$1,862.68	\$1,862.68				
15757	FREE SKIN FLAP WITH MICROVASCULAR ANASTOMOSIS		\$1,862.68	\$1,862.68				
15758	FREE FASCIAL FLAP WITH MICROVASCULAR ANASTOMOSIS		\$1,862.68	\$1,862.68	1			
	GRAFT; COMPOSITE (EG, FULL THICKNESS OF EXTERNAL EAR OR		. ,	. ,				
15760	NASAL ALA),		\$465.47	\$465.47				
15769	GRFG AUTOL SOFT TISS DIR EXC		\$379.72	\$379.72				Added Effective 01/01/2020

Physician	Fee Schedule 2020		1				1	
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Refer to C	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary chai	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered t	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
15770	GRAFT; DERMA-FAT-FASCIA		\$424.18	\$424.18				
15771	GRFG AUTOL FAT LIPO 50 CC/<		\$377.28	\$449.66				Added Effective 01/01/2020
15772	GRFG AUTOL FAT LIPO EA ADDL		\$113.13	\$142.96				Added Effective 01/01/2020
15773	GRFG AUTOL FAT LIPO 25 CC/<		\$381.50	\$453.88				Added Effective 01/01/2020
15774	GFRG AUTOL FAT LIPO EA ADDL		\$108.73	\$138.56				Added Effective 01/01/2020
	IMPLANTATION OF BIOLOGIC IMPLANT (EG, ACELLULAR DERMAL							
	MATRIX) FOR SOFT TISSUE REINFORCEMENT (EG, BREAST,							
	TRUNK)(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY							
15777	PROCEDURE)		\$170.66	\$170.66				
	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE							
15780	WRINKLING, RHYTI	R	\$221.16	\$241.68				
15781	DERMABRASION; SEGMENTAL, FACE	R	\$197.07	\$247.63				
15782	DERMABRASION; REGIONAL, OTHER THAN FACE	R	\$142.07	\$158.03				
4.5500			45450	4.70.04				
15783	DERMABRASION; SUPERFICIAL, ANY SITE, (EG, TATTOO REMOVAL)	R	\$151.50	\$176.31				
15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)		\$67.87	\$76.19				
45707	ABRASION; EACH ADDITIONAL FOUR LESIONS OR LESS (LIST		040.50	040.50				
15787	SEPARATELY IN ADD		\$13.50	\$16.58				
15788	CHEMICAL PEEL, FACIAL, EPIDERMAL		\$100.13	\$100.13				
15789	CHEMICAL PEEL, FACIAL; DERMAL		\$180.23	\$180.23				
15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL		\$65.39 \$117.62	\$65.39				
15793	CHEMICAL PEEL, NONFACIAL; DERMAL			\$117.62				
15819	CERVICOPLASTY		\$496.26	\$496.26				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomary chai	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	ise lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
					<u></u>		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
15820	BLEPHAROPLASTY, LOWER EYELID;	R	\$321.09	\$321.09				
	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED							
15821	FAT PAD	R	\$358.36	\$358.36				
15822	BLEPHAROPLASTY, UPPER EYELID;	R	\$285.62	\$285.62				
	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN							
15823	WEIGHTING DOWN LID	R	\$416.75	\$416.75				
15824	RHYTIDECTOMY; FOREHEAD	R	\$504.16	\$504.16				
	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL							
15825	FLAP, P-FLAP)	R	\$735.05	\$735.05				
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES	R	\$448.87	\$448.87				
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK	R	\$821.68	\$821.68				
	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM							
15829	(SMAS) FLAP	R	\$895.01	\$895.01				
15830	EXCISE EXCESS SKIN, ADBOMEN	R	\$818.54	\$818.54				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE							
15832	(INCLUDING LIPECTOMY)	R	\$576.57	\$576.57				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE							
15833	(INCLUDING LIPECTOMY)	R	\$488.07	\$488.07				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE							
15834	(INCLUDING LIPECTOMY)	R	\$520.36	\$520.36				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE		·					
15835	(INCLUDING LIPECTOMY)	R	\$539.59	\$539.59				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE			,	1			
15836	(INCLUDING LIPECTOMY)	R	\$441.40	\$441.40				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE	1	+	+ · · · · · •				
15837	(INCLUDING LIPECTOMY)	R	\$417.88	\$417.88				
10001	Maracas and En Colomity		Ψ+17.00	Ψ-17.00				

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	CPT book for descriptions							
	column indicates Prior Auth is required	<u> </u>						
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE							
15838	(INCLUDING LIPECTOMY)	R	\$374.40	\$374.40				
	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE							
15839	(INCLUDING LIPECTOMY)	R	\$338.37	\$338.37				
	GRAFT FOR FACIAL NERVE PARALYSIS; FREE FASCIA GRAFT							
15840	(INCLUDING OBTAINI		\$831.97	\$831.97				
	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT							
15841	(INCLUDING OBTAINI		\$1,151.32	\$1,151.32				
	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE FLAP BY							
15842	MICROSURGICAL		\$1,898.74	\$1,898.74				
	GRAFT FOR FACIAL NERVE PARALYSIS; REGIONAL MUSCLE							
15845	TRANSFER		\$812.98	\$812.98				
	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL),							
15850	SAME SURGEON		\$33.52	\$33.52				
	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL),							
15851	OTHER SURGEON		\$29.99	\$34.01				
	DRESSING CHANGE (FOR OTHER THAN BURNS) UNDER ANESTHESIA							
15852	(OTHER THAN LO		\$32.84	\$38.74				
	INTRAVENOUS INJECTION OF AGENT (EG, FLUORESCEIN) TO TEST							
15860	VASCULAR FLOW		\$99.50	\$99.50				
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK	R	\$144.85	\$144.85				
15877	SUCTION ASSISTED LIPECTOMY; TRUNK	R	\$144.85	\$144.85				
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY	R	\$144.85	\$144.85				
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY	R	\$144.85	\$144.85				
15920	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY; WITH PRIMARY SU		\$310.70	\$310.70				

Physician	Fee Schedule 2020							
Note:								
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary chai	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a $$ P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY;							
15922	WITH FLAP CLOSU		\$458.39	\$458.39				
15931	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE;		\$330.52	\$330.52				
	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE;							
15933	WITH OSTECTOMY		\$503.23	\$503.23				
45004			4==4.00	4==4.00				
15934	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE;		\$571.06	\$571.06				
45005	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE;		ф 7 20 Б 7	ф 7 20 5 7				
15935	WITH OSTECTOM		\$739.57	\$739.57				
45006	EXCISION, SACRAL PRESSURE ULCER, IN PREPARATION FOR		ФСБ 7 4Б	CE7 1				
15936	MUSCLE OR MYOCUTAN EXCISION, SACRAL PRESSURE ULCER, IN PREPARATION FOR		\$657.15	\$657.15				
15937	MUSCLE OR MYOCUTAN		\$807.05	\$807.05				
15937	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE;		\$353.28	\$353.28				
13340	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE;		ψ333.20	ψ333.20				
15941	WITH OSTECTOMY		\$520.71	\$520.71				
10041	WITH COTECTONIT		ψ020.71	Ψ020.7 1				
15944	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE;		\$591.31	\$591.31				
10044	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE;		φοστιστ	φοστ.στ	+	+		
15945	WITH OSTECTO		\$681.75	\$681.75				
100.10	EXCISION, ISCHIAL PRESSURE ULCER, WITH OSTECTOMY, IN		4001.110	ψοστιτο				
15946	PREPARATION FOR M		\$1,105.54	\$1,105.54				
	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY		, .,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	+			
15950	SUTURE;		\$294.07	\$294.07				
	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY		1					
15951	SUTURE; WITH OSTEC		\$524.40	\$524.40				

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ae for the service	·				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP							
15952	CLOSURE;		\$523.25	\$523.25				
1	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP							
15953	CLOSURE; WITH		\$623.21	\$623.21				
45050	EXCISION, TROCHANTERIC PRESSURE ULCER, IN PREPARATION FOR		4054.00	4054.00				
15956	MUSCLE OR		\$951.66	\$951.66				
45050	EXCISION, TROCHANTERIC PRESSURE ULCER, IN PREPARATION FOR		0075 57	4075 57				
15958	MUSCLE OR	П	\$975.57	\$975.57				
15999	UNLISTED PROCEDURE, EXCISION PRESSURE ULCER	R	\$0.00	\$0.00				
16000	INITIAL TREATMENT, FIRST DEGREE BURN, WHEN NO MORE THAN LOCAL TREATMEN		\$31.54	\$36.23				
16000	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS,		φ31.3 4					
16020	INITIAL OR		\$28.76	\$33.32				
10020	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS,		φ20.70	φυυ.υΖ			+	+
16025	INITIAL OR		\$61.54	\$67.57				
10023	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS,		ΨΟ1.04	ΨΟΤ.ΟΤ				
16030	INITIAL OR		\$76.93	\$76.93				
16035	ESCHAROTOMY; INITIAL INCISION		\$191.61	\$191.61				
	ESCHAROTOMY; EACH ADDITIONAL INCISION (LIST SEPARATELY IN		V 10 110 1	4.01.01				
16036	ADDITION TO		\$64.19	\$64.19				
	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY,							
17000	CRYOSURGERY, CHEMOSURG		\$43.54	\$43.54				
	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY,							
17003	CRYOSURGERY, CHEMOSURG		\$7.92	\$7.92				
	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY,							
17004	CRYOSURGERY, CHEMOSURG		\$143.35	\$143.35				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I onar	1	<u> </u>		+		
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS		7/	77				
17106	(EG, LASER		\$163.48	\$189.36				
	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS							
17107	(EG, LASER		\$324.95	\$374.57				
	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS							
17108	(EG, LASER		\$651.15	\$651.15				
	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY,							
17110	CRYOSURGERY, CHEMOSURG		\$22.23	\$27.60				
	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY,							
17111	CRYOSURGERY, CHEMOSURG		\$43.22	\$43.22				
	CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD							
17250	FLESH, SINUS OR		\$20.20	\$24.76				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17260	ELECTROSURGERY,		\$42.82	\$57.97				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17261	ELECTROSURGERY,		\$54.42	\$73.06				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17262	ELECTROSURGERY,		\$73.19	\$97.60				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17263	ELECTROSURGERY,		\$86.34	\$116.51				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17264	ELECTROSURGERY,		\$96.51	\$131.25				
1.000	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,		.	4.00 5-5				
17266	ELECTROSURGERY,		\$120.81	\$162.52				
1.70-5	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,		4=0.4=	470.46				
17270	ELECTROSURGERY,		\$58.15	\$76.12				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-8924							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
47074	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,		400.04	***				
17271	ELECTROSURGERY,		\$69.61	\$93.08				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17272	ELECTROSURGERY,		\$84.59	\$114.10				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17273	ELECTROSURGERY,		\$99.36	\$133.96				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17274	ELECTROSURGERY,		\$125.36	\$168.41				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17276	ELECTROSURGERY,		\$150.56	\$196.29				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17280	ELECTROSURGERY,		\$58.64	\$80.77				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17281	ELECTROSURGERY,		\$81.41	\$109.44				
17282	DESTRUCTION, MALIGNANT LESION		\$98.45	\$132.91				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17283	ELECTROSURGERY,		\$123.17	\$163.54				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17284	ELECTROSURGERY,		\$147.82	\$194.89				
	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY,							
17286	ELECTROSURGERY,		\$201.33	\$259.27				
17311	MOHS, 1 STAGE, H//HF/G		\$264.71	\$458.27				
17312	MOHS, ADDITIONAL STAGE		\$140.90	\$273.83				
17313	MOHS, 1 STAGE, T/A/L		\$237.41	\$418.03				
17314	MOHS, ADDITIONAL STAGE, T/A/L		\$130.45	\$253.73				
17315	MOHS SURG, ADDITIONAL BLOCK		\$36.96	\$54.98				
17340	CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE		\$25.66	\$29.42				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
17360	CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID)		\$45.19	\$48.81				
	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND							
17999	SUBCUTANEOUS TISSUE	R	\$0.00	\$0.00				
19000	PUNCTURE ASPIRATION OF CYST OF BREAST;		\$31.45	\$36.54				
	PUNCTURE ASPIRATION OF CYST OF BREAST; EACH ADDITIONAL							
19001	CYST (LIST		\$16.76	\$19.98				
					1			
19020	MASTOTOMY WITH EXPLORATION OR DRAINAGE OF ABSCESS, DEEP		\$143.24	\$143.24				
	INJECTION PROCEDURE ONLY FOR MAMMARY DUCTOGRAM OR				1			
19030	GALACTOGRAM		\$59.01	\$59.01				
19081	BX BREAST 1ST LESION STRTCTC		\$145.68	\$502.98				
19082	BX BREAST ADD LESION STRTCTC		\$69.99	\$403.48				
19083	BX BREAST 1ST LESION US IMAG		\$136.63	\$499.10				
19084	BX BREAST ADD LESION US IMAG		\$65.79	\$397.73				
19085	BX BREAST 1ST LESION MR IMAG		\$159.63	\$752.11				
19086	BX BREAST ADD LESION MR IMAG		\$72.71	\$596.88				
	BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, NOT USING							
19100	IMAGING GUIDANC		\$49.01	\$57.59				
19101	BIOPSY OF BREAST; OPEN, INCISIONAL		\$165.54	\$165.54	1			
	BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, USING							
19102	IMAGING GUIDANCE		\$78.40	\$177.78				
1 2 2 2	BIOPSY OF BREAST; PERCUTANEOUS, AUTOMATED VACUUM		,	Ţ .	†	1		
19103	ASSISTED OR ROTATING		\$92.41	\$349.76				
19105	ABLATION, CRYOSURGERY OF FIBROADENOMA		\$139.21	\$1,278.99	+	1		
10.00	NIPPLE EXPLORATION, WITH OR WITHOUT EXCISION OF A SOLITARY		¥.00.2.	7 1,21 3.00	+	1		+
19110	LACTIFEROUS		\$200.15	\$200.15				
19112	EXCISION OF LACTIFEROUS DUCT FISTULA		\$174.56	\$174.56				+
19112	EXCISION OF EACH ENGOGRACITY TO TOLA	Į	ψ117.30	ψ117.00	<u> </u>			

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physiciai	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION OF CYST, FIBROADENOMA, OR OTHER BENIGN OR							
19120	MALIGNANT TUMOR,		\$263.73	\$263.73				
	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE							
19125	PLACEMENT OF		\$264.02	\$264.02				
	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE							
19126	PLACEMENT OF		\$132.40	\$132.40				
19260	EXCISION OF CHEST WALL TUMOR INCLUDING RIBS		\$568.89	\$568.89				
	EXCISION OF CHEST WALL TUMOR INVOLVING RIBS, WITH PLASTIC							
19271	RECONSTRUCTI		\$942.37	\$942.37				
	EXCISION OF CHEST WALL TUMOR INVOLVING RIBS, WITH PLASTIC							
19272	RECONSTRUCTI		\$971.48	\$971.48				
19281	PERQ DEVICE BREAST 1ST IMAG		\$82.85	\$184.53				
19282	PERQ DEVICE BREAST EA IMAG		\$39.93	\$126.86				
19283	PERQ DEV BREAST 1ST STRTCTC		\$83.62	\$208.59				
19284	PERQ DEV BREAST ADD STRTCTC		\$40.19	\$151.44				
19285	PERQ DEV BREAST 1ST US IMAG		\$70.93	\$346.99				
19286	PERQ DEV BREAST ADD US IMA		\$34.45	\$289.03				
19287	PERQ DEV BREAST 1ST MR GUIDE		\$113.64	\$639.89				
19288	PERQ DEV BREAST ADD MR GUIDE		\$51.57	\$507.70				
19294	PREP TUM CAV IORT PRTL MAST		\$130.59	\$130.59				Added Effective 1/1/2018
19300	REMOVAL OF EXTRA BREAST TISSUE		\$256.03	\$353.44				
19301	MASTECTOMY PARTIAL REMOVAL OF BREAST		\$281.70	\$281.70				
19302	MASTECTOMY WITH AXILLARY LYMPHADENECTOMY		\$604.90	\$604.90				
19303	MASTECTOMY, SIMPLE, COMPLETE		\$621.09	\$621.09				
19304	MASTECTOMY, SUBCUTANEOUS		\$373.04	\$373.04				
19305	MASTECTOMY, RADICAL, W/PEC NUSCLES, AXILLARY LYMPH NODES		\$748.26	\$748.26				

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	esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes listed	d on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code F		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MASTECTOMY, RADICAL, W/PEC MUSCLES, AXILLARY AND INTERNAL							
	MAMM LYMPH NODES		\$778.05	\$778.05				
	MASTECTOMY, MODIFIED RADICAL		\$782.45	\$782.45				
	MASTOPEXY	R	\$698.93	\$698.93				
19318 F	REDUCTION MAMMAPLASTY	R	\$829.81	\$829.81				
		R	\$267.38	\$267.38				
19325 N	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT	R	\$421.12	\$421.12				
	REMOVAL OF INTACT MAMMARY IMPLANT	R	\$274.70	\$274.70				
	REMOVAL OF MAMMARY IMPLANT MATERIAL		\$332.98	\$332.98				
	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING							
	MASTOPEXY, MASTECTO	R	\$453.06	\$453.06				
	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING							
19342 N	MASTOPEXY, MASTECTOMY	R	\$651.49	\$651.49				
19350 N	NIPPLE/AREOLA RECONSTRUCTION		\$464.34	\$464.34				
E	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE							
19357 E	EXPANDER,	R	\$874.10	\$874.10				
19361 E	BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP	R	\$1,157.11	\$1,157.11				
19364 E	BREAST RECONSTRUCTION WITH FREE FLAP	R	\$1,344.26	\$1,344.26				
19366 E	BREAST RECONSTRUCTION WITH OTHER TECHNIQUE	R	\$1,099.33	\$1,099.33		İ		
	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS		·	·		1		
19367 N	MYOCUTANEOUS FL	R	\$1,359.87	\$1,359.87		1		
	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS			,			1	
	MYOCUTANEOUS FL	R	\$1,548.26	\$1,548.26		1		
	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS			, ,	1		1	
	MYOCUTANEOUS FL	R	\$1,475.78	\$1,475.78				
	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST	R	\$417.12	\$417.12				
	PERIPROSTHETIC CAPSULECTOMY, BREAST	R	\$508.98	\$508.98		1		

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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					l		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
19380	REVISION OF RECONSTRUCTED BREAST		\$508.91	\$508.91				
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT	R	\$113.32	\$113.32				
19499	UNLISTED PROCEDURE, BREAST	R	\$250.00	\$325.00				
	EXPLORATION OF PENETRATING WOUND (SEPARATE PROCEDURE);							
20100	NECK		\$440.26	\$440.26				
	EXPLORATION OF PENETRATING WOUND (SEPARATE PROCEDURE);							
20101	CHEST		\$139.13	\$139.13				
	EXPLORATION OF PENETRATING WOUND (SEPARATE PROCEDURE);							
20102	ABDOMEN/FLANK/B		\$170.42	\$170.42				
	EXPLORATION OF PENETRATING WOUND (SEPARATE PROCEDURE);							
20103	EXTREMITY		\$229.30	\$229.30				
	EXCISION OF EPIPHYSEAL BAR, WITH OR WITHOUT AUTOGENOUS							
20150	SOFT TISSUE GRA		\$743.56	\$743.56				
20200	BIOPSY, MUSCLE; SUPERFICIAL		\$77.26	\$77.26				
20205	BIOPSY, MUSCLE; DEEP		\$127.40	\$127.40				
20206	BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE		\$58.20	\$58.20				
	BIOPSY, BONE, TROCAR, OR NEEDLE; SUPERFICIAL (EG, ILIUM,							
20220	STERNUM, SPIN		\$74.59	\$74.59				
	BIOPSY, BONE, TROCAR, OR NEEDLE; DEEP (EG, VERTEBRAL BODY,							
20225	FEMUR)		\$125.78	\$125.78				
	BIOPSY, BONE, OPEN; SUPERFICIAL (EG, ILIUM, STERNUM, SPINOUS							
20240	PROCESS,		\$144.88	\$144.88				
20245	BIOPSY, BONE, OPEN; DEEP (EG, HUMERUS, ISCHIUM, FEMUR)		\$214.70	\$214.70				
20250	BIOPSY, VERTEBRAL BODY, OPEN; THORACIC		\$290.31	\$290.31				
20251	BIOPSY, VERTEBRAL BODY, OPEN; LUMBAR OR CERVICAL		\$330.41	\$330.41				
	INJECTION OF SINUS TRACT; THERAPEUTIC (SEPARATE							
20500	PROCEDURE)		\$40.43	\$45.25				

Physicia	n Fee Schedule 2020							
Note:								
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Codes lis	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
The Ane	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	ise lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
20501	INJECTION OF SINUS TRACT; DIAGNOSTIC (SINOGRAM)		\$30.83	\$30.83				
	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH;							
20520	SIMPLE		\$64.28	\$73.81				
	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; DEEP							
20525	OR COMPLICATE		\$162.61	\$162.61				
	INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC,							
20526	CORTICOSTEROID), CARPAL		\$36.32	\$46.38				
20527	INJECTION, ENZYME (EG, COLLAGENASE), PALMAR FASCIAL CORD		\$47.66	\$60.07				
20021	INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT,		Ψ+7.00	φοσ.στ				
20550	APONEUROSIS (EG, PLAN		\$31.93	\$53.93				
20551	INJECTION(S); SINGLE TENDON ORIGIN/INSERTION		\$36.32	\$46.38				
	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), ONE OR		+++++++++++++++++++++++++++++++++++++	V 10100				
20552	TWO MUSCLE(S		\$36.32	\$46.38				
	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), THREE OR							
20553	MORE MUSCL		\$36.32	\$46.38				
20555	PLACE NDL MUSC/TIS FOR RT		\$255.46	\$255.46				
20560	NDL INSJ W/O NJX 1 OR 2 MUSC		\$13.20	\$20.20				Added Effective 01/01/2020
20561	NDL INSJ W/O NJX 3+ MUSC		\$19.92	\$30.03				Added Effective 01/01/2020
	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; SMALL JOINT							
20600	OR BURSA (EG,		\$26.88	\$33.19				
	ASPIRATION AND/OR INJECTION OF SMALL JOINT OR JOINT CAPSULE							
20604	WITH RECORDING AND REPORTING USING ULTRASOUND GUIDANCE		\$37.30	\$56.19				Added Effective 1/1/2015

Physician	Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	oniary chai						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						+
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Oodes iis	The lab lee solicadic that begin with a 1-of Q are currently non-covered in	or priyatolal	113					+
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Jour	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; INTERMEDIATE	I A IIIu	(r donity)	(Norm domity)	Jonip.	Comp.	Value	110100
20605	JOINT OR BUR		\$27.20	\$33.24				
20000	ASPIRATION AND/OR INJECTION OF INTERMEDIATE JOINT OR JOINT		Ψ27.20	ψ00.2-τ				+
	CAPSULE WITH RECORDING AND REPORTING USING ULTRASOUND							
20606	GUIDANCE		\$42.59	\$62.25				Added effective 1/1/2015
20000	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; MAJOR JOINT		Ψ+2.55	ψ02.23				Added effective 1/1/2013
20610	OR BURSA (EG,		\$50.81	\$50.81				
20010	ASPIRATION AND/OR INJECTION OF MAJOR JOINT OR JOINT		ψ30.01	ψ50.01				
	CAPSULE WITH RECORDING AND REPORTING USING ULTRASOUND							
20611	GUIDANCE		\$49.84	\$71.57				Added effective 1/1/2015
20011	ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY		ψ49.04	ψ11.51				Added effective 1/1/2013
20612	LOCATION		\$28.90	\$41.49				
20615	ASPIRATION AND INJECTION FOR TREATMENT OF BONE CYST		\$73.47	\$80.04				
20013	INSERTION OF WIRE OR PIN WITH APPLICATION OF SKELETAL		Ψ1 3.41	ψ00.04	+			+
20650	TRACTION, INCLUD		\$93.11	\$93.11				
20030	APPLICATION OF CRANIAL TONGS, CALIPER, OR STEREOTACTIC		ψ93.11	ψ95.11				+
20660	FRAME, INCLUDIN		\$120.60	\$120.60				
20661	APPLICATION OF HALO, INCLUDING REMOVAL; CRANIAL		\$243.55	\$243.55				
20662	APPLICATION OF HALO, INCLUDING REMOVAL; PELVIC		\$362.42	\$362.42				
20663	APPLICATION OF HALO, INCL REMOVAL; FEMORAL		\$286.12	\$286.12				
20000	APPLICATION OF HALO, INCLUDING REMOVAL, CRANIAL, 6 OR MORE		Ψ200.12	Ψ200.12				
20664	PINS PLACED		\$346.60	\$346.60				
20007	1 110 1 11010		ψ0-10.00	ψ0-10.00				
20665	REMOVAL OF TONGS OR HALO APPLIED BY ANOTHER PHYSICIAN		\$52.08	\$52.08				
20000	REMOVAL OF IMPLANT; SUPERFICIAL, (EG, BURIED WIRE, PIN OR		Ψ02.00	ψ02.00				+
20670	ROD) (SEPARA		\$62.19	\$72.11				
20070	INOD/ (OLI MINI		Ψ02.13	Ψ12.11				

Physiciar	n Fee Schedule 2020	I	1			1		
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REMOVAL OF IMPLANT; DEEP (EG, BURIED WIRE, PIN, SCREW,							
20680	METAL BAND, NAI		\$197.08	\$197.08				
	APPLICATION OF A UNIPLANE (PINS OR WIRES IN ONE PLANE),							
20690	UNILATERAL,		\$215.55	\$215.55				
00000	APPLICATION OF A MULTIPLANE (PINS OR WIRES IN MORE THAN ONE		0057.54	0057.54				
20692	PLANE),		\$357.51	\$357.51				
00000	ADJUSTMENT OR REVISION OF EXTERNAL FIXATION SYSTEM		# 000 00	фоос оо				
20693	REQUIRING ANESTHESI		\$236.03	\$236.03				
20694	REMOVAL, UNDER ANESTHESIA, OF EXTERNAL FIXATION SYSTEM		\$191.50	\$191.50				
20696	APPLICATION OF MULTIPLANE (PINS OR WIRES)		\$834.91	\$834.91				
20697	EXCHANGE (IE, REMOVAL & REPLACEMENT) OF STRUT		\$981.78	\$981.78				
20700	MNL PREP&INSJ DP RX DLVR DEV		\$67.81	\$67.81		_		Added Effective 01/01/2020
20701	RMVL DEEP RX DELIVERY DEVICE		\$50.63	\$50.63				Added Effective 01/01/2020
20702	MNL PREP&INSJ IMED RX DEV		\$112.82	\$112.82				Added Effective 01/01/2020
20703	RMVL IMED RX DELIVERY DEVICE		\$80.92	\$80.92				Added Effective 01/01/2020
20704	MNL PREP&INSJ I-ARTIC RX DEV		\$117.53	\$117.53				Added Effective 01/01/2020
20705	RMVL I-ARTIC RX DELIVERY DEV		\$96.75	\$96.75				Added Effective 01/01/2020
	REPLANTATION, ARM (INCLUDES SURGICAL NECK OF HUMERUS							
20802	THROUGH ELBOW JOI		\$2,322.48	\$2,322.48				

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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPLANTATION, FOREARM (INCLUDES RADIUS AND ULNA TO RADIAL							
20805	CARPAL JOINT		\$2,842.59	\$2,842.59				
	REPLANTATION, HAND (INCLUDES HAND THROUGH							
20808	METACARPOPHALANGEAL JOINTS),		\$3,534.17	\$3,534.17				
	REPLANTATION, DIGIT, EXCLUDING THUMB (INCLUDES							
20816	METACARPOPHALANGEAL JOI		\$1,742.19	\$1,742.19				
	REPLANTATION, DIGIT, EXCLUDING THUMB (INCLUDES DISTAL TIP TO							
20822	SUBLIMIS		\$1,440.23	\$1,440.23				
	REPLANTATION, THUMB (INCLUDES CARPOMETACARPAL JOINT TO							
20824	MP JOINT), COMP		\$1,742.19	\$1,742.19				
	REPLANTATION, THUMB (INCLUDES DISTAL TIP TO MP JOINT),							
20827	COMPLETE AMPUTA		\$1,480.85	\$1,480.85				
20838	REPLANTATION, FOOT, COMPLETE AMPUTATION		\$2,322.48	\$2,322.48				
	BONE GRAFT, ANY DONOR AREA; MINOR OR SMALL (EG, DOWEL OR							
20900	BUTTON)		\$233.63	\$233.63				
20902	BONE GRAFT, ANY DONOR AREA; MAJOR OR LARGE		\$349.98	\$349.98				
20910	CARTILAGE GRAFT; COSTOCHONDRAL		\$170.97	\$170.97				
20912	CARTILAGE GRAFT; NASAL SEPTUM		\$316.70	\$316.70				
20920	FASCIA LATA GRAFT; BY STRIPPER		\$260.46	\$260.46				
	FASCIA LATA GRAFT; BY INCISION AND AREA EXPOSURE, COMPLEX							
20922	OR SHEET		\$312.24	\$312.24				
	TENDON GRAFT, FROM A DISTANCE (EG, PALMARIS, TOE EXTENSOR,							
20924	PLANTARIS)		\$344.07	\$344.07				
20926	TISSUE GRAFTS, OTHER (EG, PARATENON, FAT, DERMIS)		\$226.54	\$226.54				
20930	ALLOGRAFT FOR SPINE SURGERY ONLY; MORSELIZED		\$230.58	\$230.58				
20931	ALLOGRAFT FOR SPINE SURGERY ONLY; STRUCTURAL		\$106.32	\$106.32				
20932	OSTEOART ALGRFT W/SURF & B1		\$578.90	\$578.90				Effective 1/1/2019

Physician	Fee Schedule 2020							
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
20933	HEMICRT INTRCLRY ALGRFT PRTL		\$531.03	\$531.03				Effective 1/1/2019
20933	HEMICRT INTRCLRY ALGRFT PRTL		\$531.03	\$531.03				Effective 1/1/2019
20934	INTERCALARY ALGRFT COMPL		\$578.61	\$578.61				Effective 1/1/2019
	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING							
20936	THE GRAFT); LOCA		\$351.05	\$351.05				
	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING							
20937	THE GRAFT);		\$163.91	\$163.91				
	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING							
20938	THE GRAFT);		\$177.29	\$177.29				
20939	BONE MARROW ASPIR BONE GRFG		\$53.54	\$53.54				Added Effective 1/1/2018
	MONITORING OF INTERSTITIAL FLUID PRESSURE (INCLUDES							
20950	INSERTION OF DEVIC		\$70.34	\$70.34				
20955	BONE GRAFT WITH MICROVASCULAR ANASTOMOSIS; FIBULA		\$2,206.66	\$2,206.66				
20956	BONE GRAFT WITH MICROVASCULAR ANASTOMOSIS; ILIAC CREST		\$1,887.34	\$1,887.34				
20957	BONE GRAFT WITH MICROVASCULAR ANASTOMOSIS; METATARSAL		\$1,955.28	\$1,955.28				
	BONE GRAFT WITH MICROVASCULAR ANASTOMOSIS; OTHER THAN							
20962	FIBULA, ILIAC CR		\$2,163.55	\$2,163.55				
	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR							
20969	ANASTOMOSIS; OTHER THAN IL		\$2,470.78	\$2,470.78				
	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR		405.55	40.405.55				
20970	ANASTOMOSIS; ILIAC CREST		\$2,420.39	\$2,420.39				
	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR							
20972	ANASTOMOSIS; METATARSAL		\$2,439.05	\$2,439.05				
	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR							
20973	ANASTOMOSIS; GREAT TOE WIT		\$2,601.34	\$2,601.34				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ELECTRICAL STIMULATION TO AID BONE HEALING; NONINVASIVE							
20974	(NONOPERATIVE)		\$76.94	\$122.80				
	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE							
20975	(OPERATIVE)		\$179.22	\$179.22				
	LOW INTENSITY ULTRASOUND STIMULATION TO AID BONE HEALING,							
20979	NONINVASIVE		\$11.61	\$11.61				
	ABLATION, BONE TUMOR(S) (EG, OSTEOID OSTEOMA, METASTASIS)		****	40.057.00				
20982	RADIOFREQUEN		\$303.62	\$2,957.32				
00000	DESTRUCTION OF 1 OR MORE BONE GROWTHS, ACCESSED		#200 40	ΦE 404 00				A data di affa ationa 4/4/0045
20983	THROUGH THE SKIN		\$320.13 \$117.79	\$5,101.83				Added effective 1/1/2015
20985	CPTR-ASST DIR MS PX		\$117.79	\$117.79				+
20999	UNLISTED PROCEDURE, MUSCULOSKELETAL SYSTEM, GENERAL	R	\$0.00	\$0.00				
21010	ARTHROTOMY, TEMPOROMANDIBULAR JOINT	K	\$563.11	\$563.11				+
21010	AKTTIKOTOMT, TEMIFOROMANDIBOLAK SOMT		φυσυ. ΤΤ	φυσυ. ΤΤ			+	+
21011	EXCISION, TUMOR, SOFT TISSUE OF FACE OR SCALP, SUBQ,<2CM		\$177.12	\$224.33				
21011	2 CM OR GREATER		\$243.12	\$243.12				
21012	EXCISION, TUMOR, SOFT TISSUE OF FACE & SCALP, SUBFASCIAL		Ψ240.12	ΨΖ-40.12				
21013	<2CM		\$286.72	\$350.25				
21014	2 CM OR GREATER		\$376.05	\$376.05				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT			, , , , , , ,				†
21015	TISSUE OF FA		\$341.93	\$341.93				
21016	2 CM OR GREATER		\$756.32	\$756.32				
	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS);							1
21025	MANDIBLE		\$212.35	\$267.87				
	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS);							
21026	FACIAL BONE(\$181.84	\$223.95				

Physiciar	n Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REMOVAL BY CONTOURING OF BENIGN TUMOR OF FACIAL BONE							
21029	(EG, FIBROUS		\$354.30	\$478.09				
	EXCISION OF BENIGN TUMOR OR CYST OF MAXILLA OR ZYGOMA BY							
21030	ENUCLEATION A		\$310.90	\$310.90				
21031	EXCISION OF TORUS MANDIBULARIS		\$116.11	\$165.46				
21032	EXCISION OF MAXILLARY TORUS PALATINUS		\$185.84	\$237.87				
21034	EXCISION MALIGNANT TUMOR OF MAXILLA OR ZYGOMA		\$652.22	\$652.22				
04040	EXCISION OF BENIGN TUMOR OR CYST OF MANDIBLE, BY		# 404.00	0400.04				
21040	ENUCLEATION AND/OR		\$101.83	\$138.84				
21044	EXCISION OF MALIGNANT TUMOR OF MANDIBLE;		\$608.25	\$608.25				
24045	EXCISION OF MALIGNANT TUMOR OF MANDIBLE; RADICAL RESECTION		\$852.72	\$852.72				
21045	EXCISION OF BENIGN TUMOR OR CYST OF MANDIBLE; REQUIRING	1	\$852.72	\$852.72				
21046	INTRA-ORAL		\$668.15	\$668.15				
21046	EXCISION OF BENIGN TUMOR OR CYST OF MANDIBLE; REQUIRING		φ000.13	φυσο. 13				
21047	EXTRA-ORAL		\$833.04	\$833.04				
21047	EXCISION OF BENIGN TUMOR OR CYST OF MAXILLA; REQUIRING		φ033.04	φ033.04			+	+
21048	INTRA-ORAL OSTE		\$687.94	\$687.94				
21040	EXCISION OF BENIGN TUMOR OR CYST OF MAXILLA; REQUIRING		Ψ007.94	ψ007.94				
21049	EXTRA-ORAL OSTE		\$789.70	\$789.70				
21040	CONDYLECTOMY, TEMPOROMANDIBULAR JOINT (SEPARATE	+	Ψ100.10	Ψ100.10				
21050	PROCEDURE)		\$652.45	\$652.45				
	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR	1	7552.15	7002.10				
21060	JOINT (SEPARATE		\$616.66	\$616.66				
21070	CORONOIDECTOMY (SEPARATE PROCEDURE)	+	\$427.35	\$427.35				
21073	MNPJ OF TMJ W/ANESTH		\$180.10	\$274.74				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04070	IMPRESSION AND CUSTOM PREPARATION; INTERIM OBTURATOR PROSTHESIS		t4 044 02	¢4 446 50				
21079	IMPRESSION AND CUSTOM PREPARATION; DEFINITIVE OBTURATOR		\$1,041.93	\$1,416.50				
21080	PROSTHESIS		\$1,170.47	\$1,591.30				
21000	IMPRESSION AND CUSTOM PREPARATION; MANDIBULAR RESECTION		φ1,170.47	φ1,391.30				
21081	PROSTHESIS		\$1,066.67	\$1,450.09				
21001	IMPRESSION AND CUSTOM PREPARATION; PALATAL AUGMENTATION		Ψ1,000.01	Ψ1,400.00				
21082	PROSTHESIS		\$972.98	\$1,322.74				
	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT		700-000	7 1,5==11				
21083	PROSTHESIS		\$900.10	\$1,223.71				
21084	PREPARE FACE/ORAL PROSTHESIS		\$1,050.17	\$1,427.56				
21085	IMPRESSION AND CUSTOM PREPARATION; ORAL SURGICAL SPLINT		\$419.52	\$570.39				
21086	IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS		\$1,162.15	\$1,579.90				
21087	IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS		\$1,162.15	\$1,579.90				
21088	IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS	R	\$1,162.15	\$1,579.90				
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE	R	\$0.00	\$0.00				
21100	APPLICATION OF HALO TYPE APPLIANCE FOR MAXILLOFACIAL FIXATION, INCLUDE		\$149.65	\$149.65				
21100	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS		φ149.00	φ 149.00	-			
21110	OTHER THAN		\$232.94	\$307.10				
21110	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT		ΨΔΟΔ.34	ψουτ.10				+
21116	ARTHROGRAPHY		\$44.81	\$44.81				
	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT,		Ţ	Ţ				
21120	PROSTHETIC MATERIAL)		\$245.88	\$245.88				
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE		\$386.48	\$386.48				

Physician	Fee Schedule 2020							
Note:	1 00 03/1044/10 2020							
	les in Red;				+			†
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	column indicates Prior Auth is required							†
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u>, </u>				†
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					†
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
_		Τ΄ ΄						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
-	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE	171114	(1 0.0)	(item demoy)				
21122	OSTEOTOMIES (EG, WEDGE		\$425.75	\$425.75				
	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL			,				†
21123	BONE GRAFTS		\$556.56	\$556.56				
	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC		*	, , , , , , ,				
21125	MATERIAL		\$322.24	\$322.24				
	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT,							
21127	ONLAY OR		\$540.57	\$540.57				
21137	REDUCTION FOREHEAD; CONTOURING ONLY	R	\$523.00	\$523.00				
	REDUCTION FOREHEAD; CONTOURING AND APPLICATION OF							
21138	PROSTHETIC MATERIAL	R	\$650.09	\$650.09				
	REDUCTION FOREHEAD; CONTOURING AND SETBACK OF ANTERIOR							
21139	FRONTAL SINUS W	R	\$746.42	\$746.42				
	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT							
21141	MOVEMENT IN AN	R	\$921.94	\$921.94				
	RECONSTRUCTION MIDFACE, LEFORT I; TWO PIECES, SEGMENT							
21142	MOVEMENT IN ANY	R	\$956.18	\$956.18				
	RECONSTRUCTION MIDFACE, LEFORT I; THREE OR MORE PIECES,							
21143	SEGMENT MOVEME	R	\$994.02	\$994.02				
	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT							
21145	MOVEMENT IN AN	R	\$980.63	\$980.63				
	RECONSTRUCTION MIDFACE, LEFORT I; TWO PIECES, SEGMENT							
21146	MOVEMENT IN ANY	R	\$1,014.86	\$1,014.86				
	RECONSTRUCTION MIDFACE, LEFORT I; THREE OR MORE PIECES,							
21147	SEGMENT MOVEME	R	\$1,052.71	\$1,052.71				
	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG,							
21150	TREACHER-CO	R	\$1,264.14	\$1,264.14				

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	1				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	<u> </u>						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RECONSTRUCTION MIDFACE, LEFORT II; ANY DIRECTION,							
21151	REQUIRING BONE GRAFT	R	\$1,415.73	\$1,415.73				
	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY							
21154	TYPE, REQUIRING	R	\$1,516.22	\$1,516.22				
	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY							
21155	TYPE, REQUIRING	R	\$1,718.85	\$1,718.85				
04450	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND		00.400.04	40.400.04				
21159	INTRACRANIAL) WITH FOREH	R	\$2,123.01	\$2,123.01				
04460	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND		CO 205 44	#0 205 44				
21160	INTRACRANIAL) WITH FOREH RECONSTRUCTION SUPERIOR-LATERAL ORBITAL RIM AND LOWER	R	\$2,325.11	\$2,325.11				+
21172	FOREHEAD, ADVANC		\$1,389.65	\$1,389.65				
21172	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS		φ1,369.05	φ1,309.00				
21175	AND LOWER		\$1,668.06	\$1,668.06				
21173	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR		φ1,000.00	φ1,000.00				
21179	SUPRAORBITAL RIM		\$1,111.76	\$1,111.76				
21170	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR		Ψ1,111.70	Ψ1,111.70				+
21180	SUPRAORBITAL RIM		\$1,264.14	\$1,264.14				
	RECONSTRUCTION BY CONTOURING OF BENIGN TUMOR OF		+ 1,2 + 11 + 1	+ 1,= 5 11 1				
21181	CRANIAL BONES (EG, FIB		\$528.05	\$528.05				
	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD,		*					
21182	NASOETHMOID COMPLEX		\$1,590.04	\$1,590.04				
	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD,							
21183	NASOETHMOID COMPLEX		\$1,725.08	\$1,725.80				
	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD,							
21184	NASOETHMOID COMPLEX		\$1,920.97	\$1,920.97				

Physician	Fee Schedule 2020			1	Ι		1	
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	les in Red;				+			
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R" in PA	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT							
21188	TYPE) AND BONE		\$1,111.76	\$1,111.76				
	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL,							
21193	C, OR L OSTEO	R	\$841.41	\$841.41				
	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL,		4077.04	0.75.04				
21194	C, OR L OSTEO	R	\$975.01	\$975.01				
04405	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL		40.40.00	40.40.00				
21195	SPLIT; WITHOUT	R	\$843.39	\$843.39				
24400	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL	_	#000 06	\$929.86				
21196 21198	SPLIT; WITH OSTEOTOMY, MANDIBLE, SEGMENTAL;	R R	\$929.86 \$831.81	\$831.81				
21190	OSTEOTOMY, MANDIBLE, SEGMENTAL, OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS	K	φου 1.01	φου 1.01				
21199	ADVANCEMENT		\$757.27	\$757.27				
21199	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR		φ131.21	φισι.Ζι	+		+	+
21206	SCHUCHARD)	R	\$692.92	\$692.92				
21200	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT,		Ψ032.32	Ψ032.32				
21208	ALLOGRAFT, OR	R	\$608.54	\$608.54				
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION	R	\$325.86	\$325.86			+	
	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES		+	+ + + + + + + + + + + + + + + + + + + 			1	
21210	OBTAINING GRAFT		\$476.02	\$640.17				
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)		\$502.86	\$675.73	1			
	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR							
21230	EAR (INCLUDES		\$614.70	\$614.70				
	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR							
21235	(INCLUDES OBTAINING G		\$426.41	\$426.41				
	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT							
21240	AUTOGRAFT (INCL	1	\$884.99	\$884.99				

Physician	n Fee Schedule 2020							
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Refer to	CPT book for descriptions							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT		\$826.81	\$826.81				
	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC							
21243	JOINT REPLACEME		\$984.00	\$984.00				
	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL							
21244	BONE PLATE (EG		\$752.36	\$752.36				
04045	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL		****	400400				
21245	IMPLANT; PARTIAL		\$664.60	\$664.60				
24246	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE		\$603.96	\$603.96				
21246	RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND		\$603.96	\$603.96				
21247	CARTILAGE AUTOGRAFT		\$1,402.11	\$1,402.11				
21241	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT		ψ1,402.11	ψ1,402.11				
21248	(EG, BLADE,		\$557.82	\$747.98				
21240	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT		Ψ007.02	Ψ1-11.00				+
21249	(EG, BLADE,		\$892.10	\$1,201.89				
	RECONSTRUCTION OF ZYGOMATIC ARCH AND GLENOID FOSSA		ψσσ <u>-</u> σ	ψ.,=σσσ				
21255	WITH BONE AND CARTI		\$1,035.90	\$1,035.90				
	RECONSTRUCTION OF ORBIT WITH OSTEOTOMIES (EXTRACRANIAL)		. ,					
21256	AND WITH BONE		\$1,002.85	\$1,002.85				
	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH							
21260	BONE GRAFTS;	<u> </u>	\$1,023.40	\$1,023.40				
	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH							
21261	BONE GRAFTS;		\$1,380.57	\$1,380.57				
21263	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; W		\$1,760.80	\$1,760.80				
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Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES,		7/	, ,				
21267	UNILATERAL, WITH BONE		\$961.83	\$961.83				
	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES,							
21268	UNILATERAL, WITH BONE		\$1,159.15	\$1,159.15				
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL		\$646.81	\$646.81				
21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION		\$578.78	\$578.78				
21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)		\$373.17	\$373.17				
21282	LATERAL CANTHOPEXY		\$236.09	\$236.09				
	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR							
21295	TREATMENT OF BENIGN		\$70.87	\$70.87				
	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR							
21296	TREATMENT OF BENIGN		\$218.93	\$218.93				
21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE	R	\$0.00	\$0.00				
	CLOSED TREATMENT OF NASAL BONE FRACTURE WITHOUT							
21310	MANIPULATION		\$39.32	\$39.32				
	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITHOUT							
21315	STABILIZATION		\$95.02	\$95.02				
	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITH							
21320	STABILIZATION		\$124.16	\$124.16				
21325	OPEN TREATMENT OF NASAL FRACTURE; UNCOMPLICATED		\$225.63	\$225.63				
	OPEN TREATMENT OF NASAL FRACTURE; COMPLICATED, WITH							
21330	INTERNAL AND/OR		\$341.50	\$341.50				
	OPEN TREATMENT OF NASAL FRACTURE; WITH CONCOMITANT							
21335	OPEN TREATMENT OF		\$550.66	\$550.66				
	OPEN TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR							
21336	WITHOUT STABILIZATION		\$279.32	\$279.32				

Physician	Fee Schedule 2020	Ι	1					
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	rae for the service	2					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR		7/	77				
21337	WITHOUT STABILIZATI		\$158.82	\$158.82				
	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITHOUT							
21338	EXTERNAL FIXATION		\$327.65	\$327.65				
	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITH EXTERNAL							
21339	FIXATION		\$429.01	\$429.01				
	PERCUTANEOUS TREATMENT OF NASOETHMOID COMPLEX							
21340	FRACTURE, WITH SPLINT, W		\$559.74	\$559.74				
21343	OPEN TREATMENT OF DEPRESSED FRONTAL SINUS FRACTURE		\$627.26	\$627.26				
	OPEN TREATMENT OF COMPLICATED (EG, COMMINUTED OR							
21344	INVOLVING POSTERIOR W		\$813.00	\$813.00				
	CLOSED TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE							
21345	(LEFORT II TYPE), W		\$455.47	\$455.47				
	OPEN TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE							
21346	(LEFORT II TYPE); WIT		\$568.48	\$568.48				
	OPEN TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE							
21347	(LEFORT II TYPE);		\$658.94	\$658.94				
	OPEN TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE							
21348	(LEFORT II TYPE); WIT		\$815.86	\$815.86				
	PERCUTANEOUS TREATMENT OF FRACTURE OF MALAR AREA,							
21355	INCLUDING ZYGOMATIC		\$149.26	\$149.26				
0.4050	OPEN TREATMENT OF DEPRESSED ZYGOMATIC ARCH FRACTURE		#000 F0	4000 50				
21356	(EG, GILLIES APPRO		\$268.52	\$268.52				
04000	OPEN TREATMENT OF DEPRESSED MALAR FRACTURE, INCLUDING		0004.40	0004.40				
21360	ZYGOMATIC ARCH A	<u> </u>	\$394.12	\$394.12	1			
04005	OPEN TREATMENT OF COMPLICATED (EG, COMMINUTED OR		ф 7 00 7 0	ф 7 00 7 0				
21365	INVOLVING CRANIAL NER		\$780.79	\$780.79				

Physician	Fee Schedule 2020							
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R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF COMPLICATED (EG, COMMINUTED OR							
21366	INVOLVING CRANIAL NER		\$868.75	\$868.75				
0.400=	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE;		4=0= 00	4=0= 00				
21385	TRANSANTRAL APPROACH		\$535.86	\$535.86				
04000	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE;		# 504.00	# 504.00				
21386	PERIORBITAL APPROACH		\$524.83	\$524.83				
04207	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE;		£400.00	£400.20				
21387	COMBINED APPROACH OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE;		\$489.30	\$489.30				+
21390	PERIORBITAL APPROACH		\$630.08	\$630.08				
21390	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE;		φ030.06	\$030.06				
21395	PERIORBITAL APPROACH		\$639.31	\$639.31				
21393	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT;		φ039.31	φυσθ.σ ι			+	+
21400	WITHOUT MANIPUL		\$87.36	\$87.36				
21400	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT;		ψ07.50	ψ07.00				+
21401	WITH MANIPULATI		\$166.47	\$166.47				
21101	OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT;		ψ100.17	Ψ100.17				+
21406	WITHOUT IMPLANT		\$349.92	\$349.92				
	OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT;		ψο : σ.σ.	ψο : σ: σ =				
21407	WITH IMPLANT		\$445.34	\$445.34				
	OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT;		,					
21408	WITH BONE GRAFTIN		\$591.28	\$591.28				
	CLOSED TREATMENT OF PALATAL OR MAXILLARY FRACTURE							
21421	(LEFORT I TYPE), WIT		\$320.60	\$320.60				
	OPEN TREATMENT OF PALATAL OR MAXILLARY FRACTURE (LEFORT I							
21422	TYPE);		\$520.06	\$520.06				

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	column indicates Prior Auth is required						+	
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service				_	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร				+	
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Proc			Inpat. Rate	Outpat. Rate	Tech.			
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04400	OPEN TREATMENT OF PALATAL OR MAXILLARY FRACTURE (LEFORT I		Φ570.00	# 570.00				
21423	TYPE);		\$576.99	\$576.99				
0.4.0.4	CLOSED TREATMENT OF CRANIOFACIAL SEPARATION (LEFORT III		4070.00	4070.00				
21431	TYPE) USING		\$372.09	\$372.09				
0.4.400	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LEFORT III							
21432	TYPE); WITH WIRI		\$437.94	\$437.94				
	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LEFORT III							
21433	TYPE); COMPLICAT		\$1,227.90	\$1,227.90				
	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LEFORT III							
21435	TYPE); COMPLICAT		\$874.09	\$874.09				
	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LEFORT III							
21436	TYPE); COMPLICAT		\$1,212.58	\$1,212.58				
	CLOSED TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR							
21440	RIDGE FRACTURE		\$163.09	\$163.09				
	OPEN TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR							
21445	RIDGE FRACTURE (SEP		\$325.09	\$325.09				
	CLOSED TREATMENT OF MANDIBULAR FRACTURE; WITHOUT							
21450	MANIPULATION		\$164.07	\$164.07				
21451	CLOSED TREATMENT OF MANDIBULAR FRACTURE		\$307.87	\$307.87				
	PERCUTANEOUS TREATMENT OF MANDIBULAR FRACTURE, WITH							
21452	EXTERNAL FIXATION		\$95.70	\$95.70				
	CLOSED TREATMENT OF MANDIBULAR FRACTURE WITH							
21453	INTERDENTAL FIXATION		\$343.46	\$343.46			1	
	OPEN TREATMENT OF MANDIBULAR FRACTURE WITH EXTERNAL							
21454	FIXATION		\$431.41	\$431.41				
	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITHOUT							
21461	INTERDENTAL FIXATION		\$512.79	\$512.79				

Dhysisian	Fee Schedule 2020	1		1	1		1	1
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	les in Dade					_	_	
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	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITH INTERDENTAL							
21462	FIXATION		\$615.14	\$615.14				
21465	OPEN TREATMENT OF MANDIBULAR CONDYLAR FRACTURE		\$577.03	\$577.03				
	OPEN TREATMENT OF COMPLICATED MANDIBULAR FRACTURE BY							
21470	MULTIPLE SURGICAL		\$918.12	\$918.12				
	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION;							
21480	INITIAL OR SUBSEQUE		\$41.01	\$41.01				
	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION;							
21485	COMPLICATED (EG,		\$143.68	\$173.05				
21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION		\$507.01	\$507.01				
21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE		\$221.65	\$221.65				
21499	UNLISTED MUSCULOSKELETAL PROCEDURE, HEAD	R	\$132.50	\$172.25				
	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT							
21501	TISSUES OF NECK		\$158.42	\$158.42				
	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT							
21502	TISSUES OF NECK		\$320.39	\$320.39				
	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR							
21510	OSTEOMYELITIS OR		\$262.21	\$262.21				
21550	BIOPSY, SOFT TISSUE OF NECK OR THORAX		\$73.30	\$84.70				
21552	3 CM OR GREATER		\$325.14	\$325.14				
21554	5 CM OR GREATER		\$535.14	\$535.14				1
	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX;							1
21555	SUBCUTANEOUS		\$169.01	\$169.01				
	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX; DEEP,						Ī	
21556	SUBFASCIAL,		\$272.41	\$272.41			1	
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT							
21557	TISSUE OF NE		\$513.43	\$513.43			1	

Physician	n Fee Schedule 2020			1				
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cha	ge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Ĭ					
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		T						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
21558	5 CM OR GREATER	FAIIIU	\$1,006.20	\$1,006.20	Comp.	Comp.	Value	Notes
21600	EXCISION OF RIB, PARTIAL		\$326.07	\$326.07		+	+	+
21000	EXCISION OF IXIB, PAINTIAL		φ320.01	ψ320.07				+
21601	EXC CHEST WALL TUMOR W/RIBS		\$938.43	\$938.43				Added Effective 01/01/2020
21602	EXC CH WAL TUM W/O LYMPHADEC		\$1,254.02	\$1,254.02				Added Effective 01/01/2020
21603	EXC CH WAL TUM W/LYMPHADEC		\$1,389.43	\$1,389.43				Added Effective 01/01/2020
21610	COSTOTRANSVERSECTOMY (SEPARATE PROCEDURE)		\$407.73	\$407.73				
21615	EXCISION FIRST AND/OR CERVICAL RIB;		\$584.30	\$584.30				
21616	EXCISION FIRST AND/OR CERVICAL RIB; WITH SYMPATHECTOMY		\$557.18	\$557.18				
21620	OSTECTOMY OF STERNUM, PARTIAL		\$390.85	\$390.85				
21627	STERNAL DEBRIDEMENT		\$334.61	\$334.61				
21630	RADICAL RESECTION OF STERNUM;		\$866.80	\$866.80				
	RADICAL RESECTION OF STERNUM; WITH MEDIASTINAL							
21632	LYMPHADENECTOMY		\$851.16	\$851.16				
21685	HYOID MYOTOMY AND SUSPENSION		\$673.66	\$673.66				
	DIVISION OF SCALENUS ANTICUS; WITHOUT RESECTION OF							
21700	CERVICAL RIB		\$295.09	\$295.09				
	DIVISION OF SCALENUS ANTICUS; WITH RESECTION OF CERVICAL							
21705	RIB		\$418.39	\$418.39				
	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN							
21720	OPERATION; WITHO		\$275.26	\$275.26				
	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN							
21725	OPERATION; WITH		\$340.00	\$340.00				
21740	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; OPEN		\$733.46	\$733.46				

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	es in Red;							
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnar	ge for the servic	e		_	+	+
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.					_	+	
	se lab fee schedule for covered codes not listed below in the 80000-89249 r					_		
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai T	ns T					
							Base	+
Droo			Innat Bata	Outpot Boto	Tech.	Prof.	Unit	
Proc	Burnedow Burnelotter	DA III I	Inpat. Rate	Outpat. Rate				N. 4
Code	Procedure Description RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM;	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04740	,		фого оо	фого оо				
21742	MINIMALLY INVA		\$653.30	\$653.30				
04740	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM;		#0.00	#050.04				
21743	MINIMALLY INVA		\$0.00	\$859.84		_	+	
0.4750	CLOSURE OF MEDIAN STERNOTOMY SEPARATION WITH OR		4500.04	# 500.04				
21750	WITHOUT DEBRIDEMENT		\$526.84	\$526.84				
	OPEN TREATMENT OF BROKEN RIBS WITH INSERTION OF							
21811	HARDWARE		\$488.16	\$488.16				Added effective 1/1/2015
04040	OPEN TREATMENT OF BROKEN RIBS WITH INSERTION OF		4505.40	#505.40				1,11,1,5,1; 1/1/2015
21812	HARDWARE		\$585.49	\$585.49				Added effective 1/1/2015
0.4040	OPEN TREATMENT OF BROKEN RIBS WITH INSERTION OF		4700.50	4700 50				
21813	HARDWARE		\$796.59	\$796.59				Added effective 1/1/2015
21820	CLOSED TREATMENT OF STERNUM FRACTURE		\$75.82	\$75.82				
	OPEN TREATMENT OF STERNUM FRACTURE WITH OR WITHOUT							
21825	SKELETAL FIXATION	_	\$412.41	\$412.41				
21899	UNLISTED PROCEDURE, NECK OR THORAX	R	\$0.00	\$0.00				
21920	BIOPSY, SOFT TISSUE BACK OR FLANK; SUPERFICIAL		\$72.25	\$82.84				
21925	BIOPSY, SOFT TISSUE OF BACK OR FLANK; DEEP		\$184.20	\$184.20				
21930	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK		\$277.06	\$277.06				
21931	3 CM OR GREATER		\$340.33	\$340.33				
	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBFASCIAL;							
21932	LESS THAN 5 CM		\$488.30	\$488.30				
21933	5 CM OR GREATER		\$539.01	\$539.01				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT							
21935	TISSUE OF BA		\$710.71	\$710.71				
21936	5 CM OR GREATER		\$1,046.66	\$1,046.66				
22010	I&D P-SPINE C/T/CERV-THOR		\$600.01	\$600.01				

Physician	Fee Schedule 2020							
Note:	The destination 2020							
	les in Red;							†
	CPT book for descriptions							†
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	rge for the service)					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered t	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INCISION AND DRAINAGE, OPEN, OF DEEP ABSCESS (SUBFASCIAL),							
22015	POSTERIOR S		\$594.70	\$594.70				
	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG,							
22100	SPINOUS PROCESS		\$496.96	\$496.96				
	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG,							
22101	SPINOUS PROCESS		\$512.47	\$512.47				
	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG,							
22102	SPINOUS PROCESS		\$401.07	\$401.07				
	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG,							
22103	SPINOUS PROCESS		\$137.47	\$137.47				
	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY							
22110	LESION, WITHOUT		\$640.65	\$640.65				
00440	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY		4045.04	40.45.04				
22112	LESION, WITHOUT		\$645.24	\$645.24				
00444	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY		# 500.00	# 500.00				
22114	LESION, WITHOUT PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY		\$562.98	\$562.98				
22446	LESION, WITHOUT		\$136.10	\$136.10				
22116 22206	OSTEOTOMY OF SPINE THREE COLUMNS THOR		\$1,808.68	\$1,808.68				
22207	OSTEOTOMY OF SPINE THREE COLUMNS THOR OSTEOTOMY OF SPINE THREE COLUMNS LUM		\$1,785.54	\$1,785.54				+
22207	OSTEOTOMY OF SPINE THREE COLONINS LOW		\$458.70	\$458.70				+
22200	OSTEOTOMY OF SPINE THREE COLONE VERT SEG OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL	+	ψ430.70	φ+30.70	+		+	+
22210	APPROACH, ONE VERTEBRA		\$1,090.52	\$1,090.52				
22210	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL		ψ1,030.32	ψ1,030.32			+	+
22212	APPROACH, ONE VERTEBRA		\$1,064.81	\$1,064.81				
	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL		ψ1,00 τ.01	ψ1,00 r.01	+		+	+
22214	APPROACH, ONE VERTEBRA		\$1,002.69	\$1,002.69				
IT	particular, one ventebroom		Ψ1,002.00	Ψ1,002.00				

Note:	Physician	Fee Schedule 2020							
2020 Codes in Rad;							+	†	
Refer to CPT book for descriptions R'n PA column indicates Pixe Auth is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and outsomary charge for the service The Anesthesia Base Rela is \$15.20. Each 15 ft. Singuile increment I line unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description OSTECTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL 22216 APPROACH, ONE VERTEBRA OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22220 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22222 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22223 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 22224 APPROACH, SINGLE OSTECTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR 222310 MANIPULATION, CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT 22310 MANIPULATION, CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR 22311 AND OR 22312 DISLOCATION(S) REQUIR OPEN TREATMENT AND/OR REDUCTION OF ODDOTOID FRACTURE(S) AND OR 22313 AND OR 22314 AND OR 22315 PRACTURE(S) AND/OR REDUCTION OF VERTEBRAL 22316 PRACTURE(S) AND/OR 22317 PRACTURE(S) AND/OR 22318 AND OR 23218 FRACTURE(S) AND/OR 23219 AND OR 23222 FRACTURE(S) AND/OR 23236 FRACTURE(S) AND/OR 23236 FRACTURE(S) AND/OR 23237 FRACTURE(S) AND/OR 23238 FRACTURE(S) AND/OR 23230 FRACTURE(S) AND/OR 232310 OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 23237 FRACTURE(S) AND/OR 23238 FRACTURE(S) AND/		es in Red:							
RT DP A column indicates Prior Auth is required		•						+	
Codes listed as '30.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 incluse incremental time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Proc Procedure Description OSTECTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL 22216 APPROACH, ONE VERTIEBRA S334.85 S334									
The Anesthesia Base Rate is \$15.20. Each 15 minute incremental time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians. Proc Code Procedure Description OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, DRV EVERTEBRA OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR COSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR COSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR COSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR COSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR SA34.85 CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT STANDARD SA34.85 CLOSED TREATMENT OF VERTEBRAL FRACTURE(S), WITHOUT STANDARD SA34.85 CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL STACTURE(S) AND/OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL STACTURE(S) AND/OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL STACTURE(S) AND/OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL OPEN T			marv char	ge for the service	2				
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.	The Anest	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, ONE VERTEBRA OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR APPROACH, SINGLE CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT STANDARD S			ange.						
Proc Code Procedure Description				ns					
Proc Code Procedure Description PA Ind Inpat. Rate (NonFacility) Comp. Comp. Value Notes			<u> </u>						
Code								Base	
OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL \$334.85 \$334.85 \$334.85 \$22216 APPROACH, ONE VERTEBRA \$334.85 \$334.85 \$334.85 \$22221 APPROACH, SINGLE \$1,101.50	Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
22216 APPROACH, ONE VERTEBRA \$334.85 \$	Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR \$1,101.50		OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL							
22220 APPROACH, SINGLE \$1,101.50 \$1,101.50 \$1,101.50 \$22222 APPROACH, SINGLE \$994.71 \$994.71 \$994.71 \$994.71 \$22224 APPROACH, SINGLE \$1,049.65 \$1,049.65 \$1,049.65 \$1,049.65 \$334.85	22216			\$334.85	\$334.85				
OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR \$994.71 \$									
22222	22220			\$1,101.50	\$1,101.50				
OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR S1,049.65 \$1,049.65									
22224 APPROACH, SINGLE	22222			\$994.71	\$994.71				
OSTEOTOMY OF SPINE, INCLUDING DISKECTOMY, ANTERIOR \$334.85 \$334.85 \$334.85 \$22226 APPROACH, SINGLE \$334.85 \$334.85 \$334.85 \$2310 MANIPULATION, \$138.94									
22226 APPROACH, SINGLE	22224			\$1,049.65	\$1,049.65				
CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT 22310 MANIPULATION, CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR 22315 DISLOCATION(S) REQUIR OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR 22318 AND OR CPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR 22319 AND OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22325 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL COPEN TREATMENT									
22310 MANIPULATION, \$138.94	22226			\$334.85	\$334.85				
CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR \$414.00									
22315 DISLOCATION(S) REQUIR \$414.00 \$414.00 \$414.00 \$2318 AND OR \$1,087.92	22310			\$138.94	\$138.94				
OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) \$1,087.92 \$1,087	00045	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
22318 AND OR \$1,087.92 \$1,087.92	22315	DISLOCATION(S) REQUIR		\$414.00	\$414.00				
OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22325 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22326 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22327 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22328 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22328 FRACTURE(S) AND/ OR S270.79 \$270.79	00040			04 007 00	#4 007 00				
22319 AND OR \$1,228.21 \$1,228.21	22318			\$1,087.92	\$1,087.92				
OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22325 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22326 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22327 FRACTURE(S) AND/ OR OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22328 FRACTURE(S) AND/ OR \$1,000.18 \$270.79 \$270.79	22240			¢4 000 04	¢4 000 04				
22325 FRACTURE(S) AND/ OR \$760.14 \$760.14	22319			Φ1,220.21	φ1,220.21				
OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL \$1,034.65 \$1,034.65 \$1,034.65 \$1,034.65 \$1,034.65 \$1,000.18 \$1,00	22325			\$760.14	\$760.14				
22326 FRACTURE(S) AND/ OR \$1,034.65 \$1,034.65	22323			φ100.14	φ100.14	+			+
OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22327 FRACTURE(S) AND/ OR S1,000.18 \$1,000.18 OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22328 FRACTURE(S) AND/ OR \$270.79	22326			\$1 034 65	\$1 034 65				
22327 FRACTURE(S) AND/ OR \$1,000.18 \$1,000.18 OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL \$270.79 \$270.79	22020			ψ1,00-4.00	ψ1,004.00				+
OPEN TREATMENT AND/OR REDUCTION OF VERTEBRAL 22328 FRACTURE(S) AND/ OR \$270.79	22327			\$1,000,18	\$1,000,18				
22328 FRACTURE(S) AND/ OR \$270.79	22021			ψ1,000.10	ψ1,000.10				+
	22328			\$270.79	\$270.79				
122505 IMANIPULATION OF SPINE REQUIRING ANESTHESIA. ANY REGION I I\$91.21 I\$91.21 I I I I	22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION		\$91.21	\$91.21				†

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	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							+
	red as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ne for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T Trial y Gridi	T TOT THE SETVICE					+
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
000.00		1	1					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INJECTION OF BONE CEMENT INTO BODY OF MIDDLE SPINE BONE							
22510	ACCESSED THROUGH THE SKIN USING IMAGING GUIDANCE		\$368.00	\$1,325.01				Added effective 1/1/2015
	INJECTION OF BONE CEMENT INTO BODY OF MIDDLE SPINE BONE							
22511	ACCESSED THROUGH THE SKIN USING IMAGING GUIDANCE		\$345.25	\$1,311.06				Added effective 1/1/2015
	IN JECTION OF BONE OFMENT INTO BODY OF MIDDLE OR LOWER							
00540	INJECTION OF BONE CEMENT INTO BODY OF MIDDLE OR LOWER		Φ470 44	ф 7 24 02				A -1-11 - ff + i 4/4/0045
22512	SPINE ACCESSED THROUGH THE SKIN USING IMAGING GUIDANCE		\$172.11	\$734.83				Added effective 1/1/2015
	INJECTION OF BONE CEMENT INTO BODY OF MIDDLE SPINE BONE							
22513	ACCESSED THROUGH THE SKIN USING IMAGING GUIDANCE		\$435.13	\$5,426.92				Added effective 1/1/2015
22313	ACCESSED THROUGH THE SKIN USING IIVIAGING GUIDANCE		φ 4 33.13	\$5,420.92				Added effective 1/1/2015
	INJECTION OF BONE CEMENT INTO BODY OF LOWER SPINE BONE							
22514	ACCESSED THROUGH THE SKIN USING IMAGING GUIDANCE		\$405.26	\$5,396.27				Added effective 1/1/2015
22014	INJECTION OF BONE CEMENT INTO BODY OF MIDDLE OR LOWER		ψ+00.20	ψ0,000.27				7 daed checkve 1/ 1/2010
	SPINE BONE ACCESSED THROUGH THE SKIN USING IMAGING							
22515	GUIDANCE		\$184.24	\$3,270.54				Added effective 1/1/2015
	PERCUTANEOUS INTRADISCAL ELECTROTHERM ANNULOPLASTY,		4.0	φσ,=: σ:σ:				7.4464 67764176 77 77 72 76
22526	SINGLE LEVEL		\$257.02	\$1,384.12				
	PERCUTANEOUS INTRADISCAL ELECTROTHERM ANNULOPLASTY,			<u> </u>				
22527	ADDITIONAL LEVELS		\$119.74	\$1,113.91				
	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING							
22532	MINIMAL DISKEC		\$1,187.65	\$1,187.65				
	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING							
22533	MINIMAL DISKEC		\$1,110.00	\$1,110.00				

Physician	Fee Schedule 2020							
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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						†
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					†
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING							
22534	MINIMAL DISKEC		\$281.33	\$281.33				
	ARTHRODESIS, ANTERIOR TRANSORAL OR EXTRAORAL TECHNIQUE,							
22548	CLIVUS-C1-C2		\$1,409.34	\$1,409.34				
	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE							
	PREP, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION							
22551	OF SPINAL CORD		\$1,517.32	\$1,517.32				
	ARTHRODESIS, ANTERIOR INTERBODY, EACH ADDTL INTERSPACE,							
22552	USE IN CONJUCTION W/PROC 22551		\$353.67	\$353.67				
	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING							
22554	MINIMAL DISKECTOM		\$1,122.76	\$1,122.76				
	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING							
22556	MINIMAL DISKECTOM		\$1,321.97	\$1,321.97				
	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING							
22558	MINIMAL DISKECTOM		\$1,245.80	\$1,245.80				
00505	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING		0000 74	# 000 74				
22585	MINIMAL DISKECTOM		\$329.71	\$329.71	_			
22586	ARTHRODESIS, PRE-SCRAL INTERBODY TECHNIQUE	1	\$1,228.42	\$1,228.42	+		+	
22500	ARTHRODESIS, POSTERIOR TECHNIQUE, CRANIOCERVICAL		¢4 224 24	¢4 224 24				
22590 22595	(OCCIPUT-C2) ARTHRODESIS, POSTERIOR TECHNIQUE, ATLAS-AXIS (C1-C2)		\$1,234.34 \$1,230.22	\$1,234.34 \$1,230.22			1	+
22090	ARTHRODESIS, POSTERIOR TECHNIQUE, ATLAS-AXIS (CT-C2) ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE,		φ1,∠3U.∠∠	φ1,∠3U.∠∠			1	+
22600	SINGLE LEVEL; CERV		\$1,032.47	\$1,032.47				
22000	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE,	+	φ1,032.41	φ1,032.41	+		+	+
22610	SINGLE LEVEL; THOR		\$975.13	\$975.13				
22010	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE,	+	φυι υ. 10	φυίο.13	+		+	+
22612	SINGLE LEVEL; LUMB		\$1,225.89	\$1,225.89				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	ge for the service	<i>i</i>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE,		, ,	,		•		
22614	SINGLE LEVEL; EACH		\$362.87	\$362.87				
	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING							
22630	LAMINECTOMY AND/		\$1,158.89	\$1,158.89				
	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING							
22632	LAMINECTOMY AND/		\$307.23	\$307.23				
	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL							
	TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING							
	LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE							
	INTERSPACE (OTHER THAN FOR DECOMPRESSION) SINGLE							
22633	INTERSPACE AND SEGMENT; LUMBAR		\$1,471.52	\$1,471.52				
	EACH ADDITIONAL INTERSPACE AND SEGMENT (LIST SEPARATELY							
22634	IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		\$397.96	\$397.96				
	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR							
22800	WITHOUT CAST; UP		\$1,164.44	\$1,164.44				
00000	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR		A 744 00	4.744.00				
22802	WITHOUT CAST; 7		\$1,744.29	\$1,744.29			_	
00004	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR		#4 000 04	04 000 04				
22804	WITHOUT CAST; 13		\$1,898.64	\$1,898.64				
22000	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR		¢4 202 02	¢4 202 02				
22808	WITHOUT CAST; 2 T ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR		\$1,303.92	\$1,303.92				
22810	WITHOUT CAST; 4 T		\$1,421.30	\$1,421.30				
22010	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR		φ1,421.30	φ1,421.30				+
22812	WITHOUT CAST; 8 O		\$1,708.17	\$1,708.17				
22012	IMILLIOUI CASI, 0 C		φ1,100.11	φ1,100.11				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	KYPHECTOMY, CIRCUMFERENTIAL EXPOSURE OF SPINE AND							
22818	RESECTION OF VERTEBR		\$1,764.05	\$1,764.05				
	KYPHECTOMY, CIRCUMFERENTIAL EXPOSURE OF SPINE AND							
22819	RESECTION OF VERTEBR		\$1,896.86	\$1,896.66				
22830	EXPLORATION OF SPINAL FUSION		\$703.42	\$703.42				
	POSTERIOR NON-SEGMENTAL INSTRUMENTATION (EG,							
22840	HARRINGTON ROD TECHNIQUE,		\$368.19	\$368.19				
22841	INTERNAL SPINAL FIXATION BY WIRING OF SPINOUS PROCESSES		\$218.05	\$218.05				
	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE							
22842	FIXATION, DUAL RODS W		\$422.19	\$422.19				
	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE							
22843	FIXATION, DUAL RODS W		\$526.56	\$526.56				
	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE							
22844	FIXATION, DUAL RODS W		\$643.45	\$643.45				
22845	ANTERIOR INSTRUMENTATION; 2 TO 3 VERTEBRAL SEGMENTS		\$350.96	\$350.96				
22846	ANTERIOR INSTRUMENTATION; 4 TO 7 VERTEBRAL SEGMENTS		\$486.20	\$486.20				
22847	ANTERIOR INSTRUMENTATION; 8 OR MORE VERTEBRAL SEGMENTS		\$540.18	\$540.18				
	PELVIC FIXATION (ATTACHMENT OF CAUDAL END OF							
22848	INSTRUMENTATION TO PELVIC		\$352.32	\$352.32				
22849	REINSERTION OF SPINAL FIXATION DEVICE		\$740.65	\$740.65				
	REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION (EG,							
22850	HARRINGTON ROD)		\$545.91	\$545.91				
	APPLICATION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG,							
22851	SYNTHETIC		\$394.07	\$394.07				
22852	REMOVAL OF POSTERIOR SEGMENTAL INSTRUMENTATION		\$547.49	\$547.49				

Physician	Fee Schedule 2020							
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	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ne					
Codes list	The lab lee scriedule that begin with a 1- or Q are currently non-covered to	л риузісіаі І						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
22853	INSJ BIOMECHANICAL DEVICE	Ailiu	\$211.42	\$211.42	Jonip.	Jonip.	Value	Added Effective 1/1/2017
22854	INSJ BIOMECHANICAL DEVICE		\$273.68	\$273.68				Added Effective 1/1/2017
22855	REMOVAL OF ANTERIOR INSTRUMENTATION		\$497.49	\$497.49				ridded Elicotive 1/1/2017
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC)		\$1,280.26	\$1,280.26				
22857	TOTAL LUMBAR DISC ARTHROPLASTY, ANTERIOR APPROACH		\$1,089.01	\$1,089.01				
22001	TO THE EDWIDTHY DISCONNENT OF ENGLISH THE NOTE OF THE PROPERTY		Ψ1,000.01	ψ1,000.01				
22858	INSERTION OF ARTIFICIAL UPPER SPINE DISC ANTERIOR APPROACH		\$401.85	\$401.85				Added effective 1/1/2015
22859	INSJ BIOMECHANICAL DEVICE		\$273.68	\$273.68				Added Effective 1/1/2017
22861	REV INCL REPLACEMENT TOTAL DISC ARTHROPLASTY		\$1,549.96	\$1,549.96				riddd Elledilol If If Ed IT
22862	REVISE LUMBAR DISC ARTHROPLASTY		\$1,325.39	\$1,325.39				
22864	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICAL DISC)		\$1,439.29	\$1,439.29				
22865	REMOVAL TOTAL LUMBAR DISC ARTHROPLASTY		\$1,290.41	\$1,290.41				
22867	INSJ STABLJ DEV W/DCMPRN		\$782.97	\$782.97				Added Effective 1/1/2017
22868	INSJ STABLJ DEV W/DCMPRN		\$197.79	\$197.79				Added Effective 1/1/2017
22869	INSJ STABLJ DEV W/O DCMPRN		\$429.91	\$429.91				Added Effective 1/1/2017
22870	INSJ STABLJ DEV W/O DCMPRN		\$115.32	\$115.32				Added Effective 1/1/2017
22899	UNLISTED PROCEDURE, SPINE	R	\$500.00	\$650.00				
			,	,				
22900	EXCISION, ABDOMINAL WALL TUMOR, SUBFASCIAL (EG, DESMOID)		\$288.34	\$288.34				
22901	5 CM OR GREATER		\$481.77	\$481.77				
	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBQ; LESS							
22902	THAN 3 CM		\$242.39	\$300.31				
22903	3 CM OR GREATER		\$318.49	\$318.49				
	RADICAL RESECTION OF TUMOR; SOFT TISSUE OF ABD WALL; LESS							
22904	THAN 5 CM		\$755.94	\$755.94				
22905	5 CM OR GREATER		\$980.19	\$980.19				
22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM	R	\$800.00	\$1,040.00				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
23000	REMOVAL OF SUBDELTOID CALCAREOUS DEPOSITS, OPEN		\$219.22	\$219.22				
23020	CAPSULAR CONTRACTURE RELEASE (EG, SEVER TYPE PROCEDURE)		\$463.57	\$463.57				
23030	DRAIN SHOULDER LESION		\$159.17	\$159.17				
23031	INCISION AND DRAINAGE, SHOULDER AREA; INFECTED BURSA		\$86.85	\$93.56				
	INCISION, BONE CORTEX (EG, OSTEOMYELITIS OR BONE ABSCESS),							
23035	SHOULDER AR		\$420.98	\$420.98				
	ARTHROTOMY, GLENOHUMERAL JOINT, INCLUDING EXPLORATION,							
23040	DRAINAGE, OR RE		\$530.55	\$530.55				
	ARTHROTOMY, ACROMIOCLAVICULAR, STERNOCLAVICULAR JOINT,							
23044	INCLUDING		\$401.81	\$401.81				
23065	BIOPSY, SOFT TISSUE OF SHOULDER AREA; SUPERFICIAL		\$85.62	\$85.62				
23066	BIOPSY, SOFT TISSUE OF SHOULDER AREA; DEEP		\$151.75	\$151.75				
23071	3 CM OR GREATER		\$301.88	\$301.88				
23073	5 CM OR GREATER		\$500.90	\$500.90				
23075	EXCISION, SOFT TISSUE TUMOR, SHOULDER AREA; SUBCUTANEOUS		\$120.77	\$120.77				
	EXCISION, SOFT TISSUE TUMOR, SHOULDER AREA; DEEP,							
23076	SUBFASCIAL, OR		\$319.67	\$319.67				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT							
23077	TISSUE OF		\$661.36	\$661.36				
23078	5 CM OR GREATER		\$1,020.16	\$1,020.16				
23100	ARTHROTOMY, GLENOHUMERAL JOINT, INCLUDING BIOPSY		\$388.45	\$388.45				
	ARTHROTOMY, ACROMIOCLAVICULAR JOINT OR							
23101	STERNOCLAVICULAR JOINT, INCLUDI		\$361.45	\$361.45				
	ARTHROTOMY; GLENOHUMERAL JOINT, WITH SYNOVECTOMY, WITH							
23105	OR WITHOUT BIOP		\$534.96	\$534.96				

Physician	Fee Schedule 2020		1					
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROTOMY; STERNOCLAVICULAR JOINT, WITH SYNOVECTOMY,							
23106	WITH OR WITHOUT		\$309.99	\$309.99				
	ARTHROTOMY, GLENOHUMERAL JOINT, WITH JOINT EXPLORATION,							
23107	WITH OR WITHOU		\$534.66	\$534.66				
23120	CLAVICULECTOMY; PARTIAL		\$336.76	\$336.76				
23125	CLAVICULECTOMY; TOTAL		\$519.74	\$519.74				
	ACROMIOPLASTY OR ACROMIONECTOMY, PARTIAL, WITH OR							
23130	WITHOUT CORACOACROMI		\$425.13	\$425.13				
00440	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		#040.00	4040.00				
23140	CLAVICLE OR SCAP		\$318.00	\$318.00				
00445	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		# 500.07	4500.07				
23145	CLAVICLE OR SCAP EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		\$500.97	\$500.97				
22446	CLAVICLE OR SCAP		\$380.20	\$380.20				
23146	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		\$300.20	\$30U.ZU				
23150	PROXIMAL HUMERUS		\$431.52	\$431.52				
23130	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		φ431.3Z	φ 4 31.32				+
23155	PROXIMAL HUMERUS		\$550.43	\$550.43				
23156	EXCISION OR CURETTAGE OF BONE CYST		\$470.04	\$470.04				
20100	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),		ψ+7 0.0+	ψ+10.0+				
23170	CLAVICLE		\$331.95	\$331.95				
20170	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),		Ψ001.00	Ψ001.00				
23172	SCAPULA		\$339.24	\$339.24			1	
	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),		7000.2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		1	
23174	HUMERAL HEAD T		\$514.31	\$514.31				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR				1			†
23180	DIAPHYSECTOMY) BONE		\$361.08	\$361.08			1	

Physician	Fee Schedule 2020							
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R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
23182	DIAPHYSECTOMY) BONE		\$421.99	\$421.99				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
23184	DIAPHYSECTOMY) BONE		\$525.45	\$525.45				
23190	OSTECTOMY OF SCAPULA, PARTIAL (EG, SUPERIOR MEDIAL ANGLE)		\$385.57	\$385.57				
23195	RESECTION, HUMERAL HEAD		\$538.31	\$538.31				
23200	RADICAL RESECTION FOR TUMOR; CLAVICLE		\$600.82	\$600.82				
23210	RADICAL RESECTION FOR TUMOR; SCAPULA		\$610.15	\$610.15				
23220	RADICAL RESECTION OF BONE TUMOR, PROXIMAL HUMERUS;		\$763.09	\$763.09				
23330	REMOVAL OF FOREIGN BODY, SHOULDER; SUBCUTANEOUS		\$61.90	\$69.27				
00004	REMOVAL OF FOREIGN BODY, SHOULDER; DEEP (EG, NEER		4070.00	4070.00				
23331	HEMIARTHROPLASTY REM		\$272.03	\$272.03			_	
00000	REMOVAL OF FOREIGN BODY, SHOULDER; COMPLICATED (EG,		ФСОО C4	# 000 04				
23332	TOTAL SHOULDER)		\$609.61	\$609.61	_			
23333	REMOVE SHOULDER FB DEEP SHOULDER PROSTHESIS REMOVAL		\$356.13 \$844.97	\$356.13				
23334				\$844.97				
23335 23350	SHOULDER PROSTHESIS REMOVAL INJECTION OF DYE FOR X-RAY IMAGING OF SHOULDER JOINT		\$1,009.28 \$44.51	\$1,009.28 \$44.51				Effective 1/1/2014
23330	MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM;		\$44.51	Φ44.51				Effective 1/1/2014
23397	MULTIPLE		\$878.46	\$878.46				
23381	MOLTIFEL		ψ0/0.40	ψ070.40				+
23400	SCAPULOPEXY (EG, SPRENGELS DEFORMITY OR FOR PARALYSIS)		\$685.04	\$685.04				
23405	TENOTOMY, SHOULDER AREA; SINGLE TENDON		\$458.82	\$458.82	+			
23-00	TENOTOMY, SHOULDER AREA; MULTIPLE TENDONS THROUGH SAME		ψ 100.02	ψ 100.02				+
23406	INCISION		\$593.91	\$593.91				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the servic	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
			.		<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR							
23410	CUFF) OPEN; ACUT		\$685.14	\$685.14				
	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR							
23412	CUFF) OPEN; CHRO		\$783.46	\$783.46				
	CORACOACROMIAL LIGAMENT RELEASE, WITH OR WITHOUT							
23415	ACROMIOPLASTY		\$438.16	\$438.16				
	RECONSTRUCTION OF COMPLETE SHOULDER (ROTATOR) CUFF							
23420	AVULSION, CHRONIC		\$820.33	\$820.33				
23430	TENODESIS OF LONG TENDON OF BICEPS		\$506.31	\$506.31				
23440	RESECTION OR TRANSPLANTATION OF LONG TENDON OF BICEPS		\$516.53	\$516.53				
	CAPSULORRHAPHY, ANTERIOR; PUTTI-PLATT PROCEDURE OR							
23450	MAGNUSON TYPE OPERA		\$768.61	\$768.61				
	CAPSULORRHAPHY, ANTERIOR; WITH LABRAL REPAIR (EG, BANKART							
23455	PROCEDURE)		\$883.62	\$883.62				
23460	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH BONE BLOCK		\$861.99	\$861.99				
	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH CORACOID							
23462	PROCESS TRANSFER		\$895.08	\$895.08				
	CAPSULORRHAPHY, GLENOHUMERAL JOINT, POSTERIOR, WITH OR							
23465	WITHOUT BONE BL		\$878.95	\$878.95				
	CAPSULORRHAPHY, GLENOHUMERAL JOINT, ANY TYPE MULTI-							
23466	DIRECTIONAL INSTABI		\$908.78	\$908.78				
23470	ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY		\$986.94	\$986.94				
	ARTHROPLASTY, GLENOHUMERAL JOINT; TOTAL SHOULDER							
23472	(GLENOID AND PROXIMAL		\$1,143.49	\$1,143.49				
23473	REVISION OF TOTAL SHOULDER ARTHROPLASTY		\$1,303.07	\$1,303.07				
23474	HUMERAL AND GLENOID COMPONENT		\$1,407.95	\$1,407.95				

Physician	Fee Schedule 2020			T				
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
23480	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION;		\$511.41	\$511.41				
	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION;							
23485	WITH BONE GRAF		\$721.94	\$721.94				
	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR							
23490	WIRING) WITH OR		\$619.00	\$619.00				
	PROPHÝLACTIC TREATMENT (NAILING, PINNING, PLATING OR							
23491	WIRING) WITH OR		\$791.86	\$791.86				
	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITHOUT							
23500	MANIPULATION		\$106.58	\$106.58				
	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITH							
23505	MANIPULATION		\$182.04	\$182.04				
	OPEN TREATMENT OF CLAVICULAR FRACTURE, WITH OR WITHOUT							
23515	INTERNAL OR EXT		\$418.79	\$418.79				
	CLOSED TREATMENT OF STERNOCLAVICULAR DISLOCATION;							
23520	WITHOUT MANIPULATION		\$101.20	\$101.20				
	CLOSED TREATMENT OF STERNOCLAVICULAR DISLOCATION; WITH							
23525	MANIPULATION		\$159.44	\$159.44				
	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE							
23530	OR CHRONIC;		\$404.59	\$404.59				
	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE							
23532	OR CHRONIC; WITH		\$445.56	\$445.56				
00540	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION;		0.407.64	4.07.6 <i>t</i>				
23540	WITHOUT MANIPULATIO		\$107.81	\$107.81				
00545	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION; WITH		0450.04	0450.04				
23545	MANIPULATION		\$150.24	\$150.24				
2255	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE		¢450.07	¢450.07				
23550	OR CHRONIC;		\$458.87	\$458.87				

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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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			l		<u> </u> .		Base	
Proc		L	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE			4.50.50				
23552	OR CHRONIC; WIT		\$453.72	\$453.72				
	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITHOUT							
23570	MANIPULATION		\$113.29	\$113.29				
	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITH							
23575	MANIPULATION, WITH OR WITH		\$198.06	\$198.06				
	OPEN TREATMENT OF SCAPULAR FRACTURE (BODY, GLENOID OR		1					
23585	ACROMION) WITH O		\$484.65	\$484.65				
	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR							
23600	ANATOMICAL NECK)		\$168.93	\$168.93				
	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR		1					
23605	ANATOMICAL NECK)		\$279.95	\$279.95				
	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR		1					
23615	ANATOMICAL NECK) FRACT		\$576.68	\$576.68				
	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR		1					
23616	ANATOMICAL NECK) FRACT		\$1,268.03	\$1,268.03				
	CLOSED TREATMENT OF GREATER HUMERAL TUBEROSITY		1					
23620	FRACTURE; WITHOUT		\$115.82	\$154.45				
	CLOSED TREATMENT OF GREATER HUMERAL TUBEROSITY							
23625	FRACTURE; WITH MANIPULA	ļ	\$223.85	\$223.85	1		ļ	
	OPEN TREATMENT OF GREATER HUMERAL TUBEROSITY FRACTURE,		1					
23630	WITH OR WITHOUT		\$472.76	\$472.76	1		1	
	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH							
23650	MANIPULATION; WITHOUT		\$157.23	\$157.23				
	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH		1.					
23655	MANIPULATION; REQUIRING		\$214.28	\$214.28				
23660	OPEN TREATMENT OF ACUTE SHOULDER DISLOCATION		\$485.34	\$485.34			1	

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Code	Procedure Description CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00005	·		COO 4 O 4	фоод од				
23665	OF GREATER HUM		\$224.31	\$224.31				
00070	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE		φ540.04	Φ 5 40.04				
23670	OF GREATER HUMER		\$518.61	\$518.61			+	
00075	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL		0004.50	0004.50				
23675	OR ANATOMICAL		\$284.56	\$284.56				
00000	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL		0.50.04	0050.04				
23680	OR ANATOMICAL NE		\$653.04	\$653.04				
00700	MANIPULATION UNDER ANESTHESIA, SHOULDER JOINT, INCLUDING		A 40000	# 400.00				
23700	APPLICATION O		\$136.80	\$136.80				
23800	ARTHRODESIS, GLENOHUMERAL JOINT;		\$893.30	\$893.30				
	ARTHRODESIS, GLENOHUMERAL JOINT; WITH AUTOGENOUS GRAFT							
23802	(INCLUDES OBTAI		\$862.28	\$862.28				
23900	INTERTHORACOSCAPULAR AMPUTATION (FOREQUARTER)		\$935.39	\$935.39				
23920	DISARTICULATION OF SHOULDER;		\$832.27	\$832.27				
	DISARTICULATION OF SHOULDER; SECONDARY CLOSURE OR SCAR							
23921	REVISION		\$280.11	\$280.11				
23929	UNLISTED PROCEDURE, SHOULDER	R	\$0.00	\$0.00				
	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; DEEP							
23930	ABSCESS OR HEMATO		\$130.59	\$130.59			1	
23931	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; BURSA		\$60.56	\$70.62				
	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR							
23935	OSTEOMYELITIS OR		\$307.90	\$307.90				
	ARTHROTOMY, ELBOW, INCLUDING EXPLORATION, DRAINAGE, OR							
24000	REMOVAL OF FORE		\$373.76	\$373.76				
	ARTHROTOMY OF THE ELBOW, WITH CAPSULAR EXCISION FOR		1					
24006	CAPSULAR RELEASE		\$475.23	\$475.23			1	

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	That y Chai	T The service	,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		l ne					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA;	Ailiu	(i dointy)	(Norm acmity)	Jonny.	Comp.	Value	Notes
24065	SUPERFICIAL		\$72.59	\$83.19				
21000	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; DEEP		Ψ12.00	φοσ. το				
24066	(SUBFASCIAL OR		\$227.90	\$227.90				
24071	3 CM OR GREATER		\$292.84	\$292.84				
24073	5 CM OR GREATER	+	\$503.58	\$503.58				
24070	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA;	+	Ψ000.00	φοσσ.σσ				
24075	SUBCUTANEOUS		\$172.82	\$172.82				
21070	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA;		Ψ172.02	Ψ172.02				
24076	DEEP (SUBFASC		\$291.34	\$291.34				
24070	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT	+	Ψ201.04	Ψ201.04				
24077	TISSUE OF UP		\$636.09	\$636.09				
24079	5 CM OR GREATER	+	\$940.21	\$940.21				
24100	ARTHROTOMY, ELBOW; WITH SYNOVIAL BIOPSY ONLY		\$267.26	\$267.26				
21100	ARTHROTOMY, ELBOW; WITH JOINT EXPLORATION, WITH OR		Ψ207.20	Ψ201.20				
24101	WITHOUT BIOPSY, WIT		\$405.99	\$405.99				
24102	ARTHROTOMY, ELBOW; WITH SYNOVECTOMY		\$525.75	\$525.75				
24105	EXCISION, OLECRANON BURSA		\$217.08	\$217.08				
21100	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		Ψ211.00	Ψ211.00				
24110	HUMERUS;		\$443.66	\$443.66				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		Ψ110.00	ψ.10.00				
24115	HUMERUS; WITH AUTO		\$498.88	\$498.88				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		+ .00.00	+ .00.00				
24116	HUMERUS; WITH ALLO		\$623.02	\$623.02				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		,	+				
24120	HEAD OR NECK OF		\$371.91	\$371.91				
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	ise lab fee schedule for covered codes not listed below in the 80000-89249							
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Code	Procedure Description EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04405			#007.00	0007.00				
24125	HEAD OR NECK OF	4	\$387.26	\$387.26				
0.4.4.0.0	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		A 455 50	0.455.50				
24126	HEAD OR NECK OF		\$455.59	\$455.59				
24130	EXCISION, RADIAL HEAD		\$381.37	\$381.37				
	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),							
24134	SHAFT OR DISTA		\$526.72	\$526.72				
	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),							
24136	RADIAL HEAD OR		\$472.94	\$472.94				
	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),							
24138	OLECRANON PROC		\$413.12	\$413.12				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
24140	DIAPHYSECTOMY) BONE		\$521.64	\$521.64				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
24145	DIAPHYSECTOMY) BONE		\$405.08	\$405.08				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
24147	DIAPHYSECTOMY) BONE		\$408.94	\$408.94				
	RADICAL RESECTION OF CAPSULE, SOFT TISSUE, AND							
24149	HETEROTOPIC BONE, ELBOW		\$757.93	\$757.93				
24150	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS;		\$796.82	\$796.82				
24152	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK;		\$489.63	\$489.63				
24155	RESECTION OF ELBOW JOINT (ARTHRECTOMY)		\$656.14	\$656.14				
24160	IMPLANT REMOVAL; ELBOW JOINT		\$367.28	\$367.28				
24164	IMPLANT REMOVAL; RADIAL HEAD		\$340.09	\$340.09				
	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA;							
24200	SUBCUTANEOUS		\$59.15	\$66.66				
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA; DEEP							
24201	(SUBFASCIAL OR		\$220.16	\$220.16				
24220	INJECTION PROCEDURE FOR ELBOW ARTHROGRAPHY		\$53.33	\$53.33				
24300	MANIPULATION, ELBOW, UNDER ANESTHESIA		\$261.85	\$261.85				
	MUSCLE OR TENDON TRANSFER, ANY TYPE, UPPER ARM OR ELBOW,							
24301	SINGLE (EXCLU		\$528.76	\$528.76				
24305	TENDON LENGTHENING, UPPER ARM OR ELBOW, EACH TENDON		\$299.76	\$299.76				
24310	TENOTOMY, OPEN, ELBOW TO SHOULDER, EACH TENDON		\$258.63	\$258.63				
	TENOPLASTY, WITH MUSCLE TRANSFER, WITH OR WITHOUT FREE							
24320	GRAFT, ELBOW TO		\$571.84	\$571.84				
24330	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT);		\$538.54	\$538.54				
	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT);							
24331	WITH EXTENSOR		\$592.55	\$592.55				
24332	TENOLYSIS, TRICEPS		\$368.65	\$368.65				
			,	,				
24340	TENODESIS OF BICEPS TENDON AT ELBOW (SEPARATE PROCEDURE)		\$437.64	\$437.64				
	REPAIR, TENDON OR MUSCLE, UPPER ARM OR ELBOW, EACH		¥ 101101	Ţ.c				
24341	TENDON OR MUSCLE,		\$419.10	\$419.10				
2.0	REINSERTION OF RUPTURED BICEPS OR TRICEPS TENDON, DISTAL,		Ψ.1.0.10	ψ.10.10				
24342	WITH OR WITH		\$618.43	\$618.43				
24042	REPAIR LATERAL COLLATERAL LIGAMENT, ELBOW, WITH LOCAL		φοτοιπο	ψο το. το	+			+
24343	TISSUE		\$483.35	\$483.35				
2-10-10	RECONSTRUCTION LATERAL COLLATERAL LIGAMENT, ELBOW, WITH		ψ-100.00	ψ-100.00	+		+	
24344	TENDON GRAFT		\$732.22	\$732.22				
27077	REPAIR MEDIAL COLLATERAL LIGAMENT, ELBOW, WITH LOCAL		ψ1 02.22	ψ1 02.22	+		+	+
24345	ITISSUE		\$483.35	\$483.35				
24345	TIOOUL	<u> </u>	φ403.33	φ403.33				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RECONSTRUCTION MEDIAL COLLATERAL LIGAMENT, ELBOW, WITH							
24346	TENDON GRAFT		\$732.22	\$732.22				
24357	REPAIR ELBOW, PERC		\$323.70	\$323.70				
24358	REPAIR ELBOW W/DEB, OPEN		\$382.45	\$382.45				
24359	REPAIR ELBOW DEB/ATTCH OPEN		\$488.66	\$488.66				
24360	ARTHROPLASTY, ELBOW; WITH MEMBRANE (EG, FASCIAL)		\$808.77	\$808.77				
	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERAL PROSTHETIC							
24361	REPLACEMENT		\$796.91	\$796.91				
	ARTHROPLASTY, ELBOW; WITH IMPLANT AND FASCIA LATA							
24362	LIGAMENT RECONSTRUCT		\$618.50	\$794.72				
	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERUS AND PROXIMAL							
24363	ULNAR PROSTHETIC		\$1,225.00	\$1,225.00				
24365	ARTHROPLASTY, RADIAL HEAD;		\$463.31	\$463.31				
24366	ARTHROPLASTY, RADIAL HEAD; WITH IMPLANT		\$594.53	\$594.53				
24370	REVISION OF TOTAL ELBOW ARTHROPLASTY		\$1,232.05	\$1,232.05				
24371	HUMERAL AND ULNAR COMPONENT		\$1,420.54	\$1,420.54				
24400	OSTEOTOMY, HUMERUS, WITH OR WITHOUT INTERNAL FIXATION		\$568.97	\$568.97				
	MULTIPLE OSTEOTOMIES WITH REALIGNMENT ON INTRAMEDULLARY							
24410	ROD, HUMERAL S		\$845.66	\$845.66				
	OSTEOPLASTY, HUMERUS (EG, SHORTENING OR LENGTHENING)							
24420	(EXCLUDING 64876)		\$757.28	\$757.28				
	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITHOUT GRAFT							
24430	(EG, COMPRESSIO		\$809.82	\$809.82				
	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITH ILIAC OR							
24435	OTHER AUTOGRAFT		\$845.40	\$845.40				
1	HEMIEPIPHYSEAL ARREST (EG, CUBITUS VARUS OR VALGUS, DISTAL							
24470	HUMERUS)		\$488.16	\$488.16				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l		·				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DECOMPRESSION FASCIOTOMY, FOREARM, WITH BRACHIAL ARTERY			,				
24495	EXPLORATION		\$403.67	\$403.67				
	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR							
24498	WIRING), WITH OR		\$649.09	\$649.09				
	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITHOUT							
24500	MANIPULATION		\$165.20	\$165.20				
	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITH							
24505	MANIPULATION, WITH OR		\$279.68	\$279.68				
	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE WITH							
24515	PLATE/SCREWS, WITH OR WI		\$616.68	\$616.68				
	TREATMENT OF HUMERAL SHAFT FRACTURE, WITH INSERTION OF							
24516	INTRAMEDULLARY		\$616.68	\$616.68				
	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR							
24530	HUMERAL FRACTURE, W		\$180.26	\$180.26				
	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR							
24535	HUMERAL FRACTURE, W		\$340.07	\$340.07				
	PERCUTANEOUS SKELETAL FIXATION OF SUPRACONDYLAR OR							
24538	TRANSCONDYLAR HUMER		\$504.35	\$504.35				
	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR							
24545	TRANSCONDYLAR FRACTURE, WIT		\$589.21	\$589.21				
	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR							
24546	TRANSCONDYLAR FRACTURE, WIT		\$736.23	\$736.23				
	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE,							
24560	MEDIAL OR LATERAL;		\$142.11	\$142.11				
	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE,							
24565	MEDIAL OR LATERAL; W		\$258.83	\$258.83				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ae for the service	<u> </u>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PERCUTANEOUS SKELETAL FIXATION OF HUMERAL EPICONDYLAR							
24566	FRACTURE, MEDIAL		\$396.26	\$396.26				
	OPEN TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL							
24575	OR LATERAL, WIT		\$529.87	\$529.87				
	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL							
24576	OR LATERAL; WITH		\$144.01	\$144.01				
0.4577	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL		4000.00	# 000 00				
24577	OR LATERAL; WITH		\$282.03	\$282.03				
04570	OPEN TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR		Ф Г 7 Г СО	ф г 75 00				
24579	LATERAL, WITH O PERCUTANEOUS SKELETAL FIXATION OF HUMERAL CONDYLAR		\$575.68	\$575.68				
04500	FRACTURE, MEDIAL OR		\$433.08	\$433.08				
24582	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR		\$433.08	\$433.08				
24586	DISLOCATION OF THE ELB		\$873.83	\$873.83				
24300	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR		φ013.03	φ073.03				+
24587	DISLOCATION OF THE ELB		\$839.16	\$839.16				
24007	TREATMENT OF CLOSED ELBOW DISLOCATION; WITHOUT		ψ000.10	Ψ000.10				
24600	ANESTHESIA		\$178.34	\$178.34				
21000	TREATMENT OF CLOSED ELBOW DISLOCATION; REQUIRING		ψ170.01	ψ170.01				
24605	ANESTHESIA		\$219.48	\$219.48				
		 	 	 				
24615	OPEN TREATMENT OF ACUTE OR CHRONIC ELBOW DISLOCATION		\$542.19	\$542.19				
	CLOSED TREATMENT OF MONTEGGIA TYPE OF FRACTURE	1						
24620	DISLOCATION AT ELBOW		\$309.49	\$309.49				
	OPEN TREATMENT OF MONTEGGIA TYPE OF FRACTURE							
24635	DISLOCATION AT ELBOW (FRA		\$704.35	\$704.35				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF RADIAL HEAD SUBLUXATION IN CHILD,		400 70	400 70				
24640	NURSEMAID ELBOW,		\$62.78	\$62.78				
	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE;		l					
24650	WITHOUT MANIPULATION		\$97.17	\$127.35				
	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITH							
24655	MANIPULATION		\$214.03	\$214.03				
	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR							
24665	WITHOUT INTERN		\$444.59	\$444.59				
	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR							
24666	WITHOUT INTERN		\$574.62	\$574.62				
	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END							
24670	(OLECRANON PROCESS);		\$128.99	\$128.99				
	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END							
24675	(OLECRANON PROCESS);		\$239.90	\$239.90				
	OPEN TREATMENT OF ULNAR FRACTURE PROXIMAL END							
24685	(OLECRANON PROCESS), WIT		\$502.59	\$502.59				
24800	ARTHRODESIS, ELBOW JOINT; LOCAL		\$637.15	\$637.15				
	ARTHRODESIS, ELBOW JOINT; WITH AUTOGENOUS GRAFT							
24802	(INCLUDES OBTAINING GR		\$750.35	\$750.35				
24900	AMPUTATION, ARM THROUGH HUMERUS; WITH PRIMARY CLOSURE		\$496.82	\$496.82				
	AMPUTATION, ARM THROUGH HUMERUS; OPEN, CIRCULAR							
24920	(GUILLOTINE)		\$465.76	\$465.76				
	AMPUTATION, ARM THROUGH HUMERUS; SECONDARY CLOSURE OR							
24925	SCAR REVISION		\$380.36	\$380.36				
24930	AMPUTATION, ARM THROUGH HUMERUS; RE-AMPUTATION		\$523.13	\$523.13				
24931	AMPUTATION, ARM THROUGH HUMERUS; WITH IMPLANT		\$687.92	\$687.92				

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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
24935	STUMP ELONGATION, UPPER EXTREMITY		\$843.56	\$843.56				
24940	CINEPLASTY, UPPER EXTREMITY, COMPLETE PROCEDURE	_	\$1,079.77	\$1,079.77				
24999	UNLISTED PROCEDURE, HUMERUS OR ELBOW	R	\$0.00	\$0.00				
05000	INCISION, EXTENSOR TENDON SHEATH, WRIST (EG, DEQUERVAINS		001404	004404				
25000	DISEASE)		\$214.64	\$214.64				
0=004	INCISION, FLEXOR TENDON SHEATH, WRIST (EG, FLEXOR CARPI		4040 54	4040.54				
25001	RADIALIS)		\$219.51	\$219.51				
05000	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST, FLEXOR		4000.04	4000.04				
25020	OR EXTENSOR		\$298.24	\$298.24				
05000	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST, FLEXOR		0545.04	0545.04				
25023	OR EXTENSOR		\$515.01	\$515.01				
05004	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST, FLEXOR		0544.00	ΦΕ44 OO				
25024	AND EXTENSOR		\$514.28	\$514.28				
05005	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST, FLEXOR		0004.70	0004.70				
25025	AND EXTENSOR	-	\$834.78	\$834.78				
25020	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; DEEP ABSCESS OR HEMATOMA		\$207.20	\$207.20				
25028 25031	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; BURSA		\$134.33	\$134.33				
23031	INCISION AND DRAINAGE, FOREARM AND/OR WRIST, BURSA INCISION, DEEP, BONE CORTEX, FOREARM AND/OR WRIST (EG,		φ134.33	φ134.33			-	
25035	OSTEOMYELITIS O		\$393.94	\$393.94				
25035	ARTHROTOMY, RADIOCARPAL OR MIDCARPAL JOINT, WITH		φ393.9 4	დაშა.შ 4				
25040	EXPLORATION, DRAINAGE		\$368.45	\$368.45				
20040	EAFLONATION, DRAINAGE	+	φ300.43	φ300.43				+
25065	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; SUPERFICIAL		\$82.38	\$92.43				
	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; DEEP							
25066	(SUBFASCIAL OR		\$160.21	\$160.21				
25071	3 CM OR GREATER		\$306.72	\$306.72				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
25073	3 CM OR GREATER		\$381.76	\$381.76				
	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA;							
25075	SUBCUTANEOU		\$173.66	\$173.66				
	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA;							
25076	DEEP (SUBFA		\$257.37	\$257.37				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT							
25077	TISSUE OF FO		\$539.46	\$539.46				
25078	3 CM OR GREATER		\$820.00	\$820.00				
25085	CAPSULOTOMY, WRIST (EG, CONTRACTURE)		\$291.70	\$291.70				
25100	ARTHROTOMY, WRIST JOINT; WITH BIOPSY		\$252.39	\$252.39				
	ARTHROTOMY, WRIST JOINT; WITH JOINT EXPLORATION, WITH OR							
25101	WITHOUT BIOPS		\$304.28	\$304.28				
25105	ARTHROTOMY, WRIST JOINT; WITH SYNOVECTOMY		\$382.77	\$382.77				
	ARTHROTOMY, DISTAL RADIOULNAR JOINT INCLUDING REPAIR OF							
25107	TRIANGULAR		\$336.08	\$336.08				
25109	EXCISE TENDON, FOREARM/WRIST		\$355.42	\$355.42				
0.5.4.4.0			* 40 7 40	4.07.40				
25110	EXCISION, LESION OF TENDON SHEATH, FOREARM AND/OR WRIST		\$197.49	\$197.49				
25111	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); PRIMARY		\$194.80	\$194.80				
25112	EVOISION OF CANCLION MIDIST (DODGAL OF VOLAR), DECURPONT		\$244.34	\$244.34				
25112	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); RECURRENT RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM		\$244.34	\$244.34	1			+
25115	TENDON SHEATHS		\$405.09	\$405.09				
20110	RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM		φ403.09	φ 4 υ3.υ 8	-			
25116	TENDON SHEATHS		\$441.64	\$441.64				
23110	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE		φ441.04	φ441.04	+			+
25118	COMPARTMENT:		\$286.47	\$286.47			1	
20110	[COMPANTIMENT,		φ200.41	φ200.47				

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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
05440	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE		# 004.00	# 004.00				
25119	COMPARTMENT; WITH		\$391.23	\$391.23			+	
05400	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		0070 44	0070 44				
25120	RADIUS OR ULNA		\$370.11	\$370.11			_	
05405	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		* 445.00	* 4 4 5 00				
25125	RADIUS OR ULNA		\$415.90	\$415.90				
05.400	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF							
25126	RADIUS OR ULNA		\$418.82	\$418.82				
05400	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		4070.07	4070.07				
25130	CARPAL BONES;		\$278.27	\$278.27				
05405	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		0000 40	****				
25135	CARPAL BONES; WI		\$363.10	\$363.10				
0.5.4.0.0	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		004440	401110				
25136	CARPAL BONES; WI		\$314.46	\$314.46				
05445	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS),		4050.00	4050.00				
25145	FOREARM AND/OR		\$353.00	\$353.00				
05450	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR		4000.04	4000.04				
25150	DIAPHYSECTOMY) OF B		\$398.61	\$398.61				
05454	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR		000000	4000 0 4				
25151	DIAPHYSECTOMY) OF B		\$380.31	\$380.31				
25170	RADICAL RESECTION FOR TUMOR, RADIUS OR ULNA		\$605.92	\$605.92				
25210	CARPECTOMY; ONE BONE		\$313.19	\$313.19			1	
25215	CARPECTOMY; ALL BONES OF PROXIMAL ROW		\$484.46	\$484.46				<u> </u>
25230	RADIAL STYLOIDECTOMY (SEPARATE PROCEDURE)		\$312.66	\$312.66				
	EXCISION DISTAL ULNA PARTIAL OR COMPLETE (EG, DARRACH TYPE							
25240	OR MATCHED		\$307.13	\$307.13				
25246	INJECTION PROCEDURE FOR WRIST ARTHROGRAPHY		\$57.17	\$57.17				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXPLORATION WITH REMOVAL OF DEEP FOREIGN BODY, FOREARM							
25248	OR WRIST		\$213.01	\$213.01				
25250	REMOVAL OF WRIST PROSTHESIS; (SEPARATE PROCEDURE)		\$358.28	\$358.28				
05054	REMOVAL OF WRIST PROSTHESIS; COMPLICATED, INCLUDING		4=0.4=0	\$504.50				
25251	TOTAL WRIST		\$521.50	\$521.50				
25259	MANIPULATION, WRIST, UNDER ANESTHESIA		\$259.01	\$259.01				
25260	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST;		#257.60	ФОБТ СО				
25260	PRIMARY, SINGL REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST;		\$357.69	\$357.69				
25263	SECONDARY, SIN		\$396.05	\$396.05				
20203	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST;		\$396.05	\$396.05				
25265	SECONDARY, WIT		\$526.90	\$526.90				
23203	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR		φ320.90	φ320.90				+
25270	WRIST; PRIMARY, SIN		\$271.04	\$271.04				
20210	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR		Ψ27 1.04	Ψ211.04			-	+
25272	WRIST; SECONDARY,		\$303.46	\$303.46				
	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR		4000.10	4000				
25274	WRIST; SECONDARY, W		\$452.68	\$452.68				
	REPAIR, TENDON SHEATH, EXTENSOR, FOREARM AND/OR WRIST,		,	·				
25275	WITH FREE GRAFT		\$466.73	\$466.73				
	LENGTHENING OR SHORTENING OF FLEXOR OR EXTENSOR							
25280	TENDON, FOREARM AND/OR		\$330.08	\$330.08				
	TENOTOMY, OPEN, FLEXOR OR EXTENSOR TENDON, FOREARM							
25290	AND/OR WRIST, SINGL		\$223.81	\$223.81				
	TENOLYSIS, FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR							
25295	WRIST, SINGLE, EA		\$278.13	\$278.13				
25300	TENODESIS AT WRIST; FLEXORS OF FINGERS		\$474.57	\$474.57				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
25301	TENODESIS AT WRIST; EXTENSORS OF FINGERS		\$447.65	\$447.65				
	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR,							
25310	FOREARM AND/OR		\$445.30	\$445.30				
	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR,							
25312	FOREARM AND/OR		\$502.92	\$502.92				
	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN							
25315	CONTRACTURE), FO		\$526.04	\$526.04				
	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN							
25316	CONTRACTURE), FO		\$664.19	\$664.19				
	CAPSULORRHAPHY OR RECONSTRUCTION, WRIST, OPEN (EG,							
25320	CAPSULODESIS, LIGAM		\$556.11	\$556.11				
	ARTHROPLASTY, WRIST, WITH OR WITHOUT INTERPOSITION, WITH							
25332	OR WITHOUT		\$624.59	\$624.59				
25335	CENTRALIZATION OF WRIST ON ULNA (EG, RADIAL CLUB HAND)		\$699.29	\$699.29				
	RECONSTRUCTION FOR STABILIZATION OF UNSTABLE DISTAL ULNA							
25337	OR DISTAL		\$544.67	\$544.67				
25350	OSTEOTOMY, RADIUS; DISTAL THIRD		\$476.23	\$476.23				
25355	OSTEOTOMY, RADIUS; MIDDLE OR PROXIMAL THIRD		\$561.05	\$561.05				
25360	OSTEOTOMY; ULNA		\$427.21	\$427.21				
25365	OSTEOTOMY; RADIUS AND ULNA		\$655.95	\$655.95				
	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON							
25370	INTRAMEDULLARY ROD (SOFIELD		\$724.18	\$724.18				
	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON							
25375	INTRAMEDULLARY ROD (SOFIELD		\$740.06	\$740.06				
25390	OSTEOPLASTY, RADIUS OR ULNA; SHORTENING		\$562.05	\$562.05				
25391	OSTEOPLASTY, RADIUS OR ULNA; LENGTHENING WITH AUTOGRAFT		\$722.77	\$722.77				

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	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech.	Prof.	Base Unit Value	Notes
Oode	Toccure Description	I A IIIG	(i dointy)	(Noni acinty)	Comp.	Jonip.	Value	Notes
25392	OSTEOPLASTY, RADIUS AND ULNA; SHORTENING (EXCLUDING 64876)		\$766.17	\$766.17				
25393	OSTEOPLASTY, RADIUS AND ULNA; LENGTHENING WITH AUTOGRAFT		\$874.73	\$874.73				
25394	OSTEOPLASTY, CARPAL BONE, SHORTENING		\$545.64	\$545.64				
	REPAIR OF NONUNION OR MALUNION, RADIUS OR ULNA; WITHOUT							
25400	GRAFT (EG,		\$633.90	\$633.90				
	REPAIR OF NONUNION OR MALUNION, RADIUS OR ULNA; WITH							
25405	AUTOGRAFT (INCLUD		\$777.76	\$777.76				
	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITHOUT							
25415	GRAFT (EG,		\$723.86	\$723.86				
	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITH							
25420	AUTOGRAFT (INCLU		\$899.81	\$899.81				
25425	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS OR ULNA		\$732.87	\$732.87				
25426	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS AND ULNA		\$803.92	\$803.92				
05400	INSERTION OF VASCULAR PEDICLE INTO CARPAL BONE (EG, HORI		# 400.00	400.00				
25430	PROCEDURE) REPAIR OF NONUNION OF CARPAL BONE (EXCLUDING CARPAL		\$482.06	\$482.06				
25431	SCAPHOID (NAVICULA		\$480.17	\$480.17				
25431	REPAIR OF NONUNION, SCAPHOID CARPAL (NAVICULAR) BONE, WITH		\$400.1 <i>1</i>	\$40U.17				
25440	OR WITHOUT		\$571.15	\$571.15				
			+	ψοο				
25441	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS		\$710.37	\$710.37				
25442	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL ULNA		\$522.42	\$522.42				
25443	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; SCAPHOID CARPAL (NAVICULAR)		\$578.44	\$578.44				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
25444	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; LUNATE		\$624.53	\$624.53				
25445	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; TRAPEZIUM		\$591.68	\$591.68				
	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS							
25446	AND PARTIAL OR		\$1,072.90	\$1,072.90				
	ARTHROPLASTY, INTERPOSITION, INTERCARPAL OR							
25447	CARPOMETACARPAL JOINTS		\$586.06	\$586.06				
	REVISION OF ARTHROPLASTY, INCLUDING REMOVAL OF IMPLANT,							
25449	WRIST JOINT		\$642.82	\$642.82				
	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL							
25450	RADIUS OR ULNA		\$450.05	\$450.05				
	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL							
25455	RADIUS AND ULN		\$536.62	\$536.62				
	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR							
25490	WIRING) WITH OR		\$535.20	\$535.20				
	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR		V	+ - - - - - - - - - -				
25491	WIRING) WITH OR		\$560.22	\$560.22				
20.0.	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR		φοσσ.22	φοσσ. <u>Ε</u> Ε				
25492	WIRING) WITH OR		\$689.90	\$689.90				
20402	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITHOUT		φοσσ.σσ	Ψ000.00				
25500	MANIPULATION		\$105.78	\$137.03				
20000	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITH		ψ100.70	ψ107.00				
25505	MANIPULATION		\$253.69	\$253.69				
2000	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH OR WITHOUT		Ψ233.03	Ψ233.08			-	
25515	INTERNAL OR		\$487.53	\$487.53				
20010	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE AND CLOSED		φ 4 01.33	φ 4 01.33				
25520			фо го 4 <i>Б</i>	¢252.45				
25520	TREATMENT OF		\$353.15	\$353.15				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	!				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							<u> </u>
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							<u> </u>
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r physiciar	<u>IS</u>					
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D			In most Dodg	O. 4	Table	Prof.	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.		Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
05505	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL		#000 F0	# 000 F0				
25525	AND/ OR EXTERNA		\$686.56	\$686.56				
05500	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL		A700 70	4700 70				
25526	AND/ OR EXTERNA		\$729.72	\$729.72				
05500	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITHOUT		000 45	# 400.00				
25530	MANIPULATION		\$98.15	\$130.88				
05505	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITH		* 050.05	* 050.05				
25535	MANIPULATION		\$252.95	\$252.95				<u> </u>
05545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE, WITH OR WITHOUT		Φ477 40	Φ 4 7 7 4 O				
25545	INTERNAL OR		\$477.49	\$477.49				
05500	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES;		# 404.04	MADA 04				
25560	WITHOUT MANIPULA		\$134.64	\$134.64				
05505	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES;		#007.00	4007.00				
25565	WITH MANIPULATIO		\$297.23	\$297.23				
05574	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH		£400.04	# 400.04				
25574	INTERNAL OR OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH		\$426.04	\$426.04				<u> </u>
05575	·		#c0c 04	#606.04				
25575	INTERNAL OR CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR		\$606.91	\$606.91				<u> </u>
25600	SMITH TYPE)		\$194.55	\$194.55				
25600	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR		\$194.55	\$194.55				
25605			¢205 15	¢205 15				
25605 25606	SMITH TYPE) TREAT FX, DISTAL RADIAL		\$385.15 \$478.57	\$385.15 \$478.57		+		
25606	TREAT FX, DISTAL RADIAL TREAT FX, RADIAL EXTRA-ARTICULAR		\$478.57	\$478.57		+		
25607	TREAT FX, RADIAL EXTRA-ARTICULAR TREAT FX, RADIAL INTRA-ARTICULAR		\$487.92 \$559.34	\$487.92 \$559.34		+		
20000	I TEAT FA, RADIAL INTRA-ARTICULAR		φυσ9.34			+		
25609	TREAT FX, RADIAL W/INTERNAL FIXATION 3 OR MORE FRAGMENTS		\$714.87	\$714.87				

Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR)							
25622	FRACTURE; WITHOUT		\$109.90	\$140.48				
	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR)							
25624	FRACTURE; WITH MANIPUL		\$188.66	\$237.88				
	OPEN TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE,		4440					
25628	WITH OR WITHOU		\$448.60	\$448.60				
05000	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING		440.77	.				
25630	CARPAL SCAPHOID		\$116.77	\$146.14				
05005	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING		#470.00	0004.04				
25635	CARPAL SCAPHOID		\$179.28	\$224.34				
05045	OPEN TREATMENT OF CARPAL BONE FRACTURE (OTHER THAN		¢400.00	¢400.00				
25645 25650	CARPAL SCAPHOID CLOSED TREATMENT OF ULNAR STYLOID FRACTURE		\$403.26 \$128.64	\$403.26 \$164.31				+
25050	CLOSED TREATMENT OF ULNAR STYLOID FRACTURE		\$128.04	\$104.31				
25651	PERCUTANEOUS SKELETAL FIXATION OF ULNAR STYLOID FRACTURE		\$285.82	\$285.82				
25652	OPEN TREATMENT OF ULNAR STYLOID FRACTURE		\$421.07	\$421.07	+			
20002	CLOSED TREATMENT OF RADIOCARPAL OR INTERCARPAL		Ψ.2	ψ121.07				
25660	DISLOCATION, ONE OR MOR		\$188.06	\$188.06				
	OPEN TREATMENT OF RADIOCARPAL OR INTERCARPAL		V.00.00	Ţ.55.55				
25670	DISLOCATION, ONE OR MORE		\$437.78	\$437.78				
	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIOULNAR							
25671	DISLOCATION		\$346.81	\$346.81				
	CLOSED TREATMENT OF DISTAL RADIOULNAR DISLOCATION WITH							
25675	MANIPULATION		\$199.70	\$199.70				
	OPEN TREATMENT OF DISTAL RADIOULNAR DISLOCATION, ACUTE							
25676	OR CHRONIC		\$444.85	\$444.85				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)			1	
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						1	
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF							
25680	FRACTURE DISLOCATION		\$239.40	\$239.40				
	OPEN TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF							
25685	FRACTURE DISLOCATION		\$541.60	\$541.60				
	CLOSED TREATMENT OF LUNATE DISLOCATION, WITH							
25690	MANIPULATION		\$300.31	\$300.31				
25695	OPEN TREATMENT OF LUNATE DISLOCATION		\$450.24	\$450.24				
	ARTHRODESIS, WRIST; COMPLETE, WITHOUT BONE GRAFT							
25800	(INCLUDES RADIOCARPAL		\$607.42	\$607.42				
25805	ARTHRODESIS, WRIST; WITH SLIDING GRAFT		\$705.61	\$705.61				
	ARTHRODESIS, WRIST; WITH ILIAC OR OTHER AUTOGRAFT							
25810	(INCLUDES OBTAINING		\$673.41	\$673.41				
	ARTHRODESIS, WRIST; LIMITED, WITHOUT BONE GRAFT (EG,							
25820	INTERCARPAL OR		\$484.46	\$484.46				
	ARTHRODESIS, WRIST; WITH AUTOGRAFT (INCLUDES OBTAINING							
25825	GRAFT)		\$596.29	\$596.29				
	ARTHRODESIS, DISTAL RADIOULNAR JOINT WITH SEGMENTAL							
25830	RESECTION OF ULNA,		\$544.67	\$544.67				
25900	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA;		\$460.88	\$460.88				
	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA; OPEN,							
25905	CIRCULAR (GUILLOTI		\$465.13	\$465.13				
	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA; SECONDARY							
25907	CLOSURE OR SCA		\$391.58	\$391.58				
	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA; RE-							
25909	AMPUTATION		\$420.22	\$420.22				
25915	KRUKENBERG PROCEDURE		\$974.92	\$974.92				
25920	DISARTICULATION THROUGH WRIST;		\$454.30	\$454.30				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thai y onai	ge for the service	'				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Code	Procedure Description DISARTICULATION THROUGH WRIST; SECONDARY CLOSURE OR	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
25922	SCAR REVISION		\$377.88	\$377.88				
25922	DISARTICULATION THROUGH WRIST; RE-AMPUTATION		\$461.74	\$461.74				
25924 25927	TRANSMETACARPAL AMPUTATION;		\$461.74	\$461.74				
25927	TRANSMETACARPAL AMPUTATION, TRANSMETACARPAL AMPUTATION; SECONDARY CLOSURE OR SCAR		\$441.03	\$441.03				
25020	REVISION		\$359.68	\$359.68				
25929 25931	TRANSMETACARPAL AMPUTATION; RE-AMPUTATION		\$359.88	\$359.68				
25931	UNLISTED PROCEDURE, FOREARM OR WRIST	R	\$0.00	\$0.00				
26010	DRAINAGE OF FINGER ABSCESS; SIMPLE	I.	\$51.37	\$57.81			_	
26010	DRAINAGE OF FINGER ABSCESS; SIMPLE DRAINAGE OF FINGER ABSCESS; COMPLICATED (EG, FELON)		\$109.93	\$109.93			_	
26020	DRAINAGE OF TENDON SHEATH, DIGIT AND/OR PALM, EACH		\$232.75	\$232.75				
26025	DRAINAGE OF PALMAR BURSA; SINGLE, BURSA		\$266.20	\$266.20				
26030	DRAINAGE OF PALMAR BURSA; MULTIPLE BURSA		\$334.78	\$334.78			_	
20030	INCISION, BONE CORTEX, HAND OR FINGER (EG, OSTEOMYELITIS OR		φ334.70	φ334.76				
26034	BONE ABSCE		\$294.74	\$294.74				
20054	DECOMPRESSION FINGERS AND/OR HAND, INJECTION INJURY (EG,		Ψ234.74	Ψ294.74				
26035	GREASE GUN)		\$405.47	\$405.47				
26037	DECOMPRESSIVE FASCIOTOMY, HAND (EXCLUDES 26035)		\$392.38	\$392.38				
20007	FASCIOTOMY, PALMAR (EG, DUPUYTREN'S CONTRACTURE);		ψ002.00	Ψ002.00			-	
26040	PERCUTANEOUS		\$179.29	\$179.29				
20040	FASCIOTOMY, PALMAR (EG, DUPUYTREN'S CONTRACTURE); OPEN,		ψ17 0.20	ψ17 0.20			-	
26045	PARTIAL		\$303.87	\$303.87				
26055	TENDON SHEATH INCISION (EG, FOR TRIGGER FINGER)		\$176.70	\$176.70			+	
26060	TENOTOMY, PERCUTANEOUS, SINGLE, EACH DIGIT		\$113.96	\$173.96				
20000	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF		ψ110.00	ψ110.00				
26070	LOOSE OR FOREIGN		\$145.23	\$182.24				
20010	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF		ψ1-τ0.20	ψ102.27			+	+
26075	LOOSE OR FOREIGN		\$217.39	\$217.39				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thai y Chai		-				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne ne					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF	FAIIIU	(i acility)	(Norm actinity)	Comp.	Comp.	Value	140165
26080	LOOSE OR FOREIGN		\$207.53	\$207.53				
26100	ARTHROTOMY WITH BIOPSY; CARPOMETACARPAL JOINT, EACH		\$195.01	\$195.01				
20100	AKTHKOTOWIT WITH BIOLOT, OAKLOWETAOAKI AL JOHNT, LACIT		ψ193.01	ψ190.01				
26105	ARTHROTOMY WITH BIOPSY; METACARPOPHALANGEAL JOINT, EACH		\$233.18	\$233.18				
26110	ARTHROTOMY WITH BIOPSY; INTERPHALANGEAL JOINT, EACH		\$190.51	\$190.51			+	
26111	1.5 CM OR GREATER		\$297.01	\$297.01				
26113	1.5 CM OR GREATER		\$390.87	\$390.87				
20110	EXCISION, TUMOR OR VASCULAR MALFORMATION, SOFT TISSUE OF		φοσοιον	φοσσ.στ				
26115	HAND OR FINGE		\$170.16	\$170.16				
20110	EXCISION, TUMOR OR VASCULAR MALFORMATION, SOFT TISSUE OF		ψ17 0.10	ψ17 0.10				
26116	HAND OR FINGE		\$266.87	\$266.87				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT		+	+				
26117	TISSUE OF HA		\$399.89	\$399.89				
26118	3 CM OR GREATER		\$767.50	\$767.50				
	FASCIECTOMY, PALM ONLY, WITH OR WITHOUT Z-PLASTY, OTHER		4.6.166	4.000				
26121	LOCAL TISSUE		\$506.63	\$506.63				
	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
26123	INCLUDING PRO		\$534.78	\$534.78				
	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
26125	INCLUDING PRO		\$216.48	\$216.48				
26130	SYNOVECTOMY, CARPOMETACARPAL JOINT		\$305.81	\$305.81				
	SYNOVECTOMY, METACARPOPHALANGEAL JOINT INCLUDING						1	
26135	INTRINSIC RELEASE AND		\$346.00	\$346.00				
			1				1	
26140			\$308.78	\$308.78				
26135 26140	SYNOVECTOMY, PROXIMAL INTERPHALANGEAL JOINT, INCLUDING EXTENSOR		\$346.00 \$308.78	\$346.00 \$308.78				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249					+		
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar T	ns T					
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Code	Procedure Description SYNOVECTOMY, TENDON SHEATH, RADICAL (TENOSYNOVECTOMY),	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00445			#200 74	#200 74				
26145	FLEXOR TENDON,	 	\$322.71	\$322.71				
00400	EXCISION OF LESION OF TENDON SHEATH OR JOINT CAPSULE (EG,		#450.00	0450.00				
26160	CYST, MUCOUS	-	\$159.98	\$159.98				
00470	EXCISION OF TENDON, PALM, FLEXOR, SINGLE (SEPARATE		0000 44	0000 44				
26170	PROCEDURE), EACH		\$222.41	\$222.41				
00400	EXCISION OF TENDON, FINGER, FLEXOR (SEPARATE PROCEDURE),		0074.50	0074 50				
26180	EACH TENDON		\$271.53	\$271.53				
00405	OFOAMOIDEOTOMY THUMB OR EINOFD (OFDADATE DROOFDUDE)		#000 00	# 000 00				
26185	SESAMOIDECTOMY, THUMB OR FINGER (SEPARATE PROCEDURE)	-	\$263.33	\$263.33				
00000	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		0004.74	0004.74				
26200	METACARPAL;		\$291.71	\$291.71				
00005	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		0.400.44	0.400.44				
26205	METACARPAL; WITH		\$409.14	\$409.14				
00040	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		4005.00	4005.00				
26210	PROXIMAL, MIDDLE		\$265.99	\$265.99				
00045	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		0074.50	0074 50				
26215	PROXIMAL, MIDDLE		\$371.53	\$371.53				
00000	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR		4005.00	4005.00				
26230	DIAPHYSECTOMY) BONE		\$305.92	\$305.92				
00005	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR		0000.00	#000 00				
26235	DIAPHYSECTOMY) BONE		\$299.88	\$299.88				
00000	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR		0004.60	0004.00				
26236	DIAPHYSECTOMY) BONE	<u> </u>	\$264.82	\$264.82				
26250	RADICAL RESECTION, METACARPAL (EG, TUMOR);	<u> </u>	\$399.97	\$399.97				
	RADICAL RESECTION, PROXIMAL OR MIDDLE PHALANX OF FINGER							
26260	(EG, TUMOR);	1	\$375.04	\$375.04				

Physician	Fee Schedule 2020							
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	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	2						
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		T '						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
26262	RADICAL RESECTION, DISTAL PHALANX OF FINGER (EG, TUMOR)		\$304.62	\$304.62				
26320	REMOVAL OF IMPLANT FROM FINGER OR HAND		\$218.54	\$218.54				
26340	MANIPULATION, FINGER JOINT, UNDER ANESTHESIA, EACH JOINT		\$196.88	\$196.88				
	MANIPULATION, PALMAR FASCIAL CORD (IE, DUPUYTREN'S CORD)							
26341	POST ENZYME INJECTION (EG, COLLAGENASE), SINGE CORD		\$58.80	\$77.15				
	REPAIR OR ADVANCEMENT, FLEXOR TENDON, NOT IN ZONE 2							
26350	DIGITAL FLEXOR TEN		\$347.03	\$347.03				
	REPAIR OR ADVANCEMENT, FLEXOR TENDON, NOT IN ZONE 2							
26352	DIGITAL FLEXOR TEN		\$416.79	\$416.79				
	REPAIR OR ADVANCEMENT, FLEXOR TENDON, IN ZONE 2 DIGITAL							
26356	FLEXOR TENDON		\$430.39	\$430.39				
	REPAIR OR ADVANCEMENT, FLEXOR TENDON, IN ZONE 2 DIGITAL							
26357	FLEXOR TENDON		\$444.85	\$444.85				
	REPAIR OR ADVANCEMENT, FLEXOR TENDON, IN ZONE 2 DIGITAL							
26358	FLEXOR TENDON		\$484.34	\$484.34				
	REPAIR OR ADVANCEMENT OF PROFUNDUS TENDON, WITH INTACT							
26370	SUPERFICIALIS		\$404.33	\$404.33				
	REPAIR OR ADVANCEMENT OF PROFUNDUS TENDON, WITH INTACT							
26372	SUPERFICIALIS		\$442.01	\$442.01				
	REPAIR OR ADVANCEMENT OF PROFUNDUS TENDON, WITH INTACT							
26373	SUPERFICIALIS		\$435.77	\$435.77				
	EXCISION FLEXOR TENDON, WITH IMPLANTATION OF SYNTHETIC		400.55					
26390	ROD FOR DELAYED		\$499.29	\$499.29				
	REMOVAL OF SYNTHETIC ROD AND INSERTION OF FLEXOR TENDON			1.5.40.04				
26392	GRAFT, HAND OR		\$548.24	\$548.24				

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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	tomary char	ge for the service) 				
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	Tor priysiciai	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Brace dura Decembrica	PA Ind					Value	Notes
Code	Procedure Description REPAIR, EXTENSOR TENDON, HAND, PRIMARY OR SECONDARY;	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
26410	WITHOUT FREE GRAF		\$228.87	\$228.87				
20410	REPAIR, EXTENSOR TENDON, HAND, PRIMARY OR SECONDARY;		φ220.0 <i>1</i>	ֆ∠∠o.o <i>1</i>				
26412	WITH FREE GRAFT		\$358.19	\$358.19				
20412	EXCISION OF EXTENSOR TENDON, WITH IMPLANTATION OF		φ330.19	<u>გავი. 19</u>				
26415	SYNTHETIC ROD FOR DE		\$439.13	\$439.13				
20415	REMOVAL OF SYNTHETIC ROD AND INSERTION OF EXTENSOR		\$439.13	\$ 4 39.13				
26416	TENDON GRAFT (INCLU		\$531.86	\$531.86				
20410	REPAIR, EXTENSOR TENDON, FINGER, PRIMARY OR SECONDARY;		φυσ 1.00	φυσ 1.00				
26418	WITHOUT FREE GR		\$228.32	\$228.32				
20410	REPAIR, EXTENSOR TENDON, FINGER, PRIMARY OR SECONDARY;		φ220.32	ΦΖΖΟ.3Ζ				
26420	WITH FREE GRAFT		\$362.59	\$362.59				
20420	REPAIR OF EXTENSOR TENDON, CENTRAL SLIP, SECONDARY (EG.		φ302.39	φ30Z.59				
26426	BOUTONNIERE		\$367.20	\$367.20				
20420	REPAIR OF EXTENSOR TENDON, CENTRAL SLIP, SECONDARY (EG,		φ307.20	φ301.20				
26428	BOUTONNIERE		\$374.29	\$374.29				
20420	CLOSED TREATMENT OF DISTAL EXTENSOR TENDON INSERTION,	-	φ3/4.29	φ3/4.29			-	
26432	WITH OR WITHOUT		\$168.20	\$210.44				
20432	REPAIR OF EXTENSOR TENDON, DISTAL INSERTION, PRIMARY OR	-	φ100.20	φ210.44			-	
26433	SECONDARY; WIT		\$251.12	\$251.12				
20433	REPAIR OF EXTENSOR TENDON, DISTAL INSERTION, PRIMARY OR	+	φ231.12	φ231.12			+	
26434	SECONDARY; WIT		\$323.37	\$323.37				
26437	REALIGNMENT OF EXTENSOR TENDON, HAND, EACH TENDON		\$287.42	\$287.42				+
26440	TENOLYSIS, FLEXOR TENDON; PALM OR FINGER, EACH TENDON		\$249.77	\$249.77				+
20440	TENOLIGIO, TELACIT TENDON, FALIN CITTINGEN, LACIT TENDON		Ψ243.11	Ψ243.11				
26442	TENOLYSIS, FLEXOR TENDON; PALM AND FINGER, EACH TENDON		\$283.72	\$283.72				

Physician Fee Schedule 2020 Note: 2020 Codes in Red; Refer to CPT book for descriptions R° in PA column indicates Prior Auth is required Codes listed as '500' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 8000-99249 range. Codes listed for covered codes not listed below in the 8000-99249 range. Codes listed for the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PA Ind (Facility) Comp. Comp. Comp. Comp. Comp. Comp. Comp. Comp. Com	Dhyaisian	Fac Cahadula 2020		1	1		1	1	
2020 Codes in Red; Refer to CPT book for descriptions R° in PA column indicates Prior Auth is required Godes listed as \$50.00" pay 45% of billed amount not to exceed provider's usual and oustomary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use table for covered codes not listed below in the \$8000-99249 range. Codes listed as the schedule final begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PA Ind Code Procedure Description Procedure Description Page Ind Code Page	_	ree Schedule 2020							
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Procedure Description							+	Door	
Code Procedure Description PA Ind (Facility) (NonFacility) Comp. Comp. Value Notes 26445 TENOLYSIS, EXTENSOR TENDON, HAND OR FINGER, EACH TENDON \$222.36 \$222.37 \$222.37 <	_			In a Data	0.44. 0.4.	-	Durk		
TENOLYSIS, EXTENSOR TENDON, HAND OR FINGER, EACH TENDON \$222.36 \$222.3				•	•				
TENOLYSIS, COMPLEX, EXTENSOR TENDON, FINGER, INCLUDING FOREARM, EACH T S360.23 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.21 \$360.22 \$360.21 \$360.22 \$360.21 \$360.22	Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
TENDLYSIS, COMPLEX, EXTENSOR TENDON, FINGER, INCLUDING FOREARM, EACH T \$360.23 \$360.21	26445	TENOLYSIS. EXTENSOR TENDON. HAND OR FINGER. EACH TENDON		\$222.36	\$222.36				
\$360.23 \$360.25 \$360				*	V				
26450 TENOTOMY, FLEXOR, PALM, OPEN, EACH TENDON \$173.78 \$173.78 26455 TENOTOMY, FLEXOR, FINGER, OPEN, EACH TENDON \$161.71 \$161.71 26460 TENOTOMY, EXTENSOR, HAND OR FINGER, OPEN, EACH TENDON \$151.14 \$151.14 26471 TENODESIS; OF PROXIMAL INTERPHALANGEAL JOINT, EACH JOINT \$290.45 \$290.45 26474 TENODESIS; OF DISTAL JOINT, EACH JOINT \$292.70 \$292.70 LENGTHENING OF TENDON, EXTENSOR, HAND OR FINGER, EACH \$230.79 \$230.79 SHORTENING OF TENDON, EXTENSOR, HAND OR FINGER, EACH \$270.60 \$270.60 LENGTHENING OF TENDON, FLEXOR, HAND OR FINGER, EACH \$297.74 \$297.74 26479 TENDON \$325.94 \$325.94 36480 OR DORSUM OF HA \$392.56 \$392.56 26483 OR DORSUM OF HA \$492.94 \$492.94 TRANSFER OR TRANSPLANT OF TENDON, CARPOMETACARPAL AREA \$492.94 \$492.94 26485 TENDON GRAFT, E \$414.21 \$414.21 TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITHOUT FREE \$414.21 \$414.21	26449			\$360.23	\$360.23				
26455 TENOTOMY, FLEXOR, FINGER, OPEN, EACH TENDON \$161.71 \$161.71 26460 TENOTOMY, EXTENSOR, HAND OR FINGER, OPEN, EACH TENDON \$151.14 \$151.14 26471 TENODESIS; OF PROXIMAL INTERPHALANGEAL JOINT, EACH JOINT \$290.45 \$290.45 26474 TENDOBESIS; OF DISTAL JOINT, EACH JOINT \$292.70 \$292.70 LENGTHENING OF TENDON, EXTENSOR, HAND OR FINGER, EACH \$230.79 \$230.79 SHORTENING OF TENDON, EXTENSOR, HAND OR FINGER, EACH \$270.60 \$270.60 26476 TENDON \$297.74 \$297.74 26478 TENDON \$297.74 \$297.74 SHORTENING OF TENDON, FLEXOR, HAND OR FINGER, EACH \$297.74 \$297.74 26479 TENDON \$325.94 \$325.94 SHORTENING OF TENDON, FLEXOR, HAND OR FINGER, EACH \$325.94 \$325.94 26479 TENDON \$325.94 \$325.94 TRANSFER OR TRANSPLANT OF TENDON, CARPOMETACARPAL AREA \$392.56 \$392.56 OR DORSUM OF HA \$492.94 \$492.94 TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITHOUT FREE \$414.21 \$414.21							+		
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26471 TENODESIS; OF PROXIMAL INTERPHALANGEAL JOINT, EACH JOINT \$290.45 \$290.45 \$292.70	20.00			ψ101 ·	4.01.7 1		†		
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26474 TENODESIS; OF DISTAL JOINT, EACH JOINT \$292.70 \$292.70	26471	TENODESIS; OF PROXIMAL INTERPHALANGEAL JOINT, EACH JOINT		\$290.45	\$290.45				
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26485 TENDON GRAFT, E \$414.21 \$414.21 \$ TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITH FREE						†	1		
TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITH FREE	26485			\$414.21	\$414.21				
				1					
126489 LENDON GRAFT (INCL 1 1 1 1 1 1 1 1 1	26489	TENDON GRAFT (INCL		\$367.68	\$367.68				

Physiciar	n Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPPONENSPLASTY; SUPERFICIALIS TENDON TRANSFER TYPE, EACH							
26490	TENDON		\$474.77	\$474.77				
	OPPONENSPLASTY; TENDON TRANSFER WITH GRAFT (INCLUDES							
26492	OBTAINING GRAFT),		\$533.17	\$533.17				
26494	OPPONENSPLASTY; HYPOTHENAR MUSCLE TRANSFER		\$461.37	\$461.37				
26496	OPPONENSPLASTY; OTHER METHODS		\$540.41	\$540.41				
00407	TRANSFER OF TENDON TO RESTORE INTRINSIC FUNCTION; RING		0547.44	0547.44				
26497	AND SMALL FINGE		\$517.14	\$517.14				
00400	TRANSFER OF TENDON TO RESTORE INTRINSIC FUNCTION; ALL		0700.44	0700.44				
26498	FOUR FINGERS		\$763.14	\$763.14				
26499	CORRECTION CLAW FINGER, OTHER METHODS RECONSTRUCTION OF TENDON PULLEY, EACH TENDON; WITH		\$489.42	\$489.42				
20500	LOCAL TISSUES (SEPA		\$274.57	\$274.57				
26500	RECONSTRUCTION OF TENDON PULLEY, EACH TENDON; WITH		\$214.51	\$214.31				
26502	TENDON OR FASCIAL G		\$362.21	\$362.21				
26508	RELEASE OF THENAR MUSCLE(S) (EG, THUMB CONTRACTURE)		\$293.42	\$293.42				
26510	CROSS INTRINSIC TRANSFER, EACH TENDON		\$275.43	\$275.43				+
26516	CAPSULODESIS, METACARPOPHALANGEAL JOINT; SINGLE DIGIT		\$325.93	\$325.93				
26517	CAPSULODESIS, METACARPOPHALANGEAL JOINT; TWO DIGITS		\$464.24	\$464.24				
20017	CAPSULODESIS, METACARPOPHALANGEAL JOINT; THREE OR FOUR		ψ+0+.2+	ψτοτ.Ζτ				
26518	DIGITS		\$454.56	\$454.56				
	CAPSULECTOMY OR CAPSULOTOMY; METACARPOPHALANGEAL		7.000	¥ .550				+
26520	JOINT, EACH JOINT		\$284.43	\$284.43				
	CAPSULECTOMY OR CAPSULOTOMY; INTERPHALANGEAL JOINT,		7-00	7-50				
26525	EACH JOINT		\$260.59	\$260.59				
26530	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; EACH JOINT	1	\$346.27	\$346.27	1			

Physician	Fee Schedule 2020							
Note:								
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Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered t	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; WITH							
26531	PROSTHETIC IMPLANT, EACH		\$427.47	\$427.47				
26535	ARTHROPLASTY, INTERPHALANGEAL JOINT; EACH JOINT		\$289.16	\$289.16				
	ARTHROPLASTY, INTERPHALANGEAL JOINT; WITH PROSTHETIC							
26536	IMPLANT, EACH JOI		\$400.12	\$400.12				
	REPAIR OF COLLATERAL LIGAMENT, METACARPOPHALANGEAL OR							
26540	INTERPHALANGEAL		\$382.25	\$382.25				
	RECONSTRUCTION, COLLATERAL LIGAMENT,							
26541	METACARPOPHALANGEAL JOINT, SINGLE		\$516.12	\$516.12				
	RECONSTRUCTION, COLLATERAL LIGAMENT,							
26542	METACARPOPHALANGEAL JOINT, SINGLE		\$362.86	\$362.86				
	RECONSTRUCTION, COLLATERAL LIGAMENT, INTERPHALANGEAL							
26545	JOINT, SINGLE,		\$354.93	\$354.93				
	REPAIR NON-UNION, METACARPAL OR PHALANX, (INCLUDES							
26546	OBTAINING BONE GRAF		\$486.30	\$486.30				
	REPAIR AND RECONSTRUCTION, FINGER, VOLAR PLATE,							
26548	INTERPHALANGEAL JOINT		\$402.90	\$402.90				
26550	POLLICIZATION OF A DIGIT		\$1,219.54	\$1,219.54				
	TRANSFER, TOE-TO-HAND WITH MICROVASCULAR ANASTOMOSIS;							
26551	GREAT TOE WRAP-A		\$2,534.05	\$2,534.05				
	TRANSFER, TOE-TO-HAND WITH MICROVASCULAR ANASTOMOSIS;							
26553	OTHER THAN GREAT		\$2,516.42	\$2,516.42				
	TRANSFER, TOE-TO-HAND WITH MICROVASCULAR ANASTOMOSIS;							
26554	OTHER THAN GREAT		\$3,002.47	\$3,002.47				
	TRANSFER, FINGER TO ANOTHER POSITION WITHOUT							
26555	MICROVASCULAR ANASTOMOSIS		\$948.75	\$948.75				

Dhygigian	r Fee Schedule 2020		1	1	I			
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
26556	TRANSFER, FREE TOE JOINT, WITH MICROVASCULAR ANASTOMOSIS		\$2,559.25	\$2,559.25				
	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH							
26560	SKIN FLAPS		\$294.23	\$294.23				
	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH							
26561	SKIN FLAPS AND		\$584.46	\$584.46				
	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE;							
26562	COMPLEX (EG, INVOLVI		\$585.00	\$585.00				
26565	OSTEOTOMY; METACARPAL, EACH		\$366.02	\$366.02				
26567	OSTEOTOMY; PHALANX OF FINGER, EACH		\$322.69	\$322.69				
26568	OSTEOPLASTY, LENGTHENING, METACARPAL OR PHALANX		\$506.52	\$506.52				
26580	REPAIR CLEFT HAND		\$1,039.76	\$1,039.76				
	RECONSTRUCTION OF POLYDACTYLOUS DIGIT, SOFT TISSUE AND							
26587	BONE		\$425.75	\$425.75				
26590	REPAIR MACRODACTYLIA, EACH DIGIT		\$1,023.89	\$1,023.89				
26591	REPAIR, INTRINSIC MUSCLES OF HAND, EACH MUSCLE		\$156.00	\$156.00				
26593	RELEASE, INTRINSIC MUSCLES HAND, EACH MUSCLE		\$271.01	\$271.01				
	EXCISION OF CONSTRICTING RING OF FINGER, WITH MULTIPLE Z-							
26596	PLASTIES		\$507.34	\$507.34			1	
	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE;		7	7001101				
26600	WITHOUT MANIPULATION,		\$79.11	\$99.76				
	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITH		4.0	4000				
26605	MANIPULATION, EA		\$117.81	\$148.52			1	
	CLOSED TREATMENT OF METACARPAL FRACTURE, WITH		Ψ. 17.01	ψ.10.0 <u>L</u>				+
26607	MANIPULATION, WITH EXTER		\$259.31	\$259.31				
20001	PERCUTANEOUS SKELETAL FIXATION OF METACARPAL FRACTURE,	1	Ψ200.01	Ψ200.01			+	+
26608	EACH BONE		\$259.31	\$259.31				
20000	ILAOU DOME	<u> </u>	Ψ200.01	ΨΖΟΘ.Ο Ι				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00045	OPEN TREATMENT OF METACARPAL FRACTURE, SINGLE, WITH OR		****	****				
26615	WITHOUT INTERNA		\$302.06	\$302.06				
00044	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION,		440.00	44000				
26641	THUMB, WITH MANIPULAT		\$142.92	\$142.92				
00045	CLOSED TREATMENT OF CARPOMETACARPAL FRACTURE		0404.45	¢404.45				
26645	DISLOCATION, THUMB (BENNE PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL		\$191.15	\$191.15	1			
26650	FRACTURE DISLOCATION		\$284.20	\$284.20				
20030	OPEN TREATMENT OF CARPOMETACARPAL FRACTURE		φ204.2U	φ204.2U				
26665	DISLOCATION, THUMB (BENNETT		\$407.39	\$407.39				
20003	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER		Ψ407.39	φ407.39				
26670	THAN THUMB, WIT		\$132.06	\$132.06				
20070	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER		Ψ102.00	ψ102.00				
26675	THAN THUMB, WIT		\$261.27	\$261.27				
200.0	PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL		Ψ201.21	Ψ201.27				
26676	DISLOCATION, OTHER T		\$301.86	\$301.86				
	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER			,				
26685	THAN THUMB; WITH		\$368.51	\$368.51				
	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER		-					
26686	THAN THUMB; COMPL		\$414.01	\$414.01				
	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION,							
26700	SINGLE, WITH		\$129.91	\$129.91				
	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION,							
26705	SINGLE, WITH		\$171.38	\$171.38				
	PERCUTANEOUS SKELETAL FIXATION OF METACARPOPHALANGEAL							
26706	DISLOCATION, SIN		\$288.12	\$288.12				

Physician	n Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l lary orian		·				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF METACARPOPHALANGEAL DISLOCATION,							
26715	SINGLE, WITH OR WIT		\$287.61	\$287.61				
	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE,							
26720	PROXIMAL OR MIDDLE PHAL		\$64.17	\$78.92				
	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE,							
26725	PROXIMAL OR MIDDLE PHAL		\$119.55	\$140.21				
	PERCUTANEOUS SKELETAL FIXATION OF UNSTABLE PHALANGEAL							
26727	SHAFT FRACTURE,		\$219.32	\$219.32				
	OPEN TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL							
26735	OR MIDDLE PHALAN		\$282.71	\$282.71				
	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING							
26740	METACARPOPHALANGEAL		\$72.56	\$88.11				
00740	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING		4400 45	4.00.45				
26742	METACARPOPHALANGEAL		\$169.45	\$169.45				
00740	OPEN TREATMENT OF ARTICULAR FRACTURE, INVOLVING		#200 70	#200 70				
26746	METACARPOPHALANGEAL OR CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER		\$309.70	\$309.70				
26750	OR THUMB; WITHO		¢71.64	¢74.64				
26750	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER		\$71.64	\$71.64				
26755	OR THUMB; WITH		\$119.76	\$119.76				
20733	PERCUTANEOUS SKELETAL FIXATION OF DISTAL PHALANGEAL		φ119.70	φ119.70				
26756	FRACTURE, FINGER O		\$181.93	\$181.93				
20100	OPEN TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR		ψ101.00	Ψ101.30				
26765	THUMB, WITH OR		\$200.83	\$200.83				
20700	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION,		Ψ200.00	Ψ200.00				
26770	SINGLE, WITH		\$107.13	\$107.13				
_0,,0	0022,		Ψ107.10	Ψ101.10				

Physician	n Fee Schedule 2020							1
Note:								
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u> </u>				1
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION,							
26775	SINGLE, WITH		\$137.44	\$137.44				
	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT							
26776	DISLOCATION,		\$199.27	\$199.27				
	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION,							
26785	WITH OR WITHOUT		\$211.05	\$211.05				
	FUSION IN OPPOSITION, THUMB, WITH AUTOGENOUS GRAFT			400.00				
26820	(INCLUDES OBTAINING		\$433.93	\$433.93				
00044	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR		# 000 00	#000 00				
26841	WITHOUT INTERNAL		\$389.03	\$389.03				
00040	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR		# 400.00	# 400 00				
26842	WITHOUT INTERNAL ARTHRODESIS, CARPOMETACARPAL JOINT, DIGIT, OTHER THAN		\$490.83	\$490.83				
26843	THUMB, EACH:		\$409.15	\$409.15				
20043	ARTHRODESIS, CARPOMETACARPAL JOINT, DIGIT, OTHER THAN		\$4 09.15	\$409.15				
26844	THUMB, EACH; WIT		\$467.85	\$467.85				
20044	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT		Ψ407.03	Ψ407.00				+
26850	INTERNAL FIXAT		\$335.44	\$335.44				
20000	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT		ψ000.44	ψυσυ				+
26852	INTERNAL FIXAT		\$411.59	\$411.59				
20002	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT		Ψ111.00	ψ111.00				
26860	INTERNAL FIXATION;		\$263.61	\$263.61				
	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT			,				1
26861	INTERNAL FIXATION;		\$121.32	\$121.32				
	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT							
26862	INTERNAL FIXATION;		\$366.22	\$366.22				

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	olumn indicates Prior Auth is required				+	+		
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	man, shar	as for the somiler					
The Appet	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	mary char	ge for the service	 				
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r priysiciar I	1S					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Due and true Decembring	DA In al	•	•				Notes
Code	Procedure Description ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00000			фо40 co	#040.00				
26863	INTERNAL FIXATION;		\$218.68	\$218.68	-			
00040	AMPUTATION, METACARPAL, WITH FINGER OR THUMB (RAY		0074 00	0074 00				
26910	AMPUTATION, SINGLE,		\$371.69	\$371.69	-			
00054	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY		#040 OO	#040.00				
26951	JOINT OR PHALAN		\$218.29	\$218.29				
00050	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY		4000 70	4000 70				
26952	JOINT OR PHALAN	_	\$300.70	\$300.70				
26989	UNLISTED PROCEDURE, HANDS OR FINGERS	R	\$750.00	\$975.00				
	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; DEEP			****				
26990	ABSCESS OR HEMAT		\$293.90	\$293.90				
	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; INFECTED							
26991	BURSA		\$233.12	\$233.12				
	INCISION, BONE CORTEX, PELVIS AND/OR HIP JOINT (EG,							
26992	OSTEOMYELITIS OR B		\$606.57	\$606.57				
	TENOTOMY, ADDUCTOR OF HIP, PERCUTANEOUS (SEPARATE							
27000	PROCEDURE)		\$210.09	\$210.09				
27001	TENOTOMY, ADDUCTOR OF HIP, OPEN		\$297.94	\$297.94				
	TENOTOMY, ADDUCTOR, SUBCUTANEOUS, OPEN, WITH OBTURATOR							
27003	NEURECTOMY		\$399.44	\$399.44				
27005	TENOTOMY, HIP FLEXOR(S), OPEN (SEPARATE PROCEDURE)		\$367.60	\$367.60				
	TENOTOMY, ABDUCTORS AND/OR EXTENSOR(S) OF HIP, OPEN							
27006	(SEPARATE PROCEDUR		\$421.93	\$421.93				
27025	FASCIOTOMY, HIP OR THIGH, ANY TYPE		\$487.07	\$487.07				
27027	DECOMPRESSION FASCIOTOMY (IES),PELVIC(BUTTOCK)		\$663.42	\$663.42				
27030	ARTHROTOMY, HIP, WITH DRAINAGE (EG, INFECTION)		\$706.27	\$706.27				

Physician	Fee Schedule 2020			1				
Note:	The education of the control of the							
	l des in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	go for the convice	,			+	
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T Char	T The service	,			+	
	se lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered t		ne .					
Codes lis	ted on the lab lee schedule that begin with a 1- or Q are currently horr-covered i	T priysicia	15					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	ARTHROTOMY, HIP, INCLUDING EXPLORATION OR REMOVAL OF	I A IIIu	(i dointy)	(Norm acmity)	Jonip.	Joinp.	Value	140103
27033	LOOSE OR FOREIGN		\$717.21	\$717.21				
	DENERVATION, HIP JOINT, INTRAPELVIC OR EXTRAPELVIC INTRA-		+	 				
27035	ARTICULAR BRA		\$833.09	\$833.09				
	CAPSULECTOMY OR CAPSULOTOMY, HIP, WITH OR WITHOUT		+000.00	+				
27036	EXCISION OF HETEROTO		\$686.12	\$686.12				
27040	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; SUPERFICIAL		\$117.64	\$117.64				
	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; DEEP, SUBFASCIAL			-				
27041	OR		\$356.96	\$356.96				
27043	3 CM OR GREATER		\$339.82	\$339.82				
27045	5 CM OR GREATER		\$540.47	\$540.47				
27047	EXCISION, TUMOR, PELVIS AND HIP AREA; SUBCUTANEOUS TISSUE		\$268.57	\$268.57				
	EXCISION, TUMOR, PELVIS AND HIP AREA; DEEP, SUBFASCIAL,							
27048	INTRAMUSCULAR		\$303.32	\$303.32				
	RADICAL RESECTION OF TUMOR, SOFT TISSUE OF PELVIS AND HIP							
27049	AREA (EG,		\$684.79	\$684.79				
27050	ARTHROTOMY, WITH BIOPSY; SACROILIAC JOINT		\$259.53	\$259.53				
27052	ARTHROTOMY, WITH BIOPSY; HIP JOINT		\$385.51	\$385.51				
27054	ARTHROTOMY WITH SYNOVECTOMY, HIP JOINT		\$538.64	\$538.64				
27057	DECOMPRESSION FASCIOTOMY(IES), PELVIC(BUTTOCK)		\$730.18	\$730.18				
27059	5 CM OR GREATER		\$1,330.50	\$1,330.50				
27060	EXCISION; ISCHIAL BURSA		\$260.73	\$260.73				
27062	EXCISION; TROCHANTERIC BURSA OR CALCIFICATION		\$269.55	\$269.55				
27065	EXCISION OF BONE CYST OR BENIGN TUMOR; SUPERFICIAL (WING OF ILIUM,		\$317.93	\$317.93				

Physician	Fee Schedule 2020							
Note:								
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
					<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07000	EXCISION OF BONE CYST OR BENIGN TUMOR; DEEP, WITH OR		0540.50	0540.50				
27066	WITHOUT AUTOGRAFT		\$512.56	\$512.56				
07067	EXCISION OF BONE CYST OR BENIGN TUMOR; WITH AUTOGRAFT		Ф 7 00 7 4	Ф 7 00 7 4				
27067	REQUIRING SEPARA PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION) (EG,		\$729.74	\$729.74				
27070	OSTEOMYELITIS OR		\$509.26	\$509.26				
27070	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION) (EG,		φ309.20	φ309.20				+
27071	OSTEOMYELITIS OR		\$563.40	\$563.40				
27071	RADICAL RESECTION OF TUMOR OR INFECTION; WING OF ILIUM,		ψ303.40	ψ505.40				
27075	ONE PUBIC OR		\$884.64	\$884.64				
27070	RADICAL RESECTION OF TUMOR OR INFECTION; ILIUM, INCLUDING		φοσ 1.0 1	φοσ 1.σ 1				+
27076	ACETABULUM,		\$1,028.62	\$1,028.62				
	RADICAL RESECTION OF TUMOR OR INFECTION; INNOMINATE BONE,		7 1,5 = 5 15 =	7 1,5 = 5 15 =				†
27077	TOTAL		\$1,212.53	\$1,212.53				
	RADICAL RESECTION OF TUMOR OR INFECTION; ISCHIAL		,					
27078	TUBEROSITY AND GREATE		\$635.36	\$635.36				
27080	COCCYGECTOMY, PRIMARY		\$314.55	\$314.55				
	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; SUBCUTANEOUS							
27086	TISSUE		\$62.88	\$70.66				
	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; DEEP (SUBFASCIAL OR							
27087	INTRAMUSCU		\$346.72	\$346.72				
27090	REMOVAL HIP PROSTHESIS;(SEPARATE PROCEDURE)		\$631.41	\$631.41				
l	REMOVAL OF HIP PROSTHESIS; COMPLICATED, INCLUDING TOTAL							
27091	HIP PROSTHESIS		\$1,209.08	\$1,209.08				
07000	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITHOUT		***	000.04				
27093	ANESTHESIA		\$62.81	\$62.81				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	des in Red;						i	
Refer to (CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomary chai	rge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITH							
27095	ANESTHESIA		\$72.12	\$72.12				
	INJECTION PROCEDURE FOR SACROILIAC JOINT, ARTHROGRAPHY							
27096	AND/ OR		\$292.09	\$292.09				
27097	RELEASE OR RECESSION, HAMSTRING, PROXIMAL		\$474.51	\$474.51				
27098	TRANSFER, ADDUCTOR TO ISCHIUM		\$474.51	\$474.51				
	TRANSFER EXTERNAL OBLIQUE MUSCLE TO GREATER							
27100	TROCHANTER INCLUDING FASCI		\$550.66	\$550.66				
07405	TRANSFER PARASPINAL MUSCLE TO HIP (INCLUDES FASCIAL OR							
27105	TENDON EXTENSIO		\$521.44	\$521.44				
27110	TRANSFER ILIOPSOAS; TO GREATER TROCHANTER OF FEMUR		\$696.28	\$696.28				
27111	TRANSFER ILIOPSOAS; TO FEMORAL NECK		\$687.72	\$687.72				
07400	ACETABULOPLASTY; (EG, WHITMAN, COLONNA, HAYGROVES, OR		#4 000 07	04 000 07				
27120	CUP TYPE)		\$1,039.27	\$1,039.27				
07400	ACETABULOPLASTY; RESECTION, FEMORAL HEAD (EG,		¢004.07	¢004.07				
27122	GIRDLESTONE PROCEDURE) HEMIARTHROPLASTY, HIP, PARTIAL (EG, FEMORAL STEM		\$934.97	\$934.97				
27125	PROSTHESIS, BIPOLAR		\$914.33	\$914.33				
27 125	ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL		Φ914.33	ֆ৪14.33				
27130	PROSTHETIC REPLACEMENT (\$1,300.74	\$1,300.74				
27 130	CONVERSION OF PREVIOUS HIP SURGERY TO TOTAL HIP		φ1,300.74	\$1,300.74				
27132	ARTHROPLASTY, WITH OR		\$1,488.80	\$1,488.80				
21 102	REVISION OF TOTAL HIP ARTHROPLASTY; BOTH COMPONENTS,		ψ1,400.00	ψ1,400.00				
27134	WITH OR WITHOUT		\$1,707.39	\$1,707.39				
21107	REVISION OF TOTAL HIP ARTHROPLASTY; ACETABULAR		ψ1,707.00	ψ1,707.00		+		
27137	COMPONENT ONLY, WITH OR		\$1,306.01	\$1,306.01				

Physician	n Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	1				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REVISION OF TOTAL HIP ARTHROPLASTY; FEMORAL COMPONENT							
27138	ONLY, WITH OR WI		\$1,316.66	\$1,316.66				
	OSTEOTOMY AND TRANSFER OF GREATER TROCHANTER OF FEMUR							
27140	(SEPARATE PROCED		\$673.33	\$673.33				
27146	OSTEOTOMY,ILIAC,ACETABULAR OR INNOMINATE BONE;		\$727.22	\$727.22				
l	OSTEOTOMY, ILIAC, ACETABULAR OR INNOMINATE BONE; WITH							
27147	OPEN REDUCTION O		\$1,038.09	\$1,038.09				
07454	OSTEOTOMY, ILIAC, ACETABULAR OR INNOMINATE BONE; WITH		4.000.00	4.000.00				
27151	FEMORAL OSTEOTOM		\$1,090.69	\$1,090.69				
07450	OSTEOTOMY, ILIAC, ACETABULAR OR INNOMINATE BONE; WITH		04.457.70	A 457.70				
27156	FEMORAL OSTEOTOM		\$1,157.78	\$1,157.78				
27158	OSTEOTOMY, PELVIS, BILATERAL (EG, CONGENITAL MALFORMATION)		\$982.04	\$982.04				
27161	OSTEOTOMY, FELVIS, BILATERAL (EG, CONGENTIAL MALFORMATION) OSTEOTOMY, FEMORAL NECK (SEPARATE PROCEDURE)		\$885.97	\$885.97				
27 101	OSTEOTOMY, INTERTROCHANTERIC OR SUBTROCHANTERIC		φοου.91	φοσσ.στ				
27165	INCLUDING INTERNAL OR		\$988.81	\$988.81				
27 103	BONE GRAFT, FEMORAL HEAD, NECK, INTERTROCHANTERIC OR		ψ300.01	ψ900.01				
27170	SUBTROCHANTERIC A		\$941.76	\$941.76				
21110	TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; BY TRACTION,		ψ5+1.70	ΨΟΨΙ.ΤΟ				
27175	WITHOUT REDUCTION		\$248.47	\$248.47				
27 17 0	TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; BY SINGLE OR		Ψ2 10.17	Ψ2 10.17				+
27176	MULTIPLE PINNING,		\$639.54	\$639.54				
	OPEN TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; SINGLE OR		+ 300.0.	+ 300.0.				+
27177	MULTIPLE PINNIN		\$785.90	\$785.90				
	OPEN TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; CLOSED							
27178	MANIPULATION WITH		\$633.96	\$633.96				

Physician	Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
					L .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07470	OPEN TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; OSTEOPLASTY		4000 50	****				
27179	OF FEMORAL NE		\$686.56	\$686.56				
07404	OPEN TREATMENT OF SLIPPED FEMORAL EPIPHYSIS; OSTEOTOMY		4000.07	#				
27181	AND INTERNAL		\$809.87	\$809.87				
07405	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING, GREATER TROCHANTER OF		\$338.99	¢220.00				
27185	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR		\$338.99	\$338.99				
27187	WIRING) WITH OR		\$867.48	\$867.48				
27197	CLSD TX PELVIC RING FX		\$92.27	\$92.27				Added Effective 1/1/2017
27198	CLSD TX PELVIC RING FX		\$237.92	\$237.92				Added Effective 1/1/2017 Added Effective 1/1/2017
27200	CLOSED TREATMENT OF COCCYGEAL FRACTURE		\$95.74	\$95.74				Added Effective 1/1/2017
27202	OPEN TREATMENT OF COCCYGEAL FRACTURE		\$377.90	\$377.90				
21202	OPEN TREATMENT OF ILIAC SPINE(S), TUBEROSITY AVULSION, OR		ΨΟΤΤΙΟΟ	φοννίου				+
27215	ILIAC WING		\$654.55	\$654.55				
	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC RING		+ + + + + + + + + + + + + + + + + + + 	40000				
27216	FRACTURE AND/O		\$548.05	\$548.05				
	OPEN TREATMENT OF ANTERIOR RING FRACTURE AND/OR		70.000	7				
27217	DISLOCATION WITH INTER		\$833.92	\$833.92				
	OPEN TREATMENT OF POSTERIOR RING FRACTURE AND/OR		·					
27218	DISLOCATION WITH INTE		\$999.41	\$999.41				
	CLOSED TREATMENT OF ACETABULUM (HIP SOCKET) FRACTURE(S);							
27220	WITHOUT		\$284.16	\$284.16				
	CLOSED TREATMENT OF ACETABULUM (HIP SOCKET) FRACTURE(S);							
27222	WITH MANIPULA		\$517.20	\$517.20				
	OPEN TREATMENT OF POSTERIOR OR ANTERIOR ACETABULAR							
27226	WALL FRACTURE, WITH		\$893.24	\$893.24				

Physician F	Fee Schedule 2020							
Note:								
2020 Code	es in Red;							
Refer to Cl	PT book for descriptions							
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Codes liste	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	;				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
_							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF ACETABULAR FRACTURE(S) INVOLVING							
27227	ANTERIOR OR POSTERI		\$1,057.74	\$1,057.74				
.=	OPEN TREATMENT OF ACETABULAR FRACTURE(S) INVOLVING							
27228	ANTERIOR AND POSTER		\$1,138.10	\$1,138.10				
07000	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END,		0040.70	#0.40.70				
27230	NECK; WITHOUT		\$243.73	\$243.73				
07000	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END,		ΦE40.00	ΦE 40, 00				
27232	NECK; WITH PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE,		\$549.82	\$549.82				+
27225	, ,		\$764.73	\$764.73				
27235	PROXIMAL END, NECK OPEN TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, NECK,		\$704.73	\$704.73				
27236	INTERNAL FIXAT		\$934.33	\$934.33				
27230	CLOSED TREATMENT OF INTERTROCHANTERIC,		φ934.33	φ934.33				
27238	PERTROCHANTERIC, OR SUBTROCHANT		\$297.43	\$297.43				
27230	CLOSED TREATMENT OF INTERTROCHANTERIC.		Ψ297.43	Ψ291.43				
27240	PERTROCHANTERIC, OR SUBTROCHANT		\$616.02	\$616.02				
27240	TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR		Ψ010.02	ψ010.02				+
27244	SUBTROCHANTERIC FE		\$921.94	\$921.94				
	TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR		Ψ021.01	Ψ021.01				
27245	SUBTROCHANTERIC FE		\$1,050.17	\$1,050.17				
	CLOSED TREATMENT OF GREATER TROCHANTERIC FRACTURE,		ψ 1,000111	ψ 1,000111				
27246	WITHOUT MANIPULATIO		\$246.32	\$246.32				
	OPEN TREATMENT OF GREATER TROCHANTERIC FRACTURE, WITH							
27248	OR WITHOUT INTER		\$670.98	\$670.98				
	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; WITHOUT							
27250	ANESTHESIA		\$281.65	\$281.65				

Physician	Fee Schedule 2020					1	1	
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	les in Red;							
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	red as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	3				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I		5				
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ango						
	red on the lab fee schedule that begin with a P or Q are currently non-covered for		ne .					
Codes lis	T	л риузісіаі І	1 5					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; REQUIRING	FAIIIU	(i acility)	(Norm active)	Comp.	Comp.	Value	Notes
27252	ANESTHESIA		\$410.81	\$410.81				
21232	OPEN TREATMENT OF HIP DISLOCATION, TRAUMATIC, WITHOUT		ψ410.01	ψ+10.01				
27253	INTERNAL FIXATIO		\$755.25	\$755.25				
21200	OPEN TREATMENT OF HIP DISLOCATION, TRAUMATIC, WITH		Ψ1 33.23	ψ133.23				
27254	ACETABULAR WALL AND		\$923.80	\$923.80				
21254	TREATMENT OF SPONTANEOUS HIP DISLOCATION		ψ923.00	ψ923.00				
27256	(DEVELOPMENTAL, INCLUDING		\$167.12	\$167.12				
21200	TREATMENT OF SPONTANEOUS HIP DISLOCATION		Ψ107.12	Ψ107.12				
27257	(DEVELOPMENTAL, INCLUDING		\$283.09	\$283.09				
21201	OPEN TREATMENT OF SPONTANEOUS HIP DISLOCATION		Ψ200.00	Ψ200.00				
27258	(DEVELOPMENTAL, INCLUDIN		\$845.48	\$845.48				
21200	OPEN TREATMENT OF SPONTANEOUS HIP DISLOCATION		ψ0+3.+0	ψ0+0.+0				
27259	(DEVELOPMENTAL, INCLUDIN		\$1,058.92	\$1,058.92				
27200	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION;		ψ1,000.02	ψ1,000.02				
27265	WITHOUT ANESTHE		\$269.66	\$269.66				
27200	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION;		Ψ200.00	Ψ200.00				+
27266	REQUIRING REGIO		\$363.44	\$363.44				
27267	CLTX THIGH FX W/O MNP		\$316.58	\$316.58				+
27268	CLTX THIGH FX W/MNPJ		\$391.05	\$391.05				
27269	OPTX THIGH FX		\$936.68	\$936.68				
27275	MANIPULATION, HIP JOINT, REQUIRING GENERAL ANESTHESIA		\$116.40	\$116.40		1		+
	FUSION SACROILIAC JOINT THROUGH THE SKIN OR MINIMALLY		Ţ.10.10	Ţ 1 10.10				
27279	INVASIVE USING IMAGE GUIDANCE		\$446.94	\$446.94				Added effective 1/1/2015
				,				
27280	ARTHRODESIS, SACROILIAC JOINT (INCLUDING OBTAINING GRAFT)		\$659.38	\$659.38				

Physician	Fee Schedule 2020							1
Note:	T de Goriedale 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	go for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tilaly Clial	T The service	7				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ne .					
Codes list	ed on the lab fee schedule that begin with a 1- of Q are currently non-covered to	i priyaiciai	113					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Jour	1 Toocaare Besonption	I A III	(i domity)	(Itom domey)	Comp.	Comp.	Value	110103
27282	ARTHRODESIS, SYMPHYSIS PUBIS (INCLUDING OBTAINING GRAFT)		\$592.89	\$592.89				
27284	ARTHRODESIS, HIP JOINT (INCLUDING OBTAINING GRAFT);		\$905.58	\$905.58				
_	ARTHRODESIS, HIP JOINT (INCLUDING OBTAINING GRAFT); WITH			, , , , , , ,				
27286	SUBTROCHANTER		\$921.83	\$921.83				
				,				1
27290	INTERPELVIABDOMINAL AMPUTATION (HINDQUARTER AMPUTATION)		\$1,431.65	\$1,431.65				
27295	DISARTICULATION OF HIP		\$1,023.55	\$1,023.55				
27299	UNLISTED PROCEDURE, PELVIS OR HIP JOINT	R	\$800.00	\$1,040.00				
	INCISION AND DRAINAGE, DEEP ABSCESS, BURSA, OR HEMATOMA,							
27301	THIGH OR KNEE		\$250.59	\$250.59				
	INCISION, DEEP, WITH OPENING OF BONE CORTEX, FEMUR OR KNEE							
27303	(EG,		\$406.16	\$406.16				
27305	FASCIOTOMY, ILIOTIBIAL (TENOTOMY), OPEN		\$277.49	\$277.49				
	TENOTOMY, PERCUTANEOUS, ADDUCTOR OR HAMSTRING; SINGLE							
27306	TENDON (SEPARATE		\$186.45	\$186.45				
	TENOTOMY, PERCUTANEOUS, ADDUCTOR OR HAMSTRING;							
27307	MULTIPLE TENDONS		\$247.92	\$247.92				
	ARTHROTOMY, KNEE, WITH EXPLORATION, DRAINAGE, OR REMOVAL							
27310	OF FOREIGN BO		\$536.56	\$536.56				
27323	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; SUPERFICIAL		\$93.71	\$105.91				
	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; DEEP (SUBFASCIAL							
27324	OR		\$214.40	\$214.40				
27325	NEURECTOMY, HAMSTRING MUSCLE		\$360.70	\$360.70				
27326	NEURECTOMY, POPLITEAL		\$339.94	\$339.94				
27327	EXCISION, TUMOR, THIGH OR KNEE AREA; SUBCUTANEOUS		\$197.91	\$197.91				

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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnar	ge for the service			-	+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						+	
	se lab fee schedule for covered codes not listed below in the 80000-89249 i						+	
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai T	ns T					-
							Base	
Droo			Innet Bete	Outpot Boto	Tech.	Prof.	Unit	
Proc	But and draw But and office	DA III I	Inpat. Rate	Outpat. Rate				Nata
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07000	EXCISION, TUMOR, THIGH OR KNEE AREA; DEEP, SUBFASCIAL, OR		#000 7 0	#000 7 0				
27328	INTRAMUSCULA		\$282.72	\$282.72			+	
07000	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT		6740.04	4740.04				
27329	TISSUE OF TH		\$710.04	\$710.04			_	
27330	ARTHROTOMY, KNEE; WITH SYNOVIAL BIOPSY ONLY		\$328.59	\$328.59				
07004	ARTHROTOMY, KNEE; INCLUDING JOINT EXPLORATION, BIOPSY, OR			4000				
27331	REMOVAL OF L		\$386.98	\$386.98				
	ARTHROTOMY, WITH EXCISION OF SEMILUNAR CARTILAGE		0=1101	0=44.04				
27332	(MENISCECTOMY) KNEE;		\$541.94	\$541.94				
	ARTHROTOMY, WITH EXCISION OF SEMILUNAR CARTILAGE							
27333	(MENISCECTOMY) KNEE;		\$502.73	\$502.73				
	ARTHROTOMY, WITH SYNOVECTOMY, KNEE; ANTERIOR OR							
27334	POSTERIOR		\$549.34	\$549.34				
	ARTHROTOMY, WITH SYNOVECTOMY, KNEE; ANTERIOR AND							
27335	POSTERIOR INCLUDING		\$634.91	\$634.91				
27337	3 CM OR GREATER		\$302.46	\$302.46				
27339	5 CM OR GREATER		\$545.82	\$545.82				
27340	EXCISION, PREPATELLAR BURSA		\$233.36	\$233.36				
	EXCISION OF SYNOVIAL CYST OF POPLITEAL SPACE (EG, BAKER'S							
27345	CYST)		\$339.30	\$339.30				
l	EXCISION OF LESION OF MENISCUS OR CAPSULE (EG, CYST,		 					
27347	GANGLION), KNEE		\$247.34	\$247.34				
27350	PATELLECTOMY OR HEMIPATELLECTOMY		\$509.69	\$509.69			1	
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		1					
27355	FEMUR;		\$440.36	\$440.36				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF		1					
27356	FEMUR; WITH ALLO		\$504.85	\$504.85				

Physician	r Fee Schedule 2020							
Note:	The education 2020							
	des in Red;	1					+	
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF							
27357	FEMUR; WITH AUTO		\$553.36	\$553.36				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF							
27358	FEMUR; WITH INTE		\$278.62	\$278.62				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR							
27360	DIAPHYSECTOMY) BONE		\$534.45	\$534.45				
27364	5 CM OR GREATER		\$1,143.19	\$1,143.19				
27365	RADICAL RESECTION TUMOR, BONE, FEMUR OR KNEE		\$839.06	\$839.06				
27369	NJX CNTRST KNE ARTHG/CT/MRI		\$33.13	\$108.58				Effective 1/1/2019
			700110	Ţ 100100				
27372	REMOVAL OF FOREIGN BODY, DEEP, THIGH REGION OR KNEE AREA		\$245.99	\$245.99				
27380	SUTURE OF INFRAPATELLAR TENDON; PRIMARY		\$438.86	\$438.86				
2.000	SUTURE OF INFRAPATELLAR TENDON; SECONDARY		ψ 100.00	ψ 100.00				
27381	RECONSTRUCTION, INCLUDING FA		\$629.97	\$629.97				
27001	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE:		Ψ020.01	Ψ020.01				
27385	PRIMARY		\$482.00	\$482.00				
21303	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE;	1	ψ402.00	ψ+02.00			+	
27386	SECONDARY RECONSTRUC		\$667.97	\$667.97				
27390	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; SINGLE TENDON		\$277.69	\$277.69			+	
21390	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP, SINGLE TENDONS,		φ211.08	φ211.09				
27204	ONE LEG		\$362.97	¢262.07				
27391	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; MULTIPLE TENDONS,		φ30∠.9 <i>1</i>	\$362.97				-
07202			¢406.00	£406.00				
27392	BILATERAL TENDON CINCLE TENDON		\$486.83	\$486.83				
27393	LENGTHENING OF HAMSTRING TENDON; SINGLE TENDON		\$349.27	\$349.27				
	LENGTHENING OF HAMSTRING TENDON; MULTIPLE TENDONS, ONE							
27394	LEG		\$410.40	\$410.40				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07005	LENGTHENING OF HAMSTRING TENDON; MULTIPLE TENDONS,		0040.70	0010 70				
27395	BILATERAL		\$642.79	\$642.79				
07000	TRANSPIANT HAMOTRING TENDON TO BATELLA SINGLE TENDON		0404.40	0404.40				
27396	TRANSPLANT, HAMSTRING TENDON TO PATELLA; SINGLE TENDON		\$431.42	\$431.42				
07007	TRANSPLANT, HAMSTRING TENDON TO PATELLA; MULTIPLE		0547.40	0547.40				
27397	TENDONS		\$547.19	\$547.19				
07.400	TRANSFER, TENDON OR MUSCLE, HAMSTRINGS TO FEMUR (EG,		* 400 00	* 400 00				
27400	EGGER'S TYPE		\$490.30	\$490.30				
27403	ARTHROTOMY WITH MENISCUS REPAIR, KNEE		\$499.63	\$499.63				
07.405	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE;		45.45.00	4=4=00				
27405	COLLATERAL		\$547.23	\$547.23				
	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE;							
27407	CRUCIATE		\$549.42	\$549.42				
07.400	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE;		4044.50	*				
27409	COLLATERAL AND		\$811.53	\$811.53				
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION, KNEE		\$1,179.03	\$1,179.03				
27415	OSTEOCHONDRAL KNEE AUTOGRAFT OPEN		\$980.98	\$980.98				
27416	OSTEOCHONDRAL KNEE AUTOGRAFT		\$733.15	\$733.15				
	ANTERIOR TIBIAL TUBERCLEPLASTY (EG, MAQUET TYPE							
27418	PROCEDURE)		\$661.14	\$661.14				
	RECONSTRUCTION OF DISLOCATING PATELLA; (EG, HAUSER TYPE							
27420	PROCEDURE)		\$605.55	\$605.55			1	
	RECONSTRUCTION OF DISLOCATING PATELLA; WITH EXTENSOR							
27422	REALIGNMENT AND/O		\$618.60	\$618.60				
27424	RECONSTRUCTION OF DISLOCATING PATELLA; WITH PATELLECTOMY		\$627.11	\$627.11				
27425	LATERAL RETINACULAR RELEASE, OPEN		\$347.40	\$347.40				

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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; EXTRA-							
27427	ARTICULAR		\$607.63	\$607.63				
	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-							
27428	ARTICULAR (OPEN		\$745.89	\$745.89				
	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-							
27429	ARTICULAR (OPEN		\$694.76	\$694.76				
27430	QUADRICEPSPLASTY (EG, BENNETT OR THOMPSON TYPE)		\$549.25	\$549.25				
27435	CAPSULOTOMY, POSTERIOR CAPSULAR RELEASE, KNEE		\$472.48	\$472.48				
27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS		\$530.59	\$530.59				
27438	ARTHROPLASTY, PATELLA; WITH PROSTHESIS		\$706.12	\$706.12				
27440	ARTHROPLASTY, KNEE, TIBIAL PLATEAU;		\$646.80	\$646.80				
	ARTHROPLASTY, KNEE, TIBIAL PLATEAU; WITH DEBRIDEMENT AND							
27441	PARTIAL		\$569.70	\$569.70				
27442	ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE;		\$783.21	\$783.21				
21442	ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE; ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE;		φ103.Z1	Φ103.Z1			_	
27443	WITH DEBRID		\$729.37	\$729.37				
27443	WITH DEBRID		φ129.51	φ129.31			+	+
27445	ARTHROPLASTY, KNEE, HINGE PROSTHESIS (EG, WALLDIUS TYPE)		\$1,145.96	\$1,145.96				
	ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL OR		, ,	,				†
27446	LATERAL COMPARTMENT		\$1,051.39	\$1,051.39				
	ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND		ψ 1,00 1100	ψ 1,00 1100				†
27447	LATERAL COMPARTMEN		\$1,373.97	\$1,373.97				
	OSTEOTOMY, FEMUR, SHAFT OR SUPRACONDYLAR; WITHOUT		. ,	. ,	1			†
27448	FIXATION		\$696.75	\$696.75				
07.450	OCTECTORY FEMALE CHAFT OF CUEFACONEN AS ANTHER TOTAL		#000 G3	#000 GS				
27450	OSTEOTOMY, FEMUR, SHAFT OR SUPRACONDYLAR; WITH FIXATION		\$839.20	\$839.20				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OSTEOTOMY, MULTIPLE, WITH REALIGNMENT ON INTRAMEDULLARY							
27454	ROD, FEMORAL S		\$849.38	\$849.38				
	OSTEOTOMY, PROXIMAL TIBIA, INCLUDING FIBULAR EXCISION OR							
27455	OSTEOTOMY		\$721.93	\$721.93				
	OSTEOTOMY, PROXIMAL TIBIA, INCLUDING FIBULAR EXCISION OR							
27457	OSTEOTOMY		\$778.46	\$778.46				
27465	OSTEOPLASTY, FEMUR; SHORTENING (EXCLUDING 64876)		\$753.67	\$753.67				
27466	OSTEOPLASTY, FEMUR; LENGTHENING		\$857.88	\$857.88				
	OSTEOPLASTY, FEMUR; COMBINED, LENGTHENING AND							
27468	SHORTENING WITH FEMORAL		\$1,036.42	\$1,036.42				
	REPAIR, NONUNION OR MALUNION, FEMUR, DISTAL TO HEAD AND							
27470	NECK; WITHOUT		\$945.17	\$945.17				
	REPAIR, NONUNION OR MALUNION, FEMUR, DISTAL TO HEAD AND							
27472	NECK; WITH ILI		\$1,090.97	\$1,090.97				
	ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS); DISTAL							
27475	FEMUR		\$476.44	\$476.44				
	ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS); TIBIA							
27477	AND FIBULA.		\$655.92	\$655.92				
	ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS);		,	,				
27479	COMBINED DISTAL F		\$715.27	\$715.27				
	ARREST, HEMIEPIPHYSEAL, DISTAL FEMUR OR PROXIMAL TIBIA OR		· -	-				
27485	FIBULA (EG,		\$487.59	\$487.59				
	REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT		¥ 101100					
27486	ALLOGRAFT; ONE		\$1,162.27	\$1,162.27				
	REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT		7 .,	7 .,				
27487	ALLOGRAFT; FEMORA		\$1,526.10	\$1,526.10				
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Ulliary Criar		-				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	REMOVAL OF PROSTHESIS, INCLUDING TOTAL KNEE PROSTHESIS.	I A IIIu	(i aciiity)	(Norm demity)	Comp.	Joinp.	Value	Hotes
27488	METHYLMETHACRY		\$921.03	\$921.03				
27 100	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR		Ψ021.00	ψ021.00				
27495	WIRING) WITH OR		\$959.83	\$959.83				
27 100	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE		Ψ000.00	Ψ000.00				
27496	COMPARTMENT (FLEXOR O		\$278.87	\$278.87				
27 100	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE		Ψ27 0.07	ψ27 0.07				
27497	COMPARTMENT (FLEXOR O		\$341.46	\$341.46				
27 107	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE		φστιτο	φστιτισ				
27498	COMPARTMENTS;		\$389.33	\$389.33				
21 100	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE		Ψ000.00	ψοσο.σο				
27499	COMPARTMENTS; WI		\$448.36	\$448.36				
	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITHOUT		V. 10.00	ψ · · · · · · · ·				
27500	MANIPULATION		\$320.26	\$320.26				
	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR		V 020:20	4020.20				
27501	FEMORAL FRACTURE WI		\$320.26	\$320.26				
	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITH		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
27502	MANIPULATION, WITH OR		\$514.18	\$514.18				
	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR			, ,				
27503	FEMORAL FRACTURE WI		\$514.18	\$514.18				
	OPEN TREATMENT OF FEMORAL SHAFT FRACTURE, WITH OR		¥ 5 1 11 12 1	701111				
27506	WITHOUT EXTERNAL		\$959.33	\$959.33				
	OPEN TREATMENT OF FEMORAL SHAFT FRACTURE WITH						1	
27507	PLATE/SCREWS, WITH OR WI		\$868.96	\$868.96				
	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL						1	
27508	OR LATERAL		\$281.86	\$281.86				
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	ge for the service	,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE.		(* 22222)	(**************************************				
27509	DISTAL END, MEDIAL		\$327.64	\$327.64				
	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL							
27510	OR LATERAL		\$449.73	\$449.73				
	OPEN TREATMENT OF FEMORAL SUPRACONDYLAR OR							
27511	TRANSCONDYLAR FRACTURE WITH		\$858.15	\$858.15				
	OPEN TREATMENT OF FEMORAL SUPRACONDYLAR OR							
27513	TRANSCONDYLAR FRACTURE WITH		\$984.28	\$984.28				
	OPEN TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL							
27514	OR LATERAL COND		\$953.10	\$953.10				
	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL							
27516	SEPARATION; WITHOUT		\$290.90	\$290.90				
	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL							
27517	SEPARATION; WITH		\$481.47	\$481.47				
	OPEN TREATMENT OF DISTAL FEMORAL EPIPHYSEAL SEPARATION,							
27519	WITH OR WITHOU		\$795.44	\$795.44				
	CLOSED TREATMENT OF PATELLAR FRACTURE, WITHOUT							
27520	MANIPULATION		\$130.34	\$171.11				
	OPEN TREATMENT OF PATELLAR FRACTURE, WITH INTERNAL							
27524	FIXATION AND/OR PAR		\$592.67	\$592.67				
	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU);		4400.5-	4400.5-				
27530	WITHOUT	ļ	\$198.37	\$198.37				
	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU);			4074.00				
27532	WITH OR WITHO		\$374.29	\$374.29				
07505	OPEN TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU);		4000.00	0000 00				
27535	UNICONDYLAR, WI		\$663.23	\$663.23				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	OPEN TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU);	Ailiu	(i dointy)	(Non acinty)	Jonip.	Joinp.	Value	140103
27536	BICONDYLAR, WIT		\$785.01	\$785.01				
27000	CLOSED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR		ψ100.01	Ψ7 00.01				
27538	TUBEROSITY FRACTURE(\$238.94	\$238.94				
27000	OPEN TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR		Ψ200.01	Ψ200.01				
27540	TUBEROSITY FRACTURE(S)		\$699.25	\$699.25				
27010			φοσσ.2σ	Ψ000.20				
27550	CLOSED TREATMENT OF KNEE DISLOCATION; WITHOUT ANESTHESIA		\$239.95	\$239.95				
	CLOSED TREATMENT OF KNEE DISLOCATION; REQUIRING		7-00:00	V				
27552	ANESTHESIA		\$321.73	\$321.73				
	OPEN TREATMENT OF KNEE DISLOCATION, WITH OR WITHOUT							
27556	INTERNAL OR EXTERN		\$777.38	\$777.38				
	OPEN TREATMENT OF KNEE DISLOCATION, WITH OR WITHOUT			,				
27557	INTERNAL OR EXTERN		\$914.27	\$914.27				
	OPEN TREATMENT OF KNEE DISLOCATION, WITH OR WITHOUT							
27558	INTERNAL OR EXTERN		\$942.15	\$942.15				
	CLOSED TREATMENT OF PATELLAR DISLOCATION; WITHOUT							
27560	ANESTHESIA		\$149.05	\$149.05				
	CLOSED TREATMENT OF PATELLAR DISLOCATION; REQUIRING							
27562	ANESTHESIA		\$318.21	\$318.21				
	OPEN TREATMENT OF PATELLAR DISLOCATION, WITH OR WITHOUT							
27566	PARTIAL OR TOT		\$661.22	\$661.22				
	MANIPULATION OF KNEE JOINT UNDER GENERAL ANESTHESIA							
27570	(INCLUDES APPLICAT		\$102.53	\$102.53				
27580	ARTHRODESIS, KNEE, ANY TECHNIQUE		\$843.06	\$843.06				
27590	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL;		\$588.56	\$588.56				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	<u>or physiciar</u>	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; IMMEDIATE							
27591	FITTING TECHNIQ		\$692.38	\$692.38				
	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; OPEN,							
27592	CIRCULAR (GUILLOTIN		\$513.40	\$513.40				
	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; SECONDARY							
27594	CLOSURE OR SCAR		\$299.29	\$299.29				
	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; RE-							
27596	AMPUTATION		\$514.76	\$514.76				
27598	DISARTICULATION AT KNEE		\$593.07	\$593.07				
27599	UNLISTED PROCEDURE, FEMUR OR KNEE	R	\$0.00	\$0.00				
	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL							
27600	COMPARTMENTS ON		\$253.78	\$253.78				
	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR							
27601	COMPARTMENT(S) ONLY		\$253.07	\$253.07				
	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL,							
27602	AND POSTERIOR		\$321.89	\$321.89				
	INCISION AND DRAINAGE, LEG OR ANKLE; DEEP ABSCESS OR							
27603	HEMATOMA		\$203.20	\$203.20				
27604	INCISION AND DRAINAGE, LEG OR ANKLE; INFECTED BURSA		\$141.20	\$154.88				
	TENOTOMY, PERCUTANEOUS, ACHILLES TENDON (SEPARATE							
27605	PROCEDURE); LOCAL		\$117.80	\$117.80				
	TENOTOMY, PERCUTANEOUS, ACHILLES TENDON (SEPARATE							
27606	PROCEDURE); GENERAL		\$178.93	\$178.93				
27607	INCISION (EG, OSTEOMYELITIS OR BONE ABSCESS), LEG OR ANKLE		\$391.88	\$391.88				
	ARTHROTOMY, ANKLE, INCLUDING EXPLORATION, DRAINAGE, OR							
27610			\$440.07	\$440.07				
27610	REMOVAL OF FORE		\$440.07	\$440.07				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROTOMY, POSTERIOR CAPSULAR RELEASE, ANKLE, WITH OR							
27612	WITHOUT ACHILLE		\$428.17	\$428.17				
27613	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; SUPERFICIAL		\$73.62	\$82.61				
	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; DEEP (SUBFASCIAL							
27614	OR		\$225.08	\$225.08				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT							
27615	TISSUE OF LE		\$601.21	\$601.21				
27616	5 CM OR GREATER		\$932.31	\$932.31				
27618	EXCISION, TUMOR, LEG OR ANKLE AREA; SUBCUTANEOUS TISSUE		\$209.06	\$209.06				
	EXCISION, TUMOR, LEG OR ANKLE AREA; DEEP (SUBFASCIAL OR							
27619	INTRAMUSCULAR)		\$361.22	\$361.22				
	ARTHROTOMY, ANKLE, WITH JOINT EXPLORATION, WITH OR							
27620	WITHOUT BIOPSY, WIT		\$352.03	\$352.03				
27625	ARTHROTOMY, WITH SYNOVECTOMY, ANKLE;		\$495.71	\$495.71				
	ARTHROTOMY, WITH SYNOVECTOMY, ANKLE; INCLUDING					İ		
27626	TENOSYNOVECTOMY		\$570.79	\$570.79				
	EXCISION OF LESION OF TENDON SHEATH OR CAPSULE (EG, CYST							
27630	OR GANGLION),		\$230.77	\$230.77				
27632	3 CM OR GREATER		\$299.06	\$299.06				
27634	5 CM OR GREATER		\$489.38	\$489.38			1	
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA						1	
27635	OR FIBULA;		\$460.42	\$460.42			1	
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA			<u> </u>	†		†	†
27637	OR FIBULA; W		\$529.40	\$529.40				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA		, , =====	,				
27638	OR FIBULA: W		\$572.56	\$572.56				

Note:	Physician	Fee Schedule 2020							
2020 Codes in Red; Refer to CPT book for descriptions R* in PA column indicates Prior Auth is required Codes islated as '300' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR PARTIAL EXCISION (CRATERIZATION, CRATERIZATION,		1 00 001104410 2020						+	
Refer to CPT book for descriptions R'm PA Column indicates Prof Auth is required Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute incremented time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE PARTIAL EXCISION (TATERIZATION, SAUCERIZATION, OR Settled Non-Procedure Description PARTIAL EXCISION (TO THUMOR, BONE; TIBIA ST45.89 ST46.80 ST		les in Red:				+			
RT in PA column indicates Prior Auth is required Codes listed as \$50.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit		•							†
Codes listed as \$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment-1 time unit. Please use lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE PARTIAL EXCISION (SATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE 27641 DIAPHYSECTOMY) BONE 27645 RADICAL RESECTION OF TOMOR, BONE; TIBIA 27646 RADICAL RESECTION OF TUMOR, BONE; FIBULA 27647 RADICAL RESECTION OF TUMOR, BONE; FIBULA 27648 INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY SA133 333 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27650 TENDON; REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27654 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES 27656 REPAIR, FASCIAL DEFECT OF LEG 2524.89 \$224.89 2524.89 2524.89 2524.89 2524.89 2524.89 2524.89 2524.89 2524.89 2526.60 2665 REPAIR, FASCIAL DEFECT OF LEG 2524.89									
The Anesthesia Base Rate is \$15.0. Each 15 minute increment=1 time unit.			mary chai	ge for the service)				
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION) BONE PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DAILY SECTION OR TUMOR, BONE; TIBIA ST45.89 S745.89 S745.									
Proc Procedure Description PA Ind (Facility) (NonFacility) Comp. Comp. Notes	Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Proc Procedure Description	Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc Procedure Description									
Procedure Description									
PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) BONE	Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
27640 DIAPHYSECTOMY) BONE	Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR									
27641 DIAPHYSECTOMY BONE \$465.23 \$465.23 \$465.23 \$2745.5 RADICAL RESECTION OF TUMOR, BONE; FIBIJA \$745.89 \$745.89 \$745.89 \$745.89 \$745.89 \$745.89 \$745.89 \$745.89 \$745.89 \$7647.80 \$7647.80 \$7647.80 \$7647.80 \$7648.80 \$762.91 \$672.9	27640			\$600.87	\$600.87				
27645 RADICAL RESECTION OF TUMOR, BONE; TIBIA \$745.89 \$745									
27646 RADICAL RESECTION OF TUMOR, BONE; FIBULA \$672.91 \$672.91 \$672.91 \$7647 RADICAL RESECTION OF TUMOR, BONE; TALUS OR CALCANEUS \$628.62 \$628.62 \$628.62 \$7684 NJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY \$43.33		DIAPHYSECTOMY) BONE							
27647 RADICAL RESECTION OF TUMOR, BONE; TALUS OR CALCANEUS \$628.62 \$628.62 27648 IINJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY \$43.33 \$43.33 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES \$541.27 \$541.27 27650 TENDON; \$541.27 \$541.27 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES \$599.41 \$599.41 27652 TENDON; WITH \$599.41 \$599.41 27654 REPAIR, SECONDARY, ACHILLES TENDON, WITH OR WITHOUT GRAFT \$607.33 \$607.33 27656 REPAIR, FASCIAL DEFECT OF LEG \$224.89 \$224.89 REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH \$257.68 \$257.68 27658 TENDON \$362.62 \$362.62 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITHOUT GRAFT, \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$301.18 \$301.18 27665 GRAFT, EACH T \$301.18 \$301.18		RADICAL RESECTION OF TUMOR, BONE; TIBIA							
27648 INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY \$43.33 \$43.27 \$4									
REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON; REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON; WITH REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON; WITH REPAIR, SECONDARY, ACHILLES TENDON, WITH OR WITHOUT GRAFT S607.33 S607.33 S607.33 REPAIR, FASCIAL DEFECT OF LEG REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH TENDON REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITHOUT FIBULAR REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR									
27650 TENDON; \$541.27 \$541.27 REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES \$599.41 \$599.41 27652 TENDON; WITH \$599.41 \$599.41 27654 REPAIR, SECONDARY, ACHILLES TENDON, WITH OR WITHOUT GRAFT \$607.33 \$607.33 27656 REPAIR, FASCIAL DEFECT OF LEG \$224.89 \$224.89 REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH \$257.68 \$257.68 27658 TENDON \$362.62 \$362.62 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITHOUT GRAFT, EACH TENDON \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$301.18 27665 GRAFT, EACH T \$301.18 \$301.18 REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR \$301.18 \$301.18	27648			\$43.33	\$43.33				
REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES \$599.41 \$599.41 \$599.41 \$27652 TENDON; WITH \$599.41 \$									
27652 TENDON; WITH \$599.41 \$599.41 27654 REPAIR, SECONDARY, ACHILLES TENDON, WITH OR WITHOUT GRAFT \$607.33 \$607.33 27656 REPAIR, FASCIAL DEFECT OF LEG \$224.89 \$224.89 REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH \$257.68 \$257.68 27658 TENDON \$257.68 \$257.68 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$231.16 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18 27665 GRAFT, EACH T \$301.18 \$301.18	27650			\$541.27	\$541.27				
27654 REPAIR, SECONDARY, ACHILLES TENDON, WITH OR WITHOUT GRAFT \$607.33 \$607.33 \$224.89 \$224.89 \$224.89 \$224.89 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.68 \$257.69 \$362.62 \$362.6									
27656 REPAIR, FASCIAL DEFECT OF LEG \$224.89 \$224.89 REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH \$257.68 \$257.68 27658 TENDON \$257.68 \$257.68 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$231.16 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18 REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR \$301.18	27652	TENDON; WITH		\$599.41	\$599.41				
27656 REPAIR, FASCIAL DEFECT OF LEG \$224.89 \$224.89 REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH \$257.68 \$257.68 27658 TENDON \$257.68 \$257.68 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$231.16 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18 REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR \$301.18	07054	DEDAID CECONDARY ACHILLEC TENDON WITH OR WITHOUT ORACT		# 007.00	# 007.00				
REPAIR, FLEXOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, EACH 27658 TENDON REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27659 GRAFT, EACH TEN REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, 27664 EACH TENDON REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27665 GRAFT, EACH T REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR						-			
27658 TENDON \$257.68 \$257.68 REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$362.62 \$362.62 27659 GRAFT, EACH TEN \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$301.18 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18 27665 GRAFT, EACH T \$301.18 \$301.18	27656			\$224.89	\$224.89				
REPAIR, FLEXOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27659 GRAFT, EACH TEN REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, 27664 EACH TENDON REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27665 GRAFT, EACH T REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR	27650			¢057.60	¢057.60				
27659 GRAFT, EACH TEN \$362.62 \$362.62 REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, \$231.16 \$231.16 27664 EACH TENDON \$231.16 \$301.18 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18 27665 GRAFT, EACH T \$301.18 \$301.18 REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR \$301.18 \$301.18	27000			φ237.00	φ237.00				
REPAIR, EXTENSOR TENDON, LEG; PRIMARY, WITHOUT GRAFT, 27664 EACH TENDON REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27665 GRAFT, EACH T REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR	27650			¢362 62	¢362 62				
27664 EACH TENDON \$231.16 \$231.16 REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT \$301.18 \$301.18	21039			ψ302.02	ψ30Z.0Z	+		+	+
REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WITHOUT 27665 GRAFT, EACH T \$301.18 \$301.18 REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR	27664			\$231.16	\$231.16				
27665 GRAFT, EACH T \$301.18 \$301.18 \$301.18	27004			Ψ231.10	Ψ231.10				
REPAIR, DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR	27665			\$301.18	\$301.18				
	27000			φοστιτο	ΨΟΟΤΙΤΟ	+			
27675 OSTEOTOMY \$393.45 \$393.45	27675			\$393 45	\$393 45				
REPAIR, DISLOCATING PERONEAL TENDONS; WITH FIBULAR				+ 300.10	+ 300.10				
27676 OSTEOTOMY \$461.41	27676			\$461.41	\$461.41				

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_	Fee Schedule 2020				_			
Note:								
	es in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required		1					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TENOLYSIS, FLEXOR OR EXTENSOR TENDON, LEG AND/OR ANKLE;							
27680	SINGLE, EACH T		\$282.90	\$282.90				
	TENOLYSIS, FLEXOR OR EXTENSOR TENDON, LEG AND/OR ANKLE;							
27681	MULTIPLE TENDO		\$367.65	\$367.65				
	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE;							
27685	SINGLE TENDON (SEPA		\$291.10	\$291.10				
	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE;							
27686	MULTIPLE TENDONS		\$401.17	\$401.17				
27687	GASTROCNEMIUS RECESSION (EG, STRAYER PROCEDURE)		\$336.01	\$336.01				
	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE							
27690	REDIRECTION OR		\$439.55	\$439.55				
	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE							
27691	REDIRECTION OR		\$512.94	\$512.94				
	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE							
27692	REDIRECTION OR		\$116.37	\$116.37				
27695	REPAIR, PRIMARY, DISRUPTED LIGAMENT, ANKLE; COLLATERAL		\$419.72	\$419.72				
	REPAIR, PRIMARY, DISRUPTED LIGAMENT, ANKLE; BOTH							
27696	COLLATERAL LIGAMENTS		\$444.08	\$444.08				
	REPAIR, SECONDARY, DISRUPTED LIGAMENT, ANKLE, COLLATERAL							
27698	(EG, WATSON-J		\$609.90	\$609.90				
27700	ARTHROPLASTY, ANKLE;		\$589.09	\$589.09				
27702	ARTHROPLASTY, ANKLE; WITH IMPLANT (TOTAL ANKLE)		\$901.83	\$901.83				
27703	ARTHROPLASTY, ANKLE; REVISION, TOTAL ANKLE		\$850.54	\$850.54				
27704	REMOVAL OF ANKLE IMPLANT		\$391.73	\$391.73				
27705	OSTEOTOMY; TIBIA		\$613.41	\$613.41				
27707	OSTEOTOMY; FIBULA		\$255.46	\$255.46				
27709	OSTEOTOMY; TIBIA AND FIBULA		\$634.02	\$634.02				

Physician	Fee Schedule 2020							
Note:	T GG GGNGGGIG 2020							
	es in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u> </u>				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		Τ΄ ΄						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OSTEOTOMY; MULTIPLE, WITH REALIGNMENT ON INTRAMEDULLARY							
27712	ROD (EG, SOFIE		\$680.93	\$680.93				
27715	OSTEOPLASTY, TIBIA AND FIBULA, LENGTHENING OR SHORTENING		\$764.49	\$764.49				
	REPAIR OF NONUNION OR MALUNION, TIBIA; WITHOUT GRAFT, (EG,							
27720	COMPRESSION		\$750.69	\$750.69				
27722	DEDAID OF NONLINION OF MALLINION TIPLA: WITH SUIDING CRAFT		\$641.91	\$641.91				
21122	REPAIR OF NONUNION OR MALUNION, TIBIA; WITH SLIDING GRAFT REPAIR OF NONUNION OR MALUNION, TIBIA; WITH ILIAC OR OTHER		φ041.91	φ041.91				
27724	AUTOGRAFT		\$840.83	\$840.83				
21124	REPAIR OF NONUNION OR MALUNION, TIBIA; BY SYNOSTOSIS, WITH		ψ040.03	ψ040.03				
27725	FIBULA, ANY		\$640.88	\$640.88				
27726	REPAIR FIBULA NONUNION		\$691.61	\$691.61				
27727	REPAIR OF CONGENITAL PSEUDARTHROSIS, TIBIA		\$674.54	\$674.54	1			
27730	ARREST, EPIPHYSEAL (EPIPHYSIODESIS), OPEN; DISTAL TIBIA		\$318.59	\$318.59				
27732	ARREST, EPIPHYSEAL (EPIPHYSIODESIS), OPEN; DISTAL FIBULA		\$297.49	\$297.49				
	ARREST, EPIPHYSEAL (EPIPHYSIODESIS), OPEN; DISTAL TIBIA AND			, -				
27734	FIBULA		\$463.65	\$463.65				
	ARREST, EPIPHYSEAL (EPIPHYSIODESIS), ANY METHOD, COMBINED,							
27740	PROXIMAL AN		\$514.03	\$514.03				
	ARREST, EPIPHYSEAL (EPIPHYSIODESIS), ANY METHOD, COMBINED,							
27742	PROXIMAL AN		\$571.33	\$571.33				
	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR							
27745	WIRING) WITH OR		\$549.90	\$549.90				
	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR							
27750	WITHOUT FIBULAR		\$189.78	\$189.78				

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Note:	ree Scriedule 2020							-
	es in Red;							-
								
	PT book for descriptions							
	column indicates Prior Auth is required						+	
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service				+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						+	
	se lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 i						+	
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar T	1S				_	
							Base	
Droo			Innet Bete	Outpot Boto	Tech.	Prof.	Unit	
Proc	Burnedow Burnelotter	DA III I	Inpat. Rate	Outpat. Rate				Nata
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07750	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR		\$207.00	#207.00				
27752	WITHOUT FIBULAR		\$307.62	\$307.62			+	
07750	PERCUTANEOUS SKELETAL FIXATION OF TIBIAL SHAFT FRACTURE		440.00	* 440.00				
27756	(WITH OR WITHO		\$413.30	\$413.30			_	
07750	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE, (WITH OR WITHOUT		#700 07	\$700.07				
27758	FIBULAR FRAC		\$723.37	\$723.37				
.===	TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT			4700.04				
27759	FIBULAR FRACTURE)		\$792.21	\$792.21				
07700	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITHOUT		# 400.05	* 400 05				
27760	MANIPULATION		\$126.05	\$160.65				
.==	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITH		40.40.40	0.40.40				
27762	MANIPULATION, WITH		\$243.12	\$243.12				
	OPEN TREATMENT OF MEDIAL MALLEOLUS FRACTURE, WITH OR							
27766	WITHOUT INTERNAL		\$465.01	\$465.01				
27767	CLTX POST ANKLE FX W/0 MNP		\$191.37	\$190.48				
27768	CLTX POST ANKLE FX W/MNP		\$299.37	\$299.37				
27769	OPTX POST ANKLE FX		\$520.12	\$520.12				
	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE;							
27780	WITHOUT MANIPUL		\$105.22	\$131.64				
l	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE;							
27781	WITH MANIPULATI		\$223.39	\$223.39				
 	OPEN TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE,			 				
27784	WITH OR WITHOUT		\$360.34	\$360.34				
	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL							
27786	MALLEOLUS); WITHO		\$121.08	\$154.88				
	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL							
27788	MALLEOLUS); WITH		\$180.71	\$224.57				

Physician	Fee Schedule 2020							1
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPEN TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL							
27792	MALLEOLUS), WITH OR		\$432.95	\$432.95				
	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE,							
27808	(INCLUDING POTTS); WIT		\$161.48	\$161.48				
	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE,							
27810	(INCLUDING POTTS); WIT		\$296.33	\$296.33				
	OPEN TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, WITH OR							
27814	WITHOUT INTERNAL		\$596.72	\$596.72				
	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE;							
27816	WITHOUT MANIPULATION		\$185.96	\$185.96				
	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITH							
27818	MANIPULATION		\$349.43	\$349.43				
	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR							
27822	WITHOUT INTERNA		\$579.67	\$579.67				
	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR							
27823	WITHOUT INTERNA		\$712.71	\$712.71				
l	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING							
27824	ARTICULAR PORTION OF DI		\$185.96	\$185.96				
	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING							
27825	ARTICULAR PORTION OF DI		\$349.43	\$349.43				
07000	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR		Φ 5 40.54	0540.54				
27826	SURFACE/ PORTIO		\$518.51	\$518.51				
07007	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR		#050.07	4050.07				
27827	SURFACE/ PORTIO		\$650.27	\$650.27				
07000	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR		Φ 7 54.07	Φ75 4 O7				
27828	SURFACE/ PORTIO		\$754.67	\$754.67				

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	olumn indicates Prior Auth is required	<u> </u>						
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	<u>ns</u>					
							Door	
			In a Date	O11 D-1-	T	D 6	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07000	OPEN TREATMENT OF DISTAL TIBIOFIBULAR JOINT (SYNDESMOSIS)		#0.40.00	#0.40.00				
27829	DISRUPTION,		\$343.29	\$343.29				
07000	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT		0004.05	0004.05				
27830	DISLOCATION; WITHOUT		\$201.05	\$201.05				
07004	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT		***	40.40.00				
27831	DISLOCATION; REQUIRING		\$246.38	\$246.38				
	OPEN TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION,		0.40.40	40.40.40				
27832	WITH OR WIT		\$349.40	\$349.40				
	CLOSED TREATMENT OF ANKLE DISLOCATION; WITHOUT							
27840	ANESTHESIA		\$180.56	\$180.56				
	CLOSED TREATMENT OF ANKLE DISLOCATION; REQUIRING							
27842	ANESTHESIA, WITH OR		\$235.65	\$235.65				
	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT							
27846	PERCUTANEOUS SKEL		\$528.96	\$528.96				
	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT							
27848	PERCUTANEOUS SKEL		\$562.95	\$562.95				
	MANIPULATION OF ANKLE UNDER GENERAL ANESTHESIA (INCLUDES							
27860	APPLICATION O		\$110.07	\$110.07				
27870	ARTHRODESIS, ANKLE, OPEN		\$717.51	\$717.51				
27871	ARTHRODESIS, TIBIOFIBULAR JOINT, PROXIMAL OR DISTAL		\$489.23	\$489.23				
27880	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA;		\$576.79	\$576.79				
	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; WITH IMMEDIATE		1.					
27881	FITTING TECH		\$655.20	\$655.20				
	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; OPEN, CIRCULAR		1.					
27882	(GUILLOTINE)		\$460.79	\$460.79				
	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; SECONDARY							
27884	CLOSURE OR SCAR		\$322.35	\$322.35				

Physician	Fee Schedule 2020							
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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv char	ae for the service	3				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
27886	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; RE-AMPUTATION		\$469.89	\$469.89				
	AMPUTATION, ANKLE, THROUGH MALLEOLI OF TIBIA AND FIBULA (EG,							
27888	SYME, PIR		\$549.92	\$549.92				
27889	ANKLE DISARTICULATION		\$522.58	\$522.58				
	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL							
27892	COMPARTMENTS ON		\$283.42	\$283.42				
	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR							
27893	COMPARTMENT(S) ONLY, WITH		\$282.71	\$282.71				
	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL,							
27894	AND POSTERIOR		\$351.52	\$351.52				
27899	UNLISTED PROCEDURE, LEG OR ANKLE	R	\$0.00	\$0.00				
28001	INCISION AND DRAINAGE, BURSA, FOOT		\$86.83	\$93.80				
	INCISION AND DRAINAGE BELOW FASCIA, WITH OR WITHOUT							
28002	TENDON SHEATH		\$178.70	\$178.70				
	INCISION AND DRAINAGE BELOW FASCIA, WITH OR WITHOUT							
28003	TENDON SHEATH		\$281.06	\$328.00				
28005	INCISION, BONE CORTEX, FOOT		\$348.73	\$348.73				
28008	FASCIOTOMY, FOOT AND/OR TOE		\$201.88	\$201.88				
28010	TENOTOMY, PERCUTANEOUS, TOE; SINGLE TENDON		\$143.72	\$192.26				
28011	TENOTOMY, PERCUTANEOUS, TOE; MULTIPLE TENDONS		\$145.44	\$169.17				
	ARTHROTOMY, INCLUDING EXPLORATION, DRAINAGE, OR REMOVAL		1	40746				
28020	OF LOOSE OR FO		\$271.01	\$271.01				
	ARTHROTOMY, INCLUDING EXPLORATION, DRAINAGE, OR REMOVAL							
28022	OF LOOSE OR FO		\$173.68	\$210.43				
	ARTHROTOMY, INCLUDING EXPLORATION, DRAINAGE, OR REMOVAL		4.50.55	4.00.05				
28024	OF LOOSE OR FO		\$158.78	\$190.83				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tilary Criai		7				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	rango						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
Codes list	ed on the lab lee schedule that begin with a 1- or Q are currently horr-covered to	Гриузіска						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
3000	RELEASE, TARSAL TUNNEL (POSTERIOR TIBIAL NERVE	171114	(i dointy)	(Norm domey)	Comp.	Comp.	Value	110100
28035	DECOMPRESSION)		\$329.36	\$329.36				
28039	1.5 CM OR GREATER		\$249.62	\$342.75				
28041	1.5 CM OR GREATER		\$328.28	\$328.28				
28043	EXCISION, TUMOR, FOOT; SUBCUTANEOUS TISSUE		\$151.32	\$151.32				
28045	EXCISION, TUMOR, FOOT; DEEP, SUBFASCIAL, INTRAMUSCULAR		\$249.07	\$249.07				
	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT		7-10101	7=10101				
28046	TISSUE OF FO		\$438.82	\$438.82				
28047	3 CM OR GREATER		\$700.21	\$700.21				
	ARTHROTOMY WITH BIOPSY; INTERTARSAL OR TARSOMETATARSAL							
28050	JOINT		\$232.96	\$232.96				
28052	ARTHROTOMY WITH BIOPSY; METATARSOPHALANGEAL JOINT		\$170.25	\$221.48				
28054	ARTHROTOMY WITH BIOPSY; INTERPHALANGEAL JOINT		\$161.08	\$161.08				
28055	NEURECTOMY, FOOT		\$289.13	\$289.13				
28060	FASCIECTOMY, PLANTAR FASCIA; PARTIAL (SEPARATE PROCEDURE)		\$274.25	\$274.25				
28062	FASCIECTOMY, PLANTAR FASCIA; RADICAL (SEPARATE PROCEDURE)		\$393.07	\$393.07				
28070	SYNOVECTOMY; INTERTARSAL OR TARSOMETATARSAL JOINT, EACH		\$270.62	\$270.62				
28072	SYNOVECTOMY; METATARSOPHALANGEAL JOINT, EACH		\$223.07	\$223.07				
28080	EXCISION, INTERDIGITAL NEUROMA, SINGLE, EACH		\$213.41	\$213.41				
28086	SYNOVECTOMY, TENDON SHEATH, FOOT; FLEXOR		\$227.49	\$227.49				
28088	SYNOVECTOMY, TENDON SHEATH, FOOT; EXTENSOR		\$213.04	\$213.04				
	EXCISION OF LESION, TENDON, TENDON SHEATH, OR CAPSULE							
28090	(INCLUDING		\$213.05	\$213.05				
	EXCISION OF LESION, TENDON, TENDON SHEATH, OR CAPSULE							
28092	(INCLUDING		\$162.93	\$162.93				

Physician	Fee Schedule 2020							
Note:								
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Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,							
28100	TALUS OR CALCANEUS		\$294.03	\$294.03				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,							
28102	TALUS OR CALCANEUS		\$418.62	\$418.62				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,							
28103	TALUS OR CALCANEUS		\$346.23	\$346.23				
	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,							
28104	TARSAL OR METATARS		\$270.65	\$270.65				
00400	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		0000 47	#000 17				
28106	TARSAL OR METATARS		\$389.17	\$389.17				
00407	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		4000 40	0000 40				
28107	TARSAL OR METATARS		\$293.43	\$293.43				
00400	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR,		# 400.00	ф000 <i>ББ</i>				
28108	PHALANGES OF FOOT OSTECTOMY, PARTIAL EXCISION, FIFTH METATARSAL HEAD		\$183.23	\$239.55				+
28110	(BUNIONETTE) (SEPAR		\$214.91	\$214.91				
28111	OSTECTOMY, COMPLETE EXCISION; FIRST METATARSAL HEAD		\$287.13	\$287.13				
20111	OSTECTOMY, COMPLETE EXCISION; OTHER METATARSAL HEAD		φ207.13	φ207.13	+			
28112	(SECOND, THIRD OR		\$241.27	\$241.27				
28113	OSTECTOMY, COMPLETE EXCISION; FIFTH METATARSAL HEAD		\$250.77	\$250.77				
20113	OSTECTOMY, COMPLETE EXCISION; ALL METATARSAL HEADS, WITH		Ψ230.11	Ψ230.77				
28114	PARTIAL PROXI		\$490.56	\$490.56				
28116	OSTECTOMY, EXCISION OF TARSAL COALITION		\$341.88	\$341.88	+			
28118	OSTECTOMY, CALCANEUS;		\$332.34	\$332.34	+	+		+
	OSTECTOMY, CALCANEUS; FOR SPUR, WITH OR WITHOUT PLANTAR		1,700=.01	7552.5	1			
28119	FASCIAL RELEAS		\$309.41	\$309.41				

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	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION,							
28120	SEQUESTRECTOMY, OR		\$292.60	\$292.60				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION,							
28122	SEQUESTRECTOMY, OR		\$327.54	\$327.54				
	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION,							
28124	SEQUESTRECTOMY, OR		\$192.93	\$248.05				
28126	RESECTION, PARTIAL OR COMPLETE, PHALANGEAL BASE, EACH TOE		\$161.60	\$214.97				
28130	TALECTOMY (ASTRAGALECTOMY)		\$425.03	\$425.03				
28140	METATARSECTOMY		\$336.56	\$336.56				
28150	PHALANGECTOMY, TOE, EACH TOE		\$209.86	\$209.86				
28153	RESECTION, CONDYLE(S), DISTAL END OF PHALANX, EACH TOE		\$162.03	\$215.53				
	HEMIPHALANGECTOMY OR INTERPHALANGEAL JOINT EXCISION,							
28160	TOE, PROXIMAL END		\$169.83	\$225.08				
28171	RADICAL RESECTION OF TUMOR, BONE; TARSAL		\$499.19	\$499.19				
28173	RADICAL RESECTION OF TUMOR, BONE; METATARSAL		\$411.97	\$411.97				
28175	RADICAL RESECTION OF TUMOR, BONE; PHALANX OF TOE		\$322.43	\$322.43				
28190	REMOVAL OF FOREIGN BODY, FOOT; SUBCUTANEOUS		\$64.23	\$71.21				
28192	REMOVAL OF FOREIGN BODY, FOOT; DEEP		\$189.89	\$189.89				
28193	REMOVAL OF FOREIGN BODY, FOOT; COMPLICATED		\$230.75	\$230.75				
28200	REPAIR OF FOOT TENDON		\$278.45	\$278.45				
	REPAIR, TENDON, FLEXOR, FOOT; SECONDARY WITH FREE GRAFT,							
28202	EACH TENDON		\$362.03	\$362.03				
	REPAIR, TENDON, EXTENSOR, FOOT; PRIMARY OR SECONDARY,							
28208	EACH TENDON		\$202.78	\$202.78				
	REPAIR, TENDON, EXTENSOR, FOOT; SECONDARY WITH FREE							
28210	GRAFT, EACH TENDON		\$339.38	\$339.38				
28220	TENOLYSIS, FLEXOR, FOOT; SINGLE TENDON		\$187.65	\$239.55				

Physician	Fee Schedule 2020							
Note:	The education 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary chai		;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		no.					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
28222	TENOLYSIS, FLEXOR, FOOT; MULTIPLE TENDONS	PAIIIU	\$258.42	\$344.25	Comp.	Comp.	Value	Notes
28225	TENOLYSIS, FLEXOR, FOOT, MOLTIFLE TENDONS TENOLYSIS, EXTENSOR, FOOT; SINGLE TENDON		\$170.00	\$170.00				
28226	TENOLYSIS, EXTENSOR, FOOT, SINGLE TENDONS TENOLYSIS, EXTENSOR, FOOT, MULTIPLE TENDONS		\$225.67	\$225.67				
20220	TENOTOMY, OPEN, TENDON FLEXOR; FOOT, SINGLE OR MULTIPLE		φ223.0 <i>1</i>	φ223.0 <i>1</i>				
28230			\$155.31	\$187.90				
28230	TENDON(S) (SEP TENOTOMY, OPEN, TENDON FLEXOR; TOE, SINGLE TENDON		\$155.31	\$187.90				
00000			¢400.70	¢4.40.00				
28232 28234	(SEPARATE PROCEDURE) TENOTOMY, OPEN, EXTENSOR, FOOT OR TOE, EACH TENDON		\$120.76 \$117.53	\$142.22 \$138.05				
28234	· · · · · · · · · · · · · · · · · · ·		\$117.53	\$138.05				
00000	RECONSTRUCTION (ADVANCEMENT), POSTERIOR TIBIAL TENDON		¢407.00	¢407.00				
28238	WITH EXCISION OF		\$427.90	\$427.90		_	_	
00040	TENOTOMY, LENGTHENING, OR RELEASE, ABDUCTOR HALLUCIS		# 400.04	¢400.04				
28240	MUSCLE		\$183.61	\$183.61				
00050	DIVISION OF PLANTAR FASCIA AND MUSCLE (EG, STEINDLER		007.00	007.00				
28250	STRIPPING) (SEPAR		\$297.86	\$297.86			_	
00000	CAPSULOTOMY, MIDFOOT; MEDIAL RELEASE ONLY (SEPARATE		* 050 50	4050 50				
28260	PROCEDURE)		\$350.56	\$350.56			_	
28261	CAPSULOTOMY, MIDFOOT; WITH TENDON LENGTHENING		\$434.36	\$434.36			_	
00000	CAPSULOTOMY, MIDFOOT; EXTENSIVE, INCLUDING POSTERIOR		Φ740.44	φ 740.44				
28262	TALOTIBIAL CAPSUL		\$712.14	\$712.14				
28264	CAPSULOTOMY, MIDTARSAL (EG, HEYMAN TYPE PROCEDURE)		\$572.41	\$572.41				
00070	CAPSULOTOMY; METATARSOPHALANGEAL JOINT, WITH OR		0475.05	0040.50				
28270	WITHOUT TENORRHAPHY, E		\$175.25	\$210.52				
	CAPSULOTOMY; INTERPHALANGEAL JOINT, EACH JOINT (SEPARATE		1,00,40					
28272	PROCEDURE)		\$139.42	\$166.78				
	SYNDACTYLIZATION, TOES (EG, WEBBING OR KELIKIAN TYPE		 					
28280	PROCEDURE)		\$211.50	\$211.50				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service	;	-	-		
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							4
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai T	1S					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dracedowe Decembrish	DAInd		•		Comp.	Value	Notes
Code	Procedure Description CORRECTION, HAMMERTOE (EG, INTERPHALANGEAL FUSION,	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
20205	PARTIAL OR TOTAL		\$256.09	\$256.09				
28285	CORRECTION, COCK-UP FIFTH TOE, WITH PLASTIC SKIN CLOSURE		\$230.09	\$200.09				
20206			¢224 66	\$234.66				
28286	(EG, RUIZ-MOR OSTECTOMY, PARTIAL, EXOSTECTOMY OR CONDYLECTOMY,		\$234.66	\$234.00				
28288	METATARSAL HEAD, EACH		\$220.48	\$220.48				
20200	HALLUX RIGIDUS CORRECTION WITH CHEILECTOMY, DEBRIDEMENT		φ22U.40	\$ 220.40				_
28289	AND CAPSULAR		\$284.76	\$284.76				
28291	CORRJ HALUX RIGDUS W/IMPLT	+	\$387.61	\$577.34				Added Effective 1/1/2017
20291	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT		φ307.01	ψ377.54				Added Effective 1/1/2017
28292	SESAMOIDECTOMY; KE		\$390.18	\$390.18				
28295	CORRECTION HALLUX VALGUS		\$430.82	\$734.39				Added Effective 1/1/2017
20233	CORRECTION HALLUX VALGUS (BUNION), WITH OR WITHOUT		ψ430.02	Ψ104.00				Added Effective 1/1/2017
28296	SESAMOIDECTOMY; WI		\$515.11	\$515.11				
20200	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT	+	φοτοίττ	φοτοίττ				+
28297	SESAMOIDECTOMY;		\$522.44	\$522.44				
20201	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT		Ψ022.11	Ψ022		1		
28298	SESAMOIDECTOMY; BY		\$478.31	\$478.31				
	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT		ψ 1.1 G.G.1	ψ σσ .				
28299	SESAMOIDECTOMY; BY		\$546.46	\$546.46				
	OSTEOTOMY; CALCANEUS (EG, DWYER OR CHAMBERS TYPE	 	+	70.00.00				
28300	PROCEDURE), WITH OR		\$461.69	\$461.69				
28302	OSTEOTOMY; TALUS		\$533.57	\$533.57				
		1						
28304	OSTEOTOMY, TARSAL BONES, OTHER THAN CALCANEUS OR TALUS;		\$444.15	\$444.15				
	OSTEOTOMY, TARSAL BONES, OTHER THAN CALCANEUS OR TALUS;	1						
28305	WITH AUTOGRAFT		\$582.37	\$582.37				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I I I I I I I I I I I I I I I I I I I						
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
3000	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR	. / ta	(i dointy)	(itoin domity)	Gomp.	Comp.	Value	110100
28306	ANGULAR CORRECTI		\$301.55	\$301.55				
	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR		,	, , , , , , , , , , , , , , , , , , , ,				
28307	ANGULAR CORRECTI		\$353.15	\$353.15				
	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR		·					
28308	ANGULAR CORRECTI		\$314.66	\$314.66				
	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR							
28309	ANGULAR CORRECTI		\$467.67	\$467.67				
	OSTEOTOMY, SHORTENING, ANGULAR OR ROTATIONAL							
28310	CORRECTION; PROXIMAL PHAL		\$270.53	\$270.53				
	OSTEOTOMY, SHORTENING, ANGULAR OR ROTATIONAL							
28312	CORRECTION; OTHER PHALANG		\$259.13	\$259.13				
	RECONSTRUCTION, ANGULAR DEFORMITY OF TOE, SOFT TISSUE							
28313	PROCEDURES ONLY		\$181.38	\$215.85				
28315	SESAMOIDECTOMY, FIRST TOE (SEPARATE PROCEDURE)		\$258.67	\$258.67				
28320	REPAIR, NONUNION OR MALUNION; TARSAL BONES		\$515.16	\$515.16				
	REPAIR, NONUNION OR MALUNION; METATARSAL, WITH OR							
28322	WITHOUT BONE GRAFT		\$373.52	\$373.52				
28340	RECONSTRUCTION, TOE, MACRODACTYLY; SOFT TISSUE RESECTION		\$385.24	\$385.24				
00011	RECONSTRUCTION, TOE, MACRODACTYLY; REQUIRING BONE		A 450 40	4.50.40				
28341	RESECTION POLICE AND A STATE OF THE STATE OF		\$459.42	\$459.42				
28344	RECONSTRUCTION, TOE(S); POLYDACTYLY		\$227.97	\$227.97				
00045	RECONSTRUCTION, TOE(S); SYNDACTYLY, WITH OR WITHOUT SKIN		# 000 6 4	#000 C 4				
28345	GRAFT(S), EAC		\$322.94	\$322.94				
28360	RECONSTRUCTION, CLEFT FOOT		\$733.33	\$733.33				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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1_			<u></u> .				Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITHOUT							
28400	MANIPULATION		\$103.17	\$137.63			1	
	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITH							
28405	MANIPULATION		\$244.29	\$244.29			1	
	PERCUTANEOUS SKELETAL FIXATION OF CALCANEAL FRACTURE,							
28406	WITH MANIPULATIO		\$356.72	\$356.72			1	
	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT							
28415	INTERNAL OR EXTE		\$665.39	\$665.39				
	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT							
28420	INTERNAL OR EXTE		\$795.33	\$795.33				
	CLOSED TREATMENT OF TALUS FRACTURE; WITHOUT							
28430	MANIPULATION		\$98.87	\$131.73				
28435	CLOSED TREATMENT OF TALUS FRACTURE; WITH MANIPULATION		\$197.64	\$197.64				
	PERCUTANEOUS SKELETAL FIXATION OF TALUS FRACTURE, WITH							
28436	MANIPULATION		\$258.02	\$258.02			1	
	OPEN TREATMENT OF TALUS FRACTURE, WITH OR WITHOUT							
28445	INTERNAL OR EXTERNAL		\$527.69	\$527.69				
28446	OSTEOCHONDRAL TALUS AUTOGRFT		\$899.30	\$899.30				
	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND							
28450	CALCANEUS); WITHOU		\$83.09	\$108.17				
	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND							
28455	CALCANEUS); WITH		\$128.60	\$162.66				
	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE FRACTURE							
28456	(EXCEPT TALUS A		\$140.25	\$140.25				
	OPEN TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS							
28465	AND CALCANEUS), W		\$360.48	\$360.48				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSED TREATMENT OF METATARSAL FRACTURE; WITHOUT		, ,,	, ,	'	<u> </u>		
28470	MANIPULATION, EACH		\$81.37	\$105.51				
	CLOSED TREATMENT OF METATARSAL FRACTURE; WITH							
28475	MANIPULATION, EACH		\$119.07	\$150.45				
	PERCUTANEOUS SKELETAL FIXATION OF METATARSAL FRACTURE,							
28476	WITH MANIPULATI		\$193.76	\$193.76				
	OPEN TREATMENT OF METATARSAL FRACTURE, WITH OR WITHOUT							
28485	INTERNAL OR EXT		\$295.92	\$295.92				
	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR							
28490	PHALANGES; WITHOUT		\$44.14	\$56.21				
	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR							
28495	PHALANGES; WITH		\$61.61	\$76.63				
00.400	PERCUTANEOUS SKELETAL FIXATION OF FRACTURE GREAT TOE,		* 40 7 00	4.07.00				
28496	PHALANX OR PHALA		\$127.02	\$127.02				
00505	OPEN TREATMENT OF FRACTURE GREAT TOE, PHALANX OR		# 404.00	# 404.00				
28505	PHALANGES, WITH OR WI CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES,		\$194.82	\$194.82				
28510	OTHER THAN GREAT T		\$43.76	\$55.70				
20010	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES,		Φ43.76	φοο. <i>1</i> υ			_	
28515	OTHER THAN GREAT T		\$57.60	\$72.62				
20313	OPEN TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER		φυ1.00	ψ1 2.02				+
28525	THAN GREAT TOE		\$152.68	\$152.68				
28530	CLOSED TREATMENT OF SESAMOID FRACTURE		\$45.48	\$58.89				
23000	OPEN TREATMENT OF SESAMOID FRACTURE, WITH OR WITHOUT		ψ 10.40	Ψ00.00	+			+
28531	INTERNAL FIXATION		\$117.99	\$117.99				
	CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN		7	+ 111100				
28540	TALOTARSAL; WI		\$64.96	\$73.01				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
28545	TALOTARSAL:		\$102.80	\$102.80				
20040	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE		\$102.00	\$102.00				
28546	DISLOCATION, OTHER THAN		\$169.23	\$169.23				
20040	OPEN TREATMENT OF TARSAL BONE DISLOCATION, WITH OR		\$109.23	\$109.23				
28555	WITHOUT INTERNAL OR		\$338.77	\$338.77				
20000	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION;		φ330. <i>I I</i>	φ330.11				
28570	WITHOUT ANESTHESIA		\$71.23	\$92.55				
20370	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION;		φ/ 1.23	φ92.00				
28575	REQUIRING ANESTHESIA		\$169.89	\$169.89				
20373	PERCUTANEOUS SKELETAL FIXATION OF TALOTARSAL JOINT		\$109.09	φ109.09				
28576	DISLOCATION, WITH		\$194.54	\$194.54				
20370	OPEN TREATMENT OF TALOTARSAL JOINT DISLOCATION, WITH OR		φ194.54	φ194.54				
28585	WITHOUT INTERN		\$365.30	\$365.30				
20303	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION;		φ303.30	φ303.30				
28600	WITHOUT ANESTHE		\$62.71	\$71.83				
20000	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION;		ψ02.71	ψ11.00				
28605	REQUIRING ANEST		\$139.89	\$139.89				
20003	PERCUTANEOUS SKELETAL FIXATION OF TARSOMETATARSAL JOINT		ψ109.09	ψ109.09				
28606	DISLOCATION, W		\$238.43	\$238.43				
20000	OPEN TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION,		Ψ200.40	Ψ200.40				
28615	WITH OR WITHOUT		\$302.23	\$302.23				
20010	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT		Ψ002.20	ψ302.20				
28630	DISLOCATION; WITHOUT		\$64.90	\$78.72				
20000	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT		ψ04.00	ψ10.12				
28635	DISLOCATION; REQUIRING		\$78.40	\$97.84				
_0000	Dieles, tion, tregonate		Ψ1 0.70	Ψ07.0-τ				<u> </u>

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Proc		DA. .	Inpat. Rate	Outpat. Rate	Tech.	Prof.		
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00000	PERCUTANEOUS SKELETAL FIXATION OF METATARSOPHALANGEAL		#457.00	0457.00				
28636	JOINT DISLOCATIO		\$157.22	\$157.22				
00045	OPEN TREATMENT OF METATARSOPHALANGEAL JOINT		001001	4040.04				
28645	DISLOCATION, WITH OR WITHO		\$212.34	\$212.34				
00000	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION;		#50.00	450.00				
28660	WITHOUT ANESTHE		\$52.98	\$52.98				
	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION;		A-70 00	***				
28665	REQUIRING ANEST		\$70.69	\$83.83				
00000	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT		# 450.00	450.00				
28666	DISLOCATION, W		\$150.28	\$150.28				
00075	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION,		# 400.07	0400.07				
28675	WITH OR WITHOUT		\$169.07	\$169.07				
28705	ARTHRODESIS; PANTALAR		\$879.94	\$879.94				
28715	ARTHRODESIS; TRIPLE		\$734.04	\$734.04				
28725	ARTHRODESIS; SUBTALAR		\$606.86	\$606.86				
00700	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR		\$504.54	0504.54				
28730	TRANSVERSE;		\$564.51	\$564.51				
00705	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR		Φ Γ ΩΩ Γ Ω	ΦE00 E0				
28735	TRANSVERSE; WIT		\$590.56	\$590.56				
00707	ARTHRODESIS, WITH TENDON LENGTHENING AND ADVANCEMENT,		φ 5 00.00	# 500.00				
28737	MIDTARSAL, TARSA		\$526.23	\$526.23				
00740	ADTUDODECIC MIDTADOAL OD TADOOMETATADOAL CINCLE ICINIT		фоо т оо	фоо т оо				
28740	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, SINGLE JOINT		\$337.29	\$337.29				<u> </u>
28750	ARTHRODESIS, GREAT TOE; METATARSOPHALANGEAL JOINT		\$302.59	\$302.59				
28755	ARTHRODESIS, GREAT TOE; INTERPHALANGEAL JOINT		\$241.37	\$241.37				
00700	ARTHRODESIS, WITH EXTENSOR HALLUCIS LONGUS TRANSFER TO		0004.44	0004.44				
28760	FIRST METATARSA		\$321.14	\$321.14				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
28800	AMPUTATION, FOOT; MIDTARSAL (EG, CHOPART TYPE PROCEDURE)		\$423.54	\$423.54				
28805	AMPUTATION, FOOT; TRANSMETATARSAL		\$420.46	\$420.46				
28810	AMPUTATION, METATARSAL, WITH TOE, SINGLE		\$285.37	\$285.37				
28820	AMPUTATION, TOE; METATARSOPHALANGEAL JOINT		\$184.84	\$184.84				
28825	AMPUTATION, TOE; INTERPHALANGEAL JOINT		\$166.18	\$166.18				
	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A							
28890	PHYSICIAN, REQU		\$161.86	\$254.74				
28899	UNLISTED PROCEDURE, FOOT OR TOES	R	\$0.00	\$0.00				
	APPLICATION OF HALO TYPE BODY CAST (SEE 20661-20663 FOR							
29000	INSERTION)		\$120.75	\$120.75				
29010	APPLICATION OF RISSER JACKET, LOCALIZER, BODY; ONLY		\$131.20	\$131.20				
	APPLICATION OF RISSER JACKET, LOCALIZER, BODY; INCLUDING							
29015	HEAD		\$109.98	\$141.23				
29035	APPLICATION OF BODY CAST, SHOULDER TO HIPS;		\$85.87	\$112.02				
	APPLICATION OF BODY CAST, SHOULDER TO HIPS; INCLUDING HEAD,							
29040	MINERVA TY		\$126.61	\$126.61				
	APPLICATION OF BODY CAST, SHOULDER TO HIPS; INCLUDING ONE							
29044	THIGH		\$126.53	\$126.53				
	APPLICATION OF BODY CAST, SHOULDER TO HIPS; INCLUDING BOTH							
29046	THIGHS		\$139.28	\$139.28				
29049	APPLICATION, CAST; FIGURE-OF-EIGHT		\$33.21	\$38.84				
29055	APPLICATION, CAST; SHOULDER SPICA		\$88.55	\$88.55				
29058	APPLICATION, CAST; PLASTER VELPEAU		\$58.06	\$58.06				
29065	APPLICATION, CAST; SHOULDER TO HAND (LONG ARM)		\$39.42	\$50.15				
29075	APPLICATION, CAST; ELBOW TO FINGER (SHORT ARM)		\$33.21	\$41.39				
29085	APPLICATION, CAST; HAND AND LOWER FOREARM (GAUNTLET)		\$34.18	\$40.88				
29086	APPLICATION, CAST; FINGER (EG, CONTRACTURE)		\$32.50	\$40.50				

Physician	Fee Schedule 2020							
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Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech.	Prof.	Base Unit Value	Notes
29105	APPLICATION OF LONG ARM SPLINT (SHOULDER TO HAND)	171110	\$34.18	\$40.88	- Comp.	- Comp.	Value	110100
			70.110	7 10100				
29125	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); STATIC		\$23.49	\$28.45				
29126	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); DYNAMIC		\$29.42	\$34.78				
29130	APPLICATION OF FINGER SPLINT; STATIC		\$17.44	\$19.72				
29131	APPLICATION OF FINGER SPLINT; DYNAMIC		\$22.83	\$28.06				
29200	STRAPPING; THORAX		\$23.42	\$27.04				
29240	STRAPPING; SHOULDER (EG, VELPEAU)		\$28.80	\$28.80				
29260	STRAPPING; ELBOW OR WRIST		\$19.95	\$23.04				
29280	STRAPPING; HAND OR FINGER		\$18.27	\$21.08				
29305	APPLICATION OF HIP SPICA CAST; ONE LEG		\$117.53	\$117.53				
	APPLICATION OF HIP SPICA CAST; ONE AND ONE-HALF SPICA OR							
29325	BOTH LEGS		\$126.92	\$126.92				
29345	APPLICATION OF LONG LEG CAST (THIGH TO TOES);		\$58.65	\$72.33				
	APPLICATION OF LONG LEG CAST (THIGH TO TOES); WALKER OR							
29355	AMBULATORY TYP		\$63.78	\$78.53				
29358	APPLICATION OF LONG LEG CAST BRACE		\$74.66	\$99.33				
29365	APPLICATION OF CYLINDER CAST (THIGH TO ANKLE)		\$49.56	\$61.09				
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);		\$38.75	\$49.34				
	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);							
29425	WALKING OR AMBULAT		\$46.05	\$59.06				
29435	APPLICATION OF PATELLAR TENDON BEARING (PTB) CAST		\$54.82	\$70.65				
29440	ADDING WALKER TO PREVIOUSLY APPLIED CAST		\$20.54	\$23.62				
29445	APPLICATION OF RIGID TOTAL CONTACT LEG CAST		\$104.63	\$104.63				
	APPLICATION OF CLUBFOOT CAST WITH MOLDING OR							
29450	MANIPULATION, LONG OR SHO		\$36.13	\$41.36	1			
29505	APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES)		\$37.24	\$37.24				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
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D			In a Date	0	-	D	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)		\$29.18	\$35.49				
29520	STRAPPING; HIP		\$21.40	\$26.23				
29530	STRAPPING; KNEE		\$22.63	\$27.33				
29540	STRAPPING; ANKLE AND/OR FOOT		\$19.72	\$23.74				
29550	STRAPPING; TOES		\$18.28	\$22.03				
29580	STRAPPING; UNNA BOOT		\$28.29	\$38.89				
29581	APPLICATION OF MULTI-LAYER VENOUS WOUND COMPRESSION		\$24.28	\$62.81				
29582	THIGH AND LEG, INCLUDING ANKLE AND FOOT, WHEN PERFORMED		\$12.63	\$53.98				
29584	UPPER ARM, FOREARM, HAND, AND FINGERS	+	\$12.63	\$53.98	+			
29700	REMOVAL OR BIVALVING; GAUNTLET, BOOT OR BODY CAST		\$31.33	\$35.62				
29700	REMOVAL OR BIVALVING, GAUNTLET, BOOT OR BODY CAST		\$38.77	\$43.47				
29705	REMOVAL OR BIVALVING, FULL ARM OR FULL LEG CAST REMOVAL OR BIVALVING; SHOULDER OR HIP SPICA, MINERVA, OR		φ30.//	\$43.47				
20740	RISSER JACKET		\$47.06	ΦE2 00				
29710 29720	REPAIR OF SPICA, BODY CAST OR JACKET		\$24.01	\$53.09 \$27.09				
29720	WINDOWING OF CAST		\$24.01	\$27.09				
	WEDGING OF CAST (EXCEPT CLUBFOOT CASTS)		\$39.42	\$44.52				
29740				\$52.08				
29750 29799	WEDGING OF CLUBFOOT CAST UNLISTED PROCEDURE, CASTING OR STRAPPING	Ь	\$45.38 \$43.50	\$52.08				
		R		\$273.67				
29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC,	1	\$273.67		+	-		+
29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL	 	\$544.32	\$544.32				
29805	ARTHROSCOPY, SHOULDER, DIAGNOSTIC	 	\$273.62	\$273.62				
29806	ARTHROSCOPY, SHOULDER, SURGICAL; CAPSULORRHAPHY		\$756.24	\$756.24				
29807	ARTHROSCOPY, SHOULDER, SURGICAL; REPAIR OF SLAP LESION		\$735.75	\$735.75				
	ARTHROSCOPY, SHOULDER, SURGICAL; WITH REMOVAL OF LOOSE							
29819	BODY OR FOREIGN		\$508.71	\$508.71				
29820	ARTHROSCOPY, SHOULDER, SURGICAL		\$475.75	\$475.75				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
29821	ARTHROSCOPY, SHOULDER, SURGICAL; SYNOVECTOMY, COMPLETE		\$524.59	\$524.59				
29822	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED		\$496.95	\$496.95				
			V 100100	Ų 100100				
29823	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, EXTENSIVE		\$557.11	\$557.11				
	ARTHROSCOPY, SHOULDER, SURGICAL; DISTAL CLAVICULECTOMY		7001111	7				
29824	INCLUDING DISTA		\$459.49	\$459.49				
	ARTHROSCOPY, SHOULDER, SURGICAL; WITH LYSIS AND		V 100110	Ų 100110				
29825	RESECTION OF ADHESIONS		\$516.49	\$516.49				
	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF		+	70.00.00				
29826	SUBACROMIAL SPACE WI		\$610.22	\$610.22				
	ARTHROSCOPY, SHOULDER, SURGICAL; WITH ROTATOR CUFF		+ + + + + + + + + + + + + + + + + + + 	V				
29827	REPAIR		\$787.23	\$787.23				
29828	ARTHIROSCOPY BICEPS TENIDESIS		\$692.79	\$692.79				
	ARTHROSCOPY, ELBOW, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL		700=110	7 0 0 0 0 0				
29830	BIOPSY (SEPAR		\$328.06	\$328.06				
	ARTHROSCOPY, ELBOW, SURGICAL; WITH REMOVAL OF LOOSE		70000	70-0100				
29834	BODY OR FOREIGN BO		\$359.84	\$359.84				
29835	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, PARTIAL		\$371.54	\$371.54		1		
						1		
29836	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, COMPLETE		\$432.76	\$432.76				
29837	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, LIMITED		\$394.61	\$394.61				
29838	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, EXTENSIVE		\$434.52	\$434.52				
	ARTHROSCOPY, WRIST, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL		7.02	7.0		+		
29840	BIOPSY (SEPAR		\$259.53	\$259.53				
200 10	ARTHROSCOPY, WRIST, SURGICAL; FOR INFECTION, LAVAGE AND		Ψ <u>2</u> 00.00	Ψ200.00		+		
20843			\$344 27	\$344.27				
29843	ARTHROSCOPY, WRIST, SURGICAL; FOR INFECTION, LAVAGE AND DRAINAGE		\$344.27	\$344.27				

	ee Schedule 2020							
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Codes liste	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	9				
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please use	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
,							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, PARTIAL		\$355.54	\$355.54				
	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, COMPLETE		\$431.08	\$431.08				
	ARTHROSCOPY, WRIST, SURGICAL; EXCISION AND/OR REPAIR OF							
29846	TRIANGULAR		\$473.77	\$473.77				
	ARTHROSCOPY, WRIST, SURGICAL; INTERNAL FIXATION FOR							
	FRACTURE OR INSTAB		\$408.77	\$408.77				
	ENDOSCOPY, WRIST, SURGICAL, WITH RELEASE OF TRANSVERSE							
	CARPAL LIGAMENT		\$236.88	\$236.88				
	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR			4-10.1-				
	SPINE(S) AND/OR		\$412.51	\$549.17				
	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR		****	#200.05				
	SPINE(S) AND/OR		\$699.25	\$699.25				
	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE,		0007.44	0007.44				
	PROXIMAL (PLATEAU		\$637.41	\$637.41				
	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE,		Ф740 O4	\$748.91				
	PROXIMAL (PLATEAU ARTHROSCOPY, HIP, DIAGNOSTIC WITH OR WITHOUT SYNOVIAL		\$748.91	\$748.91	1			
	BIOPSY (SEPARATE		\$375.33	\$375.33				
	ARTHROSCOPY, HIP, SURGICAL; WITH REMOVAL OF LOOSE BODY	_	φ3/3.33	φ3/3.33				
	OR FOREIGN BODY		\$547.74	\$547.74				
	ARTHROSCOPY, HIP, SURGICAL; WITH DEBRIDEMENT/SHAVING OF		ψυτιιτ	ψ0+1.1+				
	ARTICULAR CART		\$601.41	\$601.41				
	ARTHROSCOPY, HIP, SURGICAL; WITH SYNOVECTOMY	+	\$552.29	\$552.29	+			+
	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL	+	Ψ002.20	¥002.20	+	+		+
	AUTOGRAFT(S) (EG, MOSAICPLA		\$763.08	\$763.08				
	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL ALLOGRAFT		T- 00.00	+,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
29867	(EG, MOSAICPLASTY		\$913.20	\$913.20				

Physician	Fee Schedule 2020							1
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	,				1
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROSCOPY, KNEE, SURGICAL; MENISCAL TRANSPLANTATION		•	,		-		
29868	(INCLUDES ARTHRO		\$1,240.49	\$1,240.49				
	ARTHROSCOPY, KNEE, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL							
29870	BIOPSY (SEPARA		\$268.33	\$268.33				
	ARTHROSCOPY, KNEE, SURGICAL; FOR INFECTION, LAVAGE AND							
29871	DRAINAGE		\$389.48	\$389.48				
29873	ARTHROSCOPY, KNEE, SURGICAL; WITH LATERAL RELEASE		\$360.23	\$360.23				
	ARTHROSCOPY, KNEE, SURGICAL; FOR REMOVAL OF LOOSE BODY							
29874	OR FOREIGN BODY		\$469.26	\$469.26				
	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, LIMITED (EG,							
29875	PLICA OR SHELF		\$431.23	\$431.23				
	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, MAJOR, TWO OR							
29876	MORE COMPARTME		\$525.51	\$525.51				
	ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF							
29877	ARTICULAR CARTILAG		\$493.05	\$493.05				
	ARTHROSCOPY, KNEE, SURGICAL; ABRASION ARTHROPLASTY							
29879	(INCLUDES CHONDROPL		\$538.89	\$538.89				
	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL							
29880	AND LATERAL,		\$568.94	\$568.94				
	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL							
29881	OR LATERAL,		\$519.01	\$519.01				
	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL							
29882	OR LATERAL)		\$570.66	\$570.66				
	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL							
29883	AND LATERAL)		\$641.12	\$641.12				
	ARTHROSCOPY, KNEE, SURGICAL; WITH LYSIS OF ADHESIONS, WITH							
29884	OR WITHOUT		\$478.61	\$478.61				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	es in Red;							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR							
29885	OSTEOCHONDRITIS DISSECANS WI		\$506.78	\$506.78				
	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT							
29886	OSTEOCHONDRITIS DISSE		\$418.82	\$418.82				
	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT							
29887	OSTEOCHONDRITIS DISSE		\$575.48	\$575.48				
	ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT							
29888	REPAIR/AUGMENTATION		\$922.93	\$922.93				
	ARTHROSCOPICALLY AIDED POSTERIOR CRUCIATE LIGAMENT							
29889	REPAIR/ AUGMENTATIO		\$631.75	\$631.75				
	ARTHROSCOPY, ANKLE, SURGICAL, EXCISION OF OSTEOCHONDRAL							
29891	DEFECT OF TALU		\$513.66	\$513.66				
	ARTHROSCOPICALLY AIDED REPAIR OF LARGE OSTEOCHONDRITIS							
29892	DISSECANS LESIO		\$530.95	\$530.95				
29893	ENDOSCOPIC PLANTAR FASCIOTOMY		\$295.86	\$295.86				
	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS),		470.07	470.07				
29894	SURGICAL; WITH		\$478.37	\$478.37				
00005	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS),		040404	0.40.4.0.4				
29895	SURGICAL;		\$464.84	\$464.84				
00007	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS),		# 400.74	0.400.74				
29897	SURGICAL;		\$483.71	\$483.71			4	
20000	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS),		ф <i>Б</i> Б7 77	ф <i>ББ</i> 7 77				
29898	SURGICAL;		\$557.77	\$557.77				
20000	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS),		¢700.04	¢700.04				
29899	SURGICAL; WITH ARTHROSCOPY, METACARPOPHALANGEAL JOINT, DIAGNOSTIC,		\$722.91	\$722.91				+
20000			#22F 00	#22E 00				
29900	INCLUDES SYNOVIAL		\$325.00	\$325.00				

Physician	n Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	ornary orial	T Total the service					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ne					
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Proc	Due codure Decembries	DA los d	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit Value	Notes
Code	Procedure Description ARTHROSCOPY, METACARPOPHALANGEAL JOINT, SURGICAL; WITH	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
29901	DEBRIDEMENT		\$358.76	\$358.76				
29901	ARTHROSCOPY, METACARPOPHALANGEAL JOINT, SURGICAL; WITH		φ330.70	φ330.70				
29902	REDUCTION OF		\$385.42	\$385.42				
29902	SUBTALAR ARTHO W/FB RMVL		\$464.04	\$464.04	+		_	
29904	SUBTALAR ARTHRO W/SYNOVECTOMY		\$499.64	\$499.64	+		_	
29905	SUBTALAR ARTHRO W/STNOVECTOWT		\$526.35	\$526.35			_	
29906	SUBTALAR ARTHRO W/DEB		\$645.92	\$645.92			_	
29907	ARTHROSCOPY, HIP, SURGICAL; WITH FEMOROPLASTY		\$899.59	\$899.59			_	
29915	ARTHROSCOPY, HIP, SURGICAL, WITH ACETABULOPLASTY		\$916.51	\$916.51	+		_	
29916	ARTHROSCOPY, HIP, SURGICAL; WITH LABRAL REPAIR		\$916.51	\$916.51	+		_	
29999	UNLISTED PROCEDURE, ARTHROSCOPY	R	\$0.00	\$0.00	+		_	
29999	UNLISTED PROCEDURE, ARTHROSCOPT	K	φυ.υυ	φυ.υυ			_	
30000	DRAINAGE ABSCESS OR HEMATOMA, NASAL, INTERNAL APPROACH		\$49.49	\$57.27				
30020	DRAINAGE ABSCESS OR HEMATOMA, NASAL SEPTUM		\$50.00	\$58.05				
30100	BIOPSY, INTRANASAL		\$38.78	\$48.03				
30110	EXCISION, NASAL POLYP(S), SIMPLE		\$67.06	\$84.36				
30115	EXCISION, NASAL POLYP(S), EXTENSIVE		\$207.37	\$207.37				
	EXCISION OR DESTRUCTION (EG, LASER), INTRANASAL LESION;							
30117	INTERNAL APPRO		\$173.50	\$173.50				
	EXCISION OR DESTRUCTION (EG, LASER), INTRANASAL LESION;							
30118	EXTERNAL APPRO		\$508.04	\$508.04				
	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR							
30120	RHINOPHYMA	R	\$351.88	\$351.88				
30124	EXCISION DERMOID CYST, NOSE; SIMPLE, SKIN, SUBCUTANEOUS		\$109.89	\$127.86				
30125	EXCISION DERMOID CYST, NOSE; COMPLEX, UNDER BONE OR CARTILAGE		\$365.84	\$365.84				

Physician	Fee Schedule 2020							
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Refer to 0	CPT book for descriptions							
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The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION INFERIOR TURBINATE, PARTIAL OR COMPLETE, ANY							
30130	METHOD		\$141.94	\$141.94				
	SUBMUCOUS RESECTION INFERIOR TURBINATE, PARTIAL OR							
30140	COMPLETE, ANY METHO		\$186.05	\$186.05				
30150	RHINECTOMY; PARTIAL		\$487.26	\$487.26				
30160	RHINECTOMY; TOTAL		\$610.09	\$610.09				
30200	INJECTION INTO TURBINATE(S), THERAPEUTIC		\$33.78	\$33.78				
30210	DISPLACEMENT THERAPY (PROETZ TYPE)		\$34.44	\$37.93				
30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)		\$67.86	\$88.11				
20200	DEMOVAL FOREIGN DODY INTRANACAL OFFICE TYPE PROCEDURE		# 20 40	£40.00				
30300	REMOVAL FOREIGN BODY, INTRANASAL; OFFICE TYPE PROCEDURE REMOVAL FOREIGN BODY, INTRANASAL; REQUIRING GENERAL		\$36.43	\$42.60				
30310	ANESTHESIA		\$103.87	\$103.87				
30310	ANESTRESIA		\$103.0 <i>1</i>	\$103.07				
30320	REMOVAL FOREIGN BODY, INTRANASAL; BY LATERAL RHINOTOMY		\$254.33	\$254.33				
30320	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR		φ254.55	φ254.55				
30400	ELEVATION OF	R	\$571.59	\$571.59				
30400	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING	11	ψ011.00	ψ07 1.00				
30410	BONY PYRAMID.	R	\$802.40	\$802.40				
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR	R	\$982.73	\$982.73				
00120	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF		Ψ002.70	Ψ002.70				
30430	NASAL TIP WORK	R	\$376.86	\$376.86				
	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK	-	,	Ţ - : - : - · ·				
30435	WITH OSTEOTOM	R	\$629.04	\$629.04				
	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK							
30450	AND OSTEOTOMIES	R	\$853.53	\$853.53				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO							
30460	CONGENITAL CLEFT LIP AND/		\$530.91	\$530.91				
	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO							
30462	CONGENITAL CLEFT LIP AND/	R	\$1,062.64	\$1,062.64				
	REPAIR OF NASAL VESTIBULAR STENOSIS (EG, SPREADER							
30465	GRAFTING, LATERAL NA		\$590.90	\$590.90				
	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT							
30520	CARTILAGE SCORING,		\$376.62	\$376.62				
30540	REPAIR CHOANAL ATRESIA; INTRANASAL		\$413.74	\$413.74				
30545	REPAIR CHOANAL ATRESIA; TRANSPALATINE		\$632.63	\$632.63				
30560	LYSIS INTRANASAL SYNECHIA		\$44.34	\$51.72				
	REPAIR FISTULA; OROMAXILLARY (COMBINE WITH 31030 IF							
30580	ANTROTOMY IS INCLU		\$422.43	\$422.43				
30600	REPAIR FISTULA; ORONASAL		\$282.11	\$282.11				
	SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT							
30620	INCLUDE OBTAINING G		\$380.02	\$380.02				
30630	REPAIR NASAL SEPTAL PERFORATIONS		\$385.04	\$385.04				
	CAUTERY AND/OR ABLATION, MUCOSA OF INFERIOR TURBINATES,							
30801	UNILATERAL OR		\$37.45	\$43.75				
	CAUTERY AND/OR ABLATION, MUCOSA OF INFERIOR TURBINATES,							
30802	UNILATERAL OR		\$85.99	\$85.99				
	CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED							
30901	CAUTERY AND/OR PAC		\$44.47	\$51.98				
	CONTROL NASAL HEMORRHAGE, ANTERIOR, COMPLEX (EXTENSIVE							
30903	CAUTERY AND/OR		\$69.93	\$69.93				
	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR							
30905	NASAL PACKS AND/OR		\$109.95	\$109.95				

Physician	Fee Schedule 2020							
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	les in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR							
30906	NASAL PACKS AND/OR		\$103.53	\$103.53				
30915	LIGATION ARTERIES; ETHMOIDAL		\$342.59	\$342.59				
30920	LIGATION ARTERIES; INTERNAL MAXILLARY ARTERY, TRANSANTRAL		\$506.86	\$506.86				
30930	FRACTURE NASAL INFERIOR TURBINATE(S), THERAPEUTIC		\$56.49	\$56.49				
30999	UNLISTED PROCEDURE, NOSE	R	\$112.50	\$150.00				
	LAVAGE BY CANNULATION; MAXILLARY SINUS (ANTRUM PUNCTURE							
31000	OR NATURAL OST		\$39.26	\$45.03				
31002	LAVAGE BY CANNULATION; SPHENOID SINUS		\$61.96	\$68.13				
31020	SINUSOTOMY, MAXILLARY (ANTROTOMY); INTRANASAL		\$160.85	\$160.85				
	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC)							
31030	WITHOUT REMO		\$377.27	\$377.27				
	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC)							
31032	WITH REMOVAL		\$420.07	\$420.07				
31040	PTERYGOMAXILLARY FOSSA SURGERY, ANY APPROACH		\$494.04	\$494.04				
31050	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY;		\$324.18	\$324.18				
	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY; WITH							
31051	MUCOSAL STRIPPING O		\$439.45	\$439.45				
31070	SINUSOTOMY FRONTAL; EXTERNAL, SIMPLE (TREPHINE OPERATION)		\$256.49	\$256.49				
	SINUSOTOMY FRONTAL; TRANSORBITAL, UNILATERAL (FOR							
31075	MUCOCELE OR OSTEOMA,		\$560.10	\$560.10				
	SINUSOTOMY FRONTAL; OBLITERATIVE WITHOUT OSTEOPLASTIC							
31080	FLAP, BROW INCIS		\$589.10	\$589.10				
	SINUSOTOMY FRONTAL; OBLITERATIVE, WITHOUT OSTEOPLASTIC							
31081	FLAP, CORONAL		\$658.46	\$658.46				

Physician	Fee Schedule 2020							T
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv char	ae for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP,							
31084	BROW INCISIO		\$808.43	\$808.43				
	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP,							
31085	CORONAL INCI		\$855.14	\$855.14				
	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC							
31086	FLAP, BROW INCI		\$671.03	\$671.03				
	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC							
31087	FLAP, CORONAL		\$667.23	\$667.23				
	SINUSOTOMY, UNILATERAL, THREE OR MORE PARANASAL SINUSES							
31090	(FRONTAL,		\$608.96	\$608.96				
31200	ETHMOIDECTOMY; INTRANASAL, ANTERIOR		\$272.91	\$272.91				
31201	ETHMOIDECTOMY; INTRANASAL, TOTAL		\$438.35	\$438.35				
31205	ETHMOIDECTOMY; EXTRANASAL, TOTAL		\$518.23	\$518.23				
31225	MAXILLECTOMY; WITHOUT ORBITAL EXENTERATION		\$1,024.73	\$1,024.73				
31230	MAXILLECTOMY; WITH ORBITAL EXENTERATION (EN BLOC)		\$1,261.34	\$1,261.34				
	NASAL ENDOSCOPY, DIAGNOSTIC, UNILATERAL OR BILATERAL							
31231	(SEPARATE PROCEDU		\$72.67	\$72.67				
	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH MAXILLARY							
31233	SINUSOSCOPY (VIA INFE		\$106.31	\$199.96				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH SPHENOID							
31235	SINUSOSCOPY (VIA PUNCT		\$125.95	\$228.42				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH BIOPSY,							
31237	POLYPECTOMY OR DEBRIDEME		\$144.86	\$144.86				
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONTROL OF NASAL							
31238	HEMORRHAGE		\$162.52	\$218.44				
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH							
31239	DACRYOCYSTORHINOSTOMY		\$569.91	\$569.91				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary cha	ge for the service	e				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONCHA BULLOSA							
31240	RESECTION		\$175.16	\$175.16				
31241	NSL/SINS NDSC W/ARTERY LIG		\$355.09	\$355.09				Added Effective 1/1/2018
31253	NSL/SINS NDSC TOTAL		\$398.20	\$398.20				Added Effective 1/1/2018
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY,							
31254	PARTIAL (ANTERIOR		\$312.80	\$312.80				
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY,							
31255	TOTAL (ANTERIOR A		\$470.91	\$470.91				
	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY							
31256	ANTROSTOMY;		\$207.62	\$207.62				
31257	NSL/SINS NDSC TOT W/SPHENDT		\$354.45	\$354.45				Added Effective 1/1/2018
31259	NSL/SINS NDSC SPHN TISS RMVL		\$375.75	\$375.75				Added Effective 1/1/2018
	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY							
31267	ANTROSTOMY; WITH REMOV		\$320.18	\$320.18				
	NASAL/SINUS ENDOSCOPY, SURGICAL WITH FRONTAL SINUS							
31276	EXPLORATION, WITH O		\$457.67	\$457.67				
31287	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY;		\$265.20	\$265.20				
	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY;							
31288	WITH REMOVAL OF T		\$310.52	\$310.52				
	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH REPAIR OF							
31290	CEREBROSPINAL FLUID LE		\$863.15	\$863.15				
	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH REPAIR OF							
31291	CEREBROSPINAL FLUID LE		\$906.69	\$906.69				
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH MEDIAL OR INFERIOR							
31292	ORBITAL WALL		\$786.12	\$786.12				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH MEDIAL ORBITAL WALL							
31293	AND INFERIOR		\$850.35	\$850.35				Updated Effective 01/01/2020

Physician	n Fee Schedule 2020							T
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH OPTIC NERVE							
31294	DECOMPRESSION		\$974.74	\$974.74				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF							
31295	MAXILLARY SINUS OSTIUM		\$125.55	\$1,397.22				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF FRONTAL							
31296	SINUS OSTIUM		\$143.11	\$1,417.38				Updated Effective 01/01/2020
	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF							
31297	SPHENOID SINUS OSTIUM		\$114.36	\$1,385.52				Updated Effective 01/01/2020
31298	NSL/SINS NDSC W/SINS DILAT		\$204.23	\$2,662.75				Updated Effective 01/01/2020
31299	UNLISTED PROCEDURE, ACCESSORY SINUSES	R	\$0.00	\$0.00		+		opuated Encouve on on 2020
01200	LARYNGOTOMY (THYROTOMY, LARYNGOFISSURE); WITH REMOVAL	1	ψ0.00	ψ0.00				+
31300	OF TUMOR OR		\$731.38	\$731.38				
31360	LARYNGECTOMY; TOTAL, WITHOUT RADICAL NECK DISSECTION		\$1,018.21	\$1,018.21				
31365	LARYNGECTOMY; TOTAL, WITH RADICAL NECK DISSECTION		\$1,443.84	\$1,443.84				
	LARYNGECTOMY; SUBTOTAL SUPRAGLOTTIC, WITHOUT RADICAL		, ,	,				
31367	NECK DISSECTION		\$1,064.49	\$1,064.49				
	LARYNGECTOMY; SUBTOTAL SUPRAGLOTTIC, WITH RADICAL NECK		. ,	. ,				
31368	DISSECTION		\$1,488.14	\$1,488.14				
31370	PARTIAL LARYNGECTOMY (HEMILARYNGECTOMY); HORIZONTAL		\$1,049.34	\$1,049.34				
31375	PARTIAL LARYNGECTOMY (HEMILARYNGECTOMY); LATEROVERTICAL		\$978.80	\$978.80				
0.4000			* • • • • • • • • • • • • • • • • • • •	04.054.75				
31380	PARTIAL LARYNGECTOMY (HEMILARYNGECTOMY); ANTERO LATERO		\$1,051.75	\$1,051.75				
31382	PARTIAL LARYNGECTOMY (HEMILARYNGECTOMY); ANTERO-LATERO- VERTICAL		\$1,016.87	\$1,016.87				
31302	VENTIOAL	1	φι,υισ.ο/	φ1,010.0 <i>1</i>				

Physician	Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0.4000	PHARYNGOLARYNGECTOMY, WITH RADICAL NECK DISSECTION;							
31390	WITHOUT RECONSTRUC		\$1,445.36	\$1,445.36				
04005	PHARYNGOLARYNGECTOMY, WITH RADICAL NECK DISSECTION;		4.774.00	A 774 00				
31395	WITH RECONSTRUCTIO		\$1,774.98	\$1,774.98				
31400	ARYTENOIDECTOMY OR ARYTENOIDOPEXY, EXTERNAL APPROACH		\$497.44	\$497.44				
31420	EPIGLOTTIDECTOMY	+	\$502.98	\$502.98	+			+
31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE		\$102.35	\$102.35				
01000	TRACHEOTOMY TUBE CHANGE PRIOR TO ESTABLISHMENT OF		Ψ102.00	Ψ102.00				
31502	FISTULA TRACT		\$36.33	\$36.33				
01002	I TO TO LEAT THE ACT		Ψ00.00	Ψ00.00				
31505	LARYNGOSCOPY, INDIRECT; DIAGNOSTIC (SEPARATE PROCEDURE)		\$24.88	\$30.65				
31510	LARYNGOSCOPY, INDIRECT; WITH BIOPSY		\$72.79	\$72.79				
31511	LARYNGOSCOPY, INDIRECT; WITH REMOVAL OF FOREIGN BODY		\$91.56	\$91.56				
31512	LARYNGOSCOPY, INDIRECT; WITH REMOVAL OF LESION		\$113.61	\$113.61				
31513	LARYNGOSCOPY, INDIRECT; WITH VOCAL CORD INJECTION		\$142.74	\$142.74				
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; FOR							
31515	ASPIRATION		\$86.53	\$86.53				
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY;							
31520	DIAGNOSTIC, NEWBORN		\$123.48	\$123.48				
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY;							
31525	DIAGNOSTIC, EXCEPT		\$112.27	\$141.77				
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY;							
31526	DIAGNOSTIC, WITH		\$172.89	\$172.89				
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY;							
31527	WITH INSERTION OF		\$183.44	\$183.44				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY;							
31528	WITH DILATION, INIT		\$148.18	\$148.18				
31529	LARYNGOSCOPY DIRECT		\$150.70	\$150.70				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY							
31530	REMOVAL;		\$206.31	\$206.31				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY							
31531	REMOVAL; WITH OPERA		\$252.24	\$252.24				
31535	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY;		\$211.22	\$211.22				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY; WITH							
31536	OPERATING MICROSCOP		\$216.25	\$216.25				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR							
31540	AND/ OR STRIPP		\$277.90	\$277.90				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR							
31541	AND/ OR STRIPP		\$244.99	\$244.99				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH OPERATING							
31545	MICROSCOPE OR TELESCOP		\$285.05	\$285.05				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH OPERATING							
31546	MICROSCOPE OR TELESCOP		\$435.71	\$435.71				
31551	LARYNGOPLASTY LARYNGEAL STEN		\$1,132.05	\$1,132.05				Added Effective 1/1/2017
31552	LARYNGOPLASTY LARYNGEAL STEN		\$1,140.36	\$1,140.36				Added Effective 1/1/2017
31553	LARYNGOPLASTY LARYNGEAL STEN		\$1,242.13	\$1,242.13				Added Effective 1/1/2017
31554	LARYNGOPLASTY LARYNGEAL STEN		\$1,303.99	\$1,303.99				Added Effective 1/1/2017
31560	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY;		\$306.45	\$306.45				
	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY;							
31561	WITH OPERATING	<u> </u>	\$338.20	\$338.20	<u> </u>			
31570	LARYNGOSCOPY, DIRECTC;		\$194.52	\$260.91				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0.455.4	LARYNGOSCOPY, DIRECT, WITH INJECTION INTO VOCAL CORD(S),		4044.00	004400				
31571	THERAPEUTIC;		\$241.02	\$241.02				
31572	LARGSC W/LASER DSTRJ LES		\$145.61	\$377.97				Added Effective 1/1/2017
31573	LARGSC W/THER INJECTION		\$119.98	\$203.94				Added Effective 1/1/2017
31574	LARGSC W/NJX AUGMENTATION		\$119.98	\$766.12				Added Effective 1/1/2017
31575	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; DIAGNOSTIC		\$58.04	\$58.04				
31576	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH BIOPSY		\$133.42	\$133.42				
	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF							
31577	FOREIGN BODY		\$166.23	\$166.23				
31578	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF LESION		\$192.36	\$192.36				
	LARYNGOSCOPY, FLEXIBLE OR RIGID FIBEROPTIC, WITH							
31579	STROBOSCOPY		\$103.88	\$135.13				
	LARYNGOPLASTY; FOR LARYNGEAL WEB, TWO STAGE, WITH KEEL							
31580	INSERTION AND		\$740.60	\$740.60				
31584	LARYNGOPLASTY; WITH OPEN REDUCTION OF FRACTURE		\$916.59	\$916.59				
31587	LARYNGOPLASTY, CRICOID SPLIT		\$446.74	\$446.74				
31590	LARYNGEAL REINNERVATION BY NEUROMUSCULAR PEDICLE		\$356.18	\$356.18				
31591	LARYNGOPLASTY MEDIALIZATION		\$821.93	\$821.93				Added Effective 1/1/2017
31592	CRICOTRACHEAL RESECTION		\$1,340.46	\$1,340.46				Added Effective 1/1/2017
31599	UNLISTED PROCEDURE, LARYNX	R	\$354.50	\$460.85				
31600	TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);		\$230.38	\$230.38				
	TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE); UNDER TWO							
31601	YEARS		\$281.53	\$281.53				
31603	TRACHEOSTOMY, EMERGENCY PROCEDURE; TRANSTRACHEAL		\$251.27	\$251.27				
	TRACHEOSTOMY, EMERGENCY PROCEDURE; CRICOTHYROID							
31605	MEMBRANE		\$229.58	\$229.58				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	1
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04040	TRACHEGOTOMY FENECTRATION PROCEDURE MUTULCIAN ELARG		# 400.40	# 400.40				
31610	TRACHEOSTOMY, FENESTRATION PROCEDURE WITH SKIN FLAPS		\$432.19	\$432.19				
04044	CONSTRUCTION OF TRACHEOESOPHAGEAL FISTULA AND		0045.07	A0 45 07				
31611	SUBSEQUENT INSERTION OF		\$345.87	\$345.87				
0.4040	TRACHEAL PUNCTURE, PERCUTANEOUS WITH TRANSTRACHEAL		004.00	404.00				
31612	ASPIRATION AND/OR		\$61.00	\$61.00				
31613	TRACHEOSTOMA REVISION; SIMPLE, WITHOUT FLAP ROTATION		\$190.50	\$190.50				
31614	TRACHEOSTOMA REVISION; COMPLEX, WITH FLAP ROTATION		\$377.81	\$377.81				
	TRACHEOBRONCHOSCOPY THROUGH ESTABLISHED							
31615	TRACHEOSTOMY INCISION		\$118.98	\$118.98				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31622	FLUOROSCOPIC GUIDANCE		\$186.18	\$186.18				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31623	FLUOROSCOPIC GUIDANCE		\$127.23	\$181.17				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31624	FLUOROSCOPIC GUIDANCE		\$128.64	\$182.84				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31625	FLUOROSCOPIC GUIDANCE		\$210.12	\$210.12				
31626	WITH PLACEMENT OF FIDUCIAL MARKERS, SINGLE OR MULTIPLE		\$161.11	\$310.89				
31627	WITH COMPUTER-ASSISTED, IMAGE-GUIDED NAVIGATION		\$78.26	\$829.71				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31628	FLUOROSCOPIC GUIDANCE		\$251.92	\$251.92				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31629	FLUOROSCOPIC GUIDANCE		\$222.75	\$222.75				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT					1		
31630	FLUOROSCOPIC GUIDANCE		\$224.02	\$224.02				
31631	BRONCHOSCOPY, RIGID OR FLEXIBLE,		\$245.57	\$245.57				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31632	FLUOROSCOPIC GUIDANCE		\$41.99	\$53.30				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31633	FLUOROSCOPIC GUIDANCE		\$52.65	\$65.75				
31634	BRONCHOSCOPY WITH BALLON OCCLUSION		\$180.39	\$1,575.18				
31635	BRONCHOSCOPY, RIGID OR FLEXIBLE		\$242.37	\$242.37				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31636	FLUOROSCOPIC GUIDANCE		\$180.52	\$180.52				
31637	BRONCHOSCOPY, RIGID OR FLEXIBLE		\$64.53	\$64.53				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31638	FLUOROSCOPIC GUIDANCE		\$200.75	\$200.75				
	BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT							
31640	FLUOROSCOPIC GUIDANCE		\$295.88	\$295.88				
	BRONCHOSCOPY, (RIGID OR FLEXIBLE); WITH DESTRUCTION OF							
31641	TUMOR OR RELIEF		\$341.25	\$341.25				
	BRONCHOSCOPY, (RIGID OR FLEXIBLE); WITH PLACEMENT OF							
31643	CATHETER(S) FOR		\$148.43	\$161.39				
	BRONCHOSCOPY, (RIGID OR FLEXIBLE); WITH THERAPEUTIC							
31645	ASPIRATION OF		\$197.11	\$197.11				
31646	BRONCHOSCOPY, (RIGID OR FLEXIBLE); WITH THERAPEUTIC		\$168.45	\$168.45				
	WITH EBUS (ULTRASOUND) GUIDED TRANSTRACHEAL							
31652	/TRANSBRONCHIAL ONE OR TWO MEDIASTINAL LUMPH NODES		\$191.54	\$681.82				Added Effective 1/1/2016
	WITH EBUS (ULTRASOUND) GUIDED TRANSTRACHEAL							
31653	/TRANSBRONCHIAL THREE OR MORE MEDIATINAL LYMPH NODES		\$211.44	\$725.26				Added Effective 1/1/2016
	WITH TRANSENDOSCOPIC ENDOBRONCHIAL DURING		 					
31654	BRONCHOSCOPIC DIAGNOSTIC THERAPEUTIC INTERVENTION(S)		\$55.47	\$84.97				Added Effective 1/1/2016

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	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
			l		_		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
31717	CATHETERIZATION WITH BRONCHIAL BRUSH BIOPSY		\$83.25	\$83.25				
31720	CATHETER ASPIRATION (SEPARATE PROCEDURE); NASOTRACHEAL		\$53.14	\$53.14				
0.4705	CATHETER ASPIRATION (SEPARATE PROCEDURE);			400.00				
31725	TRACHEOBRONCHIAL WITH FIBERS		\$98.98	\$98.98				
	TRANSTRACHEAL (PERCUTANEOUS) INTRODUCTION OF NEEDLE							
31730	WIRE DILATOR/ STEN		\$155.47	\$155.47				
31750	TRACHEOPLASTY; CERVICAL		\$530.22	\$530.22				
0.4===	TRACHEOPLASTY; TRACHEOPHARYNGEAL FISTULIZATION, EACH		4000 70	4000 70				
31755	STAGE		\$822.78	\$822.78				
31760	TRACHEOPLASTY; INTRATHORACIC		\$967.85	\$967.85				
31766	CARINAL RECONSTRUCTION		\$1,366.42	\$1,366.42				
31770	BRONCHOPLASTY; GRAFT REPAIR		\$1,075.36	\$1,075.36				
31775	BRONCHOPLASTY; EXCISION STENOSIS AND ANASTOMOSIS		\$1,135.69	\$1,135.69				
31780	EXCISION TRACHEAL STENOSIS AND ANASTOMOSIS; CERVICAL		\$988.97	\$988.97				
	EXCISION TRACHEAL STENOSIS AND ANASTOMOSIS;							
31781	CERVICOTHORACIC		\$1,151.86	\$1,151.86				
31785	EXCISION OF TRACHEAL TUMOR OR CARCINOMA; CERVICAL		\$741.29	\$741.29				
31786	EXCISION OF TRACHEAL TUMOR OR CARCINOMA; THORACIC		\$1,072.57	\$1,072.57				
31800	SUTURE OF TRACHEAL WOUND OR INJURY; CERVICAL		\$348.55	\$348.55				
31805	SUTURE OF TRACHEAL WOUND OR INJURY; INTRATHORACIC	<u> </u>	\$667.09	\$667.09				
	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA; WITHOUT		1,007.54	4007.54				
31820	PLASTIC REPAIR	1	\$227.51	\$227.51				
31825	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA	1	\$333.36	\$333.36				
31830	REVISION OF TRACHEOSTOMY SCAR	<u> </u>	\$233.38	\$233.38				
31899	UNLISTED PROCEDURE, TRACHEA, BRONCHI	R	\$0.00	\$0.00				
32035	THORACOSTOMY; WITH RIB RESECTION FOR EMPYEMA	1	\$403.89	\$403.89				
32036	THORACOSTOMY; WITH OPEN FLAP DRAINAGE FOR EMPYEMA	<u> </u>	\$445.15	\$445.15				

Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	Э				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	THORACOTOMY, WITH DIAGNOSTIC BIOPSY(IES) OF LUNG							
32096	INFILTRATES(S) (EG. WEDGE, INCISIONAL), UNILATERAL		\$656.11	\$656.11				
	THORACOTOMY, WITH DIAGNOSTIC BIOPSY(IES) OF LUNG							
32097	NODULE(S) OR MASS(ES) (EG. WEDGE, INCISIONAL), UNILATERAL		\$656.11	\$656.11				
32098	THORACOTOMY, WITH BIOPSY(IES) OF PLEURA		\$616.63	\$616.63				
32100	THORACOTOMY, MAJOR; WITH EXPLORATION AND BIOPSY		\$648.00	\$648.00				
	THORACOTOMY, MAJOR; WITH CONTROL OF TRAUMATIC							
32110	HEMORRHAGE AND/OR REPAIR		\$702.64	\$702.64				
32120	THORACOTOMY, MAJOR; FOR POSTOPERATIVE COMPLICATIONS		\$577.55	\$577.55				
	THORACOTOMY, MAJOR; WITH OPEN INTRAPLEURAL							
32124	PNEUMONOLYSIS		\$667.86	\$667.86				
00440	THORACOTOMY, MAJOR; WITH CYST(S) REMOVAL, WITH OR		474000	* = 40.00				
32140	WITHOUT A PLEURAL		\$746.82	\$746.82				
00444	THORACOTOMY, MAJOR; WITH EXCISION-PLICATION OF BULLAE,		4777 00	A777 00				
32141	WITH OR WITHOUT		\$777.66	\$777.66				
00450	THORACOTOMY, MAJOR; WITH REMOVAL OF INTRAPLEURAL		#000 00	# 000 00				
32150	FOREIGN BODY OR FIBRI		\$690.63	\$690.63			_	
20454	THORACOTOMY, MAJOR; WITH REMOVAL OF INTRAPULMONARY FOREIGN BODY		\$643.16	\$643.16				
32151 32160			\$491.04	\$491.04				
32100	THORACOTOMY, MAJOR; WITH CARDIAC MASSAGE		\$491.04	\$491.04				
32200	PNEUMONOSTOMY; WITH OPEN DRAINAGE OF ABSCESS OR CYST		\$591.80	\$591.80				
32200	PNEUMONOSTOMY, WITH OPEN DRAINAGE OF ABSCESS OR CYST		φυθ 1.00	φυθ1.00				+
32201	OR CYST		\$201.98	\$201.98				
32215	PLEURAL SCARIFICATION FOR REPEAT PNEUMOTHORAX		\$530.98	\$530.98	+			+
32220	DECORTICATION, PULMONARY (SEPARATE PROCEDURE); TOTAL		\$1,014.23	\$1,014.23	+			+
32220	DECORTION FULINIONART (SEPARATE PROCEDURE), TOTAL		φ1,014.23	φ1,014.23				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
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	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciai	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
32225	DECORTICATION, PULMONARY (SEPARATE PROCEDURE); PARTIAL		\$728.03	\$728.03				
32310	PLEURECTOMY, PARIETAL (SEPARATE PROCEDURE)		\$716.82	\$716.82				
32320	DECORTICATION AND PARIETAL PLEURECTOMY		\$1,130.02	\$1,130.02				
32400	BIOPSY, PLEURA; PERCUTANEOUS NEEDLE		\$94.26	\$94.26				
32405	BIOPSY, LUNG OR MEDIASTINUM, PERCUTANEOUS NEEDLE		\$117.87	\$117.87				
32440	REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;		\$1,146.00	\$1,146.00				
	REMOVAL OF LUNG, TOTAL PNEUMONECTOMY; WITH RESECTION OF							
32442	SEGMENT OF TRA		\$1,290.43	\$1,290.43				
32445	REMOVAL OF LUNG, TOTAL PNEUMONECTOMY; EXTRAPLEURAL		\$1,328.82	\$1,328.82				
	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE							
32480	LOBE (LOBECTOM		\$1,110.19	\$1,110.19				
	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; TWO						1	
32482	LOBES (BILOBECTOM		\$1,082.51	\$1,082.51				
	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE			,				
32484	SEGMENT		\$1,111.27	\$1,111.27				
	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; WITH			,				
32486	CIRCUMFERENTIAL		\$1,189.69	\$1,189.69				
32488	REMOVAL OF LUNG, OTHER THAN		\$1,276.17	\$1,276.17	1			
	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY;		<u> </u>	1	1			
32491	EXCISION-PLICATION OF		\$1,083.94	\$1,083.94				
	RESECTION AND REPAIR OF PORTION OF BRONCHUS			1	1			
32501	(BRONCHOPLASTY) WHEN PERFO		\$270.23	\$270.23				
	RESECTION OF APICAL LUNG TUMOR (EG, PANCOAST TUMOR),		1					
32503	INCLUDING CHEST W		\$1,388.84	\$1,388.84				
32000	RESECTION OF APICAL LUNG TUMOR (EG, PANCOAST TUMOR),		Ţ.,000.0 i	<i>ϕ 1,000.0</i> .		+	†	+
32504	INCLUDING CHEST W		\$1,590.47	\$1,590.47				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T		7				
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	sted on the lab fee schedule that begin with a P or Q are currently non-covered f		ne					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	THORACOTOMY; WITH THERAPEUTIC WEDGE RESECTION (EG,	FAIIIU	(i acility)	(Norm actinity)	Comp.	Comp.	Value	Notes
32505	MASS, NODULE), INITIAL		\$757.06	\$757.06				
02000	WITH THERAPEUTIC WEDGE RESECTION (EG, MASS OR NODULE),		Ψ131.00	Ψ101.00				
	EACH ADDITIONAL RESECTION, IPSILATERAL (LIST SEPARATELY IN							
32506	ADDITION TO CODE FOR PRIMARY PROCEDURE)		\$128.37	\$128.37				
32300	WITH DIAGNOSTIC WEDGE RESECTION FOLLOWED BY ANATOMIC		ψ120.51	ψ120.31				
	LUNG RESECTION (LIST SEPARATELY IN ADDITION TO CODE FOR							
32507	PRIMARY PROCEDURE)		\$128.37	\$128.37				
32301	TRIMART TROCEDORE)		ψ120.51	ψ120.31				
32540	EXTRAPLEURAL ENUCLEATION OF EMPYEMA (EMPYEMECTOMY)		\$753.39	\$753.39				
32550	INSET PLEURAL CATH		\$180.99	\$580.35				
32551	INSERTION OF CHEST TUBE		\$139.15	\$139.15				
			Ţ	7 1001110				
32552	REMOVAL OF INDWELLING TUNNELED PLEURAL CATHETER W/CUFF		\$118.88	\$133.43				
	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RAD THERAPY							
32553	GUIDANCE		\$154.55	\$419.41				
32554	THORACENTESIS, NEEDLE OR CATHETER, ASPIRATION		\$73.02	\$684.72				
32555	WITH IMAGING GUIDANCE		\$91.46	\$442.92				
32556	PLEURAL DRAINAGE, PERCUTANEOUS, WITH INSERTION		\$100.34	\$466.79				
32557	WITH IMAGING GUIDANCE		\$132.93	\$851.61				
32560	TREAT LUNG LINING CHEMICALLY		\$89.01	\$221.93				
	INSTILLATION(S), VIA CHEST TUBE/CATHETER, AGENT FOR							
32561	PLEURODESIS		\$54.42	\$69.98				
32562	SUBSEQUENT DAY		\$48.70	\$62.22				
	THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE); LUNGS							
32601	AND PLEURAL SPACE		\$267.14	\$267.14				
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char	ge for the service)				
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	ise lab fee schedule for covered codes not listed below in the 80000-89249							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dream dura Description	PA Ind	•				Value	Notes
Code	Procedure Description THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE);	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
22604	PERICARDIAL SAC, WITH B		\$376.99	\$376.99				
32604	THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE);		\$370.99	\$376.99				
32606	MEDIASTINAL SPACE, WITH		\$365.84	\$365.84				
32000	THORACOSCOPY; WITH DIAGNOSTIC BIOPSY(IES) OF LUNG		\$303.04	\$303.04				
32607	INFILTRATES(S) (EG, WEDGE, INCISIONAL), UNILATERAL		\$251.88	\$251.88				
32007	WITH DIAGNOSTIC BIOPSY(IES) OF LUNG NODULES(S) OR MASS(ES)		φ231.00	φ231.00				
32608	(EG, WEDGE, INCISIONAL), UNILATERAL		\$309.51	\$309.51				
32609	WITH BIOPSY(IES) OF PLEURA		\$213.57	\$213.57				
32009	THORACOSCOPY, SURGICAL; WITH PLEURODESIS (EG, MECHANICAL		φ213.31	φ213.3 <i>1</i>				
32650	OR CHEMICAL)		\$530.98	\$530.98				
32030	THORACOSCOPY, SURGICAL; WITH PARTIAL PULMONARY		φ030.96	φυσυ.96				
32651	DECORTICATION		\$728.03	\$728.03				
32031	THORACOSCOPY, SURGICAL; WITH TOTAL PULMONARY		φ120.U3	φ120.03				
32652	DECORTICATION, INCLUDING		\$1,014.23	\$1,014.23				
32032	THORACOSCOPY, SURGICAL; WITH REMOVAL OF INTRAPLEURAL		φ1,014.23	\$1,014.23				
32653	FOREIGN BODY OR F		\$690.63	\$690.63				
32033	THORACOSCOPY, SURGICAL; WITH CONTROL OF TRAUMATIC		φ090.03	φ090.03				
32654	HEMORRHAGE		\$702.64	\$702.64				
32034	THORACOSCOPY, SURGICAL; WITH EXCISION-PLICATION OF BULLAE,		\$102.04	\$702.04			+	
32655	INCLUDING A		\$785.87	\$785.87				
32656	THORACOSCOPY, SURGICAL; WITH PARIETAL PLEURECTOMY		\$770.74	\$770.74				
32030	THORACOSCOPY, SURGICAL; WITH PARIETAL PLEURECTOMY THORACOSCOPY, SURGICAL; WITH REMOVAL OF CLOT OR FOREIGN		ψ110.14	ψ110.14				+
32658	BODY FROM		\$742.02	\$742.02				
32030	THORACOSCOPY, SURGICAL; WITH CREATION OF PERICARDIAL		ψ142.02	ψ142.02				+
32659	WINDOW OR PARTIAL		\$757.99	\$757.99				
32038	INTROOM ON PARTIAL		काउा.चच	का जा .चच				

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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physiciar	าร				1	
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	THORACOSCOPY, SURGICAL; WITH EXCISION OF PERICARDIAL							
32661	CYST, TUMOR, OR M		\$656.49	\$656.49				
	THORACOSCOPY, SURGICAL; WITH EXCISION OF MEDIASTINAL							
32662	CYST, TUMOR, OR M		\$919.29	\$919.29				
	THORACOSCOPY, SURGICAL; WITH LOBECTOMY, TOTAL OR							
32663	SEGMENTAL		\$1,049.94	\$1,049.94				
32664	THORACOSCOPY, SURGICAL; WITH THORACIC SYMPATHECTOMY		\$733.08	\$733.08				
	THORACOSCOPY, SURGICAL; WITH ESOPHAGOMYOTOMY (HELLER							
32665	TYPE)		\$880.74	\$880.74				
	WITH THERAPEUTIC WEDGE RESECTION (EG, MASS, NODULE),							
32666	INITIAL UNILATERAL		\$707.35	\$707.35				
	WITH THERAPEUTIC WEDGE RESCECTION (EG, MASS OR NODULE),							
	EACH ADDITIONAL RESECTION, IPSILATERAL (LIST SEPARATELY IN							
32667	ADDITION TO CODE FOR PRIMARY PROCEDURE)		\$128.37	\$128.37				
	WITH DIAGNOSTIC WEDGE RESECTION FOLLOWED BY ANATOMIC							
	LUNG RESECTION (LIST SEPARATELY IN ADDITION TO CODE FOR							
32668	PRIMARY PROCEDURE)		\$129.08	\$129.08				
32669	WITH REMOVAL OF A SINGLE LUNG SEGMENT (SEGMENTECTOMY)		\$1,091.92	\$1,091.92				
32670	WITH REMOVAL OF TWO LOBES (BILOBECTOMY)		\$1,304.16	\$1,304.16				
32671	WITH REMOVAL OF LUNG (PNEUMONECTOMY)		\$1,448.08	\$1,448.08				
	WITH RESECTION-PLICATION FOR EMPHYSEMATOUS LUNG							
	(BULLOUS OR NON-BULLOUS) FOR LUNG VOLUMNE REDUCTION							
	(LVRS) UNILATERAL INCLUDES ANY PLEURAL PROCEDURE, WHEN							
32672	PERFORMED		\$1,237.88	\$1,237.88			<u> </u>	
32673	WITH RESECTION OF THYMUS, UNILATERAL OR BILATERAL		\$976.84	\$976.84				

WITH MEDIASTINAL AND REGIONAL LYMPHADENECTOMY (LIST 32674 SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) 32701 THORACIC TARGET(S) DELINEATION FOR STEREOTACTIC 32800 REPAIR LUNG HERNIA THROUGH CHEST WALL CLOSURE OF CHEST WALL FOLLOWING OPEN FLAP DRAINAGE FOR 32810 EMPYEMA (CLAGET 32815 OPEN CLOSURE OF MAJOR BRONCHIAL FISTULA WITH MEDIASTINAL AND REGIONAL LYMPHADENECTOMY (LIST \$176.04 \$176.04 \$176.04 \$177.96 \$177.96 \$615.54 \$615.54 \$543.35 \$543.35	Notes
2020 Codes in Red; Refer to CPT book for descriptions R" in PA column indicates Prior Auth is required Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description WITH MEDIASTINAL AND REGIONAL LYMPHADENECTOMY (LIST 32674 SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) 32701 THORACIC TARGET(S) DELINEATION FOR STEREOTACTIC 32800 REPAIR LUNG HERNIA THROUGH CHEST WALL CLOSURE OF CHEST WALL FOLLOWING OPEN FLAP DRAINAGE FOR Base Unit (Facility) (NonFacility) (NonFacility) (NonFacility) (NonFacility) (NonFacility) (Separate Value) (Separate Valu	Notes
R" in PA column indicates Prior Auth is required Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description WITH MEDIASTINAL AND REGIONAL LYMPHADENECTOMY (LIST 32674 SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) 32701 THORACIC TARGET(S) DELINEATION FOR STEREOTACTIC 32800 REPAIR LUNG HERNIA THROUGH CHEST WALL CLOSURE OF CHEST WALL FOLLOWING OPEN FLAP DRAINAGE FOR 32810 EMPYEMA (CLAGET 32815 OPEN CLOSURE OF MAJOR BRONCHIAL FISTULA S1,098.67 S1,098.67	Notes
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32815 OPEN CLOSURE OF MAJOR BRONCHIAL FISTULA \$1,098.67 \$1,098.67	
32820 MAJOR RECONSTRUCTION, CHEST WALL (POSTTRAUMATIC) \$1,169.03 \$1,169.03	
32851 LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS \$1,837.68 \$1,837.68	
32852 LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS \$1,992.98 \$1,992.98	
LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC);	
32853 WITHOUT \$2,297.38 \$2,297.38	
LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC);	
32854 WITH \$2,452.91 \$2,452.91	
BACKBENCH STANDARD PREPARATION OF CADAVER DONOR LUNG	
32855 ALLOGRAFT PRIOR T \$0.00 \$0.00 32856 BACKBENCH STANDARD PREPARATION OF CADAVER \$0.00 \$0.00	
32856 BACKBENCH STANDARD PREPARATION OF CADAVER \$0.00 \$0.00 \$0.00 \$2900 RESECTION OF RIBS, EXTRAPLEURAL, ALL STAGES \$799.08 \$799.08	
32900 RESECTION OF RIDS, EXTRAPLEURAL, ALL STAGES \$799.00 \$799.00	
32905 THORACOPLASTY, SCHEDE TYPE OR EXTRAPLEURAL (ALL STAGES); \$966.82 \$966.82	
THORACOPLASTY, SCHEDE TYPE OR EXTRAPLEURAL (ALL STAGES); \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
32906 WITH CLOSURE \$1,223.12 \$1,223.12	
PNEUMONOLYSIS, EXTRAPERIOSTEAL, INCLUDING FILLING OR	
32940 PACKING PROCEDURE \$879.78	
1 ACKING I ROCEDORE	
32960 PNEUMOTHORAX, THERAPEUTIC, INTRAPLEURAL INJECTION OF AIR \$82.10	

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
32994	ABLATE PULM TUMOR PERQ CRYBL		\$389.03	\$4,596.60				Added Effective 1/1/2018
32997	TOTAL LUNG LAVAGE (UNILATERAL)		\$245.69	\$245.69				
32998	ABLATION THERAPY FOR PULMONARY TUMOR		\$217.55	\$1,913.89				
32999	UNLISTED PROCEDURE, LUNGS AND PLEURA	R	\$0.00	\$0.00				
33010	PERICARDIOCENTESIS; INITIAL		\$110.44	\$110.44				
33011	PERICARDIOCENTESIS; SUBSEQUENT		\$83.53	\$98.42				
33015	TUBE PERICARDIOSTOMY		\$294.82	\$294.82				
33016	PERICARDIOCENTESIS W/IMAGING		\$190.73	\$190.73				Added Effective 01/01/2020
33017	PRCRD DRG 6YR+ W/O CGEN CAR		\$197.97	\$197.97				Added Effective 01/01/2020
33018	PRCRD DRG 0-5YR OR W/ANOMLY		\$226.18	\$226.18				Added Effective 01/01/2020
33010	PRCRU DRG 0-51R OR W/ANOWL1		\$220.10	\$220.10				Added Effective 01/01/2020
33019	PERQ PRCRD DRG INSJ CATH CT		\$183.27	\$183.27				Added Effective 01/01/2020
33013	PERICARDIOTOMY FOR REMOVAL OF CLOT OR FOREIGN BODY		ψ103.21	ψ103.2 <i>1</i>				Added Lifective 01/01/2020
33020	(PRIMARY PROCEDURE)		\$742.02	\$742.02				
33020	CREATION OF PERICARDIAL WINDOW OR PARTIAL RESECTION FOR		ψ1 42.02	ψ1 42.02				
33025	DRAINAGE		\$757.99	\$757.99				
00020	PERICARDIECTOMY, SUBTOTAL OR COMPLETE; WITHOUT		ψ101.00	Ψ101.00				
33030	CARDIOPULMONARY BYPASS		\$1,146.74	\$1,146.74				
	PERICARDIECTOMY, SUBTOTAL OR COMPLETE; WITH		ψ.,	V 1, 1 1 U 1				
33031	CARDIOPULMONARY BYPASS		\$992.45	\$992.45				
33050	EXCISION OF PERICARDIAL CYST OR TUMOR		\$656.49	\$656.49				†
	EXCISION OF INTRACARDIAC TUMOR, RESECTION WITH		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1			
33120	CARDIOPULMONARY BYPASS		\$1,562.79	\$1,562.79				
33130	RESECTION OF EXTERNAL CARDIAC TUMOR		\$989.12	\$989.12	1			1

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description TRANSMYOCARDIAL LASER REVASCULARIZATION, BY	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
33140	THORACOTOMY; (SEPARATE		\$962.45	\$962.45				
33140			\$902.45	\$902.45				
22444	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY		фоол 4.4	фоол 4.4				
33141 33202	THORACOTOMY; PERFORMED AT INSERTION EPICARDIAL ELECTRODE. OPEN INCISION		\$205.14 \$579.83	\$205.14 \$579.83				
		-						
33203	INSERTION EPICARDIAL ELECTRODE, ENDOSCOPIC APPROACH	-	\$595.61	\$595.61			_	
2222	INSERTION OR REPLACEMENT OF PERMANENT PACEMAKER WITH		£447.40	¢447.40				
33206	TRANSVENOUS	-	\$417.13	\$417.13				
00007	INSERTION OR REPLACEMENT OF PERMANENT PACEMAKER WITH		# 407.00	# 407 00				
33207	TRANSVENOUS		\$487.60	\$487.60				
00000	INSERTION OR REPLACEMENT OF PERMANENT PACEMAKER WITH		# 505.05	# 505.05				
33208	TRANSVENOUS		\$505.85	\$505.85				
00040	INSERTION OR REPLACEMENT OF TEMPORARY TRANSVENOUS		0404.04	4404.04				
33210	SINGLE CHAMBER CARDI		\$191.91	\$191.91				
00044	INSERTION OR REPLACEMENT OF TEMPORARY TRANSVENOUS DUAL		40404					
33211	CHAMBER PACING		\$194.84	\$194.84				
00040	INSERTION OR REPLACEMENT OF PACEMAKER PULSE GENERATOR		4040.50	0010 50				
33212	ONLY; SINGLE CHA		\$318.56	\$318.56				
	INSERTION OR REPLACEMENT OF PACEMAKER PULSE GENERATOR							
33213	ONLY; DUAL CHAMB		\$346.15	\$346.15				
	UPGRADE OF IMPLANTED PACEMAKER SYSTEM, CONVERSION OF							
33214	SINGLE CHAMBER SY		\$388.62	\$388.62				
	REPOSITIONING OF PREVIOUSLY IMPLANTED TRANSVENOUS							
33215	PACEMAKER OR PACING		\$227.30	\$227.30				
	INSERTION OF A TRANSVENOUS ELECTRODE; SINGLE CHAMBER							
33216	(ONE ELECTRODE)		\$296.78	\$296.78				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	INSERTION OF A TRANSVENOUS ELECTRODE; DUAL CHAMBER (TWO	PAIIIU	(Facility)	(NOTIFACILITY)	Comp.	Comp.	Value	Notes
33217	ELECTRODES)		\$307.35	\$307.35				
33217	REPAIR OF SINGLE TRANSVENOUS ELECTRODE FOR A SINGLE		φ307.33	φ307.33				
33218	CHAMBER, PERMANENT		\$285.48	\$285.48				
33210	REPAIR OF TWO TRANSVENOUS ELECTRODES FOR A DUAL		φ200.40	φ200.40				
33220	CHAMBER PERMANENT PACE		\$287.83	\$287.83				
33221	WITH EXISTING MULTIPLE LEADS		\$284.52	\$284.52				
33222	REVISION OR RELOCATION OF SKIN POCKET FOR PACEMAKER		\$284.52	\$312.11				
33222	REVISION OR RELOCATION OF SKIN FOCKET FOR FACEWAKER		कुउ । य. । ।	φ312.11				
33223	REVISION OF SKIN POCKET FOR SINGLE OR DUAL CHAMBER PACING		\$357.60	\$357.60				
	INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM,							
33224	FOR LEFT VENTRIC		\$370.55	\$370.55				
	INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM,							
33225	FOR LEFT VENTRIC		\$329.30	\$329.30				
	REPOSITIONING OF PREVIOUSLY IMPLANTED CARDIAC VENOUS							
33226	SYSTEM (LEFT		\$356.85	\$356.85				
	REMOVAL OF PERMANENT PACEMAKER PULSE GENERATOR WITH							
	REPLACEMENT OF PACEMAKER PULSE GENERATOR; SINGLE LEAD							
33227	SYSTEM		\$271.44	\$271.44				
33228	DUAL LEAD SYSTEM		\$283.14	\$283.14				
33229	MULTIPLE LEAD SYSTEM		\$294.84	\$294.84				
33230	WITH EXISTING DUAL LEADS		\$306.31	\$306.31				
33231	WITH EXISTING MULTIPLE LEADS		\$318.01	\$318.01				
33233	REMOVAL OF PERMANENT PACEMAKER PULSE GENERATOR	†	\$159.17	\$159.17				
33234	REMOVAL OF TRANSVENOUS PACEMAKER ELECTRODE(S); SINGLE LEAD SYSTEM, ATR		\$391.36	\$391.36				
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Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00005	REMOVAL OF TRANSVENOUS PACEMAKER ELECTRODE(S); DUAL		044440	044440				
33235	LEAD SYSTEM		\$444.49	\$444.49				
00000	REMOVAL OF PERMANENT EPICARDIAL PACEMAKER AND		* 405 40	A 405 40				
33236	ELECTRODES BY THORACOTOM		\$465.43	\$465.43				
00007	REMOVAL OF PERMANENT EPICARDIAL PACEMAKER AND		***	4057.00				
33237	ELECTRODES BY THORACOTOM		\$657.32	\$657.32				
	REMOVAL OF PERMANENT TRANSVENOUS ELECTRODE(S) BY		47.40.05	4740.05				
33238	THORACOTOMY		\$740.05	\$740.05				
	INSERTION OF SINGLE OR DUAL CHAMBER PACING CARDIOVERTER-							
33240	DEFIBRILLATOR		\$376.96	\$376.96				
	SUBCUTANEOUS REMOVAL OF SINGLE OR DUAL CHAMBER PACING							
33241	CARDIOVERTER-		\$155.53	\$155.53				
	REMOVAL OF SINGLE OR DUAL CHAMBER PACING CARDIOVERTER-							
33243	DEFIBRILLATOR		\$909.36	\$909.36				
	REMOVAL OF SINGLE OR DUAL CHAMBER PACING CARDIOVERTER-							
33244	DEFIBRILLATOR		\$524.08	\$524.08				
	INSERTION OR REPOSITIONING OF ELECTRODE LEAD(S) FOR SINGLE							
33249	OR DUAL CHA		\$894.41	\$894.41				
	OPERATIVE ABLATION OF SUPRAVENTRICULAR ARRHYTHMOGENIC							
33250	FOCUS OR PATHWAY		\$904.33	\$904.33				
	OPERATIVE ABLATION OF SUPRAVENTRICULAR ARRHYTHMOGENIC		1					
33251	FOCUS OR PATHWAY		\$1,180.43	\$1,180.43				
33254	OPERATIVE ABLATION OF ATRIA, LIMITED		\$1,016.17	\$1,016.17				
	OPERATIVE ABLATION OF ATRIA, WITHOUT CARDIOPULMONARY		1					
33255	BYPASS		\$1,225.95	\$1,225.95				
22052	ODERATIVE ARIATION OF ATRIA WITH CARRIODIUMONARY RYBACO		m4 400 00	¢4 400 00				
33256	OPERATIVE ABLATION OF ATRIA, WITH CARDIOPULMONARY BYPASS		\$1,466.00	\$1,466.00				

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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
33257	ABLATE ATRIA, LMTD, ADD-ON		\$474.42	\$474.42				
33258	ABLATE ATRIA, X10SV, ADD-ON		\$536.43	\$536.43				
33259	ABLATE ATRIA W/BYPASS ADD-ON		\$703.77	\$703.77				
00004	OPERATIVE ABLATION OF VENTRICULAR ARRHYTHMOGENIC FOCUS		#4 400 05	* 400.05				
33261	WITH CARDIOPULM		\$1,103.05	\$1,103.05				
	REMOVAL OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE							
	GENERATOR WITH REPLACEMENT OF PACING CARDIOVERTER-		400= 40	4005.40				
33262	DEFIBRILLATOR PULSE GENERATOR; SINGLE LEAD SYSTEM		\$295.16	\$295.16				
33263	DUAL LEAD SYSTEM		\$306.86	\$306.86				
33264	MULTIPLE LEAD SYSTEM		\$318.56	\$318.56				
	ENDOSCOPIC ABLATION OF ATRIA, WITHOUT CARDIOPULMONARY							
33265	BYPASS		\$1,016.17	\$1,016.17				
	ENDOSCOPIC ABLATION OF ATRIA, EXTENSIVE, WITHOUT							
33266	CARDIOPULMONARY BYPASS		\$1,394.19	\$1,394.19				
1								
33270	INSERTION OR REPLACEMENT OF DEFIBRILLATOR WITH ELECTRODE		\$471.19	\$471.19				Added effective 1/1/2015
33271	INSERTION OF DEFIBRILLATOR ELECTRODE		\$395.84	\$395.84				Added effective 1/1/2015
33272	REMOVAL OF DEFIBRILLATOR ELECTRODE		\$290.94	\$290.94				Added effective 1/1/2015
1	REPOSITIONING OF PREVIOUSLY IMPLANTED DEFIBRILLATOR							
33273	ELECTRODE		\$321.92	\$321.92				Added effective 1/1/2015
33274	TCAT INSJ/RPL PERM LDLS PM		\$395.51	\$395.51				Effective 1/1/2019
								
33275	TCAT RMVL PERM LDLS PM		\$426.03	\$426.03				Updated Effective 01/01/2020
33285	INSJ SUBQ CAR RHYTHM MNTR		\$72.42	\$3,818.63				Effective 1/1/2019
33286	RMVL SUBQ CAR RHYTHM MNTR		\$71.03	\$103.92				Effective 1/1/2019
33289	TCAT IMPL WRLS P-ART PRS SNR		\$267.35	\$267.35				Effective 1/1/2019
33300	REPAIR OF CARDIAC WOUND; WITHOUT BYPASS		\$923.41	\$923.41				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
33305	REPAIR OF CARDIAC WOUND; WITH CARDIOPULMONARY BYPASS		\$1,105.28	\$1,105.28				
	CARDIOTOMY, EXPLORATORY (INCLUDES REMOVAL OF FOREIGN							
33310	BODY, ATRIAL OR		\$851.81	\$851.81				
	CARDIOTOMY, EXPLORATORY (INCLUDES REMOVAL OF FOREIGN							
33315	BODY, ATRIAL OR		\$1,042.10	\$1,042.10				
	SUTURE REPAIR OF AORTA OR GREAT VESSELS; WITHOUT SHUNT							
33320	OR CARDIOPULMON		\$891.85	\$891.85				
	SUTURE REPAIR OF AORTA OR GREAT VESSELS; WITH SHUNT							
33321	BYPASS		\$1,220.99	\$1,220.99				
	SUTURE REPAIR OF AORTA OR GREAT VESSELS; WITH							
33322	CARDIOPULMONARY BYPASS		\$1,211.02	\$1,211.02				
	INSERTION OF GRAFT, AORTA OR GREAT VESSELS; WITHOUT							
33330	SHUNT, OR		\$948.66	\$948.66				
	INSERTION OF GRAFT, AORTA OR GREAT VESSELS; WITH							
33335	CARDIOPULMONARY BYPAS		\$1,273.92	\$1,273.92				
33340	PERQ CLSR TCAT L ATR APNDGE		\$648.71	\$648.71				Added Effective 1/1/2017
33361	TRANSCATHETER AORTIC VALVE REPLACEMENT		\$1,081.48	\$1,081.48				
33362	OPEN FEMORAL ARTERY APPROACH		\$1,183.09	\$1,183.09				
33363	OPEN AXILLARY ARTERY APPROACH		\$1,225.02	\$1,225.02				
33364	OPEN ILIAC ARTERY APPROACH		\$1,302.70	\$1,302.70				
33365	TRANSAORTIC APPROACH (EG. MEDIAN STERNOTOMY,		\$1,427.26	\$1,427.26				
33366	TRCATH REPLACE AORTIC VALVE		\$1,553.22	\$1,553.22				
33367	CARDIOPULMONARY BYPASS SUPPORT WITH PERCUTANEO		\$501.76	\$501.76				
33368	CARDIOPULMONARY BYPASS SUPPORT WITH OPEN PERI		\$608.10	\$608.10				
33369	CARDIOPULMONARY BYPASS SUPPORT WITH CENTRAL ART		\$802.92	\$802.92				
33390	VALVULOPLASTY AORTIC VALVE		\$1,552.92	\$1,552.92				Added Effective 1/1/2017
33391	VALVULOPLASTY AORTIC VALVE		\$1,840.22	\$1,840.22				Added Effective 1/1/2017

Physician	Fee Schedule 2020							
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ae for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		Τ΄ ΄						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
33404	CONSTRUCTION OF APICAL-AORTIC CONDUIT	7.110	\$1,755.14	\$1,755.14	Gomp.	Gomp.	Value	110100
00.10.1	REPLACEMENT, AORTIC VALVE, WITH CARDIOPULMONARY BYPASS;		ψ1,7 σσ.11	ψ1,100.11			+	
33405	WITH PROSTHETI		\$1,782.46	\$1,782.46				
00.00	REPLACEMENT, AORTIC VALVE, WITH CARDIOPULMONARY BYPASS;		ψ .,. σ <u>=</u> σ	ψ.,. σ <u>=</u> σ				
33406	WITH ALLOGRAFT		\$2,134.09	\$2,134.09				
	REPLACEMENT, AORTIC VALVE, WITH CARDIOPULMONARY BYPASS;		ψ=, το ττο σ	ψ=, το ττο σ				
33410	WITH STENTLESS		\$1,638.43	\$1,638.43				
	REPLACEMENT, AORTIC VALVE; WITH AORTIC ANNULUS		, , , , , , , , ,	+ ,				
33411	ENLARGEMENT, NONCORONAR		\$2,108.86	\$2,108.86				
	REPLACEMENT, AORTIC VALVE, WITH TRANSVENTRICULAR AORTIC							
33412	ANNULUS ENLARG		\$2,164.32	\$2,164.32				
	REPLACEMENT, AORTIC VALVE; BY TRANSLOCATION OF							
33413	AUTOLOGOUS PULMONARY VA		\$2,280.46	\$2,280.46				
	REPAIR OF LEFT VENTRICULAR OUTFLOW TRACT OBSTRUCTION BY							
33414	PATCH ENLARGEM		\$2,076.87	\$2,076.87				
	RESECTION OR INCISION OF SUBVALVULAR TISSUE FOR DISCRETE							
33415	SUBVALVULAR A		\$1,681.22	\$1,681.22				
	VENTRICULOMYOTOMY (-MYECTOMY) FOR IDIOPATHIC							
33416	HYPERTROPHIC SUBAORTIC		\$1,703.51	\$1,703.51				
33417	AORTOPLASTY (GUSSET) FOR SUPRAVALVULAR STENOSIS		\$1,883.41	\$1,883.41				
	REPLACEMENT OF AORTIC VALVE WITH PROSTHETIC VALVE							
33418	ACCESSED THROUGH THE SKIN		\$1,503.43	\$1,503.43				Added effective 1/1/2015
	REPLACEMENT OF AORTIC VALVE WITH PROSTHETIC VALVE							
33419	ACCESSED THROUGH THE SKIN		\$354.48	\$354.48				Added effective 1/1/2015
33420	VALVOTOMY, MITRAL VALVE; CLOSED HEART		\$1,198.26	\$1,198.26				
	VALVOTOMY, MITRAL VALVE; OPEN HEART, WITH							
33422	CARDIOPULMONARY BYPASS		\$1,666.80	\$1,666.80				

Physician	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
33425	VALVULOPLASTY, MITRAL VALVE, WITH CARDIOPULMONARY BYPASS;		\$1,720.74	\$1,720.74				
00.400	VALVULOPLASTY, MITRAL VALVE, WITH CARDIOPULMONARY		0.1 700 15	A 700 45				
33426	BYPASS; WITH PROSTHE VALVULOPLASTY, MITRAL VALVE, WITH CARDIOPULMONARY		\$1,763.15	\$1,763.15				
22427	' '		CO COE 40	#0.005.40				
33427	BYPASS; RADICAL		\$2,025.12	\$2,025.12				
33430	REPLACEMENT, MITRAL VALVE, WITH CARDIOPULMONARY BYPASS		\$1,946.50	\$1,946.50				
33440	RPLCMT A-VALVE TLCJ AUTOL PV		\$2,763.73	\$2,763.73	+			Effective 1/1/2019
00110	1.11 ZSM171 V/LEVZ 1250 NG 1521 V		Ψ2,1 σσ.1 σ	Ψ2,1 σσ.1 σ				211001110 17 172010
33460	VALVECTOMY, TRICUSPID VALVE, WITH CARDIOPULMONARY BYPASS		\$1,448.00	\$1,448.00				
33463	VALVULOPLASTY, TRICUSPID VALVE; WITHOUT RING INSERTION		\$1,729.79	\$1,729.79				
33464	VALVULOPLASTY, TRICUSPID VALVE; WITH RING INSERTION		\$1,779.97	\$1,779.97				
	REPLACEMENT, TRICUSPID VALVE, WITH CARDIOPULMONARY							
33465	BYPASS		\$1,800.51	\$1,800.51				
	TRICUSPID VALVE REPOSITIONING AND PLICATION FOR EBSTEIN							
33468	ANOMALY		\$1,911.56	\$1,911.56				
	VALVOTOMY, PULMONARY VALVE, CLOSED HEART;							
33470	TRANSVENTRICULAR		\$1,163.93	\$1,163.93				
	VALVOTOMY, PULMONARY VALVE, CLOSED HEART; VIA PULMONARY							
33471	ARTERY		\$1,391.80	\$1,391.80				
	VALVOTOMY, PULMONARY VALVE, OPEN HEART; WITH							
33474	CARDIOPULMONARY BYPASS		\$1,452.13	\$1,452.13				
33475	REPLACEMENT, PULMONARY VALVE		\$1,885.46	\$1,885.46				
00.470	RIGHT VENTRICULAR RESECTION FOR INFUNDIBULAR STENOSIS,		¢4 500 00	¢4 500 00				
33476	WITH OR WITHOUT		\$1,592.30	\$1,592.30				

Physician	Fee Schedule 2020		1	1	1			T
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	column indicates Prior Auth is required							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSCATHETER PULMONARY VALVE IMPLANTATION INCLUDING							
33477	PRE-STENTING VALVE DEL SITE		\$1,058.75	\$1,058.75				Added Effective 1/1/2016
	OUTFLOW TRACT AUGMENTATION (GUSSET), WITH OR WITHOUT							
33478	COMMISSUROTOMY OR		\$1,715.16	\$1,715.16				
00500	REPAIR OF ANOMALOUS CORONARY ARTERY FROM PULMONARY		04 000 04	04.000.04				
33506	ARTERY ORIGIN; BY		\$1,809.64	\$1,809.64				
22507	REPAIR OF ANOMALOUS (EG, INTRAMURAL) AORTIC ORIGIN OF		¢4 244 06	¢4 244 0C				
33507	CORONARY ARTERY ENDOSCOPY, SURGICAL, INCLUDING VIDEO-ASSISTED HARVEST OF		\$1,344.06	\$1,344.06				
33508	VEIN(S) FOR		\$12.53	\$12.53				
33300	CORONARY ARTERY BYPASS, VEIN ONLY; SINGLE CORONARY		φ12.55	φ12.55				+
33510	VENOUS GRAFT		\$1,602.35	\$1,602.35				
33310	CORONARY ARTERY BYPASS, VEIN ONLY; TWO CORONARY VENOUS		Ψ1,002.00	Ψ1,002.00				
33511	GRAFTS		\$1,759.16	\$1,759.16				
00011	CORONARY ARTERY BYPASS, VEIN ONLY; THREE CORONARY		Ψ1,100.10	ψ1,7 σσ.1 σ				
33512	VENOUS GRAFTS		\$1,915.68	\$1,915.68				
	CORONARY ARTERY BYPASS, VEIN ONLY; FOUR CORONARY VENOUS		,	,				
33513	GRAFTS		\$2,072.22	\$2,072.22				
	CORONARY ARTERY BYPASS, VEIN ONLY; FIVE CORONARY VENOUS							
33514	GRAFTS		\$2,228.23	\$2,228.23				
	CORONARY ARTERY BYPASS, VEIN ONLY; SIX OR MORE CORONARY							
33516	VENOUS GRAFTS		\$2,384.48	\$2,384.48				
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND							
33517	ARTERIAL GRAFT(S); S		\$156.27	\$156.27				
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND							
33518	ARTERIAL GRAFT(S); T		\$313.06	\$313.06				

Physician	n Fee Schedule 2020		1		1	<u> </u>	1	
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2020 Co	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND							
33519	ARTERIAL GRAFT(S); T		\$469.07	\$469.07				
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND							
33521	ARTERIAL GRAFT(S); F		\$625.88	\$625.88				
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND							
33522	ARTERIAL GRAFT(S); F		\$782.40	\$782.40				
	CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND		****	400004				
33523	ARTERIAL GRAFT(S); S		\$939.21	\$939.21				
22520	REOPERATION, CORONARY ARTERY BYPASS PROCEDURE OR VALVE		#200 50	#200 50				
33530	PROCEDURE, MORE		\$309.50	\$309.50				
22522	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); SINGLE		¢4 CE4 O4	¢4 654 04				
33533	ARTERIAL GRAFT CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); TWO		\$1,651.21	\$1,651.21			_	
33534	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S), TWO		\$1,856.89	\$1,856.89				
33334	CORONARY ARTERIAL CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); THREE		φ1,030.09	φ1,030.09			_	
33535	CORONARY ARTERI		\$2,062.56	\$2,062.56				
00000	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); FOUR OR		Ψ2,002.00	Ψ2,002.00				
33536	MORE CORONARY		\$2,267.94	\$2,267.94				
00000	MONE CONCINUITY		Ψ2,207.01	Ψ2,207.01				
33542	MYOCARDIAL RESECTION (EG, VENTRICULAR ANEURYSMECTOMY)		\$1,738.27	\$1,738.27				
	REPAIR OF POSTINFARCTION VENTRICULAR SEPTAL DEFECT, WITH		+ 1,1 00.21	ψ .,. σσ. <u> </u>				
33545	OR WITHOUT		\$2,085.73	\$2,085.73				
	SURGICAL VENTRICULAR RESTORATION PROCEDURE, INCLUDES		. ,	. ,				
33548	PROSTHETIC PATCH,		\$1,763.03	\$1,763.03				
	CORONARY ENDARTERECTOMY, OPEN, ANY METHOD, OF LEFT							
33572	ANTERIOR DESCENDING		\$232.52	\$232.52				

Total Content Total Conten	Physician	Fee Schedule 2020							
2020 Codes in Red;		T de Goriedule 2020							
Refer to CPT book for descriptions R'n PA column indicates Prior Auth is required Codes listed as '\$0.00'' pay 45% of billed amount not be exceed provider's usual and customary charge for the service The Ansathseas Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 8000-89249 range. Proc Code Procodure Description CLOSURE OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY 31,913.93 SUTURE OR P CLOSURE OF SEMILUNAR VALVE (AORTIC OR PULMONARY) BY 31,913.93 SUTURE OR PATCH ANASTOMOSIS OF PULMONARY ARTERY TO AORTA (DAMUS-KAYE- 33806 STANSEL PROCEDURE REPAIR OF COMPLEX CARDIAC ANOMALY OTHER THAN PULMONARY 33808 ATRESIA WITH REPAIR OF COMPLEX CARDIAC ANOMALY OTHER THAN PULMONARY REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE REPAIR OF FOUNDEL OUTLET RIGHT VENTRICLE WITH 33811 INTRAVENTRICULAR TUNNEL REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE REPAIR OF FOUNDEL OUTLET RIGHT VENTRICLE WITH 33812 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33815 ATRESIA WITH REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33816 NITRAVENTRICULAR TUNNEL REPAIR OF FOUNDEL OUTLET RIGHT VENTRICLE WITH 33811 INTRAVENTRICULAR TUNNEL REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33815 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33816 REPAIR OF SOME XEARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33817 AVRICULAR TUNNEL REPAIR OF SOME XEARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33818 REPAIR OF SOME XEARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33819 OBSTRUCTION AND AORTIC 34820 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS 31510.20 31610 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH		les in Pad:							
Ref in PA column indicates Prior Auth is required Codes listed as 50 007 by a 5% of billed amount not to exceed provider's usual and customary charge for the service Codes issued as 50 007 by a 5% of billed amount not to exceed provider's usual and customary charge for the service Codes issued as 50 007 by a 5% of billed amount not be compared to the service Codes issued to the lab fee schedule from covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued and the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued and the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued and the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes issued and the lab fee schedule feet with a Code issued and the lab feet feet feet feet feet feet feet fee									
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The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians. Proc Code Procedure Description CLOSURE OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY STUTIER OR P. CLOSURE OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY STUTIER OR P. CLOSURE OF SEMILUNAR VALVE (AORTIC OR PULMONARY) BY STUTIER OR PATCH ANASTOMOSIS OF PULMONARY ARTERY TO AORTA (DAMUS-KAYE-STANSEL PROCEDURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE 33608 ATRESIA WITH A STANSEL PROCEDURE REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33610 INTRAVENTRICULAR TUNNEL REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33617 REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33618 ATRESIA BY LOUSURE REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33619 33619 ATRESIA BY LOUSURE REPAIR OF ORMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33610 ATRESIA BY CLOSURE REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33611 INTRAVENTRICULAR TUNNEL REPAIR OF DUBLE OUTLET RIGHT VENTRICLE WITH 33612 ATRESIA BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33613 33615 ATRESIA BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33616 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED 33618 33619 OBSTRUCTION AND AORTIC 33629 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF COMPLEX CARDIAC ANOMALY WITH			mary char	go for the convice					
Procedure Description Closure OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY 33600 SUTURE OF SEMILUNAR VALVE (AORTIC OR PULMONARY) BY 33602 SUTURE OR PATCH ANASTOMOSIS OF PULMONARY ARTERY TO AORTA (DAMUS-KAYE- REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33611 INTRAVENTRICULAR TUNNEL REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33612 REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33613 ATRESIAN BY CLOSURE REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33614 REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33615 ATRESIAN BY CLOSURE REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33610 OBSTRUCIAR TUNNEL REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33618 ATRESIAN BY CLOSURE REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33619 OBSTRUCIAR TUNNEL REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33610 OBSTRUCIAR TUNNEL REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33610 OBSTRUCIAR TUNNEL REPAIR OF OMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33610 OBSTRUCION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STEINT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH			Tilary Criai	T	;			+	
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc			rango						
Proc Code Procedure Description				ne ne					
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Pacedure Description CLOSURE OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY SUTURE OR P S1,913.93 \$1,749.30 \$1	Proc			Innat Rate	Outnat Rate	Tech	Prof		
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33600 SUTURE OR P \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,913.93 \$1,749.30 \$1,749	Code	CLOSURE OF ATRIOVENTRICULAR VALVE (MITRAL OR TRICUSPID) BY	FAIIIU	(i acility)	(Noni acinty)	Comp.	Comp.	Value	Notes
CLOSURE OF SEMILUNAR VALVE (AORTIC OR PULMONARY) BY 33602 SUTURE OR PATCH \$1,749.30 \$1,749.3	33600			\$1 013 03	\$1 913 93				
33602 SUTURE OR PATCH	00000			ψ1,010.00	ψ1,010.00				
ANASTOMOSIS OF PULMONARY ARTERY TO AORTA (DAMUS-KAYE- 33606 STANSEL PROCEDURE REPAIR OF COMPLEX CARDIAC ANOMALY OTHER THAN PULMONARY 33608 ATRESIA WITH REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE 33610 WITH SUBAORT REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33611 INTRAVENTRICULAR TUNNEL REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33612 INTRAVENTRICULAR TUNNEL REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33615 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33616 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT TRANSTHORACIC INSERTION OF COMPLEX CARDIAC ANOMALY WITH RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33602	,		\$1 749 30	\$1.749.30				
33606 STANSEL PROCEDURE \$2,076.87 \$2,076.87 \$2,076.87 \$2,076.87 \$2,076.87 \$2,076.87 \$2,076.87 \$2,076.87 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,098.59 \$2,076.87	00002			ψ1,7 43.50	ψ1,7 43.30				
REPAIR OF COMPLEX CARDIAC ANOMALY OTHER THAN PULMONARY \$2,098.59 \$2,098.	33606			\$2,076,87	\$2 076 87				
33608 ATRESIA WITH	00000			Ψ2,070.01	φ2,010.01				
REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE 33610 WITH SUBAORT REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33611 INTRAVENTRICULAR TUNNEL REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33612 INTRAVENTRICULAR TUNNEL REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33615 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH REPAIR OF COMPLEX CARDIAC ANOMALY WITH	33608			\$2,098,59	\$2,098,59				
33610 WITH SUBAORT \$2,076.87 \$2,076.87 \$2,076.87	00000			Ψ2,000.00	Ψ2,000.00				
REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33611 INTRAVENTRICULAR TUNNEL REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33612 INTRAVENTRICULAR TUNNEL REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33615 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33618 REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33610	· ·		\$2 076 87	\$2 076 87				
33611 INTRAVENTRICULAR TUNNEL \$2,134.09 \$2,134.09 \$2,134.09 \$3612 INTRAVENTRICULAR TUNNEL \$2,158.45 \$2,158.45 \$2,158.45 \$2,158.45 \$3612 INTRAVENTRICULAR TUNNEL \$2,158.45 \$2,158.45 \$2,158.45 \$3615 ATRESIA) BY CLOSURE \$2,112.67 \$2,112.67 \$2,112.67 \$3617 BY MODIFIED \$2,162.85 \$2,162.85 \$2,162.85 \$2,162.85 \$3619 OBSTRUCTION AND AORTIC \$2,422.04 \$2,422.04 \$2,422.04 \$3620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 \$3619 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.8	00010			Ψ2,070.01	Ψ2,010.01				
REPAIR OF DOUBLE OUTLET RIGHT VENTRICLE WITH 33612 INTRAVENTRICULAR TUNNEL REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33615 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33618 BY MODIFIED 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33611			\$2 134 09	\$2 134 09				
33612 INTRAVENTRICULAR TUNNEL \$2,158.45 \$2,158.45 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33615 ATRESIA) BY CLOSURE \$2,112.67 \$2,112.67 REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED \$2,162.85 \$2,162.85 REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC \$2,422.04 \$2,422.04 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88 \$810.88 RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH \$1.00	00011			ψ2,101.00	Ψ2,101.00			+	
REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, TRICUSPID 33615 ATRESIA) BY CLOSURE REPAIR OF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33612			\$2 158 45	\$2 158 45				
33615 ATRESIA) BY CLOSURE \$2,112.67 \$2,112.67 \$2,112.67 \$2,112.67 \$3617 BY MODIFIED \$2,162.85 \$2,162.85 \$2,162.85 \$2,162.85 \$2,162.85 \$2,162.85 \$2,422.04 \$2,422.04 \$2,422.04 \$2,422.04 \$3620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 \$3621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88 \$810.88	00012			ψ2,100.10	Ψ2,100.10			+	
REPAIR ÓF COMPLEX CARDIAC ANOMALIES (EG, SINGLE VENTRICLE) 33617 BY MODIFIED REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH S13621 RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33615	\		\$2,112,67	\$2.112.67				
33617 BY MODIFIED \$2,162.85 \$2,162.85 REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC \$2,422.04 \$2,422.04 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT \$810.88 \$810.88 \$810.88 RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH \$810.88	000.0			Ψ=, : : = : σ :	ψ=, : :=:σ:				
REPAIR OF SINGLE VENTRICLE WITH AORTIC OUTFLOW 33619 OBSTRUCTION AND AORTIC 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT WITH CATHETER REMOVAL AND CLOSURE RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH \$2,422.04 \$2,422.04 \$1,510.20 \$1,510.20 \$810.88	33617	,		\$2.162.85	\$2.162.85				
33619 OBSTRUCTION AND AORTIC \$2,422.04 \$2,422.04 33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88									
33620 APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS \$1,510.20 \$1,510.20 TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88 RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33619			\$2,422,04	\$2,422.04				
TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT 33621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88 RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH									
33621 WITH CATHETER REMOVAL AND CLOSURE \$810.88 \$810.88				1 , , , , , , ,					
RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY WITH	33621			\$810.88	\$810.88				
33622 OBSTRUCTION AND AORTIC ARCH HYPOPLASIA \$3,180.03 \$3,180.03	33622			\$3,180.03	\$3,180.03				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPAIR ATRIAL SEPTAL DEFECT, SECUNDUM, WITH							
33641	CARDIOPULMONARY BYPASS, WI		\$1,387.38	\$1,387.38				
	DIRECT OR PATCH CLOSURE, SINUS VENOSUS, WITH OR WITHOUT							
33645	ANOMALOUS PULM		\$1,527.33	\$1,527.33				
	REPAIR OF ATRIAL SEPTAL DEFECT AND VENTRICULAR SEPTAL							
33647	DEFECT, WITH DIR		\$1,894.40	\$1,894.40				
	REPAIR OF INCOMPLETE OR PARTIAL ATRIOVENTRICULAR CANAL			·				
33660	(OSTIUM PRIMUM		\$1,686.70	\$1,686.70				
	REPAIR OF INTERMEDIATE OR TRANSITIONAL ATRIOVENTRICULAR		. ,	,				
33665	CANAL, WITH OR		\$1,772.67	\$1,772.67				
	REPAIR OF COMPLETE ATRIOVENTRICULAR CANAL, WITH OR		+ ,	, ,				
33670	WITHOUT PROSTHETIC		\$2,134.09	\$2,134.09				
33675	CLOSURE MULT VENTRICULAR SEPTAL DEFECTS		\$1,610.55	\$1,610.55				
000.0	CLOSURE MUTL VENTRICULAR SEPTAL DEFECTS W/ PUL		ψ1,010.00	ψ1,010.00				
33676	VALVOTOMY		\$1,660.70	\$1,660.70				
00010	CLOSURE MULT VENTRICULAR SEPTAL DEFECTS W/REMOVAL PUL		ψ1,000.70	ψ1,000.70	+			
33677	ARTERY BAND		\$1,726.47	\$1,726.47				
00011	CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH OR WITHOUT		ψ1,720.47	ψ1,720.47				
33681	PATCH:		\$1,862.71	\$1,862.71				
33001	CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH OR WITHOUT		ψ1,002.71	ψ1,002.71				
33684	PATCH; WITH PULM		\$1,919.93	\$1,919.93				
33004	CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH OR WITHOUT	-	ψ1,818.83	ψ1,818.83				
22600	PATCH; WITH REMO		\$1,948.40	\$1,948.40				
33688	BANDING OF PULMONARY ARTERY		. ,		+			<u> </u>
33690			\$1,234.29	\$1,234.29	+			
00000	COMPLETE REPAIR TETRALOGY OF FALLOT WITHOUT PULMONARY		40.070.07	00 070 07				
33692	ATRESIA;		\$2,076.87	\$2,076.87				

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	Fee Schedule 2020						+	
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
						_	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	COMPLETE REPAIR TETRALOGY OF FALLOT WITHOUT PULMONARY							
33694	ATRESIA; WITH		\$2,105.63	\$2,105.63				
	COMPLETE REPAIR TETRALOGY OF FALLOT WITH PULMONARY							
33697	ATRESIA INCLUDING		\$2,162.85	\$2,162.85				
	REPAIR SINUS OF VALSALVA FISTULA, WITH CARDIOPULMONARY							
33702	BYPASS;		\$1,691.78	\$1,691.78				
	REPAIR SINUS OF VALSALVA FISTULA, WITH CARDIOPULMONARY							
33710	BYPASS; WITH RE		\$1,921.11	\$1,921.11				
	REPAIR SINUS OF VALSALVA ANEURYSM, WITH CARDIOPULMONARY							
33720	BYPASS		\$1,691.78	\$1,691.78				
33722	CLOSURE OF AORTICO-LEFT VENTRICULAR TUNNEL		\$1,749.30	\$1,749.30				
33724	REPAIR VENOUS ANOMALY		\$1,162.72	\$1,162.72				
33726	REPAIR PUL VENOUS STENOSIS		\$1,535.66	\$1,535.66				
	COMPLETE REPAIR OF ANOMALOUS VENOUS RETURN							
33730	(SUPRACARDIAC, INTRACARDIAC		\$2,094.77	\$2,094.77				
	REPAIR OF COR TRIATRIATUM OR SUPRAVALVULAR MITRAL RING BY							
33732	RESECTION OF		\$1,765.34	\$1,765.34				
	ATRIAL SEPTECTOMY OR SEPTOSTOMY; CLOSED HEART (BLALOCK-							
33735	HANLON TYPE		\$1,393.38	\$1,393.38				
	ATRIAL SEPTECTOMY OR SEPTOSTOMY; OPEN HEART WITH							
33736	CARDIOPULMONARY BYPAS		\$1,466.15	\$1,466.15				
	ATRIAL SEPTECTOMY OR SEPTOSTOMY; OPEN HEART, WITH							1
33737	INFLOW OCCLUSION		\$1,408.93	\$1,408.93			1	
	SHUNT; SUBCLAVIAN TO PULMONARY ARTERY (BLALOCK-TAUSSIG							
33750	TYPE OPERATION)		\$1,288.28	\$1,288.28				
	SHUNT; ASCENDING AORTA TO PULMONARY ARTERY (WATERSTON							
33755	TYPE OPERATION)		\$1,298.55	\$1,298.55				

Physician	n Fee Schedule 2020							
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	des in Red;							
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv cha	rae for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		Τ΄,						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SHUNT; DESCENDING AORTA TO PULMONARY ARTERY (POTTS-							
33762	SMITH TYPE OPERATIO		\$1,298.55	\$1,298.55				
33764	SHUNT; CENTRAL, WITH PROSTHETIC GRAFT		\$1,298.55	\$1,298.55				
	SHUNT; SUPERIOR VENA CAVA TO PULMONARY ARTERY FOR FLOW							
33766	TO ONE LUNG		\$1,327.01	\$1,327.01				
	SHUNT; SUPERIOR VENA CAVA TO PULMONARY ARTERY FOR FLOW							
33767	TO BOTH LUNGS		\$1,494.91	\$1,494.91				
	ANASTOMOSIS, CAVOPULMONARY, SECOND SUPERIOR VENA CAVA							
33768	(LIST SEPARATELY		\$336.31	\$336.31				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES WITH							
33770	VENTRICULAR SEPTAL		\$2,155.51	\$2,155.51				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES WITH							
33771	VENTRICULAR SEPTAL		\$2,191.61	\$2,191.61				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, ATRIAL							
33774	BAFFLE PROCEDURE		\$1,829.60	\$1,829.60				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, ATRIAL							
33775	BAFFLE PROCEDURE		\$1,865.40	\$1,865.40				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, ATRIAL							
33776	BAFFLE PROCEDURE		\$2,034.37	\$2,034.37				Updated Effective 01/01/2020
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, ATRIAL							
33777	BAFFLE PROCEDURE		\$1,901.49	\$1,901.49				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, AORTIC							
33778	PULMONARY ARTERY		\$2,303.44	\$2,303.44				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, AORTIC							
33779	PULMONARY ARTERY		\$2,310.49	\$2,310.49				
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, AORTIC							
33780	PULMONARY ARTERY		\$2,331.91	\$2,331.91				

Physician	Fee Schedule 2020							
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	CPT book for descriptions							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPAIR OF TRANSPOSITION OF THE GREAT ARTERIES, AORTIC							
33781	PULMONARY ARTERY		\$2,317.53	\$2,317.53				
	AORTIC ROOT TRANSLOCATION WITH VENTRICULAR SEPTAL							
33782	DEFECT AND PULMONARY STENOSIS REPAIR		\$2,255.38	\$2,255.38				
33783	WITH REIMPLANTATION OF 2 OR BOTH CORONARY OSTIA		\$2,453.91	\$2,453.91				
33786	TOTAL REPAIR, TRUNCUS ARTERIOSUS (RASTELLI TYPE OPERATION)		\$2,191.61	\$2,191.61				
33788	REIMPLANTATION OF AN ANOMALOUS PULMONARY ARTERY		\$1,663.68	\$1,663.68				
	AORTIC SUSPENSION (AORTOPEXY) FOR TRACHEAL							
33800	DECOMPRESSION (EG, FOR		\$885.69	\$885.69				
33802	DIVISION OF ABERRANT VESSEL (VASCULAR RING);		\$1,184.11	\$1,184.11				
	DIVISION OF ABERRANT VESSEL (VASCULAR RING); WITH							
33803	REANASTOMOSIS		\$1,241.04	\$1,241.04				
	OBLITERATION OF AORTOPULMONARY SEPTAL DEFECT; WITHOUT			. ,				
33813	CARDIOPULMONARY		\$1,269.79	\$1,269.79				
	OBLITERATION OF AORTOPULMONARY SEPTAL DEFECT; WITH		, ,	+ ,				
33814	CARDIOPULMONARY BYP		\$1,663.32	\$1,663.32				
33820	REPAIR OF PATENT DUCTUS ARTERIOSUS; BY LIGATION		\$1,155.35	\$1,155.35				
-	REPAIR OF PATENT DUCTUS ARTERIOSUS; BY DIVISION, UNDER 18		ψ 1, 100100	ψ.,.σσ.σσ				
33822	YEARS		\$1,184.11	\$1,184.11				
00022	REPAIR OF PATENT DUCTUS ARTERIOSUS; BY DIVISION, 18 YEARS		ψ1,101.11	Ψ1,101.11				
33824	AND OLDER		\$1,241.04	\$1,241.04				
30027	EXCISION OF COARCTATION OF AORTA, WITH OR WITHOUT		ψ1,2-1.0-	Ψ1,2-71.0-7				
33840	ASSOCIATED PATENT DU		\$1,546.80	\$1,546.80				
00040	EXCISION OF COARCTATION OF AORTA, WITH OR WITHOUT		ψ1,040.00	ψ1,040.00				
33845	ASSOCIATED PATENT DU		\$1,589.94	\$1,589.94				
JJ045	ASSOCIATED FATEINT DU		φ1,309.9 4	ֆ 1,၁၀9.94				

Physician	Fee Schedule 2020		T	T				T
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	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION OF COARCTATION OF AORTA, WITH OR WITHOUT							
33851	ASSOCIATED PATENT DU		\$1,561.18	\$1,561.18				
	REPAIR OF HYPOPLASTIC OR INTERRUPTED AORTIC ARCH USING							
33852	AUTOGENOUS OR		\$1,632.78	\$1,632.78				
	REPAIR OF HYPOPLASTIC OR INTERRUPTED AORTIC ARCH USING							
33853	AUTOGENOUS OR		\$2,105.63	\$2,105.63				
33858	AS-AORT GRF F/AORTIC DSJ		\$2,742.19	\$2,742.19				Added Effective 01/01/2020
33859	AS-AORT GRF F/DS OTH/THN DSJ		\$1,967.51	\$1,967.51				Added Effective 01/01/2020
	ASCENDING AORTA GRAFT, WITH CARDIOPULMONARY BYPASS,							
33860	WITH OR WITHOUT VA		\$1,997.55	\$1,997.55				
	ASCENDING AORTA GRAFT, WITH CARDIOPULMONARY BYPASS,							
33863	WITH OR WITHOUT VA		\$2,112.29	\$2,112.29				
33864	ASCENDING AORTIC GRAFT		\$2,576.54	\$2,576.54				
33866	AORTIC HEMIARCH GRAFT		\$842.31	\$842.31				Effective 1/1/2019
33870	TRANSVERSE ARCH GRAFT, WITH CARDIOPULMONARY BYPASS	<u> </u>	\$2,491.00	\$2,491.00				
33871	TRANSVRS A-ARCH GRF HYPTHRM		\$2,636.00	\$2,636.00				Added Effective 01/01/2020
33875	DESCENDING THORACIC AORTA GRAFT, WITH OR WITHOUT BYPASS		\$1,764.53	\$1,764.53				
	REPAIR OF THORACOABDOMINAL AORTIC ANEURYSM WITH GRAFT,							
33877	WITH OR WITHOUT		\$2,568.99	\$2,568.99				
	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA (EG,							
33880	ANEURYSM,		\$1,394.81	\$1,394.81				
33881	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA (EG, ANEURYSM,		\$1,196.79	\$1,196.79				

Physiciar	Fee Schedule 2020							
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	des in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
22002	PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR		#000 00	#000.00				
33883	ENDOVASCULAR REPAIR OF		\$882.80	\$882.80				
22004	PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR		#224 40	#224 40				
33884	ENDOVASCULAR REPAIR OF PLACEMENT OF DISTAL EXTENSION PROSTHESIS(S) DELAYED		\$331.40	\$331.40				
33886	AFTER ENDOVASCULAR		\$761.26	\$761.26				
33000	OPEN SUBCLAVIAN TO CAROTID ARTERY TRANSPOSITION		\$701.20	\$701.20				+
33889	PERFORMED IN CONJUNCTI		\$660.98	\$660.98				
00000	BYPASS GRAFT, WITH OTHER THAN VEIN, TRANSCERVICAL		Ψ000.50	Ψ000.30				
33891	RETROPHARYNGEAL		\$841.96	\$841.96				
00001	PULMONARY ARTERY EMBOLECTOMY; WITH CARDIOPULMONARY		ΨΟΤΙΙΟΟ	φοτιου				
33910	BYPASS		\$1,101.70	\$1,101.70				
	PULMONARY ARTERY EMBOLECTOMY; WITHOUT		Ţ 1,10 111 0	7 1,10 1110				
33915	CARDIOPULMONARY BYPASS		\$929.18	\$929.18				
	PULMONARY ENDARTERECTOMY, WITH OR WITHOUT							
33916	EMBOLECTOMY, WITH CARDIOPULM		\$1,263.84	\$1,263.84				
	REPAIR OF PULMONARY ARTERY STENOSIS BY RECONSTRUCTION							
33917	WITH PATCH OR GR		\$1,771.59	\$1,771.59				
	REPAIR OF PULMONARY ATRESIA WITH VENTRICULAR SEPTAL							
33920	DEFECT, BY CONSTRU		\$2,120.01	\$2,120.01				
	TRANSECTION OF PULMONARY ARTERY WITH CARDIOPULMONARY							
33922	BYPASS		\$1,430.53	\$1,430.53				
	LIGATION AND TAKEDOWN OF A SYSTEMIC-TO-PULMONARY ARTERY							
33924	SHUNT, PERFORM		\$287.63	\$287.63				
	REPAIR OF PULMONARY ARTERY ARBORIZATION ANOMALIES BY							
33925	UNIFOCALIZATION;		\$1,377.37	\$1,377.37				Rate updated 1/1/2018

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Jiliary Gilai T	ge for the service	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	ranga						+
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		nc				+	+
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	REPAIR OF PULMONARY ARTERY ARBORIZATION ANOMALIES BY	FAIIIU	(i acility)	(Noni acinty)	Comp.	Comp.	Value	Notes
33926	UNIFOCALIZATION:		\$1,859.13	\$1,859.13				
33927	IMPLTJ TOT RPLCMT HRT SYS		\$2,043.74	\$2,043.74				Added Effective 1/1/2018
33928	RMVL & RPLCMT TOT HRT SYS		\$0.00	\$0.00				Added Effective 1/1/2018
33929	RMVL RPLCMT HRT SYS F/TRNSPL		\$0.00	\$0.00				Added Effective 1/1/2018
33323	DONOR CARDIECTOMY-PNEUMONECTOMY (INCLUDING COLD		ψ0.00	ψ0.00				Added Effective 1/1/2010
33930	PRESERVATION)		\$1,440.00	\$1,920.00				
3330	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR		ψ1,440.00	ψ1,920.00				
33933	HEART/LUNG ALLOGRAFT P		\$0.00	\$0.00				
33333	HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-		ψ0.00	ψ0.00				+
33935	PNEUMONECTOMY		\$2,776.05	\$2,776.05				
33940	DONOR CARDIECTOMY (INCLUDING COLD PRESERVATION)		\$2,770.03	\$3,000.00			+	+
33340	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR HEART		Ψ2,230.00	ψ3,000.00				+
33944	ALLOGRAFT PRIOR		\$0.00	\$0.00				
33344	ALLOGICAL I I NIGIC		ψ0.00	ψ0.00				+
33945	HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY		\$3,167.39	\$3,167.39				
00010	INITIATION OF EXTERNAL VEIN TO VEIN BLOOD CIRCULATION IN		ψο, τον .σσ	φο, τον .σσ				+
33946	HEART AND LUNGS USING A PUMP		\$252.80	\$252.80				Added effective 1/1/2015
00010	INITIATION OF EXTERNAL VEIN TO ARTERY BLOOD CIRCULATION IN		Ψ202.00	Ψ202.00				714464 611661176 17 172616
33947	HEART AND LUNGS USING A PUMP		\$279.23	\$279.23				Added effective 1/1/2015
00011	DAILY MANAGEMENT OF EXTERNAL VEIN TO VEIN BLOOD		Ψ2. 0.20	Ψ2. σ.2σ			+	7.4464 51156175 17 172616
33948	CIRCULATION IN HEART AND LUNGS USING A PUMP		\$199.74	\$199.74				Added effective 1/1/2015
200.0	DAILY MANAGEMENT OF EXTERNAL VEIN TO ARTERY BLOOD		ψ 100.7 1	Ψ 100.1 1				7.13333 311331173 17.172313
33949	CIRCULATION IN HEART AND LUNGS USING A PUMP		\$194.37	\$194.37				Added effective 1/1/2015
300.0	INSERTION OF TUBE ACCESSED THROUGH THE SKIN FOR EXTERNAL	1	¥101.01	¥ 10 1.07				
	BLOOD CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT							
33951	BIRTH THROUGH 5 YEARS OF AGE		\$360.23	\$360.23				Added effective 1/1/2015
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INSERTION OF TUBE ACCESSED THROUGH THE SKIN FOR EXTERNAL							
	BLOOD CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT							
33952	6 YEARS AND OLDER		\$351.07	\$351.07				Added effective 1/1/2015
	INSERTION OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT BIRTH							
33953	THROUGH 5 YEARS OF AGE		\$401.94	\$401.94				Added effective 1/1/2015
	INSERTION OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT 6							
33954	YEARS AND OLDER		\$392.22	\$392.22				Added effective 1/1/2015
	INSERTION OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33955	PUMP PATIENT BIRTH THROUGH 5 YEARS OF AGE		\$724.24	\$724.24				Added effective 1/1/2015
	INSERTION OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33956	PUMP PATIENT 6 YEARS AND OLDER		\$688.02	\$688.02				Added effective 1/1/2015
	REPOSITIONING OF TUBE ACCESSED THROUGH THE SKIN FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33957	PUMP PATIENT BIRTH THROUGH 5 YEARS OF AGE		\$160.72	\$160.72				Added effective 1/1/2015
	REPOSITIONING OF TUBE ACCESSED THROUGH THE SKIN FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33958	PUMP PATIENT 6 YEARS AND OLDER		\$155.80	\$155.80				Added effective 1/1/2015
	REPOSITIONING OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT BIRTH							
33959	THROUGH 5 YEARS OF AGE		\$204.20	\$204.20				Added effective 1/1/2015
	REPOSITIONING OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT 6							
33962	YEARS AND OLDER		\$192.56	\$192.56				Added effective 1/1/2015

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPOSITIONING OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33963	PUMP PATIENT BIRTH THROUGH 5 YEARS OF AGE		\$408.08	\$408.08				Added effective 1/1/2015
	REPOSITIONING OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33964	PUMP PATIENT 6 YEARS AND OLDER		\$418.72	\$418.72				Added effective 1/1/2015
	REMOVAL OF TUBE ACCESSED THROUGH THE SKIN FOR EXTERNAL							
	BLOOD CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT							
33965	BIRTH THROUGH 5 YEARS OF AGE		\$160.72	\$160.72				Added effective 1/1/2015
	REMOVAL OF TUBE ACCESSED THROUGH THE SKIN FOR EXTERNAL							
	BLOOD CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT							
33966	6 YEARS AND OLDER		\$193.94	\$193.94				Added effective 1/1/2015
	INSERTION OF INTRA-AORTIC BALLOON ASSIST DEVICE,							
33967	PERCUTANEOUS		\$196.92	\$198.21				
	REMOVAL OF INTRA-AORTIC BALLOON ASSIST DEVICE,							
33968	PERCUTANEOUS		\$31.37	\$31.37				
	REMOVAL OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT BIRTH							
33969	THROUGH 5 YEARS OF AGE		\$237.02	\$237.02				Added effective 1/1/2015
	INSERTION OF INTRA-AORTIC BALLOON ASSIST DEVICE THROUGH							
33970	THE FEMORAL AR		\$462.75	\$462.75				
	REMOVAL OF INTRA-AORTIC BALLOON ASSIST DEVICE INCLUDING							
33971	REPAIR OF FEMO		\$279.06	\$279.06				
	INSERTION OF INTRA-AORTIC BALLOON ASSIST DEVICE THROUGH							
33973	THE ASCENDING		\$512.93	\$512.93				
	REMOVAL OF INTRA-AORTIC BALLOON ASSIST DEVICE FROM THE							
33974	ASCENDING AORTA		\$543.61	\$543.61				
33974	ASCENDING AORTA		\$543.61	\$543.61				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tomary chai	ge for the service	*				
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description INSERTION OF VENTRICULAR ASSIST DEVICE: EXTRACORPOREAL.	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
33975	SINGLE VENTRICULAR ASSIST DEVICE, EXTRACORPOREAL,		\$1,020.70	¢4 020 70				
33975	INSERTION OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL,		\$1,020.70	\$1,020.70		_		
22076			¢4 200 06	¢4 200 00				
33976	BIVENTRICULAR REMOVAL OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL,		\$1,390.86	\$1,390.86		_		
22077			¢002.00	¢002.00				
33977	SINGLE VENTRICLE		\$893.09	\$893.09				
22070	REMOVAL OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL,		¢4 000 70	¢4 000 70				
33978	BIVENTRICULAR		\$1,020.70	\$1,020.70		_	_	
00070	INSERTION OF VENTRICULAR ASSIST DEVICE, IMPLANTABLE		#055.07	0055.07				
33979	INTRACORPOREAL, SI		\$955.07	\$955.07				
00000	REMOVAL OF VENTRICULAR ASSIST DEVICE, IMPLANTABLE		007.50	0007.50				
33980	INTRACORPOREAL, SING		\$837.56	\$837.56				
33981	REPLACE VAD PUMP EXT		\$689.75	\$689.75				
33982	REPLACE VAD INTRA W/O BP		\$1,615.61	\$1,615.61				
33983	REPLACE VAD INTRA W/BP		\$1,897.00	\$1,897.00				
	REMOVAL OF TUBE OPEN PROCEDURE FOR EXTERNAL BLOOD							
	CIRCULATION IN HEART AND LUNGS USING A PUMP PATIENT 6		****					
33984	YEARS AND OLDER		\$233.65	\$233.65				Added effective 1/1/2015
	REMOVAL OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A							
33985	PUMP PATIENT BIRTH THROUGH 5 YEARS OF AGE		\$446.57	\$446.57				Added effective 1/1/2015
	REMOVAL OF TUBE ACCESSED THROUGH THE CHEST FOR							
	EXTERNAL BLOOD CIRCULATION IN HEART AND LUNGS USING A			1.				
33986	PUMP PATIENT 6 YEARS AND OLDER		\$426.22	\$426.22				Added effective 1/1/2015
	INCISION OF ARTERY FOR CREATION OF A CHANNEL FOR BLOOD							
33987	CIRCULATION USING A PUMP		\$171.04	\$171.04				Added effective 1/1/2015

Physician	Fee Schedule 2020							
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INSERTION OF LEFT HEART VENT THROUGH CHEST FOR BLOOD							
33988	OXYGENATION REWARMING AND RETURN		\$635.96	\$635.96				Added effective 1/1/2015
	REMOVAL OF LEFT HEART VENT THROUGH CHEST FOR BLOOD							
33989	OXYGENATION REWARMING AND RETURN		\$404.22	\$404.22				Added effective 1/1/2015
33990	INSERTION OF VENTRICULAR ASSIST DEVICE		\$351.64	\$351.64				
33991	BOTH ARTERIAL AND VENOUS ACCESS, WITH TRANSSEPTAL		\$512.51	\$512.51				
33992	REMOVAL OF PERCUTANEOUS VENTRICULAR ASSIST DEVICE		\$167.66	\$167.66				
33993	REPOSITIONING OF PERCUTANEOUS VENTRICULAR ASSIST		\$147.21	\$147.21				
33999	UNLISTED PROCEDURE, CARDIAC SURGERY	R	\$0.00	\$0.00				
	EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT							
34001	CATHETER; CAROTID, SUBCLA		\$645.42	\$645.42				
	EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT							
34051	CATHETER; INNOMINATE,		\$674.60	\$674.60				
	EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT							
34101	CATHETER; AXILLARY, BRACH		\$521.42	\$521.42				
04444	EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT		#450.00	0.450.00				
34111	CATHETER; RADIAL OR ULNAR EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT		\$452.90	\$452.90				
24454	,		фоо <i>с</i> 77	#005 77				
34151	CATHETER; RENAL, CELIAC, EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT		\$825.77	\$825.77				
24204	,		¢517.00	\$517.89				
34201	CATHETER; FEMOROPOPLITEAL		\$517.89	\$517.89				
34203	EMBOLECTOMY OR THROMBECTOMY, WITH OR WITHOUT CATHETER;	.	\$597.81	\$597.81				
34203	THROMBECTOMY OR THROMBECTOMY, WITH OR WITHOUT CATHETER, THROMBECTOMY, DIRECT OR WITH CATHETER; VENA CAVA, ILIAC	,	ι ο. τευφ	φυσι.υι		_		+
34401	VEIN, BY ABDOM		\$591.79	\$591.79				
07701	THROMBECTOMY, DIRECT OR WITH CATHETER; VENA CAVA, ILIAC,	+	ψυσι./ σ	Ψυσι.ισ				+
34421	FEMOROPOPLITE		\$497.38	\$497.38				
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	<u> </u>				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1		-				
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	THROMBECTOMY, DIRECT OR WITH CATHETER; VENA CAVA, ILIAC,		, , ,			•		
34451	FEMOROPOPLITE		\$724.01	\$724.01				
	THROMBECTOMY, DIRECT OR WITH CATHETER; SUBCLAVIAN VEIN,							
34471	BY NECK INCISI		\$375.12	\$375.12				
	THROMBECTOMY, DIRECT OR WITH CATHETER; AXILLARY AND							
34490	SUBCLAVIAN VEIN, B		\$423.44	\$423.44				
34501	VALVULOPLASTY, FEMORAL VEIN		\$502.96	\$502.96				
34502	RECONSTRUCTION OF VENA CAVA, ANY METHOD		\$1,341.34	\$1,341.34				
34510	VENOUS VALVE TRANSPOSITION, ANY VEIN DONOR		\$608.50	\$608.50				
34520	CROSS-OVER VEIN GRAFT TO VENOUS SYSTEM		\$638.54	\$638.54				
34530	SAPHENOPOPLITEAL VEIN ANASTOMOSIS		\$845.42	\$845.42				
34701	EVASC RPR A-AO NDGFT		\$989.88	\$989.88				Added Effective 1/1/2018
34702	EVASC RPR A-AO NDGFT RPT		\$1,480.49	\$1,480.49				Added Effective 1/1/2018
34703	EVASC RPR A-UNILAC NDGFT		\$1,114.11	\$1,114.11				Added Effective 1/1/2018
34704	EVASC RPR A-UNILAC NDGFT RPT		\$1,855.95	\$1,855.95				Added Effective 1/1/2018
34705	EVAC RPR A-BIILIAC NDGFT		\$1,228.98	\$1,228.98				Added Effective 1/1/2018
34706	EVASC RPR A-BIILIAC RPT		\$1,851.05	\$1,851.05				Added Effective 1/1/2018
34707	EVASC RPR ILIO-ILIAC NDGFT		\$923.51	\$923.51				Added Effective 1/1/2018
34708	EVASC RPR ILIO-ILIAC RPT		\$1,488.10	\$1,488.10				Added Effective 1/1/2018
34709	PLMT XTN PROSTH EVASC RPR		\$260.52	\$260.52				Added Effective 1/1/2018
34710	DLYD PLMT XTN PROSTH 1ST VSL		\$643.15	\$643.15				Added Effective 1/1/2018
34711	DLYD PLMT XTN PROSTH EA ADDL		\$240.51	\$240.51				Added Effective 1/1/2018
34712	TCAT DLVR ENHNCD FIXJ DEV		\$547.96	\$547.96				Added Effective 1/1/2018
34713	PERQ ACCESS & CLSR FEM ART		\$103.70	\$103.70				Added Effective 1/1/2018
34714	OPN FEM ART EXPOS CNDT CRTJ		\$217.74	\$217.74				Added Effective 1/1/2018
34715	OPN AX/SUBCLA ART EXPOS		\$243.69	\$243.69				Added Effective 1/1/2018
34716	OPN AX/SUBCLA ART EXPOS CNDT		\$301.85	\$301.85				Added Effective 1/1/2018

OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34831 PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34832 PLUS REPAIR O OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE AVAILABLE OF AORTIC OR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE AVAILABLE OF AORTIC OR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE AVAILABLE OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN Added effective 1/1/2015	Dhyaisian	Fac Cabadula 2020						ı	
2020 Codes in Red; Red;		ree Schedule 2020				+			
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Codes listed as \$0.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PA Ind Inpat. Rate (Facility) Comp. Comp. Post. Comp. Comp. Comp. Value Notes Added Effective 01/01/2020 Added Effective 0						_			
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-93249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PA Ind Inpat. Rate (Pacility) Proc. Comp. Proc. Comp. Proc. Comp. Inpat. Rate (NonFacility) Proc. Comp. Added Effective 01/01/2020 Added Effective			<u> </u>						
Please use lab fee schedule for covered codes not listed below in the 80000-99249 range.			mary char	ge for the service)				
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description Advisor Pal Inpat. Rate (Pacility) Proc Code Procedure Description Advisor Pal Inpat. Rate (Pacility) Advi									
Proc Procedure Description									
Proc Procedure Description	Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciai	ns					
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Pain									
34717 EVASC RPR A-ILIAC NDGFT \$1,006.21 \$1,006.20 \$1				•	•				
State	Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
State									
34806 ANEURYSM PRESS SENSOR ADD-ON \$85.15 \$85.15 ENDOVASCULAR PLACEMENT OF ILIAC ARTERY OCCLUSION DEVICE S4808 (LIST SEPARATE \$168.70 \$168.70 OPEN FEMORAL ARTERY EXPOSURE FOR DELIVERY OF 34812 ENDOVASCULAR PROSTHESIS, \$276.20 \$276.20 PLACEMENT OF FEMORAL-FEMORAL PROSTHETIC GRAFT DURING 34813 ENDOVASCULAR AORT \$196.20 \$196.20 OPEN ILIAC ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR 34820 PROSTHESIS OR \$398.76 \$398.76 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34830 PLUS REPAIR O \$1,378.68 \$1,378.68 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34831 PLUS REPAIR O \$1,490.71 \$1,490.71 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34832 PLUS REPAIR O \$1,490.71 \$1,490.71 OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR 34833 DELIVERY OF AO \$491.53 \$491.53 OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR \$230.44 OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$0.00 \$0.00 Added effective 1/1/2015	34717	EVASC RPR A-ILIAC NDGFT		\$362.04	\$362.04				Added Effective 01/01/2020
34806 ANEURYSM PRESS SENSOR ADD-ON \$85.15 \$85.15 ENDOVASCULAR PLACEMENT OF ILIAC ARTERY OCCLUSION DEVICE S4808 (LIST SEPARATE \$168.70 \$168.70 OPEN FEMORAL ARTERY EXPOSURE FOR DELIVERY OF 34812 ENDOVASCULAR PROSTHESIS, \$276.20 \$276.20 PLACEMENT OF FEMORAL-FEMORAL PROSTHETIC GRAFT DURING 34813 ENDOVASCULAR AORT \$196.20 \$196.20 OPEN ILIAC ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR 34820 PROSTHESIS OR \$398.76 \$398.76 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34830 PLUS REPAIR O \$1,378.68 \$1,378.68 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34831 PLUS REPAIR O \$1,490.71 \$1,490.71 OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34832 PLUS REPAIR O \$1,490.71 \$1,490.71 OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR 34833 DELIVERY OF AO \$491.53 \$491.53 OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR \$230.44 OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$0.00 \$0.00 Added effective 1/1/2015									
ENDOVASCULAR PLACEMENT OF ILIAC ARTERY OCCLUSION DEVICE \$168.70									Added Effective 01/01/2020
34808 (LIST SEPARATE \$168.70	34806			\$85.15	\$85.15				
OPEN FEMORAL ARTERY EXPOSURE FOR DELIVERY OF 34812 ENDOVASCULAR PROSTHESIS, PLACEMENT OF FEMORAL-FEMORAL PROSTHETIC GRAFT DURING 34813 ENDOVASCULAR AORT OPEN ILIAC ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR 34820 PROSTHESIS OR OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, OPEN REPAIR O OPEN REPAIR O OPEN REPAIR O OPEN REPAIR O OPEN REPAIR O OPEN REPAIR O OPEN REPAIR O OPEN LIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR DELIVERY OF AO OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN TIME OR ADRIA METERY STRONG STRONG STRONG SALES \$276.20									
SAB12 ENDOVASCULAR PROSTHESIS, \$276.20	34808			\$168.70	\$168.70				
PLACEMENT OF FEMORAL-FEMORAL PROSTHETIC GRAFT DURING SUDVASCULAR AORT SUDVASCULAR AORT SUBSTITUTE OF NEIGH OF N									
Sample S	34812			\$276.20	\$276.20				
OPEN ILIAC ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR 34820 PROSTHESIS OR OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34830 PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34831 PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34832 PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN DEPLOYMENT OF AORTIC OR OPHON BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN LANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME OPEN ILIAC ARTERY EXPOSURE FOR DISSECTION, \$1,490.71 \$1,490.71 \$1,490.71 \$1,490.71 \$1,490.71 \$230.44 \$230.44 \$230.44 \$230.44 Added effective 1/1/2015									
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OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR O OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR OF OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR OF OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, PLUS REPAIR O OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME OPEN REPAIR O \$1,378.68 \$1,378.68 \$1,378.68 \$1,378.68 \$1,378.68 \$1,378.68 \$1,378.68 \$1,490.71 \$1									
S1,378.68 S1,490.71 S1,4	34820			\$398.76	\$398.76				
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OPEN REPAIR OF INFRARENAL AORTIC ANEURYSM OR DISSECTION, 34832 PLUS REPAIR O OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE OPEN BRACHIAL ARTERY EXPOSURE TO		· ·							
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OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR 34833 DELIVERY OF AO OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE \$230.44 \$230.44 \$230.44 \$230.44 Added effective 1/1/2015									
DELIVERY OF AO OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$491.53 \$491.53 \$ \$491.53 \$ \$491.53 \$ \$0.00 \$ \$230.44 \$ \$230.44 \$ \$0.00 \$ Added effective 1/1/2015	34832			\$1,490.71	\$1,490.71				
OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE 34834 DEPLOYMENT OF AORTIC OR PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$0.00 \$0.00 Added effective 1/1/2015		OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR							
34834 DEPLOYMENT OF AORTIC OR \$230.44	34833	DELIVERY OF AO		\$491.53	\$491.53				
PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$0.00 \$0.00 Added effective 1/1/2015		OPEN BRACHIAL ARTERY EXPOSURE TO ASSIST IN THE							
OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN 34839 TIME \$0.00 \$0.00 \$0.00 Added effective 1/1/2015	34834	DEPLOYMENT OF AORTIC OR		\$230.44	\$230.44				
34839 TIME \$0.00 \$0.00 Added effective 1/1/2015		PHYSICIAN PLANNING OF A PATIENT-SPECIFIC GRAFT FOR REPAIR							
34839 TIME \$0.00 \$0.00 Added effective 1/1/2015		OF AORTA REQUIRING A MINIMUM OF 90 MINUTES OF PHYSICIAN							
· · ·	34839			\$0.00	\$0.00				Added effective 1/1/2015
	34841								

Physician	Fee Schedule 2020								
Note:						+			
	les in Red;								
Refer to CPT book for descriptions									
	column indicates Prior Auth is required								
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv char	ae for the service	1					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.								
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.							
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns						
		T '							
							Base		
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit		
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes	
34842	ENDOVASC VISC AORTA 2 GRAFT		\$0.00	\$0.00					
34843	ENDOVASC VISC AORTA 3 GRAF		\$0.00	\$0.00					
34844	ENDOVASC VISC AORTA 4 GRAFT		\$0.00	\$0.00					
34845	VISC & INFRAREN ABD 1 PROSTH		\$0.00	\$0.00					
34846	VISC & INFRAREN ABD 2 PROSTH		\$0.00	\$0.00					
34847	VISC & INFRAREN ABD 3 PROSTH		\$0.00	\$0.00					
34848	VISC & INFRAREN ABD 4+ PROST		\$0.00	\$0.00					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35001	(PARTIAL OR TOT		\$1,036.03	\$1,036.03					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35002	(PARTIAL OR TOT		\$967.74	\$967.74					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35005	(PARTIAL OR TOT		\$816.63	\$816.63					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35011	(PARTIAL OR TOT		\$731.19	\$731.19					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35013	(PARTIAL OR TOT		\$936.23	\$936.23					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35021	(PARTIAL OR TOT		\$1,077.67	\$1,077.67					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35022	(PARTIAL OR TOT		\$1,085.08	\$1,085.08					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35045	(PARTIAL OR TOT		\$684.85	\$684.85					
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35081	(PARTIAL OR TOT		\$1,326.86	\$1,326.86					
0.500.5	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION								
35082	(PARTIAL OR TOT		\$1,571.70	\$1,571.70					

Physician	Fee Schedule 2020							
Note:								
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	ge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0=004	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		4. 505.00					
35091	(PARTIAL OR TOT		\$1,535.88	\$1,535.88				
05000	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		* 4 000 04	4.000.04				
35092	(PARTIAL OR TOT		\$1,889.34	\$1,889.34				
25402	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		£4 20C 00	£4 20C 00				
35102	(PARTIAL OR TOT DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		\$1,386.89	\$1,386.89				
35103	(PARTIAL OR TOT		\$1,747.01	\$1,747.01				
33103	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		\$1,747.01	φ1,747.01				
35111	(PARTIAL OR TOT		\$1,005.65	\$1,005.65				
33111	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		ψ1,000.00	ψ1,003.03				
35112	(PARTIAL OR TOT		\$844.22	\$844.22				
00112	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		ψο ττ.22	ΨΟΤΙΙΖΕ				
35121	(PARTIAL OR TOT		\$1,325.97	\$1,325.97				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION		Ţ :,c=c:c:	7 1,0=0101				
35122	(PARTIAL OR TOT		\$1,518.22	\$1,518.22				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35131	(PARTIAL OR TOT		\$1,001.31	\$1,001.31				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35132	(PARTIAL OR TOT		\$1,186.63	\$1,186.63				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35141	(PARTIAL OR TOT		\$853.95	\$853.95				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35142	(PARTIAL OR TOT		\$939.56	\$939.56				
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35151	(PARTIAL OR TOT		\$945.88	\$945.88				

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	ted as ' 0.00 " pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DIRECT REPAIR OF ANEURYSM, PSEUDOANEURYSM, OR EXCISION							
35152	(PARTIAL OR TOT		\$749.67	\$749.67				
35180	REPAIR, CONGENITAL ARTERIOVENOUS FISTULA; HEAD AND NECK		\$590.46	\$590.46				
	REPAIR, CONGENITAL ARTERIOVENOUS FISTULA; THORAX AND							
35182	ABDOMEN		\$797.79	\$797.79				
35184	REPAIR, CONGENITAL ARTERIOVENOUS FISTULA; EXTREMITIES		\$625.22	\$625.22				
	REPAIR, ACQUIRED OR TRAUMATIC ARTERIOVENOUS FISTULA; HEAD							
35188	AND NECK		\$640.56	\$640.56				
	REPAIR, ACQUIRED OR TRAUMATIC ARTERIOVENOUS FISTULA;							
35189	THORAX AND ABDOME		\$859.95	\$859.95				
	REPAIR, ACQUIRED OR TRAUMATIC ARTERIOVENOUS FISTULA;							
35190	EXTREMITIES		\$675.30	\$675.30				
35201	REPAIR BLOOD VESSEL, DIRECT; NECK		\$578.39	\$578.39				
35206	REPAIR BLOOD VESSEL, DIRECT; UPPER EXTREMITY		\$570.70	\$570.70				
35207	REPAIR BLOOD VESSEL, DIRECT; HAND, FINGER		\$602.43	\$602.43				
35211	REPAIR BLOOD VESSEL, DIRECT; INTRATHORACIC, WITH BYPASS		\$1,013.08	\$1,013.08				
35216	REPAIR BLOOD VESSEL, DIRECT		\$839.36	\$839.36				
35221	REPAIR BLOOD VESSEL, DIRECT; INTRA-ABDOMINAL		\$794.29	\$794.29				
35226	REPAIR BLOOD VESSEL, DIRECT; LOWER EXTREMITY		\$562.85	\$562.85				
35231	REPAIR BLOOD VESSEL WITH VEIN GRAFT; NECK		\$756.05	\$756.05				
35236	REPAIR BLOOD VESSEL WITH VEIN GRAFT; UPPER EXTREMITY		\$660.14	\$660.14				
	REPAIR BLOOD VESSEL WITH VEIN GRAFT; INTRATHORACIC, WITH							
35241	BYPASS		\$1,045.62	\$1,045.62				
	REPAIR BLOOD VESSEL WITH VEIN GRAFT; INTRATHORACIC,							
35246	WITHOUT BYPASS		\$1,039.17	\$1,039.17				<u> </u>

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2020 Code	•							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	Э				
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered f	for physiciar	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
35251	REPAIR BLOOD VESSEL WITH VEIN GRAFT; INTRA-ABDOMINAL		\$775.92	\$775.92				
35256	REPAIR BLOOD VESSEL WITH VEIN GRAFT; LOWER EXTREMITY		\$688.21	\$688.21				
35261	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN; NECK		\$722.49	\$722.49				
35266	REPAIR BLOOD VESSEL WITH GRAFT		\$635.28	\$635.28				
	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN;							
35271	INTRATHORACIC, WITH BY		\$989.56	\$989.56				
	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN;							
35276	INTRATHORACIC, WITHOUT		\$848.30	\$848.30				
	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN; INTRA-							
35281	ABDOMINAL		\$988.75	\$988.75				
	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN; LOWER							
35286	EXTREMITY		\$687.02	\$687.02				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35301	CAROTID, VERTEBRAL		\$924.15	\$924.15				
35302	THROMBOENDARTERECTOMY, SUPERFICIAL FEMORAL ARTERY		\$869.22	\$869.22				
35303	THROMBOENDARTERECTOMY, POPLITEAL ARTERY		\$955.83	\$955.83				
35304	THROMBOENDARTERECTOMY, TIBIOPERONEAL TRUNK ARTERY		\$994.77	\$994.77				
	THROMBOENDARTERECTOMY, TIBIAL OR PERONEAL ARTERY,							
35305	INITIAL VESSEL		\$955.83	\$955.83				
	THROMBOENDARTERECTOMY, EACH ADDITIONAL TIBIAL OR							
35306	PERONEAL ARTERY		\$360.74	\$360.74				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35311	SUBCLAVIAN, INNOMI		\$1,367.17	\$1,367.17				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;			,				
35321	AXILLARY-BRACHIAL		\$738.10	\$738.10				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35331	ABDOMINAL AORTA		\$1,072.40	\$1,072.40	I	1		

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	Fee Schedule 2020							
Note:								
	es in Red;							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35341	MESENTERIC, CELIAC		\$1,246.23	\$1,246.23				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35351	ILIAC		\$1,035.08	\$1,035.08				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35355	ILIOFEMORAL		\$929.63	\$929.63				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35361	COMBINED AORTOILIA		\$1,263.78	\$1,263.78				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35363	COMBINED		\$1,397.25	\$1,397.25				
35371	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH		\$704.10	\$704.10				
	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;							
35372	DEEP (PROFUNDA) FE		\$716.15	\$716.15				
	REOPERATION, CAROTID, THROMBOENDARTERECTOMY, MORE							
35390	THAN ONE MONTH AFTER		\$147.88	\$147.88				
	ANGIOSCOPY (NON-CORONARY VESSELS OR GRAFTS) DURING							
35400	THERAPEUTIC INTERVE		\$151.60	\$151.60				
35500	HARVEST OF UPPER EXTREMITY VEIN, ONE SEGMENT		\$210.19	\$210.19				
35501	BYPASS GRAFT, WITH VEIN; CAROTID		\$1,138.74	\$1,138.74				
35506	BYPASS GRAFT, WITH VEIN; CAROTID-SUBCLAVIAN		\$1,137.56	\$1,137.56				
35508	BYPASS GRAFT, WITH VEIN; CAROTID-VERTEBRAL		\$1,074.09	\$1,074.09				
35509	BYPASS GRAFT, WITH VEIN; CAROTID-CAROTID		\$1,092.22	\$1,092.22				
35510	BYPASS GRAFT, WITH VEIN; CAROTID-BRACHIAL		\$975.05	\$975.05				
35511	BYPASS GRAFT, WITH VEIN; SUBCLAVIAN-SUBCLAVIAN		\$777.20	\$777.20				1
35512	BYPASS GRAFT, WITH VEIN; SUBCLAVIAN-BRACHIAL		\$956.29	\$956.29				
35515	BYPASS GRAFT, WITH VEIN; SUBCLAVIAN-VERTEBRAL		\$855.59	\$855.59				1
35516	BYPASS GRAFT, WITH VEIN; SUBCLAVIAN-AXILLARY		\$988.55	\$988.55				1
35518	BYPASS GRAFT, WITH VEIN; AXILLARY-AXILLARY		\$962.99	\$962.99				

Physician	Fee Schedule 2020							
Note:						+	+	
2020 Code	es in Red:							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv char	ge for the service	<u> </u>				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
35521	BYPASS GRAFT, WITH VEIN; AXILLARY-FEMORAL		\$985.63	\$985.63				
35522	BYPASS GRAFT, WITH VEIN; AXILLARY-BRACHIAL		\$928.60	\$928.60				
35523	ARTERY BYPASS GRAFT		\$1,049.13	\$1,049.13				
35525	BYPASS GRAFT, WITH VEIN; BRACHIAL-BRACHIAL		\$886.32	\$886.32				
35526	BYPASS GRAFT, WITH VEIN; AORTOSUBCLAVIAN OR CAROTID		\$953.30	\$953.30				
35531	BYPASS GRAFT, WITH VEIN; AORTOCELIAC OR AORTOMESENTERIC		\$1,347.14	\$1,347.14				
35533	BYPASS GRAFT, WITH VEIN; AXILLARY-FEMORAL-FEMORAL		\$1,233.91	\$1,233.91				
35535	DECOMPRESSION FASCIOTOMY (IES), PELVIC (BUTTOCK)		\$1,685.55	\$1,685.55				
35536	BYPASS GRAFT, WITH VEIN; SPLENORENAL		\$1,309.80	\$1,309.80				
35537	BYPASS GRAFT, AORTOILIAC		\$1,682.71	\$1,682.71				
35538	BYPASS GRAFT, AOTOBI-ILIAC		\$1,880.70	\$1,880.70				
35539	BYPASS GRAFT, AORTOFEMORAL		\$1,767.47	\$1,767.47				
35540	BYPASS GRAFT, AORTOBIFEMORAL		\$1,971.31	\$1,971.31				
35556	BYPASS GRAFT, WITH VEIN; FEMORAL-POPLITEAL		\$1,045.93	\$1,045.93				
35558	BYPASS GRAFT, WITH VEIN; FEMORAL-FEMORAL		\$894.82	\$894.82				
35560	BYPASS GRAFT, WITH VEIN; AORTORENAL		\$1,286.91	\$1,286.91				
35563	BYPASS GRAFT, WITH VEIN; ILIOILIAC		\$670.29	\$670.29				
35565	BYPASS GRAFT, WITH VEIN; ILIOFEMORAL		\$965.59	\$965.59				
	BYPASS GRAFT, WITH VEIN; FEMORAL-ANTERIOR TIBIAL, POSTERIOR							
35566	TIBIAL,		\$1,245.24	\$1,245.24				
35570	BYPASS GRAFT, WITH VEIN; TIBIAL-TIBIAL, PERONEAL-TIBIAL		\$1,301.33	\$1,301.33				
	BYPASS GRAFT, WITH VEIN; POPLITEAL-TIBIAL, -PERONEAL ARTERY							
35571	OR OTHER D		\$1,102.17	\$1,102.17	1			
	HARVEST OF FEMOROPOPLITEAL VEIN, ONE SEGMENT, FOR							
35572	VASCULAR RECONSTRUCT		\$278.71	\$278.71	1			
35583	IN-SITU VEIN BYPASS; FEMORAL-POPLITEAL		\$1,117.21	\$1,117.21				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	IN-SITU VEIN BYPASS; FEMORAL-ANTERIOR TIBIAL, POSTERIOR							
35585	TIBIAL, OR PER		\$1,287.06	\$1,287.06				
35587	IN-SITU VEIN BYPASS; POPLITEAL-TIBIAL, PERONEAL		\$1,178.19	\$1,178.19				
	HARVEST OF UPPER EXTREMITY ARTERY, ONE SEGMENT, FOR							
35600	CORONARY ARTERY BY		\$207.06	\$207.06				
35601	BYPASS GRAFT, WITH OTHER THAN VEIN; CAROTID		\$1,061.04	\$1,061.04				
35606	BYPASS GRAFT, WITH OTHER THAN VEIN; CAROTID-SUBCLAVIAN		\$1,066.59	\$1,066.59				
35612	BYPASS GRAFT, WITH OTHER THAN VEIN; SUBCLAVIAN-SUBCLAVIAN		\$951.71	\$951.71				
35616	BYPASS GRAFT, WITH OTHER THAN VEIN; SUBCLAVIAN-AXILLARY		\$955.70	\$955.70				
35621	BYPASS GRAFT, WITH OTHER THAN VEIN; AXILLARY-FEMORAL		\$934.91	\$934.91				
	BYPASS GRAFT, WITH OTHER THAN VEIN; AXILLARY-POPLITEAL OR -							
35623	TIBIAL		\$714.35	\$714.35				
	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOSUBCLAVIAN OR							
35626	CAROTID		\$1,302.44	\$1,302.44				
	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOCELIAC,							
35631	AORTOMESENTERIC,		\$1,245.65	\$1,245.65				
35632	BYPASS GRAFT, OTHER THAN VEIN, ILIO-CELIAC		\$1,600.40	\$1,600.40				
35633	BYPASS GRAFT, OTHER THAN VEIN, ILIO-CELIAC		\$1,728.58	\$1,728.28				
35634	BYPASS GRAFT, OTHER THAN VEIN, ILIO-CELIAC	1	\$1,566.28	\$1,566.28				
05000	BYPASS GRAFT, WITH OTHER THAN VEIN; SPLENORENAL (SPLENIC			04.040.04				
35636	TO RENAL ARTE	1	\$1,042.24	\$1,042.24				
35637	BYPASS GRAFT, WITH OTHER THAN VEIN, AORTOILIAC	1	\$1,337.61	\$1,337.61				
35638	BYPASS GRAFT, WITH OTHER THAN VEIN, AORTOBI-ILIAC		\$1,359.03	\$1,359.03				
35642	BYPASS GRAFT, WITH OTHER THAN VEIN; CAROTID-VERTEBRAL		\$820.57	\$820.57				

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	Fee Schedule 2020				_			
Note:								
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	Э				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
35645	BYPASS GRAFT, WITH OTHER THAN VEIN; SUBCLAVIAN-VERTEBRAL		\$823.95	\$823.95				
35646	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOBIFEMORAL		\$1,457.00	\$1,457.00				
35647	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOFEMORAL		\$1,189.26	\$1,189.26				
35650	BYPASS GRAFT, WITH OTHER THAN VEIN; AXILLARY-AXILLARY		\$917.63	\$917.63				
	BYPASS GRAFT, WITH OTHER THAN VEIN; AXILLARY-FEMORAL-							
35654	FEMORAL		\$1,217.20	\$1,217.20				
35656	BYPASS GRAFT, WITH OTHER THAN VEIN; FEMORAL-POPLITEAL		\$969.73	\$969.73				
35661	BYPASS GRAFT, WITH OTHER THAN VEIN; FEMORAL-FEMORAL		\$832.01	\$832.01				
35663	BYPASS GRAFT, WITH OTHER THAN VEIN; ILIOILIAC		\$908.67	\$908.67				
35665	BYPASS GRAFT, WITH OTHER THAN VEIN; ILIOFEMORAL		\$976.19	\$976.19				
	BYPASS GRAFT, WITH OTHER THAN VEIN; FEMORAL-ANTERIOR							
35666	TIBIAL, POSTERIOR		\$1,103.86	\$1,103.86				
	BYPASS GRAFT, WITH OTHER THAN VEIN; POPLITEAL-TIBIAL OR -							
35671	PERONEAL ARTE		\$874.97	\$874.97				
	BYPASS GRAFT; COMPOSITE, PROSTHETIC AND VEIN (LIST							
35681	SEPARATELY IN ADDIT		\$601.23	\$601.23				
	BYPASS GRAFT; AUTOGENOUS COMPOSITE, TWO SEGMENTS OF							
35682	VEINS FROM TWO		\$344.11	\$345.93				
	BYPASS GRAFT; AUTOGENOUS COMPOSITE, THREE OR MORE							
35683	SEGMENTS OF VEIN FRO		\$393.97	\$396.57				
	PLACEMENT OF VEIN PATCH OR CUFF AT DISTAL ANASTOMOSIS OF							
35685	BYPASS GRAFT,		\$165.52	\$165.52				
	CREATION OF DISTAL ARTERIOVENOUS FISTULA DURING LOWER							
35686	EXTREMITY BYPASS		\$136.91	\$136.91				
	TRANSPOSITION AND/OR REIMPLANTATION; VERTEBRAL TO				†		†	
35691	CAROTID ARTERY		\$1,108.86	\$1,108.86				

Physician	Fee Schedule 2020							
Note:								
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSPOSITION AND/OR REIMPLANTATION; VERTEBRAL TO							
35693	SUBCLAVIAN ARTERY		\$709.64	\$709.64				
	TRANSPOSITION AND/OR REIMPLANTATION; SUBCLAVIAN TO							
35694	CAROTID ARTERY		\$825.59	\$825.59				
	TRANSPOSITION AND/OR REIMPLANTATION; CAROTID TO							
35695	SUBCLAVIAN ARTERY		\$825.59	\$825.59				
	REIMPLANTATION, VISCERAL ARTERY TO INFRARENAL AORTIC							
35697	PROSTHESIS, EACH		\$122.87	\$122.87				
	REOPERATION, FEMORAL-POPLITEAL OR FEMORAL (POPLITEAL)-							
35700	ANTERIOR TIBIAL,		\$142.80	\$142.80				
	EXPLORATION (NOT FOLLOWED BY SURGICAL REPAIR), WITH OR							
35701	WITHOUT LYSIS O		\$351.12	\$351.12				Updated Effective 01/01/2020
35702	EXPL N/FLWD SURG UXTR ART		\$329.70	\$329.70				Added Effective 01/01/2020
35703	EXPL N/FLWD SURG LXTR ART		\$335.39	\$335.39				Added Effective 01/01/2020
00700	EXPLORATION (NOT FOLLOWED BY SURGICAL REPAIR), WITH OR		ψ000.00	Ψ000.00				Added Effective 01/01/2020
35721	WITHOUT LYSIS O		\$309.32	\$309.32				
35741	EXPLORATION (NOT FOLLOWED BY SURGICAL REPAIR)		\$314.85	\$314.85				
007 11	EXPLORATION (NOT FOLLOWED BY SURGICAL REPAIR), WITH OR		ψο τ τ.σσ	ΨΟ 1 1.00				
35761	WITHOUT LYSIS O		\$316.76	\$316.76				
-	EXPLORATION FOR POSTOPERATIVE HEMORRHAGE, THROMBOSIS		ψοισσ	ψο τοιι σ				
35800	OR INFECTION; NEC		\$342.42	\$342.42				
	EXPLORATION FOR POSTOPERATIVE HEMORRHAGE, THROMBOSIS	†		1	1			
35820	OR INFECTION; CHE		\$588.74	\$588.74				
	EXPLORATION FOR POSTOPERATIVE HEMORRHAGE, THROMBOSIS							
35840	OR INFECTION; ABD		\$482.15	\$482.15				

Physician	n Fee Schedule 2020							
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omony obox	ac for the convice				+	
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary chai		"				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Drago dura Dagarintian	PA Ind	•	•		Comp.	Value	Notes
Code	Procedure Description EXPLORATION FOR POSTOPERATIVE HEMORRHAGE, THROMBOSIS	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
35860	OR INFECTION:		\$317.00	\$317.00				
35870	REPAIR OF GRAFT-ENTERIC FISTULA		\$942.55	\$942.55				
33070	THROMBECTOMY OF ARTERIAL OR VENOUS GRAFT (OTHER THAN		Φ942.55	φ94Z.33				
35875	HEMODIALYSIS GRAF		\$526.45	\$526.45				
33073	THROMBECTOMY OF ARTERIAL OR VENOUS GRAFT (OTHER THAN		\$ 320.43	φ320.43				
25076	· ·		#620.42	#620.42				
35876	HEMODIALYSIS GRAF		\$639.13	\$639.13				
25070	REVISION, LOWER EXTREMITY ARTERIAL BYPASS, WITHOUT		ф 7 07 00	Ф 7 07 00				
35879	THROMBECTOMY, OPEN;		\$727.03	\$727.03				
25004	REVISION, LOWER EXTREMITY ARTERIAL BYPASS, WITHOUT		ф 7 00 07	¢700.07				
35881	THROMBECTOMY, OPEN;		\$798.37	\$798.37			_	
05000	REVISION, FEM ANASTOMOSIS OF SYN ARTERIAL BYPASS GRAFT		#070.55	0070 55				
35883	W/NONAUTOGENOUS VEIN		\$972.55	\$972.55				
05004	REVISION, FEM ANASTOMOSIS OF SYN ARTERIAL BYPASS GRAFT		A4 000 05	44.000.05				
35884	W/AUTOGENOUS VEIN PATCH		\$1,033.25	\$1,033.25				
35901	EXCISION OF INFECTED GRAFT; NECK		\$440.80	\$440.80				
35903	EXCISION OF INFECTED GRAFT; EXTREMITY		\$481.29	\$481.29				
35905	EXCISION OF INFECTED GRAFT; THORAX		\$723.67	\$723.67				
35907	EXCISION OF INFECTED GRAFT; ABDOMEN		\$746.85	\$746.85				
36000	INTRODUCTION OF NEEDLE OR INTRACATHETER, VEIN		\$9.47	\$12.69				
	INJECTION PROCEDURES (EG, THROMBIN) FOR PERCUTANEOUS		1					
36002	TREATMENT OF EXTR		\$84.99	\$134.56				
	INJECTION PROCEDURE FOR EXTREMITY VENOGRAPHY (INCLUDING							
36005	INTRODUCTION O		\$41.45	\$41.45				
36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA		\$135.43	\$135.43				
-	<u>'</u>	-	-					

Physician	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER							
36011	BRANCH (EG, R		\$148.45	\$148.45				
	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND							
36012	ORDER, OR MORE		\$182.68	\$182.68				
	INTRODUCTION OF CATHETER, RIGHT HEART OR MAIN PULMONARY							
36013	ARTERY		\$138.07	\$138.07				
	SELECTIVE CATHETER PLACEMENT, LEFT OR RIGHT PULMONARY							
36014	ARTERY		\$156.33	\$156.33				
	SELECTIVE CATHETER PLACEMENT, SEGMENTAL OR							
36015	SUBSEGMENTAL PULMONARY ARTE		\$182.68	\$182.68				
	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR							
36100	VERTEBRAL ARTERY		\$165.86	\$165.86				
	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY							
36140	ARTERY		\$102.63	\$102.63				
00400	INTRODUCTION OF NEEDLE OR INTRACATHETER, AORTIC,		*	044400				
36160	TRANSLUMBAR		\$144.68	\$144.68				
36200	INTRODUCTION OF CATHETER, AORTA		\$168.64	\$168.64				
00045	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST		0044.00	0044.00				
36215	ORDER THORAC SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL		\$211.32	\$211.32				+
20246			CO40 74	CO40 74				
36216	SECOND ORDER SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL		\$249.74	\$249.74				
36217	THIRD ORDER OR		\$297.78	\$297.78				
30217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL		φ231.10	φ231.10	1			
36218	SECOND ORDER		\$47.48	\$47.48				
36221	NON-SELECTIVE CATHETER PLACEMENT, THORACIC AORTA,		\$174.58	\$888.61	+			+
36222	SELECTIVE CATHETER PLACEMENT, THORACIC AORTA,		\$236.23	\$1,113.58	+			+
30222	JOLLLOTIVE GATHETER FLAGEINENT, COMMINION CAROTID OR		φ230.23	φ1,113.30				

Physician	Fee Schedule 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	lilary Grai	T			-		
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ango						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo							
Codes list	T	л рпузісіаі I	15					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
36223	SELECTIVE CATHETER PLACEMENT, COMMON CAROTID OR	FAIIIU	\$255.43	\$1,213.67	Comp.	Comp.	Value	Notes
36224	SELECTIVE CATHETER PLACEMENT, INTERNAL CAROTID		\$278.48	\$1,318.90				
36225	SELECTIVE CATHETER PLACEMENT, INTERNAL CAROTID		\$254.43	\$1,204.15				
36226	SELECTIVE CATHETER PLACEMENT, VERTEBRAL ARTERY		\$279.00	\$1,345.00				
36227	SELECTIVE CATHETER PLACEMENT, VERTEBIOLE ARTERIT		\$88.25	\$196.79		-		
36228	SELECTIVE CATHETER PLACEMENT, EACH INTRACRANIAL		\$180.03	\$925.33				
30220	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST		ψ100.03	ψ920.00				
36245	ORDER ABDOMI		\$239.58	\$239.58				
30243	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL		Ψ239.30	Ψ239.30		-		
36246	SECOND ORDER		\$249.74	\$249.74				
30240	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL		Ψ243.14	Ψ243.14				
36247	THIRD ORDER OR		\$297.78	\$297.78				
30247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL		Ψ291.10	Ψ231.10				
36248	SECOND ORDER		\$47.48	\$47.48				
36251	SELECTIVE CATHETER PLACEMENT (FIRST-ORDER),		\$226.84	\$1,128.74		-		
36252	BILATERAL		\$295.51	\$1,241.60				
36253	SUPERSELECTIVE CATHETER PLACEMENT		\$315.90	\$1,725.36				
36254	BILATERAL		\$340.81	\$1,795.75				
0020+	INSERTION OF IMPLANTABLE INTRA-ARTERIAL INFUSION PUMP (EG,		φο-τοιο τ	Ψ1,700.70				
36260	FOR CHEMOTH		\$487.06	\$487.06				
36261	REVISION OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP		\$217.91	\$217.91				
36262	REMOVAL OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP		\$170.06	\$170.06				
36299	UNLISTED PROCEDURE, VASCULAR INJECTION	R	\$0.00	\$0.00				
30233	VENIPUNCTURE, UNDER AGE 3 YEARS, NECESSITATING PHYSICIAN'S		Ψ0.00	Ψ0.00				
36400	SKILL, NOT		\$6.73	\$7.94				
36405	BL DRAW <3 YRS SCALP VEIN		\$13.41	\$18.08				
36406	BL DRAW <3 YRS OTHER VEIN		\$7.15	\$9.82				
36410	NON-ROUTINE BL DRAW 3/> YRS		\$7.66	\$11.67				+
JU4 10	INOIN-INOUTHAL DE DIVAVA OF TIVO		Ψ1.00	ψ11.01				

Physician	Fee Schedule 2020	1			1			
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I I I I I I I I I I I I I I I I I I I		1				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc		.	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
36415	ROUTINE VENIPUNCTURE		\$8.45	\$8.45				
00440	COLLECTION OF CAPILLARY BLOOD SPECIMEN (EG, FINGER, HEEL,		фо 0 7	#0.07				
36416 36420	EAR STICK) VENIPUNCTURE, CUTDOWN; UNDER AGE 1 YEAR		\$3.27 \$44.53	\$3.27 \$44.53				
36425	AGE 1 OR OVER		\$24.69	\$24.69				
36430	TRANSFUSION, BLOOD OR BLOOD COMPONENTS		\$14.58	\$24.69				
36440	PUSH TRANSFUSION, BLOOD, 2 YEARS OR UNDER		\$14.58	\$27.45 \$57.14				
36450	EXCHANGE TRANSFUSION, BLOOD; NEWBORN		\$95.02	\$120.24				
36455	EXCHANGE TRANSFUSION, BLOOD; OTHER THAN NEWBORN		\$137.54	\$137.54				
36456	PRTL EXCHANGE TRANSFUSE NB		\$87.14	\$87.14		+		Added Effective 1/1/2017
36460	TRANSFUSION, INTRAUTERINE, FETAL		\$346.19	\$346.19		-		Added Effective 1/1/2017
36465	NJX NONCMPND SCLRSNT 1 VEIN		\$96.02	\$1,183.75		-		Added Effective 1/1/2018
36466	NJX NONCMPND SCLRSNT MLT VN		\$122.16	\$1,238.09				Added Effective 1/1/2018
36470	INJECTION THERAPY OF VEIN		\$65.80	\$118.00				Added Effective 1/1/2010
30470	INSECTION THERAIT OF VEIN		ψ03.00	ψ110.00				
36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG		\$50.17	\$55.40				
36473	ENDOVENOUS MCHNCHEM 1ST VEIN		\$141.94	\$1,114.27				Added Effective 1/1/2017
36474	ENDOVENOUS MCHNCHEM ADD-ON		\$71.10	\$207.81				Added Effective 1/1/2017
00171	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN,		Ψίτιο	Ψ207.01				7 (4464 211664) 6 17 1726 17
36475	EXTREMITY, INCLUSIVE	R	\$273.44	\$1,379.06				
330	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN,	1.	7	Ţ .,c. 3.00				
36476	EXTREMITY, INCLUSIVE	R	\$134.04	\$306.01				
	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN,		Ţ · - · · · ·	,				
36478	EXTREMITY, INCLUSIVE	R	\$271.71	\$1,103.62				
	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN,		+	Ţ ·, · · · · ·				
36479	EXTREMITY, INCLUSIVE	R	\$134.04	\$308.82				
			1					
36481	PERCUTANEOUS PORTAL VEIN CATHETERIZATION BY ANY METHOD		\$362.09	\$362.09				

Physician	Fee Schedule 2020							
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
36482	ENDOVEN THER CHEM ADHES 1ST		\$142.44	\$1,576.64				Added Effective 1/1/2018
36483	ENDOVEN THER CHEM ADHES SBSQ		\$71.11	\$110.79				Added Effective 1/1/2018
	VENOUS CATHETERIZATION FOR SELECTIVE ORGAN BLOOD							
36500	SAMPLING		\$105.68	\$105.68				
	CATHETERIZATION OF UMBILICAL VEIN FOR DIAGNOSIS OR							
36510	THERAPY, NEWBORN		\$37.03	\$41.59				
36511	THERAPEUTIC APHERESIS; FOR WHITE BLOOD CELLS		\$69.62	\$69.62				
36512	THERAPEUTIC APHERESIS; FOR RED BLOOD CELLS		\$69.62	\$69.62				
36513	THERAPEUTIC APHERESIS; FOR PLATELETS		\$69.62	\$69.62				
36514	THERAPEUTIC APHERESIS; FOR PLASMA PHERESIS		\$69.62	\$69.62				
	THERAPEUTIC APHERESIS; WITH EXTRACORPOREAL							
36515	IMMUNOADSORPTION AND PLASMA		\$69.62	\$69.62				
	THERAPEUTIC APHERESIS; WITH EXTRACORPOREAL SELECTIVE							
36516	ADSORPTION OR		\$69.62	\$69.62				
36522	PHOTOPHERESIS, EXTRACORPOREAL		\$124.51	\$124.51				
	INSERTION OF NON-TUNNELED CENTRALLY INSERTED CENTRAL							
36555	VENOUS CATHETER;		\$102.82	\$237.45				
	INSERTION OF NON-TUNNELED CENTRALLY INSERTED CENTRAL							
36556	VENOUS CATHETER;		\$98.73	\$98.73				
	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS							
36557	CATHETER, WITH		\$227.78	\$511.70				
	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS			1.				
36558	CATHETER, WITH		\$223.76	\$223.76				
	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS							
36560	ACCESS DEVICE,		\$270.61	\$948.94				
	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS							
36561	ACCESS DEVICE,		\$269.91	\$269.91				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thai y Chai		7				+
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Codes lis	led on the lab fee scriedule that begin with a 1- of Q are currently non-covered to	n priysiciai	113					
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0000	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS	i A iiiu	(i dointy)	(Norm domey)	Comp.	Jonip.	Value	110100
36563	ACCESS DEVICE		\$271.50	\$882.00				
00000	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS		Ψ27 1.00	ψοσ2.σσ				+
36565	ACCESS DEVICE,		\$261.39	\$760.11				
00000	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS		Ψ201.00	ψ/ 00.11				
36566	ACCESS DEVICE,		\$279.86	\$795.03				
00000	INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS		Ψ27 0.00	ψ1 00.00				+
36568	CATHETER (PICC), WIT		\$75.58	\$273.17				
00000	INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS		ψ1 0.00	Ψ270.17				+
36569	CATHETER (PICC), WIT		\$71.15	\$230.20				
00000	INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS ACCESS		Ψσ	Ψ200.20				
36570	DEVICE, WITH		\$235.91	\$1,208.95				
000.0	INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS ACCESS		+	4 1,200.00				
36571	DEVICE, WITH		\$235.08	\$1,088.38				
36572	INSJ PICC RS&I <5 YR		\$75.38	\$316.89				Effective 1/1/2019
36573	INSJ PICC RS&I 5 YR+		\$69.70	\$298.15				Effective 1/1/2019
	REPAIR OF TUNNELED OR NON-TUNNELED CENTRAL VENOUS		700110	7=00110				
36575	ACCESS CATHETER, WIT		\$41.28	\$120.68				
	REPAIR OF CENTRAL VENOUS ACCESS DEVICE, WITH		¥	7 1 2 1 2 1				
36576	SUBCUTANEOUS PORT OR PUMP		\$152.03	\$305.17				
	REPLACEMENT, CATHETER ONLY, OF CENTRAL VENOUS ACCESS		,					1
36578	DEVICE, WITH		\$172.26	\$387.06				
	REPLACEMENT, COMPLETE, OF A NON-TUNNELED CENTRALLY		1	1,	1			
36580	INSERTED CENTRAL VE		\$52.36	\$192.65				
	REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED		, , =	,				
36581	CENTRAL VENOUS		\$161.28	\$455.48				
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Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED							
36582	CENTRAL VENOUS		\$235.54	\$849.89				
	REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED							
36583	CENTRAL VENOUS		\$237.49	\$503.94				
	REPLACEMENT, COMPLETE, OF A PERIPHERALLY INSERTED							
36584	CENTRAL VENOUS CATHE		\$52.79	\$201.05				
	REPLACEMENT, COMPLETE, OF A PERIPHERALLY INSERTED		****	4.005.00				
36585	CENTRAL VENOUS ACCES		\$220.69	\$1,065.26				
00500	REMOVAL OF TUNNELED CENTRAL VENOUS CATHETER, WITHOUT		# 400.00	0400.00				
36589	SUBCUTANEOUS PORT		\$108.02	\$126.26		_		
20500	REMOVAL OF TUNNELED CENTRAL VENOUS ACCESS DEVICE, WITH		¢450.70	¢450.70				
36590	SUBCUTANEOUS PO DRAW BLOOD OFF VENOUS DEVICE		\$152.70 \$16.32	\$152.70 \$16.32				+
36591 36592	COLLECT BLOOD FROM PICC		\$10.32	\$10.32				+
36593	DECLOT VASCULAR DEVICE		\$35.31	\$35.31				
30393	MECHANICAL REMOVAL OF PERICATHETER OBSTRUCTIVE MATERIAL		φ30.3 I	φου.ο i		_		
36595	(EG, FIBRIN SH		\$148.07	\$596.95				
30393	MECHANICAL REMOVAL OF INTRALUMINAL (INTRACATHETER)		φ140.07	φυθυ.θυ				
36596	OBSTRUCTIVE MATERIA		\$35.73	\$136.71				
30330	REPOSITIONING OF PREVIOUSLY PLACED CENTRAL VENOUS		ψ00.70	ψ100.71				
36597	CATHETER UNDER		\$47.66	\$118.06				
30007	CONTRAST INJECTION(S) FOR RADIOLOGIC EVALUATION OF	1	Ψ17.00	ψ110.00				+
36598	EXISTING CENTRAL VE		\$90.87	\$90.97				
36600	ARTERIAL PUNCTURE, WITHDRAWAL OF BLOOD FOR DIAGNOSIS		\$17.39	\$17.39				
	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING,	1		·				
36620	MONITORING OR		\$54.85	\$54.85				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING,							
36625	MONITORING OR		\$89.36	\$89.36				
	ARTERIAL CATHETERIZATION FOR PROLONGED INFUSION THERAPY							
36640	(CHEMOTHERAPY)		\$133.57	\$133.57				
	CATHETERIZATION, UMBILICAL ARTERY, NEWBORN, FOR DIAGNOSIS							
36660	OR THERAPY		\$55.20	\$55.20				
36680	PLACEMENT OF NEEDLE FOR INTRAOSSEOUS INFUSION		\$70.90	\$70.90				
	INSERTION OF CANNULA FOR HEMODIALYSIS, OTHER PURPOSE							
36800	(SEPARATE PROCEDU		\$137.65	\$137.65				
	INSERTION OF CANNULA FOR HEMODIALYSIS, OTHER PURPOSE							
36810	(SEPARATE PROCEDU		\$264.56	\$264.56				
	INSERTION OF CANNULA FOR HEMODIALYSIS, OTHER PURPOSE							
36815	(SEPARATE PROCEDU		\$183.74	\$183.74				
	ARTERIOVENOUS ANASTOMOSIS, OPEN; BY UPPER ARM CEPHALIC		7.00	7.00				
36818	VEIN TRANSPOSIT		\$544.36	\$544.36				
-	ARTERIOVENOUS ANASTOMOSIS, OPEN; BY UPPER ARM BASILIC		4000	40				
36819	VEIN TRANSPOSITI		\$612.48	\$612.48				
00010	ARTERIOVENOUS ANASTOMOSIS, OPEN; BY FOREARM VEIN		ψο 12.10	Ψ012.10				
36820	TRANSPOSITION		\$610.47	\$610.47				
00020	ARTERIOVENOUS ANASTOMOSIS, OPEN; DIRECT, ANY SITE (EG,		ΨΟΤΟ.ΤΙ	φο το. ττ				
36821	CIMINO TYPE)		\$475.86	\$475.86				
00021	INSERTION OF ARTERIAL AND VENOUS CANNULA(S) FOR ISOLATED		ψ-1 0.00	ψ-1 0.00				+
36823	EXTRACORPOREA		\$936.63	\$936.63				
50020	CREATION OF ARTERIOVENOUS FISTULA BY OTHER THAN DIRECT		Ψυσυ.υυ	Ψ000.00				+
36825	ARTERIOVENOUS		\$628.76	\$628.76				
30023	CREATION OF ARTERIOVENOUS FISTULA BY OTHER THAN DIRECT		Ψ020.70	ψ020.70				+
36830	ARTERIOVENOUS		\$552.78	\$552.78				
30030	JANTENIOVENOUS		φυυΖ./ ο	φυυΖ.70				

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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	THROMBECTOMY, OPEN, ARTERIOVENOUS FISTULA WITHOUT							
36831	REVISION, AUTOGENOUS		\$322.84	\$322.84				
	REVISION, OPEN, ARTERIOVENOUS FISTULA; WITHOUT							
36832	THROMBECTOMY, AUTOGENOU		\$429.83	\$429.83				
	REVISION, OPEN, ARTERIOVENOUS FISTULA; WITH THROMBECTOMY,							
36833	AUTOGENOUS O		\$492.02	\$492.02				
36835	INSERTION OF THOMAS SHUNT (SEPARATE PROCEDURE)		\$302.83	\$302.83				
	DISTAL REVASCULARIZATION AND INTERVAL LIGATION (DRIL),							
36838	UPPER EXTREMITY		\$909.16	\$909.16				
	EXTERNAL CANNULA DECLOTTING (SEPARATE PROCEDURE);							
36860	WITHOUT BALLOON CATH		\$138.36	\$138.36				
	EXTERNAL CANNULA DECLOTTING (SEPARATE PROCEDURE); WITH							
36861	BALLOON CATHETE		\$184.85	\$184.85				
	THROMBECTOMY, PERCUTANEOUS, ARTERIOVENOUS FISTULA,							
36870	AUTOGENOUS OR		\$214.29	\$941.19				
36901	INTRO CATH DIALYSIS CIRCUIT		\$118.83	\$429.95				Added Effective 1/1/2017
36902	INTRO CATH DIALYSIS CIRCUIT		\$177.13	\$908.51				Added Effective 1/1/2017
36903	INTRO CATH DIALYSIS CIRCUIT		\$242.56	\$4,120.92				Added Effective 1/1/2017
36904	THRMBC/NFS DIALYSIS CIRCUIT		\$279.28	\$1,326.45				Added Effective 1/1/2017
36905	THRMBC/NFS DIALYSIS CIRCUIT		\$350.55	\$1,696.88				Added Effective 1/1/2017
36906	THRMBC/NFS DIALYSIS CIRCUIT		\$409.08	\$5,006.35				Added Effective 1/1/2017
36907	BALO ANGIOP CTR DIALYSIS SEG		\$102.11	\$543.44				Added Effective 1/1/2017
36908	STENT PLMT CTR DIALYSIS SEG		\$153.06	\$1,983.61				Added Effective 1/1/2017
36909	DIALYSIS CIRCUIT EMBOLJ		\$145.21	\$1,449.43				Added Effective 1/1/2017
37140	VENOUS ANASTOMOSIS, OPEN; PORTOCAVAL		\$1,168.05	\$1,168.05				
37145	VENOUS ANASTOMOSIS, OPEN; RENOPORTAL		\$1,180.85	\$1,180.85				
37160	VENOUS ANASTOMOSIS, OPEN; CAVAL-MESENTERIC		\$1,159.19	\$1,159.19				
37180	VENOUS ANASTOMOSIS, OPEN; SPLENORENAL, PROXIMAL		\$1,127.27	\$1,127.27				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Omary chai	ge for the service	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description VENOUS ANASTOMOSIS, OPEN; SPLENORENAL, DISTAL (SELECTIVE	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
37181	DECOMPRESSION		\$1,264.26	¢4 264 26				
37 181	INSERTION OF TRANSVENOUS INTRAHEPATIC PORTOSYSTEMIC		\$1,204.20	\$1,264.26				
27402			¢604.70	¢604.70				
37182	SHUNT(S) (TIPS) REVISION OF TRANSVENOUS INTRAHEPATIC PORTOSYSTEMIC		\$691.70	\$691.70				
27402			\$321.59	¢204 F0				
37183	SHUNT(S) (TIPS) PRIMARY PERCUTANEOUS TRANSLUMINAL MECHANICAL		\$321.59	\$321.59				
27404			фо <i>Е</i> С 00	¢0.405.00				
37184	THROMBECTOMY, NONCORONARY PRIMARY PERCUTANEOUS TRANSLUMINAL MECHANICAL		\$356.92	\$2,105.80				
07405			¢404.00	ф000 0 <i>5</i>				
37185	THROMBECTOMY, NONCORONARY	_	\$131.08	\$688.35				
07407	PERCUTANEOUS TRANSLUMINAL MECHANICAL THROMBECTOMY,		#224.04	¢0.047.00				
37187	VEIN(S), INCLUDING	_	\$331.84	\$2,047.29				
07400	PERCUTANEOUS TRANSLUMINAL MECHANICAL THROMBECTOMY,		0000 47	04.704.00				
37188	VEIN(S), INCLUDING INSERTION OF INTRAVASCULAR VENA CAVA FILTER,	_	\$239.47	\$1,764.83				
	,							
	ENDOVASCULAR APPROACH INCLUDING VASCULAR ACCESS,							
	VESSEL SELECTION, AND RADIOLOGICAL SUPERVISION AND							
	INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND							
07404	IMAGING GUIDANCE (ULTRASOUND AND FLUROSCOPY), WHEN		# 404.05	0004044				
37191	PERFORMED		\$194.25	\$2,040.44				
	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							
37192	PERFO		\$301.23	\$1,379.12				

Physician	n Fee Schedule 2020							
Note:	The econedule 2020							+
	des in Red;	+						
	CPT book for descriptions	+						
	column indicates Prior Auth is required							+
	column indicates Frior Admis required sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omori obor	go for the convice				+	+
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Je for the service	;				+
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						+
	se lab fee scriedule for covered codes not listed below in the outloi-09249 sted on the lab fee schedule that begin with a P or Q are currently non-covered f							+
Codes iis		or priysicia T	115					+
	+	+					Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	Procedure Description	PAIIIU	(Facility)	(NOTIF actility)	Comp.	Comp.	Value	Notes
	RETRIEVAL (REMOVAL) OF INTRAVASCULAR VENA CAVA FILTER,							
	ENDOVASCULAR APPROACH INCLUDING VASCULAR ACCESS,							
	VESSEL SELECTION, AND RADIOLOGICAL SUPERVISION AND							
	INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND							
37193	IMAGING GUIDANCE (ULTRASOUND AND FLUOROSCOPY), WHEN		\$300.97	\$1,316.84				
37195	THROMBOLYSIS, CEREBRAL, BY INTRAVENOUS INFUSION	+	\$211.50	\$211.50			+	+
37197	TRANSCATHETER RETRIEVAL, PERCUTANEOUS, OF INTRA		\$250.01	\$1,303.87				+
37200	TRANSCATHETER BIOPSY	+	\$179.61	\$179.61			+	+
37200	TRANSCATHETER OCCLUSION OR EMBOLIZATION (EG, FOR TUMOR	+	ψ17 3.01	Ψ173.01			_	+
37204	DESTRUCTION, TO		\$940.24	\$940.24				
31204	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S),		ψ940.24	ψ340.24				+
37205	(EXCEPT CORONARY		\$391.57	\$391.57				
37203	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S),		ψυστ.στ	ψ391.37				+
37206	(EXCEPT CORONARY		\$195.49	\$195.49				
37200	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S),		ψ190.49	ψ190.49				+
37207	(NON-CORONARY		\$391.57	\$391.57				
01201	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S),		φοστιστ	φοσ τ.στ				+
37208	(NON-CORONARY		\$195.49	\$195.49				
37210	EMBOLIZATION, UTERINE FIBROID	+	\$399.76	\$1,488.04				+
37211	TRANSCATHETER THERAPY, ARTERIAL INFUSION FOR		\$327.91	\$327.91				+
37212	TRANSCATHETER THERAPY, VENOUS INFUSION FOR THROM		\$289.50	\$289.50				+
37213	TRANSCATHETER THERAPY, ARTERIAL OR VENOUS INFUS	+	\$202.48	\$202.48				+
37214	CESSATION OF THROMBOLYSIS INCLUDING REMOVAL OF		\$118.33	\$118.33				+
	TRANSCATHETER PLACEMENT OF INTRAVASCULAR STENT(S),		+ 1 1 0 . 0 0	Ţ 1 10.00				+
37215	CERVICAL CAROTID AR		\$815.30	\$815.30				
5,2,0	TOTAL CONTROLLE AND AND		Ψ510.00	Ψ5 10.00				

Notes 2020 Codes in Red; Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for descriptions Refer to CPT book for description Refer to CPT book for description Refer to CPT book for description Refer to	Physician	n Fee Schedule 2020							
Revision Red; Red; Red; Red; Red; Red; Red; Revision Red;	_	The econedule 2020							
Refer to CPT book for descriptions R'in PA column indicates Prior Auth is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description TRANSCATHETER PLACEMENT OF INTRAVASCULAR STENT(S), STENT PLACEMITER PLACEMENT RETEO CAROTID STENT PLACEMITER PLACEMENT RETEO CAROTID REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, LILAC ARTERY, UNILATERAL, INITIAL VESSEL, WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL LILAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL: WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL LILAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL: WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL LILAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL: WITH TRANSLUMINAL ANGIOPLASTY VISED IN CONJUCTION WITH STZ20, 37221 LILAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL LILAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL S166.42 \$449.53 \$3923 (USED IN CONJUCTION WITH TRANSLUMINAL STENT PLACEMENTIS), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL S172.98 \$798.72 \$172.98 \$798.72 \$196.42 \$2.253.73 \$3923 (USED IN CONJUCTION WITH TRANSLUMINAL		dos in Pad							
RETINE A Column indicates Prior Auth is required Codes listed as '50.00" pay 45% of Ilbiled amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89289 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description TRANSCATHETER PLACEMENT OF INTRAVASCULAR STENT(S), 37216 CERVICAL CAROTIDI AR 37217 STENT PLACEMIT RETRO CAROTID INSERTION OF STENTS IN BLOOD VESSELS OF CHEST OPEN OR ACCESSED THROUGH THE SKIN WITH RADIOLOGICAL SUPERVISION 37218 AND INTERPRETATION REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT REVASCULARIZATION WITH TRANSLUMINAL STENT TRANSLUMINAL ANGIOPLASTY WITHIN SAME VESSEL STEAD ANGIOPLASTY USED IN CONJUCTION WITH 37220, 37222 37222 37222 37222 37223 ILIAC ARTERY PLACEMENT SIN BLOOD ASSTULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, EVASCULARIZATION WITH TRANSLUMINAL STENT TRANSLUMINAL ANGIOPLASTY WITHIN SAME VESSEL STEAD S								+	+
Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.00. Each 15 fize. Eac									
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Proc Code Procedure Description				nc				+	+
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37216 CERVICAL CAROTID S785.20 S785.20 S7217 STENT PLACEMENT RETRO CAROTID S906.18	Code		FAIIIU	(Facility)	(NOTIF actility)	Comp.	Comp.	Value	Notes
37217 STENT PLACEMT RETRO CAROTID \$906.18 \$906.1	37216			¢785 20	¢785 20				
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37218 AND INTERPRETATION \$672.32 \$672.32 Added effective 1/1/2015 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL \$380.96 \$2,769.69 ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL \$463.45 \$4,092.38 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL; WITH TRANSLUMINAL ANGIOPLASTY USED IN CONJUCTION WITH 37220, 37221 \$172.98 \$798.72 ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL \$196.42 \$2,253.73 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL STENT \$196.42 \$2,253.74 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES \$19.393.82 \$199.393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES \$19.393.82 \$19.393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES \$19.393.82 \$19.393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES \$19.393.82 \$19.393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES \$10.200.200.200.200.200.200.200.200.200.2									
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37221 PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL; WITH TRANSLUMINAL ANGIOPLASTY USED IN CONJUCTION WITH 37220, 37221 \$172.98 \$798.72 ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL (USED IN CONJUCTION WITH 37221) \$196.42 \$2,253.73 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),		II IAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT							
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ILIAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL; WITH TRANSLUMINAL ANGIOPLASTY USED IN CONJUCTION WITH 37220, 37221 \$172.98 \$798.72 ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL 37223 (USED IN CONJUCTION WITH 37221) \$196.42 \$2,253.73 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY \$419.53 \$3,327.49 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82	07221	\ /'		ψ+00.+0	Ψ+,002.00				
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37222 37221 \$172.98 \$798.72 ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL 37223 (USED IN CONJUCTION WITH 37221) \$196.42 \$2,253.73 REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY \$419.53 \$3,327.49 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),									
ILIAC ARTERY REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL 37223 (USED IN CONJUCTION WITH 37221) REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	37222	· · · · · · · · · · · · · · · · · · ·		\$172 98	\$798 72				
PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL (USED IN CONJUCTION WITH 37221) REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S), REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	0.222			ψ17 <u>2.00</u>	ψ. σσ Ξ			+	
37223 (USED IN CONJUCTION WITH 37221) \$196.42 \$2,253.73									
REVASCULARIZATION, ENDOVASCÚLAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY \$419.53 \$3,327.49 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	37223			\$196.42	\$2,253,73				
FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL 37224 ANGIOPLASTY \$419.53 \$3,327.49 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	0.220			ψ.σσ <u>=</u>	ψ=,==σσ				
37224 ANGIOPLASTY \$419.53 \$3,327.49 REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),									
REVASCULARIZATION WITH ATHERECTOMY, INCLUDES 37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	37224			\$419.53	\$3.327.49				
37225 ANGIOPLASTY WITHIN THE SAME VESSEL \$565.21 \$9,393.82 SECTION WITH TRANSLUMINAL STENT PLACEMENT(S),				+	+-,				
REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),	37225			\$565.21	\$9.393.82				
				+ 200	+ 3,000.02				
	37226			\$465.52	\$7,862.85				

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	olumn indicates Prior Auth is required						1	
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnar	ge for the service	9		_	<u> </u>	
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						1	
	e lab fee schedule for covered codes not listed below in the 80000-89249 r						1	
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r pnysiciar I	1S 				1	<u> </u>
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
	REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S)							
37227	AND ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN SAME VESSEL		\$682.71	\$12,699.65				
31221	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS,		φ002.7 1	\$12,099.03			+	-
	TIBIAL/PERONEAL ARTERY, UNILATERAL, INITIAL VESSEL; WITH							
37228	TRANSLUMINAL ANGIOPLASTY		\$512.70	\$4,736.52				
31220	REVASCULARIZATION WITH ATHERECTOMY, INCLUDES		φ312.70	φ4,730.32			+	-
37229	ANGIOPLASTY WITHIN THE SAME VESSEL		\$661.94	\$9,313.71				
31229	REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),		Ψ001.94	ψθ,515.71			+	
37230	INCLUDES ANGIOPLASTY WITHIN SAME VESSEL		\$638.50	\$7,317.51				
07200	REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S)		φοσο.σσ	φτ,σττ.στ				+
	AND ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME							
37231	VESSEL		\$693.98	\$11,741.01				
07201	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS,		Ψ000.00	Ψ11,711.01			†	
	TIBIAL/PERONEAL ARTERY, UNILATERAL, EACH ADDITIONAL VESSEL;							
	WITH TRANSLUMINAL ANGIOPLASTY USE IN CONJUCTION WITH							
37232	37228-37231		\$185.44	\$1,063.97				
0.202	REVASCULARIZATION WITH ATHERECTOMY, INCLUDES		ψσσ	ψ1,000.01			†	
	ANGIOPLASTY WITHIN THE SAME VESSEL USE IN CONJUCTION WITH							
37233	37229-37231		\$304.71	\$1,300.44				
	REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S),		+ 2 0	+ 1,000				
	INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL USE IN							
37234	CONJUCTION WITH 37230, 37231		\$253.98	\$3,387.42				
	REVASCULARIZATION WITH TRANSLUMINAL STENT PLACEMENT(S)			, , , , , , ,	1		1	
	AND ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME							
37235	VESSEL USE IN CONJUCTION WITH 37231		\$360.49	\$3,619.15				
37236	OPEN/PERQ PLACE STENT 1ST		\$377.71	\$2,096.92				

Physician	Fee Schedule 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	go for the convice	,		-		+
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I		,		-		+
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ango						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ne					
Codes liste	T	л риузісіаі І	113					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
37237	OPEN/PERQ PLACE STENT EA ADD	Ailiu	\$176.55	\$911.84	Jonip.	Jonip.	Value	Notes
37238	OPEN/PERQ PLACE STENT SAME		\$264.58	\$3,043.77				+
37239	OPEN/PERQ PLACE STENT EA ADD		\$123.23	\$1,512.31				
37241	VASC EMBOLIZE/OCCLUDE VENOU		\$366.17	\$3,377.96				
37242	VASC EMBOLIZE/OCCLUDE ARTERY		\$408.85	\$5,672.04				
37243	VASC EMBOLIZE/OCCLUDE ORGAN		\$487.47	\$7,157.85				
37244	VASC EMBOLIZE/OCCLUDE BLEED		\$568.69	\$5,031.13				
37246	TRLUML BALO ANGIOP 1ST ART		\$290.74	\$1,598.35				Added Effective 1/1/2017
37247	TRLUML BALO ANGIOP ADDL ART		\$144.20	\$648.95				Added Effective 1/1/2017
37248	TRLUML BALO ANGIOP 1ST VEIN		\$249.99	\$1,111.06				Added Effective 1/1/2017
37249	TRLUML BALO ANGIOP ADDL VEIN		\$122.68	\$477.46				Added Effective 1/1/2017
	INTERVASCULAR ULTRASOUND DIAG EVALUATION /RADIOLOGICAL							
37252	SUPERVISION INITIAL NONCORONARY VESSEL	R	\$75.78	\$1,033.05				Added Effective 1/1/2016
37253	EACH ADDITIONAL NONCORONARY VESSEL	R	\$60.60	\$164.35				Added Effective 1/1/2016
37605	LIGATION; INTERNAL OR COMMON CAROTID ARTERY		\$310.26	\$310.26				
	LIGATION; INTERNAL OR COMMON CAROTID ARTERY, WITH							
37606	GRADUAL OCCLUSION, A		\$312.14	\$312.14				
37607	LIGATION OR BANDING OF ANGIOACCESS ARTERIOVENOUS FISTULA		\$270.69	\$270.69				
37609	LIGATION OR BIOPSY, TEMPORAL ARTERY		\$135.39	\$135.39				
37615	LIGATION, MAJOR ARTERY (EG, POST-TRAUMATIC, RUPTURE); NECK		\$306.53	\$306.53				
37616	LIGATION, MAJOR ARTERY (EG, POST-TRAUMATIC, RUPTURE); CHEST		\$564.15	\$564.15				
	LIGATION, MAJOR ARTERY (EG, POST-TRAUMATIC, RUPTURE);							
37617	ABDOMEN		\$668.38	\$668.38				
	LIGATION, MAJOR ARTERY (EG, POST-TRAUMATIC, RUPTURE);							
37618	EXTREMITY		\$273.77	\$273.77				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar	ns T					
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Proc	Bus as done Bus windless	DA III	Inpat. Rate	Outpat. Rate	Tech.		Unit	Natas
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
37619	LIGATION OF INFERIOR VENA CAVA		\$1,325.28	\$1,325.28				
37650	LIGATION OF FEMORAL VEIN		\$249.28	\$249.28				
37660	LIGATION OF COMMON ILIAC VEIN		\$463.39	\$463.39				
.==	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT		4040.00	40.40.00				
37700	SAPHENOFEMORAL JUNCTIO		\$218.66	\$218.66				
37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN		\$308.05	\$308.05				
07700	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS		0000 40	0000 40				
37722	VEINS FROM		\$366.19	\$366.19				
	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR							
37735	SHORT SAPHENOU		\$555.02	\$555.02				
	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON		4500.00	4500.00				
37760	TYPE), WITH		\$528.06	\$528.06				
	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING							
37761	US GUIDANCE, WHEN PERFORMED, 1 LEG		\$426.59	\$426.59				
	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; 10-20							
37765	STAB INCISION		\$340.01	\$340.01				
	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; MORE			1				
37766	THAN 20 INCISI		\$414.34	\$414.34				
	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT							
37780	SAPHENOPOPLITEAL JUNC		\$162.49	\$162.49				
	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN							
37785	CLUSTER(S), ONE L		\$135.12	\$135.12				
	PENILE REVASCULARIZATION, ARTERY, WITH OR WITHOUT VEIN							
37788	GRAFT		\$1,067.94	\$1,067.94				
37790	PENILE VENOUS OCCLUSIVE PROCEDURE		\$401.58	\$401.58				
37799	UNLISTED PROCEDURE, VASCULAR SURGERY	R	\$0.00	\$0.00				
38100	SPLENECTOMY; TOTAL (SEPARATE PROCEDURE)		\$625.14	\$625.14				

Physician	Fee Schedule 2020							
Note:	The content 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omony obox	ac for the convice				+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary chai	T T THE SERVICE	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		no.					
Codes iis		or priysicia T	115					
-							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
38101	SPLENECTOMY; PARTIAL (SEPARATE PROCEDURE)	PAIIIU	\$593.61	\$593.61	Comp.	Comp.	Value	Notes
30101	SPLENECTOMY, FARTIAL (SEPARATE PROCEDURE) SPLENECTOMY; TOTAL, EN BLOC FOR EXTENSIVE DISEASE, IN		φυθυ.01	φυθυ.01				
38102	CONJUNCTION WITH		\$222.27	\$222.27				
30102	REPAIR OF RUPTURED SPLEEN (SPLENORRHAPHY) WITH OR		ΦΖΖΖ.Ζ Ι	ΦΖΖΖ.Ζ Ι				
20115			\$610.56	¢640.56				
38115	WITHOUT PARTIAL LAPAROSCOPY, SURGICAL, SPLENECTOMY		\$683.05	\$610.56 \$683.05				
38120				\$126.98				
38200 38204	INJECTION PROCEDURE FOR SPLENOPORTOGRAPHY BL DONOR SEARCH MANAGEMENT		\$126.98 \$81.93	\$81.93				
38204			\$81.93	\$81.93				
20005	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING		000 44	фсо 4.4				
38205	FOR TRANSPLANTA BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING		\$60.14	\$60.14			_	
20000			000 44	фсо 4.4				
38206	FOR TRANSPLANTA		\$60.14	\$60.14				
00007	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		47.07	φ ₄ 7.07				
38207	CELLS; CRYOPRESERVA		\$47.87	\$47.87			_	
00000	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		# 50.00	#50.00				
38208	CELLS; THAWING OF		\$52.26	\$52.26				
00000	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		# 40.00	# 40.00				
38209	CELLS; THAWING OF		\$46.23	\$46.23			_	
00040	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		450.00	#50.00				
38210	CELLS; SPECIFIC CEL		\$50.08	\$50.08				
00044	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		#50.00	450.00				
38211	CELLS; TUMOR CELL		\$50.08	\$50.08				
00040	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR		#50.00	450.00				
38212	CELLS; RED BLOOD CE		\$50.08	\$50.08				
	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR							
38213	CELLS; PLATELET		\$50.08	\$50.08				

Note: 2020 Codes Refer to CP R" in PA coll Codes listed	ee Schedule 2020 s in Red; T book for descriptions lumn indicates Prior Auth is required							
Refer to CP R" in PA col Codes listed	T book for descriptions							
R" in PA coll Codes listed								
Codes listed	lumn indicates Prior Auth is required							
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THE AIRCOUN	esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please use	lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes listed	d on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR							
	CELLS; PLASMA (VOLU		\$41.58	\$41.58				
	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR							
	CELLS; CELL		\$50.08	\$50.08				
	BONE MARROW; ASPIRATION ONLY		\$43.19	\$151.60				
	BONE MARROW; BIOPSY, NEEDLE OR TROCAR		\$54.88	\$162.78				
	DX BONE MARROW BX & ASPIR		\$62.32	\$130.21				Added Effective 1/1/2018
	BONE MARROW HARVESTING FOR TRANSPLANTATION		\$172.39	\$172.39				
	AUTOGLOUS		\$147.54	\$147.54				
	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL		* 404.00	# 404.00				
	TRANSPLANTATION;		\$124.92	\$124.92				
	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL		# 400.00	# 400.00				
	TRANSPLANTATION;		\$123.60	\$123.60			_	
	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL		# 00 5 0	\$60.50				
	TRANSPLANTATION; HPC BOOST		\$68.50	\$68.50				
38243 I	HPC BOOS1		\$94.02	\$94.02	1			+
38300	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; SIMPLE		\$53.64	\$61.42				
	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; SIMPLE DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS;		Φ 33.04	\$01.42				
	EXTENSIVE		\$185.74	\$185.74				
	LYMPHANGIOTOMY OR OTHER OPERATIONS ON LYMPHATIC		φ100.74	\$100.74				
	CHANNELS		\$234.84	\$234.84				
	SUTURE AND/OR LIGATION OF THORACIC DUCT; CERVICAL		Ψ204.04	Ψ204.04				
	APPROACH		\$329.17	\$329.17				
	SUTURE AND/OR LIGATION OF THORACIC DUCT; THORACIC		Ψ020.17	Ψ020.11				+
	APPROACH		\$594.28	\$594.28				

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	n Fee Schedule 2020	-					_	
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SUTURE AND/OR LIGATION OF THORACIC DUCT; ABDOMINAL							
38382	APPROACH		\$428.41	\$428.41				
38500	BIOPSY OR EXCISION OF LYMPH NODE(S); OPEN, SUPERFICIAL		\$133.22	\$133.22				
	BIOPSY OR EXCISION OF LYMPH NODE(S); BY NEEDLE, SUPERFICIAL							
38505	(EG, CERVI		\$52.60	\$67.62				
	BIOPSY OR EXCISION OF LYMPH NODE(S); OPEN, DEEP CERVICAL							
38510	NODE(S)		\$193.50	\$193.50				
	BIOPSY OR EXCISION OF LYMPH NODE(S); OPEN, DEEP CERVICAL							
38520	NODE(S) WITH		\$236.41	\$236.41				
	BIOPSY OR EXCISION OF LYMPH NODE(S); OPEN, DEEP AXILLARY							
38525	NODE(S)		\$210.58	\$210.58				
	BIOPSY OR EXCISION OF LYMPH NODE(S); OPEN, INTERNAL							
38530	MAMMARY NODE(S)		\$271.60	\$271.60				
38531	OPEN BX/EXC INGUÍNOFEM NODES		\$350.70	\$350.70				Effective 1/1/2019
38542	DISSECTION, DEEP JUGULAR NODE(S)		\$287.35	\$287.35				
	EXCISION OF CYSTIC HYGROMA, AXILLARY OR CERVICAL; WITHOUT							
38550	DEEP		\$290.33	\$290.33				
	EXCISION OF CYSTIC HYGROMA, AXILLARY OR CERVICAL; WITH							
38555	DEEP NEUROVASCU		\$611.46	\$611.46				
	LIMITED LYMPHADENECTOMY FOR STAGING (SEPARATE							
38562	PROCEDURE); PELVIC AND		\$496.86	\$496.86				
	LIMITED LYMPHADENECTOMY FOR STAGING (SEPARATE		,	,				1
38564	PROCEDURE); RETROPERITON		\$528.34	\$528.34				
	LAPAROSCOPY, SURGICAL; WITH RETROPERITONEAL LYMPH NODE	1	, , =====	, , =				†
38570	SAMPLING (BIOPS		\$434.46	\$434.46				
	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC	†						
38571	LYMPHADENECTOMY		\$565.05	\$565.05				
0007	[\$500.00	Ψ300.00				

Physician	n Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.			7				+
	ise lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered		ne ne					+
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC	FAIIIG	(i acility)	(Noni acinty)	Comp.	Comp.	Value	Notes
38572	LYMPHADENECTOMY AND		\$736.91	\$736.91				Rate updated 1/1/2018
38573	LAPS PELVIC LYMPHADEC		\$926.52	\$926.52				Added Effective 1/1/2018
38589	UNLISTED LAPAROSCOPY PROCEDURE, LYMPHATIC SYSTEM	R	\$0.00	\$0.00				Added Effective 1/1/2010
38700	SUPRAHYOID LYMPHADENECTOMY		\$512.23	\$512.23				+
38720	CERVICAL LYMPHADENECTOMY (COMPLETE)		\$832.11	\$832.11				+
30120	CERVICAL LYMPHADENECTOMY (MODIFIED RADICAL NECK		ψ032.11	ψ032.11				+
38724	DISSECTION)		\$821.68	\$821.68				
38740	AXILLARY LYMPHADENECTOMY; SUPERFICIAL		\$335.18	\$335.18				+
38745	AXILLARY LYMPHADENECTOMY; COMPLETE		\$501.95	\$501.95				+
30743	THORACIC LYMPHADENECTOMY, REGIONAL, INCLUDING		Ψ501.95	ψ301.93				+
38746	MEDIASTINAL AND PERITRAC		\$203.12	\$203.12				
30740	ABDOMINAL LYMPHADENECTOMY, REGIONAL, INCLUDING CELIAC,		Ψ200.12	Ψ200.12				+
38747	GASTRIC, PORTAL		\$226.49	\$226.49				
30141	INGUINOFEMORAL LYMPHADENECTOMY, SUPERFICIAL, INCLUDING		Ψ220.40	Ψ220.43				+
38760	CLOQUETS NODE		\$450.96	\$450.96				
00700	INGUINOFEMORAL LYMPHADENECTOMY, SUPERFICIAL, IN		ψ+00.00	φ-100.00				+
38765	CONTINUITY WITH PELVIC		\$838.20	\$838.20				
00700	PELVIC LYMPHADENECTOMY, INCLUDING EXTERNAL ILIAC,		Ψ000.20	φοσο.20				+
38770	HYPOGASTRIC, AND		\$810.15	\$810.15				
00770	RETROPERITONEAL TRANSABDOMINAL LYMPHADENECTOMY,		φοτοίτο	φοτοίτο				+
38780	EXTENSIVE, INCLUDING		\$951.96	\$951.96				
38790	INJECTION PROCEDURE; LYMPHANGIOGRAPHY		\$86.46	\$86.46				+
30700	INCOMENTAL PROPERTY OF THE PRO		ψ50.40	ψου.πο				+
38792	INJECTION PROCEDURE; FOR IDENTIFICATION OF SENTINEL NODE		\$113.93	\$113.93				
38794	CANNULATION, THORACIC DUCT		\$204.25	\$204.25				+
5570			Ψ=0 1.20	Ψ=0 1.20				

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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	l omoniobor	go for the comin					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char	ge for the service	*				
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	sted on the lab fee schedule that begin with a P or Q are currently non-covered f							
Codes iis	sted on the lab lee schedule that begin with a P or Q are currently non-covered i	or physicia	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dranadura Dagarintian	DA Ind		•				Notes
Code	Procedure Description INTRAOPERATIVE IDENTIFICATION OF SENTINEL LYMPH NODE(S),	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INCLUDES INJECTION OF NON-RADIOACTIVE DYE, USE IN							
	, and the second							
20000	CONJUCTION WITH 19302, 19307, 38500, 38510, 38520, 38525, 38530,		¢440.07	¢440.07				
38900	38542, 38740, 38745	<u> </u>	\$119.87	\$119.87				
38999	UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM	R	\$0.00	\$0.00				
20000	MEDIASTINOTOMY WITH EXPLORATION, DRAINAGE, REMOVAL OF		# 220 44	# 220 44				
39000	FOREIGN BODY, OR		\$336.11	\$336.11			_	
00040	MEDIASTINOTOMY WITH EXPLORATION, DRAINAGE, REMOVAL OF		0074.04	0074.04				
39010	FOREIGN BODY, OR		\$674.24	\$674.24				
39200	EXCISION OF MEDIASTINAL CYST		\$726.46	\$726.46				
39220	EXCISION OF MEDIASTINAL TUMOR		\$943.68	\$943.68				
39401	MEDIATINOSCOPY; INCLUDES BIOPSY(IES) OF MEDIASTINAL MASS		\$253.10	\$253.10				Added Effective 1/1/2016
39402	WITH LYMPH NODE BIOPSY(IES)		\$330.66	\$330.66				Added Effective 1/1/2016
39499	UNLISTED PROCEDURE, MEDIASTINUM	R	\$0.00	\$0.00				
39501	REPAIR, LACERATION OF DIAPHRAGM, ANY APPROACH		\$692.01	\$692.01				
	REPAIR, NEONATAL DIAPHRAGMATIC HERNIA, WITH OR WITHOUT		•					
39503	CHEST TUBE INSE		\$1,721.61	\$1,721.61				
	REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL),							
39540	TRAUMATIC; ACUTE		\$737.37	\$737.37				
	REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL),							
39541	TRAUMATIC; CHRONIC		\$768.14	\$768.14				
	IMBRICATION OF DIAPHRAGM FOR EVENTRATION, TRANSTHORACIC		·	i i				
39545	OR TRANSABDOMI		\$598.78	\$598.78				
	RESECTION, DIAPHRAGM; WITH SIMPLE REPAIR (EG, PRIMARY							
39560	SUTURE)		\$602.51	\$602.51				
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RESECTION, DIAPHRAGM; WITH COMPLEX REPAIR (EG, PROSTHETIC							
39561	MATERIAL, LO		\$827.49	\$827.49				
39599	UNLISTED PROCEDURE, DIAPHRAGM	R	\$0.00	\$0.00				
40490	BIOPSY OF LIP		\$47.42	\$57.35				
40500	VERMILIONECTOMY (LIP SHAVE), WITH MUCOSAL ADVANCEMENT		\$282.84	\$282.84				
	EXCISION OF LIP; TRANSVERSE WEDGE EXCISION WITH PRIMARY							
40510	CLOSURE		\$310.91	\$310.91				
	EXCISION OF LIP; V-EXCISION WITH PRIMARY DIRECT LINEAR		,	, , , , ,				
40520	CLOSURE		\$270.44	\$270.44				
	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH LOCAL		¥=: 5:::	7=: 5::::				
40525	FLAP (EG,		\$497.22	\$497.22				
10020	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH CROSS		ψ101.22	ψ 101 . <u>L</u> L				
40527	LIP FLAP		\$595.01	\$595.01				
10021	RESECTION OF LIP, MORE THAN ONE-FOURTH, WITHOUT		φοσο.στ	φοσο.σ τ				
40530	RECONSTRUCTION		\$305.60	\$305.60				
40650	REPAIR LIP, FULL THICKNESS; VERMILION ONLY		\$238.10	\$238.10				
40652	REPAIR LIP, FULL THICKNESS; UP TO HALF VERTICAL HEIGHT		\$279.20	\$279.20				
40002	REPAIR LIP, FULL THICKNESS; OVER ONE-HALF VERTICAL HEIGHT,		Ψ219.20	Ψ213.20				
40654	OR COMPLEX		\$351.05	\$351.05				
40054	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY,		φ331.03	φοστ.υσ				
40700	PARTIAL OR COMPL		\$611.31	\$611.31				
40700	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY		φυιι.σι	φυτισι				
40704			¢4 000 00	¢4 000 00				
40701	BILATERAL, ONE ST		\$1,000.92	\$1,000.92				
40700	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY		004045	0040.45				
40702	BILATERAL, ONE OF		\$640.15	\$640.15				

Physician	Fee Schedule 2020	1						
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; SECONDARY, BY							
40720	RECREATION		\$679.54	\$679.54				
	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; WITH CROSS LIP							
40761	PEDICLE FL		\$743.84	\$743.84				
40799	UNLISTED PROCEDURE, LIPS	R	\$175.00	\$227.50				
	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH;							
40800	SIMPLE		\$44.49	\$54.41				
	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH;							
40801	COMPLICATED		\$99.46	\$122.26				
	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH;							
40804	SIMPLE		\$44.16	\$51.93				
	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH;							
40805	COMPLICATED		\$151.81	\$151.81				
40806	INCISION OF LABIAL FRENUM (FRENOTOMY)		\$19.48	\$19.48				
40808	BIOPSY, VESTIBULE OF MOUTH		\$38.84	\$49.03				
	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF							
40810	MOUTH; WITHOU		\$55.47	\$71.30				
	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF							
40812	MOUTH; WITH S		\$89.83	\$109.95				
	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF							
40814	MOUTH; WITH		\$147.05	\$190.36				
	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF							
40816	MOUTH; COMPLE		\$154.49	\$197.67				
40818	EXCISION OF MUCOSA OF VESTIBULE OF MOUTH AS DONOR GRAFT		\$131.53	\$131.53				
	EXCISION OF FRENUM, LABIAL OR BUCCAL (FRENUMECTOMY,							
40819	FRENULECTOMY,		\$86.21	\$102.71				

Physiciar	n Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
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Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DESTRUCTION OF LESION OR SCAR OF VESTIBULE OF MOUTH BY							
40820	PHYSICAL METHOD		\$44.66	\$51.77				
40830	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; 2.5 CM OR LESS		\$69.85	\$69.85				
40004	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; OVER 2.5 CM OR		4.07.00	4.07.00				
40831	COMPLEX		\$127.86	\$127.86				
40840	VESTIBULOPLASTY; ANTERIOR		\$430.02	\$430.02				
40842	VESTIBULOPLASTY; POSTERIOR, UNILATERAL		\$430.02	\$430.02				
40843	VESTIBULOPLASTY; POSTERIOR, BILATERAL		\$602.33	\$602.33				
40844	VESTIBULOPLASTY; ENTIRE ARCH VESTIBULOPLASTY; COMPLEX (INCLUDING RIDGE EXTENSION,		\$796.00	\$796.00				
40845	MUSCLE REPOSITION		\$1,216.78	\$1,216.78				
40845	UNLISTED PROCEDURE, VESTIBULE OF MOUTH	R	\$75.00	\$97.50				
40099	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR	IX.	\$75.00	φ97.50		+		
41000	HEMATOMA OF TONGU		\$48.82	\$59.01				
41000	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR		ψ40.02	φ39.01				
41005	HEMATOMA OF TONGU		\$53.84	\$53.84				
41000	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR		ψ00.0-1	Ψ00.0-1				
41006	HEMATOMA OF TONGU		\$118.67	\$118.67				
11000	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR		ψ.10.07	ψ110.01				
41007	HEMATOMA OF TONGU		\$169.88	\$169.88				
	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR		+	+ 100.00				
41008	HEMATOMA OF TONGU		\$109.61	\$123.83				
	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR							
41009	HEMATOMA OF TONGU		\$195.34	\$195.34				
41010	INCISION OF LINGUAL FRENUM (FRENOTOMY)		\$45.81	\$45.81				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR							
41015	HEMATOMA OF FLOOR		\$134.92	\$134.92				
	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR							
41016	HEMATOMA OF FLOOR		\$217.36	\$217.36				
	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR							
41017	HEMATOMA OF FLOOR		\$150.11	\$150.11				
	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR							
41018	HEMATOMA OF FLOOR		\$254.03	\$254.03				
41019	PLACE NEEDLES H&N FOR RT		\$377.11	\$377.11				
41100	BIOPSY OF TONGUE; ANTERIOR TWO-THIRDS		\$59.04	\$69.76				
41105	BIOPSY OF TONGUE; POSTERIOR ONE-THIRD		\$56.93	\$70.74				
41108	BIOPSY OF FLOOR OF MOUTH		\$42.93	\$54.33				
41110	EXCISION OF LESION OF TONGUE WITHOUT CLOSURE		\$63.92	\$81.35				
	EXCISION OF LESION OF TONGUE WITH CLOSURE; ANTERIOR TWO-							
41112	THIRDS		\$114.81	\$146.87				
	EXCISION OF LESION OF TONGUE WITH CLOSURE; POSTERIOR ONE-							
41113	THIRD		\$145.39	\$191.12				
	EXCISION OF LESION OF TONGUE WITH CLOSURE; WITH LOCAL							
41114	TONGUE FLAP		\$420.36	\$420.36				
41115	EXCISION OF LINGUAL FRENUM (FRENECTOMY)		\$101.46	\$101.46				
41116	EXCISION, LESION OF FLOOR OF MOUTH		\$142.60	\$142.60				
41120	GLOSSECTOMY; LESS THAN ONE-HALF TONGUE		\$475.75	\$475.75				
41130	GLOSSECTOMY; HEMIGLOSSECTOMY		\$572.07	\$572.07				
	GLOSSECTOMY; PARTIAL, WITH UNILATERAL RADICAL NECK							
41135	DISSECTION		\$974.31	\$974.31				
	GLOSSECTOMY; COMPLETE OR TOTAL, WITH OR WITHOUT							
41140	TRACHEOSTOMY, WITHOUT		\$1,254.60	\$1,254.60				

Physician	Fee Schedule 2020				1			
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	GLOSSECTOMY; COMPLETE OR TOTAL, WITH OR WITHOUT							
41145	TRACHEOSTOMY, WITH		\$1,492.25	\$1,492.25				
	GLOSSECTOMY; COMPOSITE PROCEDURE WITH RESECTION FLOOR							
41150	OF MOUTH AND		\$1,136.41	\$1,136.41				
	GLOSSECTOMY; COMPOSITE PROCEDURE WITH RESECTION FLOOR							
41153	OF MOUTH, WITH		\$1,365.67	\$1,365.67				
	GLOSSECTOMY; COMPOSITE PROCEDURE WITH RESECTION FLOOR							
41155	OF MOUTH, MANDIB		\$1,581.07	\$1,581.07				
44050	REPAIR OF LACERATION 2.5 CM OR LESS; FLOOR OF MOUTH AND/OR		405.05	405.05				
41250	ANTERIOR		\$85.95	\$85.95				
44054	REPAIR OF LACERATION 2.5 CM OR LESS; POSTERIOR ONE-THIRD OF		Φ405 7 7	0405.77				
41251	TONGUE		\$125.77	\$125.77			_	
44050	REPAIR OF LACERATION OF TONGUE, FLOOR OF MOUTH, OVER 2.6		Φ4 <i>EE</i> Ω2	0455 00				
41252	CM OR COMPLEX SUTURE OF TONGUE TO LIP FOR MICROGNATHIA (DOUGLAS TYPE		\$155.03	\$155.03				
41510	PROCEDURE)		\$176.21	\$176.21				
41510	TONGUE BASE SUSPENSION, PERMANENT SUTURE TECH		\$464.63	\$464.63	+		+	+
+1312	FRENOPLASTY (SURGICAL REVISION OF FRENUM, EG, WITH Z-		ψ+υ+.υυ	φ+υ+.υυ	+			+
41520	PLASTY)		\$161.22	\$161.22				
41599	UNLISTED PROCEDURE, TONGUE, FLOOR OF MOUTH	R	\$0.00	\$0.00	+			+
1.000	DRAINAGE OF ABSCESS, CYST, HEMATOMA FROM DENTOALVEOLAR		***************************************	140.00	+			+
41800	STRUCTURES		\$43.82	\$53.07				
	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR		+	+ 30.0.				
41805	STRUCTURES; SOFT		\$59.39	\$59.39				
1.2.2	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR		, , , , , , ,	, , , , , , ,	1			†
41806	STRUCTURES; BONE		\$103.11	\$125.10				
41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT		\$56.25	\$75.00				

Physician	Fee Schedule 2020	1			1			
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
41821	OPERCULECTOMY, EXCISION PERICORONAL TISSUES		\$56.25	\$75.00				
	EXCISION OF FIBROUS TUBEROSITIES, DENTOALVEOLAR							
41822	STRUCTURES		\$153.66	\$153.66				
	EXCISION OF OSSEOUS TUBEROSITIES, DENTOALVEOLAR							
41823	STRUCTURES		\$213.35	\$213.35				
	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE),							
41825	DENTOALVEOLAR		\$60.36	\$80.34				
	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE),							
41826	DENTOALVEOLAR		\$98.45	\$126.21				
	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE),							
41827	DENTOALVEOLAR		\$155.88	\$206.57				
	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT							
41828	(SPECIFY)		\$206.39	\$206.39				
	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR							
41830	SEQUESTRECTOMY		\$223.87	\$223.87				
	DESTRUCTION OF LESION (EXCEPT EXCISION), DENTOALVEOLAR							
41850	STRUCTURES		\$112.50	\$150.00				
41870	PERIODONTAL MUCOSAL GRAFTING		\$187.50	\$250.00				
41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)		\$165.60	\$165.60				
41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)		\$199.46	\$199.46				
41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES	R	\$70.00	\$0.00				
42000	DRAINAGE OF ABSCESS OF PALATE, UVULA		\$44.40	\$52.71				
42100	BIOPSY OF PALATE, UVULA		\$49.51	\$60.11				
42104	EXCISION, LESION OF PALATE, UVULA; WITHOUT CLOSURE		\$72.51	\$94.24				
42106	EXCISION, LESION OF PALATE, UVULA; WITH SIMPLE PRIMARY CLOSURE		\$112.05	\$141.82				
42 100	OLOGORE		φ112.00	φ141.02				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
42107	EXCISION, LESION OF PALATE, UVULA; WITH LOCAL FLAP CLOSURE		\$201.24	\$267.09				
42120	RESECTION OF PALATE OR EXTENSIVE RESECTION OF LESION		\$367.77	\$367.77				
42140	UVULECTOMY, EXCISION OF UVULA		\$85.04	\$85.04				
	PALATOPHARYNGOPLASTY (EG, UVULOPALATOPHARYNGOPLASTY,							
42145	UVULOPHARYNGOPLAS		\$483.48	\$483.48				
	DESTRUCTION OF LESION, PALATE OR UVULA (THERMAL, CRYO OR							
42160	CHEMICAL)		\$75.76	\$96.28				
42180	REPAIR, LACERATION OF PALATE; UP TO 2 CM		\$138.29	\$138.29				
42182	REPAIR, LACERATION OF PALATE; OVER 2 CM OR COMPLEX		\$213.22	\$213.22				
	PALATOPLASTY FOR CLEFT PALATE, SOFT AND/OR HARD PALATE							
42200	ONLY		\$491.68	\$491.68				
	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR							
42205	RIDGE; SOFT TI		\$572.33	\$572.33				
	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR							
42210	RIDGE; WITH BO		\$652.65	\$652.65				
42215	PALATOPLASTY FOR CLEFT PALATE; MAJOR REVISION		\$473.96	\$473.96				
	PALATOPLASTY FOR CLEFT PALATE; SECONDARY LENGTHENING							
42220	PROCEDURE		\$359.65	\$359.65				
	PALATOPLASTY FOR CLEFT PALATE; ATTACHMENT PHARYNGEAL							
42225	FLAP		\$477.75	\$477.75				
42226	LENGTHENING OF PALATE, AND PHARYNGEAL FLAP		\$508.94	\$508.94				
42227	LENGTHENING OF PALATE, WITH ISLAND FLAP		\$468.85	\$468.85				
42235	REPAIR OF ANTERIOR PALATE, INCLUDING VOMER FLAP		\$380.84	\$380.84				
42260	REPAIR OF NASOLABIAL FISTULA		\$239.81	\$239.81				
42280	MAXILLARY IMPRESSION FOR PALATAL PROSTHESIS		\$101.23	\$101.23				
42281	INSERTION OF PIN-RETAINED PALATAL PROSTHESIS		\$95.01	\$95.01	1			
42299	UNLISTED PROCEDURE, PALATE, UVULA	R	\$0.00	\$0.00				

Physician	Fee Schedule 2020							
Note:								
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	se lab fee schedule for covered codes not listed below in the 80000-89249 i	ange.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
42300	DRAINAGE OF ABSCESS; PAROTID, SIMPLE		\$70.96	\$83.83				
42305	DRAINAGE OF ABSCESS; PAROTID, COMPLICATED		\$229.06	\$229.06				
	DRAINAGE OF ABSCESS; SUBMAXILLARY OR SUBLINGUAL,							
42310	INTRAORAL		\$61.04	\$74.85				
42320	DRAINAGE OF ABSCESS; SUBMAXILLARY, EXTERNAL		\$121.92	\$121.92				
	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY), SUBLINGUAL							
42330	OR PAROTID,		\$81.05	\$95.80				
	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY),							
42335	COMPLICATED, INTRAORAL		\$133.88	\$167.00				
	SIALOLITHOTOMY; PAROTID, EXTRAORAL OR COMPLICATED							
42340	INTRAORAL		\$199.10	\$256.09				
42400	BIOPSY OF SALIVARY GLAND; NEEDLE		\$35.91	\$46.51				
42405	BIOPSY OF SALIVARY GLAND; INCISIONAL		\$120.34	\$141.00				
42408	EXCISION OF SUBLINGUAL SALIVARY CYST (RANULA)		\$225.54	\$225.54				
42409	MARSUPIALIZATION OF SUBLINGUAL SALIVARY CYST (RANULA)		\$162.18	\$162.18				
	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE,							
42410	WITHOUT NERV		\$442.25	\$442.25				
	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE,							
42415	WITH DISSECT		\$853.94	\$853.94				
	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, WITH							
42420	DISSECTION AND		\$989.61	\$989.61				
	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, EN BLOC							
42425	REMOVAL WIT		\$695.16	\$695.16				
	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, WITH							
42426	UNILATERAL RAD		\$1,308.29	\$1,308.29				
42440	EXCISION OF SUBMANDIBULAR (SUBMAXILLARY) GLAND		\$432.06	\$432.06				
42450	EXCISION OF SUBLINGUAL GLAND		\$228.76	\$228.76				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	<u>ns</u>					<u> </u>
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
40500	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY;		4054.00	005400				
42500	PRIMARY OR SIMPLE		\$254.93	\$254.93				<u> </u>
40505	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY;		0004.40	0004.40				
42505	SECONDARY OR COMPLI		\$391.48	\$391.48				<u> </u>
40507	DAROTID DUOT DIVERDIONI DILATERAL (MILLIE TVDE DROCEDUDE)		0045.00	0045.00				
42507	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE);		\$315.89	\$315.89		_		
40500	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE);		Φ554.00	Ø554.00				
42509	WITH EXCISIO		\$551.08	\$551.08				
40540	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE);		0.454.04	0.454.04				
42510	WITH LIGATIO		\$451.84	\$451.84		_		
42550	INJECTION PROCEDURE FOR SIALOGRAPHY		\$49.45	\$49.45				
42600	CLOSURE SALIVARY FISTULA		\$249.91	\$249.91				
42650	DILATION SALIVARY DUCT		\$28.80	\$34.03				
40000	DILATION AND CATHETERIZATION OF SALIVARY DUCT, WITH OR		44.00	* 40.00				
42660	WITHOUT INJECTI		\$41.32	\$48.03				<u> </u>
42665	LIGATION SALIVARY DUCT, INTRAORAL	_	\$132.10	\$132.10				<u> </u>
42699	UNLISTED PROCEDURE, SALIVARY GLANDS OR DUCTS	R	\$0.00	\$0.00				
42700	INCISION AND DRAINAGE ABSCESS; PERITONSILLAR		\$59.90	\$71.30				<u> </u>
40700	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR		Ø400.00	m400 00				
42720	PARAPHARYNGEAL, INTR		\$132.63	\$132.63		1		
40705	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR		0055.05	#055 O5				
42725	PARAPHARYNGEAL, EXTE		\$355.25	\$355.25				ļ —
42800	BIOPSY; OROPHARYNX		\$51.19	\$61.11				
42802	BIOPSY; HYPOPHARYNX		\$74.00	\$74.00				
42804	BIOPSY; NASOPHARYNX, VISIBLE LESION, SIMPLE		\$67.31	\$67.31		1		
42806	BIOPSY; NASOPHARYNX, SURVEY FOR UNKNOWN PRIMARY LESION		\$86.33	\$86.33				

Physician	Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	That y Chai		,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
-	i roodano 2000. puoli	171110	(i domey)	(rtorn domey)			1 4.14.0	
42808	EXCISION OR DESTRUCTION OF LESION OF PHARYNX, ANY METHOD		\$140.66	\$140.66				
42809	REMOVAL OF FOREIGN BODY FROM PHARYNX		\$75.58	\$75.58				
	EXCISION BRANCHIAL CLEFT CYST OR VESTIGE, CONFINED TO SKIN							
42810	AND SUBCUTA		\$189.54	\$189.54				
42815	EXTENDING BENEATH		\$452.46	\$452.46				
42820	TONSILLECTOMY AND ADENOIDECTOMY; UNDER AGE 12		\$209.24	\$209.24				
42821	TONSILLECTOMY AND ADENOIDECTOMY; AGE 12 OR OVER		\$236.90	\$236.90				
42825	TONSILLECTOMY, PRIMARY OR SECONDARY; UNDER AGE 12		\$173.02	\$173.02				
42826	TONSILLECTOMY, PRIMARY OR SECONDARY; AGE 12 OR OVER		\$207.59	\$207.59				
42830	ADENOIDECTOMY, PRIMARY; UNDER AGE 12		\$147.88	\$147.88				
42831	ADENOIDECTOMY, PRIMARY; AGE 12 OR OVER		\$145.96	\$145.96				
42835	ADENOIDECTOMY, SECONDARY; UNDER AGE 12		\$117.46	\$117.46				
42836	ADENOIDECTOMY, SECONDARY; AGE 12 OR OVER		\$173.33	\$173.33				
	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR							
42842	RETROMOLAR TRIG		\$435.74	\$435.74				
	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR							
42844	RETROMOLAR TRIG		\$695.42	\$695.42				
	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR							
42845	RETROMOLAR TRIG		\$1,195.40	\$1,195.40				
42860	EXCISION OF TONSIL TAGS		\$118.59	\$118.59				
	EXCISION OR DESTRUCTION LINGUAL TONSIL, ANY METHOD							
42870	(SEPARATE PROCEDURE		\$219.96	\$219.96				
42890	LIMITED PHARYNGECTOMY		\$608.60	\$608.60				
	RESECTION OF LATERAL PHARYNGEAL WALL OR PYRIFORM SINUS,							
42892	DIRECT CLOSURE		\$732.80	\$732.80				

Physician	n Fee Schedule 2020							
Note:								
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service	1				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I III	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RESECTION OF PHARYNGEAL WALL REQUIRING CLOSURE WITH		<u> </u>	,	•	•		
42894	MYOCUTANEOUS FLAP		\$1,082.05	\$1,082.05				
42900	SUTURE PHARYNX FOR WOUND OR INJURY		\$272.06	\$272.06				
	PHARYNGOPLASTY (PLASTIC OR RECONSTRUCTIVE OPERATION ON							
42950	PHARYNX)		\$517.14	\$517.14				
42953	PHARYNGOESOPHAGEAL REPAIR		\$433.56	\$433.56				
	PHARYNGOSTOMY (FISTULIZATION OF PHARYNX, EXTERNAL FOR							
42955	FEEDING)		\$290.23	\$290.23				
	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42960	SECONDARY (EG,		\$98.79	\$98.79				
	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42961	SECONDARY (EG,		\$203.55	\$203.55				
	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42962	SECONDARY (EG,		\$371.76	\$371.76				
	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42970	SECONDARY (EG,		\$170.32	\$170.32				
	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42971	SECONDARY (EG,		\$249.20	\$249.20				
	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR							
42972	SECONDARY (EG,		\$331.98	\$331.98				
42999	UNLISTED PROCEDURE, PHARYNX, ADENOIDS, OR TONSILS	R	\$150.00	\$195.00				
	ESOPHAGOTOMY, CERVICAL APPROACH, WITH REMOVAL OF							
43020	FOREIGN BODY		\$420.27	\$420.27				
43030	CRICOPHARYNGEAL MYOTOMY		\$484.63	\$484.63				
	ESOPHAGOTOMY, THORACIC APPROACH, WITH REMOVAL OF							
43045	FOREIGN BODY		\$943.82	\$943.82				

Physician	Fee Schedule 2020				Ī			
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION OF LESION, ESOPHAGUS, WITH PRIMARY REPAIR;							
43100	CERVICAL APPROACH		\$437.65	\$437.65				
40404	EXCISION OF LESION, ESOPHAGUS, WITH PRIMARY REPAIR;		4740.04	474004				
43101	THORACIC OR ABDOMI		\$743.34	\$743.34				
40407	TOTAL OR NEAR TOTAL ESOPHAGECTOMY, WITHOUT		4. 500.04	#4 500 04				
43107	THORACOTOMY; WITH		\$1,509.04	\$1,509.04				
40400	TOTAL OR NEAR TOTAL ESOPHAGECTOMY, WITHOUT		¢4.754.47	MA 754 47				
43108	THORACOTOMY; WITH COLON TOTAL OR NEAR TOTAL ESOPHAGECTOMY, WITH THORACOTOMY;		\$1,751.47	\$1,751.47				
12112	WITH		¢4 550 06	¢4 552 06				
43112	TOTAL OR NEAR TOTAL ESOPHAGECTOMY, WITH THORACOTOMY;		\$1,553.86	\$1,553.86				
43113	WITH COLON		\$1,780.52	\$1,780.52				
43113	PARTIAL ESOPHAGECTOMY, CERVICAL, WITH FREE INTESTINAL	+	\$1,700.32	\$1,700.52				
43116	GRAFT, INCLUDING		\$1,664.32	\$1,664.32				
43110	PARTIAL ESOPHAGECTOMY, DISTAL TWO-THIRDS, WITH		ψ1,004.32	ψ1,004.32				
43117	THORACOTOMY AND SEPARAT		\$1,629.11	\$1,629.11				
40117	PARTIAL ESOPHAGECTOMY, DISTAL TWO-THIRDS, WITH		Ψ1,020.11	Ψ1,020.11				+
43118	THORACOTOMY AND SEPARAT		\$1,722.42	\$1,722.42				
10110	PARTIAL ESOPHAGECTOMY, DISTAL TWO-THIRDS, WITH		Ψ1,7.22.12	Ψ1,122.12				
43121	THORACOTOMY ONLY, WITH		\$1,487.25	\$1,487.25				
	PARTIAL ESOPHAGECTOMY, THORACOABDOMINAL OR ABDOMINAL	 	ψ 1, 101 i=0	ψ.,.σ <u>=</u> σ				
43122	APPROACH, WITH OR		\$1,487.25	\$1,487.25				
	PARTIAL ESOPHAGECTOMY, THORACOABDOMINAL OR ABDOMINAL							
43123	APPROACH, WITH OR		\$1,722.42	\$1,722.42				
	TOTAL OR PARTIAL ESOPHAGECTOMY, WITHOUT RECONSTRUCTION			<u> </u>				
43124	(ANY APPROACH),		\$1,436.56	\$1,436.56				

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Proc		L	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
40400	DIVERTICULECTOMY OF HYPOPHARYNX OR ESOPHAGUS, WITH OR		0004.47	0004.47				
43130	WITHOUT MYOTOMY;		\$634.17	\$634.17				
10105	DIVERTICULECTOMY OF HYPOPHARYNX OR ESOPHAGUS, WITH OR		40.40.40	404040				
43135	WITHOUT MYOTOMY;		\$810.46	\$810.46				A 1 1 1 55 55 4/4/0045
43180	REMOVAL OF ESOPHAGUS TISSUE USING AN ENDOSCOPE		\$449.34	\$449.34				Added effective 1/1/2015
43191	ESOPHAGOSCOPY RIGID TRNSO DX		\$101.16	\$101.16				
43192	ESOPHAGOSCP RIG TRNSO INJECT		\$120.83	\$120.83				
43193	ESOPHAGOSCP RIG TRNSO BIOPSY		\$144.22	\$144.22				
43194	ESOPHAGOSCP RIG TRNSO REM FB		\$131.80	\$131.80				
43195	ESOPHAGOSCOPY RIGID BALLOON		\$144.48	\$144.48			_	
43196	ESOPHAGOSCP GUIDE WIRE DILAT		\$158.27	\$158.27				
43197	ESOPHAGOSCOPY FLEX DX BRUSH		\$64.95	\$140.76				
43198	ESOPHAGOSC FLEX TRNSN BIOPY		\$77.39	\$157.59				
43200	ESOPHAGOSCOPY FLEXIBLE BRUSH WITH ENDOSCOPE		\$107.69	\$107.69				
43201	ESOPH SCOPE W/SUBMUCOUS INJ		\$95.90	\$177.35				
43202	ESOPHAGOSCOPY FLEX BIOPSY		\$127.63	\$127.63 \$248.92				
43204	ESOPH SCOPE W/SCLEROSIS INJ		\$248.92					
43205 43206	ESOPHAGUS ENDOSCOPY/LIGATION WITH OPTICAL ENDOMICROSCOPY		\$188.00 \$114.89	\$188.00 \$251.50				Added Effective 1/1/2016
43206	WITH OPTICAL ENDOMICROSCOPY		\$114.89	\$251.50			1	Added Effective 1/1/2016
40040	WITH FOODIA COCACTRIC FUNDORI ACTY DARTIAL OR COMPLETE		Ф040 7 0	#040.70				A 11 - 1 Ff + 4/4/0040
43210	WITH ESOPHAGOGASTRIC FUNDOPLASTY, PARTIAL OR COMPLETE		\$348.72	\$348.72				Added Effective 1/1/2016
43211 43212	ESOPHAGOSCOP MUCOSAL RESECT ESOPHAGOSCOP STENT PLACEMENT		\$196.99	\$196.99		+	+	Added Effective 1/1/2016 Added Effective 1/1/2016
43212			\$155.35	\$155.35 \$920.77				
	ESOPHAGOSCOPY RETRO BALLOON		\$219.11					Added Effective 1/1/2016
43214 43215	ESOPHAGOSC DILATE BALLOON 30		\$158.40 \$176.79	\$158.40 \$176.79			+	Added Effective 1/1/2016 Added Effective 1/1/2016
	ESOPHAGOSCOPY FLEX REMOVE FB						+	Added Effective 1/1/2016 Added Effective 1/1/2016
43216	ESOPHAGOSCOPY LESION REMOVAL		\$175.44	\$175.44		+	+	Added Effective 1/1/2016
43217	ESOPHAGOSCOPY SNARE LES REMV		\$190.11	\$190.11				

Physician Fee Schedule 2020 Note: 2020 Codes in Red; Refer to CPT book for descriptions R° in PA column indicates Prior Auth is required Codes listed as \$0.00° pay 45% of billied amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20° Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc PA Ind Facility Facilit	
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ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH ABLATION OF	
43228 TUMOR(S), POLYP(S), \$248.34 \$248.34 \$248.34 \$43229 ESOPHAGOSCOPY LESION ABLATE \$167.11 \$545.36 \$167.11 \$545.36 \$171.20 \$171.	
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ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH ENDOSCOPIC 43231 ULTRASOUND EXAMINATI ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH TRANSENDOSCOPIC 43232 ULTRASOUND-GUID 43233 EGD BALLOON DIL ESOPH30 MM/> UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, 43235 STOMACH, AND EIT UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, 43236 STOMACH, AND EIT UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, 43237 STOMACH, AND EIT \$171.20 \$171.20 \$171.20 \$171.20 \$198.82 \$198.82 \$198.82 \$198.82 \$198.82 \$198.82 \$198.82 \$198.82 \$188.10 \$188.10 \$159.52 \$159.52 \$159.52 \$159.52 \$159.52 \$162.89	
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43236 STOMACH, AND EIT \$120.05 \$208.44	
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43237 STOMACH, AND EIT \$162.89 \$162.89	
43238 STOMACH, AND EIT \$201.78 \$201.78	
UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,	
43239 STOMACH, AND EIT \$179.22 \$179.22	
UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,	
43240 STOMACH, AND EIT \$302.65 \$302.65	
UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,	
43241 STOMACH, AND EIT \$174.01 \$174.01	

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Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered t	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43242	STOMACH, AND EIT		\$218.18	\$218.18				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43243	STOMACH, AND EIT		\$294.58	\$294.58				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43244	STOMACH, AND EIT		\$237.72	\$237.72				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43245	STOMACH, AND EIT		\$225.60	\$225.60				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43246	STOMACH, AND EIT		\$288.31	\$288.31				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43247	STOMACH, AND EIT		\$225.11	\$225.11				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43248	STOMACH, AND EIT		\$209.03	\$209.03				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,							
43249	STOMACH, AND EIT		\$192.43	\$192.43				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS.							
43250	STOMACH, AND EIT		\$227.73	\$227.73				
	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,		7	*				
43251	STOMACH, AND EIT		\$242.40	\$242.40				
43252	WITH OPTICAL ENDOMICROSCOPY		\$142.59	\$281.00				Added Effective 1/1/2016
43253	EGD US TRANSMURAL INJXN/MARK		\$218.18	\$218.18				1
43254	EGD ENDO MUCOSAL RESECTION		\$226.55	\$226.55	1			+
43255	EDG CONTROL BLEEDING ANY METHOD		\$289.35	\$289.35	1			+
10200	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,		Ψ200.00	Ψ200.00	+			
43256	STOMACH, AND EIT		\$171.96	\$171.96				
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Due and drove Danaminting	DA local	•					Notes
Code	Procedure Description UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
40057	· ·		\$000.05	¢000.05				
43257	STOMACH, AND EIT		\$228.65	\$228.65				
40050	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,		007.05	0007.05				
43258	STOMACH, AND EIT		\$287.85	\$287.85				
40050	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS,		#050.00	#050.00				
43259	STOMACH, AND EIT		\$259.82	\$259.82				
40000	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY		004470	004470				
43260	(ERCP); DIAGNOSTIC, WIT		\$344.76	\$344.76				
40004	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY		405000	****				
43261	(ERCP); WITH BIOPSY, SI		\$353.86	\$353.86				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43262	(ERCP); WITH		\$472.34	\$472.34				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY		.					
43263	(ERCP); WITH PRESSURE		\$347.24	\$347.24				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43264	(ERCP); WITH ENDOSCOPIC		\$515.23	\$515.23				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43265	(ERCP); WITH ENDOSCOPIC		\$455.99	\$455.99				
43266	EGD ENDOSCOPIC STENT PLACE		\$187.50	\$187.50				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43267	(ERCP); WITH ENDOSCOPIC		\$427.26	\$427.26				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43268	(ERCP); WITH ENDOSCOPIC		\$464.34	\$464.34				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43269	(ERCP); WITH ENDOSCOPIC		\$386.77	\$386.77				
43270	EGD LESION ABLATION		\$196.90	\$546.18				

Physician	Fee Schedule 2020							
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Please us	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43271	(ERCP); WITH ENDOSCOPIC		\$433.65	\$433.65				
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY							
43272	(ERCP); WITH ABLATION O		\$377.26	\$377.26				
43273	ENDOSCOPIC CANNULATION OF PAPLLA W/DIRECT VISUAL		\$103.25	\$103.25				
43274	ERCP DUCT STENT PLACEMENT		\$388.60	\$388.60				
43275	ERCP REMOVE FORGN BODY DUCT		\$320.31	\$320.31				
43276	ERCP STENT EXCHANGE W/DILATE		\$404.34	\$404.34				
43277	ERCP EA DUCT/AMPULLA DILATE		\$322.27	\$322.27				
43278	ERCP LESION ABLATE W/DILATE		\$366.50	\$366.50				
	REPAIR OF MUSCLE TO LOWER ESOPHAGUS AND STOMACH USING							
43279	AN ENDOSCOPE		\$969.91	\$969.91				
	REPAIR OF MUSCLE AT ESOPHAGUS AND STOMACH USING AN							
43280	ENDOSCOPE		\$820.29	\$820.29				
	REPAIR OF HERNIA OF MUSCLE AT ESOPHAGUS AND STOMACH							
43281	USING AN ENDOSCOPE		\$1,149.87	\$1,149.87				
	REPAIR OF HERNIA OF MUSCLE AT ESOPHAGUS AND STOMACH							
43282	WITH IMPLANTATION OF MESH USING AN ENDOSCOPE		\$1,293.66	\$1,293.66				
	LAPAROSCOPY, SURGICAL, ESOPHAGEAL LENGTHENING							
43283	PROCEDURE USE IN CONJUCTION WITH 43280, 43281, 43282		\$143.31	\$143.31				
43284	LAPS ESOPHGL SPHNCTR AGMNTJ		\$520.73	\$520.73				Added Effective 1/1/2017
43285	RMVL ESOPHGL SPHNCTR DEV		\$527.53	\$527.53				Added Effective 1/1/2017
43286	ESPHG TOT W/LAPS MOBLJ		\$2,511.50	\$2,511.50				Added Effective 1/1/2018
43287	ESPHG DSTL 2/3 W/LAPS MOBLJ		\$2,867.85	\$2,867.85				Added Effective 1/1/2018
43288	ESPHG THRSC MOBLJ		\$2,995.36	\$2,995.36				Added Effective 1/1/2018
43289	UNLISTED LAPAROSCOPY PROCEDURE, ESOPHAGUS	R	\$0.00	\$0.00				

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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						<u> </u>	
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ESOPHAGOPLASTY (PLASTIC REPAIR OR RECONSTRUCTION),		4500 70	4500 50				
43300	CERVICAL APPROACH;		\$596.78	\$596.78				
	ESOPHAGOPLASTY (PLASTIC REPAIR OR RECONSTRUCTION),							
43305	CERVICAL APPROACH;		\$884.58	\$884.58				
	ESOPHAGOPLASTY (PLASTIC REPAIR OR RECONSTRUCTION),							
43310	THORACIC APPROACH;		\$1,244.30	\$1,244.30			1	
	ESOPHAGOPLASTY (PLASTIC REPAIR OR RECONSTRUCTION),							
43312	THORACIC APPROACH;		\$1,223.79	\$1,223.79			1	
	ESOPHAGOPLASTY FOR CONGENITAL DEFECT (PLASTIC REPAIR OR							
43313	RECONSTRUCTION		\$2,006.95	\$2,006.95			1	
	ESOPHAGOPLASTY FOR CONGENITAL DEFECT (PLASTIC REPAIR OR							
43314	RECONSTRUCTION		\$2,206.23	\$2,206.23				
	ESOPHAGOGASTROSTOMY (CARDIOPLASTY), WITH OR WITHOUT							
43320	VAGOTOMY AND		\$788.28	\$788.28				
	ESOPHAGOGASTRIC FUNDOPLASTY; WITH FUNDIC PATCH (THAL-							
43325	NISSEN PROCEDURE)		\$796.34	\$796.34				
	ESOPHAGOGASTRIC FUNDOPLASTY PARTIAL OR COMPLETE;							
43327	LAPAROTOMY		\$721.28	\$721.28				
43328	THORACOTOMY		\$1,059.52	\$1,059.52				
43330	ESOPHAGOMYOTOMY (HELLER TYPE); ABDOMINAL APPROACH		\$781.50	\$781.50				
43331	ESOPHAGOMYOTOMY (HELLER TYPE); THORACIC APPROACH		\$880.74	\$880.74				
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA LAPAROTOMY,							
	EXCEPT NEONATAL; WITHOUT IMPLANTATION OF MESH OR OTHER							
43332	PROSTHESIS		\$1,033.11	\$1,033.11				
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA LAPAROTOMY,							
	EXCEPT NEONATAL; WITH IMPLANTATION OF MESH OR OTHER							
43333	PROSTHESIS		\$1,121.82	\$1,121.82				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA THORACOTOMY,							
	EXCEPT NEONATAL; WITHOUT IMPLANTATION OF MESH OR OTHER							
43334	PROSTHESIS		\$1,133.99	\$1,133.99				
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA THORACOTOMY,							
	EXCEPT NEONATAL; WITH IMPLANTATION OF MESH OR OTHER							
43335	PROSTHESIS		\$1,221.81	\$1,221.81				
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA							
	THORACOABDOMINAL INCISION, EXCEPT NEONATAL; WITHOUT							
43336	IMPLANTATION OF MESH OR OTHER PROSTHESIS		\$1,338.71	\$1,338.71				
	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, VIA							
	THORACOABDOMINAL INCISION, EXCEPT NEONATAL; WITH							
43337	IMPLANTATION OF MESH OR OTHER PROSTHESIS		\$1,461.25	\$1,461.25				
	ESOPHAGOGASTRIC FUNDOPLASTY PARTIAL OR COMPLETE;							
43338	LAPAROTOMY		\$118.98	\$118.98				
	ESOPHAGOJEJUNOSTOMY (WITHOUT TOTAL GASTRECTOMY);							
43340	ABDOMINAL APPROACH		\$810.40	\$810.40				
	ESOPHAGOJEJUNOSTOMY (WITHOUT TOTAL GASTRECTOMY);							
43341	THORACIC APPROACH		\$751.23	\$751.23				
	ESOPHAGOSTOMY, FISTULIZATION OF ESOPHAGUS, EXTERNAL;							
43351	THORACIC APPROACH		\$666.20	\$666.20				
	ESOPHAGOSTOMY, FISTULIZATION OF ESOPHAGUS, EXTERNAL;							
43352	CERVICAL APPROACH		\$593.79	\$593.79				
	GASTROINTESTINAL RECONSTRUCTION FOR PREVIOUS							
43360	ESOPHAGECTOMY, FOR OBSTRU		\$1,439.42	\$1,439.42				
	GASTROINTESTINAL RECONSTRUCTION FOR PREVIOUS							
43361	ESOPHAGECTOMY, FOR OBSTRU		\$1,664.32	\$1,664.32				
43400	LIGATION, DIRECT, ESOPHAGEAL VARICES		\$786.11	\$786.11				

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	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSECTION OF ESOPHAGUS WITH REPAIR, FOR ESOPHAGEAL							
43401	VARICES		\$781.25	\$781.25				
	LIGATION OR STAPLING AT GASTROESOPHAGEAL JUNCTION FOR							
43405	PRE-EXISTING		\$883.97	\$883.97				
43410	SUTURE OF ESOPHAGEAL WOUND OR INJURY; CERVICAL APPROACH		\$558.13	\$558.13				
	SUTURE OF ESOPHAGEAL WOUND OR INJURY; TRANSTHORACIC OR							
43415	TRANSABDOMINAL		\$868.33	\$868.33				
43420	CLOSURE OF ESOPHAGOSTOMY OR FISTULA; CERVICAL APPROACH		\$475.68	\$475.68				
	CLOSURE OF ESOPHAGOSTOMY OR FISTULA; TRANSTHORACIC OR							
43425	TRANSABDOMINAL		\$765.33	\$765.33				
	DILATION OF ESOPHAGUS, BY UNGUIDED SOUND OR BOUGIE,							
43450	SINGLE OR MULTIPLE		\$59.95	\$59.95				
43453	DILATION OF ESOPHAGUS, OVER GUIDE WIRE		\$87.48	\$87.48				
43456	DILATION OF ESOPHAGUS, BY BALLOON OR DILATOR, RETROGRADE		\$175.37	\$175.37				
	DILATION OF ESOPHAGUS WITH BALLOON (30 MM DIAMETER OR							
43458	LARGER) FOR ACHA		\$137.12	\$137.12				
	ESOPHAGOGASTRIC TAMPONADE, WITH BALLOON (SENGSTAAKEN							
43460	TYPE)		\$159.94	\$159.94				
43496	FREE JEJUNUM TRANSFER WITH MICROVASCULAR ANASTOMOSIS		\$0.00	\$0.00				
43499	UNLISTED PROCEDURE, ESOPHAGUS	R	\$0.00	\$0.00				
							1	
43500	GASTROTOMY; WITH EXPLORATION OR FOREIGN BODY REMOVAL		\$416.59	\$416.59				
43501	GASTROTOMY; WITH SUTURE REPAIR OF BLEEDING ULCER		\$681.01	\$681.01				

Physician	n Fee Schedule 2020							
Note:								
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Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	GASTROTOMY; WITH SUTURE REPAIR OF PRE-EXISTING							
43502	ESOPHAGOGASTRIC LACERAT		\$738.81	\$738.81				
40540	GASTROTOMY; WITH ESOPHAGEAL DILATION AND INSERTION OF		4547.04	4-1-01				
43510	PERMANENT		\$517.21	\$517.21				
40500	PYLOROMYOTOMY, CUTTING OF PYLORIC MUSCLE (FREDET-		0040.74	0040.74				
43520	RAMSTEDT TYPE OPERATI		\$346.71	\$346.71				
43605 43610	BIOPSY OF STOMACH; BY LAPAROTOMY		\$431.36 \$557.35	\$431.36 \$557.35				+
43611	EXCISION, LOCAL; ULCER OR BENIGN TUMOR OF STOMACH EXCISION, LOCAL; MALIGNANT TUMOR OF STOMACH		\$625.43	\$625.43				
43620	GASTRECTOMY, TOTAL; WITH ESOPHAGOENTEROSTOMY		\$1,107.13	\$1,107.13				
43621	GASTRECTOMY, TOTAL, WITH ESOPHAGOENTEROSTOMY GASTRECTOMY, TOTAL; WITH ROUX-EN-Y RECONSTRUCTION		\$1,120.04	\$1,120.04				
43021	GASTRECTOMY, TOTAL, WITH FORMATION OF INTESTINAL POUCH,		φ1,120.04	φ1,120.04				
43622	ANY TYPE		\$1,159.66	\$1,159.66				
43022	ANTITE		φ1,139.00	φ1,139.00				
43631	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTRODUODENOSTOMY		\$928.88	\$928.88				
43632	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTROJEJUNOSTOMY		\$928.88	\$928.88				
	GASTRECTOMY, PARTIAL, DISTAL; WITH ROUX-EN-Y							
43633	RECONSTRUCTION		\$941.79	\$941.79				
	GASTRECTOMY, PARTIAL, DISTAL; WITH FORMATION OF INTESTINAL							
43634	POUCH		\$1,253.39	\$1,253.39				
	VAGOTOMY WHEN PERFORMED WITH PARTIAL DISTAL							
43635	GASTRECTOMY (LIST SEPARATE		\$95.73	\$95.73				
	VAGOTOMY INCLUDING PYLOROPLASTY, WITH OR WITHOUT							
43640	GASTROSTOMY; TRUNCAL		\$720.24	\$720.24				
	VAGOTOMY INCLUDING PYLOROPLASTY, WITH OR WITHOUT							
43641	GASTROSTOMY; PARIETAL		\$719.99	\$719.99				

Physician	n Fee Schedule 2020							
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	des in Red;							
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	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	rge for the service	<u> </u>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tinary Gran		7				
	Ise lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
Codes lis		T priysicia	113					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	FAIIIU	(i acility)	(Norm active)	Comp.	Comp.	Value	Notes
43644	WITH GASTRIC BYP	R	\$1,202.92	\$1,202.92				
70077	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	1	ψ1,202.32	ψ1,202.52				
43645	WITH GASTRIC BYP	R	\$1,286.28	\$1,286.28				
70070	WITH GACTING BIT		ψ1,200.20	ψ1,200.20				
43647	LAPAROSCOPY, SURGICAL, IMPLANT GASTRIC ELECTRODE, ANTRUM	R	\$0.00	\$0.00				
43648	REVISION OR REMOVAL GASTRIC ELECTRODE, ANTRUM		\$0.00	\$0.00				
10010	LAPAROSCOPY, SURGICAL; TRANSECTION OF VAGUS NERVES,		Ψ0.00	ψ0.00				
43651	TRUNCAL		\$448.81	\$448.81				
10001	LAPAROSCOPY, SURGICAL; TRANSECTION OF VAGUS NERVES,		ψ110.01	ψ 1 10.0 1				
43652	SELECTIVE OR HIGHL		\$536.93	\$536.93				
10002	LAPAROSCOPY, SURGICAL; GASTROSTOMY, WITHOUT		Ψ000.00	φοσσ.σσ				
43653	CONSTRUCTION OF GASTRIC TU		\$384.37	\$384.37				
43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH	R	\$0.00	\$0.00				
	NASO- OR ORO-GASTRIC TUBE PLACEMENT, REQUIRING		V 0.00	40.00				
43752	PHYSICIAN'S SKILL AND		\$154.78	\$154.78				
	GASTRIC INTUBATION AND ASPIRATION(S) THERAPEUTIC,		V.G	V 10 111 0				
	NECESSITATING PHYSICIAN'S SKILL, INCLUDING LAVAGE IF							
43753	PERFORMED		\$18.10	\$18.10				
	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC; SINGLE		¥ 10110	7 10110				
43754	SPECIMEN		\$27.59	\$68.83				
	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC; COLLECTION							
	OF MULTIPLE FRACTIONAL SPECIMENS WITH GASTRIC							
43755	STIMULATION, INCLUDES DRUG ADMIN.		\$50.44	\$105.03				
	DUODENAL INTUBATION AND ASPIRATION, DIAGNOSTIC, INCLUDES		<u> </u>					
43756	IMAGE GUIDANCE; SINGLE SPECIMEN		\$45.40	\$190.48				
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Physician	Fee Schedule 2020	1						
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omanı abar	go for the convic			+	+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T		7				
	te lab fee schedule for covered codes not listed below in the 80000-89249	rango				-		
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f					-		
Codes list		T priysiciai	115			-		
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	DUODENAL INTUBATION AND ASPIRATION, DIAGNOSTIC, INCLUDES	FAIIIU	(i acility)	(Norm active)	Comp.	Comp.	value	Notes
	IMAGE GUIDANCE; COLLECTION OF MULTIPLE FRACTIONAL							
	SPECIMENS WITH PANCREATIC AOR GALLBLADDER STIMULATION,							
43757	INCLUDES DRUG ADMIN.		\$65.57	\$245.07				
40707	REPOSITIONING OF THE GASTRIC FEEDING TUBE, ANY METHOD,		ψ00.01	Ψ240.01				
43761	THROUGH THE DUO		\$93.49	\$93.49				
43762	RPLC GTUBE NO REVJ TRC		\$30.93	\$167.22				Effective 1/1/2019
43763	RPLC GTUBE REVJ GSTRST TRC		\$67.58	\$249.31				Effective 1/1/2019
40700	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;		ψον.οο	Ψ2-10.01				Life 617 17 20 10
43770	PLACEMENT OF	R	\$749.49	\$749.49				
10770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	+	Ψ7 10.10	ψ7 10.10				
43771	REVISION OF	R	\$864.05	\$864.05				
10111	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	1	ψου 1.00	ψου 1.00				
43772	REMOVAL OF ADJUS	R	\$659.11	\$659.11				
10112	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	1	Ψ000.11	Ψ000.11				
43773	REMOVAL AND	R	\$864.31	\$864.31				
	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE;	-	400	+++++++++++++++++++++++++++++++++++++				
43774	REMOVAL OF ADJUS	R	\$660.61	\$660.61				
43775	LONGITUDINAL GASTRECTOMY	R	\$963.54	\$963.54				
43800	PYLOROPLASTY		\$495.57	\$495.57				
43810	GASTRODUODENOSTOMY	1	\$537.88	\$537.88	1			
43820	GASTROJEJUNOSTOMY; WITHOUT VAGOTOMY	1	\$570.93	\$570.93	1			
43825	GASTROJEJUNOSTOMY; WITH VAGOTOMY, ANY TYPE	1	\$742.76	\$742.76				
	GASTROSTOMY, OPEN; WITHOUT CONSTRUCTION OF GASTRIC							
43830	TUBE (EG, STAMM		\$336.97	\$336.97				
43831	GASTROSTOMY, OPEN; NEONATAL, FOR FEEDING		\$350.16	\$350.16				

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	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	GASTROSTOMY, OPEN; WITH CONSTRUCTION OF GASTRIC TUBE							
	(EG, JANEWAY		\$559.67	\$559.67				
	GASTRORRHAPHY, SUTURE OF PERFORATED DUODENAL OR							
	GASTRIC ULCER, WOUND,		\$557.26	\$557.26				
	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS,							
	FOR MORBID OBES	R	\$842.96	\$842.96				
	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS,							
43843	FOR MORBID OBES	R	\$842.96	\$842.96				
43845	GASTROPLASTY DUODENAL SWITCH		\$1,547.93	\$1,547.93				
	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR							
43846	MORBID OBESITY;	R	\$1,058.91	\$1,058.91				
	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR							
43847	MORBID OBESITY;	R	\$1,060.21	\$1,060.21				
	REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE FOR							
43848	MORBID OBESITY, O	R	\$1,125.64	\$1,125.64				
	REVISION OF GASTRODUODENAL ANASTOMOSIS							
43850	(GASTRODUODENOSTOMY) WITH	R	\$899.17	\$899.17				
	REVISION OF GASTRODUODENAL ANASTOMOSIS							
43855	(GASTRODUODENOSTOMY) WITH	R	\$897.35	\$897.35				
	REVISION OF GASTROJEJÚNAL ANASTOMOSIS							
43860	(GASTROJEJUNOSTOMY) WITH	R	\$900.66	\$900.66				
	REVISION OF GASTROJEJUNAL ANASTOMOSIS	1		1	†		†	
	(GASTROJEJUNOSTOMY) WITH	R	\$993.49	\$993.49				
	CLOSURE OF GASTROSTOMY, SURGICAL	1	\$374.96	\$374.96	†		†	
	CLOSURE OF GASTROCOLIC FISTULA	1	\$796.34	\$796.34	†		†	
		-			1	+	1	
43881	IMPLANT GASTRIC ELECTRODE, ANTRUM, OPEN	R	\$0.00	\$0.00				

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	olumn indicates Prior Auth is required	<u> </u>	1					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciar	is .					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN		\$205.28	\$205.28				
	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF							
43887	SUBCUTANEOUS PORT COMP	R	\$201.34	\$201.34				
	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND							
43888	REPLACEMENT OF	R	\$286.41	\$286.41				
43999	UNLISTED PROCEDURE, STOMACH	R	\$75.00	\$100.00				
	ENTEROLYSIS (FREEING OF INTESTINAL ADHESION) (SEPARATE							
44005	PROCEDURE)		\$631.99	\$631.99				
	DUODENOTOMY, FOR EXPLORATION, BIOPSY(S), OR FOREIGN BODY							
44010	REMOVAL		\$490.98	\$490.98				
	TUBE OR NEEDLE CATHETER JEJUNOSTOMY FOR ENTERAL							
44015	ALIMENTATION,		\$174.18	\$174.18				
	ENTEROTOMY, SMALL INTESTINE, OTHER THAN DUODENUM; FOR							
44020	EXPLORATION,		\$563.26	\$563.26				
	ENTEROTOMY, SMALL INTESTINE, OTHER THAN DUODENUM; FOR							
44021	DECOMPRESSION (E		\$541.51	\$541.51				
	COLOTOMY, FOR EXPLORATION, BIOPSY(S), OR FOREIGN BODY							
44025	REMOVAL		\$571.56	\$571.56				
	REDUCTION OF VOLVULUS, INTUSSUSCEPTION, INTERNAL HERNIA,							
44050	BY LAPAROTOMY		\$543.16	\$543.16				
	CORRECTION OF MALROTATION BY LYSIS OF DUODENAL BANDS							
44055	AND/OR REDUCTION		\$594.11	\$594.11				
	BIOPSY OF INTESTINE BY CAPSULE, TUBE, PERORAL (ONE OR MORE							
44100	SPECIMENS)		\$99.15	\$99.15				
	EXCISION OF ONE OR MORE LESIONS OF SMALL OR LARGE							
44110	INTESTINE NOT REQUIR		\$508.50	\$508.50				
44111	EXCISION OF ONE OR MORE LESIONS SMALL/LARGE INTES		\$635.61	\$635.61				

Physician	n Fee Schedule 2020							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service			+		
The Ane	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tinary char	T	'		+		
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						+
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oue	ENTERECTOMY, RESECTION OF SMALL INTESTINE; SINGLE	I A IIIu	(i acinty)	(Nom acmity)	Comp.	Comp.	Value	Notes
44120	RESECTION AND ANASTO		\$688.69	\$688.69				
77120	ENTERECTOMY, RESECTION OF SMALL INTESTINE; EACH	+	Ψ000.00	Ψ000.00	+			+
44121	ADDITIONAL RESECTION A		\$205.93	\$205.93				
77121	ENTERECTOMY, RESECTION OF SMALL INTESTINE; WITH		Ψ200.00	Ψ200.00				+
44125	ENTEROSTOMY		\$729.61	\$729.61				
11120	ENTERECTOMY, RESECTION OF SMALL INTESTINE FOR CONGENITAL		Ψ120.01	Ψ120.01				+
44126	ATRESIA, SING		\$1,496.09	\$1,496.09				
11120	ENTERECTOMY, RESECTION OF SMALL INTESTINE FOR CONGENITAL		ψ1,100.00	ψ1,100.00				+
44127	ATRESIA, SING		\$1,720.93	\$1,720.93				
	ENTERECTOMY, RESECTION OF SMALL INTESTINE FOR CONGENITAL		Ψ1,120.00	ψ1,120.00				
44128	ATRESIA, SING		\$185.26	\$185.26				
11120	ENTEROENTEROSTOMY, ANASTOMOSIS OF INTESTINE, WITH OR		ψ.00.20	ψ100.20				
44130	WITHOUT CUTANEOUS		\$603.16	\$603.16				
44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR	R	\$0.00	\$0.00				
			70100	7				
44137	REMOVAL OF TRANSPLANTED INTESTINAL ALLOGRAFT, COMPLETE	R	\$0.00	\$0.00				
	MOBILIZATION (TAKE-DOWN) OF SPLENIC FLEXURE PERFORMED IN		70100	7				
44139	CONJUNCTION W		\$103.38	\$103.38				
44140	COLECTOMY, PARTIAL; WITH ANASTOMOSIS		\$920.07	\$920.07				
	COLECTOMY, PARTIAL; WITH SKIN LEVEL CECOSTOMY OR		70000	70-0.0				
44141	COLOSTOMY		\$889.47	\$889.47				
	COLECTOMY, PARTIAL; WITH END COLOSTOMY AND CLOSURE OF	†			†	1		
44143	DISTAL SEGMENT		\$832.65	\$832.65				
	COLECTOMY, PARTIAL; WITH RESECTION, WITH COLOSTOMY OR	†	,	,	1	1		
44144	ILEOSTOMY AND		\$825.10	\$825.10				

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	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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D			luu at Data	O. 4 at . D. 4	Task	Duef	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
44445	COLECTOMY, PARTIAL; WITH COLOPROCTOSTOMY (LOW PELVIC		04.047.07	04.047.07				
44145	ANASTOMOSIS)		\$1,047.67	\$1,047.67				
11110	COLECTOMY, PARTIAL; WITH COLOPROCTOSTOMY (LOW PELVIC		04.400.44	* 400 44				
44146	ANASTOMOSIS), WIT		\$1,130.11	\$1,130.11		_	_	
44147	COLECTOMY, PARTIAL; ABDOMINAL AND TRANSANAL APPROACH		\$967.88	\$967.88				
44 14 7	COLECTOMY, PARTIAL, ABDOMINAL AND TRANSANAL APPROACH		φ907.00	φ907.00				-
11150	ILEOSTOMY OR		¢4 000 77	¢4 000 77				
44150	COLECTOMY, TOTAL, ABDOMINAL, WITHOUT PROCTECTOMY; WITH		\$1,033.77	\$1,033.77				
11151	CONTINENT ILEOS		\$854.51	\$854.51				
44151	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH		φου4.υ I	φου4.υ I				-
44455			¢4 470 00	¢4 470 00				
44155	ILEOSTOMY		\$1,179.83	\$1,179.83				
44450	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH		#007.00	#007.00				
44156	CONTINENT ILEOSTOM		\$967.96	\$967.96				
44157	COLECTOMY, W/ILEOANAL ANASTOMOSIS		\$1,519.07	\$1,519.07				
44450	COLECTOMY, W/ILEOANAL ANASTOMOSIS AND RECTAL		¢4 550 70	¢4 550 70				
44158	MUCOSECTOMY COLECTOMY, PARTIAL, WITH REMOVAL OF TERMINAL ILEUM WITH		\$1,558.78	\$1,558.78				
44460			#040.04	#040.04				
44160	ILEOCOLOSTOMY LAPAROSCOPY, SURGICAL, ENTEROLYSIS (FREEING OF INTESTINAL		\$812.24	\$812.24				
11100	ADHESION)		ФСОБ О4	ФСОБ 0.4				
44180	1		\$635.24	\$635.24				
44400	LAPAROSCOPY, SURGICAL; JEJUNOSTOMY (EG, FOR		¢445.05	Φ44E ΩΕ				
44186	DECOMPRESSION OR FEEDING)		\$445.25	\$445.25				<u> </u>
44407	LAPAROSCOPY, SURGICAL; ILEOSTOMY OR JEJUNOSTOMY, NON-		ф 7 04.00	ф 7 04.00				
44187	TUBE		\$734.68	\$734.68				<u> </u>
14400	LAPAROSCOPY, SURGICAL, COLOSTOMY OR SKIN LEVEL		#000 F0	#000 F0				
44188	CECOSTOMY		\$806.58	\$806.58				

Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAPAROSCOPY, SURGICAL; ENTERECTOMY, RESECTION OF SMALL							
44202	INTESTINE, SING		\$1,003.41	\$1,003.41				
	LAPAROSCOPY, SURGICAL; EACH ADDITIONAL SMALL INTESTINE							
44203	RESECTION AND		\$180.61	\$180.61				
44004	LAPAROSCOPY, SURGICAL; COLECTOMY, PARTIAL, WITH			* 4 007 50				
44204	ANASTOMOSIS		\$1,037.52	\$1,037.52				
44005	LAPAROSCOPY, SURGICAL; COLECTOMY, PARTIAL, WITH REMOVAL		#040.00	# 040.00				
44205	OF TERMINAL IL		\$918.82	\$918.82				
44006	LAPAROSCOPY, SURGICAL; COLECTOMY, PARTIAL, WITH END		¢4 447 04	¢4 447 04				
44206	COLOSTOMY AND CLOS LAPAROSCOPY, SURGICAL; COLECTOMY, PARTIAL, WITH		\$1,117.91	\$1,117.91				+
44007	ANASTOMOSIS, WITH		¢4 004 07	¢4 004 07				
44207	LAPAROSCOPY, SURGICAL; COLECTOMY, PARTIAL, WITH		\$1,224.87	\$1,224.87				+
44208	ANASTOMOSIS, WITH		\$1,323.02	\$1,323.02				
44200	LAPAROSCOPY, SURGICAL; COLECTOMY, TOTAL, ABDOMINAL,		Φ1,323.02	φ1,323.UZ				+
44210	WITHOUT PROCTECTOM		\$1,170.34	\$1,170.34				
77210	LAPAROSCOPY, SURGICAL; COLECTOMY, TOTAL, ABDOMINAL, WITH		Ψ1,170.04	ψ1,170.04				
44211	PROCTECTOMY.		\$1,453.85	\$1,453.85				
11211	LAPAROSCOPY, SURGICAL; COLECTOMY, TOTAL, ABDOMINAL, WITH		ψ1,100.00	ψ1,100.00	1			+
44212	PROCTECTOMY.		\$1,357.98	\$1,357.98				
<u> </u>	LAPAROSCOPY, SURGICAL, MOBILIZATION (TAKE-DOWN) OF		7.,5555	7 .,00.100				
44213	SPLENIC FLEXURE		\$146.37	\$146.37				
	LAPAROSCOPY, SURGICAL, CLOSURE OF ENTEROSTOMY, LARGE OR							
44227	SMALL INTESTIN		\$1,145.29	\$1,145.29				
	UNLISTED LAPAROSCOPY PROCEDURE, INTESTINE (EXCEPT							
44238	RECTUM)	R	\$0.00	\$0.00				

Physiciar	n Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ENTEROSTOMY OR CECOSTOMY, TUBE (EG, FOR DECOMPRESSION							
44300	OR FEEDING) (SEP		\$421.08	\$421.08				
44310	ILEOSTOMY OR JEJUNOSTOMY, NON-TUBE		\$547.18	\$547.18				
	REVISION OF ILEOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL SCAR)							
44312	(SEPARATE		\$250.24	\$250.24				
	REVISION OF ILEOSTOMY; COMPLICATED (RECONSTRUCTION IN-							
44314	DEPTH) (SEPARATE		\$495.26	\$495.26				
	CONTINENT ILEOSTOMY (KOCK PROCEDURE) (SEPARATE							
44316	PROCEDURE)		\$692.09	\$692.09				
44320	COLOSTOMY OR SKIN LEVEL CECOSTOMY;		\$572.46	\$572.46				
	COLOSTOMY OR SKIN LEVEL CECOSTOMY; WITH MULTIPLE							
44322	BIOPSIES (EG, FOR		\$591.49	\$591.49				
44040	REVISION OF COLOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL		0407.04	4.07.04				
44340	SCAR) (SEPARATE		\$197.94	\$197.94				
44045	REVISION OF COLOSTOMY; COMPLICATED (RECONSTRUCTION IN-		0440.75	0440.75				
44345	DEPTH) (SEPARATE		\$449.75	\$449.75				
44040	REVISION OF COLOSTOMY; WITH REPAIR OF PARACOLOSTOMY		Φ 5 20.40	¢500.40				
44346	HERNIA (SEPARATE SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		\$538.49	\$538.49				
44360	PORTION OF DUODE		\$193.77	\$193.77				
44300	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		φ193. <i>I I</i>	φ193. <i>I I</i>				
44361	PORTION OF DUODE		\$214.08	\$214.08				
74301	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND	1	ψ∠ 14.00	ψ∠ 14.00				+
44363	PORTION OF DUODE		\$204.56	\$204.56				
77000	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		Ψ207.00	Ψ204.30				
44364	PORTION OF DUODE		\$268.19	\$268.19				
44304	I OKTION OF DOODE		φ200.18	ψ200.13				

Physician	n Fee Schedule 2020			1				
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND							
44365	PORTION OF DUODE		\$253.81	\$253.81				
	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND							
44366	PORTION OF DUODE		\$313.95	\$313.95				
	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND							
44369	PORTION OF DUODE		\$336.39	\$336.39				
1	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND							
44370	PORTION OF DUODE		\$171.38	\$171.38				
	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND							
44372	PORTION OF DUODE		\$318.49	\$318.49				
44070	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		****	****				
44373	PORTION OF DUODE		\$262.68	\$262.68				
4.4070	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		****	0004.04				
44376	PORTION OF DUODE		\$281.91	\$281.91				
44077	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODE		\$206.54	¢206 E4				
44377			\$296.54	\$296.54				
44070	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		\$376.09	\$376.09				
44378	PORTION OF DUODE SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND		\$376.09	\$376.09				_
44379	PORTION OF DUODE		\$279.76	\$279.76				
44379	ILEOSCOPY, THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT		\$279.70	\$279.70				
44380	COLLECTION OF		\$101.69	\$101.69				
44300	BALLOON DILATION OF SMALL BOWEL USING AN ENDOSCOPE		ψ101.08	ψ101.08		+		
44381	WHICH IS INSERTED THROUGH ABDOMINAL OPENING		\$73.66	\$740.13				Added Effective 1/1/2016
44301	WITHOUT IS INSCRICED THINOUGH ADDOMINAL OF EINING		φ13.00	ψ140.13		+		Added Ellective 1/1/2010
44382	II FOSCOPY THROUGH STOMA: WITH BIOPSY SINGLE OR MULTIPLE		\$122.95	\$122.95				
44382	ILEOSCOPY, THROUGH STOMA; WITH BIOPSY, SINGLE OR MULTIPLE		\$122.95	\$122.95				

Dhygigian	Fee Schedule 2020	l .						
Note:	T Scriedule 2020							
	lles in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnar	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes ils	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar	ns T					
							Base	
Proc			Innet Bete	Outpot Boto	Tech.	Prof.	Unit	
	Bus as deves Bassariution	DA local	Inpat. Rate	Outpat. Rate				Notes
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DI ACEMENT OF STENT IN SMALL DOWEL LISING AN ENDOSCODE							
44204	PLACEMENT OF STENT IN SMALL BOWEL USING AN ENDOSCOPE WHICH IS INSERTED THROUGH ABDOMINAL OPENING		¢400.46	\$129.16				Add Tff ative 1/1/2016
44384			\$129.16	\$129.10				Added Effective 1/1/2016
44005	ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR		C404 40	¢404.40				
44385	PELVIC) POUCH; ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR		\$124.16	\$124.16				
44206	· ·		¢407.46	¢407.46				
44386	PELVIC) POUCH; COLONOSCOPY THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT		\$107.16	\$107.16				
44200	COLLECTION OF		¢101.72	¢101.72				
44388	COLONOSCOPY THROUGH STOMA; WITH BIOPSY, SINGLE OR		\$191.73	\$191.73				
44389	MULTIPLE		\$210.07	\$210.07				
44369	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF FOREIGN		\$210.0 <i>1</i>	φ210.0 <i>1</i>				
44390	BODY		\$189.73	\$189.73				
44390	COLONOSCOPY THROUGH STOMA; WITH CONTROL OF BLEEDING		\$189.73	\$189.73				
44391	(EG, INJECTION, BI		\$280.73	\$280.73				
44391	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S),		\$280.73	\$280.73				
44392	POLYP(S), OR OTHE		\$267.50	\$267.50				
44392	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S),		\$207.30	\$207.30				
44394	POLYP(S), OR OTHE		\$285.40	\$285.40				
44394	POLTP(S), OR OTHE		\$203.40	φ <u>2</u> 03.40				
	DESTRUCTION OF LARCE ROWEL CROWTHS LISING AN ENDOSCORE							
44404	DESTRUCTION OF LARGE BOWEL GROWTHS USING AN ENDOSCOPE		\$203.68	¢2 400 55				Added Effective 1/1/2016
44401	WHICH IS INSERTED THROUGH ABDOMINAL OPENING STENT PLACEMENT IN LARGE BOWEL USING AN ENDOSCOPE WHICH		ቅ∠∪ 3.08	\$2,409.55				Added Effective 1/1/2016
44402	IS INSERTED THROUGH ABDOMINAL OPENING		\$220.69	\$220.69				Added Effective 1/1/2016
44402	RESECTION OF LARGE BOWEL TISSUE USING AN ENDOSCOPE		φ∠∠∪.09	φ∠∠∪.09				Added Effective 1/1/2016
44400			ФОБО <u>Б</u> С	¢050 56				Add - d Effective 4/4/2046
44403	WHICH IS INSERTED THROUGH ABDOMINAL OPENING		\$253.56	\$253.56				Added Effective 1/1/2016

Dhygigian	Fee Schedule 2020	T		1	T	1	1	Т
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	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	!			_	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns T				_	
							Base	
D			lanat Data	O. 4 at . D. 4 a	Task	Prof.	Unit	
Proc		_	Inpat. Rate	Outpat. Rate	Tech.			
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
1,,,,,	INJECTIONS OF LARGE BOWEL USING AN ENDOSCOPE WHICH IS		* 4 4 = 0 4	4004.50				
44404	INSERTED THROUGH ABDOMINAL OPENING		\$145.81	\$324.58				Added Effective 1/1/2016
	BALLOON DILATION OF LARGE BOWEL USING AN ENDOSCOPE							
44405	WHICH IS INSERTED THROUGH ABDOMINAL OPENING		\$155.07	\$461.40				Added Effective 1/1/2016
	ULTRASOUND EXAMINATION OF LARGE BOWEL USING AN							
44406	ENDOSCOPE WHICH IS INSERTED THROUGH ABDOMINAL OPENING		\$193.27	\$193.27				Added Effective 1/1/2016
	ULTRASOUND GUIDED FINE NEEDLE ASPIRATION/BIOPSIES OF							
	LARGE BOWEL USING AN ENDOSCOPE WHICH IS INSERTED							
44407	THROUGH ABDOMINAL OPENING		\$231.38	\$231.38				Added Effective 1/1/2016
	DECOMPRESSION OF LARGE BOWEL USING AN ENDOSCOPE WHICH							
44408	IS INSERTED THROUGH ABDOMINAL OPENING		\$195.21	\$195.21				Added Effective 1/1/2016
	INTRODUCTION OF LONG GASTROINTESTINAL TUBE (EG, MILLER-							
44500	ABBOTT) (SEPARA		\$24.52	\$24.52				
	SUTURE OF SMALL INTESTINE (ENTERORRHAPHY) FOR							
44602	PERFORATED ULCER,		\$529.77	\$529.77				
	SUTURE OF SMALL INTESTINE (ENTERORRHAPHY) FOR							
44603	PERFORATED ULCER,		\$671.14	\$671.14				
	SUTURE OF LARGE INTESTINE (COLORRHAPHY) FOR PERFORATED							
44604	ULCER, DIVERTIC		\$631.37	\$631.37				
	SUTURE OF LARGE INTESTINE (COLORRHAPHY) FOR PERFORATED							
44605	ULCER, DIVERTIC		\$708.57	\$708.57				
	INTESTINAL STRICTUROPLASTY (ENTEROTOMY AND							
44615	ENTERORRHAPHY) WITH OR WITH	<u> </u>	\$597.17	\$597.17			<u> </u>	
44620	CLOSURE OF ENTEROSTOMY, LARGE OR SMALL INTESTINE;		\$473.91	\$473.91				
	CLOSURE OF ENTEROSTOMY, LARGE OR SMALL INTESTINE; WITH							
44625	RESECTION AND		\$661.34	\$661.34				

Physician	Fee Schedule 2020							
Note:	T de Scriedule 2020							
	les in Red;							
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	column indicates Prior Auth is required						+	+
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	man, shar	as for the comics					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	mary char	ge for the service	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysicia T	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Due and time December in the	DA In al	•					Notes
Code	Procedure Description CLOSURE OF ENTEROSTOMY, LARGE OR SMALL INTESTINE; WITH	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
44606	RESECTION AND		£4,000,50	¢4 000 50				
44626			\$1,002.53	\$1,002.53				
44640	CLOSURE OF INTESTINAL CUTANEOUS FISTULA		\$599.66	\$599.66				
44650	CLOSURE OF ENTEROENTERIC OR ENTEROCOLIC FISTULA		\$635.85	\$635.85			_	
	CLOSURE OF ENTEROVESICAL FISTULA; WITHOUT INTESTINAL OR		4000.07	****				
44660	BLADDER RESECT		\$638.67	\$638.67				
	CLOSURE OF ENTEROVESICAL FISTULA; WITH INTESTINE AND/OR			****				
44661	BLADDER RESECT		\$888.20	\$888.20				
44680	INTESTINAL PLICATION (SEPARATE PROCEDURE)		\$676.59	\$676.59				
	EXCLUSION OF SMALL INTESTINE FROM PELVIS BY MESH OR OTHER							
44700	PROSTHESIS,		\$765.14	\$765.14				
	INTRAOPERATIVE COLONIC LAVAGE (LIST SEPARATELY IN ADDITION							
44701	TO CODE FOR		\$122.17	\$122.17				
	BACKBENCH STANDARD PREPARATION OF CADAVER OR LIVING							
44715	DONOR INTESTINE		\$0.00	\$0.00				
44720	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVI		\$201.57	\$201.57				
	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR							
44721	INTESTINE ALLOGRAF		\$293.80	\$293.80				
44799	UNLISTED PROCEDURE, INTESTINE	R	\$0.00	\$0.00				
	EXCISION OF MECKEL'S DIVERTICULUM (DIVERTICULECTOMY) OR							
44800	OMPHALOMESENTE		\$463.75	\$463.75				
44820	EXCISION OF LESION OF MESENTERY (SEPARATE PROCEDURE)		\$458.16	\$458.16				
44850	SUTURE OF MESENTERY (SEPARATE PROCEDURE)		\$432.40	\$432.40				
	UNLISTED PROCEDURE, MECKEL'S DIVERTICULUM AND THE							
44899	MESENTERY	R	\$0.00	\$0.00				
44900	INCISION AND DRAINAGE OF APPENDICEAL ABSCESS; OPEN		\$366.82	\$366.82				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INCISION AND DRAINAGE OF APPENDICEAL ABSCESS;							
44901	PERCUTANEOUS		\$170.77	\$170.77				
44950	APPENDECTOMY;		\$443.78	\$443.78				
	APPENDECTOMY; WHEN DONE FOR INDICATED PURPOSE AT TIME							
44955	OF OTHER MAJOR		\$112.05	\$112.05				
	APPENDECTOMY; FOR RUPTURED APPENDIX WITH ABSCESS OR							
44960	GENERALIZED PERITO		\$475.09	\$475.09				
44970	LAPAROSCOPY, SURGICAL, APPENDECTOMY		\$395.19	\$395.19				
44979	UNLISTED LAPAROSCOPY PROCEDURE, APPENDIX	R	\$0.00	\$0.00				
45000	TRANSRECTAL DRAINAGE OF PELVIC ABSCESS		\$174.07	\$174.07				
45005	INCISION AND DRAINAGE OF SUBMUCOSAL ABSCESS, RECTUM		\$97.22	\$97.22				
	INCISION AND DRAINAGE OF DEEP SUPRALEVATOR, PELVIRECTAL,							
45020	OR RETRORECTA		\$211.51	\$211.51				
	BIOPSY OF ANORECTAL WALL, ANAL APPROACH (EG, CONGENITAL							
45100	MEGACOLON)		\$158.11	\$158.11				
45108	ANORECTAL MYOMECTOMY		\$209.82	\$209.82				
	PROCTECTOMY; COMPLETE, COMBINED ABDOMINOPERINEAL, WITH							
45110	COLOSTOMY		\$1,157.25	\$1,157.25				
	PROCTECTOMY; PARTIAL RESECTION OF RECTUM,							
45111	TRANSABDOMINAL APPROACH		\$815.47	\$815.47				
	PROCTECTOMY, COMBINED ABDOMINOPERINEAL, PULL-THROUGH							
45112	PROCEDURE (EG,		\$1,217.24	\$1,217.24				
	PROCTECTOMY, PARTIAL, WITH RECTAL MUCOSECTOMY, ILEOANAL							
45113	ANASTOMOSIS,	1	\$1,236.90	\$1,236.90	1			
	PROCTECTOMY, PARTIAL, WITH ANASTOMOSIS; ABDOMINAL AND							
45114	TRANSSACRAL APPR		\$1,113.60	\$1,113.60				

Physician	Fee Schedule 2020							
Note:	1 00 001104410 2020							
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	<u> </u>						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PROCTECTOMY, PARTIAL, WITH ANASTOMOSIS; TRANSSACRAL							
45116	APPROACH ONLY (KRA		\$905.90	\$905.90				
	PROCTECTOMY, COMBINED ABDOMINOPERINEAL PULL-THROUGH							
45119	PROCEDURE (EG,		\$1,251.18	\$1,251.18				
	PROCTECTOMY, COMPLETE (FOR CONGENITAL MEGACOLON),							
45120	ABDOMINAL AND PERINE		\$1,194.08	\$1,194.08				
	PROCTECTOMY, COMPLETE (FOR CONGENITAL MEGACOLON),							
45121	ABDOMINAL AND PERINE		\$1,070.67	\$1,070.67				
	PROCTECTOMY, PARTIAL, WITHOUT ANASTOMOSIS, PERINEAL							
45123	APPROACH		\$765.59	\$765.59				
	PELVIC EXENTERATION FOR COLORECTAL MALIGNANCY, WITH							
45126	PROCTECTOMY (WITH		\$1,580.48	\$1,580.48				
	EXCISION OF RECTAL PROCIDENTIA, WITH ANASTOMOSIS; PERINEAL							
45130	APPROACH		\$665.09	\$665.09				
45405	EXCISION OF RECTAL PROCIDENTIA, WITH ANASTOMOSIS;		4000 57	4000 57				
45135	ABDOMINAL AND PERINE		\$963.57	\$963.57				
45136	EXCISION OF ILEOANAL RESERVOIR WITH ILEOSTOMY		\$1,167.19	\$1,167.19				
45150	DIVISION OF STRICTURE OF RECTUM		\$260.31	\$260.31				
45460	EXCISION OF RECTAL TUMOR BY PROCTOTOMY, TRANSSACRAL OR TRANSCOCCYGEAL		\$600.10	¢600.40				
45160			\$600.10	\$600.10				
45171	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH; NOT INCLUDING MUSCULARIS PROPRIA		\$430.31	\$430.31				
45171	INCLUDING MUSCULARIS PROPRIA		\$593.07	\$593.07	1		1	
43172	DESTRUCTION OF RECTAL TUMOR (EG, ELECTRODESSICATION,		φυθυ.υτ	φυθυ.υτ	+			+
45190	ELECTROSURGERY, L		\$394.39	\$394.39				
70100	PROCTOSIGMOIDOSCOPY, RIGID; DIAGNOSTIC, WITH OR WITHOUT		ψυστ.υσ	Ψυυπ.υυ				
45300	COLLECTION OF		\$29.62	\$36.99				
70000	OOLLEGIION OI		ΨΖΘ.0Ζ	ψ50.33				

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	column indicates Prior Auth is required				-			
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	no for the convice				+	-
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tilary Criar	Je for the service	;			+	-
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ango						+
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		<u> </u>					+
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PROCTOSIGMOIDOSCOPY, RIGID; WITH DILATION (EG, BALLOON,		, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,				
45303	GUIDE WIRE, BO		\$26.17	\$34.75				
	PROCTOSIGMOIDOSCOPY, RIGID; WITH BIOPSY, SINGLE OR							
45305	MULTIPLE		\$44.30	\$55.57				
45307	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF FOREIGN BODY		\$88.62	\$88.62				
	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE							
45308	TUMOR, POLYP, OR OT		\$64.32	\$79.48				
	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE							
45309	TUMOR, POLYP, OR OT		\$78.99	\$94.15				
	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF MULTIPLE							
45315	TUMORS, POLYPS, O		\$110.82	\$110.82				
45045	PROCTOSIGMOIDOSCOPY, RIGID; WITH CONTROL OF BLEEDING (EG,			.				
45317	INJECTION,		\$118.52	\$118.52				
45000	PROCTOSIGMOIDOSCOPY, RIGID; WITH ABLATION OF TUMOR(S),		£440.00	¢4.40.00				
45320	POLYP(S), OR OT PROCTOSIGMOIDOSCOPY, RIGID; WITH DECOMPRESSION OF		\$142.93	\$142.93				
45321	VOLVULUS		\$108.20	\$108.20				
43321	PROCTOSIGMOIDOSCOPY, RIGID; WITH TRANSENDOSCOPIC STENT		\$100.20	φ100.20				
45327	PLACEMENT (INCL		\$66.44	\$66.44				
43321	SIGMOIDOSCOPY, FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT		ψ00.44	ψ00.44				
45330	COLLECTION OF		\$47.58	\$64.08				
10000			ψ.17.00	Ψ07.00				
45331	SIGMOIDOSCOPY, FLEXIBLE; WITH BIOPSY, SINGLE OR MULTIPLE		\$83.80	\$83.80				
45332	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF FOREIGN BODY		\$108.61	\$108.61	1			
	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S),	1	,	,	†			
45333	POLYP(S), OR OTHER		\$123.91	\$123.91		Ī	I	

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Ĭ					
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SIGMOIDOSCOPY, FLEXIBLE; WITH CONTROL OF BLEEDING (EG,							
45334	INJECTION, BIPO		\$166.01	\$166.01				
	SIGMOIDOSCOPY, FLEXIBLE; WITH DIRECTED SUBMUCOSAL							
45335	INJECTION(S), ANY		\$57.66	\$104.68				
	SIGMOIDOSCOPY, FLEXIBLE; WITH DECOMPRESSION OF VOLVULUS,							
45337	ANY METHOD		\$159.75	\$159.75				
	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S),							
45338	POLYP(S), OR OTHER		\$141.81	\$141.81				
	SIGMOÌDOSCOPY, FLEXIBLE; WITH DILATION BY BALLOON, 1 OR							
45340	MORE STRICTURE		\$69.12	\$234.34				
	SIGMOIDOSCOPY, FLEXIBLE; WITH ENDOSCOPIC ULTRASOUND							
45341	EXAMINATION		\$148.42	\$148.42				
	SIGMOIDOSCOPY, FLEXIBLE; WITH TRANSENDOSCOPIC							
45342	ULTRASOUND GUIDED INTRAM		\$171.39	\$171.39				
	DESTRUCTION OF POLYPS OR GROWTHS OF LARGE BOWEL USING							
45346	AN ENDOSCOPE		\$135.88	\$2,303.45				Added Effective 1/1/2016
45047	DI ACEMENT OF CTENT IN LADOE DOWEL HOING AN ENDOCCODE		# 404.40	# 404.40				A 1-11 Eff+: 4/4/2040
45347	PLACEMENT OF STENT IN LARGE BOWEL USING AN ENDOSCOPE		\$131.18	\$131.18				Added Effective 1/1/2016
45349	REMOVAL OF LARGE BOWEL TISSUE USING AN ENDOSCOPE RUBBER BANDING OF LARGE BOWEL USING AN ENDOSCOPE		\$167.25 \$86.37	\$167.25 \$435.13				Added Effective 1/1/2016 Added Effective 1/1/2016
45350 45378	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLE		\$228.82	\$228.82				Added Effective 1/1/2016
40070	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH		φ∠∠0.0∠	φ∠∠0.0∠				+
45379	REMOVAL OF FO		\$292.40	\$292.40				
45578	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH	+	φ∠υ∠.40	φ232.40	+			+
45380	BIOPSY, SINGL		\$255.86	\$255.86				
70000	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH		Ψ200.00	Ψ200.00				+
45381	DIRECTED		\$170.02	\$284.36				
40001	DIRECTED		φ1/0.02	ψ204.30				

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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.				+			
	e lab fee schedule for covered codes not listed below in the 80000-89249 i					_		
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r physiciar	<u>is</u>			_		
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45382	CONTROL OF		\$335.55	\$335.55				
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45384	REMOVAL OF		\$330.37	\$330.37				
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45385	REMOVAL OF		\$348.27	\$348.27				
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45386	DILATION BY		\$184.55	\$530.14				
45388	DESTRUCTION OF LARGE BOWEL GROWTHS USING AN ENDOSCOPE		\$227.35	\$2,425.97				Added Effective 1/1/2016
45389	STENT PLACEMENT OF LARGE BOWEL USING AN ENDOSCOPE		\$243.40	\$243.40				Added Effective 1/1/2016
45390	REMOVAL OF LARGE BOWEL TISSUE USING AN ENDOSCOPE		\$277.89	\$277.89				Added Effective 1/1/2016
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45391	ENDOSCOPIC		\$212.17	\$212.17				
	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH							
45392	TRANSENDOSCOP		\$268.20	\$268.20				
45393	DECOMPRESSION OF LARGE BOWEL USING AN ENDOSCOPE		\$212.95	\$212.95				Added Effective 1/1/2016
	LAPAROSCOPY, SURGICAL; PROCTECTOMY, COMPLETE, COMBINED							
45395	ABDOMINOPERINEA		\$1,348.53	\$1,348.53				
	LAPAROSCOPY, SURGICAL; PROCTECTOMY, COMBINED							
45397	ABDOMINOPERINEAL PULL-THR		\$1,468.46	\$1,468.46				
45398	TYING OF LARGE BOWEL USING AN ENDOSCOPE		\$197.74	\$553.48				Added Effective 1/1/2016
45399	LARGE BOWEL PROCEDURE		\$0.00	\$0.00				Added Effective 1/1/2016
45400	LAPAROSCOPY, SURGICAL; PROCTOPEXY (FOR PROLAPSE)		\$788.46	\$788.46				
45402	LAPAROSCOPY, SURGICAL; PROCTOPEXY		\$1,071.14	\$1,071.14				
45499	UNLISTED LAPAROSCOPY PROCEDURE, RECTUM	R	\$0.00	\$0.00				
45500	PROCTOPLASTY; FOR STENOSIS		\$382.37	\$382.37				

Physician	Fee Schedule 2020							
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The Anest	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
45505	PROCTOPLASTY; FOR PROLAPSE OF MUCOUS MEMBRANE		\$361.16	\$361.16				
45520	PERIRECTAL INJECTION OF SCLEROSING SOLUTION FOR PROLAPSE		\$26.75	\$34.93				
45540	PROCTOPEXY (EG, FOR PROLAPSE); ABDOMINAL APPROACH		\$667.83	\$667.83				
45541	PROCTOPEXY (EG, FOR PROLAPSE); PERINEAL APPROACH		\$609.62	\$609.62				
	PROCTOPEXY (EG, FOR PROLAPSE); WITH SIGMOID RESECTION,							
45550	ABDOMINAL APPRO		\$758.63	\$758.63				
45560	REPAIR OF RECTOCELE (SEPARATE PROCEDURE)		\$371.78	\$371.78				
	EXPLORATION, REPAIR, AND PRESACRAL DRAINAGE FOR RECTAL							
45562	INJURY;		\$581.98	\$581.98				
	EXPLORATION, REPAIR, AND PRESACRAL DRAINAGE FOR RECTAL							
45563	INJURY; WITH		\$918.00	\$918.00				
45800	CLOSURE OF RECTOVESICAL FISTULA;		\$672.75	\$672.75				
45805	CLOSURE OF RECTOVESICAL FISTULA; WITH COLOSTOMY		\$831.02	\$831.02				
45820	CLOSURE OF RECTOURETHRAL FISTULA;		\$661.31	\$661.31				
45825	CLOSURE OF RECTOURETHRAL FISTULA; WITH COLOSTOMY		\$758.43	\$758.43				
	REDUCTION OF PROCIDENTIA (SEPARATE PROCEDURE) UNDER							
45900	ANESTHESIA		\$67.53	\$67.53				
	DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE) UNDER							
45905	ANESTHESIA OTHER		\$66.27	\$66.27				
	DILATION OF RECTAL STRICTURE (SEPARATE PROCEDURE) UNDER							
45910	ANESTHESIA OTH		\$81.07	\$81.07				
	REMOVAL OF FECAL IMPACTION OR FOREIGN BODY (SEPARATE							
45915	PROCEDURE) UNDER		\$84.44	\$84.44	1			
45055	ANORECTAL EXAM, SURGICAL, REQUIRING ANESTHESIA (GENERAL,							
45990	SPINAL, OR		\$77.97	\$77.97	1			
45999	UNLISTED PROCEDURE, RECTUM	R	\$0.00	\$0.00				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	<u> </u>						
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility) \$168.72	Comp.	Comp.	Value	Notes
46020 46030	PLACEMENT OF SETON OTHER MARKER		\$149.88	I '				
46030	REMOVAL OF ANAL SETON, OTHER MARKER		\$47.64	\$47.64				
40040	INCISION AND DRAINAGE OF ISCHIORECTAL AND/OR PERIRECTAL		¢407.07	¢407.07				
46040	ABSCESS (SEPAR		\$197.37	\$197.37				
40045	INCISION AND DRAINAGE OF INTRAMURAL, INTRAMUSCULAR, OR		#470.50	0470.50				
46045	SUBMUCOSAL ABSC		\$173.59	\$173.59				
46050	INCISION AND DRAINAGE, PERIANAL ABSCESS, SUPERFICIAL		\$44.17	\$52.22			_	
40000	INCISION AND DRAINAGE OF ISCHIORECTAL OR INTRAMURAL		0.40.04	004004				
46060	ABSCESS, WITH		\$318.31	\$318.31				
46070	INCISION, ANAL SEPTUM (INFANT)		\$121.94	\$121.94				
40000	SPHINCTEROTOMY, ANAL, DIVISION OF SPHINCTER (SEPARATE		4400 54	4.00 5.4				
46080	PROCEDURE)		\$136.54	\$136.54				
46083	INCISION OF THROMBOSED HEMORRHOID, EXTERNAL		\$50.01	\$58.46				
46200	FISSURECTOMY, WITH OR WITHOUT SPHINCTEROTOMY		\$192.90	\$192.90				
40000	PAPILLECTOMY OR EXCISION OF SINGLE TAG, ANUS (SEPARATE			004.40				
46220	PROCEDURE)		\$64.12	\$64.12				
40004	UEMORRUOIRESTAMA RACIONALE LIGATURE (EG. RURRER RAMR)		450 55	404.00				
46221	HEMORRHOIDECTOMY, BY SIMPLE LIGATURE (EG, RUBBER BAND)		\$52.75	\$61.60				
	EXCISION OF EXTERNAL HEMORRHOID TAGS AND/OR MULTIPLE							
46230	PAPILLAE		\$87.99	\$99.12				
46250	HEMORRHOIDECTOMY, EXTERNAL, COMPLETE		\$214.69	\$214.69				
46255	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE;		\$292.50	\$292.50				
	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH							
46257	FISSURECTOMY		\$338.77	\$338.77				
	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH							
46258	FISTULECTOMY, WI		\$370.78	\$370.78				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Code	Procedure Description HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
46260	EXTENSIVE;		\$389.78	¢200.70				
40200	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR		Φ309.70	\$389.78				
46261	EXTENSIVE; WITH		\$402.03	\$402.03				
40201	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR		\$402.03	\$402.03				
46262	EXTENSIVE; WITH		\$412.67	\$412.67				
40202	SURGICAL TREATMENT OF ANAL FISTULA		\$412.0 <i>1</i>	φ412.0 <i>1</i>				
46270	(FISTULECTOMY/FISTULOTOMY); SUBCUTA		\$162.14	\$162.14				
40270	SURGICAL TREATMENT OF ANAL FISTULA		\$102.14	\$102.14				
46275	(FISTULECTOMY/FISTULOTOMY); SUBMUSC		\$302.62	\$302.62				
40275	SURGICAL TREATMENT OF ANAL FISTULA		φ30Z.0Z	φ30Z.0Z				
46280	(FISTULECTOMY/FISTULOTOMY); COMPLEX		\$358.41	\$358.41				
40200	SURGICAL TREATMENT OF ANAL FISTULA		φ300.4 I	φ300.41				
46285	(FISTULECTOMY/FISTULOTOMY); SECOND		\$185.46	\$185.46				
46288	CLOSURE OF ANAL FISTULA WITH RECTAL ADVANCEMENT FLAP		\$316.34	\$316.34				
40200	ENUCLEATION OR EXCISION OF EXTERNAL THROMBOTIC		φ310.3 4	φ310.34				
46320	HEMORRHOID		\$58.42	\$67.81				
46500	INJECTION OF SCLEROSING SOLUTION, HEMORRHOIDS		\$50.65	\$54.94				
46505	CHEMODENERVATION OF INTERNAL ANAL SPHINCTER		\$138.75	\$166.31				
+0505	ANOSCOPY; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF		φ130./3	φ 100.31				
46600	SPECIMEN(S) BY BRU		\$19.16	\$22.91				
+0000	DIAGNOSTIC EXAMINATION OF ANUS WITH MAGNIFICATION AND		φ13.10	φ∠∠.ઝ Ι				
46601	CHEMICAL AGENT ENHANCEMENT USING AN ENDOSCOPE		\$75.66	\$106.70				Added Effective 1/1/2016
40001	CHEWICAL AGENT ENFIANCEWENT USING AN ENDOSCOPE	_	φ/ 3.00	φ100.70				Added Effective 1/1/2010
46604	ANOSCOPY; WITH DILATION (EG, BALLOON, GUIDE WIRE, BOUGIE)		\$44.99	\$50.09				
46606	ANOSCOPY; WITH BIOPSY, SINGLE OR MULTIPLE		\$30.05	\$34.88				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
4000=	BIOPSIES OF ANUS WITH MAGNIFICATION AND CHEMICAL AGENT		* 400.05					= "
46607	ENHANCEMENT USING AN ENDOSCOPE		\$102.05	\$148.62				Added Effective 1/1/2016
46608	ANOSCOPY; WITH REMOVAL OF FOREIGN BODY		\$75.92	\$75.92				
	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER							
46610	LESION BY HOT		\$65.18	\$65.18				
	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER							
46611	LESION BY SNAR		\$68.16	\$79.56				
	ANOSCOPY; WITH REMOVAL OF MULTIPLE TUMORS, POLYPS, OR							
46612	OTHER LESIONS BY		\$110.81	\$110.81				
	ANOSCOPY; WITH CONTROL OF BLEEDING (EG, INJECTION, BIPOLAR							
46614	CAUTERY,		\$85.84	\$106.63				
	ANOSCOPY; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER							
46615	LESION(S) NOT		\$105.50	\$126.29				
46700	ANOPLASTY, PLASTIC OPERATION FOR STRICTURE; ADULT		\$382.62	\$382.62				
46705	ANOPLASTY, PLASTIC OPERATION FOR STRICTURE; INFANT		\$302.48	\$302.48				
46706	REPAIR OF ANAL FISTULA WITH FIBRIN GLUE		\$105.07	\$105.07				
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG		\$330.57	\$330.57				
	REPAIR OF ILEOANAL POUCH FISTULA/SINUS (EG, PERINEAL OR							
46710	VAGINAL), POUC		\$708.73	\$708.73				
	REPAIR OF ILEOANAL POUCH FISTULA/SINUS (EG, PERINEAL OR							
46712	VAGINAL), POUC		\$1,488.37	\$1,488.37				
	REPAIR OF LOW IMPERFORATE ANUS; WITH ANOPERINEAL FISTULA							
46715	(CUT-BACK	<u> </u>	\$311.55	\$311.55				
	REPAIR OF LOW IMPERFORATE ANUS; WITH TRANSPOSITION OF							
46716	ANOPERINEAL OR		\$536.09	\$536.09				
	REPAIR OF HIGH IMPERFORATE ANUS WITHOUT FISTULA; PERINEAL							
46730	OR SACROPERI		\$951.53	\$951.53				

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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REPAIR OF HIGH IMPERFORATE ANUS WITHOUT FISTULA; COMBINED							
46735	TRANSABDOMIN		\$1,154.58	\$1,154.58				
	REPAIR OF HIGH IMPERFORATE ANUS WITH RECTOURETHRAL OR							
46740	RECTOVAGINAL FIS		\$1,022.82	\$1,022.82				
	REPAIR OF HIGH IMPERFORATE ANUS WITH RECTOURETHRAL OR							
46742	RECTOVAGINAL FIS		\$1,392.97	\$1,392.97				
	REPAIR OF CLOACAL ANOMALY BY ANORECTOVAGINOPLASTY AND							
46744	URETHROPLASTY,		\$1,563.77	\$1,563.77				
40740	REPAIR OF CLOACAL ANOMALY BY ANORECTOVAGINOPLASTY AND							
46746	URETHROPLASTY,		\$1,710.96	\$1,710.96				
40740	REPAIR OF CLOACAL ANOMALY BY ANORECTOVAGINOPLASTY AND		* 4 000 05	A4 000 05				
46748	URETHROPLASTY,		\$1,906.25	\$1,906.25				
40750	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE;		# 400.05	400.05				
46750	ADULT SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE;		\$406.25	\$406.25				
46751	CHILD		\$360.54	\$360.54				
40751	GRAFT (THIERSCH OPERATION) FOR RECTAL INCONTINENCE		\$300.34	\$300.54				
46753	AND/OR PROLAPSE		\$333.18	\$333.18				
46754	REMOVAL OF THIERSCH WIRE OR SUTURE, ANAL CANAL		\$91.29	\$91.29				
40734	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; MUSCLE		ψ91.29	ψ91.29				
46760	TRANSPLANT		\$527.99	\$527.99				
10700	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; LEVATOR		Ψ021.00	Ψ021.00			+	+
46761	MUSCLE IMBRIC		\$514.13	\$514.13				
1.07.01	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,		Ψ σ τ τ. τ σ	Ψ σ τ τι τ σ			+	+
46900	MOLLUSCUM		\$59.80	\$65.03				
	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,		700.00	700.00	+			
46910	MOLLUSCUM		\$63.64	\$72.22				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary cha	ge for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		Τ΄ ΄						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,	IAIIIu	(i acinty)	(Nom acmy)	Comp.	Comp.	Value	Notes
46916	MOLLUSCUM		\$63.56	\$72.54				
70310	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,		ψ00.00	Ψ12.54				
46917	MOLLUSCUM		\$86.66	\$112.68				
40317	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,		ψ00.00	ψ112.00				+
46922	MOLLUSCUM		\$93.03	\$93.03				
+00ZZ	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA,		Ψ00.00	Ψ00.00				+
46924	MOLLUSCUM		\$159.36	\$159.36				
46930	DESTRUCTION OF INTERNAL HEMMORHOIDS(S) BY THERMAL		\$104.14	\$140.64				+
10000	CURETTAGE OR CAUTERY OF ANAL FISSURE, INCLUDING DILATION		4.0	ψ110.01				
46940	OF ANAL SPHIN		\$76.22	\$83.06				
100.10	CURETTAGE OR CAUTERY OF ANAL FISSURE, INCLUDING DILATION		ψ. σ. <u>z</u> z	ψου.σο			1	
46942	OF ANAL SPHIN		\$67.09	\$73.26				
100.12	OF AUGUST THE		ψον.σσ	ψ, σ.2σ				Rate Change Effective
46945	INT HRHC LIG 1 HROID W/O IMG		\$260.96	\$260.96				01/01/2020
			+200.00					0.00020
46946	LIGATION OF INTERNAL HEMORRHOIDS; MULTIPLE PROCEDURES		\$295.36	\$295.36				Updated Effective 01/01/2020
	HEMORRHOIDOPEXY (EG, FOR PROLAPSING INTERNAL		7	7=00:00				
46947	HEMORRHOIDS) BY STAPLING		\$242.86	\$242.86				
46999	UNLISTED PROCEDURE, ANUS	R	\$0.00	\$0.00				
47000	BIOPSY OF LIVER, NEEDLE; PERCUTANEOUS		\$96.46	\$96.46				
	BIOPSY OF LIVER, NEEDLE; WHEN DONE FOR INDICATED PURPOSE							
47001	AT TIME OF OT		\$82.93	\$82.93				
	HEPATOTOMY; FOR OPEN DRAINAGE OF ABSCESS OR CYST, ONE							
47010	OR TWO STAGES		\$465.26	\$465.26				
	HEPATOTOMY; FOR PERCUTANEOUS DRAINAGE OF ABSCESS OR							
47011	CYST, ONE OR TWO S		\$186.91	\$186.91			1	

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	Fee Schedule 2020					4		
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2020 Code	•							
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	olumn indicates Prior Auth is required	1	1					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
					<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAPAROTOMY, WITH ASPIRATION AND/OR INJECTION OF HEPATIC							
47015	PARASITIC (EG,		\$466.14	\$466.14				
47100	BIOPSY OF LIVER, WEDGE		\$302.59	\$302.59				
47120	HEPATECTOMY, RESECTION OF LIVER; PARTIAL LOBECTOMY		\$968.70	\$968.70				
47122	HEPATECTOMY, RESECTION OF LIVER; TRISEGMENTECTOMY		\$1,513.60	\$1,513.60				
47125	HEPATECTOMY, RESECTION OF LIVER; TOTAL LEFT LOBECTOMY		\$1,396.80	\$1,396.80				
47130	HEPATECTOMY, RESECTION OF LIVER; TOTAL RIGHT LOBECTOMY		\$1,535.32	\$1,535.32				
	LIVER ALLOTRANSPLANTATION; ORTHOTOPIC, PARTIAL OR WHOLE,							
47135	FROM CADAVER		\$3,944.91	\$3,944.91				
	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM							
47140	LIVING DONOR; LE		\$2,288.26	\$2,288.26				
	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM							
47141	LIVING DONOR; TO	R	\$2,767.27	\$2,767.27				
	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM							
47142	LIVING DONOR; TO		\$3,048.23	\$3,048.23				
	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR							
47143	WHOLE LIVER GRAFT PRIO		\$0.00	\$0.00				
	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR							
47144	WHOLE LIVER GRAFT PRIO		\$0.00	\$0.00				
	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR							
47145	WHOLE LIVER GRAFT PRIO		\$0.00	\$0.00				
	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR							
47146	LIVER GRAFT PRIOR		\$251.83	\$251.83				
	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR							
47147	LIVER GRAFT PRIOR		\$293.80	\$293.80				
47300	MARSUPIALIZATION OF CYST OR ABSCESS OF LIVER		\$501.12	\$501.12				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char	ge for the service	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or priysicia T	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Drace drive Decement on	DA Ind	•				Value	Notes
Code	Procedure Description MANAGEMENT OF LIVER HEMORRHAGE: SIMPLE SUTURE OF LIVER	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
47350	WOUND OR INJURY		\$567.59	\$567.59				
47330			φουτ.ου	φοο <i>τ</i> .ο9				
47000	MANAGEMENT OF LIVER HEMORRHAGE; COMPLEX SUTURE OF		ф 7 00 0 7	ф 7 00 07				
47360	LIVER WOUND OR INJUR MANAGEMENT OF LIVER HEMORRHAGE; EXPLORATION OF HEPATIC		\$796.27	\$796.27				
47004	· · · · · · · · · · · · · · · · · · ·		¢4 007 45	¢4 007 45				
47361	WOUND, EXTENSIV		\$1,297.15	\$1,297.15				
47000	MANAGEMENT OF LIVER HEMORRHAGE; RE-EXPLORATION OF		# 400.00	# 400 00				
47362	HEPATIC WOUND FOR RE		\$463.36	\$463.36			_	
47070	LAPAROSCOPY, SURGICAL, ABLATION OF ONE OR MORE LIVER		070407	#704.07				
47370	TUMOR(S);		\$724.87	\$724.87				
47074	LAPAROSCOPY, SURGICAL, ABLATION OF ONE OR MORE LIVER		#	4000.00				
47371	TUMOR(S); CRYOSUR		\$683.26	\$683.26				4
47379	UNLISTED LAPAROSCOPIC PROCEDURE, LIVER	R	\$0.00	\$0.00				4
47000	ABLATION, OPEN, OF ONE OR MORE LIVER TUMOR(S);		4054 50	0054.70				
47380	RADIOFREQUENCY		\$851.70	\$851.70				4
	ABLATION, OPEN, OF ONE OR MORE LIVER TUMOR(S);							
47381	CRYOSURGICAL		\$841.92	\$841.92				
	ABLATION, ONE OR MORE LIVER TUMOR(S), PERCUTANEOUS,							
47382	RADIOFREQUENCY		\$505.21	\$505.21				
	DESTRUCTION OF 1 OR MORE LIVER GROWTHS, ACCESSED							
47383	THROUGH THE SKIN		\$391.42	\$5,608.30				Added effective 1/1/2015
47399	UNLISTED PROCEDURE, LIVER	R	\$0.00	\$0.00				
	HEPATICOTOMY OR HEPATICOSTOMY WITH EXPLORATION,							
47400	DRAINAGE, OR REMOVAL O		\$816.43	\$816.43				
	CHOLEDOCHOTOMY OR CHOLEDOCHOSTOMY WITH EXPLORATION,							
47420	DRAINAGE, OR REMOV		\$751.88	\$751.88				

Physician	Fee Schedule 2020							T
Note:								
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	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv chai	ae for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		1'						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CHOLEDOCHOTOMY OR CHOLEDOCHOSTOMY WITH EXPLORATION,		,	,				
47425	DRAINAGE, OR REMOV		\$807.61	\$807.61				
	TRANSDUODENAL SPHINCTEROTOMY OR SPHINCTEROPLASTY,							
47460	WITH OR WITHOUT		\$883.88	\$883.88				
	CHOLECYSTOTOMY OR CHOLECYSTOSTOMY WITH EXPLORATION,							
47480	DRAINAGE, OR REMOV		\$478.70	\$478.70				
47490	PERCUTANEOUS CHOLECYSTOSTOMY		\$282.22	\$282.22				
	INJECTION PROCEDURE FOR CHOLANGIOGRAPHY/ DIAGNOSTIC							
47531	/RADIOLOGICAL SUPERVISION; EXISTING ACCESS		\$78.37	\$279.66				Added Effective 1/1/2016
	NEW ACCESS (EG PERCUTANEOUD TRANSHEPATIC							
47532	CHOLANGIOGRAM)		\$177.10	\$616.15				Added Effective 1/1/2016
47533	PLACEMENT OF BILIARY DRAINAGE CATHETER; EXTERNAL		\$250.89	\$1,002.22				Added Effective 1/1/2016
47534	INTERNAL-EXTERNAL BILIARY DRAINAGE CATHETER		\$332.82	\$1,237.31				Added Effective 1/1/2016
	CONVERSION OF EXTERNAL BILIARY DRAINAGE CATHETER TO							
47535	INTERNAL-EXTERNAL /RADIOLOGICAL SUPERVISION		\$190.66	\$826.60				Added Effective 1/1/2016
	EXCHANGE OF THE BILIARY DRAINAGE CATHETER/INCLUDES							
47536	DIAGNOSTIC CHOLANGIORGRAPHY/RADIOLOGICAL SUPERVISION		\$121.08	\$608.51				Added Effective 1/1/2016
	REMOVAL OF BILIARY DRAINAGE CATHETER/REGUIRES							
47537	FLUOROSCOPIC/ RADIOLOGICAL SUPERVISION		\$81.17	\$302.38				Added Effective 1/1/2016
	PLACEMENT OF STINT(S) INTO A BILE DUCT, PERCUTANEOUS							
	INCLUDING DIAGNOSTIC BALLOON DILATION/RADIOLOCIAL							
47538	SUPERVISION		\$270.30	\$3,324.00				Added Effective 1/1/2016
	NEW ACCESS, WITHOUT PLACEMENT OF SPERATE BILIARY							
47539	DRAINAGE CATHETER		\$365.85	\$3,639.72				Added Effective 1/1/2016
	NEW ACCESS, WITHOUT PLACEMENT OF SPERATE BILIARY							
47540	DRAINAGE CATHETER/EXT OR INT		\$437.07	\$3,789.85				Added Effective 1/1/2016

Physician	n Fee Schedule 2020							
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	des in Red;							
	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	rge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PLACEMENT OF ACCESS THROUGH THE BILIARY TREE AND INTO							
	SMALL BOWEL TO ASSIST WITH ENDOSCOPIC BILIARY							
47541	PROCEDURE/RADIOLOGICAL		\$232.13	\$886.18				Added Effective 1/1/2016
47542	BALLOON DILATION OR OF AMPULLA PERCUTANEOUS EACH DUCT		\$108.27	\$387.17				Added Effective 1/1/2016
47543	ENDOLUMINAL BIOPSY(IES) TREE, PRECUTANEOUS ANY METHOD(S)		\$136.48	\$985.09				Added Effective 1/1/2016
	REMOVAL OF CALCULI/DEBRIS FROM BILIARY DUCT(S) AND OR							
	GALLBLADDER, PERCUTANEOUS / DESTRUCTIONOF CALCULI ANY							
47544	METHOD		\$173.65	\$610.89				Added Effective 1/1/2016
	BILIARY ENDOSCOPY, INTRAOPERATIVE (CHOLEDOCHOSCOPY) (LIST							
47550	SEPARATELY I		\$138.96	\$138.96				
	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER							
47552	TRACT; DIAGNOSTIC,		\$218.82	\$218.82				
	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER							
47553	TRACT; WITH BIOPSY		\$303.32	\$303.32				
47554	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER		¢207.54	#207.54				
47554	TRACT; WITH REMOVA BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER		\$387.54	\$387.54				
47555	TRACT; WITH DILATI		\$299.67	\$299.67				
47333	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER		ψ299.07	ψ299.01				+
47556	TRACT; WITH DILATI		\$329.01	\$329.01				
47562	LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY		\$522.64	\$522.64		+		+
	LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY WITH		7	7				+
47563	CHOLANGIOGRAPHY		\$562.24	\$562.24				
	LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY WITH		<u> </u>	<u> </u>		1		
47564	EXPLORATION OF COMMON DUCT		\$667.69	\$667.69				

Physician	Fee Schedule 2020							
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	es in Red;							†
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	Ĭ					
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
47570	LAPAROSCOPY, SURGICAL; CHOLECYSTOENTEROSTOMY		\$599.91	\$599.91				
47600	CHOLECYSTECTOMY;		\$553.75	\$553.75				
47605	CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY		\$599.19	\$599.19				
47610	CHOLECYSTECTOMY WITH EXPLORATION OF COMMON DUCT;		\$706.62	\$706.62				
	CHOLECYSTECTOMY WITH EXPLORATION OF COMMON DUCT; WITH							
47612	CHOLEDOCHOENTERO		\$888.61	\$888.61				
	CHOLECYSTECTOMY WITH EXPLORATION OF COMMON DUCT; WITH							
47620	TRANSDUODENAL		\$821.89	\$821.89				
	EXPLORATION FOR CONGENITAL ATRESIA OF BILE DUCTS, WITHOUT							
47700	REPAIR, WITH		\$646.52	\$646.52				
47701	PORTOENTEROSTOMY (EG, KASAI PROCEDURE)		\$1,046.04	\$1,046.04				
	EXCISION OF BILE DUCT TUMOR, WITH OR WITHOUT PRIMARY							
47711	REPAIR OF BILE DU		\$916.13	\$916.13				
	EXCISION OF BILE DUCT TUMOR, WITH OR WITHOUT PRIMARY							
47712	REPAIR OF BILE DU		\$1,079.86	\$1,079.86				
47715	EXCISION OF CHOLEDOCHAL CYST		\$687.51	\$687.51				
47720	CHOLECYSTOENTEROSTOMY; DIRECT		\$641.77	\$641.77				
47721	CHOLECYSTOENTEROSTOMY; WITH GASTROENTEROSTOMY		\$789.17	\$789.17				
47740	CHOLECYSTOENTEROSTOMY; ROUX-EN-Y		\$734.61	\$734.61				
477.44	CHOLECYSTOENTEROSTOMY; ROUX-EN-Y WITH		4004.50	4004.50				
47741	GASTROENTEROSTOMY		\$934.52	\$934.52				
47700	ANASTOMOSIS, OF EXTRAHEPATIC BILIARY DUCTS AND		4057.70	***				
47760	GASTROINTESTINAL TRACT		\$957.70	\$957.70	+			
47705	ANASTOMOSIS, OF INTRAHEPATIC DUCTS AND GASTROINTESTINAL		¢4 000 74	¢4 000 74				
47765	TRACT		\$1,022.74	\$1,022.74	1	+		+
47700	ANASTOMOSIS, ROUX-EN-Y, OF EXTRAHEPATIC BILIARY DUCTS AND		¢4 04E 54	¢4 045 54				
47780	GASTROINTEST		\$1,015.51	\$1,015.51				

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Refer to CPT book for descriptions Rin PA column indicates Prior Auth is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service Please use lab fee schedule for covered codes not listed below in the 80000-89248 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description ANASTOMOSIS ROUX-EN-Y, OF INTRAHEPATIC BILIARY DUCTS AND ANASTOMOSIS ROUX-EN-Y, OF INTRAHEPATIC BILIARY DUCTS AND ANASTOMOSIS ROUX-EN-Y, OF INTRAHEPATIC BILIARY DUCTS AND ARSTOMOSIS ROUX-EN-Y, OF INTRAHEPATIC BILIARY DUCTS AND WITH ROIL-TO-BIND RECONSTRUCTION, PILASTIC, OF EXTRAHEPATIC BILIARY DUCTS WITH ROIL-TO-BIND		des in Red:								
RT in PA column indicates Prior Auth is required Codes listed as \$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed as \$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service Codes listed Base Rate is \$15.20. Each 15 minute increment=1 time unit. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Cod										
Codes Isled as '\$0.00'' pay 45% of Dilled amount not to exceed provider's usual and customary charge for the service										
The Anesthesia Base Rate is \$16.20. Each 15 minute increment=1 time unit.			omany chai	go for the convice	_					
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.			T		-					
Code Inpat. Rate Code Procedure Description PA Ind Inpat. Rate (Facility) (NonFacility) Comp. Comp. Value Valu			range							
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ANASTOMOSIS, ROUX-EN-Y, OF INTRAHEPATIC BILIARY DUCTS AND GASTROINTEST RECONSTRUCTION, PLASTIC, OF EXTRAHEPATIC BILIARY DUCTS ### RECONSTRUCTION, PLASTIC, OF EXTRAHEPATIC BILIARY DUCTS ### RECONSTRUCTION, PLASTIC, OF EXTRAHEPATIC BILIARY DUCTS ### RECONSTRUCTION, PLASTIC, OF EXTRAHEPATIC BILIARY DUCTS ### S933.31 ### S943.66 ### S943.		Procedure Description	DA Ind	•					Notes	
A7785 GASTROINTEST \$1,133.18 \$1,13	Code		FAIIIU	(i acility)	(Norm actinity)	Comp.	Comp.	Value	Notes	
RECONSTRUCTION, PLASTIC, OF EXTRAHEPATIC BILIARY DUCTS 47801 WITH END-TO-END WITH END-TO-	47785			\$1 133 18	\$1 133 18					
47800 WITH END-TO-END \$933.31 \$933.31 \$933.31 \$47801 PLACEMENT OF CHOLEDOCHAL STENT \$497.66 \$497.77 \$479.00 \$479.0	41100			ψ1,100.10	ψ1,100.10					
PLACEMENT OF CHOLEDOCHAL STENT \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.66 \$497.67 \$787.77 \$	47800			\$033.31	\$033 31					
47802 U-TUBE HEPATICOENTEROSTOMY \$787.77 \$787.77 \$787.77 \$100 \$10			+							
SUTURE OF EXTRAHEPATIC BILIARY DUCT FOR PRE-EXISTING \$872.27			+							
A7900 INJURY (SEPARATE \$872.27 \$872.27 \$872.27 \$7999 UNLISTED PROCEDURE, BILIARY TRACT R \$500.00 \$650.00 \$650.00 \$790.00 \$	47002		+	Ψίσι.ιι	Ψίσι.τι					
47999 UNLISTÈD PROCEDURE, BILIARY TRACT R \$500.00 \$650.00	47900			\$872 27	\$872 27					
PLACEMENT OF DRAINS, PERIPANCREATIC, FOR ACUTE \$607.51 \$607.			R		•					
### 48000 PANCREATITIS; ### \$607.51 \$607.51 \$607.51 \$ PLACEMENT OF DRAINS, PERIPANCREATIC, FOR ACUTE \$719.99	17000	· ·		Ψ000.00	Ψ000.00					
PLACEMENT OF DRAINS, PERIPANCREATIC, FOR ACUTE \$719.99 \$719.99 \$719.99 \$748020 REMOVAL OF PANCREATIC CALCULUS \$600.88 \$600	48000			\$607.51	\$607.51					
A8001 PANCREATITIS; WITH \$719.99 \$719.99 \$719.99 \$780.088 \$800.80 \$800.80 \$800	10000			Ψ007.01	ψοστ.στ					
### ### ##############################	48001			\$719.99	\$719.99					
BIOPSY OF PANCREAS, OPEN (EG, FINE NEEDLE ASPIRATION, NEEDLE CORE BIOP										
48100 NEEDLE CORE BIOP \$431.13 \$431.13 48102 BIOPSY OF PANCREAS, PERCUTANEOUS NEEDLE \$200.71 \$200.71 48105 RESECT/DEBRIDE PANCREAS \$1,969.65 \$1,969.65 48120 EXCISION OF LESION OF PANCREAS (EG, CYST, ADENOMA) \$686.31 \$686.31 PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT \$961.34 \$961.34 PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT \$1,058.33 \$1,058.33 PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF \$1,126.58 \$1,126.58				V	4000.00					
### ### ##############################	48100			\$431.13	\$431.13					
48105 RESECT/DEBRIDE PANCREAS \$1,969.65 \$1,969.65 48120 EXCISION OF LESION OF PANCREAS (EG, CYST, ADENOMA) \$686.31 \$686.31 PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT \$961.34 \$961.34 PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT \$1,058.33 \$1,058.33 PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF DUODENUM \$1,126.58 \$1,126.58										
### 48120 EXCISION OF LESION OF PANCREAS (EG, CYST, ADENOMA) PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT PANCREATECTOMY; WITHOUT PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT 48145 SPLENECTOMY; WITH PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF 48146 DUODENUM										
PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT 48140 SPLENECTOMY; WITHOUT PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT 48145 SPLENECTOMY; WITH PANCREATECTOMY; WITH \$1,058.33 \$1,058.33 PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF 48146 DUODENUM \$1,126.58 \$1,126.58		EXCISION OF LESION OF PANCREAS (EG, CYST, ADENOMA)								
48140 SPLENECTOMY; WITHOUT \$961.34 \$961.34 PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT \$1,058.33 \$1,058.33 PANCREATECTOMY; WITH \$1,058.33 \$1,058.33 PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF \$1,126.58 \$1,126.58				,	,					
PANCREATECTOMY, DISTAL SUBTOTAL, WITH OR WITHOUT 48145 SPLENECTOMY; WITH PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF 48146 DUODENUM \$1,058.33 \$1,058.33 \$1,126.58 \$1,126.58	48140			\$961.34	\$961.34					
48145 SPLENECTOMY; WITH \$1,058.33 \$1,058.33 PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF \$1,126.58 \$1,126.58 48146 DUODENUM \$1,126.58 \$1,126.58			1							
PANCREATECTOMY, DISTAL, NEAR-TOTAL WITH PRESERVATION OF \$1,126.58 \$1,126.58	48145	•		\$1,058.33	\$1,058.33					
48146 DUODENUM \$1,126.58 \$1,126.58			1		. ,					
1 /	48146			\$1,126.58	\$1,126.58					
	48148	EXCISION OF AMPULLA OF VATER								

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PANCREATECTOMY, PROXIMAL SUBTOTAL WITH TOTAL							
48150	DUODENECTOMY, PARTIAL		\$1,901.07	\$1,901.07				
48152	PANCREATECTOMY, PROXIMAL SUBTOTAL WITH TOTAL DUO		\$1,791.03	\$1,791.03				
	PANCREATECTOMY, PROXIMAL SUBTOTAL WITH NEAR-TOTAL							
48153	DUODENECTOMY,		\$1,901.07	\$1,901.07				
	PANCREATECTOMY, PROXIMAL SUBTOTAL WITH NEAR-TOTAL							
48154	DUODENECTOMY,		\$1,791.03	\$1,791.03				
48155	PANCREATECTOMY, TOTAL		\$1,220.83	\$1,220.83				
48160	PANCREATECTOMY, TOTAL OR SUBTOTAL, WITH AUTOL		\$1,660.49	\$1,660.49				
	INJECTION PROCEDURE FOR INTRAOPERATIVE PANCREATOGRAPHY							
48400	(LIST SEPARATEL		\$90.68	\$90.68				
48500	MARSUPIALIZATION OF PANCREATIC CYST		\$622.42	\$622.42				
48510	EXTERNAL DRAINAGE, PSEUDOCYST OF PANCREAS; OPEN		\$566.46	\$566.46				
	EXTERNAL DRAINAGE, PSEUDOCYST OF PANCREAS;							
48511	PERCUTANEOUS		\$201.98	\$201.98				
	INTERNAL ANASTOMOSIS OF PANCREATIC CYST TO							
48520	GASTROINTESTINAL TRACT; DIR		\$742.72	\$742.72				
	INTERNAL ANASTOMOSIS OF PANCREATIC CYST TO							
48540	GASTROINTESTINAL TRACT;		\$866.71	\$866.71				
48545	PANCREATORRHAPHY FOR INJURY		\$678.83	\$678.83				
	DUODENAL EXCLUSION WITH GASTROJEJUNOSTOMY FOR							
48547	PANCREATIC INJURY		\$981.38	\$981.38				
48548	PANCREATICOJEJUNOSTOMY, SIDE-TO-SIDE ANASTOMOSIS		\$1,144.24	\$1,144.24				
	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR							
48551	PANCREAS ALLOGRAFT PRI		\$0.00	\$0.00				
	BACKBENCH RECONSTRUCTION OF CADAVER DONOR PANCREAS							
48552	ALLOGRAFT PRIOR TO		\$172.86	\$172.86				

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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
			_				Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
48554	TRANSPLANTATION OF PANCREATIC ALLOGRAFT		\$1,583.06	\$1,583.06				
48556	REMOVAL OF TRANSPLANTED PANCREATIC ALLOGRAFT		\$643.37	\$643.37				
48999	UNLISTED PROCEDURE, PANCREAS	R	\$0.00	\$0.00				
	EXPLORATORY LAPAROTOMY, EXPLORATORY CELIOTOMY WITH OR							
49000	WITHOUT BIOPSY(S		\$479.94	\$479.94				
49002	REOPENING OF RECENT LAPAROTOMY		\$467.50	\$467.50				
	EXPLORATION, RETROPERITONEAL AREA WITH OR WITHOUT							
49010	BIOPSY(S) (SEPARATE		\$546.60	\$546.60				
49013	PRPERTL PEL PACK HEMRRG TRMA		\$354.93	\$354.93				Added Effective 01/01/2020
49014	REEXPLORATION PELVIC WOUND		\$292.95	\$292.95				Added Effective 01/01/2020
	DRAINAGE OF PERITONEAL ABSCESS OR LOCALIZED PERITONITIS,							
49020	EXCLUSIVE OF		\$417.25	\$417.25				
	DRAINAGE OF PERITONEAL ABSCESS OR LOCALIZED PERITONITIS,							
49021	EXCLUSIVE OF		\$407.40	\$407.40				
	DRAINAGE OF SUBDIAPHRAGMATIC OR SUBPHRENIC ABSCESS;							
49040	OPEN		\$462.74	\$462.74				
	DRAINAGE OF SUBDIAPHRAGMATIC OR SUBPHRENIC ABSCESS;							
49041	PERCUTANEOUS		\$201.98	\$201.98				
49060	DRAINAGE OF RETROPERITONEAL ABSCESS; OPEN		\$482.71	\$482.71				
49061	DRAINAGE OF RETROPERITONEAL ABSCESS; PERCUTANEOUS		\$186.91	\$186.91				
	DRAINAGE OF EXTRAPERITONEAL LYMPHOCELE TO PERITONEAL							
49062	CAVITY, OPEN		\$554.88	\$554.88	<u></u>		<u> </u>	
	ABDOMINAL PARACENTESIS (DIAGNOSTIC OR THERAPEUTIC)							
49082	WITHOUT IMAGING GUIDANCE		\$56.27	\$127.59	<u></u>		<u> </u>	
49083	WITH IMAGING GUIDANCE		\$86.96	\$240.21				

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv chai	ge for the service	!	+			†
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					†
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PERITONEAL LAVAGE, INCLUDING IMAGING GUIDANCE, WHEN		•			-		
49084	PERFORMED		\$79.98	\$79.98				
	BIOPSY, ABDOMINAL OR RETROPERITONEAL MASS, PERCUTANEOUS							
49180	NEEDLE		\$97.40	\$97.40				
49185	SCLEROTHERAPY OF FLUID COLLECTION DIAGNOSTIC		\$100.74	\$738.75				Added Effective 1/1/2016
49203	EXC ABD TUM 5 CM OR LESS		\$888.02	\$888.02				
49204	EXC ABD TUM OVER 5 CM		\$1,133.69	\$1,133.69				
49205	EXC ADB TUM OVER 10 CM		\$1,298.06	\$1,298.06				
49215	EXCISION OF PRESACRAL OR SACROCOCCYGEAL TUMOR		\$884.30	\$884.30				
	STAGING LAPAROTOMY FOR HODGKINS DISEASE OR LYMPHOMA							
49220	(INCLUDES SPLENECT		\$792.22	\$792.22				
	UMBILECTOMY, OMPHALECTOMY, EXCISION OF UMBILICUS							
49250	(SEPARATE PROCEDURE)		\$362.29	\$362.29				
	OMENTECTOMY, EPIPLOECTOMY, RESECTION OF OMENTUM							
49255	(SEPARATE PROCEDURE)		\$284.89	\$284.89				
	LAPAROSCOPY, ABDOMEN, PERITONEUM, AND OMENTUM,							
49320	DIAGNOSTIC, WITH OR WIT		\$258.39	\$258.39				
49321	LAPAROSCOPY, SURGICAL; WITH BIOPSY (SINGLE OR MULTIPLE)		\$275.28	\$275.28				
	LAPAROSCOPY, SURGICAL; WITH ASPIRATION OF CAVITY OR CYST							
49322	(EG, OVARIAN		\$286.25	\$286.26				
	LAPAROSCOPY, SURGICAL; WITH DRAINAGE OF LYMPHOCELE TO							
49323	PERITONEAL CAVIT		\$444.79	\$444.79				
	LAPAROSCOPY, SURGICAL, REMOVAL OF FOREIGN BODY FROM							
49324	PERITONEAL CAVIT		\$270.09	\$270.09				
	LAPAROSCOPY, SURGICAL, W/REVISION OF PREV PLACED							
49325	INTRAPERITONEAL CATH		\$291.09	\$291.09				

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	Fee Schedule 2020							
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	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary chai	ge for the service					
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
49326	LAPAROSCOPY, SURGICAL, W/OMENTOPEXY		\$135.28	\$135.28				
	LAPARASCOPY WITH PLACEMENT OF INTERSTITIAL DEVICE(S) FOR							
	RADIATION THERAPY GUIDANCE, INTRA-ABDOMINAL, INTRAPÉLVIC,							
	AND/OR RETROPERITONEUM, INCLUDING IMAGING GUIDANCE. USE							
	IN CONJUCTION WITH LAPAROSCOPIC ABDOMINAL, PELVIC, OR							
49327	RETROPERITONEAL PROCEDURES.		\$115.42	\$115.42				
1000	UNLISTED LAPAROSCOPY PROCEDURE, ABDOMEN, PERITONEUM		7	***************************************				
49329	AND OMENTUM	R	\$0.00	\$0.00				
	INJECTION OF AIR OR CONTRAST INTO PERITONEAL CAVITY		7 5 1 5 5	7 0 10 0				
49400	(SEPARATE PROCEDUR		\$89.34	\$89.34				
	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL		+ + + + + + + + + + + + + + + + + + + 					
49402	CAVITY		\$584.27	\$584.27				
49405	IMAGE CATH FLUID COLXN VISC		\$174.18	\$655.14				
49406	IMAGE CATH FLUID PERI/RETRO		\$174.44	\$654.89				
49407	IMAGE CATH FLUID TRNS/VGNL		\$185.65	\$556.66		+		
	LAPAROSCOPY WITH INSERTION OF TUNNELED INTRAPERITONEAL		4.00.00	+				
	CATHETER, COMPLETE PROCEDURE, INCLUDING IMAGING							
	GUIDANCE, CATHETER PLACEMENT, CONTRAST INJECTION WHEN							
	PERFORMED, AND RADIOLOGICAL SUPERVISION AND							
49418	INTERPRETATION		\$205.02	\$1,326.55				
73710	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER, WITH		Ψ200.02	ψ1,020.00		1	+	+
49419	SUBCUTANEOUS		\$303.59	\$303.59				
73413	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR		ψυυυ.υσ	φυυυ.υθ		1	+	+
49421	DRAINAGE OR DIALY		\$274.21	\$274.21				
434Z I	REMOVAL OF PERMANENT INTRAPERITONEAL CANNULA OR		φ <i>∠ι 4.</i> ∠ ι	φ∠14.∠1				
40400			#202.20	¢202.20				
49422	CATHETER		\$302.38	\$302.38				

Physician	Fee Schedule 2020							
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	es in Red;						+	
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCHANGE OF PREVIOUSLY PLACED ABSCESS OR CYST DRAINAGE		, ,		'	<u> </u>		
49423	CATHETER UNDER		\$73.62	\$73.62				
	CONTRAST INJECTION FOR ASSESSMENT OF ABSCESS OR CYST VIA							
49424	PREVIOUSLY PL		\$38.31	\$38.31				
49425	INSERTION OF PERITONEAL-VENOUS SHUNT		\$570.59	\$570.59				
49426	REVISION OF PERITONEAL-VENOUS SHUNT		\$422.04	\$422.04				
	INJECTION PROCEDURE (EG, CONTRAST MEDIA) FOR EVALUATION							
49427	OF PREVIOUSLY		\$39.99	\$39.99				
49428	LIGATION OF PERITONEAL-VENOUS SHUNT		\$91.83	\$91.83				
49429	REMOVAL OF PERITONEAL-VENOUS SHUNT		\$294.09	\$294.09				
49435	INSERT SUBCUT EXTENSION TO INTRAPERITONEAL CATH		\$87.11	\$87.11				
49436	EMBEDDED INTRAPERITONEAL CATH EXIT SITE		\$125.90	\$125.90				
49440	PLACE GASTROSTOMY TUBE PERC		\$192.26	\$882.09				
49441	PLACE DUOD/JEJ TUBE PERC		\$209.77	\$1,044.09				
49442	PLACE CECOSTOMY TUBE PERC		\$174.16	\$851.53				
49446	CHANGE G-TUBE TO G-J PERC		\$137.67	\$868.44				
49450	REPLACE G/C TUBE PERC		\$55.78	\$605.56				
49451	REPLACE DUOD/JEJ TUBE PERC		\$76.85	\$642.65				
49452	REPLACE G-J TUBE PERC		\$119.87	\$787.74				
49460	FIX B/COLON TUBE W/DEVICE		\$39.16	\$640.87				
49465	FLUORO EXAM OF G/COLON TUDE		\$25.81	\$134.70				
	REPAIR, INITIAL INGUINAL HERNIA, PRETERM INFANT (LESS THAN 37							
49491	WEEKS		\$604.46	\$491.15				
	REPAIR, INITIAL INGUINAL HERNIA, PRETERM INFANT (LESS THAN 37							
49492	WEEKS		\$604.46	\$604.46				
	REPAIR, INITIAL INGUINAL HERNIA, FULL TERM INFANT UNDER AGE 6							
49495	MONTHS,		\$326.56	\$326.56				

Physician	Fee Schedule 2020							
Note:	1 00 001104410 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	rge for the service	2				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	That y Chai	T The service	,				
	e lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		l ne					
Oddes list	The lab lee scriedale that begin with a 1- or Q are currently non-covered to	Т	13			+		
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
3045	REPAIR, INITIAL INGUINAL HERNIA, FULL TERM INFANT UNDER AGE 6	71114	(i dointy)	(Norm domey)	Jonip.	Joinp.	Value	110100
49496	MONTHS.		\$407.03	\$407.03				
10.100	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5		4.01.00	V 101100				
49500	YEARS, WITH OR		\$286.06	\$286.06				
	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5		+ 200.00	+200.00				
49501	YEARS, WITH OR		\$374.46	\$374.46				
	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER;		70000	701110				
49505	REDUCIBLE		\$350.04	\$350.04				
	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER;			,				
49507	INCARCERATED OR		\$378.57	\$378.57				
49520	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; REDUCIBLE		\$397.92	\$397.92				
	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; INCARCERATED		•					
49521	OR STRANGULATE		\$438.14	\$438.14				
49525	REPAIR INGUINAL HERNIA, SLIDING, ANY AGE		\$381.57	\$381.57				
49540	REPAIR LUMBAR HERNIA		\$398.80	\$398.80				
49550	REPAIR INITIAL FEMORAL HERNIA, ANY AGE; REDUCIBLE		\$351.74	\$351.74				
	REPAIR INITIAL FEMORAL HERNIA, ANY AGE; INCARCERATED OR							
49553	STRANGULATED		\$364.36	\$364.36				
49555	REPAIR RECURRENT FEMORAL HERNIA; REDUCIBLE		\$407.34	\$407.34				
	REPAIR RECURRENT FEMORAL HERNIA; INCARCERATED OR							
49557	STRANGULATED		\$449.60	\$449.60				
49560	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; REDUCIBLE		\$517.20	\$517.20				
	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; INCARCERATED							
49561	OR STRANGULA		\$514.39	\$514.39				
49565	REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; REDUCIBLE		\$482.91	\$482.91				

Note:	Physician	Fee Schedule 2020							
2020 Codes in Red; Red;		The ee ochedule 2020							
Refer to CPT book for descriptions		los in Rad:							
RE' In PA column indicates Prior Auth is required Codes listed as \$0.00^* pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule from covered codes not listed below in the 8000-98249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; Hard REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; Hard REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; Hard REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; Hard REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; Hard REPAIR PROSTRICH RENIA (Eq. PREPERITONEAL FAT); REDUCIBLE REPAIR EPIGASTRIC HERNIA (Eq. PREPERITONEAL FAT); REDUCIBLE REPAIR EPIGASTRIC HERNIA (Eq. PREPERITONEAL FAT); REDUCIBLE REPAIR DEPIGASTRIC HERNIA (Eq. PREPERITONEAL FAT); REDUCIBLE REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED SASSE OR STRANGULAT SASSE PEAR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED SASSE OR STRANGULAT SASSE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR OF SIMAL OMPHALOCELE, WITH PRIMARY CLOSURE REPAIR OF LARGE OMPHALOCELE, WITH PRIMARY CLOSURE REPAIR OF LARGE OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (
Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service									
The Anesthesia Base Rate is \$15.20. Each 15 minute incremented time unit.			mary char	go for the convice				_	
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.			Tilary Criai		;			+	
Code Instead on the lab fee schedule that begin with a P or Q are currently non-covered for physicians			rango						
Proc Code Procedure Description PA Ind Inpat. Rate (NonFacility) Comp. Comp. Notes				ne ne					
Procedure Procedure Description PA Inpat. Rate (NonFacility) (No	Codes lis	ted on the lab lee scriedule that begin with a F or Q are currently hon-covered to	T priysiciai	115					
Procedure Procedure Description PA Inpat. Rate (NonFacility) (No								Rase	
Code Procedure Description PA Ind (Facility) (NonFacility) Comp. Value Notes REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; REPAIR RECURRENT INCISIONAL OR STRANGU \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$538.66 \$526.49	Proc			Innat Rate	Outnat Rate	Tech	Prof		
REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; 49566 INCARCERATED OR STRANGU MPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL 49568 OR VENTRAL HER REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REDUCIBLE (SEPARATE REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); 49570 (SEPARATE REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); 49572 INCARCERATED OR 49580 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE 49580 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED 49582 OR STRANGULAT 49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE 5297.02 \$297.02 49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED 5297.02 \$297.02 49587 OR STRANGUL 5314.40 \$314.40 5314.40 \$314.40 5312.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE 5297.02 \$437.97 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR 5297.03 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR 5297.03 \$312.85 5312.		Procedure Description	DA Ind	_	•				Notos
MICARCERATED OR STRANGU \$538.66 \$538.66 IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL 49568 OR VENTRAL HER \$226.49 \$226.49 REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REDUCIBLE SEPARATE \$270.46 \$270.46 REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); SASS.	Code		I A IIIu	(i acility)	(Norm acmity)	Comp.	Comp.	Value	Notes
MPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL	49566			\$538.66	\$538.66				
49568 OR VENTRAL HER \$226.49	40000			ψ000.00	ψ000.00				
REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REDUCIBLE (SEPARATE REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); S335.86 S35.86 S353.86 S353.86 S229.23 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED S297.02 S2	49568			\$226.49	\$226.49				
49570 (SEPARATE \$270.46 \$270.46 \$270.46 REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); \$335.86 \$335.86 \$335.86 \$49580 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE \$229.23	+3300			Ψ220.43	Ψ220.43				
REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT);	49570			\$270.46	\$270.46				
49572 INCARCERATED OR \$335.86 \$335.86 \$335.86 \$49580 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE \$229.23 \$22	40070			Ψ27 0.40	Ψ210.40				
49580 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE \$229.23 \$229.23 REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED \$297.02 \$297.02 49582 OR STRANGULAT \$297.02 \$297.02 49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE \$285.65 \$285.65 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED \$314.40 \$314.40 49587 OR STRANGUL \$314.40 \$314.40 49590 REPAIR SPIGELIAN HERNIA \$372.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE \$437.97 \$437.97 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR \$916.08 \$916.08 WITHOUT PROSTHES \$916.08 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH \$772.35 \$772.35 49600 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$497.57 \$497.57	49572			\$335.86	\$335.86				
REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED 49582 OR STRANGULAT 49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED 49587 OR STRANGUL 49589 REPAIR SPIGELIAN HERNIA 49590 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR 49605 WITHOUT PROSTHES REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH 49606 REMOVAL OF PROSTHES 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND 49611 STAGE \$297.02 \$2485.65 \$285.65 \$314.40 \$314.4									
49582 OR STRANGULAT \$297.02 \$297.02 49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE \$285.65 \$285.65 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED \$314.40 \$314.40 49587 OR STRANGUL \$3172.85 \$372.85 49590 REPAIR SPIGELIAN HERNIA \$372.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE \$437.97 \$437.97 49605 WITHOUT PROSTHES \$916.08 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$497.57 \$497.57	10000	,		Ψ220.20	Ψ220.20				
49585 REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED OR STRANGUL 49587 OR STRANGUL \$314.40 \$314.40 \$314.40 \$314.40 \$372.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR WITHOUT PROSTHES REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH 49606 REMOVAL OF PROSTHES \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$49611 STAGE	49582			\$297.02	\$297.02				
REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED \$314.40 \$31	10002	OK CITO WOOD KI		Ψ207.02	Ψ201.02				
REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED \$314.40 \$31	49585	REPAIR LIMBILICAL HERNIA AGE 5 YEARS OR OVER: REDUCIBLE		\$285.65	\$285.65				
49587 OR STRANGUL \$314.40 \$314.40 49590 REPAIR SPIGELIAN HERNIA \$372.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE \$437.97 \$437.97 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR \$916.08 \$916.08 WITHOUT PROSTHES \$916.08 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH REMOVAL OF PROSTHES \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$497.57 \$497.57	10000			Ψ200.00	Ψ200.00				
49590 REPAIR SPIGELIAN HERNIA \$372.85 \$372.85 49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE \$437.97 \$437.97 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR WITHOUT PROSTHES \$916.08 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH REMOVAL OF PROSTHES \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$497.57 \$497.57	49587			\$314 40	\$314 40				
49600 REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE \$437.97 \$4466.29 \$466.29 \$466.29 \$4466.2									
REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH OR 49605 WITHOUT PROSTHES REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH 49606 REMOVAL OF PROSTHES 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND 49611 STAGE 497.57 \$497.57									
49605 WITHOUT PROSTHES \$916.08 \$916.08 REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH \$772.35 \$772.35 49606 REMOVAL OF PROSTHES \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND \$497.57 \$497.57		,		ψ . σ σ .	V 101101				
REPAIR OF LARGE OMPHALOCELE OR GASTROSCHISIS; WITH REMOVAL OF PROSTHES \$772.35 \$772.35 \$772.35 \$772.35 \$772.35 \$772.35	49605			\$916.08	\$916.08				
49606 REMOVAL OF PROSTHES \$772.35 \$772.35 \$772.35 49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 \$466.29 49611 STAGE \$497.57 \$497.57				Ţ O T O T O	70.000				
49610 REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); FIRST STAGE \$466.29 \$466.29 \$497.57 \$497.57	49606	· · · · · · · · · · · · · · · · · · ·		\$772.35	\$772.35				
REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND 49611 STAGE \$497.57 \$497.57		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Ţ				
REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION); SECOND 49611 STAGE \$497.57 \$497.57	49610	REPAIR OF OMPHALOCELE (GROSS TYPE OPERATION): FIRST STAGE		\$466.29	\$466.29				
49611 STAGE \$497.57 \$497.57	122.0			,	Ţ :				
	49611			\$497.57	\$497.57				
	49650				I *				+

Physician Fee Schedule 2020 Note: 2020 Codes in Red; Refer to CPT book for descriptions R" in PA column indicates Prior Auth is required Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians	
2020 Codes in Red; Refer to CPT book for descriptions R" in PA column indicates Prior Auth is required Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.	
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Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.	
y	
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians	
Source in the last less controlled that sognif that a 1 of Quie currently from covered for physicians	
Base	
Proc Inpat. Rate Outpat. Rate Tech. Prof. Unit	
Code Procedure Description PA Ind (Facility) (NonFacility) Comp. Comp. Value	Notes
49651 LAPAROSCOPY, SURGICAL; REPAIR RECURRENT INGUINAL HERNIA \$387.99 \$387.99	
49652 LAPAROSCOPY, SURG, REPAIR, VENTRAL, UMBILICAL \$589.54 \$589.54	
49653 INCARCERATED OR STRANGULATED \$735.82 \$735.82	
49654 LAPAROSCOPY, SURG, REPAIR, INCISIONAL HERNIA \$676.48 \$676.48	
49655 INCARCERATED OR STRANGULATED \$814.44 \$814.44	
49656 INCARCERATED OR STRANGULATED \$679.15 \$679.15	
49657 INCARCERATED OR STRANGULATED \$980.59 \$980.59	
UNLISTED LAPAROSCOPY PROCEDURE, HERNIOPLASTY,	
49659 HERNIORRHAPHY, HERNIOTOM R \$0.00 \$0.00	
SUTURE, SECONDARY, OF ABDOMINAL WALL FOR EVISCERATION OR	
49900 DEHISCENCE \$249.61 \$249.61	
OMENTAL FLAP, EXTRA-ABDOMINAL (EG, FOR RECONSTRUCTION OF	
49904 STERNAL AND C \$1,035.89 \$1,035.89	
OMENTAL FLAP, INTRA-ABDOMINAL (LIST SEPARATELY IN ADDITION	
49905 TO CODE FOR \$303.37 \$303.37	
49906 FREE OMENTAL FLAP WITH MICROVASCULAR ANASTOMOSIS \$0.00 \$0.00	
49999 UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM R \$0.00 \$0.00	
RENAL EXPLORATION, NOT NECESSITATING OTHER SPECIFIC	
50010 PROCEDURES \$579.10 \$579.10	
50020 DRAINAGE OF PERIRENAL OR RENAL ABSCESS; OPEN \$567.20 \$567.20	
50021 DRAINAGE OF PERIRENAL OR RENAL ABSCESS; PERCUTANEOUS \$170.77 \$170.77	
50040 NEPHROSTOMY, NEPHROTOMY WITH DRAINAGE \$612.59 \$612.59	
50045 NEPHROTOMY, WITH EXPLORATION \$709.64 \$709.64	
50060 NEPHROLITHOTOMY; REMOVAL OF CALCULUS \$886.15 \$886.15	

Physician	Fee Schedule 2020							
Note:								
2020 Coc	les in Red;							
Refer to C	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	Э				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	NEPHROLITHOTOMY; SECONDARY SURGICAL OPERATION FOR							
50065	CALCULUS		\$982.15	\$982.15				
	NEPHROLITHOTOMY; COMPLICATED BY CONGENITAL KIDNEY							
50070	ABNORMALITY		\$939.93	\$939.93				
	NEPHROLITHOTOMY; REMOVAL OF LARGE STAGHORN CALCULUS							
50075	FILLING RENAL PELV		\$1,197.56	\$1,197.56				
	PERCUTANEOUS NEPHROSTOLITHOTOMY OR							
50080	PYELOSTOLITHOTOMY, WITH OR WITHOUT		\$765.39	\$765.39				
50004	PERCUTANEOUS NEPHROSTOLITHOTOMY OR			** ** ** ** ** ** ** ** ** ** ** ** **				
50081	PYELOSTOLITHOTOMY, WITH OR WITHOUT		\$1,040.14	\$1,040.14				
50400	TRANSECTION OR REPOSITIONING OF ABERRANT RENAL VESSELS		4750.50	4750 50				
50100	(SEPARATE PROCE	4	\$753.52	\$753.52				
50120	PYELOTOMY; WITH EXPLORATION		\$762.91	\$762.91				
50125	PYELOTOMY; WITH DRAINAGE, PYELOSTOMY PYELOTOMY; WITH REMOVAL OF CALCULUS (PYELOLITHOTOMY,		\$777.51	\$777.51				+
50130	PELVIOLITHOTOMY,		\$846.95	\$846.95				
50130	PYELOTOMY; COMPLICATED (EG, SECONDARY OPERATION,		\$040.95	\$646.95				
50135	CONGENITAL KIDNEY		\$1,029.21	\$1,029.21				
50200	RENAL BIOPSY; PERCUTANEOUS, BY TROCAR OR NEEDLE		\$1,029.21	\$152.52				+
50205	RENAL BIOPSY; BY SURGICAL EXPOSURE OF KIDNEY		\$540.41	\$540.41				+
30203	NEPHRECTOMY, INCLUDING PARTIAL URETERECTOMY, ANY OPEN		Ψ040.41	Ψ0-τ0τ1				
50220	APPROACH INCLUDI		\$860.66	\$860.66				
30220	NEPHRECTOMY, INCLUDING PARTIAL URETERECTOMY, ANY OPEN		Ψ000.00	ψ000.00	+			+
50225	APPROACH INCLUDI		\$1,039.88	\$1,039.88				
	NEPHRECTOMY, INCLUDING PARTIAL URETERECTOMY, ANY OPEN		+ 1,000.00	+ 1,000.00				+
50230	APPROACH INCLUDI		\$1,141.54	\$1,141.54				

Physiciar	Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to (CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	NEPHRECTOMY WITH TOTAL URETERECTOMY AND BLADDER CUFF;							
50234	THROUGH SAME INC		\$1,106.12	\$1,106.12				
	NEPHRECTOMY WITH TOTAL URETERECTOMY AND BLADDER CUFF;							
50236	THROUGH SEPARATE		\$1,202.69	\$1,202.69				
50240	NEPHRECTOMY, PARTIAL		\$1,064.37	\$1,064.37				
	ABLATION, OPEN, ONE OR MORE RENAL MASS LESION(S),							
50250	CRYOSURGICAL, INCLUD		\$862.75	\$862.75				
50280	EXCISION OR UNROOFING OF CYST(S) OF KIDNEY		\$748.77	\$748.77				
50290	EXCISION OF PERINEPHRIC CYST		\$668.54	\$668.54				
	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); FROM							
50300	CADAVER DONOR,		\$553.19	\$553.19				
=0000	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); OPEN,		* 4.00 * 4					
50320	FROM LIVING DON		\$1,188.51	\$1,188.51				Rate updated 1/1/2018
50000	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR RENAL		#0.00	# 0.00				
50323	ALLOGRAFT PRIOR		\$0.00	\$0.00				
E000E	BACKBENCH STANDARD PREPARATION OF LIVING DONOR RENAL		#0.00	#0.00				
50325	ALLOGRAFT (OPEN O BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR		\$0.00	\$0.00				
50327	RENAL ALLOGRAFT PR		\$160.64	\$160.64				
50327	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR		\$100.04	\$100.04				
50328	RENAL ALLOGRAFT PR		\$140.69	\$140.69				
30320	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR		φ 140.08	φ 140.09		+		_
50329	RENAL ALLOGRAFT PR		\$134.41	\$134.41				
50329	RECIPIENT NEPHRECTOMY (SEPARATE PROCEDURE)		\$704.29	\$704.29		+		+
30040	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT;		Ψ1 07.20	Ψ1 07.23		+		+
50360	WITHOUT RECIPIENT		\$1,552.57	\$1,552.57				

Physician	n Fee Schedule 2020							T
Note:								
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	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cha	rge for the service	е				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH							
50365	RECIPIENT		\$1,873.06	\$1,873.06				
50370	REMOVAL OF TRANSPLANTED RENAL ALLOGRAFT		\$669.85	\$669.85				
50380	RENAL AUTOTRANSPLANTATION, REIMPLANTATION OF KIDNEY		\$796.86	\$796.86				
	REMOVAL (VIA SNARE/CAPTURE) AND REPLACEMENT OF							
50382	INTERNALLY DWELLING URE		\$219.71	\$1,096.19				
	REMOVAL (VIA SNARE/CAPTURE) OF INTERNALLY DWELLING							
50384	URETERAL STENT VIA		\$200.01	\$1,057.61				
50385	CHANGE STENT VIA TRANSURETH		\$200.57	\$1,048.83				
50386	REMOVE STENT VIA TRANSURETH		\$151.61	\$678.85				
	REMOVAL AND REPLACEMENT OF EXTERNALLY ACCESSIBLE							
50387	TRANSNEPHRIC URETERAL		\$79.54	\$528.37				
	REMOVAL OF NEPHROSTOMY TUBE, REQUIRING FLUOROSCOPIC							
50389	GUIDANCE (EG, WITH		\$43.89	\$360.55				
	ASPIRATION AND/OR INJECTION OF RENAL CYST OR PELVIS BY							
50390	NEEDLE, PERCUTA		\$144.05	\$144.05				
	INSTILLATION(S) OF THERAPEUTIC AGENT INTO RENAL PELVIS AND/							
50391	OR URETER		\$77.85	\$102.10				
	MANOMETRIC STUDIES THROUGH NEPHROSTOMY OR PYELOSTOMY							
50396	TUBE, OR INDWELLI		\$75.95	\$75.95				
	PYELOPLASTY (FOLEY Y-PYELOPLASTY), PLASTIC OPERATION ON							
50400	RENAL PELVIS,		\$929.67	\$929.67				
50405	PYELOPLASTY (FOLEY Y-PYELOPLASTY), PLASTIC OPERATION ON		¢4 404 70	¢4 404 70				
50405	RENAL PELVIS,		\$1,164.79	\$1,164.79				
50400	INJECTION PROCEDURE FOR ANTEGRADE NEPHROSTOGRAM /		#400.00	#200 7 4				Add - 1 Fff - 1 1/4/2042
50430	URETEROGRAM / DIAGNOSTIC; NEW ACCESS		\$136.29	\$393.71				Added Effective 1/1/2016
50431	EXISTING ACCESS		\$53.62	\$122.70				Added Effective 1/1/2016

Dhygigian	n Fee Schedule 2020					ı		
Note:	r Fee Scriedule 2020							
	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service	9				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. se lab fee schedule for covered codes not listed below in the 80000-89249							
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f							
Codes iis	ted on the lab lee scriedule that begin with a P of Q are currently non-covered in	or priysicia T	115					+
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	PLACEMENT OF NEPHROSTOMY CATHETER,	FAIIIU	(i acility)	(Norm acmity)	Comp.	Comp.	Value	Notes
	PERCUTANEOUS,INCLUDING DIAGNOSTIC,NEPHROSTOGRAM							
50432	AND/OR URETEROGRAM / RADIOLOGICAL SUPERVISION		\$180.36	\$634.94				Added Effective 1/1/2016
30432	PLACEMENT OF NEPHROSTOMY CATHETER,		Ψ100.00	ψ004.04				Added Effective 1/1/2010
	PERCUTANEOUS,INCLUDING DIAGNOSTIC,NEPHROSTOGRAM							
	AND/OR URETEROGRAM /RADIOLOGICAL SUPERVISION/ NEW							
50433	ACCESS		\$222.93	\$853.18				Added Effective 1/1/2016
00100	CONVERT NEPHROSTOMY CATHETER TO NEPHROURETECAL		Ψ222.00	ψοσο. το				714464 211661176 17 172616
50434	CATHETER /VIA PRE-EXISTING NEPHROSTOMY TRACT		\$170.64	\$674.63				Added Effective 1/1/2016
00.0.	EXCHANGE NEPHROSTOMY CATHETER, RADIOLOGICAL		ψ 1.7 G.G.1	ψον που				714464 2.11661176 17 172616
50435	SUPERVISION		\$82.35	\$352.98				Added Effective 1/1/2016
50436	DILAT XST TRC NDURLGC PX		\$123.51	\$123.51				Effective 1/1/2019
50437	DILAT XST TRC NEW ACCESS RCS		\$206.79	\$206.79				Effective 1/1/2019
50500	NEPHRORRHAPHY, SUTURE OF KIDNEY WOUND OR INJURY		\$910.16	\$910.16				
50520	CLOSURE OF NEPHROCUTANEOUS OR PYELOCUTANEOUS FISTULA		\$781.23	\$781.23				
	CLOSURE OF NEPHROVISCERAL FISTULA (EG, RENOCOLIC),							
50525	INCLUDING VISCERAL		\$990.76	\$990.76				
	CLOSURE OF NEPHROVISCERAL FISTULA (EG, RENOCOLIC),							
50526	INCLUDING VISCERAL		\$904.55	\$904.55				
	SYMPHYSIOTOMY FOR HORSESHOE KIDNEY WITH OR WITHOUT							
50540	PYELOPLASTY AND/OR		\$959.03	\$959.03				
50541	LAPAROSCOPY, SURGICAL; ABLATION OF RENAL CYSTS		\$654.47	\$654.47				
50542	LAPAROSCOPY, SURGICAL; ABLATION OF RENAL MASS LESION(S)		\$825.28	\$825.28				
50543	LAPAROSCOPY, SURGICAL; PARTIAL NEPHRECTOMY		\$1,038.55	\$1,038.55				
50544	LAPAROSCOPY, SURGICAL; PYELOPLASTY		\$902.84	\$902.84				

Physician	Fee Schedule 2020							
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAPAROSCOPY, SURGICAL; RADICAL NEPHRECTOMY (INCLUDES		77	<u> </u>	•			
50545	REMOVAL OF GEROTA		\$978.83	\$978.83				
	LAPAROSCOPY, SURGICAL; NEPHRECTOMY, INCLUDING PARTIAL							
50546	URETERECTOMY		\$836.59	\$836.59				
	LAPAROSCOPY, SURGICAL; DONOR NEPHRECTOMY (INCLUDING		·					
50547	COLD PRESERVATION)		\$1,071.99	\$1,071.99				
50548	LAPAROSCOPY, SURGICAL; NEPHRECTOMY WITH		\$982.90	\$982.90				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50551	PYELOSTOMY, WITH OR		\$228.17	\$228.17				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50553	PYELOSTOMY, WITH OR		\$224.42	\$224.42				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50555	PYELOSTOMY, WITH OR		\$328.61	\$328.61				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50557	PYELOSTOMY, WITH OR		\$332.49	\$332.49				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50561	PYELOSTOMY, WITH OR		\$371.95	\$371.95				
	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR							
50562	PYELOSTOMY, WITH OR		\$439.42	\$439.42				
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50570	WITH OR WITHOUT		\$322.23	\$322.23				
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50572	WITH OR WITHOUT		\$516.39	\$516.39				
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50574	WITH OR WITHOUT		\$528.82	\$528.82				
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50575	WITH OR WITHOUT		\$700.13	\$700.13				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50576	WITH OR WITHOUT		\$574.28	\$574.28				
	RENAL ENDOSCOPY THROUGH NEPHROTOMY OR PYELOTOMY,							
50580	WITH OR WITHOUT		\$452.54	\$452.54				
50590	LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE		\$577.02	\$577.02				
	ABLATION, ONE OR MORE RENAL TUMOR(S), PERCUTANEOUS,							
50592	UNILATERAL,		\$287.70	\$4,024.81				
50593	PERC CYRO ABLATE RENAL TUM		\$388.97	\$3,687.39				
	URETEROTOMY WITH EXPLORATION OR DRAINAGE (SEPARATE							
50600	PROCEDURE)		\$718.14	\$718.14				
50605	URETEROTOMY FOR INSERTION OF INDWELLING STENT, ALL TYPES		\$601.01	\$601.01				
			7001101	Ţ O O O O				
50606	ENDOLUMINAL BIOPSY OF URETER AND PLEVIS, NON-ENDOSCOPIC,		\$129.18	\$399.03				Added Effective 1/1/2016
50610	URETEROLITHOTOMY; UPPER ONE-THIRD OF URETER		\$780.17	\$780.17				
50620	URETEROLITHOTOMY; MIDDLE ONE-THIRD OF URETER		\$752.17	\$752.17				
50630	URETEROLITHOTOMY; LOWER ONE-THIRD OF URETER		\$780.62	\$780.62				
			Ţ. 55.52	Ţ. 55.5				
50650	URETERECTOMY, WITH BLADDER CUFF (SEPARATE PROCEDURE)		\$833.50	\$833.50				
00000	URETERECTOMY, TOTAL, ECTOPIC URETER, COMBINATION		Ψ000.00	ψοσο.σσ				
50660	ABDOMINAL, VAGINAL AN		\$913.28	\$913.28				
00000	INJECTION PROCEDURE FOR URETEROGRAPHY OR		ψο το.Σο	ψο το.20				
50684	URETEROPYELOGRAPHY THROUGH		\$36.66	\$36.66				
00004	MANOMETRIC STUDIES THROUGH URETEROSTOMY OR INDWELLING		Ψ00.00	Ψ00.00				
50686	URETERAL CATHETE		\$55.20	\$55.20				
30000	CHANGE OF URETEROSTOMY TUBE OR EXTERNALLY ACCESSIBLE	1	φυυ.Ζυ	φυυ.Δυ				+
50600	URETERAL STENT VI		\$44.88	\$44.88				
50688	UNE I ENAL STENT VI	1	φ44.00	φ44.00				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
=0000	INJECTION PROCEDURE FOR VISUALIZATION OF ILEAL CONDUIT		40.05	å 40 0F				
50690	AND/ OR		\$43.35	\$43.35				
	DI ACEMENT CE LIDETEDAL CTENT, DEDOLITANICOLIC/DIACNICOTIC							
50000	PLACEMENT OF URETERAL STENT, PERCUTANEOUS/DIAGNOSTIC		¢470.00	Φ 7 04 5 7				A 11-1 Eff time 4/4/0040
50693 50694	NEPHROSTOGRAM/ PRE-EXISTING NEPHROSTOMY TRACT NEW ACCESS WITHOUT SEPARATE NEPHROSTOMY CATHETER		\$178.66 \$231.14	\$791.57 \$874.85				Added Effective 1/1/2016 Added Effective 1/1/2016
50695	NEW ACCESS WITHOUT SEPARATE NEPHROSTOMY CATHETER NEW ACCESS WITH SPERATE NEPHROSTOMY CATHETER		\$293.14	\$1,068.01				Added Effective 1/1/2016
50095	URETEROPLASTY, PLASTIC OPERATION ON URETER (EG,		\$293.14	\$1,000.01				Added Effective 1/1/2016
50700	STRICTURE)		\$782.24	\$782.24				
30700	URETERAL EMBOLIZATION OR OCCUSION, INCLUDING IMAGING		ψ102.24	ψ102.24				
50705	GUIDANCE		\$165.33	\$1,265.41				Added Effective 1/1/2016
50706	BALLON DILATION URETERAL STRICTURE, INCLUDING IMAGING		\$153.84	\$574.78				Added Effective 1/1/2016
00700	URETEROLYSIS, WITH OR WITHOUT REPOSITIONING OF URETER		ψ100.01	ψον 1.7 σ				7 14454 211551175 17 172515
50715	FOR RETROPERITON		\$854.13	\$854.13				
50722	URETEROLYSIS FOR OVARIAN VEIN SYNDROME		\$768.05	\$768.05				
	URETEROLYSIS FOR RETROCAVAL URETER, WITH REANASTOMOSIS							
50725	OF UPPER URINAR		\$868.09	\$868.09				
	REVISION OF URINARY-CUTANEOUS ANASTOMOSIS (ANY TYPE							
50727	UROSTOMY);		\$378.56	\$378.56				
	REVISION OF URINARY-CUTANEOUS ANASTOMOSIS (ANY TYPE							
50728	UROSTOMY); WITH RE		\$557.20	\$557.20				
	URETEROPYELOSTOMY, ANASTOMOSIS OF URETER AND RENAL							
50740	PELVIS		\$897.53	\$897.53				
	URETEROCALYCOSTOMY, ANASTOMOSIS OF URETER TO RENAL							
50750	CALYX		\$939.49	\$939.49				
50760	URETEROURETEROSTOMY		\$899.61	\$899.61				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSURETEROURETEROSTOMY, ANASTOMOSIS OF URETER TO			4077.07				
50770	CONTRALATERAL URETE		\$977.97	\$977.97				
	URETERONEOCYSTOSTOMY; ANASTOMOSIS OF SINGLE URETER TO							
50780	BLADDER		\$907.44	\$907.44				
	URETERONEOCYSTOSTOMY; ANASTOMOSIS OF DUPLICATED							
50782	URETER TO BLADDER		\$940.01	\$940.01				
	URETERONEOCYSTOSTOMY; WITH EXTENSIVE URETERAL							
50783	TAILORING		\$967.60	\$967.60				
	URETERONEOCYSTOSTOMY; WITH VESICO-PSOAS HITCH OR							
50785	BLADDER FLAP		\$1,019.26	\$1,019.26				
	URETEROENTEROSTOMY, DIRECT ANASTOMOSIS OF URETER TO							
50800	INTESTINE		\$814.57	\$814.57				
	URETEROSIGMOIDOSTOMY, WITH CREATION OF SIGMOID BLADDER							
50810	AND ESTABLISHME		\$911.97	\$911.97				
50815	URETEROCOLON CONDUIT, INCLUDING INTESTINE ANASTOMOSIS		\$1,129.11	\$1,129.11				
	URETEROILEAL CONDUIT (ILEAL BLADDER), INCLUDING INTESTINE							
50820	ANASTOMOSIS		\$1,160.83	\$1,160.83				
	CONTINENT DIVERSION, INCLUDING INTESTINE ANASTOMOSIS							
50825	USING ANY SEGMENT		\$1,668.56	\$1,668.56				
	URINARY UNDIVERSION (EG, TAKING DOWN OF URETEROILEAL							
50830	CONDUIT,		\$1,476.01	\$1,476.01				
	REPLACEMENT OF ALL OR PART OF URETER BY INTESTINE							
50840	SEGMENT, INCLUDING		\$922.36	\$922.36				
50845	CUTANEOUS APPENDICO-VESICOSTOMY		\$977.61	\$977.61				
50860	URETEROSTOMY, TRANSPLANTATION OF URETER TO SKIN		\$731.60	\$731.60				
50900	URETERORRHAPHY, SUTURE OF URETER (SEPARATE PROCEDURE)		\$664.77	\$664.77				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dracedure Decemention	PA Ind	•				Value	Notes
Code 50920	Procedure Description CLOSURE OF URETEROCUTANEOUS FISTULA	PA Ind	(Facility) \$667.32	(NonFacility) \$667.32	Comp.	Comp.	value	Notes
50920	CLOSURE OF URETEROCUTANEOUS FISTULA CLOSURE OF URETEROVISCERAL FISTULA (INCLUDING VISCERAL		\$007.32	\$007.32				
50000			#004 66	¢004.66				
50930	REPAIR) DELIGATION OF URETER		\$881.66	\$881.66 \$683.88				
50940 50945	LAPAROSCOPY, SURGICAL; URETEROLITHOTOMY		\$683.88 \$692.25	\$692.25				
50945			\$692.25	\$692.25				
500.47	LAPAROSCOPY, SURGICAL; URETERONEOCYSTOSTOMY WITH		054.00	#4.054.00				
50947	CYSTOSCOPY AND URETER		\$1,051.02	\$1,051.02				
50040	LAPAROSCOPY, SURGICAL; URETERONEOCYSTOSTOMY WITHOUT		0004.04	0004.04				
50948	CYSTOSCOPY AND URE		\$961.31	\$961.31				
50949	UNLISTED LAPAROSCOPY PROCEDURE, URETER		\$0.00	\$0.00				
50054	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY,		****	4000.00				
50951	WITH OR WITHOUT		\$220.29	\$220.29				
50050	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY,		0004.50	0004.50				
50953	WITH OR WITHOUT		\$231.52	\$231.52				
	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY,		4070 54	4070 54				
50955	WITH OR WITHOUT		\$272.54	\$272.54				
50057	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY,		4070.07	4070.07				
50957	WITH OR WITHOUT		\$272.37	\$272.37				
	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY,							
50961	WITH OR WITHOUT		\$254.12	\$254.12				
	URETERAL ENDOSCOPY THROUGH URETEROTOMY, WITH OR							
50970	WITHOUT IRRIGATION,		\$360.82	\$360.82				
	URETERAL ENDOSCOPY THROUGH URETEROTOMY, WITH OR		 					
50972	WITHOUT IRRIGATION,		\$247.37	\$247.37				
	URETERAL ENDOSCOPY THROUGH URETEROTOMY, WITH OR							
50974	WITHOUT IRRIGATION,		\$472.90	\$472.90				

Physician	Fee Schedule 2020							
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	URETERAL ENDOSCOPY THROUGH URETEROTOMY, WITH OR							
50976	WITHOUT IRRIGATION,		\$452.26	\$452.26				
	URETERAL ENDOSCOPY THROUGH URETEROTOMY, WITH OR							
50980	WITHOUT IRRIGATION,		\$292.25	\$292.25				
	CYSTOTOMY OR CYSTOSTOMY; WITH FULGURATION AND/OR							
51020	INSERTION OF RADIOACT		\$378.22	\$378.22				
	CYSTOTOMY OR CYSTOSTOMY; WITH CRYOSURGICAL							
51030	DESTRUCTION OF INTRAVESICAL		\$309.19	\$309.19				
51040	CYSTOSTOMY, CYSTOTOMY WITH DRAINAGE		\$278.22	\$278.22				
	CYSTOTOMY, WITH INSERTION OF URETERAL CATHETER OR STENT							
51045	(SEPARATE		\$322.42	\$322.42				
	CYSTOLITHOTOMY, CYSTOTOMY WITH REMOVAL OF CALCULUS,							
51050	WITHOUT VESICAL NE		\$385.22	\$385.22				
51060	TRANSVESICAL URETEROLITHOTOMY		\$541.66	\$541.66				
	CYSTOTOMY, WITH CALCULUS BASKET EXTRACTION AND/OR							
51065	ULTRASONIC OR		\$443.37	\$443.37				
51080	DRAINAGE OF PERIVESICAL OR PREVESICAL SPACE ABSCESS		\$311.54	\$311.54				
51100	DRAIN BLADDER BY NEEDLE		\$32.64	\$51.92				
51101	DRAIN BLADDER BY TROCAR/CATH		\$43.32	\$104.74				
51102	DRAIN BLADDER WITH CATH INSERTION		\$205.32	\$275.93				
54500	EXCISION OF URACHAL CYST OR SINUS, WITH OR WITHOUT			400.04				
51500	UMBILICAL HERNIA RE		\$493.34	\$493.34	1			
54500	CYSTOTOMY; FOR SIMPLE EXCISION OF VESICAL NECK (SEPARATE		#504.00	# 504.00				
51520	PROCEDURE)		\$504.93	\$504.93	1			
E4505	CYSTOTOMY; FOR EXCISION OF BLADDER DIVERTICULUM, SINGLE		# 000 00	# 000 00				
51525	OR MULTIPLE		\$686.96	\$686.96	+			
51530	CYSTOTOMY; FOR EXCISION OF BLADDER TUMOR		\$605.06	\$605.06				

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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
51535	CYSTOTOMY FOR EXCISION, INCISION, OR REPAIR OF URETEROCELE		\$571.44	\$571.44				
51550	CYSTECTOMY, PARTIAL; SIMPLE		\$736.48	\$736.48				
	CYSTECTOMY, PARTIAL; COMPLICATED (EG, POSTRADIATION,							
51555	PREVIOUS SURGERY,		\$935.80	\$935.80				
	CYSTECTOMY, PARTIAL, WITH REIMPLANTATION OF URETER(S) INTO							
51565	BLADDER		\$1,052.60	\$1,052.60				
51570	CYSTECTOMY, COMPLETE; (SEPARATE PROCEDURE)		\$1,109.65	\$1,109.65				
	CYSTECTOMY, COMPLETE; WITH BILATERAL PELVIC							
51575	LYMPHADENECTOMY, INCLUDING		\$1,487.65	\$1,487.65				
	CYSTECTOMY, COMPLETE, WITH URETEROSIGMOIDOSTOMY OR							
51580	URETEROCUTANEOUS		\$1,412.15	\$1,412.15				
	CYSTECTOMY, COMPLETE, WITH URETEROSIGMOIDOSTOMY OR							
51585	URETEROCUTANEOUS		\$1,678.02	\$1,678.02				
	CYSTECTOMY, COMPLETE, WITH URETEROILEAL CONDUIT OR							
51590	SIGMOID BLADDER,		\$1,606.35	\$1,606.35				
	CYSTECTOMY, COMPLETE, WITH URETEROILEAL CONDUIT OR							
51595	SIGMOID BLADDER,		\$1,992.75	\$1,992.75				
	CYSTECTOMY, COMPLETE, WITH CONTINENT DIVERSION, ANY OPEN							
51596	TECHNIQUE, US		\$2,083.94	\$2,083.94				
	PELVIC EXENTERATION, COMPLETE, FOR VESICAL, PROSTATIC OR							
51597	URETHRAL		\$1,961.23	\$1,961.23				
	INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING							
51600	URETHROCYSTOGRAPHY		\$34.06	\$34.06				
	INJECTION PROCEDURE AND PLACEMENT OF CHAIN FOR CONTRAST							
51605	AND/ OR CHAIN		\$41.93	\$41.93				
51610	INJECTION PROCEDURE FOR RETROGRADE URETHR		\$54.38	\$54.38				

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Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or priysiciai	ns T					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code 51700	Procedure Description BLADDER IRRIGATION, SIMPLE, LAVAGE AND/OR INSTILLATION	PA Ind	(Facility) \$29.26	(NonFacility) \$32.21	Comp.	Comp.	value	Notes
51700	INSERTION OF NON-INDWELLING BLADDER CATHETER (EG,		\$29.20	\$32.21				
E4704			#20.24	¢40.44				
51701	STRAIGHT CATHETERIZA INSERTION OF TEMPORARY INDWELLING BLADDER CATHETER;		\$20.31	\$42.41				
E4700			#00.44	¢65.70				
51702	SIMPLE (EG, FOLEY)		\$22.11	\$65.79				
E4700	INSERTION OF TEMPORARY INDWELLING BLADDER CATHETER;		#50.04	000 70				
51703	COMPLICATED (EG,		\$59.81	\$93.72	-			
51705	CHANGE OF CYSTOSTOMY TUBE; SIMPLE		\$35.12	\$40.21				
51710	CHANGE OF CYSTOSTOMY TUBE; COMPLICATED		\$51.94	\$59.59	-			
E474E	ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE		#407.00	0407.00				
51715	SUBMUCOSAL TISSUES O		\$187.38	\$187.38				
E4700	BLADDER INSTILLATION OF ANTICARCINOGENIC AGENT (INCLUDING		004.70	#70.00				
51720	DETENTION TI		\$64.76	\$70.80	0407.44	***		
51725	SIMPLE CYSTOMETROGRAM		\$74.07	\$74.07	\$107.41	\$66.76		
51726	COMPLEX CYSTOMETROGRAM		\$87.94	\$87.94	\$180.10	\$75.36		
51727	CYSTOMETROGRAM W/UP		\$245.27	\$245.27	\$180.69	\$94.65		
51728	CYSTOMETROGRAM W/VP		\$244.37	\$244.37	\$183.06	\$91.09		
51729	CYSTOMETROGRAM W/VP&UP		\$267.06	\$267.06	\$188.11	\$110.97		
- 4 - 0 0	SIMPLE UROFLOWMETRY (UFR) (EG, STOP-WATCH FLOW RATE,			***		400.05		
51736	MECHANICAL		\$36.62	\$36.62	\$4.27	\$32.35		
	COMPLEX UROFLOWMETRY (EG, CALIBRATED ELECTRONIC		400 55	400 55	0.45	0.50 15		
51741	EQUIPMENT)		\$62.55	\$62.55	\$6.12	\$56.43		
L	ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL		·-		1			
51784	SPHINCTER, OTHER TH		\$75.46	\$75.46	\$11.43	\$64.03		
	NEEDLE ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR							
51785	URETHRAL SPHINCTER, A		\$75.46	\$75.46	\$11.43	\$64.03		

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
F4700	STIMULUS EVOKED RESPONSE (EG, MEASUREMENT OF		#00.00	#00.00	#20.04	¢40.50		
51792	BULBOCAVERNOSUS REFLEX LA VOIDING PRESSURE STUDIES (VP); INTRA-ABDOMINAL VOIDING		\$88.90	\$88.90	\$39.34	\$49.56		
E4707	, , ,		Φ 7 Ε 40	Ф7E 40	Φ42.00	C4 04		
51797	PRESSURE (AP) MEASUREMENT OF POST-VOIDING RESIDUAL URINE AND/OR		\$75.13	\$75.13	\$13.28	\$61.84		
E4700			C44 4E	Φ4.4.4.E				
51798	BLADDER CAPACITY BY CYSTOPLASTY OR CYSTOURETHROPLASTY, PLASTIC OPERATION		\$14.15	\$14.15	_			
E4000	ON BLADDER AND/OR		\$836.71	\$836.71				
51800	CYSTOURETHROPLASTY WITH UNILATERAL OR BILATERAL		φουσ./ Ι	φοσο./ Ι				
51820	URETERONEOCYSTOSTOMY		\$719.45	\$719.45				
31020	ANTERIOR VESICOURETHROPEXY, OR URETHROPEXY (EG,		φ <i>1</i> 19.45	φ <i>1</i> 19.45				
51840	MARSHALL-MARCHETTI-KRA		\$564.89	\$564.89				
51640	ANTERIOR VESICOURETHROPEXY, OR URETHROPEXY (EG,		Φ004.09	\$304.09				
51841	MARSHALL-MARCHETTI-KRA		\$686.33	\$686.33				
31041	ABDOMINO-VAGINAL VESICAL NECK SUSPENSION, WITH OR		φ000.33	φυου.33				
51845	WITHOUT ENDOSCOPIC		\$579.60	\$579.60				
31043	CYSTORRHAPHY, SUTURE OF BLADDER WOUND, INJURY OR		φ37 9.00	φ57 9.00				+
51860	RUPTURE; SIMPLE		\$554.26	\$554.26				
31000	CYSTORRHAPHY, SUTURE OF BLADDER WOUND, INJURY OR		Ψ554.20	ψ334.20				
51865	RUPTURE; COMPLICATED		\$735.34	\$735.34				
51880	CLOSURE OF CYSTOSTOMY (SEPARATE PROCEDURE)		\$357.24	\$357.24				+
51900	CLOSURE OF VESICOVAGINAL FISTULA, ABDOMINAL APPROACH		\$689.18	\$689.18				+
51900	CLOSURE OF VESICOUTERINE FISTULA;		\$529.33	\$529.33	+	+		
51925	CLOSURE OF VESICOUTERINE FISTULA; WITH HYSTERECTOMY	R	\$740.46	\$740.46	+			
51940	CLOSURE, EXSTROPHY OF BLADDER	'	\$1,295.81	\$1,295.81	+			
51960	ENTEROCYSTOPLASTY, INCLUDING INTESTINAL ANASTOMOSIS		\$1,249.76	\$1,249.76				+
51980	CUTANEOUS VESICOSTOMY		\$524.37	\$524.37				+
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Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAPAROSCOPY, SURGICAL; URETHRAL SUSPENSION FOR STRESS							
51990	INCONTINENCE		\$534.61	\$534.61				
	LAPAROSCOPY, SURGICAL; SLING OPERATION FOR STRESS							
51992	INCONTINENCE (EG, FA		\$583.28	\$583.28				
51999	UNLISTED LAPAROSCOPY PROCEDURE, BLADDER	R	\$0.00	\$0.00				
52000	CYSTOURETHROSCOPY (SEPARATE PROCEDURE)		\$83.27	\$83.27				
	CYSTOURETHROSCOPY WITH IRRIGATION AND EVACUATION OF							
52001	MULTIPLE OBSTRUCTI		\$101.50	\$101.50				
	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH							
52005	OR WITHOUT		\$133.90	\$133.90				
	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH							
52007	OR WITHOUT		\$171.06	\$171.06				
	CYSTOURETHROSCOPY, WITH EJACULATORY DUCT							
52010	CATHETERIZATION, WITH OR WITH		\$118.96	\$144.44				
52204	CYSTOURETHROSCOPY, WITH BIOPSY		\$139.21	\$139.21				
	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING							
52214	CRYOSURGERY OR LASER		\$190.77	\$190.77				
	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING							
52224	CRYOSURGERY OR LASER		\$176.97	\$176.97				
	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING							
52234	CRYOSURGERY OR LASER		\$273.13	\$273.13				
	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING			1,000 5-				
52235	CRYOSURGERY OR LASER		\$366.55	\$366.55				
500.40	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING		# 500.44	# 500.44				
52240	CRYOSURGERY OR LASER		\$596.14	\$596.14				
50050	CYSTOURETHROSCOPY WITH INSERTION OF RADIOACTIVE		mo45.66	#045.00				
52250	SUBSTANCE, WITH OR WIT		\$215.80	\$215.80				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)			1	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR							
52260	INTERSTITIAL CYSTITIS;		\$176.97	\$176.97				
	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR							
52265	INTERSTITIAL CYSTITIS;		\$107.78	\$125.88				
52270	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; FEMALE		\$214.26	\$214.26				
52275	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; MALE		\$237.91	\$237.91				
	CYSTOURETHROSCOPY WITH DIRECT VISION INTERNAL							
52276	URETHROTOMY		\$249.10	\$249.10				
	CYSTOURETHROSCOPY, WITH RESECTION OF EXTERNAL							
52277	SPHINCTER (SPHINCTEROTOM		\$321.75	\$321.75				
	CYSTOURETHROSCOPY, WITH CALIBRATION AND/OR DILATION OF							
52281	URETHRAL STRICT		\$118.73	\$149.71				
52282	CYSTOURETHROSCOPY, WITH INSERTION OF URETHRAL STENT		\$313.59	\$313.59			1	
52283	CYSTOURETHROSCOPY, WITH STEROID INJECTION INTO STRICTURE		\$153.89	\$153.89				
	CYSTOURETHROSCOPY FOR TREATMENT OF THE FEMALE						1	
52285	URETHRAL SYNDROME WITH A		\$152.65	\$192.08				
52287	CYSTOURETHROSCOPY, WITH INJECTION(S)		\$134.96	\$245.05			1	
	CYSTOURETHROSCOPY; WITH URETERAL MEATOTOMY, UNILATERAL							
52290	OR BILATERAL		\$203.28	\$203.28				
	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF				†		†	
52300	ORTHOTOPIC		\$258.81	\$258.81				
	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF		,	,			1	
52301	ECTOPIC URETEROCEL		\$256.96	\$256.96				
	CYSTOURETHROSCOPY; WITH INCISION OR RESECTION OF ORIFICE		V	,	1		1	
52305	OF BLADDER		\$258.20	\$258.20				
32000	10. 55.551.		Ψ200.20	Ψ200.20				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY,							
52310	CALCULUS, OR URETERAL		\$169.94	\$169.94				
	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY,							
52315	CALCULUS, OR URETERAL		\$271.76	\$271.76				
	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY							
52317	ANY MEANS IN BLA		\$377.55	\$377.55				
	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY							
52318	ANY MEANS IN BLA		\$499.73	\$499.73				
	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION);							
52320	WITH REMOVAL O		\$279.69	\$279.69				
	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION);							
52325	WITH FRAGMENTA		\$385.30	\$385.30				
	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION);			,				
52327	WITH SUBURETER		\$260.01	\$260.01				
0202.	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION);		+	Ψ=σσισι				
52330	WITH MANIPULAT		\$249.47	\$249.47				
02000	CYSTOURETHROSCOPY, WITH INSERTION OF INDWELLING		Ψ2.10.11	Ψ2.0				
52332	URETERAL STENT (EG, GI		\$176.92	\$176.92				
02002	CYSTOURETHROSCOPY WITH INSERTION OF URETERAL GUIDE		ψ 11 0.0 <u>2</u>	ψ11 0.0 <u>L</u>				
52334	WIRE THROUGH KIDNEY		\$239.31	\$239.31				
0200+	CYSTOURETHROSCOPY; WITH TREATMENT OF URETERAL		Ψ200.01	Ψ200.01				
52341	STRICTURE (EG, BALLOON		\$243.12	\$243.12				
020+1	CYSTOURETHROSCOPY; WITH TREATMENT OF URETEROPELVIC		ΨΣ-+0.12	ΨΖ-τΟ.12				
52342	JUNCTION STRICTURE		\$263.18	\$263.18				
0Z07Z	CYSTOURETHROSCOPY; WITH TREATMENT OF INTRA-RENAL		Ψ200.10	Ψ200.10				+
52343	·		\$291.55	\$291.55				
52343	STRICTURE (EG, BALLOO	1	φ291.00	φ ∠ ઝ 1.33				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Offiary Char		;				+
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		no.					+
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							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)		Comp.	Value	Notes
Code	CYSTOURETHROSCOPY WITH URETEROSCOPY; WITH TREATMENT	PAIIIU	(Facility)	(NOTIFACILITY)	Comp.	Comp.	value	Notes
52344	OF URETERAL STRICT		\$311.60	\$311.60				
32344	CYSTOURETHROSCOPY WITH URETEROSCOPY; WITH TREATMENT		φ311.00	φ311.00				
52345	OF URETEROPELVIC		\$332.15	\$332.15				
32343	CYSTOURETHROSCOPY WITH URETEROSCOPY; WITH TREATMENT		φ332.13	φ332.13				
52346	OF INTRA-RENAL		\$373.63	\$373.63				
32340	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR		φ373.03	φ313.03				
E00E1	PYELOSCOPY; DIAGNOSTIC		\$247.37	\$247.37				
52351	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR		\$247.37	\$241.31				
E00E0	· ·		\$305.07	¢205.07				
52352	PYELOSCOPY; WITH REMOVAL O		\$305.07	\$305.07				
50050	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR		#252.42	фо го 40				
52353	PYELOSCOPY; WITH LITHOTRIP CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR		\$353.43	\$353.43				
E00E4	•		#240.00	¢240.00				
52354	PYELOSCOPY; WITH BIOPSY AN CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR		\$310.28	\$310.28				
FOOFF			\$364.94	\$364.94				
52355 52356	PYELOSCOPY; WITH RESECTION CYSTO/URETERO W/LITHOTRIPSY		\$334.30	\$304.94				
52356			\$334.30	\$334.30				
50400	CYSTOURETHROSCOPY WITH INCISION, FULGURATION, OR		£404.74	¢404.74				
52400	RESECTION OF CONGENIT CYSTOURETHROSCOPY WITH TRANSURETHRAL RESECTION OR		\$431.74	\$431.74				
50400			#040.40	¢040.40				
52402	INCISION OF EJACULAT INSERTION OF IMPLANT MATERIAL IN BLADDER USING AN		\$210.10	\$210.10				
50444			¢405.44	CO40 04				Add ad affactive 4/4/2045
52441	ENDOSCOPE		\$185.11	\$918.84				Added effective 1/1/2015
50440	INSERTION OF IMPLANT MATERIAL IN BLADDER USING AN		¢40.54	#004 77				Add - d - # 45 4/4/0045
52442	ENDOSCOPE TRANSPORTATE		\$49.51	\$694.77				Added effective 1/1/2015
52450	TRANSURETHRAL INCISION OF PROSTATE		\$352.62	\$352.62				

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Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSURETHRAL RESECTION OF BLADDER NECK (SEPARATE							
52500	PROCEDURE)		\$446.52	\$446.52				
====	TRANSURETHRAL ELECTROSURGICAL RESECTION OF PROSTATE,		****	400404				
52601	INCLUDING CONTROL		\$684.31	\$684.31				
50000	TRANSURETHRAL RESECTION; OF REGROWTH OF OBSTRUCTIVE		044440	044440				
52630	TISSUE LONGER THAN TRANSURETHRAL RESECTION; OF POSTOPERATIVE BLADDER NECK		\$444.43	\$444.43				
50640	,		#264.76	¢264.76				
52640	CONTRACTURE LASER COAGULATION OF PROSTATE, INCLUDING CONTROL OF		\$364.76	\$364.76				
52647	POSTOPERATIVE BLEE		\$635.30	\$635.30				
32047	LASER VAPORIZATION OF PROSTATE, INCLUDING CONTROL OF		φ033.30	\$033.30				
52648	POSTOPERATIVE		\$497.86	\$660.24				
52649	PROSTATE LASER ENUCLEATION		\$818.60	\$818.60				
52700	TRANSURETHRAL DRAINAGE OF PROSTATIC ABSCESS		\$281.93	\$281.93				
02700	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE		Ψ201.00	Ψ201.00				
53000	PROCEDURE); PENDULOUS		\$110.32	\$110.32				
00000	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE		ψ.1.0.0 <u>2</u>	ψ110.0 <u>2</u>				
53010	PROCEDURE); PERINEAL		\$192.02	\$192.02				
-	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE);		4.02.02	ψ.σ <u>σ.σ</u> σ				
53020	EXCEPT INFANT		\$76.12	\$76.12				
	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE);							
53025	INFANT		\$56.56	\$56.56				
53040	DRAINAGE OF DEEP PERIURETHRAL ABSCESS		\$230.59	\$230.59				
53060	DRAINAGE OF SKENE'S GLAND ABSCESS OR CYST		\$91.09	\$91.09				
	DRAINAGE OF PERINEAL URINARY EXTRAVASATION;							
53080	UNCOMPLICATED (SEPARATE		\$289.93	\$289.93				

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							Base		-
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit		
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes	
Oode	1 Toocaaro Besonption	I A IIId	(i dointy)	(Norm domity)	Comp.	Comp.	Value	110103	_
53085	DRAINAGE OF PERINEAL URINARY EXTRAVASATION; COMPLICATED		\$481.81	\$481.81					
53200	BIOPSY OF URETHRA		\$108.42	\$108.42					_
53210	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; FEMALE		\$537.99	\$537.99					
53215	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; MALE		\$719.67	\$719.67					
53220	EXCISION OR FULGURATION OF CARCINOMA OF URETHRA		\$332.93	\$332.93					
	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE);		,						
53230	FEMALE		\$497.16	\$497.16					
	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE);								
53235	MALE		\$428.25	\$428.25					
53240	MARSUPIALIZATION OF URETHRAL DIVERTICULUM, MALE OR FEMALE		\$304.01	\$304.01					
53250	EXCISION OF BULBOURETHRAL GLAND (COWPER'S GLAND)		\$285.31	\$285.31					
	· · · · · · · · · · · · · · · · · · ·								
53260	EXCISION OR FULGURATION; URETHRAL POLYP(S), DISTAL URETHRA		\$119.91	\$119.91					
53265	EXCISION OR FULGURATION; URETHRAL CARUNCLE		\$145.86	\$145.86					
53270	EXCISION OR FULGURATION; SKENE'S GLANDS		\$101.62	\$112.88					
53275	EXCISION OR FULGURATION; URETHRAL PROLAPSE		\$197.87	\$197.87					
	URETHROPLASTY; FIRST STAGE, FOR FISTULA, DIVERTICULUM, OR								
53400	STRICTURE (E		\$564.79	\$564.79					
	URETHROPLASTY; SECOND STAGE (FORMATION OF URETHRA),								
53405	INCLUDING URINARY		\$709.82	\$709.82					
	URETHROPLASTY, ONE-STAGE RECONSTRUCTION OF MALE								
53410	ANTERIOR URETHRA		\$707.47	\$707.47					
	URETHROPLASTY, TRANSPUBIC OR PERINEAL, ONE STAGE, FOR								
53415	RECONSTRUCTION O		\$889.18	\$889.18					

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	olumn indicates Prior Auth is required		<u> </u>					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF							
53420	PROSTATIC OR		\$561.11	\$707.02				
	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF							
53425	PROSTATIC OR		\$714.92	\$714.92				
53430	URETHROPLASTY, RECONSTRUCTION OF FEMALE URETHRA		\$666.51	\$666.51				
	URETHROPLASTY WITH TUBULARIZATION OF POSTERIOR URETHRA							
53431	AND/ OR LOWER		\$808.61	\$808.61				
	SLING OPERATION FOR CORRECTION OF MALE URINARY							
53440	INCONTINENCE (EG, FASCI		\$723.37	\$723.37				
	REMOVAL OR REVISION OF SLING FOR MALE URINARY							
53442	INCONTINENCE (EG, FASCIA		\$397.99	\$397.99				
53444	INSERTION OF TANDEM CUFF (DUAL CUFF)		\$577.30	\$577.30				
	INSERTION OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER,							
53445	INCLUDING		\$886.61	\$886.61				
	REMOVAL OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER,							
53446	INCLUDING PUMP,		\$528.03	\$528.03				
	REMOVAL AND REPLACEMENT OF INFLATABLE URETHRAL/BLADDER							
53447	NECK SPHINCTER		\$630.29	\$630.29				
	REMOVAL AND REPLACEMENT OF INFLATABLE URETHRAL/BLADDER							
53448	NECK SPHINCTER		\$959.21	\$959.21				
	REPAIR OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER,							
53449	INCLUDING PUMP,		\$514.28	\$514.28				
53450	URETHROMEATOPLASTY, WITH MUCOSAL ADVANCEMENT		\$247.90	\$247.90				
	URETHROMEATOPLASTY, WITH PARTIAL EXCISION OF DISTAL							
53460	URETHRAL SEGMENT		\$268.12	\$268.12				
	URETHROLYSIS, TRANSVAGINAL, SECONDARY, OPEN, INCLUDING							
53500	CYSTOURETHROSCO		\$533.60	\$533.60				

Physician	n Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY,							
53502	FEMALE		\$358.48	\$358.48				
50505	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY;		# 000 00	# 000 00				
53505	PENILE		\$362.90	\$362.90				
E0E40	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PERINEAL		¢404.07	¢404.07				
53510	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY;		\$484.07	\$484.07				
53515	PROSTATOMEMBRANOUS		\$636.54	\$636.54				
33313	CLOSURE OF URETHROSTOMY OR URETHROCUTANEOUS FISTULA,		φ030.34	\$030.34			+	
53520	MALE (SEPARATE		\$412.50	\$412.50				
00020	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR		ψ+12.00	Ψ+12.00				
53600	URETHRAL DILATOR		\$40.66	\$45.09				
	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR		Ψ 10.00	ψ 10.00				
53601	URETHRAL DILATOR		\$33.37	\$37.26				
	DILATION OF URETHRAL STRICTURE OR VESICAL NECK BY PASSAGE			,				
53605	OF SOUND OR		\$51.11	\$51.11				
	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND							
53620	FOLLOWER, MA		\$55.05	\$61.36				
	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND							
53621	FOLLOWER, MA		\$45.68	\$50.78				
	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR							
53660	INSTILLATION;		\$25.32	\$29.07				
	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR							
53661	INSTILLATION;		\$25.21	\$28.56				
	DILATION OF FEMALE URETHRA, GENERAL OR CONDUCTION							
53665	(SPINAL) ANESTHESIA		\$32.93	\$32.93				

Physician	n Fee Schedule 2020							
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The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY							
53850	MICROWAVE THERMOTHERA		\$461.57	\$461.57				
	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY							
53852	RADIOFREQUENCY		\$482.44	\$482.44				
53854	TRURL DSTRJ PRST8 TISS RF WV		\$304.20	\$1,378.87				Effective 1/1/2019
	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT,							
53855	INCLUDING URETHRAL MEASUREMENT		\$63.06	\$465.45				
	TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE							
	FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS							
53860	URINARY INCONTINENCE		\$204.13	\$1,274.92				
53899	UNLISTED PROCEDURE, URINARY SYSTEM		\$50.00	\$0.00				
	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE							
54000	PROCEDURE); NEWBORN		\$62.32	\$62.32				
	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE							
54001	PROCEDURE); EXCEPT NE		\$87.51	\$87.51				
54015	INCISION AND DRAINAGE OF PENIS, DEEP		\$175.86	\$175.86				
	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,							
54050	MOLLUSCUM		\$40.74	\$45.84				
	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,							
54055	MOLLUSCUM		\$44.56	\$52.74				
	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,							
54056	MOLLUSCUM		\$43.00	\$50.11				
	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,							
54057	MOLLUSCUM		\$80.79	\$80.79				
	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,							
54060	MOLLUSCUM		\$89.46	\$89.46				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tilary Char		;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		no.					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA,	PAIIIU	(Facility)	(NOTIFACILITY)	Comp.	Comp.	Value	Notes
54065	MOLLUSCUM		\$108.74	\$141.87				
54100	BIOPSY OF PENIS; (SEPARATE PROCEDURE)		\$74.89	\$74.89				
54105	BIOPSY OF PENIS; DEEP STRUCTURES		\$131.00	\$131.00			+	
54110	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE);		\$460.02	\$460.02				
34110	EXCISION OF PENILE PLAQUE (PETRONIE DISEASE); WITH GRAFT TO		\$400.0Z	Φ400.02				
54111	5 CM IN LE		\$652.14	\$652.14				
34111	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE); WITH GRAFT		φ032.14	Φ 032.14				
54112	GREATER THAN		\$762.71	\$762.71				
34112	REMOVAL FOREIGN BODY FROM DEEP PENILE TISSUE (EG, PLASTIC		\$702.71	φ/02./ I				
54115	IMPLANT)		\$289.48	\$289.48				
54120	AMPUTATION OF PENIS; PARTIAL		\$459.74	\$459.74				
54125	AMPUTATION OF PENIS, PARTIAL AMPUTATION OF PENIS; COMPLETE		\$714.09	\$714.09				
34123	AMPUTATION OF PENIS, COMPLETE AMPUTATION OF PENIS, RADICAL; WITH BILATERAL		\$7.14.09	φ7 14.09				
54130	INGUINOFEMORAL LYMPHADENE		\$980.46	\$980.46				
34130	AMPUTATION OF PENIS, RADICAL; IN CONTINUITY WITH BILATERAL		\$900.40	\$900.40				
54135	PELVIC		\$1,252.25	\$1,252.25				
54150	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; NEWBORN		\$76.27	\$76.27				
54 150	CIRCUMCISION, USING CLAMP OR OTHER DEVICE, NEWBORN CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE		\$10.21	\$10.21				
E4460	· · · · · · · · · · · · · · · · · · ·		¢400.00	¢400.00				
54160	OR DORSAL SLI CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE		\$120.93	\$120.93				
E4161	OR DORSAL SLI		\$158.28	\$158.28				
54161 54162	LYSIS OR EXCISION OF PENILE POST-CIRCUMCISION ADHESIONS		\$165.26	\$165.28				
54162	REPAIR INCOMPLETE CIRCUMCISION			\$165.95				
54163	FRENULOTOMY OF PENIS		\$156.40 \$136.87	\$136.40				
54200	INJECTION PROCEDURE FOR PEYRONIE DISEASE;	1	\$34.66	\$38.95				

Physician	Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INJECTION PROCEDURE FOR PEYRONIE DISEASE; WITH SURGICAL							
54205	EXPOSURE OF PL		\$360.48	\$360.48				
54220	IRRIGATION OF CORPORA CAVERNOSA FOR PRIAPISM		\$117.52	\$117.52				
54230	INJECTION PROCEDURE FOR CORPORA CAVERNOSOGRAPHY		\$60.45	\$78.42				
	DYNAMIC CAVERNOSOMETRY, INCLUDING INTRACAVERNOSAL							
54231	INJECTION OF VASOACT	R	\$101.89	\$101.89				
E 400E	INJECTION OF CORPORA CAVERNOSA WITH PHARMACOLOGIC		* 4.4.00	47.40				
54235	AGENT(S) (EG, PAPAVE		\$41.66	\$47.42	MAA 00	ΦE0. E0		
54240	PENILE PLETHYSMOGRAPHY		\$67.91	\$67.91	\$14.33	\$53.58		
54250	NOCTURNAL PENILE TUMESCENCE AND/OR RIGIDITY TEST		\$88.54	\$88.54	\$8.78	\$79.77		
E 4200	PLASTIC OPERATION OF PENIS FOR STRAIGHTENING OF CHORDEE (EG, HYPOSPADI		¢ 500 50	\$500.58				
54300	PLASTIC OPERATION ON PENIS FOR CORRECTION OF CHORDEE OR		\$500.58	\$500.58				
E 4204	FOR FIRST STAG		\$610.08	\$610.08				
54304	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR		φ010.06	φ010.00		_		
54308	(INCLUDING URINARY		\$514.42	\$514.42				
34300	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR		φ514.42	φ514.42				
54312	(INCLUDING URINARY		\$659.59	\$659.59				
04012	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR		Ψ009.09	ψ039.39				
54316	(INCLUDING URINARY		\$799.99	\$799.99				
04010	URETHROPLASTY FOR THIRD STAGE HYPOSPADIAS REPAIR TO		Ψ100.00	ψ100.00				
54318	RELEASE PENIS FROM		\$536.17	\$536.17				
01010	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT		φοσο. 17	φοσο. 17				
54322	CHORDEE OR		\$584.20	\$584.20		1		
	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT			+ · · - •		+		
54324	CHORDEE OR		\$774.40	\$774.40		1		

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT							
54326	CHORDEE OR		\$741.50	\$741.50				
	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT							
54328	CHORDEE OR		\$751.95	\$751.95				
	ONE STAGE PROXIMAL PENILE OR PENOSCROTAL HYPOSPADIAS							
54332	REPAIR REQUIRING		\$837.75	\$837.75				
	ONE STAGE PERINEAL HYPOSPADIAS REPAIR REQUIRING							
54336	EXTENSIVE DISSECTION T		\$1,094.06	\$1,094.06				
	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA,							
54340	STRICTURE, DIVERTICU		\$428.03	\$428.03				
	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA,							
54344	STRICTURE, DIVERTICU		\$918.85	\$918.85				
	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA,							
54348	STRICTURE, DIVERTICU		\$819.72	\$819.72				
	REPAIR OF HYPOSPADIAS CRIPPLE REQUIRING EXTENSIVE							
54352	DISSECTION AND EXCIS		\$1,169.73	\$1,169.73				
54360	PLASTIC OPERATION ON PENIS TO CORRECT ANGULATION		\$540.25	\$540.25				
	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO							
54380	EXTERNAL SPHINCTER		\$640.32	\$640.32				
	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO							
54385	EXTERNAL SPHINCTER		\$735.00	\$735.00				
	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO							
54390	EXTERNAL SPHINCTER		\$1,017.70	\$1,017.70				
54400	INSERTION OF PENILE PROSTHESIS; NON-INFLATABLE (SEMI-RIGID)	R	\$577.40	\$577.40				
54401	INSERTION OF PENILE PROSTHESIS; INFLATABLE (SELF-CONTAINED)	R	\$657.84	\$657.84				

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INSERTION OF MULTI-COMPONENT, INFLATABLE PENILE							
54405	PROSTHESIS, INCLUDING	R	\$855.35	\$855.35				
	REMOVAL OF ALL COMPONENTS OF A MULTI-COMPONENT,							
54406	INFLATABLE PENILE		\$525.42	\$525.42				
= 4 4 0 0	REPAIR OF COMPONENT(S) OF A MULTI-COMPONENT, INFLATABLE		4==0.00	* ==0.00				
54408	PENILE PROSTHE		\$553.68	\$553.68				
54440	REMOVAL AND REPLACEMENT OF ALL COMPONENT(S) OF A MULTI-		# 050.00	#050.00				
54410	COMPONENT, REMOVAL AND REPLACEMENT OF ALL COMPONENTS OF A MULTI-	R	\$656.06	\$656.06				
E 4 4 4 4		l _D	Ф 7 40 ОС	Ф740 OC				
54411	COMPONENT INFLATA REMOVAL OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF-	R	\$712.26	\$712.26				
54415	CONTAINED)		\$387.83	\$387.83				
34413	REMOVAL AND REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR		φ301.03	φ301.03				
54416	INFLATABLE	R	\$505.72	\$505.72				
34410	REMOVAL AND REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR	K	φ505.72	φ303.72				
54417	INFLATABLE	R	\$625.79	\$625.79				
34417	CORPORA CAVERNOSA-SAPHENOUS VEIN SHUNT (PRIAPISM	11	Ψ023.19	φυ23.79				
54420	OPERATION), UNILATERA		\$544.18	\$544.18				
01120	CORPORA CAVERNOSA-CORPUS SPONGIOSUM SHUNT (PRIAPISM		φο++.10	φοττί το				
54430	OPERATION), UNILAT		\$484.48	\$484.48				
01100	CORPORA CAVERNOSA-GLANS PENIS FISTULIZATION (EG, BIOPSY		Ψ101.10	ψ 10 1. 10				
54435	NEEDLE, WINTER		\$285.99	\$285.99				
54437	REPAIR OF TRAUMATIC CORPOREAL TEAR)(S)		\$547.20	\$547.20				Added Effective 1/1/2016
	REPLANTATION, PENIS, COMPLETE AMPUTATION INCLUDING	1				1		
54438	URETHRAL REPAIR		\$1,107.77	\$1,107.77				Added Effective 1/1/2016
54440	PLASTIC OPERATION OF PENIS FOR INJURY		\$683.52	\$683.52			1	

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	FORESKIN MANIPULATION INCLUDING LYSIS OF PREPUTIAL							
54450	ADHESIONS AND STRET		\$52.80	\$52.80				
54500	BIOPSY OF TESTIS, NEEDLE (SEPARATE PROCEDURE)		\$51.46	\$51.46				
54505	BIOPSY OF TESTIS, INCISIONAL (SEPARATE PROCEDURE)		\$155.30	\$155.30				
54512	EXCISION OF EXTRAPARENCHYMAL LESION OF TESTIS		\$385.12	\$385.12				
	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR							
54520	WITHOUT TESTICULA		\$299.72	\$299.72				
54522	ORCHIECTOMY, PARTIAL		\$437.11	\$437.11				
54530	ORCHIECTOMY, RADICAL, FOR TUMOR; INGUINAL APPROACH		\$450.97	\$450.97				
	ORCHIECTOMY, RADICAL, FOR TUMOR; WITH ABDOMINAL							
54535	EXPLORATION		\$589.24	\$589.24				
	EXPLORATION FOR UNDESCENDED TESTIS (INGUINAL OR SCROTAL							
54550	AREA)		\$371.61	\$371.61				
	EXPLORATION FOR UNDESCENDED TESTIS WITH ABDOMINAL		7011101	V • • • • • • • • • • • • • • • • • • •				
54560	EXPLORATION		\$520.54	\$520.54				
0.000	REDUCTION OF TORSION OF TESTIS, SURGICAL, WITH OR WITHOUT		+	V 0=0.0.				
54600	FIXATION OF		\$328.95	\$328.95				
54620	FIXATION OF CONTRALATERAL TESTIS		\$234.69	\$234.69				
0.020	ORCHIOPEXY, INGUINAL APPROACH, WITH OR WITHOUT HERNIA		+	420 00				
54640	REPAIR		\$349.46	\$349.46				Updated Effective 01/01/2020
01010	ORCHIOPEXY, ABDOMINAL APPROACH, FOR INTRA-ABDOMINAL		φοτο.το	φοτοιτο				Opadica Elicotive 6 1/6 1/2626
54650	TESTIS (EG,		\$552.58	\$552.58				
3-000			ψ002.00	ψυυΣ.υυ			+	
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)		\$240.31	\$240.31				
54670	SUTURE OR REPAIR OF TESTICULAR INJURY		\$303.60	\$303.60			+	+
57070	TRANSPLANTATION OF TESTIS(ES) TO THIGH (BECAUSE OF		ψυσυ.συ	ψυσυ.συ				+
54680	SCROTAL DESTRUCTION		\$577.44	\$577.44				
34000	JOCKOTAL DESTRUCTION		φυτι.44	φ311. 44				

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	olumn indicates Prior Auth is required	<u> </u>						
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r physiciai	าร					
_							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
54690	LAPAROSCOPY, SURGICAL; ORCHIECTOMY	R	\$516.32	\$516.32				
	LAPAROSCOPY, SURGICAL; ORCHIOPEXY FOR INTRA-ABDOMINAL							
54692	TESTIS	R	\$535.70	\$535.70				
	INCISION AND DRAINAGE OF EPIDIDYMIS, TESTIS AND/OR SCROTAL							
54700	SPACE (EG,		\$125.99	\$125.99				
54800	BIOPSY OF EPIDIDYMIS, NEEDLE		\$125.83	\$125.83				
54830	EXCISION OF LOCAL LESION OF EPIDIDYMIS		\$252.39	\$252.39				
54840	EXCISION OF SPERMATOCELE, WITH OR WITHOUT EPIDIDYMECTOMY		\$288.49	\$288.49				
54860	EPIDIDYMECTOMY; UNILATERAL		\$327.17	\$327.17				
54861	EPIDIDYMECTOMY; BILATERAL		\$463.89	\$463.89				
54865	EXPLORATION EPIDIDYMIS		\$256.84	\$256.84				
	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS							
54900	DEFERENS; UNILATE		\$631.22	\$631.22				
	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS							
54901	DEFERENS; BILATER		\$866.44	\$866.44				
	PUNCTURE ASPIRATION OF HYDROCELE, TUNICA VAGINALIS, WITH							
55000	OR WITHOUT		\$48.30	\$53.66				
55040	EXCISION OF HYDROCELE; UNILATERAL		\$295.37	\$295.37				
55041	EXCISION OF HYDROCELE; BILATERAL		\$436.60	\$436.60				
55060	REPAIR OF TUNICA VAGINALIS HYDROCELE (BOTTLE TYPE)		\$275.80	\$275.80				
55100	DRAINAGE OF SCROTAL WALL ABSCESS		\$78.17	\$78.17				
55110	SCROTAL EXPLORATION		\$257.26	\$257.26				
55120	REMOVAL OF FOREIGN BODY IN SCROTUM		\$193.38	\$193.38				
55150	RESECTION OF SCROTUM		\$354.28	\$354.28				
55175	SCROTOPLASTY; SIMPLE		\$276.76	\$276.76				
55180	SCROTOPLASTY; COMPLICATED		\$498.61	\$498.61				

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	Fee Schedule 2020						1	
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service				1	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						1	
	e lab fee schedule for covered codes not listed below in the 80000-89249 r						1	
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns				1	
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	VASOTOMY, CANNULIZATION WITH OR WITHOUT INCISION OF VAS,							
55200	UNILATERAL OR		\$179.18	\$179.18				
	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE),							
55250	INCLUDING	R	\$136.27	\$171.54				
	VASOTOMY FOR VASOGRAMS, SEMINAL VESICULOGRAMS, OR							
55300	EPIDIDYMOGRAMS,		\$182.24	\$182.24				
55400	VASOVASOSTOMY, VASOVASORRHAPHY		\$433.10	\$433.10				
	EXCISION OF HYDROCELE OF SPERMATIC CORD, UNILATERAL							
55500	(SEPARATE PROCEDUR		\$282.95	\$282.95				
55520	EXCISION OF LESION OF SPERMATIC CORD (SEPARATE PROCEDURE)		\$263.92	\$263.92				
	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR							
55530	VARICOCELE;		\$313.98	\$313.98				
	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR							
55535	VARICOCELE;		\$312.35	\$312.35				
	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR							
55540	VARICOCELE;		\$356.62	\$356.62				
	LAPAROSCOPY, SURGICAL, WITH LIGATION OF SPERMATIC VEINS							
55550	FOR VARICOCELE	R	\$304.18	\$304.18				
55600	VESICULOTOMY;		\$307.08	\$307.08			1	
55605	VESICULOTOMY; COMPLICATED		\$387.55	\$387.55	1		1	
55650	VESICULECTOMY, ANY APPROACH		\$542.53	\$542.53				
55680	EXCISION OF MULLERIAN DUCT CYST		\$269.49	\$269.49				
	BIOPSY, PROSTATE; NEEDLE OR PUNCH, SINGLE OR MULTIPLE, ANY							
55700	APPROACH		\$69.83	\$89.95				
55705	BIOPSY, PROSTATE; INCISIONAL, ANY APPROACH		\$228.06	\$228.06				
55706	BIOPSIES, PROSTATE, NEEDLE, TRANSPERINEAL		\$324.29	\$324.29				

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary chai	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Than y on an	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		<u> </u>						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS,		(i domey)	(itom domey)			1000	
55720	ANY APPROACH; SI		\$324.39	\$324.39				
	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS,		7	7				
55725	ANY APPROACH;		\$389.81	\$389.81				
-	PROSTATECTOMY, PERINEAL, SUBTOTAL (INCLUDING CONTROL OF		7,000.00	700000				
55801	POSTOPERATIVE		\$854.07	\$854.07				
55810	PROSTATECTOMY, PERINEAL RADICAL;		\$1,144.96	\$1,144.96				
	PROSTATECTOMY, PERINEAL RADICAL; WITH LYMPH NODE		, ,	, , , ,				
55812	BIOPSY(S) (LIMITED PE		\$1,274.01	\$1,274.01				
	PROSTATECTOMY, PERINEAL RADICAL; WITH BILATERAL PELVIC							
55815	LYMPHADENECTOMY		\$1,570.12	\$1,570.12				
	PROSTATECTOMY (INCLUDING CONTROL OF POSTOPERATIVE							
55821	BLEEDING, VASECTOMY,		\$778.78	\$778.78				
	PROSTATECTOMY (INCLUDING CONTROL OF POSTOPERATIVE							
55831	BLEEDING, VASECTOMY,		\$845.13	\$845.13				
	PROSTATECTOMY, RETROPUBIC RADICAL, WITH OR WITHOUT							
55840	NERVE SPARING;		\$1,106.74	\$1,106.74				
	PROSTATECTOMY, RETROPUBIC RADICAL, WITH OR WITHOUT							
55842	NERVE SPARING; WITH		\$1,225.69	\$1,225.69				
	PROSTATECTOMY, RETROPUBIC RADICAL, WITH OR WITHOUT							
55845	NERVE SPARING; WITH		\$1,516.87	\$1,516.87				
	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF							
55860	RADIOACTIVE SUBST		\$599.40	\$599.40				
	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF							
55862	RADIOACTIVE SUBST		\$844.19	\$844.19				
	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF							
55865	RADIOACTIVE SUBST		\$1,351.03	\$1,351.03				

Physician	Fee Schedule 2020		1		1	1		
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	ornary orial	The service	,				
	te lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAPAROSCOPY, SURGICAL PROSTATECTOMY, RETROPUBIC							
55866	RADICAL, INCLUDING NER		\$1,223.28	\$1,223.28				
	CRYOSURGICAL ABLATION OF THE PROSTATE (INCLUDES							
55873	ULTRASONIC GUIDANCE FO		\$799.77	\$799.77				
55874	TPRNL PLMT BIODEGRDABL MATRL		\$133.33	\$2,761.79				Added Effective 1/1/2018
55875	TRANSPERINEAL NEEDLE PLACEMENT PROSTATE		\$567.59	\$567.59				
	PLACEMENT INTERSTITIAL DEVICE FOR PROSTATE RADIATION							
55876	THERAPY		\$83.05	\$108.68				
55899	UNLISTED PROCEDURE, MALE GENITAL SYSTEM	R	\$0.00	\$0.00				
55920	PLACE NEEDLES PELVIC FOR RT		\$356.93	\$356.93				
56405	INCISION AND DRAINAGE OF VULVA OR PERINEAL ABSCESS		\$54.62	\$64.82				
56420	INCISION AND DRAINAGE OF BARTHOLIN'S GLAND ABSCESS		\$53.21	\$63.94				
56440	MARSUPIALIZATION OF BARTHOLIN'S GLAND CYST		\$165.05	\$165.05				
56441	LYSIS OF LABIAL ADHESIONS		\$107.89	\$107.89				
56442	HYMENOTOMY, SIMPLE INCISION		\$34.55	\$34.55				
	DESTRUCTION OF LESION(S), VULVA; SIMPLE (EG, LASER SURGERY,							
56501	ELECTROSUR		\$53.34	\$60.59				
	DESTRUCTION OF LESION(S), VULVA; EXTENSIVE (EG, LASER							
56515	SURGERY,		\$133.62	\$133.62				
	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); ONE							
56605	LESION		\$38.00	\$47.12				
	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); EACH							
56606	SEPARATE ADDITI		\$19.26	\$23.95				
56620	VULVECTOMY SIMPLE; PARTIAL		\$403.28	\$403.28				
56625	VULVECTOMY SIMPLE; COMPLETE		\$524.54	\$524.54				
56630	VULVECTOMY, RADICAL, PARTIAL;		\$747.95	\$747.95				
56631	VULVECTOMY, RADICAL, PARTIAL; WITH UNILATERAL INGUINOFEMORAL		\$1,038.69	\$1,038.69				

Physician	Fee Schedule 2020							
Note:	The Continuation 2020							
	les in Red;							
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The Apoc	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Jiliary Gilai T		;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	ranga						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		no.					
Codes iis		or priysicia T	115					
		+					Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)		Comp.	Value	Notes
Code	VULVECTOMY, RADICAL, PARTIAL; WITH BILATERAL	PAIIIU	(Facility)	(NOTIFACILITY)	Comp.	Comp.	Value	Notes
56632	INGUINOFEMORAL LYMPHADENE		\$1,228.98	\$1,228.98				
56633	VULVECTOMY, RADICAL, COMPLETE;		\$864.57	\$864.57				
30033	VULVECTOMY, RADICAL, COMPLETE, VULVECTOMY, RADICAL, COMPLETE; WITH UNILATERAL		\$004.5 <i>1</i>	\$604.57				
56634	INGUINOFEMORAL		\$1,155.31	\$1,155.31				
30034	VULVECTOMY, RADICAL, COMPLETE; WITH BILATERAL		\$1,100.01	φ1,100.01				
ECC27			£4 000 00	¢4 000 00				
56637	INGUINOFEMORAL VULVECTOMY, RADICAL, COMPLETE, WITH INGUINOFEMORAL, ILIAC,		\$1,280.96	\$1,280.96				
ECC 40	AND PELVIC		¢4 000 FF	¢4 000 EE				
56640			\$1,230.55	\$1,230.55				
56700	PARTIAL HYMENECTOMY OR REVISION OF HYMENAL RING	-	\$128.33	\$128.33				
56740	EXCISION OF BARTHOLIN'S GLAND OR CYST	-	\$195.98	\$195.98				
56800	PLASTIC REPAIR OF INTROITUS	-	\$201.62	\$201.62				
56805	CLITOROPLASTY FOR INTERSEX STATE		\$802.98	\$802.98				
50040	PERINEOPLASTY, REPAIR OF PERINEUM, NONOBSTETRICAL		*	# 400.40				
56810	(SEPARATE PROCEDURE)		\$199.16	\$199.16				
56820	COLPOSCOPY OF THE VULVA;		\$62.47	\$87.91				
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY(S)		\$86.02	\$114.28				
57000	COLPOTOMY; WITH EXPLORATION		\$148.64	\$148.64				
57010	COLPOTOMY; WITH DRAINAGE OF PELVIC ABSCESS		\$242.22	\$242.22				
57020	COLPOCENTESIS (SEPARATE PROCEDURE)		\$64.85	\$64.85				
	INCISION AND DRAINAGE OF VAGINAL HEMATOMA;							
57022	OBSTETRICAL/POSTPARTUM	1	\$118.47	\$118.47				
	INCISION AND DRAINAGE OF VAGINAL HEMATOMA; NON-							
57023	OBSTETRICAL (EG,		\$118.47	\$118.47				
57061	DESTRUCTION OF VAGINAL LESION(S); SIMPLE (EG, LASER SURGERY,	,	\$50.34	\$61.34				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DESTRUCTION OF VAGINAL LESION(S); EXTENSIVE (EG, LASER							
57065	SURGERY,		\$181.08	\$181.08				
57100	BIOPSY OF VAGINAL MUCOSA; SIMPLE (SEPARATE PROCEDURE)		\$39.94	\$48.25				
	BIOPSY OF VAGINAL MUCOSA; EXTENSIVE, REQUIRING SUTURE							
57105	(INCLUDING CYSTS		\$98.25	\$98.25				
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;		\$265.09	\$267.16				
	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL; WITH							
57107	REMOVAL OF PARAVAGI		\$903.73	\$908.39				
	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL; WITH							
57109	REMOVAL OF PARAVAGI		\$1,092.33	\$1,103.74				
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;		\$649.67	\$649.67				
	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL; WITH							
57111	REMOVAL OF PARAVAG		\$1,094.14	\$1,094.14				
	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL; WITH							
57112	REMOVAL OF PARAVAG		\$1,165.45	\$1,166.48				
57120	COLPOCLEISIS (LE FORT TYPE)		\$421.66	\$421.66				
57130	EXCISION OF VÄGINAL SEPTUM		\$154.06	\$154.06				
57135	EXCISION OF VAGINAL CYST OR TUMOR		\$138.47	\$138.47				
	IRRIGATION OF VAGINA AND/OR APPLICATION OF MEDICAMENT FOR							
57150	TREATMENT OF		\$31.10	\$33.65				
	INSERTION OF UTERINE TANDEMS AND/OR VAGINAL OVOIDS FOR							
57155	CLINICAL		\$290.92	\$290.92				
	INSERTION OF A VAGINAL RADIATION AFTERLOADING APPARATUS		1					†
57156	FOR CLINICAL BRACHYTHERAPY		\$89.60	\$130.84				
	FITTING AND INSERTION OF PESSARY OR OTHER INTRAVAGINAL		*					
57160			\$30.68	\$34 04				
57160	SUPPORT DEVICE		\$30.68	\$34.04				

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	Fee Schedule 2020							
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	ted as ' 0.00 " pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS		\$32.45	\$36.74				
	INTRODUCTION OF ANY HEMOSTATIC AGENT OR PACK FOR							
57180	SPONTANEOUS OR TRAUMA		\$54.94	\$62.32				
	COLPORRHAPHY, SUTURE OF INJURY OF VAGINA							
57200	(NONOBSTETRICAL)		\$195.25	\$195.25				
	COLPOPERINEORRHAPHY, SUTURE OF INJURY OF VAGINA AND/OR							
57210	PERINEUM		\$242.30	\$242.30				
	PLASTIC OPERATION ON URETHRAL SPHINCTER, VAGINAL							
57220	APPROACH (EG, KELLY		\$252.09	\$252.09				
57230	PLASTIC REPAIR OF URETHROCELE		\$267.32	\$267.32				
	ANTERIOR COLPORRHAPHY, REPAIR OF CYSTOCELE WITH OR							
57240	WITHOUT REPAIR OF		\$382.11	\$382.11				
	POSTERIOR COLPORRHAPHY, REPAIR OF RECTOCELE WITH OR							
57250	WITHOUT PERINEORRH		\$357.20	\$357.20				
57260	COMBINED ANTEROPOSTERIOR COLPORRHAPHY;		\$500.41	\$500.41				
	COMBINED ANTEROPOSTERIOR COLPORRHAPHY; WITH							
57265	ENTEROCELE REPAIR		\$519.90	\$519.90				
	INSERTION OF MESH OR OTHER PROSTHESIS FOR REPAIR OF							
57267	PELVIC FLOOR DEFEC		\$211.63	\$211.63				
	REPAIR OF ENTEROCELE, VAGINAL APPROACH (SEPARATE							
57268	PROCEDURE)		\$404.91	\$404.91				
	REPAIR OF ENTEROCELE, ABDOMINAL APPROACH (SEPARATE							
57270	PROCEDURE)		\$434.15	\$434.15				
57280	COLPOPEXY, ABDOMINAL APPROACH		\$518.76	\$518.76				
	COLPOPEXY, VAGINAL; EXTRA-PERITONEAL APPROACH							
57282	(SACROSPINOUS, ILIOCOCCY		\$516.32	\$516.32				

Physician	Fee Schedule 2020							
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Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or priysiciai	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Bus as drove December to a	DA In al	•					Notes
Code	Procedure Description COLPOPEXY, VAGINAL; INTRA-PERITONEAL APPROACH	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
F7000			¢400.04	¢400.04				
57283	(UTEROSACRAL, LEVATOR		\$498.84	\$498.84				
F7004	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE,		# 005.07	#00F 07				
57284	STRESS URINA		\$605.87	\$605.87			_	
57285	REPAIR PARAVAG DEFECT, VAG		\$513.59	\$513.59				
	REMOVAL OR REVISION OF SLING FOR STRESS INCONTINENCE (EG,							
57287	FASCIA OR		\$505.43	\$505.43				
	SLING OPERATION FOR STRESS INCONTINENCE (EG, FASCIA OR							
57288	SYNTHETIC)		\$682.68	\$682.68				
57289	PEREYRA PROCEDURE, INCLUDING ANTERIOR COLPORRHAPHY		\$434.93	\$434.93				
57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT		\$391.32	\$391.32				
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT		\$571.32	\$571.32				
	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT,							
57295	VAGINAL APPR		\$357.90	\$357.90				
57296	REVISION PROSTHETIC VAGINAL GRAFT, OPEN ABD APPROACH		\$687.77	\$687.77				
	CLOSURE OF RECTOVAGINAL FISTULA; VAGINAL OR TRANSANAL							
57300	APPROACH		\$452.33	\$452.33				
57305	CLOSURE OF RECTOVAGINAL FISTULA; ABDOMINAL APPROACH		\$495.41	\$495.41				
	CLOSURE OF RECTOVAGINAL FISTULA; ABDOMINAL APPROACH,							
57307	WITH CONCOMITANT		\$489.89	\$489.89				
	CLOSURE OF RECTOVAGINAL FISTULA; TRANSPERINEAL APPROACH,							
57308	WITH PERINEAL		\$507.22	\$507.22				
57310	CLOSURE OF URETHROVAGINAL FISTULA;		\$306.53	\$306.53				
	CLOSURE OF URETHROVAGINAL FISTULA; WITH							
57311	BULBOCAVERNOSUS TRANSPLANT		\$371.78	\$371.78				
57320	CLOSURE OF VESICOVAGINAL FISTULA; VAGINAL APPROACH		\$499.48	\$499.48				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
	CPT book for descriptions							
R" in PA o	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CLOSURE OF VESICOVAGINAL FISTULA; TRANSVESICAL AND							
57330	VAGINAL APPROACH		\$584.47	\$584.47				
57335	VAGINOPLASTY FOR INTERSEX STATE		\$900.98	\$900.98				Rate updated 1/1/2018
57400	DILATION OF VAGINA UNDER ANESTHESIA		\$34.66	\$34.66				
57410	PELVIC EXAMINATION UNDER ANESTHESIA		\$28.18	\$28.18				
57415	REMOVAL OF IMPACTED VAGINAL FOREIGN BODY		\$37.57	\$37.57				
F7400	COLDOCCODY OF THE ENTIRE VACINA WITH CERVIVE PRECENT.		#CC 20	¢04.00				
57420	COLPOSCOPY OF THE ENTIRE VACINA, WITH CERVIX IF PRESENT;		\$66.38	\$91.82				
E7404	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT;		#04.00	\$120.14				
57421 57423	WITH BIOPSY(S REPAIR PARAVAG DEFECT, LAP		\$91.88 \$717.12	\$717.12				
57423	LAPAROSCOPY, SURGICAL, COLPOPEXY (SUSPENSION OF VAGINAL		\$7.17.12	Φ/ 1/.1 2				
57425	APEX)		\$669.30	\$669.30				
37423	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT,		φ009.30	\$009.30				
57426	LAPAROSCOPIC APPROACH		\$638.39	\$638.39				
37420	LAFAROSCOFIC AFFROACTI		φυσυ.σε	φ030.39				+
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA:		\$41.17	\$49.89				
31432	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT		Ψ+1.17	ψ+9.09				
57454	VAGINA; WITH BIOPSY(\$59.81	\$76.04				
07 404	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT		φοσιστ	Ψ7 0.0 -1				
57455	VAGINA; WITH BIOPSY(\$83.52	\$110.50				
07 100	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT		Ψ00.02	ψ110.00				
57456	VAGINA; WITH ENDOCER		\$78.21	\$104.42				
350	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT		7. 5	Ţ <u>-</u>				
57460	VAGINA; WITH LOOP		\$121.31	\$148.40				
	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT							
57461	VAGINA; WITH LOOP		\$144.83	\$242.98				

Physician	Fee Schedule 2020							
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	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required				+			
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv char	ge for the service		+			
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
_								
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	BIOPSY, SINGLE OR MULTIPLE, OR LOCAL EXCISION OF LESION,		•	,		-		
57500	WITH OR WITHO		\$39.02	\$46.67				
	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION							
57505	AND CURETTAGE)		\$43.59	\$52.04				
57510	CAUTERY OF CERVIX; ELECTRO OR THERMAL		\$63.45	\$70.42				
57511	CAUTERY OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT		\$69.82	\$81.22				
57513	CAUTERY OF CERVIX; LASER ABLATION		\$133.87	\$133.87				
	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH							
57520	OR WITHOUT DIL		\$226.47	\$226.47				
	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH							
57522	OR WITHOUT DIL		\$205.93	\$205.93				
	TRACHELECTOMY (CERVICECTOMY), AMPUTATION OF CERVIX							
57530	(SEPARATE PROCEDURE		\$245.48	\$245.48				
	RADICAL TRACHELECTOMY, WITH BILATERAL TOTAL PELVIC							
57531	LYMPHADENECTOMY AND		\$1,187.54	\$1,187.54				
57540	EXCISION OF CERVICAL STUMP, ABDOMINAL APPROACH;		\$393.83	\$393.83				
	EXCISION OF CERVICAL STUMP, ABDOMINAL APPROACH; WITH							
57545	PELVIC FLOOR REPA		\$342.42	\$342.42				
57550	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH;		\$349.94	\$349.94				
	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH							
57555	ANTERIOR AND/OR		\$562.49	\$562.49				
	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH REPAIR		A=0.4.65	4504.65				
57556	OF ENTEROCEL		\$521.69	\$521.69				
57558	D&C CERVICAL STUMP		\$82.15	\$90.27				
57700	CERCLAGE OF UTERINE CERVIX, NONOBSTETRICAL		\$169.20	\$169.20				
	TRACHELORRHAPHY, PLASTIC REPAIR OF UTERINE CERVIX,			4.00 = :				
57720	VAGINAL APPROACH		\$199.74	\$199.74				

Physician Foe Schedule 2020 Note: 2020 Codes in Red; Refer to CPT book for descriptions R° in PA column indicates Prior Auth is required Codes listed as \$50.0° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed as \$50.0° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covared codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proce	Dhysisian	Fac Cabadula 2020			1			1	
Regir to CPT book for descriptions		ree Schedule 2020							
Refer to CPT book for descriptions Rin Pa Acolumin indicates Prior Auth is required Codes listed as \$0.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anaethrias Base Ratio is \$15.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Proc Code Procedure Description DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE S7800 PROCEDURE) ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT S0100 ENDOCERVICAL SAMPLING ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S0110 WITH COLPOSCOPY S0100 WITHOUR SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S0110 WITH COLPOSCOPY S0110 INSTAMURAL S0110 MAYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 1 TO 4 INTRAMURAL S0110 INTRAMURAL S0110 MAYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S0110 INTRAMURAL S0110 AND CONFERCION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S0110 OR WITHOUT REMO TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMO S0110 OR WITHOUT REMO TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OTAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL S0110 VALIBRE AND CORPUS AND CERVIX, WITH RADIOLAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL RADIOLAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL RADIOLAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC EXEMPTERATION FOR GYNECOLOGIC MALIGNANCY, WITH RADIOLAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC EXEMPTERATION FOR GYNECOLOGIC MALIGNANCY, WITH RADIOLAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC EXEMPTERATION FOR GYNECOLOGIC MALIGNANCY, WITH RADIOLAL ABDOMINAL HYSTERECTOMY (WITH BILATERAL TOTAL PELVI		and the Proof.					_		
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Codes Islaed as "\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service									
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the \$0000-99249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE PA Ind (Facility) Inpat. Rate (Pacility) (NonFacility) (NonFacility) Prof. Comp. Base Unit Comp. Inpat. Rate (NonFacility) Comp. Notes Base Unit Comp. Notes S1.46 \$37.90 ProceDurs ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT S100 ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S1100 ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S133.09 \$33.09 \$39.21 S157.92 S157.9			<u> </u>	1					
Please use lab fee schedule for covered codes not listed below in the 80000-99249 range.			mary char	ge for the service					<u> </u>
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description DILATION OF CERWICAL CANAL, INSTRUMENTAL (SEPARATE 57800 PROCEDURE) ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT S8100 ENDOCERWICAL SAMPLING ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S8110 WITH COLPOSCOPY S33.09 \$41.94 ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S8110 WITH COLPOSCOPY S33.09 \$39.21 S157.92 \$157.92 MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 1 TO 4 INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 1 TO 4 INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMUR MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR S8140 MORE INTRAMURAL MYOMECTOMY, WITH OR TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH S8150 OR WITHOUT REMO TOTAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL REPUBLIC EXPERTANCE OF TWO AND CERVIX, WITH REPUBLIC EXPERTANCE OF TWO AND CERVIX, WITH REPUBLIC EXPER									
Proc Procedure Description									<u> </u>
Proc Procedure Description	Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered to	or physiciar	IS T					<u> </u>
Proc Procedure Description								Page	
Code	Droo			Innet Bete	Outpot Boto	Tooh	Drof		
DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE \$31.46 \$37.90		Bus as divine Description	DA los al	•	•				Natas
S7800 PROCEDURE \$31.46 \$37.90	Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT \$33.09	57000	· · · · · · · · · · · · · · · · · · ·		#04.40	#07.00				
S8100 ENDOCERVICAL SAMPLING ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION S33.09 \$41.94	57800			\$31.40	\$37.90				<u> </u>
ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION \$33.09 \$39.21	50400			# 22.00	C44 O4				
S8110 WITH COLPOSCOPY \$33.09 \$39.21	58100			\$33.09	\$41.94				
DILATION AND CURETTAGE, DIAGNOSTIC AND/OR THERAPEUTIC \$157.92	50440			# 22.00	#20.04				
58120 (NONOBSTETRICAL) \$157.92 \$157.92 \$157.92	58110			\$33.09	\$39.21				
MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 1 TO 4 \$488.28	E0400	, and the second		¢457.00	¢457.00				
S8140 INTRAMURAL \$488.28 \$48	36120			\$157.92	\$157.92				
MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 1 TO 4 \$474.40 \$47	50140			¢400 00	¢400 20				
S8145 INTRAMURAL \$474.40 \$474.40 \$474.40 \$474.40 \$58146 MORE INTRAMUR \$819.91	36140			φ400.Z0	\$400.20				
MYOMECTOMY, EXCISION OF FIBROID TUMOR(S) OF UTERUS, 5 OR	50115			¢474.40	¢474.40				
58146 MORE INTRAMUR \$819.91 \$819.91 TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH 58150 R \$695.52 \$695.52 TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH 58152 R \$798.27 \$798.27 SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL 68180) R \$578.91 \$578.91 58180 HYSTERECTOMY), WITH OR 700 AGINECTOMY, WITH 700 AGINECTOMY, WIT	36143			φ474.4U	Φ474.40				
TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH R	59146			¢910 01	¢910.01				
58150 OR WITHOUT REMO R \$695.52 \$695.52 TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH R R \$798.27 \$798.27 58152 OR WITHOUT REMO R \$798.27 \$798.27 SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL REMOTED AND AND AND AND AND AND AND AND AND AN	36140			φ019.91	Ψ019.91				+
TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH 58152 OR WITHOUT REMO R \$798.27 \$798.27 SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR R \$578.91 \$578.91 TOTAL ABDOMINAL HYSTERECTOMY, INCLUDING PARTIAL VAGINECTOMY, WITH R \$1,013.03 \$1,013.03 RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC LYMPHADENE R \$1,274.03 \$1,274.03 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH TOTAL ABDOMINAL R \$1,764.83 \$1,764.83	58150		R	\$605.52	\$605.52				
58152 OR WITHOUT REMO R \$798.27 \$798.27 SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL R \$578.91 \$578.91 58180 HYSTERECTOMY), WITH OR R \$578.91 \$578.91 TOTAL ABDOMINAL HYSTERECTOMY, INCLUDING PARTIAL R \$1,013.03 \$1,013.03 RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL R \$1,274.03 \$1,274.03 58210 PELVIC LYMPHADENE R \$1,274.03 \$1,274.03 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH R \$1,764.83 \$1,764.83	30130		11	ψ030.32	ψ000.02				
SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL 58180 HYSTERECTOMY), WITH OR TOTAL ABDOMINAL HYSTERECTOMY, INCLUDING PARTIAL 58200 VAGINECTOMY, WITH R \$1,013.03 \$1,013.03 RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL 58210 PELVIC LYMPHADENE PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH 58240 TOTAL ABDOMINAL R \$1,764.83 \$1,764.83	58152		R	\$798 27	\$798 27				
58180 HYSTERECTOMY), WITH OR R \$578.91 \$578.91 TOTAL ABDOMINAL HYSTERECTOMY, INCLUDING PARTIAL R \$1,013.03 \$1,013.03 58200 VAGINECTOMY, WITH R \$1,013.03 \$1,013.03 RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL R \$1,274.03 \$1,274.03 58210 PELVIC LYMPHADENE R \$1,274.03 \$1,274.03 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH R \$1,764.83 \$1,764.83	00102			Ψ100.21	ψ1 30.21				+
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58200 VAGINECTOMY, WITH R \$1,013.03 \$1,013.03 RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL R \$1,274.03 \$1,274.03 58210 PELVIC LYMPHADENE R \$1,274.03 \$1,274.03 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH R \$1,764.83 \$1,764.83	30.00			Ψοιο.οι	\$370.01		1		†
RADICAL ABDOMINAL HYSTERECTOMY, WITH BILATERAL TOTAL 58210 PELVIC LYMPHADENE PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH 58240 TOTAL ABDOMINAL R \$1,274.03 \$1,274.03 \$1,764.83 \$1,764.83	58200	· ·	R	\$1 013 03	\$1 013 03				
58210 PELVIC LYMPHADENE R \$1,274.03 \$1,274.03 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH R \$1,764.83 \$1,764.83				+ -,0 -0.00	+ -,0 .0.00		1		
PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY, WITH 58240 TOTAL ABDOMINAL R \$1,764.83 \$1,764.83	58210	· · · · · · · · · · · · · · · · · · ·	R	\$1.274.03	\$1.274.03				
58240 TOTAL ABDOMINAL R \$1,764.83 \$1,764.83				+ .,=	7 .,=		1		†
1. /	58240	· ·	R	\$1.764.83	\$1.764.83				
	58260	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS;	R	\$636.38	\$636.38		1		

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	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	r pnysiciar I	18					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
58262	REMOVAL OF	D	\$685.38	\$685.38				
30202	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH	R	ψ000.00	ψ000.00				
58263	REMOVAL OF	R	\$749.48	\$749.48				
30203	INCINIOVAL OF	11	Ψ1 43.40	Ψ1+3.40				
58267	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH	R	\$778.08	\$778.08				
00201	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH		ψ110.00	ψ110.00				
58270	REPAIR OF	R	\$700.47	\$700.47				
00270	The function		φτου. ττ	ψ1 00.11				
58275	VAGINAL HYSTERECTOMY, WITH TOTAL OR PARTIAL VAGINECTOMY;	R	\$762.47	\$762.47				
	VAGINAL HYSTERECTOMY, WITH TOTAL OR PARTIAL VAGINECTOMY;		***************************************	7.5-11.				
58280	WITH REPAIR O	R	\$758.60	\$758.60				
			* ***********************************	7.00.00				
58285	VAGINAL HYSTERECTOMY, RADICAL (SCHAUTA TYPE OPERATION)	R	\$888.79	\$888.79				
			7000110	7				
58290	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS;	R	\$819.58	\$819.58				
	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250							
58291	GRAMS; WITH REMOVAL	R	\$900.96	\$900.96				
	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250							
58292	GRAMS; WITH REMOVAL	R	\$954.57	\$954.57				
	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250							
58293	GRAMS; WITH	R	\$992.02	\$992.02				
	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250							
58294	GRAMS; WITH REPAIR O	R	\$878.82	\$878.82				
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)		\$47.06	\$59.25				
58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)		\$29.40	\$35.43				

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	Fee Schedule 2020						+	
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	es in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required		<u> </u>					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	<u>18</u>					
							Dana	
			looset Dete	0.44. 0.4.	-	D	Base	
Proc		L	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	N
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
50040	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST		0.40.05	0.40.05				
58340	MATERIAL FOR SA		\$43.05	\$43.05				
500.45	TRANSCERVICAL INTRODUCTION OF FALLOPIAN TUBE CATHETER		4000.04	4000 04				
58345	FOR DIAGNOSIS AN	R	\$238.84	\$238.84			_	
50040	INCEPTION OF HEVANAN CARCHI EC FOR OUNION PRACHIVITHERARY		\$310.37	\$310.37				
58346 58350	INSERTION OF HEYMAN CAPSULES FOR CLINICAL BRACHYTHERAPY CHROMOTUBATION OF OVIDUCT, INCLUDING MATERIALS	<u> </u>	\$50.56	\$50.56				
58350	ENDOMETRIAL ABLATION, THERMAL, WITHOUT HYSTEROSCOPIC	R	\$50.56	\$50.56				
50252	, ,		¢460.06	£460.06				
58353	GUIDANCE		\$162.96	\$162.96				
50050	ENDOMETRIAL CRYOABLATION WITH ULTRASONIC GUIDANCE,		ф0 7 0 5 0	¢4 777 40				
58356	INCLUDING ENDOMETRI UTERINE SUSPENSION, WITH OR WITHOUT SHORTENING OF ROUND		\$278.58	\$1,777.40				
E0400	1		Φ0.4 <i>E</i> . <i>EE</i>	6045 55				
58400	LIGAMENTS, WIT UTERINE SUSPENSION, WITH OR WITHOUT SHORTENING OF ROUND		\$345.55	\$345.55				
E0440			¢267.60	\$367.69				
58410	LIGAMENTS, WIT HYSTERORRHAPHY, REPAIR OF RUPTURED UTERUS		\$367.69	\$307.09				-
58520	(NONOBSTETRICAL)		\$324.11	\$324.11				
36320	HYSTEROPLASTY, REPAIR OF UTERINE ANOMALY (STRASSMAN		φ324.11	φ324.11				-
58540	TYPE)		\$450.69	\$450.69				
36340	LAPAROSCOPY, SURGICAL, HYSTERECTOMY UTERUS LESS THAN		\$450.09	\$450.69				
E0E 11	250G	l _D	\$617.90	\$617.90				
58541		R	Φ017.90	φ017.90				-
E0E 40	LAPAROSCOPY, SURGICAL, HYST W/REMOVAL OF TUBES UTERUS LESS THAN 250G	l _D	\$684.88	¢604.00				
58542	LAPAROSCOPY, SURGICAL, HYSTERECTOMY UTERUS GREATER	R	φ004.0δ	\$684.88				
E0E 40		l _D	¢606 50	¢606 50				
58543	THAN 250G LAPAROSCOPY, SURGICAL, HYST W/REMOVAL OF TUBES UTERUS	R	\$696.59	\$696.59				
E0E / /		l _D	¢754.75	¢754.75				
58544	GREATER THAN 250G	R	\$754.75	\$754.75				

Physician	Fee Schedule 2020	T	1					
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech.	Prof.	Base Unit Value	Notes
Code	LAPAROSCOPY, SURGICAL, MYOMECTOMY, EXCISION; 1 TO 4	FAIIIU	(i acility)	(Non acinty)	Comp.	Comp.	Value	Notes
58545	INTRAMURAL MYOMAS		\$657.30	\$657.30				
00010	LAPAROSCOPY, SURGICAL, MYOMECTOMY, EXCISION; 5 OR MORE		Ψ007.00	Ψ001.00				
58546	INTRAMURAL MYOM		\$829.93	\$829.93				
58548	LAPAROSCOPY, SURGICAL, RADICAL HYSTERECTOMY	R	\$1,318.03	\$1,318.03				
	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR		, , , , , , , , , , , , , , , , , , , ,	, , ,				
58550	UTERUS 250 GRAMS	R	\$649.94	\$649.94				
	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR							
58552	UTERUS 250 GRAMS	R	\$640.10	\$640.10				
	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR							
58553	UTERUS GREATER T	R	\$824.72	\$824.72				
	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR							
58554	UTERUS GREATER T	R	\$816.75	\$816.75				
58555	HYSTEROSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE)		\$162.74	\$162.74				
	HYSTEROSCOPY, SURGICAL; WITH SAMPLING (BIOPSY) OF							
<mark>58558</mark>	ENDOMETRIUM AND/OR		\$213.26	\$213.26				Updated Effective 01/01/2020
	HYSTEROSCOPY, SURGICAL; WITH LYSIS OF INTRAUTERINE							
58559	ADHESIONS (ANY METH		\$273.34	\$273.34				
	HYSTEROSCOPY, SURGICAL; WITH DIVISION OR RESECTION OF			4000				
58560	INTRAUTERINE SEP		\$302.82	\$302.82				
58561	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF LEIOMYOMATA		\$426.04	\$426.04				
E0E60	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF IMPACTED FOREIGN BODY		¢242.70	¢042.70				
58562	HYSTEROSCOPY, SURGICAL; WITH ENDOMETRIAL ABLATION (EG,		\$213.72	\$213.72				
58563	ENDOMETRIAL		\$281.64	\$281.64				

Physician	n Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	rge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	That y Chai	T The service	,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		L ne					+
OCCCO III	The lab lee solicadic that begin with a 1 of Q are currently non covered to	T priyolola						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
-	110000010 200011 11000001	71110	(i domey)	(item demity)			7 4.145	Place of Service (POS) 22
	HYSTEROSCOPY, SURGICAL; WITH BILATERAL FALLOPIAN TUBE							will pay \$338.62 effective
58565	CANNULATION TO I	R	\$338.62	\$338.62				1/1/2011
58570	TLH FOR UTERUS 250G OR LESS	R	\$712.97	\$712.97				
58571	TLH W/T/O 250G OR LESS	R	\$780.91	\$780.91				
58572	TLH, UTERUS OVER 250G	R	\$886.24	\$886.24				
58573	TLH W/T/O UTERUS OVER 250G	R	\$999.29	\$999.29				
58575	LAPS TOT HYST RESJ MAL		\$1,481.83	\$1,481.83				Added Effective 1/1/2018
58578	UNLISTED LAPAROSCOPY PROCEDURE, UTERUS	R	\$0.00	\$0.00				
58579	UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS	R	\$0.00	\$0.00				
	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR							
58600	VAGINAL	R	\$271.75	\$271.75				
	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR							
58605	VAGINAL	R	\$234.00	\$234.00				
	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S) WHEN DONE AT							
58611	THE TIME OF	R	\$33.52	\$33.52				
	OCCLUSION OF FALLOPIAN TUBE(S) BY DEVICE (EG, BAND, CLIP,							
58615	FALOPE RING)	R	\$199.53	\$199.53				
	LAPAROSCOPY, SURGICAL; WITH LYSIS OF ADHESIONS							
58660	(SALPINGOLYSIS, OVARIOL	R	\$497.38	\$497.38				
	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF ADNEXAL							
58661	STRUCTURES (PARTIAL OR	R	\$503.77	\$503.77				
	LAPAROSCOPY, SURGICAL; WITH FULGURATION OR EXCISION OF							
58662	LESIONS OF THE	R	\$507.04	\$507.04				
	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS							
58670	(WITH OR WITHOUT	R	\$280.12	\$280.12				

Physician	n Fee Schedule 2020							
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	des in Red;							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omony obo	go for the convice				+	
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Offiary Chai	T T THE SERVICE	;				
	Ise lab fee schedule for covered codes not listed below in the 80000-89249	rongo						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered f							
Codes iis		ioi priysicia	115					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind		(NonFacility)		Comp.	Value	Notes
Code	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
58671	DEVICE (EG, BAND,	D	\$287.90	\$287.90				
58672	LAPAROSCOPY, SURGICAL; WITH FIMBRIOPLASTY	R R	\$548.20	\$548.20				
30072	LAPAROSCOPY, SURGICAL, WITH FIMIBRIOPLASTY LAPAROSCOPY, SURGICAL; WITH SALPINGOSTOMY	K	\$04 6.20	\$346.20				
58673	(SALPINGONEOSTOMY)	l _D	\$583.55	\$583.55				
58674	LAPS ABLTJ UTERINE FIBROIDS	R	\$652.21	\$652.21				Added Effective 1/1/2017
58074	SALPINGECTOMY, COMPLETE OR PARTIAL, UNILATERAL OR		\$052.21	\$052.21				Added Effective 1/1/2017
58700		D	\$375.33	\$375.33				
36700	BILATERAL (SEPARATE SALPINGO-OOPHORECTOMY, COMPLETE OR PARTIAL, UNILATERAL	R	\$373.33	\$373.33				
50700			¢400.70	¢400.70				
58720	OR BILATERAL	R	\$422.70	\$422.70				
58740	LYSIS OF ADHESIONS (SALPINGOLYSIS, OVARIOLYSIS)	R	\$381.93	\$381.93			_	
58750	TUBOTUBAL ANASTOMOSIS	R	\$463.53	\$463.53				
58752	TUBOUTERINE IMPLANTATION	R	\$436.37	\$436.37				
58760	FIMBRIOPLASTY	R	\$376.08	\$376.08			_	
58770	SALPINGOSTOMY (SALPINGONEOSTOMY)	R	\$372.82	\$372.82			_	
50000	DRAINAGE OF OVARIAN CYST(S), UNILATERAL OR BILATERAL,		* 405.00	# 405.00				
58800	(SEPARATE PROCED		\$195.39	\$195.39				
50005	DRAINAGE OF OVARIAN CYST(S), UNILATERAL OR BILATERAL,		****	4000 00				
58805	(SEPARATE PROCED		\$363.80	\$363.80				
58820	DRAINAGE OF OVARIAN ABSCESS; VAGINAL APPROACH, OPEN		\$202.14	\$202.14				
58822	DRAINAGE OF OVARIAN ABSCESS; ABDOMINAL APPROACH		\$296.24	\$296.24				
50000	DRAINAGE OF PELVIC ABSCESS, TRANSVAGINAL OR TRANSRECTAL		470.77	m470 77				
58823	APPROACH,		\$170.77	\$170.77				
58825	TRANSPOSITION, OVARY(S)		\$295.89	\$295.89				
50000	BIOPSY OF OVARY, UNILATERAL OR BILATERAL (SEPARATE		#000 CC	#000 CC				
58900	PROCEDURE)		\$326.30	\$326.30				

Physician	Fee Schedule 2020	1			I			
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		T						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	WEDGE RESECTION OR BISECTION OF OVARY, UNILATERAL OR							
58920	BILATERAL	R	\$400.39	\$400.39				
58925	OVARIAN CYSTECTOMY, UNILATERAL OR BILATERAL		\$397.28	\$397.28				
58940	OOPHORECTOMY, PARTIAL OR TOTAL, UNILATERAL OR BILATERAL;	R	\$398.30	\$398.30				
	OOPHORECTOMY, PARTIAL OR TOTAL, UNILATERAL OR BILATERAL;							
58943	FOR OVARIAN,	R	\$901.94	\$901.94				
	RESECTION OF OVARIAN, TUBAL OR PRIMARY PERITONEAL							
58950	MALIGNANCY WITH BILA		\$773.05	\$773.05				
	RESECTION OF OVARIAN, TUBAL OR PRIMARY PERITONEAL							
58951	MALIGNANCY WITH BILA	R	\$1,184.26	\$1,184.26				
	RESECTION OF OVARIAN, TUBAL OR PRIMARY PERITONEAL							
58952	MALIGNANCY WITH BILA	R	\$1,207.48	\$1,207.48				
	BILATERAL SALPINGO-OOPHORECTOMY WITH OMENTECTOMY,							
58953	TOTAL ABDOMINAL	R	\$1,403.32	\$1,403.32				
	BILATERAL SALPINGO-OOPHORECTOMY WITH OMENTECTOMY,		1					
58954	TOTAL ABDOMINAL	R	\$1,526.07	\$1,526.07				
	BILATERAL SALPINGO-OOPHORECTOMY WITH TOTAL							
58956	OMENTECTOMY, TOTAL ABDOMINA		\$982.70	\$982.70				
58957	RESECTION RECURRENT OVARIAN MALIGNANCY		\$1,069.48	\$1,069.48				
50050	RESECTION RECURRENT OVARIAN MALIGNANCY W/PELVIC		4. 405.00	4. 405.00				
58958	LYMPHADENECTOMY		\$1,185.03	\$1,185.03				
50000	LAPAROTOMY, FOR STAGING OR RESTAGING OF OVARIAN, TUBAL		ф 747 07	ф 747 07				
58960	OR PRIMARY		\$717.37	\$717.37	1			
50000	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM	_	¢570.00	ф 7 44 00				
58999	(NONOBSTETRICAL)	R	\$570.00	\$741.00	1			
59000	AMNIOCENTESIS; DIAGNOSTIC		\$68.54	\$68.54				

IPhysician	Fee Schedule 2020							
Note:								
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Refer to C	CPT book for descriptions							
R" in PA c	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	AMNIOCENTESIS; THERAPEUTIC AMNIOTIC FLUID REDUCTION							
59001	(INCLUDES ULTRASOU		\$127.45	\$127.45				
59012	CORDOCENTESIS (INTRAUTERINE), ANY METHOD		\$162.34	\$162.34				
59015	CHORIONIC VILLUS SAMPLING, ANY METHOD		\$99.17	\$99.17				
59020	FETAL CONTRACTION STRESS TEST		\$62.62	\$62.62	\$15.84	\$46.78		
59025	FETAL NON-STRESS TEST		\$34.83	\$34.83	\$6.87	\$27.96		
59030	FETAL SCALP BLOOD SAMPLING		\$105.88	\$105.88				
	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE,		4 =4.40					
59050	NON-ATTENDI		\$51.49	\$51.49				
50054	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE,		47.00	47.00				
59051	NON-ATTENDI		\$47.08	\$47.08				
50070	TRANSABDOMINAL AMNIOINFUSION, INCLUDING ULTRASOUND		#040.04	#000 OF				
59070	GUIDANCE		\$219.94	\$290.85	_			
50070	FETAL UMBILICAL CORD OCCLUSION, INCLUDING ULTRASOUND GUIDANCE		#250 40	#250.40				
59072	FETAL FLUID DRAINAGE (EG, VESICOCENTESIS, THORACOCENTESIS,		\$356.42	\$356.42	_			
50074	PARACENTESI		\$219.94	\$277.24				
59074 59076	FETAL SHUNT PLACEMENT, INCLUDING ULTRASOUND GUIDANCE		\$356.42	\$356.42				
59076	HYSTEROTOMY, ABDOMINAL (EG, FOR HYDATIDIFORM MOLE,		\$330.42	\$300.4Z				
59100	ABORTION)		\$309.26	\$309.26				
39100	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; TUBAL OR		φ309.20	\$309.20				
59120	OVARIAN, REQUIRING		\$455.90	\$455.90				
00120	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; TUBAL OR		ψ+00.00	ψ+00.00				
59121	OVARIAN, WITHOUT		\$375.41	\$375.41				
00121	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; ABDOMINAL		ψοιο.τι	ψο/ ο. τ ι				
59130	PREGNANCY		\$408.09	\$408.09				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T		;				
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	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		no.					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; INTERSTITIAL,	PAIIIU	(Facility)	(NOTIFACILITY)	Comp.	Comp.	Value	Notes
59135	UTERINE PREGNAN		\$673.61	\$673.61				
39133	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; INTERSTITIAL,		φ07 3.0 I	φ0/3.01				
59136	UTERINE PREGNAN		\$456.82	\$456.82				
39130	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; CERVICAL, WITH		φ430.0Z	Φ430.02				
59140	EVACUATION		\$281.40	\$281.40				
39140	LAPAROSCOPIC TREATMENT OF ECTOPIC PREGNANCY; WITHOUT		φ201.4U	φ201.4U				
59150	SALPINGECTOMY AND		\$333.06	\$333.06				
59150	LAPAROSCOPIC TREATMENT OF ECTOPIC PREGNANCY; WITH		\$333.00	\$333.00				
E01E1	SALPINGECTOMY AND/OR		\$458.93	\$458.93				
59151			\$169.28	\$169.28				
59160	CURETTAGE, POSTPARTUM INSERTION OF CERVICAL DILATOR (EG, LAMINARIA,		\$109.20	\$109.20				
59200	PROSTAGLANDIN) (SEPARATE		\$33.10	\$40.34				
59200	EPISIOTOMY OR VAGINAL REPAIR, BY OTHER THAN ATTENDING		φ33.10	\$40.34				
50200	PHYSICIAN		\$86.42	\$99.70				
59300 59320	CERCLAGE OF CERVIX, DURING PREGNANCY; VAGINAL		\$130.48	\$130.48				
59325	CERCLAGE OF CERVIX, DURING PREGNANCY; ABDOMINAL		\$203.99	\$203.99				
59350	HYSTERORRHAPHY OF RUPTURED UTERUS		\$260.13	\$260.13				
59350	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR		\$200.13	\$200.13				
E0400			#070 00	¢070.00				
59409	FORCEPS);		\$870.00	\$870.00				
E0440	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR		\$900.00	\$900.00				
59410	FORCEPS); DELIVERY OF PLACENTA (SEPARATE PROCEDURE)		\$84.65	\$84.65				
59414				\$70.87				
59430	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)		\$65.78					
59514	CESAREAN DELIVERY ONLY;		\$870.00	\$870.00				
59515	CESAREAN DELIVERY ONLY; INCLUDING POSTPARTUM CARE	1	\$900.00	\$900.00				

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	olumn indicates Prior Auth is required	L	1				-	
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary charg	ge for the service					
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r physician	IS .					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY							
59525	(LIST SEPARATEL	R	\$374.17	\$374.17				
	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY							
59612	(WITH OR WITHO		\$870.00	\$870.00	1		1	
	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY							
59614	(WITH OR WITHO		\$900.00	\$900.00			1	
	CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL							
59620	DELIVERY AFTER PRE		\$870.00	\$870.00				
	CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL							
59622	DELIVERY AFTER PRE		\$900.00	\$900.00				
	TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER,							
59812	COMPLETED SURGICALLY		\$206.50	\$206.50				
	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY;							
59820	FIRST TRIMESTER		\$228.74	\$228.74				
	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY;							
59821	SECOND TRIMESTER		\$213.02	\$213.02				
59830	TREATMENT OF SEPTIC ABORTION, COMPLETED SURGICALLY		\$309.03	\$309.03				
59840		R	\$188.52	\$188.52				
59841	INDUCED ABORTION, BY DILATION AND EVACUATION	R	\$214.12	\$214.12				
59850	INDUCED ABORTION, BY ONE OR MORE INTRA-AMNIOTIC INJECTIONS	R	\$288.16	\$288.16				
59851	INDUCED ABORTION, BY ONE OR MORE INTRA-AMNIOTIC INJECTIONS	R	\$301.09	\$301.09				
59852	INDUCED ABORTION, BY ONE OR MORE INTRA-AMNIOTIC INJECTIONS	R	\$404.59	\$404.59	<u> </u>	<u> </u>	<u> </u>	
	INDUCED ABORTION, BY ONE OR MORE VAGINAL SUPPOSITORIES							
59855	(EG, PROSTAGLAN	R	\$304.56	\$304.56	<u> </u>	<u> </u>		

Physician	Fee Schedule 2020							
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	les in Red;							
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The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I I I I I I I I I I I I I I I I I I I						
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
OOGCO 110	The lab loc concade that begin with a 1- of Q are carrently horr covered to	T priyololal						+
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INDUCED ABORTION, BY ONE OR MORE VAGINAL SUPPOSITORIES		(i domey)	(itom domey)			7 4.140	110100
59856	(EG, PROSTAGLAN	R	\$376.08	\$376.08				
	INDUCED ABORTION, BY ONE OR MORE VAGINAL SUPPOSITORIES							
59857	(EG, PROSTAGLAN	R	\$457.41	\$457.41				
59866	MULTIFETAL PREGNANCY REDUCTION(S) (MPR)	R	\$173.79	\$173.79				Rate updated 1/1/2018
59870	UTERINE EVACUATION AND CURETTAGE FOR HYDATIDIFORM MOLE		\$214.05	\$214.05				
	REMOVAL OF CERCLAGE SUTURE UNDER ANESTHESIA (OTHER							
59871	THAN LOCAL)		\$117.25	\$117.25				
	UNLISTED FETAL INVASIVE PROCEDURE, INCLUDING ULTRASOUND							
59897	GUIDANCE	R	\$0.00	\$0.00				
59899	UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY	R	\$0.00	\$0.00				
60000	INCISION AND DRAINAGE OF THYROGLOSSAL DUCT CYST, INFECTED		\$60.41	\$68.46				
60100	BIOPSY THYROID, PERCUTANEOUS CORE NEEDLE		\$45.46	\$59.54				
	EXCISION OF CYST OR ADENOMA OF THYROID, OR TRANSECTION							
60200	OF ISTHMUS		\$445.84	\$445.84				
	PARTIAL THYROID LOBECTOMY, UNILATERAL; WITH OR WITHOUT							
60210	ISTHMUSECTOMY		\$581.31	\$581.31				
	PARTIAL THYROID LOBECTOMY, UNILATERAL; WITH							
60212	CONTRALATERAL SUBTOTAL		\$738.99	\$738.99				
	TOTAL THYROID LOBECTOMY, UNILATERAL; WITH OR WITHOUT							
60220	ISTHMUSECTOMY		\$557.51	\$557.51				
22225	TOTAL THYROID LOBECTOMY, UNILATERAL; WITH CONTRALATERAL		0000007	#000 0 7				
60225	SUBTOTAL LOBEC		\$669.87	\$669.87				
60240	THYROIDECTOMY, TOTAL OR COMPLETE		\$790.92	\$790.92				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary cnai	ge for the service	9				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns T					
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Droo			Innet Bete	Outpot Boto	Tech.	Prof.	Unit	
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00050	THYROIDECTOMY, TOTAL OR SUBTOTAL FOR MALIGNANCY; WITH		070.07	#070.07				
60252	LIMITED NECK		\$879.97	\$879.97				
22254	THYROIDECTOMY, TOTAL OR SUBTOTAL FOR MALIGNANCY; WITH			* 4 0 = 0 = 4				
60254	RADICAL NECK		\$1,079.54	\$1,079.54				
	THYROIDECTOMY, REMOVAL OF ALL REMAINING THYROID TISSUE		\$5.17.07	A-1-0-				
60260	FOLLOWING PREVI		\$517.67	\$517.67				
	THYROIDECTOMY, INCLUDING SUBSTERNAL THYROID; STERNAL							
60270	SPLIT OR TRANSTHO		\$918.83	\$918.83				
	THYROIDECTOMY, INCLUDING SUBSTERNAL THYROID; CERVICAL							
60271	APPROACH		\$795.80	\$795.80				
60280	EXCISION OF THYROGLOSSAL DUCT CYST OR SINUS;		\$380.26	\$380.26				
60281	EXCISION OF THYROGLOSSAL DUCT CYST OR SINUS; RECURRENT		\$393.02	\$393.02				
60300	ASPIR/INIJ THYROID CYST		\$39.76	\$88.42				
60500	PARATHYROIDECTOMY OR EXPLORATION OF PARATHYROID(S);		\$812.72	\$812.72				
	PARATHYROIDECTOMY OR EXPLORATION OF PARATHYROID(S); RE-							
60502	EXPLORATION		\$926.98	\$926.98				
	PARATHYROIDECTOMY OR EXPLORATION OF PARATHYROID(S);							
60505	WITH MEDIASTINAL		\$999.46	\$999.46				
	PARATHYROID AUTOTRANSPLANTATION (LIST SEPARATELY IN							
60512	ADDITION TO CODE F		\$205.93	\$205.93				
	THYMECTOMY, PARTIAL OR TOTAL; TRANSCERVICAL APPROACH							
60520	(SEPARATE PROCEDU		\$887.16	\$887.16				
	THYMECTOMY, PARTIAL OR TOTAL; STERNAL SPLIT OR							
60521	TRANSTHORACIC APPROACH,		\$945.26	\$945.26				
	THYMECTOMY, PARTIAL OR TOTAL; STERNAL SPLIT OR							
60522	TRANSTHORACIC APPROACH,		\$1,061.46	\$1,061.46		1		

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	ee Schedule 2020							
Note:								
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ADRENALECTOMY, PARTIAL OR COMPLETE, OR EXPLORATION OF							
60540	ADRENAL GLAND WI		\$835.03	\$835.03				
	ADRENALECTOMY, PARTIAL OR COMPLETE, OR EXPLORATION OF							
60545	ADRENAL GLAND WI		\$982.76	\$982.76				
	EXCISION OF CAROTID BODY TUMOR; WITHOUT EXCISION OF							
60600	CAROTID ARTERY		\$826.37	\$826.37				
	EXCISION OF CAROTID BODY TUMOR; WITH EXCISION OF CAROTID							
60605	ARTERY		\$875.02	\$875.02				
	LAPAROSCOPY, SURGICAL, WITH ADRENALECTOMY, PARTIAL OR							
60650	COMPLETE, OR		\$739.73	\$739.73				
60699	UNLISTED PROCEDURE, ENDOCRINE SYSTEM	R	\$0.00	\$0.00				
	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT,							
61000	UNILATERAL OR		\$79.19	\$79.19				
	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT,							
61001	UNILATERAL OR		\$59.65	\$71.46				
	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE,							
61020	FONTANELLE, SUTURE, O		\$82.96	\$82.96				
	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE,							
61026	FONTANELLE, SUTURE, O		\$109.38	\$109.38				
	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITHOUT							
61050	INJECTION (SEP		\$80.94	\$80.94				
	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITH							
61055	INJECTION OF		\$116.66	\$116.66				
	PUNCTURE OF SHUNT TUBING OR RESERVOIR FOR ASPIRATION OR							
61070	INJECTION PROC		\$33.42	\$39.99				
61105	TWIST DRILL HOLE FOR SUBDURAL OR VENTRICULAR PUNCTURE;		\$455.26	\$455.26				

Physician	Fee Schedule 2020							
Note:								
	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_					<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
04407	TWIST DRILL HOLE FOR SUBDURAL OR VENTRICULAR PUNCTURE;		4007.00	4007.00				
61107	FOR IMPLANTING		\$307.66	\$307.66				
04400	TWIST DRILL HOLE FOR SUBDURAL OR VENTRICULAR PUNCTURE;		# 004.00	DO04.00				
61108	FOR EVACUATION BURR HOLE(S) FOR VENTRICULAR PUNCTURE (INCLUDING		\$694.06	\$694.06	1			
61120	INJECTION OF GAS, CON		\$459.02	\$459.02				
01120	BURR HOLE(S) OR TREPHINE; WITH BIOPSY OF BRAIN OR		\$459.UZ	\$459.UZ				
61140	INTRACRANIAL LESION		\$876.66	\$876.66				
01140	BURR HOLE(S) OR TREPHINE; WITH DRAINAGE OF BRAIN ABSCESS		φο/ 0.00	\$670.00			+	+
61150	OR CYST		\$937.20	\$937.20				
01100	BURR HOLE(S) OR TREPHINE; WITH SUBSEQUENT TAPPING		Ψ557.20	Ψ001.20				+
61151	(ASPIRATION) OF		\$400.64	\$400.64				
01101	BURR HOLE(S) WITH EVACUATION AND/OR DRAINAGE OF		Ψ100.01	ψ 100.01	1			+
61154	HEMATOMA, EXTRADURAL O		\$949.97	\$949.97				
	BURR HOLE(S); WITH ASPIRATION OF HEMATOMA OR CYST,		70.000	70.000				†
61156	INTRACEREBRAL		\$955.26	\$955.26				
	BURR HOLE(S); FOR IMPLANTING VENTRICULAR CATHETER,		·					
61210	RESERVOIR, EEG		\$337.68	\$337.68				
	INSERTION OF SUBCUTANEOUS RESERVOIR, PUMP OR CONTINUOUS							
61215	INFUSION SYSTE		\$575.91	\$575.91				
	BURR HOLE(S) OR TREPHINE, SUPRATENTORIAL, EXPLORATORY,							
61250	NOT FOLLOWED BY		\$574.03	\$574.03				
	BURR HOLE(S) OR TREPHINE, INFRATENTORIAL, UNILATERAL OR							
61253	BILATERAL		\$680.56	\$680.56				
61304	CRANIECTOMY OR CRANIOTOMY, EXPLORATORY; SUPRATENTORIAL		\$1,419.68	\$1,419.68				

Physician	Fee Schedule 2020							
Note:								
	les in Red;							†
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CRANIECTOMY OR CRANIOTOMY, EXPLORATORY; INFRATENTORIAL							
61305	(POSTERIOR FOSS		\$1,630.33	\$1,630.33				
	CRANIECTOMY OR CRANIOTOMY FOR EVACUATION OF HEMATOMA,							
61312	SUPRATENTORIAL;		\$1,358.30	\$1,358.30				
0.40.40	CRANIECTOMY OR CRANIOTOMY FOR EVACUATION OF HEMATOMA,							
61313	SUPRATENTORIAL;		\$1,353.94	\$1,353.94				
04044	CRANIECTOMY OR CRANIOTOMY FOR EVACUATION OF HEMATOMA,		* 400 04					
61314	INFRATENTORIAL;		\$1,469.34	\$1,469.34				
C404E	CRANIECTOMY OR CRANIOTOMY FOR EVACUATION OF HEMATOMA,		t4 500 60	¢4 500 60				
61315	INFRATENTORIAL; INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL BONE		\$1,523.63	\$1,523.63				
61316	GRAFT (LIST SEPARA		\$65.84	\$65.84				
01310	CRANIECTOMY OR CRANIOTOMY, DRAINAGE OF INTRACRANIAL		φ03.04	φυυ.04				+
61320	ABSCESS; SUPRATENT		\$1,285.74	\$1,285.74				
01320	CRANIECTOMY OR CRANIOTOMY, DRAINAGE OF INTRACRANIAL		ψ1,203.74	ψ1,203.74				+
61321	ABSCESS; INFRATENT		\$1,400.20	\$1,400.20				
01021	CRANIECTOMY OR CRANIOTOMY, DECOMPRESSIVE, WITH OR		ψ1,100.20	ψ1,100.20				
61322	WITHOUT DURAPLASTY,		\$1,335.49	\$1,335.49				
0.022	CRANIECTOMY OR CRANIOTOMY, DECOMPRESSIVE, WITH OR		ψ 1,000110	ψ 1,0001.10				
61323	WITHOUT DURAPLASTY,		\$1,383.79	\$1,383.79				
61330	DECOMPRESSION OF ORBIT ONLY, TRANSCRANIAL APPROACH		\$836.75	\$836.75				
	EXPLORATION OF ORBIT (TRANSCRANIAL APPROACH); WITH							
61333	REMOVAL OF LESION .		\$1,412.93	\$1,412.93				
	SUBTEMPORAL CRANIAL DECOMPRESSION (PSEUDOTUMOR							
61340	CEREBRI, SLIT VENTRICLE		\$797.89	\$797.89				
	CRANIECTOMY, SUBOCCIPITAL WITH CERVICAL LAMINECTOMY FOR							
61343	DECOMPRESSION		\$1,752.10	\$1,752.10				

Physician	Fee Schedule 2020	1					1	1
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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	rge for the service	<u>, </u>				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T Triany Orian		<u> </u>				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
61345	OTHER CRANIAL DECOMPRESSION, POSTERIOR FOSSA		\$1,342.43	\$1,342.43			1 2 2 2 2 2 2	
	CRANIECTOMY, SUBTEMPORAL, FOR SECTION, COMPRESSION, OR		, , , -	+ /-				
61450	DECOMPRESSION O		\$1,344.07	\$1,344.07				
	CRANIECTOMY, SUBOCCIPITAL; FOR EXPLORATION OR		, , , , , , , , , , , , , , , , , , , ,	1 7				
61458	DECOMPRESSION OF CRANIAL		\$1,612.09	\$1,612.09				
	CRANIECTOMY, SUBOCCIPITAL; FOR SECTION OF ONE OR MORE			,				
61460	CRANIAL NERVES		\$1,553.54	\$1,553.54				
	CRANIECTOMY; WITH EXCISION OF TUMOR OR OTHER BONE LESION							
61500	OF SKULL		\$1,122.09	\$1,122.09				
61501	CRANIECTOMY; FOR OSTEOMYELITIS		\$946.40	\$946.40				
	CRANIECTOMY, TREPHINATION, BONE FLAP CRANIOTOMY; FOR							
61510	EXCISION OF BRAIN		\$1,530.67	\$1,530.67				
	CRANIECTOMY, TREPHINATION, BONE FLAP CRANIOTOMY; FOR							
61512	EXCISION OF		\$1,618.54	\$1,618.54				
	CRANIECTOMY, TREPHINATION, BONE FLAP CRANIOTOMY; FOR							
61514	EXCISION OF BRAIN		\$1,488.95	\$1,488.95				
	CRANIECTOMY, TREPHINATION, BONE FLAP CRANIOTOMY; FOR							
61516	EXCISION OR		\$1,491.50	\$1,491.50				
	IMPLANTATION OF BRAIN INTRACAVITARY CHEMOTHERAPY AGENT							
61517	(LIST SEPARATEL		\$56.19	\$56.19				
	CRANIECTOMY FOR EXCISION OF BRAIN TUMOR, INFRATENTORIAL							
61518	OR POSTERIOR F		\$1,884.78	\$1,884.78				
	CRANIECTOMY FOR EXCISION OF BRAIN TUMOR, INFRATENTORIAL							
61519	OR POSTERIOR F		\$1,970.57	\$1,970.57				
	CRANIECTOMY FOR EXCISION OF BRAIN TUMOR, INFRATENTORIAL							
61520	OR POSTERIOR F		\$2,176.37	\$2,176.37				

Physician	n Fee Schedule 2020							
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	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	Ĭ					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CRANIECTOMY FOR EXCISION OF BRAIN TUMOR, INFRATENTORIAL							
61521	OR POSTERIOR F		\$2,184.95	\$2,184.95				
	CRANIECTOMY, INFRATENTORIAL OR POSTERIOR FOSSA; FOR							
61522	EXCISION OF BRAIN		\$1,435.87	\$1,435.87				
	CRANIECTOMY, INFRATENTORIAL OR POSTERIOR FOSSA; FOR							
61524	EXCISION OR		\$1,624.92	\$1,624.92				
	CRANIECTOMY, BONE FLAP CRANIOTOMY, TRANSTEMPORAL							
61526	(MASTOID) FOR EXCISIO		\$1,900.40	\$1,900.40				
04500	CRANIECTOMY, BONE FLAP CRANIOTOMY, TRANSTEMPORAL		#0.074.00	mo 074 00				
61530	(MASTOID) FOR EXCISIO		\$2,271.30	\$2,271.30				
04504	SUBDURAL IMPLANTATION OF STRIP ELECTRODES THROUGH ONE		04.045.00	04.045.00				
61531	OR MORE BURR OR CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR SUBDURAL		\$1,045.86	\$1,045.86				
61533	IMPLANTATION OF A		\$1,224.36	\$1,224.36				
01000	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR EXCISION OF		\$1,224.30	\$1,224.30				
61534	EPILEPTOGENIC		\$781.31	\$781.31				
01334	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR REMOVAL OF		Ψ/01.51	Ψ/01.51				
61535	EPIDURAL OR SUB		\$536.01	\$536.01				
01000	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR EXCISION OF		ψ000.01	Ψ000.01				
61536	CEREBRAL		\$1,549.54	\$1,549.54				
01000	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR LOBECTOMY,		ψ1,010.01	ψ1,010.01				
61537	TEMPORAL LOBE.		\$1,258.82	\$1,258.82				
	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR LOBECTOMY,		, ,	, , , , , , , , , , , , , , , , , , , ,				
61538	TEMPORAL LOBE,		\$1,723.83	\$1,723.83				
	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR LOBECTOMY,			. ,				
61539	OTHER THAN TEMP		\$1,596.50	\$1,596.50				

Physician	Fee Schedule 2020							
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	des in Red;							
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Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR LOBECTOMY,							
61540	OTHER THAN TEMP		\$1,518.91	\$1,518.91				
61541	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR TRANSECTION OF CORPUS CALL		\$1,413.73	\$1,413.73				
01341	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR PARTIAL OR		Ψ1,413.73	Ψ1,413.73				
61543	SUBTOTAL		\$1,127.98	\$1,127.98				
01010	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR EXCISION OR		Ψ1,127.00	ψ1,127.00				
61544	COAGULATION OF		\$1,503.11	\$1,503.11				
	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR EXCISION OF		, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,				
61545	CRANIOPHARYNGI		\$1,817.24	\$1,817.24				
	CRANIOTOMY FOR HYPOPHYSECTOMY OR EXCISION OF PITUITARY							
61546	TUMOR, INTRACRA		\$1,701.25	\$1,701.25				
	HYPOPHYSECTOMY OR EXCISION OF PITUITARY TUMOR,							
61548	TRANSNASAL OR TRANSSEPT		\$1,353.84	\$1,353.84				
61550	CRANIECTOMY FOR CRANIOSYNOSTOSIS; SINGLE CRANIAL SUTURE		\$761.59	\$761.59				
01330	CRANIECTOMY FOR CRANIOSYNOSTOSIS; MULTIPLE CRANIAL		Ψ101.33	Ψ101.39				
61552	SUTURES		\$994.67	\$994.67				
01002	CRANIOTOMY FOR CRANIOSYNOSTOSIS; FRONTAL OR PARIETAL		φοσ 1.07	φοστιον				
61556	BONE FLAP		\$1,116.90	\$1,116.90				
61557	CRANIOTOMY FOR CRANIOSYNOSTOSIS; BIFRONTAL BONE FLAP	†	\$1,123.08	\$1,123.08	1		1	
	EXTENSIVE CRANIECTOMY FOR MULTIPLE CRANIAL SUTURE			<u> </u>				
61558	CRANIOSYNOSTOSIS (EG		\$1,276.41	\$1,276.41				
	EXTENSIVE CRANIECTOMY FOR MULTIPLE CRANIAL SUTURE							
61559	CRANIOSYNOSTOSIS (EG		\$1,655.24	\$1,655.24				
	EXCISION, INTRA AND EXTRACRANIAL, BENIGN TUMOR OF CRANIAL							
61563	BONE (EG, FI		\$1,353.06	\$1,353.06				

Physician	Fee Schedule 2020							1
Note:								
	es in Red;							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EXCISION, INTRA AND EXTRACRANIAL, BENIGN TUMOR OF CRANIAL							
61564	BONE (EG, FI		\$1,707.01	\$1,707.01				
61566	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR SELECTIVE		\$1,507.18	\$1,507.18				
	CRANIOTOMY WITH ELEVATION OF BONE FLAP; FOR MULTIPLE							
61567	SUBPIAL TRANSECTI		\$1,722.45	\$1,722.45				
	CRANIECTOMY OR CRANIOTOMY; WITH EXCISION OF FOREIGN BODY							
61570	FROM BRAIN		\$1,188.32	\$1,188.32				
	CRANIECTOMY OR CRANIOTOMY; WITH TREATMENT OF							
61571	PENETRATING WOUND OF BRAI		\$1,289.76	\$1,289.76				
	TRANSORAL APPROACH TO SKULL BASE, BRAIN STEM OR UPPER							
61575	SPINAL CORD FOR		\$1,956.24	\$1,956.24				
	TRANSORAL APPROACH TO SKULL BASE, BRAIN STEM OR UPPER							
61576	SPINAL CORD FOR		\$1,844.59	\$1,844.59				
	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA;							
61580	EXTRADURAL, INCLUDING		\$1,511.18	\$1,511.18				
	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA;			 				
61581	EXTRADURAL, INCLUDING		\$1,715.14	\$1,715.14				
0.4500	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA;		* 4 = 5 = 5	4.550.50				
61582	EXTRADURAL, INCLUDING		\$1,556.79	\$1,556.79				
04500	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA;		Φ4 770 07	04 770 07				
61583	INTRADURAL, INCLUDING		\$1,776.67	\$1,776.67		_		
64504	ORBITOCRANIAL APPROACH TO ANTERIOR CRANIAL FOSSA,		¢4 700 44	¢4 700 44				
61584	EXTRADURAL, INCLUDIN		\$1,720.14	\$1,720.14	1			+
C4 E 0 E	ORBITOCRANIAL APPROACH TO ANTERIOR CRANIAL FOSSA,		¢4 004 44	¢4 004 44				
61585	EXTRADURAL, INCLUDIN BICORONAL, TRANSZYGOMATIC AND/OR LEFORT I OSTEOTOMY		\$1,924.41	\$1,924.41				+
64506			¢4 007 50	¢4 007 50				
61586	APPROACH TO ANTERI	L	\$1,287.53	\$1,287.53				

Physician	Fee Schedule 2020							1
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	Ĭ					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INFRATEMPORAL PRE-AURICULAR APPROACH TO MIDDLE CRANIAL							
61590	FOSSA		\$2,092.87	\$2,092.87				
	INFRATEMPORAL POST-AURICULAR APPROACH TO MIDDLE CRANIAL							
61591	FOSSA (INTERNA		\$2,194.98	\$2,194.98				
	ORBITOCRANIAL ZYGOMATIC APPROACH TO MIDDLE CRANIAL							
61592	FOSSA (CAVERNOUS SI		\$1,991.00	\$1,991.00				
04505	TRANSTEMPORAL APPROACH TO POSTERIOR CRANIAL FOSSA,		A 470 50	A 470 50				
61595	JUGULAR FORAMEN OR		\$1,470.58	\$1,470.58				
64506	TRANSCOCHLEAR APPROACH TO POSTERIOR CRANIAL FOSSA,		¢4 707 00	¢4 707 00				
61596	JUGULAR FORAMEN OR TRANSCONDYLAR (FAR LATERAL) APPROACH TO POSTERIOR		\$1,787.02	\$1,787.02				
61597	CRANIAL FOSSA, JUGUL		\$1,888.89	\$1,888.89				
01397	TRANSPETROSAL APPROACH TO POSTERIOR CRANIAL FOSSA.		φ1,000.09	φ1,000.09				
61598	CLIVUS OR FORAMEN		\$1,664.23	\$1,664.23				
01390	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR		φ1,004.23	ψ1,004.23				
61600	INFECTIOUS LESION OF		\$1,276.17	\$1,276.17				
01000	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR		Ψ1,270.11	Ψ1,270.17				
61601	INFECTIOUS LESION OF		\$1,368.44	\$1,368.44				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR		ψ 1,000111	ψ .,σσσ				
61605	INFECTIOUS LESION OF		\$1,444.82	\$1,444.82				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR			, , , , ,				
61606	INFECTIOUS LESION OF		\$1,934.79	\$1,934.79				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR							
61607	INFECTIOUS LESION OF		\$1,807.46	\$1,807.46				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR							
61608	INFECTIOUS LESION OF		\$2,102.92	\$2,102.92				

Physician	n Fee Schedule 2020	Ι			1			
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	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	1				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Than y on an						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSECTION OR LIGATION, CAROTID ARTERY IN PETROUS CANAL;		7,	1				
61611	WITHOUT REPA		\$388.06	\$388.06				
	OBLITERATION OF CAROTID ANEURYSM, ARTERIOVENOUS							
61613	MALFORMATION, OR		\$2,062.32	\$2,062.32				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR		·					
61615	INFECTIOUS LESION OF		\$1,587.56	\$1,587.56				
	RESECTION OR EXCISION OF NEOPLASTIC, VASCULAR OR							
61616	INFECTIOUS LESION OF		\$2,159.45	\$2,159.45				
	SECONDARY REPAIR OF DURA FOR CEREBROSPINAL FLUID LEAK,							
61618	ANTERIOR, MIDDL		\$816.72	\$816.72				
	SECONDARY REPAIR OF DURA FOR CEREBROSPINAL FLUID LEAK,							
61619	ANTERIOR, MIDDL		\$1,020.70	\$1,020.70				
	ENDOVASCULAR TEMPORARY BALLOON ARTERIAL OCCLUSION,							
61623	HEAD OR NECK		\$408.34	\$408.34				
	TRANSCATHETER PERMANENT OCCLUSION OR EMBOLIZATION (EG,							
61624	FOR TUMOR		\$1,044.61	\$1,044.61				
	TRANSCATHETER PERMANENT OCCLUSION OR EMBOLIZATION (EG,							
61626	FOR TUMOR		\$861.36	\$861.36				
61630	INTRACRANIAL ANGIOPLASTY		\$1,056.84	\$1,007.67				
61635	INTRACRAN ANGIOPLSTY W/STENT		\$1,105.84	\$1,105.84				
61640	DILATE IC VASOSPASM INIT		\$504.33	\$504.33				
61641	DILATE IC VASOSPASM ADD-ON		\$177.40	\$177.40				
61642	DILATE IC VASOSPASM ADD-ON		\$354.58	\$354.58				
	PERCUTANEOUS ARTERIAL TRANSLUMINAL MECHANICAL							
	THROMBECTOMY INFUSION FOR THROMBOLYSIS INTRACRANIAL							
61645	ANY METHOD		\$634.38	\$634.38				Added Effective 1/1/2016

Physician	Fee Schedule 2020							
Note:								
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Refer to 0	CPT book for descriptions							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ENDOVASCULAR INTRACRANIAL PROLONGED ADMINISTRATION							
0.4050	PHARMACOLOGIC AGENT(s) OTHER THAN FOR THROMBOLYSIS		400.40	400.40				= #
61650	ARTERIAL		\$433.13	\$433.13				Added Effective 1/1/2016
61651	EACH ADDITIONAL VASCULAR TERRITORY		\$184.45	\$184.45				Added Effective 1/1/2016
04000	SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		#0.040.05	00.040.05				
61680	SUPRATENTORIAL, SI SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		\$2,043.35	\$2,043.35				
61682	,		to 240 24	to 240 24				
01082	SUPRATENTORIAL, CO SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		\$2,340.21	\$2,340.21				
61684	INFRATENTORIAL, SI		\$2,034.27	\$2,034.27				
01004	SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		φ2,034.21	φ2,034.21				+
61686	INFRATENTORIAL, CO		\$2,459.46	\$2,459.46				
01000	SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		Ψ2,433.40	Ψ2,439.40				
61690	DURAL, SIMPLE		\$1,828.31	\$1,828.31				
01000	SURGERY OF INTRACRANIAL ARTERIOVENOUS MALFORMATION;		ψ1,020.01	Ψ1,020.01				+
61692	DURAL, COMPLEX		\$1,967.73	\$1,967.73				
	SURGERY OF COMPLEX INTRACRANIAL ANEURYSM, INTRACRANIAL		Ţ 1,001110	7 1,001111				
61697	APPROACH; CAROT		\$2,409.61	\$2,409.61				
	SURGERY OF COMPLEX INTRACRANIAL ANEURYSM, INTRACRANIAL		, ,	, ,				
61698	APPROACH;		\$2,318.66	\$2,318.66				
	SURGERY OF SIMPLE INTRACRANIAL ANEURYSM, INTRACRANIAL		·	·				
61700	APPROACH; CAROTI		\$2,009.80	\$2,009.80				
	SURGERY OF SIMPLE INTRACRANIAL ANEURYSM, INTRACRANIAL							
61702	APPROACH;		\$2,284.79	\$2,284.79				
	SURGERY OF INTRACRANIAL ANEURYSM, CERVICAL APPROACH BY							
61703	APPLICATION OF		\$859.34	\$859.34				

Physician	n Fee Schedule 2020		1					
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Ι΄	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SURGERY OF ANEURYSM, VASCULAR MALFORMATION OR CAROTID-							
61705	CAVERNOUS FISTUL		\$1,955.28	\$1,955.28				
	SURGERY OF ANEURYSM, VASCULAR MALFORMATION OR CAROTID-							
61708	CAVERNOUS FISTUL		\$1,717.93	\$1,717.93				
	SURGERY OF ANEURYSM, VASCULAR MALFORMATION OR CAROTID-							
61710	CAVERNOUS FISTUL		\$1,314.30	\$1,314.30				
0.474.4	ANASTOMOSIS, ARTERIAL, EXTRACRANIAL-INTRACRANIAL (EG,		40.050.50	40.050.50				
61711	MIDDLE		\$2,052.72	\$2,052.72				
04700	CREATION OF LESION BY STEREOTACTIC METHOD, INCLUDING		¢4 407 70	¢4 407 70				
61720	BURR HOLE(S) AND CREATION OF LESION BY STEREOTACTIC METHOD, INCLUDING		\$1,107.72	\$1,107.72				
C470E	BURR HOLE(S) AND		\$885.49	\$885.49				
61735	STEREOTACTIC BIOPSY, ASPIRATION, OR EXCISION, INCLUDING		\$885.49	\$885.49				
61750	BURR HOLE(S),		\$762.21	\$762.21				
01730	STEREOTACTIC BIOPSY, ASPIRATION, OR EXCISION, INCLUDING		φ/02.21	φ/ 02.2 I				
61751	BURR HOLE(S),		\$1,074.47	\$1,074.47				
01701	STEREOTACTIC IMPLANTATION OF DEPTH ELECTRODES INTO THE		Ψ1,07 4.47	Ψ1,07				
61760	CEREBRUM FOR LO		\$1,172.92	\$1,172.92				
01700	STEREOTACTIC LOCALIZATION, INCLUDING BURR HOLE(S), WITH		Ψ1,172.02	ψ1,172.02				
61770	INSERTION OF		\$1,047.41	\$1,047.41				
• • • • • • • • • • • • • • • • • • • •	STEREOTACTIC COMPUTER-ASSISTED PROCEDURE; CRANIAL,		+ 1,0 11111	ψ.,σ				
	INTRADURAL. LIST SEPARATELY IN ADDITION TO PRIMARY							
61781	PROCEDURE.		\$211.55	\$211.55				
	STEREOTACTIC COMPUTER-ASSISTED PROCEDURE; CRANIAL,							
	EXTRADURAL. LIST SEPARATELY IN ADDITION TO PRIMARY							
61782	PROCEDURE.		\$173.57	\$173.57				

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ	Ĭ					
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Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered t	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	STEREOTACTIC COMPUTER-ASSISTED PROCEDURE; SPINAL. LIST							
61783	SEPARATELY IN ADDITION TO PRIMARY PROCEDURE.		\$211.55	\$211.55				
	CREATION OF LESION BY STEREOTACTIC METHOD,							
61790	PERCUTANEOUS, BY NEUROLYTIC		\$729.94	\$729.94				
	CREATION OF LESION BY STEREOTACTIC METHOD,							
61791	PERCUTANEOUS, BY NEUROLYTIC		\$552.75	\$552.75				
61796	STEREOTACTIC RADIOSURGERY		\$601.71	\$601.71				
61797	EACH ADDITIONAL CRANIAL LESION, SIMPLE		\$164.37	\$164.37				
61798	1 COMPLEX CRANIAL LESION		\$601.71	\$601.71				
61799	EACH ADDITIONAL CRANIAL LESION, COMPLEX		\$227.27	\$227.27				
61800	APPLICATION OF STEREOTACTIC HEADFRAME		\$116.60	\$116.60				
	TWIST DRILL OR BURR HOLE(S) FOR IMPLANTATION OF							
61850	NEUROSTIMULATOR ELECTR		\$835.76	\$835.76				
	CRANIECTOMY OR CRANIOTOMY FOR IMPLANTATION OF							
61860	NEUROSTIMULATOR ELECTROD		\$585.61	\$585.61				
	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH							
61863	STEREOTACTIC		\$761.87	\$761.87				
	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH							
61864	STEREOTACTIC		\$217.34	\$217.34				
	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH							
61867	STEREOTACTIC		\$1,139.83	\$1,139.83				
0.4.0.0.0	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH		4000.55	4000.55				
61868	STEREOTACTIC		\$362.23	\$362.23				
	CRANIECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR							
61870	ELECTRODES, CEREBELLAR		\$301.62	\$301.62				
	REVISION OR REMOVAL OF INTRACRANIAL NEUROSTIMULATOR							
61880	ELECTRODES		\$312.36	\$312.36				

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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai	1S					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dragodyna Dogoriation	DA Ind	•	•			Value	Notes
Code	Procedure Description INSERTION OR REPLACEMENT OF CRANIAL NEUROSTIMULATOR	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
C100E	PULSE GENERATOR OR		\$128.57	¢100 57				
61885	INSERTION OR REPLACEMENT OF CRANIAL NEUROSTIMULATOR		\$128.57	\$128.57				
04000			¢440.55	¢440.55				
61886	PULSE GENERATOR OR REVISION OR REMOVAL OF CRANIAL NEUROSTIMULATOR PULSE		\$419.55	\$419.55				
64000			¢460.04	¢460.04				
61888	GENERATOR OR RECE		\$162.01	\$162.01				
62000	ELEVATION OF DEPRESSED SKULL FRACTURE; SIMPLE, EXTRADURAL		\$507.18	\$507.18				
02000	ELEVATION OF DEFRESSED SKULL FRACTURE; COMPOUND OR		φ307.10	φ507.10		+		
62005	COMMINUTED, EXTRADU		\$780.51	\$780.51				
02003	ELEVATION OF DEPRESSED SKULL FRACTURE; WITH REPAIR OF		\$700.51	\$700.51		+		
62010	DURA AND/OR		\$1,138.16	\$1,138.16				
02010	CRANIOTOMY FOR REPAIR OF DURAL/CEREBROSPINAL FLUID LEAK,		ψ1,130.10	ψ1,130.10		+	+	
62100	INCLUDING SUR		\$1,280.04	\$1,280.04				
02 100	REDUCTION OF CRANIOMEGALIC SKULL (EG, TREATED		\$1,200.04	ψ1,200.04		+	+	
62115	HYDROCEPHALUS); NOT REQU		\$1,061.77	\$1,061.77				
02110	REDUCTION OF CRANIOMEGALIC SKULL (EG, TREATED		Ψ1,001.77	ψ1,001.77				
62117	HYDROCEPHALUS); REQUIRIN		\$1,314.39	\$1,314.39				
02111	REPAIR OF ENCEPHALOCELE, SKULL VAULT, INCLUDING		ψ1,011.00	ψ1,011100		+	+	
62120	CRANIOPLASTY		\$1,156.94	\$1,156.94				
62121	CRANIOTOMY FOR REPAIR OF ENCEPHALOCELE, SKULL BASE		\$1,146.72	\$1,146.72				
62140	CRANIOPLASTY FOR SKULL DEFECT; UP TO 5 CM DIAMETER		\$788.90	\$788.90				
			,	,				
62141	CRANIOPLASTY FOR SKULL DEFECT; LARGER THAN 5 CM DIAMETER		\$963.13	\$963.13				
62142	REMOVAL OF BONE FLAP OR PROSTHETIC PLATE OF SKULL		\$695.31	\$695.31				
62143	REPLACEMENT OF BONE FLAP OR PROSTHETIC PLATE OF SKULL		\$641.40	\$641.40				

	Fee Schedule 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ						
Please us	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
		T						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CRANIOPLASTY FOR SKULL DEFECT WITH REPARATIVE BRAIN							
62145	SURGERY		\$927.42	\$927.42				
	CRANIOPLASTY WITH AUTOGRAFT (INCLUDES OBTAINING BONE							
62146	GRAFTS); UP TO 5		\$790.40	\$790.40				
	CRANIOPLASTY WITH AUTOGRAFT (INCLUDES OBTAINING BONE							
62147	GRAFTS); LARGER T		\$947.99	\$947.99				
	INCISION AND RETRIEVAL OF SUBCUTANEOUS CRANIAL BONE							
62148	GRAFT FOR CRANIOPL		\$89.82	\$89.82				
	NEUROENDOSCOPY, INTRACRANIAL, FOR PLACEMENT OR							
62160	REPLACEMENT OF VENTRICU		\$129.68	\$129.68				
	NEUROENDOSCOPY, INTRACRANIAL; WITH DISSECTION OF							
62161	ADHESIONS, FENESTRATI		\$921.37	\$921.37				
00400	NEUROENDOSCOPY, INTRACRANIAL; WITH FENESTRATION OR							
62162	EXCISION OF COLLOID		\$1,182.34	\$1,182.34				
00400	NEUROENDOSCOPY, INTRACRANIAL; WITH RETRIEVAL OF FOREIGN		Φ 747 45	ф 7 .4.7.4.5				
62163	BODY	-	\$747.15	\$747.15	-			
60464	NEUROENDOSCOPY, INTRACRANIAL; WITH EXCISION OF BRAIN TUMOR, INCLUDING		\$1,278.69	\$1,278.69				
62164	NEUROENDOSCOPY, INTRACRANIAL; WITH EXCISION OF PITUITARY		\$1,270.09	\$1,270.09				
62165	TUMOR, TRANSN		\$1,002.03	\$1,002.03				
62180	VENTRICULOCISTERNOSTOMY (TORKILDSEN TYPE OPERATION)		\$820.00	\$820.00				
02 100	CREATION OF SHUNT; SUBARACHNOID/SUBDURAL-ATRIAL, -		ψυ20.00	ψ020.00				
62190	JUGULAR, -AURICULAR		\$723.13	\$723.13				
52 100	CREATION OF SHUNT; SUBARACHNOID/SUBDURAL-PERITONEAL, -	+	ψι 20.10	Ψ120.10	+	+		+
62192	PLEURAL, OTHER		\$786.84	\$786.84				
02.102	REPLACEMENT OR IRRIGATION, SUBARACHNOID/SUBDURAL		ψ. σσ.σ :	Ψ. σσ.σ ι				
62194	CATHETER		\$139.93	\$139.93				

Physician	n Fee Schedule 2020							1
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
62200	VENTRICULOCISTERNOSTOMY, THIRD VENTRICLE;		\$918.22	\$918.22				
	VENTRICULOCISTERNOSTOMY, THIRD VENTRICLE; STEREOTACTIC,							
62201	NEUROENDOSCOPI		\$632.35	\$632.35				
62220	CREATION OF SHUNT; VENTRICULO-ATRIAL, -JUGULAR, -AURICULAR		\$843.56	\$843.56				
	CREATION OF SHUNT; VENTRICULO-PERITONEAL, -PLEURAL, OTHER							
62223	TERMINUS		\$889.15	\$889.15				
62225	REPLACEMENT OR IRRIGATION, VENTRICULAR CATHETER		\$281.05	\$281.05				
	REPLACEMENT OR REVISION OF CEREBROSPINAL FLUID SHUNT,							
62230	OBSTRUCTED VALVE		\$592.81	\$592.81				
62252	REPROGRAMMING OF PROGRAMMABLE CEREBROSPINAL SHUNT		\$58.43	\$58.43	\$28.89	\$29.54		
	REMOVAL OF COMPLETE CEREBROSPINAL FLUID SHUNT SYSTEM;							
62256	WITHOUT REPLACEM		\$372.68	\$372.68				
	REMOVAL OF COMPLETE CEREBROSPINAL FLUID SHUNT SYSTEM;							
62258	WITH REPLACEMENT		\$857.46	\$857.46				
	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION							
62263	INJECTION (EG,		\$313.87	\$313.87				
20004	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION			A 407 70				
62264	INJECTION (EG,		\$169.22	\$427.70				
62267	PERCUTANEOUS ASPIRATION WITHIN THE NUCLEUS		\$129.95	\$196.12				
62268	PERCUTANEOUS ASPIRATION, SPINAL CORD CYST OR SYRINX	1	\$202.24	\$202.24				1
62269	BIOPSY OF SPINAL CORD, PERCUTANEOUS NEEDLE		\$173.17	\$173.17				
60070	CDINIAL DUNCTURE LUMBAR DIACNOCTIC		¢50.40	¢406.75				Lindated Effective 04/04/0000
62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC		\$50.19	\$106.75	+			Updated Effective 01/01/2020
62272	THED ON DAVE DEC COE		\$70 FO	\$440.44				Rate Change Effective 01/01/2020
62272	THER SPI PNXR DRG CSF		\$70.59	\$140.11				U 1/U 1/2UZU

Physician	Fee Schedule 2020								
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	CPT book for descriptions								
	column indicates Prior Auth is required					1			
	Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service								
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns						
							Base		
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit		
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes	
62273	INJECTION, EPIDURAL, OF BLOOD OR CLOT PATCH		\$99.45	\$99.45					
	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL,								
62280	PHENOL, ICED		\$98.15	\$98.15					
	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL,								
62281	PHENOL, ICED		\$106.73	\$106.73					
	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL,								
62282	PHENOL, ICED		\$122.22	\$122.22					
	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTED								
62284	TOMOGRAPHY, SPINAL		\$106.56	\$106.56					
	ASPIRATION OR DECOMPRESSION PROCEDURE, PERCUTANEOUS,								
62287	OF NUCLEUS PULPOS		\$372.26	\$372.26					
62290	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; LUMBAR		\$160.77	\$160.77					
	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL;								
62291	CERVICAL OR THORACIC		\$142.61	\$142.61					
00000	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING		4700.50	4700.50					
62292	DISKOGRAPHY,		\$793.50	\$793.50					
00004	INJECTION PROCEDURE, ARTERIAL, FOR OCCLUSION OF		# 400.00	# 400.00					
62294	ARTERIOVENOUS MALFORMA X-RAY OF UPPER SPINAL CANAL WITH RADIOLOGICAL SUPERVISION		\$409.38	\$409.38				 	
60000			¢404.40	¢407.00				Add ad affactive 1/1/2015	
62302	AND INTERPRETATION X-RAY OF MIDDLE SPINAL CANAL WITH RADIOLOGICAL SUPERVISION		\$101.48	\$187.89				Added effective 1/1/2015	
62303	AND INTERPRETATION		\$102.77	\$194.88				Added effective 1/1/2015	
02303	X-RAY OF LOWER SPINAL CANAL WITH RADIOLOGICAL SUPERVISION		φ102.//	φ194.00		1		Added effective 1/1/2015	
62304	AND INTERPRETATION		\$99.77	\$185.41				Added effective 1/1/2015	
02304	X-RAY OF LOWER SPINAL CANAL WITH RADIOLOGICAL SUPERVISION	1	φυυ.ιι	φ100.41		+		Added ellective 1/1/2010	
62305	AND INTERPRETATION		\$104.53	\$202.07				Added effective 1/1/2015	
02303	AND INTERFREIGN	1	φ104.33	φ202.01				Auded effective 1/1/2013	

Physician	n Fee Schedule 2020							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	go for the convice					+
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Jilialy Glai		7				+
	se lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Oodes iis	The lab lee solicadic that begin with a 1-of Q are currently non-covered to	T priyaidia						+
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT	I A IIIu	(i dointy)	(Nom domey)	Comp.	Comp.	Value	110103
62310	INCLUDING NEUROLY		\$145.21	\$145.21				
62320	NJX INTERLAMINAR CRV/THRC		\$82.59	\$129.63				Added Effective 1/1/2017
62321	NJX INTERLAMINAR CRV/THRC		\$89.07	\$190.18				Added Effective 1/1/2017
62322	NJX INTERLAMINAR LMBR/SAC		\$71.09	\$120.47				Added Effective 1/1/2017
62323	NJX INTERLAMINAR LMBR/SAC		\$81.33	\$186.33				Added Effective 1/1/2017
62324	NJX INTERLAMINAR CRV/THRC		\$76.12	\$114.32				Added Effective 1/1/2017
62325	NJX INTERLAMINAR CRV/THRC		\$87.57	\$170.22				Added Effective 1/1/2017
62326	NJX INTERLAMINAR LMBR/SAC		\$74.47	\$119.44				Added Effective 1/1/2017
62327	NJX INTERLAMINAR LMBR/SAC		\$79.29	\$172.34				Added Effective 1/1/2017
62328	DX LMBR SPI PNXR W/FLUOR/CT		\$72.50	\$197.28				Added Effective 01/01/2020
60000	THER ORI PAYS OOF FLUORIOT		¢00.57	004444				Add of Effective 04/04/0000
62329	THER SPI PNXR CSF FLUOR/CT IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED		\$90.57	\$244.41				Added Effective 01/01/2020
62350	INTRATHECAL OR EPI		\$301.79	\$301.79				
02330	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED		φ301. <i>1</i> 9	φ301.79				
62351	INTRATHECAL OR EPI		\$446.28	\$446.28				
02331	REMOVAL OF PREVIOUSLY IMPLANTED INTRATHECAL OR EPIDURAL		ψ440.20	ψ440.20			+	+
62355	CATHETER		\$250.98	\$250.98				
02000	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR		Ψ200.00	Ψ230.30				+
62360	EPIDURAL DRUG		\$96.75	\$96.75				
32300	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR		Ψ00.70	Ψ00.70				+
62361	EPIDURAL DRUG		\$231.69	\$231.69				
	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR		+====================================	+ 201.00				
62362	EPIDURAL DRUG		\$303.50	\$303.50				
	1	1	7000.00	17000.00	ı			

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u> </u>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thai y Chai	T T THE SELVICE	7				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
Codes iis	The lab lee schedule that begin with a 1- of Q are currently hon-covered to	n priyaiciai	113					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Couc	REMOVAL OF SUBCUTANEOUS RESERVOIR OR PUMP, PREVIOUSLY	I A IIId	(i domey)	(Norm domey)	Comp.	Comp.	Value	Notes
62365	IMPLANTED FOR		\$249.56	\$249.56				
02000	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR		Ψ2 10.00	φ2 10.00				
62367	INTRATHECAL OR		\$17.57	\$30.58		\$25.17		
02001	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR		Ψ11.01	φοσ.σσ		Ψ20		
62368	INTRATHECAL OR		\$30.53	\$39.43		\$39.43		
62369	WITH REPROGRAMING AND REFILL		\$28.46	\$96.43		+00110		
02000	WITH TELL TO GIV WINTED THE TELL		Ψ20.10	φσσ. 10				
62370	WITH REPROGRAMING AND REFILL (REQUIRING PHYSICIAN'S SKILL)		\$38.12	\$101.44				
62380	NDSC DCMPRN 1 NTRSPC LUMBAR		\$0.00	\$0.00				Added Effective 1/1/2017
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF		75155	70.00				
63001	SPINAL CORD AND/O		\$1,006.13	\$1,006.13				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF		, , , , , , , , , , , , , , , , , , , ,	, , , , , , , ,				
63003	SPINAL CORD AND/O		\$988.70	\$988.70				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF							
63005	SPINAL CORD AND/O		\$936.90	\$936.90				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF							
63011	SPINAL CORD AND/O		\$639.40	\$639.40				
	LAMINECTOMY WITH REMOVAL OF ABNORMAL FACETS AND/OR							
63012	PARS INTER-ARTICULA		\$978.18	\$978.18				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF							
63015	SPINAL CORD AND/O		\$1,157.81	\$1,157.81				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF							
63016	SPINAL CORD AND/O		\$1,209.45	\$1,209.45				
	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF							
63017	SPINAL CORD AND/O		\$1,106.51	\$1,106.51				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes ils	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai	ns					
							Base	
Droo			Innet Bete	Outpat. Rate	Tech.	Prof.	Unit	
Proc	Bus as divine December to in	DA local	Inpat. Rate	•				Notes
Code	Procedure Description LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
62020			#000 00	#000 00				
63020	NERVE ROOT(S), LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		\$880.03	\$880.03				
62020			#020.27	¢020.27				
63030	NERVE ROOT(S), LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		\$839.37	\$839.37				
62025			\$219.26	\$219.26				
63035	NERVE ROOT(S), LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		\$219.20	\$219.20				
62040			¢4 000 74	¢4 000 74				
63040	NERVE ROOT(S), LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		\$1,222.71	\$1,222.71				
63042	NERVE ROOT(S),		\$1,205.96	\$1,205.96				
03042	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		\$1,205.96	\$1,205.90				
63043	NERVE ROOT(S),		\$283.74	\$283.74				
03043	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF		φ203.74	φ203.74				
63044	NERVE ROOT(S),		\$269.57	\$269.57				
03044	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL		\$209.57	\$209.37				
63045	OR BILATERAL WIT		\$1,081.12	\$1,081.12				
03043	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL		φ1,001.12	φ1,001.12			+	
63046	OR BILATERAL WIT		\$1,041.57	\$1,041.57				
03040	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL		φ1,041.37	φ1,041.37			+	
63047	OR BILATERAL WIT		\$921.29	\$921.29				
03047	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL		φ921.29	φ921.29				
63048	OR BILATERAL WIT		\$232.54	\$232.54				
00040	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL	+	Ψ202.04	Ψ202.04			+	
63050	CORD, TWO OR		\$1,037.95	\$1,037.95				
03030	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL		ψ1,031.33	ψ1,037.33			+	
62051	CORD, TWO OR		¢1 192 20	¢1 192 20				
63051	ICOLD, IWO OK	1	\$1,183.39	\$1,183.39				

Physician	Fee Schedule 2020							
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Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL							
63055	CORD, EQUINA AND/		\$1,344.58	\$1,344.58				
00050	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL		4.007.04	04.007.04				
63056	CORD, EQUINA AND/		\$1,237.91	\$1,237.91	_			+
00057	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL		#044.00	0044 00				
63057	CORD, EQUINA AND/ COSTOVERTEBRAL APPROACH WITH DECOMPRESSION OF SPINAL		\$211.68	\$211.68				+
63064	CORD OR NERVE ROO		\$1,420.20	\$1,420.20				
03004	COSTOVERTEBRAL APPROACH WITH DECOMPRESSION OF SPINAL		\$1,420.20	\$1,420.20				
63066	CORD OR NERVE ROO		\$173.11	\$173.11				
03000	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD		ψ1/3.11	ψ173.11			+	+
63075	AND/ OR NERVE		\$1,129.38	\$1,129.38				
00070	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD		Ψ1,123.30	ψ1,123.30				+
63076	AND/ OR NERVE		\$281.62	\$281.62				
000.0	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD		Ψ201.02	Ψ201.02			+	
63077	AND/ OR NERVE		\$1,165.29	\$1,165.29				
	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD		, , , , , , , , , , , , , , , , , , , ,	, , , , , , ,				1
63078	AND/ OR NERVE		\$177.19	\$177.19				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		·					
63081	PARTIAL OR COMPLETE,		\$1,461.59	\$1,461.59				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63082	PARTIAL OR COMPLETE,		\$308.08	\$308.08				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63085	PARTIAL OR COMPLETE,		\$1,584.26	\$1,584.26				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63086	PARTIAL OR COMPLETE,		\$229.04	\$229.04				

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	olumn indicates Prior Auth is required						_	
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service	!		_	+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						_	
	te lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 i					_	+	
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai T	ns T				-	<u> </u>
							Base	
Droo			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Proc	Due and true Dan order tions	DA In al	•	•		Comp.	Value	Notes
Code	Procedure Description VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
62007			¢1 604 00	¢4 604 20				
63087	PARTIAL OR COMPLETE, VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		\$1,684.28	\$1,684.28				
00000			#204.50	#204.50				
63088	PARTIAL OR COMPLETE, VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		\$304.59	\$304.59			-	<u> </u>
62000			¢4 670 00	¢4 670 00				
63090	PARTIAL OR COMPLETE, VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		\$1,672.09	\$1,672.09			_	
00004			¢470.04	£470.04				
63091	PARTIAL OR COMPLETE, VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		\$173.31	\$173.31			_	
00404			Φ4 F0F FF	Φ4 F0F FF				
63101	PARTIAL OR COMPLETE,		\$1,565.55	\$1,565.55				
00400	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		Φ4 F0F FF	Φ4 F0F FF				
63102	PARTIAL OR COMPLETE,		\$1,565.55	\$1,565.55			_	
00400	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),		¢400.50	¢400.50				
63103	PARTIAL OR COMPLETE,		\$183.56	\$183.56			_	
62470	LAMINECTOMY WITH MYELOTOMY (EG, BISCHOF OR DREZ TYPE),		¢4 440 EC	¢4 440 56				
63170	CERVICAL, THORA LAMINECTOMY WITH DRAINAGE OF INTRAMEDULLARY CYST/SYRINX;		\$1,119.56	\$1,119.56				
62470	· ·		¢4 404 04	¢4 404 04				
63172	TO SUBARACHNO		\$1,134.34	\$1,134.34				
63173	LAMINECTOMY WITH DRAINAGE OF INTRAMEDULLARY CYST/SYRINX; TO PERITONEAL		¢4 057 50	\$1,057.52			1	
63173			\$1,057.52	\$1,057.52			-	<u> </u>
62400	LAMINECTOMY AND SECTION OF DENTATE LIGAMENTS, WITH OR		¢050.70	¢050.70			1	
63180	WITHOUT DURAL GR LAMINECTOMY AND SECTION OF DENTATE LIGAMENTS, WITH OR		\$852.72	\$852.72			1	<u> </u>
62402	· ·		¢1 040 54	¢4 040 54				
63182	WITHOUT DURAL GR	l _D	\$1,049.54	\$1,049.54				<u> </u>
63185	LAMINECTOMY WITH RHIZOTOMY; ONE OR TWO SEGMENTS	R	\$894.68	\$894.68				<u> </u>
63190	LAMINECTOMY WITH RHIZOTOMY; MORE THAN TWO SEGMENTS		\$1,130.30	\$1,130.30				<u> </u>
63191	LAMINECTOMY WITH SECTION OF SPINAL ACCESSORY NERVE		\$885.28	\$885.28				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
22.42.4	LAMINECTOMY WITH CORDOTOMY, WITH SECTION OF ONE		****	400000				
63194	SPINOTHALAMIC TRACT, O		\$920.23	\$920.23				
00405	LAMINECTOMY WITH CORDOTOMY, WITH SECTION OF ONE		4000 50	4000 50				
63195	SPINOTHALAMIC TRACT, O		\$926.56	\$926.56				
00400	LAMINECTOMY WITH CORDOTOMY, WITH SECTION OF BOTH		#4 000 00	#4 000 00				
63196	SPINOTHALAMIC TRACTS, LAMINECTOMY WITH CORDOTOMY, WITH SECTION OF BOTH		\$1,066.22	\$1,066.22	_			
62407			¢4 047 50	¢4 047 50				
63197	SPINOTHALAMIC TRACTS, LAMINECTOMY WITH CORDOTOMY WITH SECTION OF BOTH		\$1,017.50	\$1,017.50				
63198	SPINOTHALAMIC TRACTS,		\$1,174.01	\$1,174.01				
03190	LAMINECTOMY WITH CORDOTOMY WITH SECTION OF BOTH		φ1,174.01	φ1,174.01			+	+
63199	SPINOTHALAMIC TRACTS,		\$1,338.43	\$1,338.43				
00100	LAMINECTOMY, WITH RELEASE OF TETHERED SPINAL CORD,		ψ1,330.43	ψ1,000.40				
63200	LUMBAR		\$897.68	\$897.68				
00200	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS		Ψ007.00	Ψ007.00				
63250	MALFORMATION OF		\$2,012.30	\$2,012.30				
	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS		7=,01=100	7=,0:=:00				
63251	MALFORMATION OF		\$1,855.19	\$1,855.19				
	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS		. ,					
63252	MALFORMATION OF		\$2,031.85	\$2,031.85				
	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL							
63265	LESION OTHER THA		\$1,273.16	\$1,273.16				
	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL							
63266	LESION OTHER THA		\$1,377.70	\$1,377.70	1			
	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL							
63267	LESION OTHER THA		\$1,165.55	\$1,165.55				

Physician	n Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL							
63268	LESION OTHER THA		\$903.42	\$903.42				
	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN							
63270	NEOPLASM,		\$1,298.55	\$1,298.55				
00074	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN		04 500 07	04 500 07				
63271	NEOPLASM, LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN		\$1,562.27	\$1,562.27				
63272	NEOPLASM.		¢4 440 50	¢4 440 50				
03212	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN		\$1,419.59	\$1,419.59				
63273	NEOPLASM.		\$1,211.73	\$1,211.73				
03273	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM:		φ1,211.73	φ1,211.73	+			+
63275	EXTRADURAL,		\$1,516.89	\$1,516.89				
00210	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM:		Ψ1,010.00	Ψ1,010.00				
63276	EXTRADURAL.		\$1,429.64	\$1,429.64				
002.0	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;		Ψ1,120.01	Ψ1,120.01				
63277	EXTRADURAL, L		\$1,312.78	\$1,312.78				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;			,				
63278	EXTRADURAL, S		\$1,295.56	\$1,295.56				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;			·				
63280	INTRADURAL,		\$1,658.47	\$1,658.47				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63281	INTRADURAL,		\$1,637.94	\$1,637.94				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63282	INTRADURAL,		\$1,486.98	\$1,486.98				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63283	INTRADURAL, S		\$1,278.66	\$1,278.66				

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63285	INTRADURAL,		\$1,770.69	\$1,770.69				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63286	INTRADURAL,		\$1,886.87	\$1,886.87				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63287	INTRADURAL,		\$1,810.23	\$1,810.23				
	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM;							
63290	COMBINED		\$1,869.67	\$1,869.67				
	OSTEOPLASTIC RECONSTRUCTION OF DORSAL SPINAL ELEMENTS,							
63295	FOLLOWING PRIMA		\$237.05	\$237.05				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63300	PARTIAL OR COMPLETE,		\$1,180.74	\$1,180.74				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63301	PARTIAL OR COMPLETE,		\$1,317.79	\$1,317.79				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63302	PARTIAL OR COMPLETE,		\$1,397.49	\$1,397.49				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63303	PARTIAL OR COMPLETE,		\$1,413.99	\$1,413.99				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63304	PARTIAL OR COMPLETE,		\$1,456.63	\$1,456.63				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63305	PARTIAL OR COMPLETE,		\$1,557.63	\$1,557.63				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63306	PARTIAL OR COMPLETE,		\$1,555.46	\$1,555.46				
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63307	PARTIAL OR COMPLETE,		\$1,590.69	\$1,590.69				

Physician	Fee Schedule 2020							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),							
63308	PARTIAL OR COMPLETE,		\$280.42	\$280.42				
	CREATION OF LESION OF SPINAL CORD BY STEREOTACTIC METHOD,							
63600	PERCUTANEOUS		\$734.71	\$734.71				
	STEREOTACTIC STIMULATION OF SPINAL CORD, PERCUTANEOUS,							
63610	SEPARATE PROCED		\$486.74	\$486.74				
63620	STEREOTACTIC RADIOSURGERY; 1 SPINAL LESION		\$601.71	\$601.71				
63621	STEREOTACTIC RADIOSURGERY; 1 SPINAL LESION		\$189.00	\$189.00				
	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR							
63650	ELECTRODE ARRAY, EPIDURAL		\$433.25	\$433.25				
	LAMINECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR							
63655	ELECTRODES, PLATE/PADD		\$671.06	\$671.06				
	REMOVAL OF SPINAL NEUROSTMIULATOR ELECTRODE							
63661	PERCUTANEOUS ARRAY(S)		\$227.64	\$394.52				
	REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE							
	PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCL							
63662	FLUORO		\$514.42	\$514.42				
	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF							
	SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S)							
63663	INC FLUORO		\$346.66	\$580.39				
	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF							
	SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED							
63664	VIA LAMINOTOMY OR LAMINECTOMYM, INCLUDING FLUORO		\$535.89	\$535.89	1			
	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR							
63685	PULSE GENERATOR OR		\$418.53	\$418.53				

Physician	Fee Schedule 2020			1				
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR							
63688	PULSE GENERATO		\$334.20	\$334.20				
63700	REPAIR OF MENINGOCELE; LESS THAN 5 CM DIAMETER		\$816.72	\$816.72				
63702	REPAIR OF MENINGOCELE; LARGER THAN 5 CM DIAMETER		\$918.85	\$918.85				
63704	REPAIR OF MYELOMENINGOCELE; LESS THAN 5 CM DIAMETER		\$1,020.70	\$1,020.70				
63706	REPAIR OF MYELOMENINGOCELE; LARGER THAN 5 CM DIAMETER		\$1,174.04	\$1,174.04				
	REPAIR OF DURAL/CEREBROSPINAL FLUID LEAK, NOT REQUIRING		, ,					
63707	LAMINECTOMY		\$707.90	\$707.90				
	REPAIR OF DURAL/CEREBROSPINAL FLUID LEAK OR							
63709	PSEUDOMENINGOCELE, WITH		\$924.45	\$924.45				
63710	DURAL GRAFT, SPINAL		\$681.67	\$681.67				
	CREATION OF SHUNT, LUMBAR, SUBARACHNOID-PERITONEAL, -							
63740	PLEURAL, OR OTHER		\$736.78	\$736.78				
	CREATION OF SHUNT, LUMBAR, SUBARACHNOID-PERITONEAL, -							
63741	PLEURAL, OR OTHER		\$512.18	\$512.18				
	REPLACEMENT, IRRIGATION OR REVISION OF							
63744	LUMBOSUBARACHNOID SHUNT		\$459.84	\$459.84				
	REMOVAL OF ENTIRE LUMBOSUBARACHNOID SHUNT SYSTEM							
63746	WITHOUT REPLACEMENT		\$338.62	\$338.62				
	INJECTION, ANESTHETIC AGENT; TRIGEMINAL NERVE, ANY DIVISION							
64400	OR BRANCH		\$39.54	\$81.31				Updated Effective 01/01/2020
64402	INJECTION, ANESTHETIC AGENT; FACIAL NERVE		\$55.50	\$55.50				
64405	INJECTION, ANESTHETIC AGENT; GREATER OCCIPITAL NERVE		\$42.97	\$56.46				Updated Effective 01/01/2020
64408	INJECTION, ANESTHETIC AGENT; VAGUS NERVE		\$34.75	\$53.43				Updated Effective 01/01/2020

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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	ise lab fee schedule for covered codes not listed below in the 80000-89249							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
64410	INJECTION, ANESTHETIC AGENT; PHRENIC NERVE	I A IIIQ	\$64.65	\$64.65	Comp.	Comp.	Value	140103
64413	INJECTION, ANESTHETIC AGENT; CERVICAL PLEXUS		\$52.95	\$62.87				
	,							
64415	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS, SINGLE		\$51.73	\$87.79				Updated Effective 01/01/2020
	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS, CONTINUOUS							
64416	INFUSION BY		\$52.68	\$52.68				Updated Effective 01/01/2020
64417	INJECTION, ANESTHETIC AGENT; AXILLARY NERVE		\$49.40	\$104.91				Updated Effective 01/01/2020
04417	INDECTION, AND CONTROL AND AND AND AND AND AND AND AND AND AND		ψ+3.40	φ104.01				Spaced Encouve 6 1/6 1/2020
64418	INJECTION, ANESTHETIC AGENT; SUPRASCAPULAR NERVE		\$45.97	\$66.20				Updated Effective 01/01/2020
64420	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVE, SINGLE		\$47.99	\$77.31				Updated Effective 01/01/2020
04420	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVES, MULTIPLE,		ψ+7.55	ψ11.51				Opdated Effective 01/01/2020
64421	REGIONAL BL		\$20.50	\$26.73				Updated Effective 01/01/2020
	INJECTION, ANESTHETIC AGENT; ILIOINGUINAL, ILIOHYPOGASTRIC							
64425	NERVES		\$44.62	\$85.87				Updated Effective 01/01/2020
64430	INJECTION, ANESTHETIC AGENT; PUDENDAL NERVE		\$44.36	\$69.78				Updated Effective 01/01/2020
64435	INJECTION, ANESTHETIC AGENT; PARACERVICAL (UTERINE) NERVE		\$34.98	\$56.51				Updated Effective 01/01/2020
64445	INJECTION, ANESTHETIC AGENT; SCIATIC NERVE, SINGLE		\$43.35	\$95.75				Updated Effective 01/01/2020
	INJECTION, ANESTHETIC AGENT; SCIATIC NERVE, CONTINUOUS					1		
64446	INFUSION BY		\$48.65	\$48.65				Updated Effective 01/01/2020
64447	INJECTION, ANESTHETIC AGENT; FEMORAL NERVE, SINGLE		\$43.16	\$69.10				Updated Effective 01/01/2020

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	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INJECTION, ANESTHETIC AGENT; FEMORAL NERVE, CONTINUOUS							
64448	INFUSION BY CAT		\$50.37	\$50.37				Updated Effective 01/01/2020
	INJECTION, ANESTHETIC AGENT; LUMBAR PLEXUS, POSTERIOR							
64449	APPROACH, CONTIN		\$50.42	\$50.42				Updated Effective 01/01/2020
	INJECTION, ANESTHETIC AGENT; OTHER PERIPHERAL NERVE OR							
64450	BRANCH		\$34.23	\$58.88				Updated Effective 01/01/2020
C4454	NJX AA&/STRD NRV NRVTG SI JT		\$64.16	\$160.15				Added Effective 04/04/2020
64451	NJA AA&/STRD NRV NRVTG SLJT		\$64.16	\$160.15				Added Effective 01/01/2020
64454	NJX AA&/STRD GNCLR NRV BRNCH		\$65.98	\$161.70				Added Effective 01/01/2020
04404	INJECTIONS OF ANESTHETIC AND/OR STEROID DRUG INTO NERVE		ψ00.50	ψ101.70				Added Effective 01/01/2020
64455	OF FOOT		\$40.35	\$32.04				
64461	PARAVERTEBRAL BLOCK THORACIC SINGLE INJECTION SITE		\$70.96	\$116.24				Added Effective 1/1/2016
64462	SECOND AND ANY ADDITIONAL INJECTION SITE(S)		\$44.57	\$66.04				Added Effective 1/1/2016
64463	CONTINOUS INFUSION BY CATHETER		\$69.94	\$127.89				Added Effective 1/1/2016
	INJECTION, ANESTHETIC AGENT AND/OR STEROID,		700101	7 1-1100				
64479	TRANSFORAMINAL EPIDURAL;		\$162.85	\$162.85				
	INJECTION, ANESTHETIC AGENT AND/OR STEROID,			,				1
64480	TRANSFORAMINAL EPIDURAL;		\$145.49	\$145.49				
	INJECTION, ANESTHETIC AGENT AND/OR STEROID,							
64483	TRANSFORAMINAL EPIDURAL; L		\$149.91	\$149.91				
	INJECTION, ANESTHETIC AGENT AND/OR STEROID,							
64484	TRANSFORAMINAL EPIDURAL; L		\$137.14	\$137.14				
	INJECTIONS OF LOCAL ANESTHETIC FOR PAIN CONTROL AND							
64486	ABDOMINAL WALL ANALGESIA ON ONE SIDE		\$51.42	\$95.92				Added effective 1/1/2015
	CONTINUOUS INFUSIONS OF LOCAL ANESTHETIC FOR PAIN							
64487	CONTROL AND ABDOMINAL WALL ANALGESIA ON ONE SIDE		\$59.18	\$116.88				Added effective 1/1/2015

Physician	n Fee Schedule 2020							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INJECTIONS OF LOCAL ANESTHETIC FOR PAIN CONTROL AND							
64488	ABDOMINAL WALL ANALGESIA ON BOTH SIDES		\$64.53	\$118.09				Added effective 1/1/2015
	CONTINUOUS INFUSIONS OF LOCAL ANESTHETIC FOR PAIN							
64489	CONTROL AND ABDOMINAL WALL ANALGESIA ON BOTH SIDES		\$72.47	\$162.50				Added effective 1/1/2015
	INJECTIONS OF UPPER OR MIDDLE SPINE FACET JOINT USING							
64490	IMAGING GUIDANCE		\$88.94	\$133.62				
64491	SECOND LEVEL		\$46.83	\$68.01				
64492	THIRD AND ANY ADDITIONAL LEVEL(S)		\$47.59	\$68.77				
	INJECTION(S), DIAGNOSTIC/THERAPEUTIC AGENT, PARAVERTEBRAL							
64493	FACET JOINT W/IMAGE GUIDANCE LUMBAR/SACRAL;SINGLE LEVEL		\$68.79	\$119.31				
64494	SECOND LEVEL		\$40.06	\$61.74				
64495	THIRD AND ANY ADDITIONAL LEVEL(S)		\$40.82	\$62.51				
64505	INJECTION, ANESTHETIC AGENT; SPHENOPALATINE GANGLION		\$49.68	\$57.99				
0.45.40	INJECTION, ANESTHETIC AGENT; STELLATE GANGLION (CERVICAL		450.00	#50.00				
64510	SYMPATHETIC)		\$59.22	\$59.22				
04547	IN JECTION ANECTHETIC ACENT, CURERIOR LIVEOCACTRIC DI EVILIC		#00.07	# 407.00				
64517	INJECTION, ANESTHETIC AGENT; SUPERIOR HYPOGASTRIC PLEXUS		\$89.27	\$137.32				
04500	INJECTION, ANESTHETIC AGENT; LUMBAR OR THORACIC		# 00.00	¢00.00				
64520	(PARAVERTEBRAL SYMPATH		\$63.06	\$63.06				
64520	INJECTION, ANESTHETIC AGENT; CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC		¢04 55	¢04 55				
64530	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR		\$84.55	\$84.55				+
64552			¢02.42	¢06.40				
64553	ELECTRODES; CRANIAL NERVE PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR		\$82.43	\$96.10				+
GAEEE			¢72.24	¢70.04				
64555	ELECTRODES; PERIPHERAL NE		\$73.21	\$78.84				

Physician	n Fee Schedule 2020							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR							
64561	ELECTRODES; SACRAL NERVE		\$295.59	\$591.15				
	INCISION FOR IMPLANTATION OF CRANIAL NERVE							
64568	NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR.		\$560.47	\$560.47				
	REVISION OR REPLACEMENT OF CRANIAL NERVE							
0.4500	NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION		4550.05	# 550.05				
64569	TO EXISTING PULSE GENERATOR		\$553.35	\$553.35				
0.4570	REMOVAL OF CRANIAL NERVE NEUROSTIMULATOR ELECTRODE		0407.40	0407.40				
64570	ARRAY AND PULSE GENERATOR INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES:		\$487.18	\$487.18				
CAEZE	PERIPHERAL NE		\$217.36	\$217.36				
64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES:		\$217.30	\$217.30				
64580	NEUROMUSCULAR		\$201.46	\$201.46				
04300	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES;		φ201.40	φ201.40				+
64581	SACRAL NERVE		\$571.23	\$571.23				
04301	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR		ψ37 1.23	ψ37 1.23				
64585	ELECTRODES		\$87.18	\$87.18				
0 1000	INSERTION OR REPLACEMENT OF PERIPHERAL NEUROSTIMULATOR		Ψον.το	ΨΟΥ.ΤΟ				+
64590	PULSE GENERATOR		\$126.81	\$126.81				
0.000	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR PULSE		4.20.0	Ų 1200 I				
64595	GENERATOR OR		\$84.44	\$84.44				
	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE;				1			
64600	SUPRAORBITAL,		\$149.23	\$149.23				
	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE;							
64605	SECOND AND THIRD		\$213.01	\$213.01				

Physician	Fee Schedule 2020							
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	les in Red;						+	
	CPT book for descriptions							
	column indicates Prior Auth is required							1
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	,				1
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
]						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE;		(i domey)	(real damey)				110100
64610	SECOND AND THIRD		\$436.16	\$436.16				
	CHEMODENERVATION OF PAROTID AND SUBMANDIBULAR SALIVARY			,				1
64611	GLANDS, BILATERAL		\$79.22	\$87.53				
	CHEMODENERVATION OF MUSCLE(S); MUSCLE(S) INNERVATED BY							
64612	FACIAL NERVE (E		\$79.62	\$99.07				
	CHEMODENERVATION OF MUSCLE(S); NECK MUSCLE(S) (EG, FOR							
64613	SPASMODIC		\$79.62	\$99.07				
	CHEMODENERVATION OF MUSCLE(S); EXTREMITY(S) AND/OR TRUNK							
64614	MUSCLE(S) (EG		\$88.22	\$154.30				
64615	MUSCLE(S) INNERVATED BY FACIAL, TRIGEMINAL, CERVICAL		\$101.83	\$112.68				
64616	CHEMODENERV MUSC NECK DYSTON		\$83.99	\$94.60				
64617	CHEMODENER MUSCLE LARYNX EMG		\$90.89	\$146.26				
64624	DSTRJ NULYT AGT GNCLR NRV		\$117.57	\$307.98				Added Effective 01/01/2020
64625	RF ABLTJ NRV NRVTG SI JT		\$155.64	\$377.45				Added Effective 01/01/2020
64630	DESTRUCTION BY NEUROLYTIC AGENT; PUDENDAL NERVE		\$142.47	\$142.47				
64632	DESTRUCTION BY NEUROLYTIC AGENT, PLANTAR		\$55.78	\$65.27				
	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET							
	JOINT NERVE(S) WITH IMAGING GUIDANCE(FLUROSCOPY OR							
64633	CT)CERVICAL OR THORACIC, SINGLE FACET JOINT		\$189.06	\$353.68				
	CERVICAL OR THORACIC, EACH ADDITIONAL FACET JOINT (LIST							
64634	SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		\$57.02	\$160.91				
64635	LUMBAR OR SACRAL, SINGLE FACET JOINT		\$185.30	\$347.59				
64636	LUMBAR OR SACRAL, EACH ADDITIONAL FACET JOINT(LIST SEPARAETLY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		\$49.64	\$144.74				

Physician	Fee Schedule 2020							
Note:								
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	column indicates Prior Auth is required				+			
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
_		Ι΄ ΄						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DESTRUCTION BY NEUROLYTIC AGENT; OTHER PERIPHERAL NERVE			,				
64640	OR BRANCH		\$99.93	\$99.93				
64642	CHEMODENERV 1 EXTREMITY 1-4		\$84.53	\$107.56				
64643	CHEMODENERV 1 EXTREM 1-4 EA		\$57.03	\$71.26				
64644	CHEMODENERV 1 EXTREM 5/> MUS		\$92.37	\$122.64				
64645	CHEMODENERV 1 EXTREM 5/> EA		\$65.32	\$86.80				
64646	CHEMODENERV TRUNK MUSC 1-5		\$91.51	\$115.83				
64647	CHEMODENERV TRUNK MUSC 6/>		\$105.74	\$134.20				
64702	NEUROPLASTY; DIGITAL, ONE OR BOTH, SAME DIGIT		\$248.16	\$248.16				
64704	NEUROPLASTY; NERVE OF HAND OR FOOT		\$292.57	\$292.57				
	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; OTHER							
64708	THAN SPECIFIED		\$394.24	\$394.24				
	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; SCIATIC							
64712	NERVE		\$498.00	\$498.00				
	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG;							
64713	BRACHIAL PLEXUS		\$597.33	\$597.33				
	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; LUMBAR							
64714	PLEXUS		\$488.30	\$488.30				
64716	NEUROPLASTY AND/OR TRANSPOSITION; CRANIAL NERVE (SPECIFY)		\$316.02	\$316.02				
64718	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT ELBOW		\$368.50	\$368.50				
64719	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT WRIST		\$291.92	\$291.92				
	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL							
64721	TUNNEL		\$284.77	\$284.77				
64722	DECOMPRESSION; UNSPECIFIED NERVE(S) (SPECIFY)		\$311.00	\$311.00				

Physician	Fee Schedule 2020							
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	es in Red;				1			
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
64726	DECOMPRESSION; PLANTAR DIGITAL NERVE		\$137.51	\$137.51				
	INTERNAL NEUROLYSIS, REQUIRING USE OF OPERATING							
64727	MICROSCOPE (LIST SEPAR		\$191.23	\$191.23				
64732	TRANSECTION OR AVULSION OF; SUPRAORBITAL NERVE		\$254.87	\$254.87				
64734	TRANSECTION OR AVULSION OF; INFRAORBITAL NERVE		\$275.50	\$275.50				
64736	TRANSECTION OR AVULSION OF; MENTAL NERVE		\$258.94	\$258.94				
	TRANSECTION OR AVULSION OF; INFERIOR ALVEOLAR NERVE BY							
64738	OSTEOTOMY		\$309.85	\$309.85				
64740	TRANSECTION OR AVULSION OF; LINGUAL NERVE		\$308.94	\$308.94				
	TRANSECTION OR AVULSION OF; FACIAL NERVE, DIFFERENTIAL OR							
64742	COMPLETE		\$318.22	\$318.22				
64744	TRANSECTION OR AVULSION OF; GREATER OCCIPITAL NERVE		\$333.25	\$333.25				
64746	TRANSECTION OR AVULSION OF; PHRENIC NERVE		\$284.74	\$284.74				
	TRANSECTION OR AVULSION OF; VAGUS NERVES LIMITED TO		4=00.00	4=00.00				
64755	PROXIMAL STOMACH		\$720.38	\$720.38				
0.4700	TRANSECTION OR AVULSION OF; VAGUS NERVE (VAGOTOMY),		A 400 70	A 400 70				
64760	ABDOMINAL		\$406.72	\$406.72				
0.4700	TRANSECTION OR AVULSION OF OBTURATOR NERVE, EXTRAPELVIC,		#240.00	#240.00				
64763	WITH OR WITHO TRANSECTION OR AVULSION OF OBTURATOR NERVE, INTRAPELVIC,		\$348.29	\$348.29	-			
0.4700	WITH OR WITHO		\$451.91	\$451.91				
64766	TRANSECTION OR AVULSION OF OTHER CRANIAL NERVE,		\$451.91	\$451.91	1			+
64771	EXTRADURAL		\$395.05	\$395.05				
04771	TRANSECTION OR AVULSION OF OTHER SPINAL NERVE,		φ383.U3	ტ აყა.03	+			+
64772	EXTRADURAL		\$412.42	\$412.42				
04112	EXCISION OF NEUROMA; CUTANEOUS NERVE, SURGICALLY	1	φ4 12.42	φ412.42	+			+
64774	IDENTIFIABLE		\$227.04	\$227.04				
04774	ווירוא דוו ועסרב		φ∠∠1.04	φ∠∠1.04	1			

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)			1	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r						1	
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	าร				1	
			_				Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
64776	EXCISION OF NEUROMA; DIGITAL NERVE, ONE OR BOTH, SAME DIGIT		\$227.14	\$227.14			1	
	EXCISION OF NEUROMA; DIGITAL NERVE, EACH ADDITIONAL DIGIT							
64778	(LIST SEPARA		\$174.93	\$174.93				
64782	EXCISION OF NEUROMA; HAND OR FOOT, EXCEPT DIGITAL NERVE		\$307.73	\$307.73				
	EXCISION OF NEUROMA; HAND OR FOOT, EACH ADDITIONAL NERVE,							
64783	EXCEPT SAME		\$208.02	\$208.02				
	EXCISION OF NEUROMA; MAJOR PERIPHERAL NERVE, EXCEPT							
64784	SCIATIC		\$452.19	\$452.19				
64786	EXCISION OF NEUROMA; SCIATIC NERVE		\$834.65	\$834.65				
	IMPLANTATION OF NERVE END INTO BONE OR MUSCLE (LIST							
64787	SEPARATELY IN ADDI		\$233.83	\$233.83				
	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; CUTANEOUS							
64788	NERVE		\$235.69	\$235.69				
	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; MAJOR							
64790	PERIPHERAL NERVE		\$541.66	\$541.66				
	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; EXTENSIVE							
64792	(INCLUDING MALIGNA		\$704.01	\$704.01				
64795	BIOPSY OF NERVE		\$161.64	\$161.64				
64802	SYMPATHECTOMY, CERVICAL		\$412.77	\$412.77				
64804	SYMPATHECTOMY, CERVICOTHORACIC		\$802.34	\$802.34				
64809	SYMPATHECTOMY, THORACOLUMBAR		\$707.85	\$707.85				
64818	SYMPATHECTOMY, LUMBAR		\$548.07	\$548.07				
64820	SYMPATHECTOMY; DIGITAL ARTERIES, EACH DIGIT		\$522.94	\$522.94	1			
64821	SYMPATHECTOMY; RADIAL ARTERY		\$459.57	\$459.57	1			
64822	SYMPATHECTOMY; ULNAR ARTERY		\$459.57	\$459.57				

Physician	Fee Schedule 2020							
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	les in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	rae for the service	2				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l	ge for the service	<u> </u>				
	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns			+		
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
64823	SYMPATHECTOMY; SUPERFICIAL PALMAR ARCH		\$531.34	\$531.34				
64831	SUTURE OF DIGITAL NERVE, HAND OR FOOT; ONE NERVE		\$363.66	\$363.66				
	SUTURE OF DIGITAL NERVE, HAND OR FOOT; EACH ADDITIONAL			Ì				
64832	DIGITAL NERVE (\$209.47	\$209.47				
64834	SUTURE OF ONE NERVE, HAND OR FOOT; COMMON SENSORY NERVE		\$394.17	\$394.17				
64835	SUTURE OF ONE NERVE, HAND OR FOOT; MEDIAN MOTOR THENAR		\$492.11	\$492.11				
64836	SUTURE OF ONE NERVE, HAND OR FOOT; ULNAR MOTOR		\$516.58	\$516.58				
	SUTURE OF EACH ADDITIONAL NERVE, HAND OR FOOT (LIST							
64837	SEPARATELY IN ADDI		\$323.70	\$323.70				
64840	SUTURE OF POSTERIOR TIBIAL NERVE		\$655.22	\$655.22				
	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT							
64856	SCIATIC; INCLUDIN		\$631.58	\$631.58				
	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT							
64857	SCIATIC; WITHOUT		\$687.12	\$687.12				
64858	SUTURE OF SCIATIC NERVE		\$798.55	\$798.55				
	SUTURE OF EACH ADDITIONAL MAJOR PERIPHERAL NERVE (LIST							
64859	SEPARATELY IN		\$232.97	\$232.97				
64861	SUTURE OF; BRACHIAL PLEXUS		\$919.91	\$919.91				
64862	SUTURE OF; LUMBAR PLEXUS		\$1,149.69	\$1,149.69				
64864	SUTURE OF FACIAL NERVE; EXTRACRANIAL		\$587.31	\$587.31				
04005	SUTURE OF FACIAL NERVE; INFRATEMPORAL, WITH OR WITHOUT		#700 70	#700 70				
64865	GRAFTING		\$798.78	\$798.78				
64866	ANASTOMOSIS; FACIAL-SPINAL ACCESSORY		\$783.24	\$783.24				
64868	ANASTOMOSIS; FACIAL-HYPOGLOSSAL		\$727.89	\$727.89				

Physician	Fee Schedule 2020							
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	des in Red;							
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	column indicates Prior Auth is required							1
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	е				1
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SUTURE OF NERVE; REQUIRING SECONDARY OR DELAYED SUTURE							
64872	(LIST SEPARATEL		\$104.06	\$104.06				
	SUTURE OF NERVE; REQUIRING EXTENSIVE MOBILIZATION, OR							
64874	TRANSPOSITION OF		\$156.10	\$156.10				
	SUTURE OF NERVE; REQUIRING SHORTENING OF BONE OF							
64876	EXTREMITY (LIST SEPAR		\$176.83	\$176.83				
0.400=	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK; UP		****	****				
64885	TO 4 CM IN LE		\$867.25	\$867.25				
0.4000	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK;		04.004.00	04.004.00				
64886	MORE THAN 4 CM L		\$1,034.23	\$1,034.23				
0.4000	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND,		0004.40	0004.40				
64890	HAND OR FOOT; U NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND,		\$801.43	\$801.43				
64891	HAND OR FOOT; M		\$767.84	\$767.84				
04091	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM		\$707.04	\$101.04				
64892	OR LEG; UP		\$743.59	\$743.59				
04092	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM		Ψ143.39	ψ143.39				
64893	OR LEG; MOR		\$857.50	\$857.50				
04033	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS		Ψ037.30	ψ037.30				
64895	(CABLE), HAND		\$954.57	\$954.57				
04000	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS		ψουπ.στ	ψοοπ.οτ				+
64896	(CABLE), HAND		\$1,085.03	\$1,085.03				
0.000	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS		4 1,000.00	4 1,000.00				
64897	(CABLE), ARM		\$908.77	\$908.77				
	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS							
64898	(CABLE), ARM		\$982.97	\$982.97				

Physician	Fee Schedule 2020							
Note:	T de Goriedule 2020							
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	CPT book for descriptions				+		+	
	column indicates Prior Auth is required				+		+	
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marı (ahar	an for the convinc					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	mary char	ge for the service	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	****						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for							
Codes iis	ted on the lab lee schedule that begin with a P of Q are currently non-covered to	or pnysiciai	ns T					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dracedove Decementary	DA Ind	•	•				Notes
Code	Procedure Description NERVE GRAFT, EACH ADDITIONAL NERVE; SINGLE STRAND (LIST	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
64901	SEPARATELY IN		\$593.54	\$593.54				
64901	NERVE GRAFT, EACH ADDITIONAL NERVE; MULTIPLE STRANDS		\$593.54	\$593.54	1			
04000			¢000 04	¢000.04				
64902 64905	(CABLE) (LIST NERVE PEDICLE TRANSFER; FIRST STAGE		\$690.91 \$657.06	\$690.91 \$657.06				
					-			
64907	NERVE PEDICLE TRANSFER; SECOND STAGE		\$936.43	\$936.43			_	
64910	NERVE REPAIR W/ALLOGRAFT		\$499.14	\$499.14			_	
64911	NERVE REPAIR W/VEIN AUTOGRAFT		\$609.09	\$609.09			_	A 11 1 Ff 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
64912	NRV RPR W/NRV ALGRET 1ST		\$614.88	\$614.88				Added Effective 1/1/2018
64913	NRV RPR W/NRV ALGRFT EA ADDL	Б	\$126.07	\$126.07				Added Effective 1/1/2018
64999	UNLISTED PROCEDURE, NERVOUS SYSTEM	R	\$2,800.00	\$3,640.00				
65091	EVISCERATION OF OCULAR CONTENTS; WITHOUT IMPLANT		\$399.41	\$399.41				
65093	EVISCERATION OF OCULAR CONTENTS; WITH IMPLANT		\$424.57	\$424.57				
65101	ENUCLEATION OF EYE; WITHOUT IMPLANT		\$426.70	\$426.70				
	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES NOT ATTACHED TO							
65103	IMPLANT		\$461.78	\$461.78				
l	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES ATTACHED TO							
65105	IMPLANT		\$511.32	\$511.32				
	EXENTERATION OF ORBIT (DOES NOT INCLUDE SKIN GRAFT),							
65110	REMOVAL OF ORBITA		\$843.33	\$843.33				
	EXENTERATION OF ORBIT (DOES NOT INCLUDE SKIN GRAFT),							
65112	REMOVAL OF ORBITA		\$805.70	\$805.70				
	EXENTERATION OF ORBIT (DOES NOT INCLUDE SKIN GRAFT),							
65114	REMOVAL OF ORBITA		\$877.46	\$877.46				
	MODIFICATION OF OCULAR IMPLANT WITH PLACEMENT OR							
65125	REPLACEMENT OF PEGS (\$156.56	\$156.56				

Physician	Fee Schedule 2020							
Note:								
	les in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER							
65130	EVISCERATION, IN SCLERAL		\$441.96	\$441.96				
	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER							
65135	ENUCLEATION, MUSCLES NOT		\$357.23	\$357.23				
	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER							
65140	ENUCLEATION, MUSCLES ATTA		\$393.75	\$393.75				
	REINSERTION OF OCULAR IMPLANT; WITH OR WITHOUT							
65150	CONJUNCTIVAL GRAFT		\$393.71	\$393.71				
	REINSERTION OF OCULAR IMPLANT; WITH USE OF FOREIGN							
65155	MATERIAL FOR		\$544.41	\$544.41				
65175	REMOVAL OF OCULAR IMPLANT		\$384.62	\$384.62				
	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL							
65205	SUPERFICIAL		\$28.34	\$33.30				
	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL							
65210	EMBEDDED (INCLUDES		\$31.55	\$37.72				
05000	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITHOUT		400.70	405.75				
65220	SLIT LAMP		\$28.78	\$35.75				
05000	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITH SLIT		#05.00	0.40.04				
65222	LAMP		\$35.66	\$43.31				
05005	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM ANTERIOR		# 200 00	#200 00				
65235	CHAMBER OF EYE OR REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR		\$366.69	\$366.69				
65060			\$546.11	\$546.11				
65260	SEGMENT, MAGNETIC REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR		φ040.11	φ540.11				
65265	SEGMENT, NONMAGNE		\$634.98	\$634.98				
00200	REPAIR OF LACERATION; CONJUNCTIVA, WITH OR WITHOUT		φυ34.90	φυ34.90	+		+	+
65270	NONPERFORATING		\$87.37	\$87.37				
00270	INONFERFORATING		φοι.31	φοι.31	_l			

Physician	Fee Schedule 2020							
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	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv chai	ae for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Τ΄	Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
		T .						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	REPAIR OF LACERATION; CONJUNCTIVA, BY MOBILIZATION AND	I A IIIu	(i acinty)	(Non acinty)	Comp.	Comp.	Value	Notes
65272	REARRANGEMENT,		\$151.17	\$151.17				
00212	REPAIR OF LACERATION; CONJUNCTIVA, BY MOBILIZATION AND		Ψ101.17	Ψ101.17	1			+
65273	REARRANGEMENT,		\$205.62	\$205.62				
00210	REPAIR OF LACERATION; CORNEA, NONPERFORATING, WITH OR		Ψ200.02	Ψ200.02				
65275	WITHOUT REMOVAL		\$166.57	\$166.57				
	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING,		7	7				
65280	NOT INVOLVING		\$464.06	\$464.06				
	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING,							
65285	WITH REPOSITI		\$698.27	\$698.27				
	REPAIR OF LACERATION; APPLICATION OF TISSUE GLUE, WOUNDS							
65286	OF CORNEA AND		\$221.73	\$285.96				
	REPAIR OF WOUND, EXTRAOCULAR MUSCLE, TENDON AND/OR							
65290	TENON'S CAPSULE		\$323.76	\$323.76				
	EXCISION OF LESION, CORNEA (KERATECTOMY, LAMELLAR,							
65400	PARTIAL), EXCEPT		\$346.39	\$346.39				
65410	BIOPSY OF CORNEA		\$88.45	\$88.45				
65420	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITHOUT GRAFT		\$236.88	\$236.88				
65426	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITH GRAFT		\$330.96	\$330.96				
65430	SCRAPING OF CORNEA, DIAGNOSTIC, FOR SMEAR AND/OR CULTURE		\$33.50	\$40.74				
30-30	REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT		Ψ00.00	ψ-το.ι-τ	+		+	+
65435	CHEMOCAUTERIZATION		\$38.29	\$48.62				
00-100	REMOVAL OF CORNEAL EPITHELIUM; WITH APPLICATION OF		Ψ00.20	ψ 10.02			+	+
65436	CHELATING AGENT (EG		\$139.54	\$160.06				
	DESTRUCTION OF LESION OF CORNEA BY CRYOTHERAPY,		+	+ / 00:00				
65450	PHOTOCOAGULATION OR		\$182.19	\$182.19				

Physician	n Fee Schedule 2020							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomon, obor	ran for the comin					
	sted as \$0.00 pay 45% of billed amount not to exceed provider's usual and cust sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	iomary char	ge for the service	*				
	istresia base Rate is \$15.20. Each 15 minute increment—1 time unit.							
Codes iis	sted on the lab fee schedule that begin with a P or Q are currently non-covered	ior priysicia	ns T					
							Base	
Proc			Innat Bata	Outpat. Rate	Tech.	Prof.	Unit	
	Due de duma Description	DA In al	Inpat. Rate	•				Notes
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
05000	MULTIPLE PUNCTURES OF ANTERIOR CORNEA (EG, FOR CORNEAL		¢400.07	0400 44				
65600	EROSION, TATTOO		\$130.97	\$166.11				
65710	KERATOPLASTY (CORNEAL TRANSPLANT); LAMELLAR		\$640.47	\$640.47				
05700	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (EXCEPT		Φ 7 04.50	0704.50				
65730	IN APHAKIA)		\$784.56	\$784.56				
	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN							
65750	APHAKIA)		\$833.29	\$833.29				
	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN							
65755	PSEUDOPHAKIA)		\$834.75	\$834.75				
65756	KERATOPLASTY, ENDOTHELIAL		\$815.33	\$815.33				
65757	BACKBENCH PREPARATION OF CORNEAL ENDOTHELIAL		\$0.00	\$0.00				
65760	KERATOMILEUSIS	R	\$964.08	\$964.08				
65765	KERATOPHAKIA	R	\$992.66	\$992.66				
65767	EPIKERATOPLASTY		\$646.76	\$646.76				
65770	KERATOPROSTHESIS		\$873.59	\$873.59				
65771	RADIAL KERATOTOMY		\$367.58	\$367.58				
	CORNEAL RELAXING INCISION FOR CORRECTION OF SURGICALLY							
65772	INDUCED ASTIGMA		\$195.28	\$264.48				
	CORNEAL WEDGE RESECTION FOR CORRECTION OF SURGICALLY							
65775	INDUCED ASTIGMATI		\$358.46	\$358.46				
	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE							
65778	FOR WOULD HEALING; SELF-RETAINING		\$65.57	\$1,095.71				
	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE							
65779	FOR WOULD HEALING; SINGLE LAYER, SUTURED		\$253.68	\$991.27				
	OCULAR SURFACE RECONSTRUCTION; AMNIOTIC MEMBRANE							
65780	TRANSPLANTATION		\$560.32	\$560.32				
		-	•	•	-	-	-	

Physician	Fee Schedule 2020							
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I I	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.			+			
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	OCULAR SURFACE RECONSTRUCTION; LIMBAL STEM CELL	I A IIIu	(i acinty)	(Nom acmity)	Comp.	Comp.	Value	Notes
65781	ALLOGRAFT (EG, CADAVER		\$860.34	\$860.34				
00701	OCULAR SURFACE RECONSTRUCTION; LIMBAL CONJUNCTIVAL		ψοσο.σ-	ψ000.0-1	+			+
65782	AUTOGRAFT (INCLUDES		\$741.13	\$741.13				
65785	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS	R	\$304.64	\$1,569.54	+			Added Effective 1/1/2016
00700	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE		φοσ 1.0 1	ψ1,000.01	+			714464 211661176 17 172616
65800	PROCEDURE); WITH		\$104.61	\$104.61				
00000	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE		Ψ.σσ.	ψ101.01			+	
65810	PROCEDURE); WITH REM		\$287.57	\$287.57				
	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE		7=01101	· ·				
65815	PROCEDURE); WITH REM		\$265.64	\$265.64				
65820	GONIOTOMY		\$491.28	\$491.28	+			
65850	TRABECULOTOMY AB EXTERNO		\$664.97	\$664.97				
	TRABECULOPLASTY BY LASER SURGERY, ONE OR MORE SESSIONS							
65855	(DEFINED TREATM		\$229.68	\$310.28				
	SEVERING ADHESIONS OF ANTERIOR SEGMENT, LASER TECHNIQUE			•				
65860	(SEPARATE		\$165.68	\$223.48				
	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL		·	·				
65865	TECHNIQUE (W		\$354.88	\$354.88				
	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL							
65870	TECHNIQUE (W		\$338.42	\$338.42				
	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL							
65875	TECHNIQUE (W		\$356.87	\$356.87				
	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL							
65880	TECHNIQUE (W		\$389.03	\$389.03				
	REMOVAL OF EPITHELIAL DOWNGROWTH, ANTERIOR CHAMBER OF							
65900	EYE		\$540.57	\$540.57				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns T					
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D			In a st. Data	0.44. D.4		D f	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
65920	REMOVAL OF IMPLANTED MATERIAL, ANTERIOR SEGMENT OF EYE		\$466.74	\$466.74				
65930	REMOVAL OF BLOOD CLOT, ANTERIOR SEGMENT OF EYE		\$422.24	\$422.24				
	INJECTION, ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE);							
66020	AIR OR LIQUID		\$101.70	\$101.70				
66130	EXCISION OF LESION, SCLERA		\$369.67	\$369.67				
	FISTULIZATION OF SCLERA FOR GLAUCOMA; TREPHINATION WITH							
66150	IRIDECTOMY		\$498.06	\$498.06				
	FISTULIZATION OF SCLERA FOR GLAUCOMA;							
66155	THERMOCAUTERIZATION WITH IRIDECT		\$488.32	\$488.32				
	FISTULIZATION OF SCLERA FOR GLAUCOMA; SCLERECTOMY WITH							
66160	PUNCH OR SCISSO		\$580.12	\$580.12				
	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB							
66170	EXTERNO IN ABS		\$673.07	\$673.07				
	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB							
66172	EXTERNO WITH		\$742.32	\$742.32				
	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT							
66174	RETENTION OF DEVICE OR STENT		\$857.76	\$857.76				
	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH							
66175	RETENTION OF DEVICE OR STENT		\$972.58	\$972.58				
66179	CREATION OF SHUNT TO IMPROVE EYE FLUID FLOW		\$839.42	\$839.42				Added effective 1/1/2015
	AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTENO,							
66180	SCHOCKET,		\$829.35	\$829.35				
66183	INSERT ANT DRAINAGE DEVICE		\$830.74	\$830.74				
66184	REVISION OF SHUNT TO IMPROVE EYE FLUID FLOW		\$608.89	\$608.89				Added effective 1/1/2015
66185	REVISION OF AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR		\$503.94	\$503.94				
66225	REPAIR OF SCLERAL STAPHYLOMA; WITH GRAFT		\$692.83	\$692.83				

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	column indicates Prior Auth is required		<u> </u>					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REVISION OR REPAIR OF OPERATIVE WOUND OF ANTERIOR							
66250	SEGMENT, ANY TYPE, E		\$367.55	\$367.55				
	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); EXCEPT							
66500	TRANSFIXION		\$234.45	\$234.45				
	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); WITH							
66505	TRANSFIXION AS F		\$207.16	\$207.16				
	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; FOR							
66600	REMOVAL OF LESI		\$504.94	\$504.94				
	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; WITH							
66605	CYCLECTOMY		\$696.75	\$696.75				
	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION;							
66625	PERIPHERAL FOR GLAU		\$326.70	\$326.70				
	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION;							
66630	SECTOR FOR GLAUCOMA		\$380.71	\$380.71				
	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION;							
66635	OPTICAL (SEPARATE		\$387.81	\$387.81				
66680	REPAIR OF IRIS, CILIARY BODY (AS FOR IRIDODIALYSIS)		\$331.53	\$331.53				
	SUTURE OF IRIS, CILIARY BODY (SEPARATE PROCEDURE) WITH							
66682	RETRIEVAL OF SU		\$377.79	\$377.79				
	CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION,							
66710	TRANSSCLERAL		\$299.85	\$299.85				
	CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION,							
66711	ENDOSCOPIC		\$386.94	\$386.94			<u> </u>	Updated Effective 01/01/2020
66720	CILIARY BODY DESTRUCTION; CRYOTHERAPY		\$299.12	\$299.12				
66740	CILIARY BODY DESTRUCTION; CYCLODIALYSIS		\$299.36	\$299.36				
	IRIDOTOMY/IRIDECTOMY BY LASER SURGERY (EG, FOR GLAUCOMA)							
66761	(ONE OR MORE		\$190.44	\$258.84				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249					+		
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar T	1S					
							Base	
Droo			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Proc	Due and true Dagariation	DA In al	•	•			Value	Notes
Code	Procedure Description IRIDOPLASTY BY PHOTOCOAGULATION (ONE OR MORE SESSIONS)	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
66760	,		¢040.04	#200 24				
66762	(EG, FOR IMPROV		\$219.81	\$299.21				
00770	DESTRUCTION OF CYST OR LESION IRIS OR CILIARY BODY		0007.00	0004 50				
66770	(NONEXCISIONAL		\$237.82	\$321.50				
00000	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED		0040.00	0040.00				
66820	POSTERIOR LENS		\$246.39	\$246.39				
00004	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED		* 400 7 0	0400 70				
66821	POSTERIOR LENS		\$192.76	\$192.76				
00005	REPOSITIONING OF INTRAOCULAR LENS PROSTHESIS, REQUIRING		# 400 00	0.400.00				
66825	AN INCISION		\$432.66	\$432.66				
00000	REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED		.	044400				
66830	POSTERIOR LENS CAP		\$444.32	\$444.32				
00040	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, ONE OR		404.05					
66840	MORE STAGES		\$491.25	\$491.25				
00050	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE		# 500.50	4500 50				
66850	(MECHANICAL OR		\$568.58	\$568.58				
00050	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR		#000 40	0000 40				
66852	WITHOUT VITRECT		\$628.18	\$628.18				
66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR		\$553.04	\$553.04				
00000	REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED		φ500.70	φ500.70				
66930	LENS		\$580.72	\$580.72				
00040	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN		A 554.00	0554.00				
66940	66840, 66850, 6685	1	\$554.92	\$554.92				
	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF							
66982	INTRAOCULAR LENS		\$582.42	\$582.42				Updated Effective 01/01/2020
	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF							
66983	INTRAOCULAR LENS	<u> </u>	\$567.11	\$567.11				

Note: Refer to CPT book for descriptions	Physician	Fee Schedule 2020							
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Refer to CPT book for descriptions Rin PA column indicates Prior Auth is required Cades listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service Cades listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service Rodes listed on the lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Pa		des in Red:							
R' in PA column indicates Prior Auth is required Codes listed as '50.00" pay 59's of billed amount not to exceed provider's usual and customary charge for the service The Anesthesis Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use fall for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Proceduro Description EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF BXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INSERTION OF INTRAOCULAR LENS INSERTION OF INTRAOCULAR LENS INSERTION OF INTRAOCULAR LENS Sease 20 EXCHANGE OF INTRAOCULAR LENS Sease 20 EXCHANGE OF INTRAOCULAR LENS Sease 20 EXCHANGE OF INTRAOCULAR LENS Sease 20 Sease 30 EXCHANGE OF INTRAOCULAR LENS Sease 20 Sease 30 EXCHANGE OF INTRAOCULAR LENS Sease 30 EXCHANGE O									+
Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesis Base Rate is \$15.20. Each 15 finule increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 8000-95249 range. Codes listed on the lab fee schedule for covered codes not listed below in the 8000-95249 range. Proc Code Procedure Description EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INSERTION OF INTRACCULAR LENS IMPLANTI, NOT 669940 INTRACCULAR LENS IMPLANTI, NOT 669951 CACHANGE OF INTRACCULAR LENS SABS 20 SERS 20 SE									
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use fall for covered codes not listed below in the 8000-95249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF BEXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INSERTION OF INTRAOCULAR LENS INSERTION OF INTRAOCULAR LENS S424.10 S117.73 S517.73 S517.73 S6982 EXCHANGE OF INTRAOCULAR LENS S688.20 S688			omory obor	ac for the convice	_				+
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF SETTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INSERTION OF INTRAOCULAR LENS INSERTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY SESTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY SESTION OF INTRAOCULAR LENS SERS 20 S			T		7			+	_
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians		·	rango						+
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Procedure Description								Rase	
Procedure Description	Proc			Innat Rate	Outnat Rate	Tech	Prof		
EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF \$424.10		Procedure Description	DA Ind						Notes
10 10 10 10 10 10 10 10	Code		FAIIIU	(i acility)	(Norm active)	Comp.	Comp.	Value	Inotes
INSERTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY S517.73 S517.73 S688.20 S68.20 S688.20 S68.20 S688.20 S6	66084			\$424.10	\$424.10				Undated Effective 01/01/2020
66985 IMPLANT), NOT \$517.73 \$517.73 \$517.73 66986 EXCHANGE OF INTRACCULAR LENS \$688.20 \$688.20 \$688.20 66987 XCAPSL CTRC RMVL W/ECP \$0.00 \$0.00 Added Effective 01/01/2020 66988 XCAPSL CTRC RMVL W/ECP \$0.00 \$0.00 Added Effective 01/01/2020 66999 USE OF OPHTHALMIC ENDOSCOPE (LIST SEPARATELY IN ADDITION TO CODE FOR USE OF OPHTHALMIC ENDOSCOPE (LIST SEPARATELY IN ADDITION SEGMENT OF EYE RESOLUTED SEGMENT OF EYE RESO	00304			Ψ+24.10	ψ+24.10				Opdated Effective 01/01/2020
66986 EXCHANGE OF INTRAOCULAR LENS \$688.20 \$689.20 \$689.	66085	· ·		¢517 73	¢517 73				
School S		EXCHANGE OF INTRAOCHLAR LENS							
School S	00900	EXCHANGE OF INTRACCOLAR ELINO		ψ000.20	φ000.20				+
Section Sect	66987	XCAPSL CTRC RMVL CPLX W/ECP		\$0.00	\$0.00				Added Effective 01/01/2020
USE OF OPHTHALMIC ENDOSCOPE (LIST SEPARATELY IN ADDITION									
66990 TO CODE FOR \$63.00 \$63.00 \$63.00 \$663.00 \$66999 UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE R \$0.00	66988	XCAPSL CTRC RMVL W/ECP		\$0.00	\$0.00				Added Effective 01/01/2020
66990 TO CODE FOR \$63.00 \$63.00 \$63.00 \$663.00 \$66999 UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE R \$0.00		USE OF OPHTHALMIC ENDOSCOPE (LIST SEPARATELY IN ADDITION							
66999 UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE R \$0.00 \$0.00	66990			\$63.00	\$63.00				
REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY 67005 TECHNIQUE OR LIMBAL REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY 67010 TECHNIQUE OR LIMBAL ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR 67015 CHOROIDAL FLUID, PARS S177.81 INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL 67025 APPROACH, (FLUI IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS		UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE	R		\$0.00				
S497.73 \$497					•				
67010 TECHNIQUE OR LIMBAL ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR 67015 CHOROIDAL FLUID, PARS INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL 67025 APPROACH, (FLUI IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS	67005	TECHNIQUE OR LIMBAL		\$497.73	\$497.73				
ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR 67015 CHOROIDAL FLUID, PARS INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL 67025 APPROACH, (FLUI IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS		REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY							
67015 CHOROIDAL FLUID, PARS INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL 67025 APPROACH, (FLUI IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS \$377.81 \$377.81 \$377.81 \$377.81 \$377.81 \$377.81 \$378.77 \$378.77 \$378.77 \$378.77	67010	TECHNIQUE OR LIMBAL		\$488.67	\$488.67				
INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL 67025 APPROACH, (FLUI \$378.77 \$378.77 IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR \$557.54 \$557.54 INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) \$164.69 DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS		ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR							
67025 APPROACH, (FLUI \$378.77 \$378.77 IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR \$557.54 \$557.54 INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT (SEPARATE PROCEDURE) \$164.69 \$164.69 DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS	67015	CHOROIDAL FLUID, PARS		\$377.81	\$377.81				
IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR \$557.54 \$557.54 INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) \$164.69 \$164.69 DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS					·				
IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, 67027 GANCICLOVIR \$557.54 \$557.54 INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) \$164.69 \$164.69 DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS	67025	APPROACH, (FLUI		\$378.77	\$378.77				
67027 GANCICLOVIR \$557.54 \$557.54 \$ INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT \$164.69 \$164.69 \$100 \$100 \$100 \$100 \$100 \$100 \$100 \$10					·				
INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT 67028 (SEPARATE PROCEDURE) \$164.69 \$164.69 DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS	67027			\$557.54	\$557.54				
67028 (SEPARATE PROCEDURE) \$164.69 \$164.69								1	
DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS	67028			\$164.69	\$164.69				
				1					
	67030			\$296.66	\$296.66				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to C	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SEVERING OF VITREOUS STRANDS, VITREOUS FACE ADHESIONS,							
67031	SHEETS, MEMBRAN		\$201.06	\$283.53				
67036	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH;		\$788.97	\$788.97				
	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH FOCAL							
67039	ENDOLASER		\$928.59	\$928.59				
	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH							
67040	ENDOLASER PANRETINAL		\$1,077.81	\$1,077.81				
67041	VITRECTOMY FOR MACULAR PUCKER		\$896.92	\$896.92				
67042	VITRECTOMY FOR MACULAR HOLE		\$1,027.18	\$1,027.18				
67043	VITRECTOMY FOR MEMBRANE DISSEC		\$1,077.91	\$1,077.91				
	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS;							
67101	CRYOTHERAPY OR		\$342.59	\$463.16				
	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS;							
67105	PHOTOCOAGULATION,		\$349.18	\$471.76				
	REPAIR OF RETINAL DETACHMENT; SCLERAL BUCKLING (SUCH AS							
67107	LAMELLAR SCLER		\$917.62	\$917.62				
	REPAIR OF RETINAL DETACHMENT; WITH VITRECTOMY, ANY							
67108	METHOD, WITH OR WIT		\$1,309.85	\$1,309.85				
	REPAIR OF RETINAL DETACHMENT; BY INJECTION OF AIR OR OTHER							
67110	GAS (EG,		\$546.74	\$546.74				
67113	REPAIR OF TETINAL DETACHMENT, CPLX		\$1,183.24	\$1,183.24				
67115	RELEASE OF ENCIRCLING MATERIAL (POSTERIOR SEGMENT)		\$305.90	\$305.90				
	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT;							
67120	EXTRAOCULAR		\$366.21	\$366.21				
	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT;							
67121	INTRAOCULAR		\$562.99	\$562.99				

Physician	n Fee Schedule 2020							
Note:								
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	е				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07444	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK,		4000 50	****				
67141	LATTICE DEGENERA		\$239.53	\$323.62				
07445	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK,		0.47.05	***				
67145	LATTICE DEGENERA		\$247.85	\$335.02				
67000	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULAR		\$310.27	¢400.40				
67208	EDEMA, TUMORS), DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULAR		\$310.27	\$420.10				+
67210	EDEMA, TUMORS),		\$410.56	\$531.53				
0/210	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULAR		\$410.50	φυσ 1.υσ				
67218	EDEMA, TUMORS),		\$747.55	\$747.55				
07210	EDEIVIA, TOMOROJ,		Ψ141.55	Ψ141.33				
67220	DESTRUCTION OF LOCALIZED LESION OF CHOROID (EG, CHOROIDAL		\$556.33	\$558.15				
07220	BEOTHOGHON OF EGGNELZED EEGIGN OF OFFICION (EG, OFFICIONAL		Ψ000.00	ψοσο. το				+
67221	DESTRUCTION OF LOCALIZED LESION OF CHOROID (EG, CHOROIDAL		\$179.52	\$179.52				
0.22.	BESTROSTICK OF ESCREENES ELECTRIC OF CHICKOIS (ES, CHICKOIS)		ψ17 0.0 <u>2</u>	ψ 17 0.0 <u>2</u>				
67225	DESTRUCTION OF LOCALIZED LESION OF CHOROID (EG, CHOROIDAL		\$30.92	\$32.21				
	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG,		,					
67227	DIABETIC		\$412.32	\$412.32				
	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG,			·				
67228	DIABETIC		\$691.57	\$691.57				
67229	TR RETINAL LES PRETERM INF		\$778.24	\$778.24				
	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITHOUT							
67250	GRAFT		\$442.52	\$442.52				
67255	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITH GRAFT		\$555.13	\$555.13				
67299	UNLISTED PROCEDURE, POSTERIOR SEGMENT	R	\$0.00	\$0.00				

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	es in Red;							
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 i							
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Droo			Innet Bete	Outpot Boto	Tech.	Prof.	Unit	
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Code	Procedure Description STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE;	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07044	, ,		Φ440.4 7	¢440.47				
67311	ONE HORIZONTAL M		\$412.47	\$412.47				
07040	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE;		# 400 FO	# 400 50				
67312	TWO HORIZONTAL		\$493.52	\$493.52				
07044	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE;		# 407.00	Φ407.00				
67314	ONE VERTICAL MUS		\$467.63	\$467.63				
07040	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE;		4507.00	# 507.00				
67316	TWO OR MORE VERT		\$527.08	\$527.08				
07040	STRABISMUS SURGERY, ANY PROCEDURE, SUPERIOR OBLIQUE		mana 40	0000.40				
67318	MUSCLE		\$393.19	\$393.19				
07000	TRANSPOSITION PROCEDURE (EG, FOR PARETIC EXTRAOCULAR		ΦE 40.05	ΦE 40.05				
67320	MUSCLE), ANY		\$542.65	\$542.65				
07004	STRABISMUS SURGERY ON PATIENT WITH PREVIOUS EYE SURGERY		#504.00	# 504.00				
67331	OR INJURY THAT		\$504.92	\$504.92				
07000	STRABISMUS SURGERY ON PATIENT WITH SCARRING OF		#504.40	# 504.40				
67332	EXTRAOCULAR MUSCLES (EG		\$561.19	\$561.19				
07004	STRABISMUS SURGERY BY POSTERIOR FIXATION SUTURE		#000 00	#				
67334	TECHNIQUE, WITH OR WIT		\$398.83	\$398.83				
07005	PLACEMENT OF ADJUSTABLE SUTURE(S) DURING STRABISMUS		A407.05	* 407.05				
67335	SURGERY, INCLUDING		\$187.85	\$187.85			1	<u> </u>
07040	STRABISMUS SURGERY INVOLVING EXPLORATION AND/OR REPAIR		m 400 00	# 400.00				
67340	OF DETACHED		\$498.62	\$498.62				
07040	RELEASE OF EXTENSIVE SCAR TISSUE WITHOUT DETACHING		maga 0.4	#000 04				
67343	EXTRAOCULAR MUSCLE		\$369.31	\$369.31				
67345	CHEMODENERVATION OF EXTRAOCULAR MUSCLE		\$121.48	\$151.25				
67346	BIOPSY EXTRAOCULAR MUSCLE		\$132.84	\$132.84				
67399	UNLISTED PROCEDURE, OCULAR MUSCLE	R	\$0.00	\$0.00				

Physician	Fee Schedule 2020							
Note:								
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R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered t	for physicia	ns					
					L .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07.400	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR		4 0-					
67400	TRANSCONJUNCTIVAL APPROACH);		\$577.65	\$577.65				
07.405	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR		* 400 FF	A 400 55				
67405	TRANSCONJUNCTIVAL APPROACH);		\$488.55	\$488.55				
67440	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR		ΦE00 20	ΦE00 20				
67412	TRANSCONJUNCTIVAL APPROACH); ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR		\$598.30	\$598.30				+
67413	TRANSCONJUNCTIVAL APPROACH);		\$516.94	\$516.94				
0/413	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR		\$ 516.94	φο 10.9 4			_	
67414	TRANSCONJUNCTIVAL APPROACH);		\$531.22	\$531.22				
67415	FINE NEEDLE ASPIRATION OF ORBITAL CONTENTS		\$108.74	\$108.74				
07413	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH		ψ100.74	ψ100.74				
67420	(EG, KROENLEIN);		\$869.07	\$869.07				
07 420	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH		φοσσ.στ	Ψοσοιοτ				
67430	(EG, KROENLEIN);		\$674.08	\$674.08				
	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH		+	40.1.00				
67440	(EG, KROENLEIN);		\$815.04	\$815.04				
	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH							
67445	(EG, KROENLEIN);		\$704.41	\$704.41				
	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH							
67450	(EG, KROENLEIN);		\$806.84	\$806.84				
	RETROBULBAR INJECTION; MEDICATION (SEPARATE PROCEDURE,							
67500	DOES NOT INCLUD		\$44.22	\$44.22	<u> </u>			
67505	RETROBULBAR INJECTION; ALCOHOL		\$39.47	\$53.41				
	INJECTION OF MEDICATION OR OTHER SUBSTANCE INTO TENON'S							
67515	CAPSULE		\$26.14	\$33.65				

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	CPT book for descriptions							
	column indicates Prior Auth is required	<u> </u>	<u></u>					
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_					<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07550	ODDITAL IMPLANT (IMPLANT OUTSIDE MUSCLE COME) INCEDTION		0550.07	#550.07				
67550	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); INSERTION		\$559.37	\$559.37				
.==	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); REMOVAL OR		4=00.0=	\$500.05				
67560	REVISION		\$530.65	\$530.65				
	OPTIC NERVE DECOMPRESSION (EG, INCISION OR FENESTRATION							
67570	OF OPTIC NERVE		\$579.63	\$579.63				
67599	UNLISTED PROCEDURE, ORBIT	R	\$0.00	\$0.00				
67700	BLEPHAROTOMY, DRAINAGE OF ABSCESS, EYELID		\$45.45	\$52.02				
67710	SEVERING OF TARSORRHAPHY		\$43.47	\$57.01				
67715	CANTHOTOMY (SEPARATE PROCEDURE)		\$76.48	\$76.48				
67800	EXCISION OF CHALAZION; SINGLE		\$53.44	\$66.04				
67801	EXCISION OF CHALAZION; MULTIPLE, SAME LID		\$74.87	\$93.51				
67805	EXCISION OF CHALAZION; MULTIPLE, DIFFERENT LIDS		\$84.13	\$102.63				
	EXCISION OF CHALAZION; UNDER GENERAL ANESTHESIA AND/OR							
67808	REQUIRING		\$164.46	\$164.46				
67810	BIOPSY OF EYELID		\$55.51	\$66.37				
67820	CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY		\$31.70	\$36.79				
	CORRECTION OF TRICHIASIS; EPILATION BY OTHER THAN FORCEPS							
67825	(EG, BY		\$52.31	\$64.38				
67830	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN		\$109.41	\$109.41				
	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN, WITH FREE							
67835	MUCOUS MEM		\$355.29	\$355.29				
	EXCISION OF LESION OF EYELID (EXCEPT CHALAZION) WITHOUT							
67840	CLOSURE OR WIT		\$76.46	\$92.82				
67850	DESTRUCTION OF LESION OF LID MARGIN (UP TO 1 CM)		\$60.34	\$71.33				
67875	TEMPORARY CLOSURE OF EVELIDS BY SUTURE (EC. EDOST SUTURE)		\$88.91	\$88.91				
0/0/0	TEMPORARY CLOSURE OF EYELIDS BY SUTURE (EG, FROST SUTURE)	<u> </u>	φυο.9 Ι	φ00.91	<u> </u>			

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	olumn indicates Prior Auth is required	<u> </u>				+		
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.					+		
	e lab fee schedule for covered codes not listed below in the 80000-89249 r					+		
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	r pnysiciar	ns T					
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Proc	Burnedow Breedotter	DA L. J	Inpat. Rate	Outpat. Rate	Tech.			Nete
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
07000	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN		0045 44	0045.44				
67880	TARSORRHAPHY, OR		\$215.44	\$215.44				
.=	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN		0.40.55	40.40.55				
67882	TARSORRHAPHY, OR		\$312.57	\$312.57				
07000	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR	_	#000 4 7	0000 47				
67900	CORONAL APPROACH)	R	\$239.47	\$239.47				
	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE	_						
67901	WITH SUTURE OR OT	R	\$449.83	\$449.83				
	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE	_	 					
67902	WITH AUTOLOGOUS	R	\$455.68	\$455.68				
	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR	_						
67903	ADVANCEMENT,	R	\$413.76	\$413.76				
	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR	_						
67904	ADVANCEMENT,	R	\$397.06	\$397.06				
	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH	_						
67906	FASCIAL SLING	R	\$350.04	\$350.04				
	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S							
67908	MUSCLE-LEVATOR	R	\$328.42	\$328.42				
67909	REDUCTION OF OVERCORRECTION OF PTOSIS		\$344.27	\$344.27				
67911	CORRECTION OF LID RETRACTION	R	\$345.04	\$345.04				
	CORRECTION OF LAGOPHTHALMOS, WITH IMPLANTATION OF UPPER			1				
67912	EYELID LID LOA		\$306.83	\$698.92		1		
67914	REPAIR OF ECTROPION; SUTURE		\$238.76	\$238.76		1		
67915	REPAIR OF ECTROPION; THERMOCAUTERIZATION		\$109.43	\$126.19		1		
67916	REPAIR OF ECTROPION; EXCISION TARSAL WEDGE		\$334.11	\$334.11		1		
	REPAIR OF ECTROPION; EXTENSIVE (EG, TARSAL STRIP			1.				
67917	OPERATIONS)		\$383.41	\$383.41		1		

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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
<u></u>							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
67921	REPAIR OF ENTROPION; SUTURE		\$204.74	\$204.74				
67922	REPAIR OF ENTROPION; THERMOCAUTERIZATION		\$105.10	\$121.06				
67923	REPAIR OF ENTROPION; EXCISION TARSAL WEDGE		\$361.03	\$361.03				
	REPAIR OF ENTROPION; EXTENSIVE (EG, TARSAL STRIP OR							
67924	CAPSULOPALPEBRAL F		\$369.60	\$369.60				
	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN,							
67930	TARSUS, AND/OR		\$123.44	\$140.47				
	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN,							
67935	TARSUS, AND/OR		\$285.60	\$285.60				
67938	REMOVAL OF EMBEDDED FOREIGN BODY, EYELID		\$45.26	\$52.24				
67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)		\$370.09	\$370.09				
	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS,							
67961	CONJUNCTI		\$362.93	\$362.93				
	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS,							
67966	CONJUNCTI		\$422.94	\$422.94				
	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF							
67971	TARSOCONJUNCTI		\$582.53	\$582.53				
	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF							
67973	TARSOCONJUNCTI		\$754.71	\$754.71				
	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF							
67974	TARSOCONJUNCTI		\$767.08	\$767.08				
	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF							
67975	TARSOCONJUNCTI		\$378.30	\$378.30				
67999	UNLISTED PROCEDURE, EYELIDS	R	\$0.00	\$0.00				
68020	INCISION OF CONJUNCTIVA, DRAINAGE OF CYST		\$46.30	\$53.14				
68040	EXPRESSION OF CONJUNCTIVAL FOLLICLES (EG, FOR TRACHOMA)		\$31.46	\$37.50				

Physician Fee Schedule 2020	Dhysisian	Fac Cabadula 2000		1	<u> </u>	1	1	1	T	
Refer to CPT book for descriptions	_	ree Schedule 2020								
Refer to CPT book for descriptions R'in PA column indicates Prior Auth is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description Biopsy OF CONJUNICTIVA Bistopsy OF CONJUNICTIVA, OVER 1 CM Bistopsy OF CONJUNICTIVA Bistopsy OF CONJUNICTIVA Bistop		to Body					-	4		
R*In PA column indicates Prior Auth is required Codes listed as "50.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-93249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Proc Proc Pose lingat. Rate (Reality) Biopsy OF CONJUNCTIVA Biology										
Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service										
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.										
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians			mary char	ge for the service	!					
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians										
Proc Proc Procedure Description PA Ind (Facility) (Facilit										
Proc Procedure Description PA Ind Inpat. Rate (Racility) Comp. Value Notes	Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns						
Proc Procedure Description PA Ind Inpat. Rate (Racility) Comp. Comp. Value Notes										
Code Procedure Description PA Ind (Facility) (NonFacility) Comp. Comp. Value Notes 68100 BIOPSY OF CONJUNCTIVA \$54.35 \$67.63 \$68.60 \$68.10 \$68.60 \$68.60 \$68.10 \$68.10 \$68.80 \$68.61 \$68.10 \$68.10 \$68.10 \$68.10 \$68.10 \$68.10 \$68.10 \$68.10 \$68.11 \$68.11 \$68.12 \$68.20 \$6										
BIODSY OF CONJUNCTIVA \$54.35				•	•		_			
68110 EXCISION OF LESION, CONJUNCTIVA; UP TO 1 CM \$68.80 \$85.43 68115 EXCISION OF LESION, CONJUNCTIVA; OVER 1 CM \$122.22 \$122.22 68130 EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA \$254.43 \$254.43 68130 DESTRUCTION OF LESION, CONJUNCTIVA \$63.42 \$73.35 68200 SUBCONJUNCTIVAL INJECTION \$22.08 \$29.05 CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE \$326.90 \$326.90 68320 REARRANGEMENT \$326.90 \$326.90 CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT \$458.28 \$458.28 (INCLUDES OBTAINI \$458.28 \$458.28 CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH \$441.18 \$441.18 68326 CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH \$515.36 \$515.36 REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT \$297.00 \$297.00 68336 GRAFT \$297.00 \$297.00 68335 BUCCAL MUCOUS \$448.85 \$448.85 BUCCAL MUCOUS \$448.85 \$448.85 RE			PA Ind			Comp.	Comp.	Value	Notes	
68115 EXCISION OF LESION, CONJUNCTIVA; OVER 1 CM \$122.22 \$122.22 68130 EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA \$254.43 \$254.43 68135 DESTRUCTION OF LESION, CONJUNCTIVA \$63.42 \$73.35 68200 SUBCONJUNCTIVAL INJECTION \$22.08 \$29.05 CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE \$326.90 \$326.90 68320 REARRANGEMENT \$326.90 \$326.90 CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT \$458.28 \$458.28 (INCLUDES OBTAINI \$4458.28 \$458.28 CONJUNCTIVAL GRAFT \$441.18 \$441.18 CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH \$441.18 \$441.18 68328 BUCCAL MUCOUS MEMBR \$515.36 \$515.36 REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT \$297.00 \$297.00 68330 GRAFT \$297.00 \$297.00 REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR \$448.85 \$448.85 REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR \$203.38 \$203.38 68360										
68130 EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA \$254.43 \$254.43 68135 DESTRUCTION OF LESION, CONJUNCTIVA \$63.42 \$73.35 68200 SUBCONJUNCTIVAL INJECTION \$22.08 \$29.05 CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE \$326.90 \$326.90 68320 REARRANGEMENT \$326.90 \$326.90 CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT \$458.28 \$458.28 GONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH \$441.18 \$441.18 GONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH \$515.36 \$515.36 G8328 BUCCAL MUCOUS MEMBR \$515.36 \$515.36 REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT \$297.00 \$297.00 68330 GRAFT \$297.00 \$448.85 REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR \$448.85 \$448.85 REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR \$203.38 \$203.38 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53	68110									
B8135 DESTRUCTION OF LESION, CONJUNCTIVA \$63.42 \$73.35 \$29.05 \$22.08 \$29.00 \$22.08 \$22.08 \$29.00 \$22.08 \$22.09 \$22.09 \$22.00 \$22				1.7	I *					
SUBCONJUNCTIVAL INJECTION \$22.08 \$29.05	68130	EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA								
CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE \$326.90 \$326.9	68135			\$63.42	\$73.35					
S326.90 S326	68200			\$22.08	\$29.05					
CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT 68325 (INCLUDES OBTAINI \$458.28 \$458.28 CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH 68326 CONJUNCTIVAL GRAFT \$441.18 \$441.18 CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH 68328 BUCCAL MUCOUS MEMBR \$515.36 \$515.36 REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT 68330 GRAFT \$297.00 \$297.00 REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE \$203.38 \$203.38 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53		CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE								
\$458.28	68320	REARRANGEMENT		\$326.90	\$326.90					
CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH 68326 CONJUNCTIVAL GRAFT CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH BUCCAL MUCOUS MEMBR REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT 68330 GRAFT REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53		CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT								
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CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH 68328 BUCCAL MUCOUS MEMBR REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT 68330 GRAFT REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 8448.85 REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR WITHOUT INSE 68340 WITHOUT INSE 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53		CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH								
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REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT 68330 GRAFT REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$297.00 \$297.00 \$448.85 \$448.85 \$203.38 \$203.38		CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH								
REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT 68330 GRAFT REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$297.00 \$297.00 \$448.85 \$448.85 \$203.38 \$203.38	68328	BUCCAL MUCOUS MEMBR		\$515.36	\$515.36					
REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS \$448.85 \$448.85 REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE \$203.38 \$203.38 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53		REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT								
REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR 68335 BUCCAL MUCOUS REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR 68340 WITHOUT INSE 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53	68330	GRAFT		\$297.00	\$297.00					
68335 BUCCAL MUCOUS \$448.85 \$448.85		REPAIR OF SYMBLEPHARON: WITH FREE GRAFT CONJUNCTIVA OR								
REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR \$203.38 \$203.38 \$203.38 \$203.38	68335			\$448.85	\$448.85					
68340 WITHOUT INSE \$203.38 \$203.38 68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53										
68360 CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE) \$270.53 \$270.53	68340	, , , , , , , , , , , , , , , , , , ,		\$203.38	\$203.38					
	300.0			7-00.00	1,7-00.00			+		
	68360	CONJUNCTIVAL FLAP: BRIDGE OR PARTIAL (SEPARATE PROCEDURE)		\$270.53	\$270.53					
	30000	CONJUNCTIVAL FLAP; TOTAL (SUCH AS GUNDERSON THIN FLAP OR		72.0.00	72.0.00					
68362 PURSE STRING \$428.69 \$428.69	68362			\$428 69	\$428 69					
68371 HARVESTING CONJUNCTIVAL ALLOGRAFT, LIVING DONOR \$265.09 \$265.09								+		
68399 UNLISTED PROCEDURE, CONJUNCTIVA R \$0.00 \$0.00			R					+		
68400 INCISION, DRAINAGE OF LACRIMAL GLAND \$62.99 \$76.40										

Physician	Fee Schedule 2020							
Note:	T ee Ochedule 2020							
	lles in Red;							
	CPT book for descriptions						+	
	column indicates Prior Auth is required						+	
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	man, shar	ac for the comic					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	mary char	ge for the service	*				
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes iis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysicia T	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Bus and draw December to a	DA In al		•				Natas
Code	Procedure Description INCISION, DRAINAGE OF LACRIMAL SAC (DACRYOCYSTOTOMY OR	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00400	DACRYOCYSTOSTOM		004.40	CO 4 O 4				
68420			\$81.16	\$94.84				
68440	SNIP INCISION OF LACRIMAL PUNCTUM		\$37.28	\$47.47				
00500	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT		#500.57	0500 57				
68500	FOR TUMOR; TOTAL		\$529.57	\$529.57				
	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT							
68505	FOR TUMOR; PARTI		\$549.87	\$549.87				
68510	BIOPSY OF LACRIMAL GLAND		\$241.05	\$241.05				
68520	EXCISION OF LACRIMAL SAC (DACRYOCYSTECTOMY)		\$465.10	\$465.10				
68525	BIOPSY OF LACRIMAL SAC		\$234.29	\$234.29				
68530	REMOVAL OF FOREIGN BODY OR DACRYOLITH, LACRIMAL PASSAGES		\$148.28	\$186.50				
68540	EXCISION OF LACRIMAL GLAND TUMOR; FRONTAL APPROACH		\$531.41	\$531.41				
68550	EXCISION OF LACRIMAL GLAND TUMOR; INVOLVING OSTEOTOMY		\$693.63	\$693.63				
68700	PLASTIC REPAIR OF CANALICULI		\$257.73	\$257.73				
68705	CORRECTION OF EVERTED PUNCTUM, CAUTERY		\$73.87	\$87.55				
	DACRYOCYSTORHINOSTOMY (FISTULIZATION OF LACRIMAL SAC TO							
68720	NASAL CAVITY)		\$507.27	\$507.27				
	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO							
68745	NASAL CAVITY);		\$428.38	\$428.38				
	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO							
68750	NASAL CAVITY);		\$542.71	\$542.71				
	CLOSURE OF THE LACRIMAL PUNCTUM; BY							
68760	THERMOCAUTERIZATION, LIGATION, OR		\$62.61	\$74.95				
68761	CLOSURE OF THE LACRIMAL PUNCTUM; BY PLUG, EACH		\$51.75	\$64.09				
68770	CLOSURE OF LACRIMAL FISTULA (SEPARATE PROCEDURE)		\$256.71	\$313.57				

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2020 Code	on in Body							
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	olumn indicates Prior Auth is required	L			1	+		
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnar	ge for the service		1	+		
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.				1	+		
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciar T	ns T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Due and the Denomination	PA Ind	•	•		Comp.	Value	Notes
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
68801	DILATION OF LACRIMAL PUNCTUM, WITH OR WITHOUT IRRIGATION		\$36.96	\$36.96				
00001	DILATION OF LACKIMAL FUNCTOW, WITH OR WITHOUT IRRIGATION		φ30.90	φ30.90		+		
68810	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;		\$51.50	\$51.50				
00010	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;		ψ51.50	φ51.50		+		
68811	REQUIRING GE		\$105.43	\$105.43				
00011	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;		φ103.43	φ103.43				
68815	WITH INSERTI		\$138.62	\$138.62				
68816	PROBE NL DUCT W/BALLOON		\$168.23	\$472.05				
00010	TROBE NE BOOT WIBILEOUT		ψ100.20	ψ+12.00				
68840	PROBING OF LACRIMAL CANALICULI, WITH OR WITHOUT IRRIGATION		\$43.10	\$49.67				
68850	INJECTION OF CONTRAST MEDIUM FOR DACRYOCYSTOGRAPHY		\$38.13	\$38.13		†		
68899		R	\$0.00	\$0.00		+		
69000	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; SIMPLE		\$46.50	\$51.20				
	, , , , , , , , , , , , , , , , , , , ,		,	, , ,				
69005	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; COMPLICATED		\$79.16	\$94.72				
69020	DRAINAGE EXTERNAL AUDITORY CANAL, ABSCESS		\$48.97	\$55.00				
69100	BIOPSY EXTERNAL EAR		\$32.85	\$41.70				
69105	BIOPSY EXTERNAL AUDITORY CANAL		\$37.86	\$48.59				
69110	EXCISION EXTERNAL EAR; PARTIAL, SIMPLE REPAIR	R	\$177.54	\$177.54				
69120	EXCISION EXTERNAL EAR; COMPLETE AMPUTATION		\$138.53	\$138.53				
69140	EXCISION EXOSTOSIS(ES), EXTERNAL AUDITORY CANAL		\$461.32	\$461.32				
69145	EXCISION SOFT TISSUE LESION, EXTERNAL AUDITORY CANAL		\$148.66	\$148.66				
	RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITHOUT							
69150	NECK DISSECTI		\$692.69	\$692.69				
	RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITH							
69155	NECK DISSECTION		\$965.85	\$965.85		<u> </u>		

Physician	Fee Schedule 2020							T
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	es in Red;							
	PT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL;							
69200	WITHOUT GENERAL		\$29.20	\$34.83				
	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITH							
69205	GENERAL ANESTH		\$65.12	\$65.12				
	REMOVE IMPACTED CERUMEN USING IRRIGATION/LAVAGE,		40.00	40.00				
69209	UNILATERAL		\$9.29	\$9.29				Added Effective 1/1/2016
20040	REMOVAL IMPACTED CERUMEN (SEPARATE PROCEDURE), ONE OR		004.47	004.55				
69210	BOTH EARS		\$21.47	\$24.55				
60000	DEBRIDEMENT, MASTOIDECTOMY CAVITY, SIMPLE (EG, ROUTINE		\$32.28	#20.00				
69220	CLEANING) DEBRIDEMENT, MASTOIDECTOMY CAVITY, COMPLEX (EG, WITH		\$32.28	\$38.98				
69222	ANESTHESIA OR MOR		\$51.48	\$61.41				
09222	ANEST RESIA OR WOR		φ31.40	Φ01.41				+
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION	D	\$335.58	\$335.58				
00000	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL (MEATOPLASTY)	11	ψ000.00	ψ000.00				
69310	(EG, FOR STENO		\$600.92	\$600.92				
000.0	RECONSTRUCTION EXTERNAL AUDITORY CANAL FOR CONGENITAL		Ψ000.02	Ψ000.02			+	
69320	ATRESIA, SINGLE		\$920.38	\$920.38				
69399	UNLISTED PROCEDURE, EXTERNAL EAR	R	\$0.00	\$0.00				
	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE							
69420	INFLATION		\$48.76	\$58.01				
	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE							
69421	INFLATION REQU		\$83.03	\$83.03				
69424	VENTILATING TUBE REMOVAL REQUIRING GENERAL ANESTHESIA		\$34.45	\$42.49				
	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE),							
69433	LOCAL OR TOPIC		\$64.62	\$82.45				

Note:	ee Schedule 2020							
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2020 Code	s in Rad:					-		
	PT book for descriptions				+	+		
	olumn indicates Prior Auth is required							
	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	go for the convice	,		+		
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thary Char		7		+		
	e lab fee schedule for covered codes not listed below in the 80000-89249 i	range						
	d on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
Oddes liste		л риузісіаі Т						
Date			Invest Date	Outuat Bata	T.	Duraf	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00.400	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE),		* 400 45	4400 45				
	GENERAL ANESTH		\$122.45	\$122.45				
	MIDDLE EAR EXPLORATION THROUGH POSTAURICULAR OR EAR		470.40					
	CANAL INCISION		\$470.18	\$470.18				
	TYMPANOLYSIS, TRANSCANAL		\$374.25	\$374.25				
	TRANSMASTOID ANTROTOMY (SIMPLE MASTOIDECTOMY)		\$579.30	\$579.30				
	MASTOIDECTOMY; COMPLETE		\$744.52	\$744.52				
	MASTOIDECTOMY; MODIFIED RADICAL		\$843.91	\$843.91				
	MASTOIDECTOMY; RADICAL		\$878.91	\$878.91				
	PETROUS APICECTOMY INCLUDING RADICAL MASTOIDECTOMY		\$1,019.34	\$1,019.34		_		
	RESECTION TEMPORAL BONE, EXTERNAL APPROACH		\$1,759.39	\$1,759.39				
	EXCISION AURAL POLYP		\$54.18	\$71.21				
	EXCISION AURAL GLOMUS TUMOR; TRANSCANAL		\$730.03	\$730.03				
69552	EXCISION AURAL GLOMUS TUMOR; TRANSMASTOID		\$1,046.76	\$1,046.76				
	EXCISION AURAL GLOMUS TUMOR; EXTENDED (EXTRATEMPORAL)		\$1,433.80	\$1,433.80				
	REVISION MASTOIDECTOMY; RESULTING IN COMPLETE							
	MASTOIDECTOMY		\$789.01	\$789.01				
	REVISION MASTOIDECTOMY; RESULTING IN MODIFIED RADICAL							
	MASTOIDECTOMY		\$865.08	\$865.08				
	REVISION MASTOIDECTOMY; RESULTING IN RADICAL							
	MASTOIDECTOMY		\$909.84	\$909.84				
	REVISION MASTOIDECTOMY; RESULTING IN TYMPANOPLASTY		\$931.65	\$931.65				
	REVISION MASTOIDECTOMY; WITH APICECTOMY		\$975.54	\$975.54				
	TYMPANIC MEMBRANE REPAIR, WITH OR WITHOUT SITE							
	PREPARATION OF PERFORAT		\$143.43	\$155.90				
	MYRINGOPLASTY (SURGERY CONFINED TO DRUMHEAD AND DONOR AREA)		\$393.49	\$393.49				

Note: 2020 Codes Refer to CP R" in PA coli Codes listed The Anesthe Please use	T book for descriptions umn indicates Prior Auth is required d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char						
2020 Codes Refer to CP R" in PA col Codes listed The Anesthe Please use	T book for descriptions umn indicates Prior Auth is required d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char						
Refer to CP R" in PA coll Codes listed The Anesthe Please use	T book for descriptions umn indicates Prior Auth is required d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char						
R" in PA coll Codes listed The Anesthe Please use	umn indicates Prior Auth is required d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char						
Codes listed The Anesthe Please use	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char						
The Anesthe Please use	esia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		rae for the service	2				
Please use								
	lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes listed	on the lab fee schedule that begin with a P or Q are currently non-covered t		ns					
	, , , , , , , , , , , , , , , , , , ,	T .						
				_			Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING							
	CANALPLASTY, ATTICOTOMY		\$647.12	\$647.12				
	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING							
69632	CANALPLASTY, ATTICOTOMY		\$832.12	\$832.12				
	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING							
	CANALPLASTY, ATTICOTOMY		\$792.00	\$792.00				
	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY							
	(INCLUDING CANALPLASTY,		\$875.05	\$875.05				
	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY							
	(INCLUDING CANALPLASTY,		\$998.86	\$998.86				
	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY		400400	****				
	(INCLUDING CANALPLASTY,		\$994.28	\$994.28		_		
	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		4007.00	4007.00				
	CANALPLASTY, MIDDLE EAR		\$827.98	\$827.98		_		
	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		¢4 007 40	¢4 007 40				
	CANALPLASTY, MIDDLE EAR TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		\$1,087.12	\$1,087.12				
	CANALPLASTY WITH MASTOIDECTOMY (INCLUDING		\$1,003.84	\$1,003.84				
	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		\$1,003.04	\$1,003.04				
	CANALPLASTY WITH MASTOIDECTOMY (INCLUDING		\$1,113.74	\$1,113.74				
	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		φ1,113.14	φ1,113.74				+
	CANALPLASTY, MIDDLE EAR		\$1,067.22	\$1,067.22				
	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING		ψ1,001.22	ψ1,001.22				+
	CANALPLASTY, MIDDLE EAR		\$1,156.70	\$1,156.70				
	STAPES MOBILIZATION		\$630.81	\$630.81				+
	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF	+	ψοσο.σ ι	Ψ000.01	+			+
	OSSICULAR CONTINUI		\$785.43	\$785.43				

Physician	Fee Schedule 2020							
Note:								
	es in Red;							
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary cha	rge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	lomary ona						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF		7/	,	'			
69661	OSSICULAR CONTINUI		\$991.03	\$991.03				
69662	REVISION OF STAPEDECTOMY OR STAPEDOTOMY		\$971.80	\$971.80				
69666	REPAIR OVAL WINDOW FISTULA		\$640.11	\$640.11				
69667	REPAIR ROUND WINDOW FISTULA		\$638.27	\$638.27				
69670	MASTOID OBLITERATION (SEPARATE PROCEDURE)		\$623.54	\$623.54				
69676	TYMPANIC NEURECTOMY		\$520.53	\$520.53				
	CLOSURE POSTAURICULAR FISTULA, MASTOID (SEPARATE							
69700	PROCEDURE)		\$465.10	\$465.10				
	IMPLANTATION OR REPLACEMENT OF ELECTROMAGNETIC BONE							
69710	CONDUCTION HEARING		\$775.35	\$775.35				
	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION							
69711	HEARING DEVICE IN		\$534.32	\$534.32				
	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE,							
69714	WITH PERCUTANEOU		\$651.98	\$651.98				
	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE,							
69715	WITH PERCUTANEOU		\$827.24	\$827.24				
	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE),							
69717	OSSEOINTEGRATED		\$673.16	\$673.16				
	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE),							
69718	OSSEOINTEGRATED		\$837.26	\$837.26				
	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; LATERAL TO							
69720	GENICULATE GANGL		\$933.77	\$933.77				
	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; INCLUDING							
69725	MEDIAL TO GENICUL		\$986.57	\$986.57				
	SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT							
69740	GRAFT OR DECOMPRES		\$809.97	\$809.97				

Physician	Fee Schedule 2020							
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	es in Red;							
	CPT book for descriptions				+			
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omory obor	go for the convice		+		+	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	omary char	T T THE SELVICE	;				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rongo			+		_	
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		20		+		_	
Codes list	ed on the lab lee schedule that begin with a P of Q are currently non-covered in	or priysiciai	TIS		_		_	
					+		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dracedure Decemention	DA In al	•				Value	Notes
Code	Procedure Description SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
69745	GRAFT OR DECOMPRES		\$937.42	\$937.42				
		R						
69799	UNLISTED PROCEDURE, MIDDLE EAR	K	\$0.00	\$650.00				
00004	LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING		фE00.40	фE00.40				
69801	OTHER NONEXCISIO		\$566.13	\$566.13	4		_	
69805	ENDOLYMPHATIC SAC OPERATION; WITHOUT SHUNT		\$702.40	\$702.40	4		_	
69806	ENDOLYMPHATIC SAC OPERATION; WITH SHUNT		\$814.38	\$814.38	4		_	
69905	LABYRINTHECTOMY; TRANSCANAL		\$731.73	\$731.73	4		_	
69910	LABYRINTHECTOMY; WITH MASTOIDECTOMY		\$891.06	\$891.06				
69915	VESTIBULAR NERVE SECTION, TRANSLABYRINTHINE APPROACH		\$1,107.74	\$1,107.74				
	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT		4000 70	****				
69930	MASTOIDECTOMY		\$989.78	\$989.78				
69949	UNLISTED PROCEDURE, INNER EAR	R	\$0.00	\$0.00				
69950	VESTIBULAR NERVE SECTION, TRANSCRANIAL APPROACH		\$1,159.27	\$1,159.27				
	TOTAL FACIAL NERVE DECOMPRESSION AND/OR REPAIR (MAY							
69955	INCLUDE GRAFT)		\$1,247.70	\$1,247.70				
69960	DECOMPRESSION INTERNAL AUDITORY CANAL		\$1,105.20	\$1,105.20				
69970	REMOVAL OF TUMOR, TEMPORAL BONE		\$1,237.40	\$1,237.40				
	UNLISTED PROCEDURE, TEMPORAL BONE, MIDDLE FOSSA							
69979	APPROACH	R	\$0.00	\$0.00				
	MICROSURGICAL TECHNIQUES, REQUIRING USE OF OPERATING							
69990	MICROSCOPE (LIST		\$162.90	\$162.90				
	MYELOGRAPHY, POSTERIOR FOSSA, RADIOLOGICAL SUPERVISION				1.	1.		
70010	AND INTERPRETAT		\$167.90	\$167.90	\$117.09	\$50.81		
	CISTERNOGRAPHY, POSITIVE CONTRAST, RADIOLOGICAL							
70015	SUPERVISION AND		\$87.60	\$87.60	\$36.79	\$50.81		

Physician	n Fee Schedule 2020							T
Note:								
	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service	:				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l	Ĭ					
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech. Comp.	Prof.	Base Unit Value	Notes
0000	1 Todadio Boddiption	. / t u	(i domey)	(itoin domey)	Сотр	Comp.	Value	110100
70030	RADIOLOGIC EXAMINATION, EYE, FOR DETECTION OF FOREIGN BODY		\$18.83	\$18.83	\$11.46	\$7.38		
70100	RADIOLOGIC EXAMINATION, MANDIBLE; PARTIAL, LESS THAN FOUR VIEWS		\$22.08	\$22.08	\$14.14	\$7.94		
	RADIOLOGIC EXAMINATION, MANDIBLE; COMPLETE, MINIMUM OF							
70110	FOUR VIEWS		\$27.84	\$27.84	\$16.80	\$11.04		
	RADIOLOGIC EXAMINATION, MASTOIDS; LESS THAN THREE VIEWS							
70120	PER SIDE		\$24.74	\$24.74	\$16.80	\$7.94		
70130	RADIOLOGIC EXAMINATION, MASTOIDS; COMPLETE, MINIMUM OF THREE VIEWS PER		\$36.09	\$36.09	\$21.33	\$14.75		
70134	RADIOLOGIC EXAMINATION, INTERNAL AUDITORY MEATI, COMPLETE		\$34.74	\$34.74	\$19.99	\$14.75		
70140	RADIOLOGIC EXAMINATION, FACIAL BONES; LESS THAN THREE VIEWS		\$25.03	\$25.03	\$16.80	\$8.23		
70150	RADIOLOGIC EXAMINATION, FACIAL BONES; COMPLETE, MINIMUM OF THREE VIEWS		\$32.67	\$32.67	\$21.33	\$11.33		
70160	RADIOLOGIC EXAMINATION, NASAL BONES, COMPLETE, MINIMUM OF THREE VIEWS		\$21.52	\$21.52	\$14.14	\$7.38		
	DACRYOCYSTOGRAPHY, NASOLACRIMAL DUCT, RADIOLOGICAL							
70170	SUPERVISION AND		\$38.64	\$38.64	\$25.60	\$13.04	<u> </u>	
70190	RADIOLOGIC EXAMINATION; OPTIC FORAMINA		\$25.88	\$25.88	\$16.80	\$9.09		
70200	RADIOLOGIC EXAMINATION; ORBITS, COMPLETE, MINIMUM OF FOUR VIEWS		\$33.52	\$33.52	\$21.33	\$12.19		
	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, LESS THAN		+		+=	7 .=		
70210	THREE VIEWS		\$24.17	\$24.17	\$16.80	\$7.38		
70220	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, COMPLETE, MINIMUM OF THREE		\$32.37	\$32.37	\$21.33	\$11.04		

Notes	Physician	Fee Schedule 2020							
	_	The Continue 2020							
Refer to CPT book for descriptions		los in Rad:							
R' in PA column indicates Prior Auth is required Codes Isleed as '50.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service									
Codes Sted as \$50.00^* pay 45% of Dilled amount not to exceed provider's usual and oustomary charge for the service									
The Ansethesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.			omoni obor	rae for the eervie	_	+	+		
Please use lab fee schedule for covered codes not listed below in the 80000-99249 range.			T		7	+	+		
Proc Procedure Description PA Ind Inpat. Rate Code Procedure Description PA Ind (Facility) (Facility) PA Ind PA Ind PA Ind (Facility) PA Ind PA In		·	rango						
Proc Code Procedure Description PA Ind Inpat. Rate (Hacility) Comp. Comp. Value Notes				ne					
Procedure Description	Codes lis	ted on the lab lee scrieddie that begin with a F of Q are currently non-covered in	T priysicia	113					
Procedure Description								Base	
Code Procedure Description PA Ind Facility Comp. Comp. Comp. Value Notes	Proc			Innat Rate	Outnat Rate	Tech	Prof		
TO240		Procedure Description	DA Ind	•	•				Notes
RADIOLOGIC EXAMINATION, SKULL; LESS THAN FOUR VIEWS \$27.28 \$27.28 \$16.80 \$10.48			FAIIIU					Value	Inotes
RADIOLOGIC EXAMINATION, SKULL; COMPLETE, MINIMUM OF FOUR VIEWS \$39.01 \$39.01 \$39.01 \$24.26 \$14.75 \$10.00 \$11.71 \$11.71 \$17.79 \$4.52 \$10.00 \$11.71 \$11.71 \$17.79 \$4.52 \$10.00 \$11.71 \$11.71 \$17.79 \$4.52 \$10.00 \$10.00 \$18.27 \$11.46 \$6.82 \$10.00 \$18.27 \$11.46 \$6.82 \$10.00 \$10.		,					•		
10260 VIEWS	70200			Ψ27.20	Ψ21.20	ψ10.00	ψ10.40		
RADIOLOGIC EXAMINATION, TEETH; SINGLE VIEW \$11.71 \$11.71 \$7.19 \$4.52	70260			\$39.01	\$30.01	\$24.26	\$14.75		
RADIOLOGIC EXAMINATION, TEETH; PARTIAL EXAMINATION, LESS \$18.27									
THAN FULL MOU	70000			Ψ11.71	Ψ11.71	Ψ7.19	ψ4.52		
FULL MOUTH X-RAY OF TEETH	70310			¢18 27	\$18.27	\$11.46	\$6.82		
RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN \$21.27 \$21.27 \$13.34 \$7.94									
RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN \$21.27	70020			ψ+0.00	ψ+0.00	Ψ2 1.00	Ψ0.02		
RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN	70328			\$21.27	\$21.27	\$13.34	\$7 94		
70330	70020			ΨΖ1.Ζ1	Ψ21.21	ψ10.04	Ψ1.54		
TEMPOROMANDIBULAR JOINT ARTHROGRAPHY, RADIOLOGICAL \$80.33 \$80.33 \$56.80 \$23.52	70330			\$33.15	\$33 15	\$22.67	\$10.48		
Total	7 0000			φου. το	ψου. το	Ψ22.07	Ψ10.10		
MAGNETIC RESONANCE (EG, PROTON) IMAGING, TEMPOROMANDIBULAR JOINT(S) R \$343.60 \$343.60 \$302.74 \$40.87	70332			\$80.33	\$80.33	\$56.80	\$23.52		
TO336 TEMPOROMANDIBULAR JOINT(S) R \$343.60 \$343.60 \$302.74 \$40.87 TO350 CEPHALOGRAM, ORTHODONTIC \$17.52 \$17.52 \$10.14 \$7.38 TO355 PANORAMIC X-RAY OF JAWS \$16.80 \$16.80 \$15.46 \$8.53 TO360 RADIOLOGIC EXAMINATION; NECK, SOFT TISSUE \$18.83 \$18.83 \$11.46 \$7.38 RADIOLOGIC EXAMINATION; PHARYNX OR LARYNX, INCLUDING \$49.10 \$35.20 \$13.90 TO370 FLUOROSCOPY AND/O \$49.10 \$35.20 \$13.90 COMPLEX DYNAMIC PHARYNGEAL AND SPEECH EVALUATION BY CINE OR VIDEO RECO R \$93.10 \$56.80 \$36.30 TO380 RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS \$25.52 \$25.52 \$18.14 \$7.38 TO371 STATE OF THE TOTAL OF	7 0002			Ψ00.00	ψου.σο	ψου.σο	Ψ20.02		
T0350 CEPHALOGRAM, ORTHODONTIC \$17.52 \$17.52 \$10.14 \$7.38 T0355 PANORAMIC X-RAY OF JAWS \$16.80 \$16.80 \$15.46 \$8.53 T0360 RADIOLOGIC EXAMINATION; NECK, SOFT TISSUE \$18.83 \$18.83 \$11.46 \$7.38 RADIOLOGIC EXAMINATION; PHARYNX OR LARYNX, INCLUDING \$49.10 \$35.20 \$13.90 COMPLEX DYNAMIC PHARYNGEAL AND SPEECH EVALUATION BY CINE OR VIDEO RECO R \$93.10 \$56.80 \$36.30 T0380 RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS \$25.52 \$25.52 \$18.14 \$7.38 T0350 \$17.52 \$17.52 \$10.14 \$7.38 \$17.52 \$17.52 \$10.14 \$7.38 \$17.52 \$17.52 \$10.14 \$7.38 \$18.83 \$18.83 \$11.46 \$7.38 \$18.83 \$11.46 \$7.	70336	, , ,	R	\$343.60	\$343 60	\$302.74	\$40.87		
70355 PANORAMIC X-RAY OF JAWS \$16.80 \$15.46 \$8.53						•			
T0360 RADIOLOGIC EXAMINATION; NECK, SOFT TISSUE \$18.83 \$18.83 \$11.46 \$7.38									
RADIOLOGIC EXAMINATION; PHARYNX OR LARYNX, INCLUDING \$49.10 \$49.10 \$35.20 \$13.90				•					
Total				Ţ : -:- -	7	Ţ · · · · · ·	75		
COMPLEX DYNAMIC PHARYNGEAL AND SPEECH EVALUATION BY 70371 CINE OR VIDEO RECO R \$93.10 \$93.10 \$56.80 \$36.30 70380 RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS \$25.52 \$18.14 \$7.38 7.38 7.38 7.38	70370			\$49.10	\$49.10	\$35.20	\$13.90		
70371 CINE OR VIDEO RECO R \$93.10 \$93.10 \$56.80 \$36.30 70380 RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS \$25.52 \$25.52 \$18.14 \$7.38							1		
70380 RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS \$25.52 \$25.52 \$18.14 \$7.38	70371		R	\$93.10	\$93.10	\$56.80	\$36.30		
70390 SIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION \$64.71 \$64.71 \$48.27 \$16.44									
	70390	SIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION		\$64.71	\$64.71	\$48.27	\$16.44		

Physician	Fee Schedule 2020							1
Note:	T de deficació 2020						+	
	les in Red;				+			
	CPT book for descriptions							1
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	<u> </u>						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST							
70450	MATERIAL		\$164.34	\$164.34	\$127.74	\$36.59		
	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST							
70460	MATERIAL(S)		\$201.59	\$201.59	\$153.07	\$48.51		
70.470	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST		40.45.70	0045 70				
70470	MATERIAL, FOLLOWE		\$245.70	\$245.70	\$191.23	\$54.47	_	
70400	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA		# 400.70	# 400.70	0407.74	055.04		
70480	OR OUTER, MIDDLE		\$182.78	\$182.78	\$127.74	\$55.04	+	
70404	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA		#040.40	#040.40	¢452.07	¢50.04		
70481	OR OUTER, MIDDLE COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA		\$212.12	\$212.12	\$153.07	\$59.04	_	
70482	OR OUTER, MIDDLE		\$253.37	\$253.37	\$191.23	\$62.14		
70402	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT		φ203.37	φ200.01	φ191.23	Φ02.14		
70486	CONTRAST MATERIAL		\$176.55	\$176.55	\$127.74	\$48.81		
70400	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST		ψ170.55	ψ170.33	Ψ121.14	ψ+0.01		
70487	MATERIAL(S)		\$208.70	\$208.70	\$153.07	\$55.62		
10101	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT		Ψ200.10	Ψ2000	ψ 100.01	Ψ00.02	+	
70488	CONTRAST MATERIAL,		\$252.22	\$252.22	\$191.23	\$61.00		
-	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT		4	7-5	7 10 11=0	7		
70490	CONTRAST MATERIAL		\$182.78	\$182.78	\$127.74	\$55.04		
	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST							
70491	MATERIAL(S)		\$212.12	\$212.12	\$153.07	\$59.04		
	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT							
70492	CONTRAST MATERIAL FOLLO		\$253.37	\$253.37	\$191.23	\$62.14		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEAD, WITHOUT							
70496	CONTRAST MATERIAL(S),		\$262.87	\$262.87	\$192.94	\$69.93		

Dhygigian	Fee Schedule 2020		1	T		1		T
Note:	ree Schedule 2020							
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	olumn indicates Prior Auth is required	<u> </u>				1		
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary cnarg	ge for the service			1		
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.					1		
	se lab fee schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the schedule for covered codes not listed below in the 80000-89249 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 in the 80000-89240 i		1					
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysician T	IS T					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dream dura Description	DA Ind	•	-				Notes
Code	Procedure Description COMPUTED TOMOGRAPHIC ANGIOGRAPHY, NECK, WITHOUT	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
70400			\$262.87	¢262.07	¢402.04	\$69.93		
70498	CONTRAST MATERIAL(S), MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND		\$202.07	\$262.87	\$192.94	\$69.93		
70540		Б	фосс оо	¢266.20	¢202.74	ФСО <u>Б</u> С		
70540	NECK; WITHOU MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND	R	\$366.30	\$366.30	\$302.74	\$63.56		
70542	NECK; WITH	R	\$399.60	\$399.60	\$354.09	\$45.51		
70542	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND	K	\$399.00	\$399.00	\$354.09	φ43.31		
70542	NECK: WITHOU	В	\$716.67	\$716.67	\$655.32	¢64.25		
70543	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST	R	\$7.10.07	\$7 10.07	\$655.32	\$61.35		
70544	MATERIAL(S)	R	\$411.51	\$411.51	\$365.08	\$46.44		
70544	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITH CONTRAST	K	Φ411.51	Φ411.51	\$303.06	\$40.44		
70545	MATERIAL(S)	R	\$346.92	\$346.92	\$299.54	\$47.38		
70040	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST	K	\$340.92	\$340.92	\$299.54	φ47.30		
70546	MATERIAL(S),	R	\$656.65	\$656.65	\$586.58	\$70.07		
70340	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST	K	\$636.63	\$636.63	\$500.50	\$70.07		
70547	MATERIAL(S)	R	\$410.49	\$410.49	\$364.05	\$46.44		
70547	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITH CONTRAST	1	ψ410.49	ψ410.49	\$304.03	ψ40.44		
70548	MATERIAL(S)	R	\$346.92	\$346.92	\$299.54	\$47.38		
70040	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST		ψ340.92	ψ340.92	Ψ299.54	ψ47.30		
70549	MATERIAL(S).	R	\$656.65	\$656.65	\$586.58	\$70.07		
70040	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING		ψ030.03	ψ030.03	Ψ500.50	Ψ10.01		
70551	BRAIN STEM);	R	\$366.30	\$366.30	\$302.74	\$63.56		
1,0001	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING	. `	\$000.00	4000.00	₩002.1 -	\$55.55		
70552	BRAIN STEM);	R	\$439.87	\$439.87	\$363.27	\$76.60		
7 0002	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING		ψ 100.01	ψ 100.01	ψ000.Z1	ψ. 0.00		
70553	BRAIN STEM);	R	\$774.25	\$774.25	\$672.42	\$101.84		
70555	MAGNETIC RESONANCE IMAGING, BRAIN	R	\$0.00	\$0.00	\$0.00	\$94.17		
. 0000	providence in terror in te	1.,	Ψ0.00	140.00	Ψ0.00	ΨΟ 1.17	<u> </u>	

Physician	Fee Schedule 2020							
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	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv char	ae for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		T						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING							
70557	BRAIN STEM A	R	\$0.00	\$0.00	\$0.00	\$110.40		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING							
70558	BRAIN STEM A	R	\$0.00	\$0.00	\$0.00	\$122.12		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING							
70559	BRAIN STEM A	R	\$0.00	\$0.00	\$0.00	\$122.64		
71045	X-RAY EXAM CHEST 1 VIEW		\$15.09	\$15.09	\$7.81	\$7.27		Added Effective 1/1/2018
71046	X-RAY EXAM CHEST 2 VIEWS		\$23.03	\$23.03	\$14.34	\$8.69		Added Effective 1/1/2018
71047	X-RAY EXAM CHEST 3 VIEWS		\$29.44	\$29.44	\$18.26	\$11.18		Added Effective 1/1/2018
71048	X-RAY EXAM CHEST 4+ VIEWS		\$31.64	\$31.64	\$18.78	\$12.86		Added Effective 1/1/2018
71100	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; TWO VIEWS		\$25.08	\$25.08	\$15.46	\$9.62		
	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; INCLUDING							
71101	POSTEROANTERIOR CH		\$30.03	\$30.03	\$18.14	\$11.90		
71110	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; THREE VIEWS		\$33.23	\$33.23	\$21.33	\$11.90		
	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; INCLUDING							
71111	POSTEROANTERIOR CHE		\$38.16	\$38.16	\$24.26	\$13.90		
71120	RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS		\$26.13	\$26.13	\$17.60	\$8.53		
	RADIOLOGIC EXAMINATION; STERNOCLAVICULAR JOINT OR JOINTS,							
71130	MINIMUM OF T		\$28.32	\$28.32	\$18.94	\$9.38		
71250	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL	-	\$209.42	\$209.42	\$159.75	\$49.66		
71260	COMPUTED TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)		\$244.31	\$244.31	\$191.23	\$53.08		
	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST					 .		
71270	MATERIAL, FOLLOWED BY		\$297.79	\$297.79	\$238.74	\$59.04		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST, WITHOUT		4000 5 /	4000 6 /				
71275	CONTRAST MATERIAL(S),		\$282.81	\$282.81	\$234.63	\$48.18		

Dhysisian	Fee Schedule 2020		1	1	1		1	1
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	and in Body	1					1	
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	olumn indicates Prior Auth is required	<u> </u>						
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	ns .					
			l				Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR							
71550	EVALUATION OF	R	\$371.67	\$371.67	\$302.74	\$68.93	1	
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR							
71551	EVALUATION OF	R	\$405.62	\$405.62	\$355.09	\$50.54	1	
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR							
71552	EVALUATION OF	R	\$717.99	\$717.99	\$651.83	\$66.16	1	
	MAGNETIC RESONANCE ANGIOGRAPHY, CHEST (EXCLUDING							
71555	MYOCARDIUM), WITH OR	R	\$377.83	\$377.83	\$302.74	\$75.10		
72020	RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL		\$17.98	\$17.98	\$11.46	\$6.52	1	
	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; TWO OR THREE							
72040	VIEWS		\$25.64	\$25.64	\$16.26	\$9.38		
	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; MINIMUM OF FOUR							
72050	VIEWS		\$37.59	\$37.59	\$24.26	\$13.34		
	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; COMPLETE,							
72052	INCLUDING OBLIQUE A		\$46.28	\$46.28	\$30.67	\$15.61		
72070	RADIOLOGIC EXAMINATION, SPINE; THORACIC, TWO VIEWS		\$26.98	\$26.98	\$17.60	\$9.38		
72072	RADIOLOGIC EXAMINATION, SPINE; THORACIC, THREE VIEWS		\$29.37	\$29.37	\$19.99	\$9.38		
	RADIOLOGIC EXAMINATION, SPINE; THORACIC, MINIMUM OF FOUR							
72074	VIEWS		\$34.17	\$34.17	\$24.79	\$9.38		
72080	RADIOLOGIC EXAMINATION, SPINE; THORACOLUMBAR, TWO VIEWS		\$27.52	\$27.52	\$18.14	\$9.38		
	RADIOLOGIC EXAMINATION, SPINE, ENTIRE THORACIC AND LUMBAR							
72081	INCLUDING SKULL, CERVICAL AND SACRAL SPINE.		\$29.12	\$29.12	\$18.35	\$10.77		Added Effective 1/1/2016
72082	2 or 3 views		\$46.39	\$46.39	\$33.35	\$13.03		Added Effective 1/1/2016
72083	4 or 5 views		\$50.42	\$50.42	\$36.20	\$14.22		Added Effective 1/1/2016
72084	MINIMUM 5		\$59.96	\$59.96	\$43.44	\$16.52		Added Effective 1/1/2016

Physician	Fee Schedule 2020							
Note:								
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
_					<u>_</u> .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
70400	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; TWO OR THREE		07.50	607.50	Φ40.44	Φ0 00		
72100	VIEWS RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; MINIMUM OF		\$27.52	\$27.52	\$18.14	\$9.38		
72110	FOUR VIEWS		\$38.13	\$38.13	\$24.79	\$13.34		
72110	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; COMPLETE,		φ30.13	φ30.13	φ <u>2</u> 4.79	φ13.34		+
72114	INCLUDING BENDIN		\$47.62	\$47.62	\$32.01	\$15.61		
72114	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL, BENDING VIEWS		Ψ+1.02	ψ+1.02	ψ02.01	ψ13.01		
72120	ONLY, MINIMU		\$33.64	\$33.64	\$24.26	\$9.38		
72120	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST		φοσ.σ ι	Ψ00.01	Ψ2 1.20	Ψ0.00		+
72125	MATERIAL		\$209.42	\$209.42	\$159.75	\$49.66		
	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITH CONTRAST		4		1	1		
72126	MATERIAL		\$243.19	\$243.19	\$191.23	\$51.96		
	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST							
72127	MATERIAL, FOLLOW		\$293.22	\$293.22	\$238.74	\$54.47		
	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST							
72128	MATERIAL		\$209.42	\$209.42	\$159.75	\$49.66		
	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST							
72129	MATERIAL		\$243.19	\$243.19	\$191.23	\$51.96		
	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST							
72130	MATERIAL, FOLLOW		\$293.22	\$293.22	\$238.74	\$54.47		
70.46	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST		4000 15	4000 15				
72131	MATERIAL CONTRACTOR AND ADDRESS MATERIAL CONTRACTOR		\$209.42	\$209.42	\$159.75	\$49.66		
70400	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST		004040	mo 40 40	M404.00	054.00		
72132	MATERIAL COMPLETE TOMOGRAPHY LUMBAR CRIME, WITHOUT CONTRACT		\$243.19	\$243.19	\$191.23	\$51.96		
70400	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST		# 000 00	# 000 00	# 000 74	DE 4 47		
72133	MATERIAL, FOLLOWED		\$293.22	\$293.22	\$238.74	\$54.47		

Physician	Fee Schedule 2020							
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	es in Red;						1	
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv char	ae for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
Please us	e lab fee schedule for covered codes not listed below in the 80000-89249 i	range.			1			
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciai	าร					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND		7	7				
72141	CONTENTS,	R	\$371.67	\$371.67	\$302.74	\$68.93		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72142	CONTENTS,	R	\$445.83	\$445.83	\$363.27	\$82.57		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72146	CONTENTS,	R	\$405.02	\$405.02	\$336.09	\$68.93		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72147	CONTENTS,	R	\$445.83	\$445.83	\$363.27	\$82.57		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72148	CONTENTS, LU	R	\$399.65	\$399.65	\$336.09	\$63.56		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72149	CONTENTS, LU	R	\$439.87	\$439.87	\$363.27	\$76.60		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72156	CONTENTS, WI	R	\$782.81	\$782.81	\$672.42	\$110.39		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND							
72157	CONTENTS, WI	R	\$782.81	\$782.81	\$672.42	\$110.39	1	
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND		1	1		1		
72158	CONTENTS, WI	R	\$774.25	\$774.25	\$672.42	\$101.84		
70450	MAGNETIC RESONANCE ANGIOGRAPHY, SPINAL CANAL AND		0.400.04	0.400.04	0000.00	φ 7 0.05		
72159	CONTENTS, WITH OR WIT	R	\$409.04	\$409.04	\$336.09	\$72.95	<u> </u>	
72170	RADIOLOGIC EXAMINATION, PELVIS; ONE OR TWO VIEWS		\$21.25	\$21.25	\$14.14	\$7.11	1	
72400	RADIOLOGIC EXAMINATION, PELVIS; COMPLETE, MINIMUM OF THREE VIEWS		\$27.23	\$27.23	¢40.44	\$9.09		
72190	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, PELVIS, WITHOUT		Φ∠1.∠3	Φ∠1.∠3	\$18.14	φ9.09		
72191	CONTRAST MATERIAL(S)		\$273.77	\$273.77	\$225.60	\$48.18		
12191	CONTRACT WATERIAL(S)		φ213.11	φ213.11	φ∠∠3.00	φ40.10	+	
72192	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL		\$206.31	\$206.31	\$159.75	\$46.56		

Physician	n Fee Schedule 2020							
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	des in Red;				+			1
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciai	ns					
Proc		DA local	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	Nata
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
72193	COMPUTED TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)		\$234.50	\$234.50	\$184.84	\$49.66		
	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL,							
72194	FOLLOWED BY		\$281.10	\$281.10	\$229.14	\$51.96		1
70405	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT		4057.00	4057.00	0004.00	050.00		
72195	CONTRAST	R	\$357.63	\$357.63	\$301.03	\$56.60		4
72196	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITH CONTRAST MATERIA	l _D	\$371.67	\$371.67	\$302.74	\$68.93		
72190	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT	R	φ3/ 1.0 <i>l</i>	φ3/ 1.0 <i>l</i>	\$302.74	\$00.93		
72197	CONTRAST	R	\$723.49	\$723.49	\$656.82	\$66.66		
12131	MAGNETIC RESONANCE ANGIOGRAPHY, PELVIS, WITH OR WITHOUT	11	Ψ123.43	Ψ123.49	ψ030.02	ψ00.00		+
72198	CONTRAST	R	\$377.54	\$377.54	\$302.74	\$74.80		
12.00	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; LESS THAN THREE		Ψοττίο:	ψοττιστ	φσσ2	ψσσ		
72200	VIEWS		\$21.52	\$21.52	\$14.14	\$7.38		
	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; THREE OR MORE			, -	<u> </u>			
72202	VIEWS		\$25.03	\$25.03	\$16.80	\$8.23		
	RADIOLOGIC EXAMINATION, SACRUM AND COCCYX, MINIMUM OF							
72220	TWO VIEWS		\$22.83	\$22.83	\$15.46	\$7.38		
	MYELOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND							
72240	INTERPRETATION		\$167.44	\$167.44	\$128.28	\$39.16		
	MYELOGRAPHY, THORACIC, RADIOLOGICAL SUPERVISION AND							
72255	INTERPRETATION		\$156.25	\$156.25	\$117.09	\$39.16		
	MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION AND							
72265	INTERPRETATION		\$146.15	\$146.15	\$110.14	\$36.01		
	MYELOGRAPHY, TWO OR MORE REGIONS (EG, LUMBAR/THORACIC,							
72270	CERVICAL/ THORA		\$221.86	\$221.86	\$164.82	\$57.04		

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u>, </u>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l enaily onai	1	·				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					1
]						1
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	EPIDUROGRAPHY, RADIOLOGICAL SUPERVISION AND	FAIIIU	(i acility)	(Noni acinty)	Comp.	Comp.	Value	Notes
72275	INTERPRETATION		\$79.63	\$79.63	\$59.26	\$20.37		
12213	DISKOGRAPHY, CERVICAL OR THORACIC, RADIOLOGICAL		Ψ19.03	Ψ1 9.03	ψ59.20	Ψ20.51		+
72285	SUPERVISION AND		\$262.46	\$262.46	\$226.46	\$36.01		
12203	DISKOGRAPHY, LUMBAR, RADIOLOGICAL SUPERVISION AND		Ψ202.40	Ψ202.40	Ψ220.40	φ30.01		+
72295	INTERPRETATION		\$248.08	\$248.08	\$212.07	\$36.01		
73000	RADIOLOGIC EXAMINATION; CLAVICLE, COMPLETE		\$20.96	\$20.96	\$14.14	\$6.82		
73010	RADIOLOGIC EXAMINATION; SCAPULA, COMPLETE		\$21.52	\$21.52	\$14.14	\$7.38		+
73020	RADIOLOGIC EXAMINATION, SHOULDER; ONE VIEW		\$19.32	\$19.32	\$12.80	\$6.52		+
70020	RADIOLOGIC EXAMINATION, SHOULDER; COMPLETE, MINIMUM OF		Ψ10.02	ψ10.02	Ψ12.00	Ψ0.02		+
73030	TWO VIEWS		\$23.13	\$23.13	\$15.46	\$7.67		
7 0 0 0 0	RADIOLOGIC EXAMINATION, SHOULDER, ARTHROGRAPHY,		Ψ20.10	Ψ20.10	ψ.σσ	ψ1.01		
73040	RADIOLOGICAL SUPERVISI		\$80.33	\$80.33	\$56.80	\$23.52		
	RADIOLOGIC EXAMINATION; ACROMIOCLAVICULAR JOINTS,		700100	7	700.00	1		
73050	BILATERAL, WITH OR		\$26.66	\$26.66	\$18.14	\$8.53		
73060	RADIOLOGIC EXAMINATION; HUMERUS, MINIMUM OF TWO VIEWS		\$22.83	\$22.83	\$15.46	\$7.38		
73070	RADIOLOGIC EXAMINATION, ELBOW; TWO VIEWS		\$20.66	\$20.66	\$14.14	\$6.52		1
	RADIOLOGIC EXAMINATION, ELBOW; COMPLETE, MINIMUM OF THREE							
73080	VIEWS		\$22.83	\$22.83	\$15.46	\$7.38		
	RADIOLOGIC EXAMINATION, ELBOW, ARTHROGRAPHY,							
73085	RADIOLOGICAL SUPERVISION		\$80.33	\$80.33	\$56.80	\$23.52		
73090	RADIOLOGIC EXAMINATION; FOREARM, TWO VIEWS		\$20.96	\$20.96	\$14.14	\$6.82		
	RADIOLOGIC EXAMINATION; UPPER EXTREMITY, INFANT, MINIMUM							
73092	OF TWO VIEWS		\$20.15	\$20.15	\$13.34	\$6.82		
73100	RADIOLOGIC EXAMINATION, WRIST; TWO VIEWS		\$20.15	\$20.15	\$13.34	\$6.82		
	RADIOLOGIC EXAMINATION, WRIST; COMPLETE, MINIMUM OF THREE							
73110	VIEWS		\$21.79	\$21.79	\$14.41	\$7.38		

Physician	Fee Schedule 2020							
Note:								
	es in Red;							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	,				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		Τ΄ ΄						
					1		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RADIOLOGIC EXAMINATION, WRIST, ARTHROGRAPHY,		, ,	, , ,	1	•		
73115	RADIOLOGICAL SUPERVISION		\$66.19	\$66.19	\$42.66	\$23.52		
73120	RADIOLOGIC EXAMINATION, HAND; TWO VIEWS		\$20.15	\$20.15	\$13.34	\$6.82		
73130	RADIOLOGIC EXAMINATION, HAND; MINIMUM OF THREE VIEWS		\$21.79	\$21.79	\$14.41	\$7.38		
73140	RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF TWO VIEWS		\$17.12	\$17.12	\$11.46	\$5.67		
	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT							
73200	CONTRAST MATERIAL		\$180.72	\$180.72	\$134.16	\$46.56		
	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST							
73201	MATERIAL(S)		\$209.42	\$209.42	\$159.75	\$49.66		
	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT							
73202	CONTRAST MATERIAL, FOLLO		\$252.79	\$252.79	\$200.83	\$51.96		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, UPPER EXTREMITY,							
73206	WITHOUT CONTRAST		\$246.41	\$246.41	\$198.24	\$48.18		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY,							
73218	OTHER THAN J	R	\$333.53	\$333.53	\$295.29	\$38.24		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY,							
73219	OTHER THAN J	R	\$399.60	\$399.60	\$354.09	\$45.51		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY,							
73220	OTHER THAN J	R	\$366.30	\$366.30	\$302.74	\$63.56		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF							
73221	UPPER EXTREMITY;	R	\$338.64	\$338.64	\$286.23	\$52.41		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF							
73222	UPPER EXTREMITY;	R	\$399.60	\$399.60	\$354.09	\$45.51		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF							
73223	UPPER EXTREMITY;	R	\$716.67	\$716.67	\$655.32	\$61.35		
	MAGNETIC RESONANCE ANGIOGRAPHY, UPPER EXTREMITY, WITH							
73225	OR WITHOUT CONTR	R	\$373.63	\$373.63	\$302.74	\$70.90		

Physician	n Fee Schedule 2020							
Note:	Tribo Contiduio 2020							
	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	rae for the convice	,				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tillary Griai		,		+		
	Ise lab fee schedule for covered codes not listed below in the 80000-89249	rango				+		
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>			+	1	
Codes iis		Ji priysicia T	115			-		+
						-	Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Dropo dura Deceription	PA Ind		•		Comp.	Value	Notes
Code	Procedure Description RADIOLOGIC EXAMINATION, HIP UNILATERAL, WITH PELVIS WHEN	PAIIIU	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
73501	PERFORMED		\$22.37	\$22.37	\$14.72	\$7.65		Added Effective 1/1/2016
73501	2-3 VIEWS		\$30.80	\$30.80	\$21.71	\$9.09		Added Effective 1/1/2016 Added Effective 1/1/2016
73502	MINIMUM OF 4 VIEWS		\$38.47	\$38.47	\$26.88	\$9.09		Added Effective 1/1/2016 Added Effective 1/1/2016
73303	MINIMUM OF 4 VIEWS		\$30.47	φ30.4 <i>1</i>	\$20.00	\$11.59		Added Effective 1/1/2016
73521	RADIOLOGIC EXAMINATION, HIPS, BILATERAL WITH PELVIS; 2 VIEWS		\$29.77	\$29.77	\$20.42	\$9.35		Added Effective 1/1/2016
73521	3-4VIEWS		\$36.48	\$36.48	\$24.30	\$12.18		Added Effective 1/1/2016
73522	MINIMUM OF 5 VIEWS		\$42.25	\$42.25	\$29.21	\$13.03		Added Effective 1/1/2016
73023	RADIOLOGIC EXAMINATION, HIP, ARTHROGRAPHY, RADIOLOGICAL		Φ42.2 3	φ42.23	φ 2 9.21	Φ13.03		Added Effective 1/1/2010
72525	SUPERVISION AN		\$80.33	¢00.22	ΦEG 90	\$23.52		
73525 73551	RADIOLOGIC EXAMINATION. FEMUR 1 VIEW		\$20.74	\$80.33 \$20.74	\$56.80 \$13.95	\$6.79		Added Effective 1/1/2016
73551	MINIMUM 2 VIEWS		\$24.18	\$24.18	\$16.54	\$7.65		Added Effective 1/1/2016 Added Effective 1/1/2016
	RADIOLOGIC EXAMINATION, KNEE; ONE OR TWO VIEWS		\$21.25	\$24.16	\$10.54	\$7.00		Added Effective 1/1/2016
73560 73562	RADIOLOGIC EXAMINATION, KNEE; THREE VIEWS		\$23.39	\$23.39	\$14.14	\$7.11		
73562	RADIOLOGIC EXAMINATION, KNEE; THREE VIEWS RADIOLOGIC EXAMINATION, KNEE; COMPLETE, FOUR OR MORE		\$23.39	\$23.39	\$15.46	\$7.94		
70504	VIEWS		фос 40	¢00.40	Φ4C 00	#0.00		
73564			\$26.42	\$26.42	\$16.80	\$9.62		
70505	RADIOLOGIC EXAMINATION, KNEE; BOTH KNEES, STANDING,		\$00.44	COO 44	Φ40 04	Ф 7 44		
73565	ANTEROPOSTERIOR		\$20.44	\$20.44	\$13.34	\$7.11	-	
70500	RADIOLOGIC EXAMINATION, KNEE, ARTHROGRAPHY, RADIOLOGICAL		DO 4 74	CO 4 74	Φ 74 40	¢00.50		
73580	SUPERVISION A		\$94.71	\$94.71	\$71.19	\$23.52	-	
73590	RADIOLOGIC EXAMINATION; TIBIA AND FIBULA, TWO VIEWS		\$21.25	\$21.25	\$14.14	\$7.11		
70500	RADIOLOGIC EXAMINATION; LOWER EXTREMITY, INFANT, MINIMUM		000 45	000 45	040.04	Φο οο		
73592	OF TWO VIEWS	1	\$20.15	\$20.15	\$13.34	\$6.82		
73600	RADIOLOGIC EXAMINATION, ANKLE; TWO VIEWS	1	\$20.15	\$20.15	\$13.34	\$6.82		
70010	RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE		004.70	004.70		47.00		
73610	VIEWS		\$21.79	\$21.79	\$14.41	\$7.38		

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RADIOLOGIC EXAMINATION, ANKLE, ARTHROGRAPHY,				1.			
73615	RADIOLOGICAL SUPERVISION		\$80.33	\$80.33	\$56.80	\$23.52		
73620	RADIOLOGIC EXAMINATION, FOOT; TWO VIEWS		\$20.15	\$20.15	\$13.34	\$6.82		
	RADIOLOGIC EXAMINATION, FOOT; COMPLETE, MINIMUM OF THREE				.			
73630	VIEWS		\$21.79	\$21.79	\$14.41	\$7.38		
73650	RADIOLOGIC EXAMINATION; CALCANEUS, MINIMUM OF TWO VIEWS		\$19.61	\$19.61	\$12.80	\$6.82		
73660	RADIOLOGIC EXAMINATION; TOE(S), MINIMUM OF TWO VIEWS		\$17.12	\$17.12	\$11.46	\$5.67		
70700	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT		# 400.70	¢400.70	¢40440	0.40.50		
73700	CONTRAST MATERIAL		\$180.72	\$180.72	\$134.16	\$46.56		
72704	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITH CONTRAST MATERIAL(S)		\$209.42	\$209.42	\$159.75	\$49.66		
73701	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT		\$209.42	\$209.42	\$159.75	Ф49.00		
73702	CONTRAST MATERIAL, FOLLO		\$252.79	\$252.79	\$200.83	\$51.96		
73702	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, LOWER EXTREMITY,		φ232.19	φ232.19	φ200.03	φ51.80		
73706	WITHOUT CONTRAST		\$246.41	\$246.41	\$198.24	\$48.18		
73700	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY		Ψ240.41	Ψ240.41	φ130.24	ψ40.10		
73718	OTHER THAN JO	R	\$333.53	\$338.24	\$295.29	\$38.24		
70710	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY	11	Ψ000.00	ψ000.24	Ψ233.23	ψ00.24		
73719	OTHER THAN JO	R	\$399.60	\$399.60	\$354.09	\$45.51		
7 07 10	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY		Ψοσο.σο	Ψ000.00	Ψοσσσ	ψ (σ.σ.)		
73720	OTHER THAN JO	R	\$366.30	\$366.30	\$302.74	\$63.56		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF		, , , , , , , ,	, , , , , , , ,	,	,		
73721	LOWER EXTREMITY;	R	\$344.77	\$344.77	\$292.35	\$52.41		
	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF				1			
73722	LOWER EXTREMITY;	R	\$399.60	\$399.60	\$354.09	\$45.51		

Physician	Fee Schedule 2020			I				
Note:	1 00 001104410 2020							
	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	l enary enar	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech. Comp.	Prof.	Base Unit Value	Notes
Oode	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF	I A IIIu	(i acinty)	(Nom acmty)	Comp.	Jonny.	Value	Hotes
73723	LOWER EXTREMITY;	R	\$716.67	\$716.67	\$655.32	\$61.35		
10120	MAGNETIC RESONANCE ANGIOGRAPHY, LOWER EXTREMITY, WITH	. `	ψ1 10.01	φτισ.στ	φοσο.σ2	ΨΟ1.00		+
73725	OR WITHOUT CONTR	R	\$376.27	\$376.27	\$302.74	\$73.54		
74018	X-RAY EXAM ABDOMEN 1 VIEW		\$20.57	\$20.57	\$13.30	\$7.27		Added Effective 1/1/2018
74019	X-RAY EXAM ABDOMEN 2 VIEWS		\$25.15	\$25.15	\$15.91	\$9.24		Added Effective 1/1/2018
74021	X-RAY EXAM ABDOMEN 3+ VIEWS		\$29.42	\$29.42	\$18.52	\$10.90		Added Effective 1/1/2018
	RADIOLOGIC EXAMINATION, ABDOMEN; COMPLETE ACUTE ABDOMEN		V	4_0	V.0.0	7		
74022	SERIES, INCLUD		\$36.30	\$36.30	\$23.59	\$12.71		Updated Effective 01/01/2020
	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST		,	,		·		1
74150	MATERIAL		\$203.88	\$203.88	\$153.07	\$50.81		
	COMPUTED TOMOGRAPHY, ABDOMEN; WITH CONTRAST		•	,		,		
74160	MATERIAL(S)		\$239.31	\$239.31	\$184.84	\$54.47		
	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST							
74170	MATERIAL, FOLLOWED BY		\$289.28	\$289.28	\$229.14	\$60.14		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES,							
74174	IF PERFORMED, AND IMAGE POSTPROCESSING		\$434.81	\$434.81	\$346.77	\$88.04		
74175	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN, WITHOUT CONTRAST MATERIAL(S		\$273.77	\$273.77	\$225.60	\$48.18		
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL		\$189.00	\$189.00	\$115.12	\$73.88		
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL		\$297.00	\$297.00	\$219.56	\$77.44		

Physicia	n Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	ise lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT							
	CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED							
	BY CONTRACT MATERIALS AND FURTHER SECTIONS IN ONE OR							
74178	BOTH BODY REGIONS		\$375.92	\$375.92	\$290.17	\$85.75		
74404	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN;		0074 07	074.07	0000 74			
74181	WITHOUT CONTRAST	R	\$371.67	\$371.67	\$302.74	\$68.93		
74400	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITH		# 405.00	0.405.00	* 055.00	Φ50.54		
74182	CONTRAST MATERI	R	\$405.62	\$405.62	\$355.09	\$50.54		
74400	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN;	_	ф 7 00 40	Ф 7 00 40	фо г о оо	фос cc		
74183	WITHOUT CONTRAST MAGNETIC RESONANCE ANGIOGRAPHY, ABDOMEN, WITH OR	R	\$723.49	\$723.49	\$656.82	\$66.66		
74185		 	077 54	077 54	#202 74	\$74.80		
74185	WITHOUT CONTRAST PERITONEOGRAM (EG, AFTER INJECTION OF AIR OR CONTRAST),	R	\$377.54	\$377.54	\$302.74	\$74.80		
74190	RADIOLOGICAL		\$53.26	\$53.26	\$35.20	\$18.06		
74190	RADIOLOGICAL RADIOLOGIC EXAMINATION; PHARYNX AND/OR CERVICAL		φυυ.20	φυυ.20	φ35.20	φ10.00		
74210	ESOPHAGUS		\$70.88	\$70.88	\$47.20	\$23.68		Updated Effective 01/01/2020
74210	ESOFTIAGOS		φ10.00	φ10.00	φ47.20	φ23.00		Opulated Effective 01/01/2020
74220	RADIOLOGIC EXAMINATION; ESOPHAGUS		\$72.21	\$72.21	\$48.24	\$23.97		Updated Effective 01/01/2020
14220	TVADIOLOGIO EXAMINATION, LOGI HAGOO		Ψ1Ζ.Ζ1	Ψ1Ζ.Ζ1	ψ+0.2+	Ψ20.01		opulated Effective 0 1/0 1/2020
74221	X-RAY XM ESOPHAGUS 2CNTRST		\$81.62	\$81.62	\$53.68	\$27.93		Added Effective 01/01/2020
	SWALLOWING FUNCTION, WITH		702	70	700.00	+		1000 2000 1000 1000
74230	CINERADIOGRAPHY/VIDEORADIOGRAPHY	R	\$96.12	\$96.12	\$74.96	\$21.16		Updated Effective 01/01/2020
	REMOVAL OF FOREIGN BODY(S), ESOPHAGEAL, WITH USE OF	†		,	7	T		-,
74235	BALLOON CATHETER,		\$122.00	\$122.00	\$71.19	\$50.81		
	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER;							
74240	WITH OR WITHOUT		\$90.47	\$90.47	\$58.09	\$32.38		Updated Effective 01/01/2020
	1	-						<u> </u>

Physician	Fee Schedule 2020							
Note:								
	les in Red;					+		
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary chai	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER;							
74241	WITH OR WITHOUT		\$70.32	\$70.32	\$40.27	\$30.05		
	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER;							
74245	WITH SMALL		\$103.69	\$103.69	\$64.53	\$39.16		
	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER,							
74246	AIR CONTRAST,		\$104.03	\$104.03	\$67.95	\$36.08		Updated Effective 01/01/2020
	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER,							
74247	AIR CONTRAST,		\$75.63	\$75.63	\$45.59	\$30.05		
74248	X-RAY SM INT F-THRU STD		\$62.43	\$62.43	\$34.50	\$27.93		Added Effective 01/01/2020
	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER,							
74249	AIR CONTRAST,		\$108.76	\$108.76	\$69.60	\$39.16		
	RADIOLOGIC EXAMINATION, SMALL INTESTINE, INCLUDES MULTIPLE							
74250	SERIAL FILM		\$91.03	\$91.03	\$58.35	\$32.67		Updated Effective 01/01/2020
74054	RADIOLOGIC EXAMINATION, SMALL INTESTINE, INCLUDES MULTIPLE		4007.40	#007.40	***			
74251	SERIAL FILM		\$297.13	\$297.13	\$250.32	\$46.81		Updated Effective 01/01/2020
74260	DUODENOGRAPHY, HYPOTONIC		\$61.84	\$61.84	\$40.27	\$21.57		
74004	CT COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE		#000 OF	#000 OF	0040.00	Φος οο		
74261	POSTPROCESSING; W/O CONTRAST MATERIAL		\$296.05	\$296.05	\$210.96	\$85.09		+
74262	WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES		\$332.42	\$332.42	\$239.03	\$93.40		
	RADIOLOGIC EXAMINATION, COLON; BARIUM ENEMA, WITH OR				l	 		
74270	WITHOUT KUB	1	\$115.91	\$115.91	\$74.44	\$41.47		Updated Effective 01/01/2020
7.4000	RADIOLOGIC EXAMINATION, COLON; AIR CONTRAST WITH SPECIFIC		405.00	405.00		A=0.00		
74280	HIGH DENSITY		\$165.90	\$165.90	\$115.69	\$50.22		Updated Effective 01/01/2020
74283	THERAPEUTIC ENEMA, CONTRAST OR AIR, FOR REDUCTION OF INTUSSUSCEPTION O		\$156.15	\$156.15	\$69.33	\$86.82		

Physician	n Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to (CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	Э				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
74290	CHOLECYSTOGRAPHY, ORAL CONTRAST;		\$33.89	\$33.89	\$19.99	\$13.90		
	CHOLANGIOGRAPHY AND/OR PANCREATOGRAPHY;							
74300	INTRAOPERATIVE, RADIOLOGICAL		\$39.94	\$39.94	\$25.98	\$13.96		
	CHOLANGIOGRAPHY AND/OR PANCREATOGRAPHY; ADDITIONAL SET							
74301	INTRAOPERATIVE,		\$23.19	\$23.19	\$15.08	\$8.10		
	ENDOSCOPIC CATHETERIZATION OF THE BILIARY DUCTAL SYSTEM,							
74328	RADIOLOGICAL		\$115.42	\$115.42	\$85.08	\$30.34		
	ENDOSCOPIC CATHETERIZATION OF THE PANCREATIC DUCTAL							
74329	SYSTEM, RADIOLOGIC		\$115.42	\$115.42	\$85.08	\$30.34		
	COMBINED ENDOSCOPIC CATHETERIZATION OF THE BILIARY AND							
74330	PANCREATIC DUCT		\$115.42	\$115.42	\$85.08	\$30.34		
74040	INTRODUCTION OF LONG GASTROINTESTINAL TUBE (EG, MILLER-		004.74	004.74	074.40	000 50		
74340	ABBOTT), INCLUD		\$94.71	\$94.71	\$71.19	\$23.52		
74055	PERCUTANEOUS PLACEMENT OF ENTEROCLYSIS TUBE, RADIOLOGICAL SUPERVISION		¢404.00	¢404.00	Ф 7 4.40	# 20.00		
74355	INTRALUMINAL DILATION OF STRICTURES AND/OR OBSTRUCTIONS		\$104.09	\$104.09	\$71.19	\$32.90		
74260	(EG, ESOPHAGUS		\$108.60	\$108.60	\$85.08	\$23.52		
74360	PERCUTANEOUS TRANSHEPATIC DILATION OF BILIARY DUCT		\$100.00	\$100.00	φου.υο	\$23.32		
74363	STRICTURE WITH OR		\$202.83	\$202.83	\$164.82	\$38.01		
74303	UROGRAPHY (PYELOGRAPHY), INTRAVENOUS, WITH OR WITHOUT		\$202.03	φ202.03	φ104.02	φ30.01	+	
74400	KUB, WITH OR WIT		\$66.60	\$66.60	\$45.59	\$21.01		
7 7 7 0 0	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS	+	ψ00.00	ψ00.00	ψ+υ.υυ	Ψ2 1.0 1		
74410	TECHNIQUE;		\$73.81	\$73.81	\$52.80	\$21.01		
1 77 10	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS	+	ψ10.01	ψ10.01	Ψ02.00	Ψ21.01	1	
74415	TECHNIQUE; WITH		\$78.35	\$78.35	\$57.34	\$21.01		
74420	UROGRAPHY, RETROGRADE, WITH OR WITHOUT KUB		\$86.53	\$86.53	\$71.19	\$15.34		

Physician	Fee Schedule 2020			1				T 1
Note:								
2020 Cod	les in Red;							
	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	UROGRAPHY, ANTEGRADE, (PYELOSTOGRAM, NEPHROSTOGRAM,							
74425	LOOPOGRAM),		\$50.54	\$50.54	\$35.20	\$15.34		
	CYSTOGRAPHY, MINIMUM OF THREE VIEWS, RADIOLOGICAL							
74430	SUPERVISION AND		\$42.42	\$42.42	\$28.52	\$13.90		
	VASOGRAPHY, VESICULOGRAPHY, OR EPIDIDYMOGRAPHY,							
74440	RADIOLOGICAL SUPERVISI		\$47.11	\$47.11	\$30.67	\$16.44		
	CORPORA CAVERNOSOGRAPHY, RADIOLOGICAL SUPERVISION AND							
74445	INTERPRETATION		\$79.47	\$79.47	\$30.67	\$48.81		
	URETHROCYSTOGRAPHY, RETROGRADE, RADIOLOGICAL							
74450	SUPERVISION AND INTERPRET		\$53.66	\$53.66	\$39.47	\$14.19		
	URETHROCYSTOGRAPHY, VOIDING, RADIOLOGICAL SUPERVISION					 		
74455	AND INTERPRETATI		\$56.86	\$56.86	\$42.66	\$14.19		
	RADIOLOGIC EXAMINATION, RENAL CYST STUDY, TRANSLUMBAR,							
74470	CONTRAST		\$57.38	\$57.38	\$33.86	\$23.52		
74405	DILATION OF NEPHROSTOMY, URETERS, OR URETHRA,		* 400.00	# 400.00	***	400.50		
74485	RADIOLOGICAL SUPERVISION		\$108.60	\$108.60	\$85.08	\$23.52		
74740	MAGNETIC RESONANCE IMAGING, FETAL, INCLUDING PLACENTAL	_	0004.04	0004.04	Φ000 04	#400.00		A 14 1 5% 15 14 10040
74712	AND MATERNAL PELVIC /SINGLE/1ST GESTATION	R	\$361.01	\$361.01	\$239.01	\$122.00		Added Effective 1/1/2016
74713	EACH ADDITIONAL GESTATION	R	\$174.68	\$174.68	\$102.43	\$72.25		Added Effective 1/1/2016
74740	HYSTEROSALPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND		ΦE4 G4	ΦE4 C4	Φ25 20	046.44		
74740	INTERPRETATION TRANSCERVICAL CATHETERIZATION OF FALLOPIAN TUBE,		\$51.64	\$51.64	\$35.20	\$16.44		
74740	RADIOLOGICAL SUPERVIS		\$110.66	\$110.66	COE OO	\$25.58		
74742	PERINEOGRAM (EG, VAGINOGRAM, FOR SEX DETERMINATION OR		φ110.00	φ110.00	\$85.08	ֆ∠ე.ეŏ		
74775	EXTENT OF ANOMAL		\$66.41	\$66.41	\$39.47	\$26.94		
74775 75557	CARDIAC MRI FOR MORPH W/O CONTRAST		\$309.93	\$309.93	\$170.24	\$26.94		+
75559	CARDIAC MRI W/STRESS IMG W/O CONTRAST		\$311.88	\$311.88	\$170.24	\$65.66		+
10009	TOURDING MICH MAST VESS TIMES MAC CONTINUES		φ311.00	φ311.00	φ230.27	φ05.00		

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•	Fee Schedule 2020				+			
Note:	to to Book				+			
	es in Red;							
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	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
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	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns T					
							Dana	
D			J D.4.	O44 D-4		D	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
75561	CARDIAC MRI FOR MORPH W/DYE W/O CONTRAST		\$475.58	\$475.58	\$241.68	\$57.00		
75563	CARDIAC MRI W/STRESS IMG & DYE W & W/O CONTRAST		\$477.59	\$477.59	\$301.00	\$68.25		
75505	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW		* 05.50	405 50	AFF 00	**		
75565	MAPPING		\$65.50	\$65.50	\$55.82	\$9.68		
	COMPUTED TOMOGRAPHY, HEART, W/O CONTRAST MATERIAL, WITH		405.00	405.00		404.05		
75571	QUANTITATIVE EVALUATION OF CORONARY CALCIUM		\$65.23	\$65.23	\$43.57	\$21.65		
75570	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR		0404.50	0404.50	\$405.70	***		
75572	EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY		\$191.56	\$191.56	\$125.73	\$65.82		
	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR							
	EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE		****	4070.00				
75573	SETTING OF CONGENITAL HEART DISEASE		\$272.36	\$272.36	\$178.04	\$94.31		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY							
L	ARTERIES AND BYPASS GRAFTS, WITH CONTRAST MATERIAL,							
75574	INCLUDING 3D IMAGE POSTPROCESSING		\$417.89	\$417.89	\$328.08	\$89.81		
	AORTOGRAPHY, THORACIC, WITHOUT SERIALOGRAPHY,		****	4004.00				
75600	RADIOLOGICAL SUPERVISION		\$361.36	\$361.36	\$340.35	\$21.01		
	AORTOGRAPHY, THORACIC, BY SERIALOGRAPHY, RADIOLOGICAL							
75605	SUPERVISION AND		\$389.16	\$389.16	\$340.35	\$48.81		
	AORTOGRAPHY, ABDOMINAL, BY SERIALOGRAPHY, RADIOLOGICAL							
75625	SUPERVISION AND		\$389.16	\$389.16	\$340.35	\$48.81		
75000	AORTOGRAPHY, ABDOMINAL PLUS BILATERAL ILIOFEMORAL LOWER		* 4 4 0 00	0.440.00	005474	AFO 40		
75630	EXTREMITY,		\$410.92	\$410.92	\$354.74	\$56.18		
	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMINAL AORTA AND							
75635	BILATERAL ILIOFE		\$300.86	\$300.86	\$225.60	\$75.26		
	ANGIOGRAPHY, SPINAL, SELECTIVE, RADIOLOGICAL SUPERVISION							
75705	AND INTERPRET		\$434.25	\$434.25	\$340.35	\$93.90		

Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ANGIOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL							
75710	SUPERVISION AND		\$389.16	\$389.16	\$340.35	\$48.81		
	ANGIOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL		4000 54	4000 54		450.40		
75716	SUPERVISION AND		\$396.54	\$396.54	\$340.35	\$56.18	_	
75700	ANGIOGRAPHY, VISCERAL, SELECTIVE OR SUPRASELECTIVE, (WITH		0000 40	# 000 40	Φ0.40.0 5	040.04		
75726	OR WITHOUT F		\$389.16	\$389.16	\$340.35	\$48.81	+	
75704	ANGIOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL		#200 46	#200.46	Φ240.2E	¢40.04		
75731	SUPERVISION ANGIOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL		\$389.16	\$389.16	\$340.35	\$48.81		
75722	SUPERVISION A		\$396.54	¢206 54	\$340.35	\$56.18		
75733	ANGIOGRAPHY, PELVIC, SELECTIVE OR SUPRASELECTIVE,		\$390.34	\$396.54	φ340.33	φ30.10		
75736	RADIOLOGICAL SUPERVI		\$389.16	\$389.16	\$340.35	\$48.81		
13130	ANGIOGRAPHY, PULMONARY, UNILATERAL, SELECTIVE,		φ309.10	φ309.10	φ340.33	φ40.01	+	
75741	RADIOLOGICAL SUPERVISIO		\$396.54	\$396.54	\$340.35	\$56.18		
73741	ANGIOGRAPHY, PULMONARY, BILATERAL, SELECTIVE,		ψ390.34	ψ390.34	ψ540.55	ψ30.10	+	
75743	RADIOLOGICAL SUPERVISION		\$411.58	\$411.58	\$340.35	\$71.23		
70740	ANGIOGRAPHY, PULMONARY, BY NONSELECTIVE CATHETER OR		Ψ+11.00	Ψ+11.00	Ψ0+0.00	ψ11.20		+
75746	VENOUS INJECTION.		\$389.16	\$389.16	\$340.35	\$48.81		
7 07 10	ANGIOGRAPHY, INTERNAL MAMMARY, RADIOLOGICAL SUPERVISION		Ψοσο. το	Ψ000.10	ψο τοισσ	Ψισισι	+	
75756	AND INTERPRETA		\$389.16	\$389.16	\$340.35	\$48.81		
	ANGIOGRAPHY, SELECTIVE, EACH ADDITIONAL VESSEL STUDIED		7000110	- V	7	7 10101		
75774	AFTER BASIC		\$355.69	\$355.69	\$340.35	\$15.34		
	LYMPHANGIOGRAPHY, EXTREMITY ONLY, UNILATERAL,				1		1	
75801	RADIOLOGICAL SUPERVISION		\$181.33	\$181.33	\$146.42	\$34.91		
	LYMPHANGIOGRAPHY, EXTREMITY ONLY, BILATERAL, RADIOLOGICAL							
75803	SUPERVISION		\$196.37	\$196.37	\$146.42	\$49.96		

Physician	Fee Schedule 2020							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomary chai	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, UNILATERAL,							
75805	RADIOLOGICAL SUPERVISI		\$199.73	\$199.73	\$164.82	\$34.91		
	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, BILATERAL,							
75807	RADIOLOGICAL SUPERVISIO		\$214.78	\$214.78	\$164.82	\$49.96		
	SHUNTOGRAM FOR INVESTIGATION OF PREVIOUSLY PLACED							
75809	INDWELLING NONVASCUL		\$40.95	\$40.95	\$21.33	\$19.62		
	SPLENOPORTOGRAPHY, RADIOLOGICAL SUPERVISION AND							
75810	INTERPRETATION		\$389.16	\$389.16	\$340.35	\$48.81		1
75000	VENOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL		455.04	455.04	* 05.00	000.04		
75820	SUPERVISION AND		\$55.94	\$55.94	\$25.60	\$30.34		
75000	VENOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL		#05.40	***	# 40.04	0.45.44		
75822	SUPERVISION AND		\$85.42	\$85.42	\$40.01	\$45.41		
75005	VENOGRAPHY, CAVAL, INFERIOR, WITH SERIALOGRAPHY,		#200.40	#200.40	Φ0.40.0 <i>E</i>	C40.04		
75825	RADIOLOGICAL SUPERVIS VENOGRAPHY, CAVAL, SUPERIOR, WITH SERIALOGRAPHY,		\$389.16	\$389.16	\$340.35	\$48.81		4
75827	RADIOLOGICAL SUPERVIS		\$389.16	\$389.16	\$340.35	\$48.81		
13021	VENOGRAPHY, RENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL		φ309.10	\$309.10	φ340.33	φ40.01		+
75831	SUPERVISION AND		\$389.16	\$389.16	\$340.35	\$48.81		
7 303 1	VENOGRAPHY, RENAL, BILATERAL, SELECTIVE, RADIOLOGICAL	+	φ309.10	φ309.10	φ340.33	φ40.01		+
75833	SUPERVISION AND		\$404.21	\$404.21	\$340.35	\$63.85		
7 3033	VENOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL		ψ404.21	Ψ404.21	ψυ40.00	ψ03.03		
75840	SUPERVISION A		\$389.16	\$389.16	\$340.35	\$48.81		
7 00-10	VENOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL		ψ000.10	ψοσο. το	ψυ-τυ.υυ	ψ-τυ.υ ι		+
75842	SUPERVISION AN		\$404.21	\$404.21	\$340.35	\$63.85		
1.0012	VENOGRAPHY, VENOUS SINUS (EG, PETROSAL AND INFERIOR		¥ . 5 <u>2</u> .	7.0	Ψ0.0.00	\$55.55	+	+
75860	SAGITTAL) OR JUGUL		\$389.16	\$389.16	\$340.35	\$48.81		
. 0000	5.10.1.1.2/ 01100001		Ψ000.10	ψοσο. 10	ψο 10.00	Ψ 10.01		

Physician	Fee Schedule 2020							
Note:								
2020 Cod	des in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_					<u>_</u>		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	VENOGRAPHY, SUPERIOR SAGITTAL SINUS, RADIOLOGICAL		4000.40	4000.40				
75870	SUPERVISION AND		\$389.16	\$389.16	\$340.35	\$48.81		
75070	VENOGRAPHY, EPIDURAL, RADIOLOGICAL SUPERVISION AND		****	4000.40	***	0.40.04		
75872	INTERPRETATION		\$389.16	\$389.16	\$340.35	\$48.81		<u> </u>
75000	VENOGRAPHY, ORBITAL, RADIOLOGICAL SUPERVISION AND		ΦEE 0.4	¢55.04	ФОБ CO	¢20.24		
75880	INTERPRETATION PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITH		\$55.94	\$55.94	\$25.60	\$30.34		
75885	HEMODYNAMIC EVALUATION,		\$402.20	\$402.20	\$340.35	\$61.85		
7 3003	PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITHOUT		\$4UZ.ZU	\$402.20	\$340.33	\$01.00		
75887	HEMODYNAMIC EVALUATION,		\$402.20	\$402.20	\$340.35	\$61.85		
7 300 7	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITH HEMODYNAMIC		Ψ402.20	ψ402.20	ψ540.55	ψ01.00		
75889	EVALUATION.		\$389.16	\$389.16	\$340.35	\$48.81		
7 3 0 0 3	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITHOUT		ψοσο. το	ψουσ. το	Ψ0-10.00	ψ-το.σ ι		
75891	HEMODYNAMIC EVALUATION,		\$389.16	\$389.16	\$340.35	\$48.81		
7 000 1	VENOUS SAMPLING THROUGH CATHETER, WITH OR WITHOUT		Ψ000.10	Ψ000.10	ψο 10.00	ψ 10.01		
75893	ANGIOGRAPHY (EG, FOR		\$363.88	\$363.88	\$340.35	\$23.52		
1000	TRANSCATHETER THERAPY, EMBOLIZATION, ANY METHOD,		700000	7000100	70.000	¥		
75894	RADIOLOGICAL SUPERVIS		\$708.07	\$708.07	\$651.89	\$56.18		
	ANGIOGRAPHY THROUGH EXISTING CATHETER FOR FOLLOW-UP							
75898	STUDY FOR TRANSCAT		\$99.46	\$99.46	\$28.52	\$70.94		
	MECHANICAL REMOVAL OF PERICATHETER OBSTRUCTIVE MATERIAL							
75901	(EG, FIBRIN SH		\$70.35	\$70.35	\$51.36	\$18.99		
	MECHANICAL REMOVAL OF INTRALUMINAL (INTRACATHETER)							
75902	OBSTRUCTIVE MATERIA		\$66.44	\$66.44	\$51.36	\$15.08		
	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA (EG,							
75957	ANEURYSM,		\$252.50	\$252.50	\$0.00	\$252.50		

Physician	Fee Schedule 2020							T
Note:								
	les in Red;	 					1	
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
		T						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR							
75958	ENDOVASCULAR REPAIR OF		\$168.33	\$168.33	\$0.00	\$168.33		
	PLACEMENT OF DISTAL EXTENSION PROSTHESIS(S) (DELAYED)					1		
75959	AFTER ENDOVASCUL		\$147.35	\$147.35	\$0.00	\$147.35		
	TRANSCATHETER INTRODUCTION OF INTRAVASCULAR STENT(S),							
75960	(EXCEPT CORONARY		\$437.70	\$437.70	\$402.25	\$35.44		
	TRANSCATHETER BIOPSY, RADIOLOGICAL SUPERVISION AND							
75970	INTERPRETATION		\$347.81	\$347.81	\$311.81	\$36.01		
75004	CHANGE OF PERCUTANEOUS TUBE OR DRAINAGE CATHETER WITH		004.00	004.00	# 50.00	004.40		
75984	CONTRAST MONITOR		\$84.00	\$84.00	\$52.80	\$31.19	1	
75000	RADIOLOGICAL GUIDANCE (IE, FLUOROSCOPY, ULTRASOUND, OR		¢405.00	¢405.00	¢05.00	ΦEO 04		
75989	COMPUTED	-	\$135.89	\$135.89	\$85.08	\$50.81		
70000	FLUOROSCOPY (SEPARATE PROCEDURE), UP TO ONE HOUR		¢40.04	640.04	¢25.00	Φ7 44		
76000	PHYSICIAN TIME, OTHER RADIOLOGIC EXAMINATION FROM NOSE TO RECTUM FOR FOREIGN		\$42.31	\$42.31	\$35.20	\$7.11		
76010	BODY, SINGLE VI		\$21.81	\$21.81	\$14.14	\$7.67		
70010	RADIOLOGIC EXAMINATION, ABSCESS, FISTULA OR SINUS TRACT	-	Φ∠1.01	Φ21.01	Φ14.14	φ1.01	+	
76080	STUDY, RADIOLO		\$52.05	\$52.05	\$28.52	\$23.52		
76098	RADIOLOGICAL EXAMINATION, SURGICAL SPECIMEN		\$18.27	\$18.27	\$11.46	\$6.82	+	
70030	RADIOLOGIC EXAMINATION, SINGLE PLANE BODY SECTION (EG,		Ψ10.21	Ψ10.21	ψ11.40	ψ0.02		
76100	TOMOGRAPHY), OT		\$59.09	\$59.09	\$33.86	\$25.23		
70100	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE,		Ψ00.00	Ψοσ.σσ	Ψοσ.σσ	Ψ20.20	+	
76101	HYPERCYCLOIDAL) BODY SECTI		\$63.63	\$63.63	\$38.40	\$25.23		
	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE,	1	7,00.00	1,,,,,,,	700.10	7-0.20	1	
76102	HYPERCYCLOIDAL) BODY SECTI		\$72.16	\$72.16	\$46.93	\$25.23		
	CINERADIOGRAPHY/VIDEORADIOGRAPHY, EXCEPT WHERE	†		1,	1	T	<u>† </u>	
76120	SPECIFICALLY INCLUDED	R	\$44.96	\$44.96	\$28.52	\$16.44		

Physician	Fee Schedule 2020			1				
Note:								
2020 Cod	es in Red;							
	PT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
		T						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CINERADIOGRAPHY/VIDEORADIOGRAPHY TO COMPLEMENT							
76125	ROUTINE EXAMINATION (LI	R	\$32.96	\$32.96	\$21.33	\$11.63		
	CONSULTATION ON X-RAY EXAMINATION MADE ELSEWHERE,							
76140	WRITTEN REPORT		\$19.86	\$19.86				
	3D RENDERING WITH INTERPRETATION AND REPORTING OF							
76376	COMPUTED TOMOGRAPHY,		\$97.83	\$97.83	\$89.59	\$8.24		
	3D RENDERING WITH INTERPRETATION AND REPORTING OF							
76377	COMPUTED TOMOGRAPHY,		\$127.95	\$127.95	\$95.55	\$32.40		
	COMPUTED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP							
76380	STUDY		\$136.95	\$136.95	\$94.69	\$42.26		
76390	MAGNETIC RESONANCE SPECTROSCOPY	R	\$351.96	\$351.96	\$292.16	\$59.80		
76391	MR ELASTOGRAPHY		\$177.68	\$177.68	\$132.62	\$45.06		Effective 1/1/2019
	UNLISTED FLUOROSCOPIC PROCEDURE (EG, DIAGNOSTIC,							
76496	INTERVENTIONAL)	R	\$0.00	\$0.00	\$0.00	\$0.00		
	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE (EG,							
76497	DIAGNOSTIC, INTERVENTIONAL	R	\$0.00	\$0.00	\$0.00	\$0.00		
	UNLISTED MAGNETIC RESONANCE PROCEDURE (EG, DIAGNOSTIC,							
76498	INTERVENTIONAL)	R	\$0.00	\$0.00	\$0.00	\$0.00		
76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	ECHOENCEPHALOGRAPHY, B-SCAN AND/OR REAL TIME WITH IMAGE							
76506	DOCUMENTATION		\$65.63	\$65.63	\$38.40	\$27.24		
	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; B-SCAN AND							
76510	QUANTITATIVE A-SCAN PERF		\$121.56	\$121.56	\$57.44	\$64.12		
	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; ANTERIOR SEGMENT							
76513	ULTRASOUND, IMMERS		\$69.95	\$69.95	\$41.32	\$28.63		
	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; CORNEAL PACHYMETRY,							
76514	UNILATERAL OR		\$9.01	\$9.01	\$1.80	\$7.21		

Physician	Fee Schedule 2020			1				T
Note:								
2020 Cod	es in Red;							
	CPT book for descriptions							
R" in PA o	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN;							
76519	WITH INTRAOCULAR		\$52.34	\$52.34	\$30.05	\$22.29		
	ULTRASOUND, SOFT TISSUES OF HEAD AND NECK (EG, THYROID,							
76536	PARATHYROID,		\$62.77	\$62.77	\$38.40	\$24.38		
	ULTRASOUND, CHEST, B-SCAN (INCLUDES MEDIASTINUM) AND/OR							
76604	REAL TIME WITH		\$59.29	\$59.29	\$35.20	\$24.08		
76641	ULTRASOUND OF ONE BREAST		\$81.80	\$81.80	\$51.98	\$29.82		Added effective 1/1/2015
76642	ULTRASOUND OF ONE BREAST		\$67.64	\$67.64	\$39.82	\$27.82		Added effective 1/1/2015
	ULTRASOUND, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE							
76700	DOCUMENTATIO		\$88.25	\$88.25	\$53.34	\$34.91		
	ULTRASOUND, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE					1		
76705	DOCUMENTATIO		\$63.92	\$63.92	\$38.40	\$25.53		
76706	US ABDL AORTA SCREEN AAA		\$71.08	\$71.08	\$48.58	\$22.49		Added Effective 1/1/2017
	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-							
76770	SCAN AND/OR R		\$85.39	\$85.39	\$53.34	\$32.05		
	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-							
76775	SCAN AND/OR R		\$63.63	\$63.63	\$38.40	\$25.23		
76776	ULTRASOUND, TRANSPLANTED KIDNEY, DOPPLER W/IMAGE		\$87.59	\$87.59	\$59.12	\$28.47		
76800	ULTRASOUND, SPINAL CANAL AND CONTENTS		\$86.91	\$86.91	\$38.40	\$48.51		
70004	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE		000 44	000 44	# 00.00	#00.70		
76801	DOCUMENTATION, FETAL	-	\$68.11	\$68.11	\$29.32	\$38.78	_	
76000	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE		ΦEO 40	¢52.40	#20.04	P20.64		
76802	DOCUMENTATION, FETAL	1	\$53.48	\$53.48	\$20.84	\$32.64		
76005	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE		¢00.60	¢00.60	#EG 00	¢42.02		
76805	DOCUMENTATION, FETAL	1	\$99.62	\$99.62	\$56.80	\$42.82		
70040	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE		¢407.00	¢407.02	£440.00	DO 4 57		
76810	DOCUMENTATION, FETAL		\$197.93	\$197.93	\$113.36	\$84.57		

Physician	Fee Schedule 2020	<u> </u>	1	1				
Note:								
	les in Red;							
	CPT book for descriptions							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	stomary char	ge for the service	e				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		Ĭ					
Please us	se lab fee schedule for covered codes not listed below in the 80000-8924	9 range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76811	DOCUMENTATION, FETAL		\$139.29	\$139.29	\$67.30	\$71.98		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76812	DOCUMENTATION, FETAL		\$106.62	\$106.62	\$35.57	\$71.05		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76813	DOCUMENTATION, FETAL		\$91.06	\$91.06	\$47.45	\$43.61		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76814	DOCUMENTATION, FETAL		\$61.49	\$61.49	\$24.88	\$36.62		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76815	DOCUMENTATION, LIMIT		\$66.49	\$66.49	\$38.40	\$28.09		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76816	DOCUMENTATION, FOLLO		\$80.13	\$80.13	\$47.91	\$32.22		
	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE							
76817	DOCUMENTATION,		\$71.90	\$71.90	\$43.32	\$28.58		
76818	FETAL BIOPHYSICAL PROFILE; WITH NON-STRESS TESTING		\$76.93	\$76.93	\$43.74	\$33.20		
76819	FETAL BIOPHYSICAL PROFILE; WITHOUT NON-STRESS TESTING		\$68.38	\$68.38	\$43.30	\$25.08		
76820	DOPPLER VELOCIMETRY, FETAL; UMBILICAL ARTERY		\$64.65	\$64.65	\$44.19	\$20.46		
76821	DOPPLER VELOCIMETRY, FETAL; MIDDLE CEREBRAL ARTERY		\$72.62	\$72.62	\$44.19	\$28.44		
	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL		400 70	400 70	450.04			
76825	TIME WITH IMAGE		\$92.70	\$92.70	\$53.34	\$39.36		
70000	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL		# 00.00	400.00	040.40	* 40 04		
76826	TIME WITH IMAGE		\$62.99	\$62.99	\$19.19	\$43.81		
7007	DOPPLER ECHOCARDIOGRAPHY, FETAL, PULSED WAVE AND/OR		¢02.00	¢02.00	¢47.45	¢26.74		
76827	CONTINUOUS WAVE WI		\$83.89	\$83.89	\$47.15	\$36.74	1	
76000	DOPPLER ECHOCARDIOGRAPHY, FETAL, PULSED WAVE AND/OR		¢EE OE	¢EE OE	¢20.60	¢24.42		
76828	CONTINUOUS WAVE WI		\$55.05	\$55.05	\$30.62	\$24.43		
76830	ULTRASOUND, TRANSVAGINAL		\$71.37	\$71.37	\$41.32	\$30.05		

Physician	Fee Schedule 2020		1	T				
Note:								
	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ae for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	e lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
76831	ECHO EXAM UTERUS		\$100.97	\$70.10	\$82.48	\$31.15		
	ULTRASOUND, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME							
76856	WITH IMAGE		\$71.37	\$71.37	\$41.32	\$30.05		
	ULTRASOUND, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME				1	i ·		
76857	WITH IMAGE		\$44.96	\$44.96	\$28.52	\$16.44		
76870	ULTRASOUND, SCROTUM AND CONTENTS		\$68.85	\$68.85	\$41.32	\$27.53		
76872	ULTRASOUND, TRANSRECTAL;		\$71.37	\$71.37	\$41.32	\$30.05		
	ULTRASOUND, TRANSRECTAL; PROSTATE VOLUME STUDY FOR							
76873	BRACHYTHERAPY TREAT		\$110.37	\$110.37	\$57.83	\$52.54		
	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE							
76881	DOCUMENTATION; COMPLETE		\$100.58	\$100.58	\$75.36	\$25.22		
	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE							
76882	DOCUMENTATION; LIMITED, ANATOMIC SPECIFIC		\$26.41	\$26.41	\$8.90	\$17.51		
	ULTRASOUND, INFANT HIPS, REAL TIME WITH IMAGING							
76885	DOCUMENTATION; DYNAMIC		\$70.68	\$70.68	\$39.88	\$30.79		
	ULTRASOUND, INFANT HIPS, REAL TIME WITH IMAGING							
76886	DOCUMENTATION; LIMITED		\$62.86	\$62.86	\$37.06	\$25.80		
	ULTRASONIC GUIDANCE FOR PERICARDIOCENTESIS, IMAGING							
76930	SUPERVISION AND		\$70.51	\$70.51	\$41.32	\$29.19		
	ULTRASONIC GUIDANCE FOR ENDOMYOCARDIAL BIOPSY, IMAGING							
76932	SUPERVISION AND		\$70.51	\$70.51	\$41.32	\$29.19		
	ULTRASOUND GUIDED COMPRESSION REPAIR OF ARTERIAL							
76936	PSEUDOANEURYSM OR		\$264.25	\$264.25	\$170.16	\$94.08		
	ULTRASOUND GUIDANCE FOR VASCULAR ACCESS REQUIRING							
76937	ULTRASOUND EVALUATIO		\$24.86	\$24.86	\$12.36	\$12.50		
	ULTRASOUND GUIDANCE FOR, AND MONITORING OF, VISCERAL							
76940	TISSUE ABLATION		\$123.68	\$123.68	\$46.33	\$77.35		

Physician	Fee Schedule 2020							
Note:	T de Odrieddie 2020							
	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u> </u>				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T T T T T T T T T T T T T T T T T T T	,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range				+		
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ne			+		
Oddes list	ed on the lab lee schedule that begin with a 1- of Q are currently horr-covered to	Т						
						1	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ULTRASONIC GUIDANCE FOR INTRAUTERINE FETAL TRANSFUSION		(* 3.5 3)	(20011101110)				
76941	OR CORDOCENTESI		\$99.46	\$99.46	\$41.35	\$58.11		
	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY,		,	***		1		
76942	ASPIRATION.		\$70.51	\$70.51	\$41.32	\$29.19		
	ULTRASONIC GUIDANCE FOR CHORIONIC VILLUS SAMPLING,							
76945	IMAGING SUPERVISION		\$79.80	\$79.80	\$41.35	\$38.45		
	ULTRASONIC GUIDANCE FOR AMNIOCENTESIS, IMAGING							
76946	SUPERVISION AND		\$57.76	\$57.76	\$41.32	\$16.44		
	ULTRASONIC GUIDANCE FOR ASPIRATION OF OVA, IMAGING							
76948	SUPERVISION AND		\$57.76	\$57.76	\$41.32	\$16.44		
	ULTRASONIC GUIDANCE FOR INTERSTITIAL RADIOELEMENT							
76965	APPLICATION		\$249.90	\$249.90	\$150.44	\$99.46		
76970	ULTRASOUND STUDY FOLLOW-UP (SPECIFY)		\$45.82	\$45.82	\$28.52	\$17.29		
	GASTROINTESTINAL ENDOSCOPIC ULTRASOUND, SUPERVISION AND							
76975	INTERPRETATION		\$75.42	\$75.42	\$41.32	\$34.10		
	ULTRASOUND BONE DENSITY MEASUREMENT AND							
76977	INTERPRETATION, PERIPHERAL SIT		\$32.14	\$32.14	\$23.26	\$8.88		
76978	US TRGT DYN MBUBB 1ST LES		\$245.25	\$245.25	\$179.62	\$65.64		Effective 1/1/2019
76979	US TRGT DYN MBUBB EA ADDL		\$165.60	\$165.60	\$131.07	\$34.53		Effective 1/1/2019
76981	USE PARENCHYMA		\$81.38	\$81.38	\$57.16	\$24.22		Effective 1/1/2019
76982	USE 1ST TARGET LESION		\$73.03	\$73.03	\$48.81	\$24.22		Effective 1/1/2019
76983	USE EA ADDL TARGET LESION		\$45.33	\$45.33	\$24.80	\$20.52		Effective 1/1/2019
76998	US GUIDE INTRAOP		\$0.00	\$0.00	\$0.00	\$56.67		
77001	FLUOROSCOPIC GUIDANCE FOR VEIN DEVICE PLACEMENT		\$57.63	\$57.63	\$43.14	\$14.49		
77002	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT		\$53.35	\$53.35	\$33.24	\$20.11		
77003	FLUOROSCOPICE GUIDANCE FOR SPINE INJECTION		\$52.29	\$52.29	\$30.45	\$21.84		
77011	CT SCAN FOR LOCALIZATION		\$335.49	\$335.49	\$289.50	\$45.99		
77012	CT SCAN FOR NEEDLE BIOPSY		\$223.45	\$223.45	\$179.40	\$44.05		

Physician	Fee Schedule 2020				1			
Note:								
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
77013	CT GUIDE FOR TISSUE ABLATION		\$0.00	\$0.00	\$0.00	\$173.27		
77014	CT GUIDANCE FOR PLACEMENT RADIATION THERAPY		\$119.11	\$119.11	\$86.52	\$32.59		
77021	MRI GUIDANCE FOR NEEDLE PLACEMENT		\$340.56	\$340.56	\$282.66	\$57.89		
77022	MRI FOR TISSUE ABLATION		\$0.00	\$0.00	\$0.00	\$182.17		
77046	MRI BREAST C- UNILATERAL		\$188.29	\$188.29	\$129.49	\$58.80		Effective 1/1/2019
77047	MRI BREAST C- BILATERAL		\$193.77	\$193.77	\$128.70	\$65.06		Effective 1/1/2019
77048	MRI BREAST C-+ W/CAD UNI		\$298.35	\$298.35	\$213.28	\$85.07		Effective 1/1/2019
77049	MRI BREAST C-+ W/CAD BI		\$305.31	\$305.31	\$212.23	\$93.07		Effective 1/1/2019
77053	MAMMARY DUCTOGRAM, SINGLE DUCT		\$70.50	\$70.50	\$56.59	\$13.91		
77054	MAMMARY DUCTOGRAM, MULTIPLE DUCTS		\$100.75	\$100.75	\$83.48	\$17.27		
77061	DIGITAL TOMOGRAPHY OF ONE BREAST		\$0.00	\$0.00	\$0.00	\$0.00		Added effective 1/1/2015
77062	DIGITAL TOMOGRAPHY OF BOTH BREASTS		\$0.00	\$0.00	\$0.00	\$0.00		Added effective 1/1/2015
77063	SCREENING DIGITAL TOMOGRAPHY OF BOTH BREASTS		\$42.81	\$42.81	\$18.61	\$24.20		Added effective 1/1/2015
								Rate updated 1/1/2018
77065	DX MAMMO INCL CAD UNI		\$101.11	\$101.11	\$69.69	\$31.41		Added Effective 1/1/2017
								Rate Updated 1/1/2018
77066	DX MAMMO INCL CAD BI		\$126.16	\$127.99	\$89.02	\$38.97		Added Effective 1/1/2017
								Rate updated 1/1/2018
77067	SCR MAMMO BI INCL CAD		\$103.33	\$103.33	\$73.61	\$29.72		Added Effective 1/1/2017
77071	MANUAL APPLICATION OF STRESS FOR JOINT RADIOGRAPHY		\$21.70	\$21.70				
77072	BONE AGE STUDIES		\$16.13	\$16.13	\$9.13	\$6.99		
77073	BONE LENGTH STUDIES		\$29.85	\$29.85	\$19.54	\$10.31		
77074	X-RAY, BONE SURVEY, LIMITED		\$45.43	\$45.43	\$28.17	\$17.27		
77075	X-RAY, BONE SURVEY, COMPLETE		\$62.74	\$62.74	\$42.12	\$20.62		
77076	X-RAY, BONE SUVEY, INFANT		\$52.63	\$52.63	\$26.13	\$26.49		
77077	JOINT SURVEY, 2 OR MORE JOINTS		\$38.10	\$38.10	\$26.14	\$11.97		
77078	CT SCAN, BONE MINERAL DENSITY, AXIAL SKELETON		\$98.03	\$98.03	\$88.55	\$9.48		
77080	DXA, BONE DENSITY STUDY, AXIAL SKELETON		\$76.05	\$76.05	\$67.75	\$8.29		

Physician	Fee Schedule 2020							T
Note:								
2020 Cod	les in Red;							
Refer to C	CPT book for descriptions							
R" in PA o	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	Э				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	·						
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Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
77081	DXA, BONE DENSITY STUDY, APPENDICULAR SKELETON		\$28.16	\$28.16	\$19.54	\$8.62		
77084	MRI, BONE MARROW	R	\$373.37	\$373.37	\$312.60	\$60.77		
77085	BONE DENSITY MEASUREMENT USING DEDICATED X-RAY MACHINE		\$41.97	\$41.97	\$29.73	\$12.24		Added effective 1/1/2015
	FRACTURE ASSESSMENT OF SPINE BONES USING DEDICATED X-RAY							
77086	MACHINE FOR BONE DENSITY MEASUREMENT		\$26.47	\$26.47	\$19.38	\$7.09		Added effective 1/1/2015
77261	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; SIMPLE		\$59.60	\$59.60				
77262	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; INTERMEDIATE		\$90.53	\$90.53				
77263	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; COMPLEX		\$134.55	\$134.55				
	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING;							
77280	SIMPLE		\$124.22	\$124.22	\$93.88	\$30.34		
	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING;					1		
77285	INTERMEDIATE		\$195.53	\$195.53	\$150.69	\$44.85		
	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING;							
77290	COMPLEX		\$243.00	\$243.00	\$175.77	\$67.22		
77293	RESPIRATORY MOTION MANAGEMENT SIMULATION		\$319.55	\$319.55	\$237.22	\$82.33		
77005	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; 3-		4050.04	4050.04	4755 00	* 4 * 4 * 4		
77295	DIMENSIONAL THE PARELITIC PARIOLOGY OF INFOAT		\$950.24	\$950.24	\$755.30	\$194.94		
77000	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL	_	# 50.05	Ø75.00	# 0.00	00.00		
77299	TREATMENT PLANNING	R	\$56.25	\$75.00	\$0.00	\$0.00		
77200	BASIC RADIATION DOSIMETRY CALCULATION, CENTRAL AXIS DEPTH		ФСО ОБ	¢60.05	#26.00	#00.00		
77300	DOSE CALCULA INTENSITY MODULATED RADIOTHERAPY PLAN, INCLUDING DOSE-		\$62.95	\$62.95	\$36.28	\$26.68		-
77204	VOLUME HISTOGRAM		¢4 022 62	¢4 022 62	Φ74 <i>E E</i> 4	\$317.08		
77301 77306	RADIATION THERAPY PLAN		\$1,032.62 \$110.46	\$1,032.62 \$110.46	\$715.54 \$53.02	\$57.44		Added effective 1/1/2015
77306	RADIATION THERAPY PLAN		\$110.46	\$110.46	\$97.21	\$119.62		Added effective 1/1/2015 Added effective 1/1/2015
11301	TADIATION INERAPT PLAN		φ∠ 10.03	φ∠ 10.03	φ91.21	φ119.0Z		Added effective 1/1/2015

Physiciar	n Fee Schedule 2020							
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	Э				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
77316	RADIATION THERAPY PLAN		\$140.16	\$140.16	\$82.72	\$57.44		Added effective 1/1/2015
77317	RADIATION THERAPY PLAN		\$183.36	\$183.36	\$107.80	\$75.56		Added effective 1/1/2015
77318	RADIATION THERAPY PLAN		\$265.94	\$265.94	\$146.32	\$119.62		Added effective 1/1/2015
	SPECIAL TELETHERAPY PORT PLAN, PARTICLES, HEMIBODY, TOTAL							
77321	BODY		\$149.96	\$149.96	\$109.10	\$40.87		
	SPECIAL DOSIMETRY (EG, TLD, MICRODOSIMETRY) (SPECIFY), ONLY							
77331	WHEN PRESC		\$51.05	\$51.05	\$13.60	\$37.45		
	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; SIMPLE							
77332	(SIMPLE BLOCK, SIMP		\$59.80	\$59.80	\$36.28	\$23.52		
	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; INTERMEDIATE							
77333	(MULTIPLE BLO		\$87.76	\$87.76	\$51.46	\$36.30		
	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; COMPLEX							
77334	(IRREGULAR BLOCKS,		\$140.58	\$140.58	\$87.76	\$52.81		
	CONTINUING MEDICAL PHYSICS CONSULTATION, INCLUDING							
77336	ASSESSMENT OF TREAT		\$80.55	\$80.55				
	MULTI-LEAF COLLIMATOR DEVICE(S) FOR INTENSITY MODULATED							
77338	RADIATION THERAPY, DESIGN AND CONSTRUCTION PER IMRT PLAN		\$350.91	\$350.91	\$178.30	\$172.62		
77370	SPECIAL MEDICAL RADIATION PHYSICS CONSULTATION		\$94.42	\$94.42	_			
77074	OTEDEOTACTIC DADICCUDOEDV AND TI COUDOE CODAL 7 CO DACED		ф 770.0 0	ф 770 00				
77371	STEREOTACTIC RADIOSURGERY, MULTI-SOURCE COBALT 60 BASED		\$770.69	\$770.69				
77372	STEREOTACTIC RADIOSURGERY, LINEAR ACCELERATOR BASED		\$585.00	\$585.00				
77272	STEDEOTACTIC BODY DADIATION THEDADY TDEATMENT DELIVEDY		¢4 000 93	¢4 000 93				
77373 77385	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY RADIATION THERAPY DELIVERY		\$1,090.83 \$0.00	\$1,090.83 \$0.00				Added effective 1/1/2015
77386	RADIATION THERAPY DELIVERY		\$0.00	\$0.00				Added effective 1/1/2015

Physician	Fee Schedule 2020							
Note:								
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	GUIDANCE FOR LOCALIZATION OF TARGET DELIVERY OF RADIATION							
77387	TREATMENT DELIVERY		\$0.00	\$0.00				Added effective 1/1/2015
	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOSIMETRY							
77399	AND TREATMENT	R	\$0.00	\$0.00	\$0.00	\$0.00		
77401	RADIATION TREATMENT DELIVERY, SUPERFICIAL		\$48.00	\$48.00				
77402	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA		\$48.00	\$48.00				
	RADIATION TREATMENT DELIVERY, TWO TREATMENT AREAS, 3 OR							
77407	MORE PORTS		\$56.53	\$56.53				
	RADIATION TREATMENT DELIVERY, THREE OR MORE TREATMENT		400.40	400.40				
77412	AREAS		\$63.19	\$63.19				
77417	THERAPEUTIC RADIOLOGY PORT FILM(S)		\$15.99	\$15.99				
77400	HIGH ENERGY NEUTRON RADIATION TREATMENT DELIVERY; 1 OR		004.00	004.00				
77423	MORE ISOCENTER(\$61.03	\$61.03			_	
77404	INTRAOPERATIVE RADIATION TREATMENT DELIVERY, X-RAY, SINGLE		#0.00	#0.00				
77424	TREATMENT SESSION INTRAOPERATIVE RADIATION TREATMENT DELIVERY, ELECTRONS,		\$0.00	\$0.00			_	+
77425	SINGLE TREATMENT SESSION		\$0.00	\$0.00				
77427	RADIATION TREATMENT MANAGEMENT, FIVE TREATMENTS		\$130.64	\$130.64				+
11421	RADIATION THERAPY MANAGEMENT WITH COMPLETE COURSE OF		φ130.04	φ130.04				+
77431	THERAPY CONSISTIN		\$77.75	\$77.75				
77401	STEREOTACTIC RADIATION TREATMENT MANAGEMENT OF		Ψ11.10	Ψ11.10				+
77432	CEREBRAL LESION(S) (COM		\$374.91	\$374.91				
	02. (25. 0 (2 220.01)(0) (00m		Ψοι 1.01	Ψοι 1.01				+
77435	STEREOTACTIC RADIATION THERAPY, TREATMENT MANAGEMENT		\$508.67	\$508.67				
77469	INTRAOPERATIVE RADIATION TREATMENT MANAGEMENT		\$241.26	\$241.26		†		
	SPECIAL TREATMENT PROCEDURE (EG, TOTAL BODY IRRADIATION,			<u> </u>		1		
77470	HEMIBODY		\$390.56	\$390.56	\$300.88	\$89.67		

Physician	Fee Schedule 2020							
Note:	11 00 001104410 2020					+	1	
	des in Red;					+		
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary cha	ae for the service	2				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
		1'						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY TREATMENT							
77499	MANAGEMENT	R	\$0.00	\$0.00	\$0.00	\$0.00		
77522	PROTON TREATMENT DELIVERY; SIMPLE, WITH COMPENSATION		\$0.00	\$0.00				
77525	PROTON TREATMENT DELIVERY; COMPLEX		\$0.00	\$0.00				
	HYPERTHERMIA, EXTERNALLY GENERATED; SUPERFICIAL (IE,							
77600	HEATING TO A DEPT		\$149.38	\$149.38	\$82.16	\$67.22		
	HYPERTHERMIA, EXTERNALLY GENERATED; DEEP (IE, HEATING TO							
77605	DEPTHS GREATE		\$199.55	\$199.55	\$109.87	\$89.67		
	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); 5 OR							
77610	FEWER INTERSTITI		\$149.38	\$149.38	\$82.16	\$67.22		
	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); MORE							
77615	THAN 5 INTERSTIT		\$199.55	\$199.55	\$109.87	\$89.67		
77620	HYPERTHERMIA GENERATED BY INTRACAVITARY PROBE(S)		\$149.38	\$149.38	\$82.16	\$67.22		
	INFUSION OR INSTILLATION OF RADIOELEMENT SOLUTION							
77750	(INCLUDES 3 MONTHS		\$232.97	\$232.97	\$36.01	\$196.96		
77761	INTRACAVITARY RADIATION SOURCE APPLICATION; SIMPLE		\$220.69	\$220.69	\$67.99	\$152.70		
77700	INTO A CANVITA DV DA DIATIONI COLIDOE A DDI ICATIONI, INTERMEDIATE		#207.04	#207.04	#07.04	#000 CO		
77762 77763	INTRACAVITARY RADIATION SOURCE APPLICATION; INTERMEDIATE		\$327.21 \$464.57	\$327.21 \$464.57	\$97.61 \$121.36	\$229.60 \$343.21		
11163	INTRACAVITARY RADIATION SOURCE APPLICATION; COMPLEX REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE SKIN		\$464.57	\$404.57	\$121.30	\$343.∠1		
	SURFACE BRACHYTHERAPY, BASIC DOSIMETRY/LESION DIAMETER							
77767	UP TO 2.0 CM OR 1 CHANNEL		\$167.83	\$167.83	\$124.12	\$43.72		Added Effective 1/1/2016
77768	LESION DIAMETER OVER 2.0 CM OR MULTIPLE LESION		\$261.98	\$261.98	\$204.02	\$57.96		Added Effective 1/1/2016 Added Effective 1/1/2016
77700	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE		ψ201.80	ψ201.30	ψ204.02	ψυ1.80		Added Lifective 1/1/2010
	INTERSITITAL OR INTRACAVITARY, BRACHTHERAPY/ INCLUDES							
77770	BASIC DOSIMETRY 1 CHANNEL		\$241.28	\$241.28	\$160.58	\$80.70		Added Effective 1/1/2016
77771	2-12 CHANNELS		\$450.11	\$450.11	\$292.46	\$157.66		Added Effective 1/1/2016
11111	2-12 OFMINIALEO	_l	ψ+υυ. ι ι	ψ+ου. Η	ΨΖΘΖ.40	ψ101.00	<u> </u>	Added Lifeotive 1/1/2010

Note	Physician	Fee Schedule 2020					I		
Redre To CPT book for descriptions		1 00 001104410 2020							
Refer to CPT book for descriptions R'in PA column indicates Prior Auth is required Codes listed as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anneathesia Base Rate is \$15.02. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc. Pro		les in Red:							
R' in PA column indicates Prior Auth is required Codes listed as \$30.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the service		•							
Codes Isled as '\$0.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service									
The Anesthesia Base Rate is \$15,20. Each 15 minute increment=1 time unit.			omary char	ne for the service	2				
Piesse use lab fee schedule for covered codes not listed below in the 80000-89249 range.			T Triang Gride	ge for the service	<u>, </u>				
Proc Procedure Description PA Ind (Facility) (NonFacility) Comp.		•	range			+			
Proc Procedure Description PA Ind Impat. Rate Comp. Comp				ns		+			
Procedure Description Pal Ind Inpat. Rate Code Procedure Description Pal Ind (Facility) Comp. Comp. Comp. Value Notes	Ocaco no	The second and the se	T priyololal			+			
Procedure Description Pal Ind Inpat. Rate Code Procedure Description Pal Ind (Facility) Comp. Comp. Comp. Value Notes								Base	
Code Procedure Description PA Ind Facility Comp. Comp. Comp. Value Notes	Proc			Inpat. Rate	Outpat, Rate	Tech.	Prof.		
T7772 OVER 12 CHANNÉLS \$685.14		Procedure Description	PA Ind	•	•				Notes
T7778								7 4145	
T7789									/ tadea = 1100 at 0 17 17 = 0 10
T7790 SUPERVISION, HANDLING, LOADING OF RADIATION SOURCE \$58.45 \$13.60 \$44.85 \$77799 UNLISTED PROCEDURE, CLINICAL BRACHYTHERAPY R \$0.00 \$0.0									
T7799									
THYROID UPTAKE, SINGLE OR MULTIPLY QUANTITATIVE \$63.81 \$63.81 \$63.81 \$53.8			R						
THYROID IMAGING (INCLUDING VASCULAR FLOW, WHEN PER \$160.92 \$160.92 \$146.42 \$14.50									
THYROID CARCINOMA METASTASES IMAGING; LIMITED AREA (EG, NECK AND CHEST STUDIES (EG, UR) S98.79 \$69.60 \$29.19									
THYROID CARCINOMA METASTASES IMAGING; LIMITED AREA (EG, NECK AND CHEST STUDIES (EG, URI ST)				\$186.56		\$167.10	\$19.47		
NECK AND CHEST				·			1		
STUDIES (EG, URI \$129.86 \$129.86 \$94.15 \$35.71	78015			\$98.79	\$98.79	\$69.60	\$29.19		
THYROID CARCINOMA METASTASES IMAGING; WHOLE BODY \$187.55 \$187.55 \$146.69 \$40.87		THYROID CARCINOMA METASTASES IMAGING; WITH ADDITIONAL							
THYROID CARCINOMA METASTASES UPTAKE (LIST SEPARATELY IN ADDITION TO CO \$23.59 \$23.59 \$14.98 \$8.61 \$78070 PARATHYROID IMAGING \$71.18 \$71.18 \$49.07 \$22.11 \$78071 WITH TOMOGRAPHIC (SPECT) \$279.24 \$279.24 \$232.99 \$46.25 \$279.24 \$27	78016	STUDIES (EG, URI		\$129.86	\$129.86	\$94.15	\$35.71		
R8020 ADDITION TO CO \$23.59 \$23.59 \$14.98 \$8.61				\$187.55	\$187.55	\$146.69	\$40.87		
78070 PARATHYROID IMAGING \$71.18 \$71.18 \$49.07 \$22.11		THYROID CARCINOMA METASTASES UPTAKE (LIST SEPARATELY IN							
T8071 WITH TOMOGRAPHIC (SPECT) \$279.24 \$279.24 \$232.99 \$46.25	78020	ADDITION TO CO		\$23.59	\$23.59	\$14.98	\$8.61		
T8072 WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQ \$316.55 \$254.23 \$62.32 Added Effective 1/1/2016 T8075 ADRENAL IMAGING, CORTEX AND/OR MEDULLA \$178.74 \$178.74 \$146.69 \$32.05 UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR	78070	PARATHYROID IMAGING		\$71.18	\$71.18	\$49.07	\$22.11		
R S0.00	78071	WITH TOMOGRAPHIC (SPECT)		\$279.24	\$279.24	\$232.99	\$46.25		
UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR R \$0.00	78072	WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQ		\$316.55	\$316.55	\$254.23	\$62.32		Added Effective 1/1/2016
78099 MEDICINE R \$0.00 \$0.00 \$0.00 78102 BONE MARROW IMAGING; LIMITED AREA \$79.01 \$79.01 \$55.19 \$23.82 78103 BONE MARROW IMAGING; MULTIPLE AREAS \$117.96 \$117.96 \$85.62 \$32.34 78104 BONE MARROW IMAGING; WHOLE BODY \$144.76 \$144.76 \$110.14 \$34.61 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$33.83 \$25.60 \$8.23	78075	ADRENAL IMAGING, CORTEX AND/OR MEDULLA		\$178.74	\$178.74	\$146.69	\$32.05		
78102 BONE MARROW IMAGING; LIMITED AREA \$79.01 \$79.01 \$55.19 \$23.82 78103 BONE MARROW IMAGING; MULTIPLE AREAS \$117.96 \$117.96 \$85.62 \$32.34 78104 BONE MARROW IMAGING; WHOLE BODY \$144.76 \$144.76 \$110.14 \$34.61 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$25.60 \$8.23									
78103 BONE MARROW IMAGING; MULTIPLE AREAS \$117.96 \$117.96 \$85.62 \$32.34 78104 BONE MARROW IMAGING; WHOLE BODY \$144.76 \$144.76 \$110.14 \$34.61 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$25.60 \$8.23			R						
78104 BONE MARROW IMAGING; WHOLE BODY \$144.76 \$144.76 \$110.14 \$34.61 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83 \$35.83 \$35.83 \$35.83		BONE MARROW IMAGING; LIMITED AREA			1 '	\$55.19	\$23.82		
PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION 78110 TECHNIQUE (SEPARATE \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION									
78110 TECHNIQUE (SEPARATE \$33.83 \$33.83 \$25.60 \$8.23 PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION \$33.83	78104			\$144.76	\$144.76	\$110.14	\$34.61		
PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION									
	78110			\$33.83	\$33.83	\$25.60	\$8.23		
78111 TECHNIQUE (SEPARATE \$79.22 \$69.60 \$9.62									
	78111	TECHNIQUE (SEPARATE		\$79.22	\$79.22	\$69.60	\$9.62		

Physician	n Fee Schedule 2020	I					I	
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	column indicates Prior Auth is required				-			
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	rae for the service	7	+		+	
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	T TOT THE SCIVICE	, <u> </u>	+		+	
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					
O G G G G II G	tod on the lab lee constant that begin mand 1 or & are currently non-covered to	T priyolola			+	†		
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
70400	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE); SINGLE SAMPLING		\$57.11	\$57.11	¢46.00	\$10.19		
78120	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE);		φ57.11	\$57.11	\$46.93	\$10.19		
70101	,		\$92.33	¢00.22	\$78.43	\$13.90		
78121	MULTIPLE SAMPLINGS WHOLE BLOOD VOLUME DETERMINATION, INCLUDING SEPARATE		Φ92.33	\$92.33	\$70.43	\$13.90		
78122	MEASUREMENT OF PL		\$143.85	\$143.85	\$124.55	\$19.30		
78130	RED CELL SURVIVAL STUDY:		\$103.47	\$103.47	\$77.09	\$26.38		
70130	RED CELL SURVIVAL STUDY; DIFFERENTIAL ORGAN/TISSUE		\$103.4 <i>1</i>	φ103.4 <i>1</i>	\$11.09	φ20.30		
78135	KINETICS, (EG, SPLE		\$159.27	\$159.27	\$131.74	\$27.53		
70100	LABELED RED CELL SEQUESTRATION, DIFFERENTIAL		ψ133.21	ψ133.21	ψ131.74	Ψ27.55		
78140	ORGAN/TISSUE, (EG, SPLENI		\$132.79	\$132.79	\$106.41	\$26.38		
78185	SPLEEN IMAGING ONLY, WITH OR WITHOUT VASCULAR FLOW		\$81.29	\$81.29	\$63.99	\$17.29		
78191	PLATELET SURVIVAL STUDY	+	\$224.56	\$224.56	\$198.18	\$26.38	+	
78195	LYMPHATICS AND LYMPH NODES IMAGING		\$140.48	\$140.48	\$110.14	\$30.34		
70100	UNLISTED HEMATOPOIETIC, RETICULOENDOTHELIAL AND		Ψ110.10	Ψ110.10	Ψ110.11	Ψοσιστ		
78199	LYMPHATIC PROCEDURE,	R	\$0.00	\$0.00	\$0.00	\$0.00		
78201	LIVER IMAGING; STATIC ONLY		\$82.73	\$82.73	\$63.99	\$18.74		
78202	LIVER IMAGING; WITH VASCULAR FLOW	 	\$100.00	\$100.00	\$77.89	\$22.11	+	
78205	LIVER IMAGING (SPECT);	†	\$190.65	\$190.65	\$159.75	\$30.90		
78206	LIVER IMAGING (SPECT); WITH VASCULAR FLOW	1	\$265.96	\$265.96	\$228.65	\$37.31	1	Rate updated 1/1/2018
78215	LIVER AND SPLEEN IMAGING; STATIC ONLY		\$100.24	\$100.24	\$79.23	\$21.01		· ·
78216	LIVER AND SPLEEN IMAGING; WITH VASCULAR FLOW		\$118.82	\$118.82	\$94.15	\$24.67		
	HEPATOBILARY SYSTEM IMAGING, INCLUDING GALLBLADDER WHEN							
78226	PRESENT		\$251.33	\$251.33	\$255.76	\$30.56		
	WITH PHARMACOLOGIC INTERVENTION, INCLUDING QUANTITIVE							
78227	MEASUREMENT(S) WHEN PERFORMED		\$343.77	\$343.77	\$355.15	\$36.79		
78230	SALIVARY GLAND IMAGING;		\$78.49	\$78.49	\$58.92	\$19.57		
78231	SALIVARY GLAND IMAGING; WITH SERIAL IMAGES		\$108.29	\$108.29	\$85.62	\$22.67		

Physiciar	n Fee Schedule 2020							
Note:		1			†	1		
2020 Co	des in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omarv chai	ae for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	ise lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
_		1						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
78232	SALIVARY GLAND FUNCTION STUDY		\$115.91	\$115.91	\$95.49	\$20.42	1 0.100	
78258	ESOPHAGEAL MOTILITY	1	\$109.94	\$109.94	\$77.89	\$32.05		
78261	GASTRIC MUCOSA IMAGING		\$140.99	\$140.99	\$110.95	\$30.05		
78262	GASTROESOPHAGEAL REFLUX STUDY	1	\$144.43	\$144.43	\$114.95	\$29.48		
78264	GASTRIC EMPTYING STUDY		\$145.24	\$145.24	\$111.48	\$33.76		
78265	WITH SMALL BOWEL TRANSIT		\$303.61	\$303.61	\$264.56	\$39.05		Added Effective 1/1/2016
78266	WITH SMALL BOWEL AND COLON TRANSIT, MULTIPLE DAYS		\$359.85	\$359.85	\$316.56	\$43.29		Added Effective 1/1/2016
78278	ACUTE GASTROINTESTINAL BLOOD LOSS IMAGING		\$174.56	\$174.56	\$131.74	\$42.82		
78282	GASTROINTESTINAL PROTEIN LOSS		\$0.00	\$0.00	\$0.00	\$16.44		
	INTESTINE IMAGING (EG, ECTOPIC GASTRIC MUCOSA, MECKEL'S		1	+	1	•		
78290	LOCALIZATION,		\$111.64	\$111.64	\$82.16	\$29.48		
	PERITONEAL-VENOUS SHUNT PATENCY TEST (EG, FOR LEVEEN,		7	¥ 1 1 1 1 2 1		7-0110		
78291	DENVER SHUNT)		\$120.43	\$120.43	\$82.69	\$37.74		
	UNLISTED GASTROINTESTINAL PROCEDURE, DIAGNOSTIC NUCLEAR			,	1			
78299	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
78300	BONE AND/OR JOINT IMAGING; LIMITED AREA		\$94.40	\$94.40	\$67.46	\$26.94		
78305	BONE AND/OR JOINT IMAGING; MULTIPLE AREAS	1	\$134.96	\$134.96	\$98.95	\$36.01		
78306	BONE AND/OR JOINT IMAGING; WHOLE BODY		\$152.64	\$152.64	\$115.48	\$37.15		
78315	BONE AND/OR JOINT IMAGING; THREE PHASE STUDY		\$172.79	\$172.79	\$129.09	\$43.70		
78320	BONE AND/OR JOINT IMAGING; TOMOGRAPHIC (SPECT)		\$204.31	\$204.31	\$159.75	\$44.56		
	BONE DENSITY (BONE MINERAL CONTENT) STUDY, ONE OR MORE				1	1		
78350	SITES; SINGLE P		\$30.15	\$30.15	\$20.53	\$9.62		
78351	BONE MINERAL DUAL PHOTON		\$14.39	\$14.39	1			
	UNLISTED MUSCULOSKELETAL PROCEDURE, DIAGNOSTIC NUCLEAR							
78399	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
78414	NON-IMAGING HEART FUNCTION		\$0.00	\$0.00	\$0.00	\$19.88		
78428	CARDIAC SHUNT DETECTION	1	\$94.83	\$94.83	\$61.07	\$33.76	1	

Physician	Fee Schedule 2020		1					
Note:	The ee ochedule 2020					+		
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service			+		
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	T	7		+		+
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Codes iis	ted on the lab fee scriedule that begin with a 1 of Q are currently non-covered to	Ji priysiciai	15					
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Oode	Toccurre Description	Ailiu	(i denity)	(Norm active)	Comp.	Jonip.	Value	Hotes
78429	MYOCRD IMG PET 1 STD W/CT		\$0.00	\$0.00	\$0.00	\$67.16		Added Effective 01/01/2020
70-120			ψο.ου	ψ0.00	ψο.σσ	 		710000 211000170 0110112020
78430	MYOCRD IMG PET RST/STRS W/CT		\$0.00	\$0.00	\$0.00	\$63.75		Added Effective 01/01/2020
70400	in rooks into the rooks that		\$0.00	ψ0.00	ψο.σσ	+ + + + + + + + + + + + + + + + + + +		710000 211001170 0110112020
78431	MYOCRD IMG PET RST&STRS CT		\$0.00	\$0.00	\$0.00	\$74.08		Added Effective 01/01/2020
70401	III TOOKS IIIIC FE TROTGOTKO OT		ψο.ου	ψ0.00	ψο.σσ	ψ1-1.00		710000 211000170 0110112020
78432	MYOCRD IMG PET 2RTRACER		\$0.00	\$0.00	\$0.00	\$79.04		Added Effective 01/01/2020
			-	V 0.00	 	V. C.C.		7.0.000 = 11000110 0 110 112020
78433	MYOCRD IMG PET 2RTRACER CT		\$0.00	\$0.00	\$0.00	\$86.40		Added Effective 01/01/2020
10.00		1	V 0.00	V 0.00	V 0.00	\$30110		7.0.000 = 11000110 0 110 112020
78434	AQMBF PET REST & RX STRESS		\$0.00	\$0.00	\$0.00	\$24.86		Added Effective 01/01/2020
	NON-CARDIAC VASCULAR FLOW IMAGING (IE, ANGIOGRAPHY,		70100	70100	,	7=		
78445	VENOGRAPHY)		\$71.93	\$71.93	\$50.15	\$21.79		
	NUCLEAR MEDICINE STUDY OF VESSELS OF HEART USING DRUGS		4.	4	 	+		
78451	OR EXERCISE SINGLE STUDY	R	\$161.53	\$161.53	\$109.91	\$51.61		
	MULTIPLE STUDIES, AT REST AND/OR STRESS AND/OR		¥ 10 1100	7 10 1100	Ţ	1		
78452	REDISTRIBUTION AND/OR REST REINJECTION	R	\$273.49	\$273.49	\$212.49	\$61.00		
	MYCARDIAL PERFUSION IMAGING, PLANAR SINGLE STUDY, AT REST	1	 	42.00	V = 1=110	1		
78453	OR STRESS	R	\$139.95	\$139.95	\$102.51	\$37.43		
	MULTIPLE STUDIES, AT REST AND/OR STRESS AND/OR	1	7.00.00	Ţ.55.55	7.02.01	+50		
78454	REDISTRIBUTION AND/OR REST REINJECTION	R	\$135.88	\$135.88	\$86.18	\$49.70		
78456	ACUTE VENOUS THROMBOSIS IMAGING, PEPTIDE	†	\$147.47	\$147.47	\$109.71	\$37.76		
78457	VENOUS THROMBOSIS IMAGING, VENOGRAM; UNILATERAL	1	\$105.19	\$105.19	\$71.99	\$33.20		+
78458	VENOUS THROMBOSIS IMAGING, VENOGRAM; BILATERAL		\$147.15	\$147.15	\$108.56	\$38.60		
78459	HEART MUSCLE IMAGING (PET)	R	\$0.00	\$0.00	\$0.00	\$63.20		
	1	1	70.00	+	T 2.20	700.00	1	

Notes	Physician	n Fee Schedule 2020							
2020 Codes in Rad:		Tree conclude 2020				-			
Refer to QPT book for descriptions		des in Red:				+			
R' in PA column indicates Prior Auth is required Codes listed as \$0.007 pay 45% of billied amount not to exceed provider's usual and customary charge for the service Codes listed as \$0.007 pay 45% of billied amount not to exceed provider's usual and customary charge for the service Codes listed as \$0.007 pay 45% of billied amount not to exceed provider's usual and customary charge for the service Codes listed below in the boson \$2.49 range. Codes listed on the lab fee schedule fror covered codes not listed below in the 90000-98249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Code Procedure Description Comp. Comp. Value						-			
Codes Isled as '50.00" Pay 45% of billed amount not to exceed provider's usual and customary charge for the service						_			
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.			nmary char	rge for the service					
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.			That y Grian	T The service	,				
Codes Islated on the lab fee schedule that begin with a P or Q are currently non-covered for physicians PA Ind Inpat. Rate Code Procedure Description PA Ind Inpat. Rate (Ronfacility) Notes Notes			range			-			
Proc Code Procedure Description PA Ind (Facility) Outpat. Rate (Facility) Outpat. Rate (NonFacility) Comp. Value Notes				<u> </u>		-			
Procedure Description	Codes lis	The lab lee scriedule that begin with a 1 of Q are currently non-covered to	T priyaiciai	113					
Procedure Description								Base	
Pacedure Description	Proc			Inpat. Rate	Outpat, Rate	Tech.	Prof.		
MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; QUALITATIVE OR R \$101.23 \$101.23 \$71.19 \$30.05		Procedure Description	PA Ind		•				Notes
R	Couc		I A IIIu	(i dointy)	(Norm domey)	Comp.	оотпр.	Value	140103
MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; WITH EJECTION R \$133.30 \$133.30 \$98.95 \$34.35 MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC R \$180.80 \$180.80 \$141.35 \$39.45 AVID CARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC R \$180.80 \$180.80 \$141.35 \$39.45 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; PLANAR, SINCLE STUDY AT R \$191.34 \$191.34 \$149.08 \$42.26 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; MULTIPLE R \$285.99 \$222.99 \$63.00 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$183.61 \$141.35 \$42.26 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$183.61 \$141.35 \$42.26 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$275.58 \$275.58 \$212.58 \$63.00 Rady HEART IMAGE (PET) SINGLE R \$0.00 \$0.00 \$50.00 \$59.26 Rate updated 1/1/2020 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT R \$175.24 \$175.24 \$128.93 \$46.31 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$133.85 \$132.03 \$20.18 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIU	78466		R	\$101.23	\$101.23	\$71 19	\$30.05		
R	7 0 100			ψ101.20	ψ1011 <u>2</u> 0	ψσ	φουίου		
MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC R \$180.80 \$180.80 \$141.35 \$39.45	78468	' ' '	R	\$133 30	\$133.30	\$98.95	\$34 35		
R \$180.80 \$180.80 \$141.35 \$39.45	7 0 100			ψ100.00	ψ.00.00	Ψ00.00	φσποσ		
CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; PLANAR, R \$191.34 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08 \$42.26 \$149.08	78469	· · · · · · · · · · · · · · · · · · ·	R	\$180.80	\$180.80	\$141.35	\$39.45		
R SINGLE STUDY AT R S191.34 S191.34 S149.08 S42.26				ψ.:σσ.:σσ	V.00.00	V	V		
CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; MULTIPLE R \$285.99 \$285.99 \$222.99 \$63.00 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$183.61 \$183.61 \$141.35 \$42.26 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$183.61 \$183.61 \$141.35 \$42.26 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$275.58 \$275.58 \$212.58 \$63.00 R8491 HEART IMAGE (PET) SINGLE R \$0.00 \$0.00 \$0.00 \$59.26 Rate updated 1/1/2020 R8492 HEART IMAGE (PET) MULTIPLE R \$0.00 \$0.00 \$0.00 \$69.63 Rate updated 1/1/2020 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT REST, WALL MO R \$175.24 \$175.24 \$128.93 \$46.31 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR R8499 MEDICINE R \$0.00 \$0.00 \$0.00 \$0.00 R8579 PULMONARY VENTILATION IMAGING (AEROSOL OR GAS) PULMONARY VENTILATION IMAGING, APRTICULATE PULMONARY VENTILATION (EG, AEROSOL OR GAS) AND PERFUSION PULMONARY VENTILATION (EG, AEROSOL OR GAS) AND PERFUSION	78472		R	\$191.34	\$191.34	\$149.08	\$42.26		
R \$285.99 \$285.99 \$222.99 \$63.00				, -	*	1	,		
CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$183.61 \$183.61 \$141.35 \$42.26 CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; R \$275.58 \$275.58 \$212.58 \$63.00 R4891 HEART IMAGE (PET) SINGLE R \$0.00 \$0.00 \$0.00 \$59.26 Rate updated 1/1/2020 R4992 HEART IMAGE (PET) MULTIPLE R \$0.00 \$0.00 \$0.00 \$69.63 Rate updated 1/1/2020 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT R8494 REST, WALL MO CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$175.24 \$175.24 \$128.93 \$46.31 Rate updated 1/1/2018 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR R \$0.00 \$0.00 \$0.00 \$0.00 R8579 PULMONARY VENTILATION IMAGING (AEROSOL OR GAS) PULMONARY VENTILATION IMAGING, PARTICULATE PULMONARY VENTILATION (EG, AEROSOL OR GAS) AND PERFUSION	78473	, ,	R	\$285.99	\$285.99	\$222.99	\$63.00		
R \$183.61 \$183.61 \$141.35 \$42.26									
R \$275.58 \$212.58 \$63.00	78481		R	\$183.61	\$183.61	\$141.35	\$42.26		
R \$275.58 \$212.58 \$63.00		CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE;							
Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2020 Rate updated 1/1/2018 Rate	78483		R	\$275.58	\$275.58	\$212.58	\$63.00		
CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT REST, WALL MO R	78491	HEART IMAGE (PET) SINGLE	R		\$0.00	\$0.00	\$59.26		Rate updated 1/1/2020
REST, WALL MO	78492	HEART IMAGE (PET) MULTIPLE	R	\$0.00	\$0.00	\$0.00	\$69.63		Rate updated 1/1/2020
CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE 78496 STUDY, AT REST, UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR 78499 MEDICINE 78579 PULMONARY VENTILATION IMAGING (AEROSOL OR GAS) 78580 PULMONARY PERFUSION IMAGING, PARTICULATE PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018 \$0.00 \$0.00 \$0.00 \$0.00 \$133.85 \$133.85 \$132.03 \$20.18 \$124.86 \$124.86 \$92.81 \$32.05		CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT							
T8496 STUDY, AT REST, R \$34.50 \$34.50 \$15.13 \$19.37 Rate updated 1/1/2018	78494	REST, WALL MO	R	\$175.24	\$175.24	\$128.93	\$46.31		Rate updated 1/1/2018
UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR R \$0.00		CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SINGLE							
78499 MEDICINE R \$0.00 \$0.00 \$0.00 78579 PULMONARY VENTILATION IMAGING (AEROSOL OR GAS) \$133.85 \$132.03 \$20.18 78580 PULMONARY PERFUSION IMAGING, PARTICULATE \$124.86 \$124.86 \$92.81 \$32.05 PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION \$124.86 \$124.86 \$124.86 \$124.86	78496	STUDY, AT REST,	R	\$34.50	\$34.50	\$15.13	\$19.37		Rate updated 1/1/2018
78579 PULMONARY VENTILATION IMAGING (AEROSOL OR GAS) \$133.85 \$133.85 \$132.03 \$20.18 78580 PULMONARY PERFUSION IMAGING, PARTICULATE \$124.86 \$124.86 \$92.81 \$32.05 PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION \$124.86 \$124.86 \$124.86		UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR							
78580 PULMONARY PERFUSION IMAGING, PARTICULATE \$124.86 \$124.86 \$92.81 \$32.05 PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION			R		· ·				
PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION									
	78580			\$124.86	\$124.86	\$92.81	\$32.05		
78582 IMAGING \$247.10 \$236.77 \$43.61		PULMONARY VENTILATION(EG, AEROSOL OR GAS) AND PERFUSION							
	78582	IMAGING		\$247.10	\$247.10	\$236.77	\$43.61		

Physician	Fee Schedule 2020							
Note:	Too Carround 2020							
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	tomary cha	rae for the service	1				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
		1						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	QUANTITIVE DIFFERENTIAL PULMONARY PERFUSION , INCLUDING							
78597	IMAGING WHEN PERFORMED		\$151.45	\$151.45	\$141.53	\$29.97		
	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND							
	VENTILATION(AEROSOL OR GAS) INCLUDING IMAGING WHEN							
78598	PERFORMED		\$231.79	\$231.79	\$229.35	\$34.12		
	UNLISTED RESPIRATORY PROCEDURE, DIAGNOSTIC NUCLEAR							
78599	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
78600	BRAIN IMAGING, LIMITED PROCEDURE; STATIC		\$96.90	\$96.90	\$77.89	\$19.00		
78601	BRAIN IMAGING, LIMITED PROCEDURE; WITH VASCULAR FLOW		\$114.14	\$114.14	\$91.76	\$22.37		
78605	BRAIN IMAGING, COMPLETE STUDY; STATIC		\$114.99	\$114.99	\$91.76	\$23.23		
78606	BRAIN IMAGING, COMPLETE STUDY; WITH VASCULAR FLOW		\$132.09	\$132.09	\$104.56	\$27.53		
78607	BRAIN IMAGING, COMPLETE STUDY; TOMOGRAPHIC (SPECT)		\$229.63	\$229.63	\$177.11	\$52.52		
70000	AUTOLEAR MEDICINE OTURY RRAIN WITH METAROLIO EVALUATION	_	0040.05	#040.05	ф 777 75	# 00.00		D. t
78608	NUCLEAR MEDICINE STUDY BRAIN WITH METABOLIC EVALUATION	R	\$840.35	\$840.35	\$777.75	\$62.60		Rate updated 1/1/2018
70000	NUCLEAR MEDICINE STUDY BRAIN WITH BLOOD CIRCULATION		mo 40,00	0040.00	4777 7 5	005 57		D. t
78609	EVALUATION PROMINE VACCULAR EL CIVI CANILY	R	\$843.32	\$843.32	\$777.75	\$65.57 \$13.04		Rate updated 1/1/2018
78610	BRAIN IMAGING, VASCULAR FLOW ONLY CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING		\$55.71	\$55.71	\$42.66	\$13.04		
78630	INTRODUCTION OF MATER		\$165.76	\$165.76	\$136.28	\$29.48		
70030	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING		\$100.70	\$100.70	φ130.20	\$29.40		
78635	INTRODUCTION OF MATER		\$95.18	\$95.18	\$68.80	\$26.38		
70033	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING		φ95.16	φ93.16	Φ00.00	\$20.30		
78645	INTRODUCTION OF MATER		\$117.48	\$117.48	\$92.81	\$24.67		
70045	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING		ψ117.40	ψ111.40	ψ32.01	ψ24.01		+
78647	INTRODUCTION OF MATER		\$198.62	\$198.62	\$159.75	\$38.86		
70047	INTRODUCTION OF WATER		ψ190.02	ψ190.02	ψ108.70	ψ30.00		+
78650	CEREBROSPINAL FLUID LEAKAGE DETECTION AND LOCALIZATION		\$151.74	\$151.74	\$125.36	\$26.38		

Physician	Fee Schedule 2020		1	1				T
Note:								
2020 Cod	es in Red;							
Refer to C	CPT book for descriptions							
R" in PA o	column indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary chai	rge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
78660	RADIOPHARMACEUTICAL DACRYOCYSTOGRAPHY	R	\$80.57	\$80.57	\$57.34	\$23.23		
	UNLISTED NERVOUS SYSTEM PROCEDURE, DIAGNOSTIC NUCLEAR							
78699	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
78700	KIDNEY IMAGING; STATIC ONLY		\$101.45	\$101.45	\$82.16	\$19.30		
78701	KIDNEY IMAGING; WITH VASCULAR FLOW		\$117.04	\$117.04	\$96.03	\$21.01		
	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE							
78707	STUDY WITHOUT		\$161.13	\$161.13	\$120.82	\$40.31		
	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE							
78708	STUDY, WITH		\$163.76	\$163.76	\$116.60	\$47.16		
	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; MULTIPLE							
78709	STUDIES, WITH		\$169.52	\$169.52	\$116.60	\$52.92		
78710	KIDNEY IMAGING, TOMOGRAPHIC (SPECT)		\$188.38	\$188.38	\$159.75	\$28.63		
78725	KIDNEY FUNCTION STUDY, NON-IMAGING RADIOISOTOPIC STUDY		\$64.71	\$64.71	\$48.27	\$16.44		
78730	URINARY BLADDER RESIDUAL STUDY		\$54.81	\$54.81	\$39.47	\$15.34		
	URETERAL REFLUX STUDY (RADIOPHARMACEUTICAL VOIDING							
78740	CYSTOGRAM)		\$82.01	\$82.01	\$57.34	\$24.67		
78761	TESTICULAR IMAGING; WITH VASCULAR FLOW		\$117.32	\$117.32	\$86.42	\$30.90		
	UNLISTED GENITOURINARY PROCEDURE, DIAGNOSTIC NUCLEAR							
78799	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR							
78800	DISTRIBUTION OF	R	\$193.95	\$193.95	\$168.32	\$25.63		Updated Effective 01/01/2020
	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR							
78801	DISTRIBUTION OF	R	\$213.15	\$213.15	\$184.11	\$29.04		Updated Effective 01/01/2020
	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR							
78802	DISTRIBUTION OF	R	\$234.16	\$234.16	\$203.31	\$30.85		Updated Effective 01/01/2020
	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR							
78803	DISTRIBUTION OF	R	\$291.90	\$291.90	\$249.75	\$42.15		Updated Effective 01/01/2020

Physician	Fee Schedule 2020							T
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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	<u> </u>						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR							
78804	DISTRIBUTION OF	R	\$492.62	\$492.62	\$453.07	\$39.55		Updated Effective 01/01/2020
	RADIOPHARMACEUTICAL LOCALIZATION OF INFLAMMATORY							
78805	PROCESS; LIMITED AREA	R	\$123.25	\$123.25	\$91.76	\$31.49		
	RADIOPHARMACEUTICAL LOCALIZATION OF INFLAMMATORY							
78806	PROCESS; WHOLE BODY	R	\$210.78	\$210.78	\$173.89	\$36.89		
	RADIOPHARMACEUTICAL LOCALIZATION OF INFLAMMATORY							
78807	PROCESS; TOMOGRAPHIC	R	\$223.67	\$223.67	\$177.11	\$46.56		
78808	INJECTION PROCEDURE FOR RADIOPHARMACEUTICAL		\$36.49	\$36.49				
78811	PET IMAGE LTD AREA	R	\$1,036.97	\$1,036.97	\$969.32	\$67.65		Updated Effective 01/01/2019
	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); SKULL							
78812	BASE TO MID-T	R	\$1,046.27	\$1,046.27	\$969.32	\$76.95		Updated Effective 01/01/2019
	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); WHOLE							
78813	BODY	R	\$1,031.51	\$1,031.51	\$969.32	\$62.19		Updated Effective 01/01/2019
	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH							
78814	CONCURRENTLY	R	\$1,037.44	\$1,037.44	\$969.32	\$68.12		Updated Effective 01/01/2019
	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH	_						
78815	CONCURRENTLY	R	\$1,044.56	\$1,044.56	\$969.32	\$75.24		Updated Effective 01/01/2019
70040	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) WITH		* * * * * * * * * *		****	477.00		
78816	CONCURRENTLY	R	\$1,046.34	\$1,046.34	\$969.32	\$77.02		Updated Effective 01/01/2019
78830	RP LOCLZJ TUM SPECT W/CT 1		\$369.72	\$369.72	\$312.01	\$57.72		Added Effective 01/01/2020
78831	RP LOCLZJ TUM SPECT 2 AREAS		\$533.63	\$533.63	\$463.19	\$70.44		Added Effective 01/01/2020
78832	RP LOCLZJ TUM SPECT W/CT 2		\$693.62	\$693.62	\$611.57	\$82.05		Added Effective 01/01/2020

Physician	Fee Schedule 2020			Ī				
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
78835	RP QUAN MEAS SINGLE AREA		\$78.02	\$78.02	\$59.91	\$18.11		Added Effective 01/01/2020
	UNLISTED MISCELLANEOUS PROCEDURE, DIAGNOSTIC NUCLEAR							
78999	MEDICINE	R	\$0.00	\$0.00	\$0.00	\$0.00		
79005	RADIOPHARMACEUTICAL THERAPY, BY ORAL ADMINISTRATION	R	\$141.27	\$141.27	\$70.48	\$70.79		
	RADIOPHARMACEUTICAL THERAPY, BY INTRAVENOUS							
79101	ADMINISTRATION	R	\$147.80	\$147.80	\$70.48	\$77.32		
	RADIOPHARMACEUTICAL THERAPY, BY INTRACAVITARY							
79200	ADMINISTRATION	R	\$156.85	\$156.85	\$71.19	\$85.67		
79300	NUCLR RX INTERSTIT COLLOID	R	\$0.00	\$0.00	\$0.00	\$73.28		
	RADIOPHARMACEUTICAL THERAPY, RADIOLABELED MONOCLONAL							
79403	ANTIBODY BY	R	\$203.02	\$203.02	\$112.58	\$90.44		
	RADIOPHARMACEUTICAL THERAPY, BY INTRA-ARTICULAR							
79440	ADMINISTRATION	R	\$156.85	\$156.85	\$71.19	\$85.67		
	RADIOPHARMACEUTICAL THERAPY, BY INTRA-ARTERIAL							
79445	PARTICULATE ADMINISTRAT	R	\$166.24	\$166.24	\$71.00	\$95.24		
79999	RADIOPHARMACEUTICAL THERAPY, UNLISTED PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
80050	GENERAL HEALTH PANEL		\$48.45	\$48.45				
80055	OBSTETRIC PANEL		\$0.00	\$0.00				
80081	OBSTETRIC PANEL		\$105.37	\$101.97				Added Effective 1/1/2016
	CLINICAL PATHOLOGY CONSULTATION; LIMITED, WITHOUT REVIEW			1				
80500	OF PATIENT'S		\$15.54	\$15.80				
	CLINICAL PATHOLOGY CONSULTATION; COMPREHENSIVE, FOR A			1.				
80502	COMPLEX DIAGNOST		\$53.21	\$53.98		1		
81099	UNLISTED URINALYSIS PROCEDURE	R	\$0.01	\$0.01				
81163	BRCA1&2 GENE FULL SEQ ALYS		\$0.00	\$0.00				Effective 1/1/2019
81164	BRCA1&2 GEN FUL DUP/DEL ALYS		\$0.00	\$0.00				Effective 1/1/2019

Physician	Fee Schedule 2020							1
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	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ange			+			
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
81165	BRCA1 GENE FULL SEQ ALYS		\$0.00	\$0.00			- Tuius	Effective 1/1/2019
81166	BRCA1 GENE FULL DUP/DEL ALYS		\$0.00	\$0.00				Effective 1/1/2019
81167	BRCA2 GENE FULL DUP/DEL ALYS		\$0.00	\$0.00				Effective 1/1/2019
81171	AFF2 GENE DETC ABNOR ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81171	AFF2 GENE DETC ABNOR ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81172	AFF2 GENE CHARAC ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81173	AR GENE FULL GENE SEQUENCE		\$0.00	\$0.00				Effective 1/1/2019
81174	AR GENE KNOWN FAMIL VARIANT		\$0.00	\$0.00				Effective 1/1/2019
81177	ATN1 GENE DETC ABNOR ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81178	ATXN1 GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81179	ATXN2 GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81180	ATXN3 GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81181	ATXN7 GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81182	ATXN8OS GEN DETC ABNOR ALLEL		\$0.00	\$0.00				Effective 1/1/2019
81183	ATXN10 GENE DETC ABNOR ALLEL		\$0.00	\$0.00				Effective 1/1/2019
81184	CACNA1A GEN DETC ABNOR ALLEL		\$0.00	\$0.00				Effective 1/1/2019
81185	CACNA1A GENE FULL GENE SEQ		\$0.00	\$0.00				Effective 1/1/2019
81186	CACNA1A GEN KNOWN FAMIL VRNT		\$0.00	\$0.00				Effective 1/1/2019
81187	CNBP GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81188	CSTB GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81189	CSTB GENE FULL GENE SEQUENCE		\$0.00	\$0.00				Effective 1/1/2019
81190	CSTB GENE KNOWN FAMIL VRNT		\$0.00	\$0.00				Effective 1/1/2019
81204	AR GENE CHARAC ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81229	CYTOGEN MICROARRAY TEST		\$1,250.00	\$1,250.00				Added Effective 1/1/2017
81233	BTK GENE COMMON VARIANTS		\$0.00	\$0.00				Effective 1/1/2019
81234	DMPK GENE DETC ABNOR ALLELE		\$0.00	\$0.00				Effective 1/1/2019
81236	EZH2 GENE FULL GENE SEQUENCE		\$0.00	\$0.00				Effective 1/1/2019
81237	EZH2 GENE COMMON VARIANTS		\$0.00	\$0.00				Effective 1/1/2019

Physician	Fee Schedule 2020							
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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thary onar	T TOT THE SCIVICE	,			+	
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	range						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
81239	DMPK GENE CHARAC ALLELES		\$0.00	\$0.00			1	Effective 1/1/2019
81271	HTT GENE DETC ABNOR ALLELES		\$0.00	\$0.00				Effective 1/1/2019
81289	FXN GENE KNOWN FAMIL VARIANT		\$0.00	\$0.00				Effective 1/1/2019
81320	PLCG2 GENE COMMON VARIANTS		\$0.00	\$0.00				Effective 1/1/2019
81327	SEPT9 METHYLATION ANALYSIS		\$0.00	\$0.00				Added Effective 1/1/2017
81329	SMN1 GENE DOS/DELETION ALYS		\$0.00	\$0.00				Effective 1/1/2019
81333	TGFBI GENE COMMON VARIANTS		\$0.00	\$0.00				Effective 1/1/2019
81539	ONCOLOGY PROSTATE PROB SCORE		\$0.00	\$0.00				Added Effective 1/1/2017
81596	NFCT DS CHRNC HCV 6 ASSAYS		\$0.00	\$0.00				Effective 1/1/2019
82642	DIHYDROTESTOSTERONE		\$0.00	\$0.00				Effective 1/1/2019
83698	LIPOPROTEIN-ASSOCIATED PHOSPHOLIPASE		\$47.43	\$47.43				
83722	LIPOPRTN DIR MEAS SD LDL CHL		\$0.00	\$0.00				Effective 1/1/2019
84999	UNLISTED CHEMISTRY PROCEDURE	R	\$0.00	\$0.00				
	BLOOD SMEAR, PERIPHERAL, INTERPRETATION BY PHYSICIAN WITH							
85060	WRITTEN REPO		\$18.61	\$18.61		\$18.61		
85097	BONE MARROW, SMEAR INTERPRETATION		\$38.90	\$66.01				
85999	UNLISTED HEMATOLOGY AND COAGULATION PROCEDURE		\$0.00	\$0.00				
	BLOOD BANK PHYSICIAN SERVICES; DIFFICULT CROSS MATCH							
86077	AND/OR EVALUATION		\$37.61	\$39.16				
	BLOOD BANK PHYSICIAN SERVICES; INVESTIGATION OF							
86078	TRANSFUSION REACTION		\$37.87	\$39.93				
	BLOOD BANK PHYSICIAN SERVICES; AUTHORIZATION FOR							
86079	DEVIATION FROM STANDA		\$38.13	\$39.93				
86485	SKIN TEST; CANDIDA		\$5.68	\$5.68				
86486	SKIN TEST, NOS ANTIGEN		\$4.45	\$4.45				
86490	SKIN TEST; COCCIDIOIDOMYCOSIS		\$7.99	\$7.99				
86510	SKIN TEST; HISTOPLASMOSIS		\$8.76	\$8.76				
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL		\$6.95	\$6.95				

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
86794	ZIKA VIRUS IGM ANTIBODY		\$0.00	\$0.00				Added Effective 1/1/2018
86849	UNLISTED IMMUNOLOGY PROCEDURE		\$110.00	\$110.00				
86850	ANTIBODY SCREEN, RBC, EACH SERUM TECHNIQUE		\$47.17	\$47.17				
86860	RBC ANTIBODY ELUTION		\$0.00	\$0.00				
86870	RBC ANTIBODY IDENTIFICATION		\$0.00	\$0.00				
86890	AUTOLOGOUS BLOOD PROCESS		\$0.00	\$0.00				
86891	AUTOLOGOUS BLOOD OP SALVAGE		\$0.00	\$0.00				
	BLOOD TYPING, FOR PATERNITY TESTING, PER INDIVIDUAL; ABO, RH							
86910	AND MN		\$26.06	\$26.06				
	BLOOD TYPING, FOR PATERNITY TESTING, PER INDIVIDUAL; EACH							
86911	ADDITIONAL		\$0.00	\$0.00				
86920	COMPATIBILITY TEST EACH UNIT; IMMEDIATE SPIN TECHNIQUE		\$0.00	\$0.00				
86921	COMPATIBILITY TEST EACH UNIT; INCUBATION TECHNIQUE		\$21.18	\$21.18				
86922	COMPATIBILITY TEST EACH UNIT; ANTIGLOBULIN TECHNIQUE		\$31.00	\$31.00				
86923	COMPATIBILITY TEST EACH UNIT; ELECTRONIC		\$0.00	\$0.00				
86927	FRESH FROZEN PLASMA, THAWING, EACH UNIT		\$31.13	\$31.13				
				•				
86930	FROZEN BLOOD, EACH UNIT; FREEZING (INCLUDES PREPARATION)		\$0.00	\$0.00				
	PRETREATMENT OF SERUM FOR USE IN RBC ANTIBODY							
86976	IDENTIFICATION; BY DILUT		\$0.00	\$0.00				
	PRETREATMENT OF SERUM FOR USE IN RBC ANTIBODY		70100	7 - 1 - 1				
86977	IDENTIFICATION; INCUBATI		\$50.00	\$50.00				
	PRETREATMENT OF SERUM FOR USE IN RBC ANTIBODY		7-0.00	7-0.00			+	+
86978	IDENTIFICATION; BY		\$0.00	\$0.00				
86985	SPLITTING OF BLOOD OR BLOOD PRODUCTS, EACH UNIT		\$0.00	\$0.00	+		1	+
86999	UNLISTED TRANSFUSION MEDICINE PROCEDURE	R	\$0.00	\$0.00	+			+
87426	CORONA VIRUS AG (Rapid test)	. ,	\$26.37	\$26.37				Added Effective 7/1/20
87483	CNS DNA AMP PROBE TYPE 12-25		\$0.00	\$0.00				Added Effective 1/1/2017
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
87634	RSV DNA/RNA AMP PROBE		\$0.00	\$0.00		,		Added Effective 1/1/2018
87662	ZIKA VIRUS DNA/RNA AMP PROBE		\$0.00	\$0.00				Added Effective 1/1/2018
87636	SARSCOV2 & INF A&B AMP PRB		\$142.63	\$142.63				Added Effective 10/6/2020
87637	SARSOV2 & INF A & B & RSV AMP PRB		\$142.63	\$142.63				Added Effective 10/6/2020
87999	UNLISTED MICROBIOLOGY PROCEDURE	R	\$0.01	\$0.01				
	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT			T				
88104	CERVICAL OR VAGIN		\$35.44	\$35.44	\$6.87	\$22.81		
	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT							
88106	CERVICAL OR VAGIN		\$30.28	\$30.28	\$7.47	\$22.81		
	CYTOPATHOLOGY, CONCENTRATION TECHNIQUE, SMEARS AND							
88108	INTERPRETATION (EG.		\$34.15	\$34.15	\$11.08	\$23.07		
	CYTOPATHOLOGY, SELECTIVE CELLULAR ENHANCEMENT							
88112	TECHNIQUE WITH INTERPRET		\$87.65	\$87.65	\$38.80	\$48.26		
	CYTOPATHOLOGY, IN SITU HYBRIDIZATION, URINARY TRACT							
	SPECIMEN WITH MORPHOMETRIC ANALYSIS, 3-5 MOLECULAR							
88120	PROBES, EACH SPECIMEN, MANUAL		\$398.47	\$398.47	\$352.78	\$45.69		
	CYTOPATHOLOGY, IN SITU HYBRIDIZATION, URINARY TRACT							
	SPECIMEN WITH MORPHOMETRIC ANALYSIS, 3-5 MOLECULAR							
	PROBES, EACH SPECIMEN, USING COMPUTER-ASSISTED							
88121	TECHNOLOGY		\$336.46	\$336.46	\$295.81	\$40.65		
88125	CYTOPATHOLOGY, FORENSIC (EG, SPERM)		\$14.95	\$14.95	\$4.64	\$10.31		
	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING				1	1	1	
88141	SYSTEM), REQUIRING		\$18.02	\$18.02				
	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND		i i	i i			1	
88160	INTERPRETATION		\$36.56	\$36.56	\$16.25	\$20.31		
	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; PREPARATION,				1		1	
88161	SCREENING AND		\$36.81	\$36.81	\$16.50	\$20.31		

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	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; EXTENDED							
88162	STUDY INVOLVING OVER		\$45.06	\$45.06	\$13.15	\$31.91		
	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE;							
88172	IMMEDIATE CYTOHISTO		\$44.34	\$44.34	\$19.08	\$25.25		
	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE;							
88173	INTERPRETATION AND		\$97.13	\$97.13	\$44.59	\$52.54		
	IMMEDIATE CYTOHISTOLOGIC STUDY TO DETERMINE ADEQUACY							
	FOR DIAGNOSIS, EACH SEPARATE ADDITIONAL EVALUATION							
	EPISODE, SAME SITE. USE IN CONJUNCTION WITH PROCEDURE							
88177	88172		\$24.33	\$24.33	\$5.64	\$18.69		
88182	FLOW CYTOMETRY, CELL CYCLE OR DNA ANALYSIS		\$62.64	\$62.64	\$30.18	\$32.46		
88184	FLOWCYTOMETRY/TC 1 MARKER		\$34.20	\$34.20				
88185	FLOWCYTOMETRY/TC ADD-ON		\$16.85	\$16.85				
88187	FLOW CYTOMETRY, INTERPRETATION; 2 TO 8 MARKERS		\$52.09	\$52.09				
88188	FLOW CYTOMETRY, INTERPRETATION; 9 TO 15 MARKERS		\$64.95	\$64.95				
88189	FLOW CYTOMETRY, INTERPRETATION; 16 OR MORE MARKERS		\$85.56	\$85.56				
88199	UNLISTED CYTOPATHOLOGY PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	CYTOGENETICS AND MOLECULAR CYTOGENETICS,							
88291	INTERPRETATION AND REPORT		\$23.66	\$23.66				
88299	UNLISTED CYTOGENETIC STUDY	R	\$0.00	\$0.00				†
88300	LEVEL I - SURGICAL PATHOLOGY, GROSS EXAMINATION ONLY	1	\$12.35	\$12.35	\$8.51	\$3.84		
	LEVEL II - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC	†			†	1		†
88302	EXAMINATION		\$34.49	\$34.49	\$29.54	\$4.95		
	LEVEL III - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC	1			1	, ,,,		
88304	EXAMINATION	1	\$43.71	\$43.71	\$35.41	\$8.30		
	LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC	1			+	72.20		
88305	EXAMINATION		\$61.81	\$61.81	\$29.66	\$32.15		

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or pnysiciai	1S		-			
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Droo			Innet Bete	Outnot Boto	Tech.	Prof.	Unit	
Proc	Due and during Department on	DA local	Inpat. Rate	Outpat. Rate				Notes
Code	Procedure Description LEVEL V - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00007	,		¢450.00	Φ450 00	DO4 00	# 00 F 0		
88307	EXAMINATION		\$152.38	\$152.38	\$91.80	\$60.58		
00000	LEVEL VI - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC		#000 F0	#000 F0	# 400.00	0405.00		
88309	EXAMINATION		\$232.59	\$232.59	\$126.69	\$105.90	1	
00044	DECALCIFICATION PROCEDURE (LIST SEPARATELY IN ADDITION TO		040.57	040.57	Φ0.57	040.00		
88311	CODE FOR SUR		\$12.57	\$12.57	\$2.57	\$10.00		
00040	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR		φ74 00	Ø74 00	ΦΕΟ ΟΖ	000.00		
88312	PRIMARY SERVIC		\$71.03	\$71.03	\$50.97	\$20.06		
00040	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR		Φ54.40	054.40	0.40 55	00.00		
88313	PRIMARY SERVIC		\$51.43	\$51.43	\$42.55	\$8.88		
00044	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR		000 47	000 47	# 40.00	040.05		
88314	PRIMARY SERVIC		\$38.47	\$38.47	\$18.83	\$19.65		
00040	DETERMINATIVE HISTOCHEMISTRY OR CYTOCHEMISTRY TO		\$50.40	050.40	000.40	004.05		
88319	IDENTIFY ENZYME		\$52.13	\$52.13	\$30.18	\$21.95		
00004	CONSULTATION AND REPORT ON REFERRED SLIDES PREPARED		#50.00	050.40				
88321	ELSEWHERE		\$52.09	\$53.13				
00000	CONSULTATION AND REPORT ON REFERRED MATERIAL REQUIRING		000 40	000.40	400.00	45400		
88323	PREPARATION OF		\$88.10	\$88.10	\$33.80	\$54.30		
00005	CONSULTATION, COMPREHENSIVE, WITH REVIEW OF RECORDS AND		007.04	007.04				
88325	SPECIMENS, WIT		\$87.31	\$87.31	+			
88329	PATHOLOGY CONSULTATION DURING SURGERY;		\$28.04	\$29.85				
00004	PATHOLOGY CONSULTATION DURING SURGERY; FIRST TISSUE		#05 OC	005.00	000.40	645.00		
88331	BLOCK, WITH FROZEN		\$65.92	\$65.92	\$20.10	\$45.83		
00000	PATHOLOGY CONSULTATION DURING SURGERY; EACH ADDITIONAL		000.07	000.07	05.66	004.15		
88332	TISSUE BLOCK WI		\$30.37	\$30.37	\$5.92	\$24.45		
	PATHOLOGY CONSULTATION DURING SURGERY; CYTOLOGIC					450.40		
88333	EXAMINATION (EG, TOUC		\$65.23	\$65.23	\$15.07	\$50.16		

Physician	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	Э				
The Anest	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PATHOLOGY CONSULTATION DURING SURGERY; CYTOLOGIC							
88334	EXAMINATION (EG, TOUC		\$33.85	\$33.85	\$9.19	\$24.66		
88341	IMMUNOHISTOCHEMISTRYSINGLE ANTIBODY STAIN		\$50.45	\$50.45	\$33.09	\$17.35		Added effective 1/1/2015
	IMMUNOHISTOCHEMISTRY (INCLUDING TISSUE					 		
88342	IMMUNOPEROXIDASE), EACH ANTIBOD		\$71.97	\$71.97	\$40.25	\$31.71		
88344	IMMUNOHISTOCHEMISTRY MULTIPLEX ANTIBODY STAIN		\$87.48	\$87.48	\$55.60	\$31.88		Added effective 1/1/2015
00040	IMAMUNOS LIODECCENT CTUDY, EACH ANTIDODY, DIDECT METLIOD		ΦEE 40	ΦEE 40	#00.00	60470		
88346	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; DIRECT METHOD		\$55.43	\$55.43	\$20.63	\$34.79		
88348 88350	ELECTRON MICROSCOPY; DIAGNOSTIC		\$182.50	\$182.50	\$116.88	\$65.62 \$22.80		Add - d Effective 1/1/2010
88355	EACH ADDITIONAL SINGLE ANTIBODY STRAIN PROCEDURE MORPHOMETRIC ANALYSIS; SKELETAL MUSCLE		\$54.37 \$144.26	\$54.37 \$144.26	\$31.56 \$67.33	\$76.93		Added Effective 1/1/2016
88356	MORPHOMETRIC ANALYSIS; SKELETAL MUSCLE MORPHOMETRIC ANALYSIS; NERVE		\$195.20	\$195.20	\$70.94	\$124.26		
88358	MORPHOMETRIC ANALYSIS; NERVE		\$133.68	\$133.68	\$18.28	\$115.41		
00330	MORPHOMETRIC ANALYSIS, TUMOR IMMUNOHISTOCHEMISTRY (EG,		φ133.00	φ133.00	Φ10.20	φ115.41		
88360	HER-2/ NEU, EST		\$78.85	\$78.85	\$32.67	\$46.18		
00300	MORPHOMETRIC ANALYSIS, TUMOR IMMUNOHISTOCHEMISTRY (EG,		φ10.03	Ψ70.03	ψ32.07	ψ40.10		
88361	HER-2/ NEU, EST		\$99.02	\$99.06	\$58.34	\$40.67		
88362	NERVE TEASING PREPARATIONS		\$131.79	\$131.79	\$42.55	\$89.24		
00002	EXAMINATION AND SELECTION OF RETRIEVED ARCHIVAL TISSUE(S)		Ψ101.70	ψ101.70	Ψ+2.00	Ψ00.2-1		
88363	FOR MOLECULAR ANAYLSIS		\$14.84	\$33.23				
88364	IN SITU HYBRIDIZATION (FISH); ADDITIONAL SINGLE PROBE STAIN		\$72.34	\$72.34	\$50.69	\$21.65		Added effective 1/1/2015
88365	IN SITU HYBRIDIZATION (EG, FISH), EACH PROBE		\$64.41	\$64.41	\$26.57	\$37.84		
88366	IN SITY HYBRIDIZATION (FISH); MULTIPLEX PROBE STAIN		\$112.81	\$112.81	\$62.59	\$50.22		Added effective 1/1/2015
	MORPHOMETRIC ANALYSIS, IN SITU HYBRIDIZATION, EACH PROBE;	1			1	<u> </u>	1	
88367	USING COMPUTER-ASSIST TECH		\$223.71	\$223.71	\$170.60	\$53.11		
	MORPHOMETRIC ANALYSIS, IN SITU HYBRIDIZATION, EACH PROBE;					1		
88368	MANUAL		\$133.95	\$133.95	\$75.55	\$58.40		

Physician	Fee Schedule 2020							
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range						+
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MORPHOMETRIC ANALYSIS, IN SITU HIBRIDIZATION; ADDITIONAL		(1 3.3.1.3)	(4.01.1.0.01.1.0)				
88369	SINGLE PROBE STAIN		\$55.26	\$55.26	\$35.16	\$20.10		Added effective 1/1/2015
	OPTICAL ENDOMICROSCOPIC IMAGE(S) INTERPRETATION AND							
88375	REPORT, REAL-TIME OR REFERRED, EACH ENDOSCOPIC SESSION		\$39.56	\$39.56				Added Effective 1/1/2016
	MORPHOMETRIC ANALYSIS, IN SITU HIBRIDIZATION; MULTIPLEX							
88377	PROBE STAIN		\$159.99	\$159.99	\$107.35	\$52.64		Added effective 1/1/2015
88380	MICRODISSECTION LASER		\$143.23	\$143.23	\$94.35	\$64.98		
88381	MICRODISSECTION MANUAL		\$125.85	\$125.85	\$96.43	\$44.21		
	MACROSCOPIC EXAMINATION, DISSECTION, AND PREPARATION OF							
	TISSUE FOR NON-MICROSCOPIC ANALYTICAL STUDIES; EACH							
88387	TISSUE PREPARATION		\$29.69	\$29.69	\$5.55	\$24.14		
88388	TISS EX MOLECUL STUDY ADD-ON		\$24.52	\$24.52	\$7.12	\$19.58		
88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	CAFFEINE HALOTHANE CONTRACTURE TEST (CHCT) FOR							
89049	MALIGNANT HYPERTHERMIA		\$49.98	\$133.93				
	SPUTUM, OBTAINING SPECIMEN, AEROSOL INDUCED TECHNIQUE							
89220	(SEPARATE PROCED		\$11.99	\$11.99				Rate updated 1/1/2018
89230	SWEAT COLLECTION BY IONTOPHORESIS		\$2.59	\$2.59				Rate updated 1/1/2018
89240	UNLISTED MISCELLANEOUS PATHOLOGY TEST	R	\$0.00	\$0.00				
	SEMEN ANALYSIS; MOTILITY AND COUNT (NOT INCLUDING HUHNER							
89310	TEST)		\$12.17	\$12.17				
	SEMEN ANALYSIS; COMPLETE (VOLUME, COUNT, MOTILITY, AND			1.				
89320	DIFFERENTIAL)		\$16.96	\$16.96				
89325	SPERM ANTIBODIES		\$15.10	\$15.10				
90384	RH IG FULL-DOSE IM					\$3.30		

Physician	Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	<u>,</u>				
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	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RHO(D) IMMUNE GLOBULIN (RHIG), HUMAN, MINI-DOSE, FOR		<u> </u>		•	•		
90385	INTRAMUSCULAR USE					\$3.30		
90386	RHO(D) IMMUNE GLOBULIN (RHIGIV), HUMAN, FOR INTRAVENOUS USE					\$3.30		
90460	IM ADMIN 1ST/ONLY COMPONENT		\$15.60	\$15.60				Rate updated 1/1/2018
90461	IM ADMIN EACH ADDL COMPONENT		\$9.80	\$9.80				Rate updated 1/1/2018
90471	IMMUNIZATION ADMIN		\$15.60	\$15.60				Rate updated 1/1/2018
90472	IMMUNIZATION ADMIN EACH ADD		\$9.80	\$9.80				Rate updated 1/1/2018
90473	IMMUNE ADMIN ORAL/NASAL		\$15.60	\$15.60				Rate updated 1/1/2018
90474	IMMUNE ADMIN ORAL/NASAL ADDL		\$9.80	\$9.80				Rate updated 1/1/2018
90619	MENACWY-TT VACCINE IM		\$0.00	\$0.00				Added Effective 01/01/2020
90620	MENB PR W/OMV VACCINE		\$122.95	\$122.95				Added Effective 2/1/2015
90621	MENB RLP VACCINE		\$95.75	\$95.75				Added Effective 2/1/2015
90630	VACCINE FOR INFLUENZA FOR INJECTION INTO SKIN		\$0.00	\$28.60				Updated Effective 01/01/2019
90632	HEP A VACCINE ADULT IM			\$51.55		\$3.30		
90633	HEP A VACC PED/ADOL DOSAGE-2 DOSE			\$29.55		\$3.30		
90634	HEP A VACC PED/ADOL 3 DOSE			\$29.55		\$3.30		
90636	HEP A/HEP B VACC ADULT IM			\$92.50		\$3.30		
90644	MENINGOCCL HIB VAC 4 DOSE IM			\$115.18				
	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3							
90647	DOSE SCHEDU			\$22.77		\$3.30		
	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-T CONJUGATE (4							
90648	DOSE SCHEDULE			\$26.21		\$3.30		
	HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18							
90649	(QUADRIVALENT			\$141.38		\$3.30		

Physician	Fee Schedule 2020							
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	ed on the lab fee schedule that begin with a P or Q are currently non-covere							
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00050	VACCINE FOR HUMAN PAPILLOMA VIRUS (3 DOSE SCHEDULE)			0400.75				A 11 - 1 - 15 - 15 4/4/0045
90650	INJECTION INTO MUSCLE			\$128.75				Added effective 1/1/2015
00054	VACCINE FOR HUMAN PAPILLOMA VIRUS (3 DOSE SCHEDULE)			4007.40				
90651	INJECTION INTO MUSCLE			\$227.18				Updated Effective 01/01/2020
90653	FLU VACCINE, ADJUVANTED IM, 65 AND OLDER ONLY			\$46.20		40.00		Added Effective 7/1/18
90654	FLU VACCINE NO PRESERV ID			\$18.92		\$3.30		
90655	FLU VAC NO PRSV 3 VAL 6-35 M			\$17.24		\$3.30		
90656	FLU VACCINE NO PRESERV 3 & >			\$12.40		\$3.30		
90657	FLU VACCINE, 3 YRS, IM			\$6.02		\$3.30		
90658	FLU VACCINE 3 YRS & > IM			\$14.35		\$3.30		
90660	FLU VACCINE, NASAL			\$21.70		\$3.30		
90661	FLU VACC CELL CULT PRSV FREE			\$20.66		\$3.30		
90662	FLU VACC PRSV FREE INC ANTIG			\$31.82		\$3.30		
90670	PNEUMOCOCCAL VACC 13 VAL IM			\$145.11		\$3.30		
90672	FLU VACCINE 4 VALENT NASAL			\$24.60		\$3.30		
90673	FLU VACC RIV3 NO PRESERV			\$36.48				
90674	CCIIV4 VAC NO PRSV 0.5 ML IM		\$0.00	\$24.05				Updated Effective 09/01/2017
90680	ROTOVIRUS VACC 3 DOSE ORAL			\$75.20		\$3.30		
90681	ROTAVIRUS VACC 2 DOSE ORAL			\$106.57		\$3.30		
90682	RIV4 VACC RECOMBINANT DNA IM			\$46.31				Added Effective 1/1/2018
90685	FLU VAC NO PRSV 4 VAL 6-35 M			\$23.23		\$3.30		
90686	FLU VAC NO PRSV 4 VAL 3 YRS+			\$19.41		\$3.30		
90687	FLU VACC 4 6-35 MONTHS IM			\$14.35				Added Effective 7/1/2014
90688	FLU VACC 4 VAL 3 YRS PLUS IM			\$15.90		\$3.30		
90689	VACC IIV4 NO PRSRV 0.25ML IM		\$0.00	\$22.79				Updated Effective 1/1/2019
90694	VACC AIIV4 NO PRSRV 0.5ML IM		\$0.00	\$0.00				Added Effective 01/01/2020

	Fee Schedule 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomory obor	go for the convice			+	+	
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Storriary Criai		;		+	+	
	e lab fee schedule for covered codes not listed below in the 80000-8924:	9 rango						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered		ne					
Codes liste		loi priysicia	113					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
90696	DTAP-IPV VACC 4-6 YR IM	IAIIIG	(i denity)	\$48.00	Comp.	\$3.30	Value	Notes
90697	VACCINE DTaP-IPV-Hib-HepB FOR INTRAMUSCULAR USE		\$0.00	\$0.00		Ψ0.00		Added Effective 1/1/2016
90698	DTAP-HIB-IP VACCINE, IM		ψ0.00	\$70.72		\$3.30		/ tadea Elicotive 1/1/2010
90700	DTAP VACCINE, < 7 YRS, IM			\$23.47		\$3.30		
90702	DT VACCINE < 7 YRS IM			\$23.47		\$3.30		
90707	MMR VACCINE, SC			\$56.14		\$3.30		
90710	MMRV VACCINE, SC			\$157.64		\$3.30		
90713	POLIOVIRUS, IPV, SC/IM			\$27.44		\$3.30		
90714	TD VACCINE NO PRSRV 7/> IM			\$19.30		\$3.30		
90715	TDAP VACCINE 7 YRS/> IM			\$31.84		\$3.30		
90716	CHICKEN POX VACCINE SC			\$94.14		\$3.30		
90723	DTAP-HEP B-IPV VACCINE, IM			\$70.72		\$3.30		
				, -		1		
90732	PNEUMOCOCCAL VACCINE 23 VAL IM			\$105.19		\$3.30		Updated Effective 01/01/2020
90733	MENINGOCOCCAL VACCINE, SC			\$106.49		\$3.30		
90734	MENINGOCOCCAL VACCINE IM			\$117.41		\$3.30		
90736	ZOSTER VACC, SC			\$165.69		\$3.30		
90739	HEPB VACC 2 DOSE ADULT IM			\$117.99		\$3.30		Added Effective 1/1/2018
90740	HEPB VACC ILL PAT 3 DOSE IM			\$119.42		\$3.30		
90743	HEP B VACC, ADOL, 2 DOSE, IM			\$24.22		\$3.30		
90744	HEP B VACC PED/ADOL 3 DOSE IM			\$24.22		\$3.30		
90746	HEP B VACC ADULT 3 DOSE IM			\$59.71		\$3.30		
90747	HEP B VACC ILL PAT 4 DOSE IM			\$119.42		\$3.30		
90748	HEP B/HIB VACCINE IM			\$43.56		\$3.30		
90750	HZV VACC RECOMBINANT IM NJX			\$280.00				Added Effective 1/1/2018
90756	CCIIV4 VACC ABX IM			\$22.79				Added Effective 1/1/2018
90785	INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADD		\$10.48	\$10.48				
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION		\$94.84	\$97.80				

Physician	Fee Schedule 2020							
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Jonal y Gridi	ge for the service					
	se lab fee schedule for covered codes not listed below in the 80000-89249	9 range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MED SERV		\$102.49	\$105.30				
90832	PSYCHOTHERAPY, 30 MINUTES WITH PT AND/OR FAM MEM		\$46.94	\$47.41				
90833	PSYCHOTHERAPY, 30 MIN WITH PT AND/OR FAM MEM W/E&M		\$48.11	\$48.35				
90834	PSYCHOTHERAPY, 45 MIN WITH PAT AND/OR FAMILY MEMBER		\$62.66	\$62.90				
90836	PSYCHOTHERAPY, 45 MIN WITH PAT AND/OR FAM W/E&M		\$60.71	\$61.17				
	,							
90837	PSYCHOTHERAPY, 60 MIN WITH PATIENT AND/OR FAMILY		\$93.67	\$94.13				
90838	PSYCHOTHERAPY, 60 MIN WITH PAT AND/OR FAM MEM W/E&M		\$80.26	\$80.73				
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MIN		\$107.36	\$108.14				Rate updated 1/1/2016
90840	EACH ADDITIONAL 30 MIN		\$51.63	\$51.38				Added Effective 1/1/2016
00010	Z/IGH7/BBH10HV/L2 00 HIIIV		ψο 1.00	ψο 1.00				*From 1/1/14 to 6/27/14 use
								54.35 for inpatient and
								outpatient rates; For 6/28/14
								on, use rates listed in
90845	PSYCHOANALYSIS		\$67.22	\$67.69				columns;
000.0			V 0.1.==	401.00				, and the state of
								*From 1/1/14 to 6/27/14 use
								56.93 for inpatient and 54.04
								for outpatient For 6/28/14 on,
90846	FAMILY PSYCHOTHERAPY W/O PATIENT		\$75.73	\$76.19				use rates listed in columns;
			+,	7, 55				and the second of the second o
								*From 1/1/14 to 6/27/14 use
								67.26 for inpatient and 64.82
	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH							for outpatient For 6/28/14 on,
90847	PATIENT PRESENT)		\$78.18	\$78.65				use rates listed in columns;
	p	_	+	+				

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomori obor	as for the semiler	<u> </u>				+
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	tomary char	ge for the service	*				
	se lab fee schedule for covered codes not listed below in the 80000-89249	rango						+
	ted on the lab fee schedule that begin with a P or Q are currently non-covered							
Codes list		T priyaiciai	15					
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
-	i recodure Decemption	71110	(i domey)	(Herm demity)			Tuius	110100
								*From 1/1/14 to 6/27/14 use
								20.52 for inpatient and 24.08
								for outpatient For 6/28/14 on,
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY		\$22.10	\$24.44				use rates listed in columns;
								*From 1/1/14 to 6/27/14 use
								17.85 for inpatient and 17.85
	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY							for outpatient For 6/28/14 on,
90853	GROUP)		\$18.82	\$19.29				use rates listed in columns;
	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND							
90865	THERAPEUTIC PURPOSES (EG		\$96.43	\$96.43				
								Outpatient only Limit one per
90867	Therapeutic repetitive transcranial magnetic stimulation		N/A	\$329.41				365 days Effective 8/13/2019
								Outpatient only. Limit 36 visits
				* * * * * * * * * * * * * * * * * * *				in a 7 calendar week period.
90868	subsequent delivery and management per session		N/A	\$167.91				EFF: 8/13/2019
00060	TDANISCDANIAL MACNITIC STIMULATION TOTATMENT		\$434.21	¢424.24				Undeted Effective 09/12/2010
90869	TRANSCRANIAL MAGNETIC STIMULATION TREATMENT ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY		⊅434.∠1	\$434.21				Updated Effective 08/13/2019
90870	MONITORING)		\$71.86	\$71.86				
90070	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING		φ11.00	φ/ 1.00	+			+
90875	BIOFEEDBACK TRAIN		\$31.67	\$31.67				
90013	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING		ψ31.07	ψ51.07	+	+		+
90876	BIOFEEDBACK TRAIN		\$49.28	\$49.28				
90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE	R	\$21.53	\$21.53				+
90899	JUNLISTED PSTCHIATRIC SERVICE OR PROCEDURE	ĮΚ	ֆ∠ 1.ექ	ֆ∠1.ექ			1	

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	:				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
90901	BIOFEEDBACK TRAINING BY ANY MODALITY		\$19.78	\$19.78				
	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR							
90911	URETHRAL SPHINCTE		\$99.96	\$99.96				
90912	BFB TRAINING 1ST 15 MIN		\$35.56	\$61.76				Added Effective 01/01/2020
90913	BFB TRAINING EA ADDL 15 MIN		\$19.75	\$25.46				Added Effective 01/01/2020
30313	DI DI INAMINO LA ADDE 13 MIN		ψ13.73	Ψ 2 3. 1 0				Added Effective 01/01/2020
90935	HEMODIALYSIS PROCEDURE WITH SINGLE PHYSICIAN EVALUATION		\$78.19	\$78.19				
	HEMODIALYSIS PROCEDURE REQUIRING REPEATED EVALUATION(S)							
90937	WITH OR WITHOU		\$137.37	\$137.37				
	HEMODIALYSIS ACCESS FLOW STUDY TO DETERMINE BLOOD FLOW							
90940	IN GRAFTS AND		\$55.62	\$55.62	\$32.72	\$22.90		
	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG,							
90945	PERITONEAL DIALYSIS,		\$73.57	\$73.57				
	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG,							
90947	PERITONEAL DIALYSIS,		\$122.84	\$122.84				
90951	ESRD RELATED SERVICES MONTHLY FOR PATIENTS < 2		\$781.51	\$781.51				
90952	ESRD SERV 2-3 VSTS P MO <2		\$0.00	\$0.00				
90953	ESRD SERV 1 VISIT P MO <2		\$0.00	\$0.00				
90954	ESRD RELATED SERVICES MONTLY FOR PATIENTS 2-11		\$653.63	\$653.63				
90955	ESRD RELATED SERVICES MONTLY WITH 2-3		\$361.08	\$361.08				
90956	ESRD RELATED SERVICES MONTLY WITH 1		\$239.73	\$239.73				
90957	ESRD RELATED SERVICES MONTHLY FOR PATIENTS 12-19		\$522.49	\$522.49				
90958	ESRD RELATED SERVICES MONTLY WITH 2-3		\$346.84	\$346.84		1	1	
90959	ESRD RELATED SERVICES MONTLY WITH 1		\$221.93	\$221.93				
90960	ESRD RELATED SERVICES MONTHLY FOR PATIENTS >20		\$227.27	\$227.27		1		

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	ee Schedule 2020							
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	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ıs					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
90962	ESRD RELATED SERVICES MONTLY WITH 1		\$129.06	\$129.06				
90963	ESRD RELATED SERVICES FOR HOME DIALYSIS PATIENTS<2		\$417.16	\$417.16				
90964	ESRD RELATED SERVICES FOR HOME DIALYSIS PTS 2-11		\$363.75	\$363.75				
90965	ESRD RELATED SERVICES FOR HOME DIALYSIS PTS 12-19		\$346.55	\$346.55				
90966	ESRD RELATED SERVICES FOR HOME DIALYSIS PTS >20		\$179.21	\$179.21				
90967	ESRD RELATED SERVICES FOR DIALYSIS < FULL MONTH		\$15.43	\$15.43				
90968	ESRD RELATED SERVICES FOR DIALYSIS < MONTH, AGE 2-11		\$12.46	\$12.46				
90969	ESRD RELATED SERVICES FOR DIALYSIS < MONTH, AGE 12-19		\$12.16	\$12.16				
90970	ESRD RELATED SERVICES FOR DIALYSIS <month,age>20</month,age>		\$6.23	\$6.23				
	DIALYSIS TRAINING, PATIENT, INCLUDING HELPER WHERE							
90989	APPLICABLE, ANY MOD		\$394.96	\$394.96				
90997	HEMOPERFUSION (EG, WITH ACTIVATED CHARCOAL OR RESIN)		\$120.91	\$120.91				
90999	,	R	\$0.00	\$0.00				
	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS		•					
91010	AND/ OR		\$113.70	\$113.70	\$22.38	\$91.32		
	ESOPHAGEAL MOTILITY STUDY WITH INTERPRETATION AND		1	1	1			
	REPORT; WITH STIMULATION OR PERFUSION DURING 2-							
	DIMINSIONAL DATA STUDY. LIST SEPERATELY IN ADDITION TO							
91013	PRIMARY PROCEDURE.		\$20.18	\$20.18	\$11.57	\$8.60		
91020	GASTRIC MOTILITY (MANOMETRIC) STUDIES		\$126.89	\$126.89	\$21.04	\$105.85		
91022	DUODENAL MOTILITY (MANOMETRIC) STUDY		\$158.62	\$158.62	\$101.07	\$57.55		
3.022			Ţ 100.0 <u>L</u>	7.00.02	Ψ.σσ.	\$01.00		
91030	ESOPHAGUS, ACID PERFUSION (BERNSTEIN) TEST FOR ESOPHAGITIS		\$51.45	\$51.45	\$6.12	\$45.33		
	ESOPHAGUS, GASTROESOPHAGEAL REFLUX TEST; WITH NASAL		+	751110	70	+ .0.00		+
91034	CATHETER PH		\$165.59	\$165.59	\$126.58	\$39.01		
31001	ESOPHAGUS, GASTROESOPHAGEAL REFLUX TEST; WITH MUCOSAL		ψ.00.00	ψ.00.00	ψ120.00	Ψ00.01		+
91035	ATTACHED TELEMET		\$325.86	\$325.86	\$262.84	\$63.02		
5 1000	ATTACHED TELEVICI	<u> </u>	Ψ020.00	Ψ020.00	ΨΖ0Ζ.04	ψ00.02	<u> </u>	<u> </u>

Physician	n Fee Schedule 2020							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv cha	rae for the service)				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
		T						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ESOPHAGEAL FUNCTION TEST, GASTROESOPHAGEAL REFLUX TEST		(* 3.5.1.1. 5)	(10111111111111111111111111111111111111				
91037	WITH NASAL CATH		\$106.65	\$106.65	\$67.64	\$39.01		
	ESOPHAGEAL FUNCTION TEST, GASTROESOPHAGEAL REFLUX TEST							
91038	WITH NASAL CATH		\$92.39	\$92.39	\$48.25	\$44.14		
91040	ESOPHAGEAL BALLOON DISTENSION PROVOCATION STUDY		\$315.88	\$315.88	\$276.87	\$39.01		
	BREATH HYDROGEN TEST (EG, FOR DETECTION OF LACTASE							
91065	DEFICIENCY, FRUCTOS		\$36.68	\$36.68	\$9.61	\$27.08		
	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE							
91110	ENDOSCOPY),		\$656.41	\$656.41	\$517.76	\$138.65		
91111	ESOPHAGEAL CAPSULE ENDOSCOPY		\$584.25	\$584.25	\$620.70	\$46.88		
	RECTAL SENSATION, TONE, AND COMPLIANCE TEST (IE, RESPONSE							
91120	TO GRADED BA		\$311.80	\$311.80	\$272.53	\$39.27		
91122	ANORECTAL MANOMETRY		\$103.69	\$103.69	\$20.16	\$83.53		
91132	ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS;		\$9.63	\$9.63	\$3.35	\$6.28		
	ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS; WITH							
91133	PROVOCATIVE TEST		\$9.63	\$9.63	\$3.35	\$6.28		
91200	MEASURING THE STIFFNESS IN THE LIVER VIA ELASTOGRAPHY		\$27.22	\$27.22	\$15.50	\$11.72		Added effective 1/1/2015
91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND							
92002	EVALUATION WITH		\$51.67	\$51.67				
	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND							
92004	EVALUATION WITH		\$94.51	\$94.51				
	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND							
92012	EVALUATION, WITH		\$46.92	\$46.92				
	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND							
92014	EVALUATION, WITH		\$69.80	\$69.80				
92015	DETERMINATION OF REFRACTIVE STATE		\$20.22	\$20.22				

Physiciar	Fee Schedule 2020								
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)					
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.								
	se lab fee schedule for covered codes not listed below in the 80000-89249								
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns						
							Base		
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit		
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes	
	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER								
92018	GENERAL ANESTHESIA,		\$57.64	\$57.64					
	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER								
92019	GENERAL ANESTHESIA,		\$45.47	\$51.78					
92020	GONIOSCOPY (SEPARATE PROCEDURE)		\$14.99	\$18.88					
92025	CORNEAL TOPOGRAPHY		\$21.74	\$21.74	\$8.37	\$13.37			
	SENSORIMOTOR EXAMINATION WITH MULTIPLE MEASUREMENTS OF								
92060	OCULAR DEVIATIO		\$41.60	\$41.60	\$13.97	\$27.62			
	ORTHOPTIC AND/OR PLEOPTIC TRAINING, WITH CONTINUING		400 74						
92065	MEDICAL DIRECTION		\$32.71	\$32.71	\$18.82	\$13.89			
00074	FITTING OF CONTACT LENS FOR TREATMENT OF OCULAR SURFACE		407.00	400.40					
92071	DISEASE.		\$27.03	\$30.13					
00070	FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS,		ф 7 0.07	#00.40					
92072	INITIAL FITTING. VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH		\$78.07	\$96.16					
00004	INTERPRETATION		COC 45	фос <i>4</i> Е	¢00.44	\$14.31			
92081	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH		\$36.45	\$36.45	\$22.14	\$14.51			
02002	INTERPRETATION		¢40.64	\$48.64	\$30.81	\$17.82			
92082	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH		\$48.64	\$40.0 4	φ3U.01	\$17.02			
92083	INTERPRETATION		\$55.27	\$55.27	\$35.15	\$20.12			
92003	SERIAL TONOMETRY (SEPARATE PROCEDURE) WITH MULTIPLE		φ33.21	φ33.21	φου. 10	φ20.12		+	
92100	MEASUREMENTS OF		\$30.59	\$33.94					
92132	DIAGNOSTIC IMAGING OF EYES	+	\$31.75	\$31.75	\$13.35	\$18.40	+		——
52 15Z	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING,	+	Ψ01.70	Ψ01.70	ψ10.00	ψ10.40	+		
	POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT,								
92133	UNILATERAL OR BILATERAL, OPTIC NERVE		\$38.87	\$38.87	\$13.35	\$25.52			
32 133	PONIENTEINE ON BIENTEINE, OF HO NEIVE		ψυυ.υ1	ψ50.07	ψ10.00	ψΖΟ.υΖ			

Physician	Fee Schedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1			1			
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING;							
92134	RETINA		\$38.87	\$38.87	\$13.35	\$25.52		
	OPHTHALMIC BIOMETRY BY PARTIAL COHERENCE							
92136	INTERFEROMETRY WITH INTRAOCUL		\$56.53	\$21.47	\$35.06	\$21.47		
	PROVOCATIVE TESTS FOR GLAUCOMA, WITH INTERPRETATION AND							
92140	REPORT, WITHOU		\$18.94	\$22.96				
92145	CORNEAL HYSTERESIS DETERMINATION		\$11.98	\$11.98	\$4.89	\$7.09		Added effective 1/1/2015
92201	OPSCPY EXTND RTA DRAW UNI/BI		\$18.14	\$19.70				Added Effective 01/01/2020
92202	OPSCPY EXTND ON/MAC DRAW		\$11.73	\$12.51				Added Effective 01/01/2020
92225	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACH		\$23.54	\$29.58				
92226	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACH		\$20.52	\$25.89				
92227	REMOTE IMAGING FOR DETECTION OF RETINAL DISEASE WITH ANAYLSIS AND REPORT UNDER PHYSICIAN SUPERVISION, UNILATERAL OR BILATERAL		\$10.09	\$10.09				
92228	REMOTE IMAGING FOR MONITORING AND MANAGEMENT OF ACTIVE RETINAL DISEASE WITH PHYSICIAN REVIEW, INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL		\$26.11	\$26.11	\$10.98	\$15.13		
92230	FLUORESCEIN ANGIOSCOPY WITH INTERPRETATION AND REPORT		\$27.83	\$37.09				
92235	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETAT		\$68.33	\$68.33	\$28.01	\$40.32		
92240	INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH		\$157.53	\$157.53	\$120.61	\$36.92		Rate updated 1/1/2018

Physician	Fee Schedule 2020							
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
92242	FLUORESCEIN ICG ANGIOGRAPHY		\$169.78	\$169.78	\$125.52	\$44.26		Added Effective 1/1/2017
92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT		\$49.01	\$49.01	\$31.58	\$17.44		
92260	OPHTHALMODYNAMOMETRY		\$22.64	\$29.88				
	NEEDLE OCULOELECTROMYOGRAPHY, ONE OR MORE							
92265	EXTRAOCULAR MUSCLES, ONE OR		\$32.03	\$32.03	\$6.39	\$25.65		
92270	ELECTRO-OCULOGRAPHY WITH INTERPRETATION AND REPORT		\$42.95	\$42.95	\$8.53	\$34.42		
	COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALOSCOPE OR							
92283	EQUIVALENT		\$15.65	\$15.65	\$3.22	\$12.43		
	DARK ADAPTATION EXAMINATION WITH INTERPRETATION AND							
92284	REPORT		\$23.41	\$23.41	\$4.80	\$18.61		
	EXTERNAL OCULAR PHOTOGRAPHY WITH INTERPRETATION AND							
92285	REPORT FOR		\$13.89	\$13.89	\$2.95	\$10.94		
	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH							
92286	INTERPRETATION AND REPORT; W		\$53.79	\$53.79	\$10.95	\$42.84		
	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH							
92287	INTERPRETATION AND REPORT; W		\$104.82	\$104.82	\$67.85	\$36.97		Rate updated 1/1/2018
00040	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF		000 74	400.74				
92310	AND FITTING OF		\$69.74	\$69.74				
00044	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF		044 40	450.50				
92311	AND FITTING OF		\$44.49	\$56.56	-			
00040	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF		ΦE2 26	¢60.00				
92312	AND FITTING OF PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF		\$53.26	\$68.82	+	1		+
02212	AND FITTING OF		\$39.53	\$51.33				
92313 92340	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; MONOFOCAL	-	\$33.00	\$33.00	-			
92340	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; MONOFOCAL FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; BIFOCAL		\$38.00	\$38.00	1			
9234 I	ITITING OF SPECTACLES, EXCEPT FOR APPIANIA, DIFUCAL			ტ ან.სს	_			

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	ns T				-	
							Base	
D			Innat Data	Outract Data	Table	Duef		
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00050	FITTING OF SPECTACLE PROSTUESIS FOR ARHAMA, MONOFOCAL		¢22.00	¢22.00				
92352	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MONOFOCAL		\$33.00	\$33.00				
00050	FITTING OF ODECTACLE DECCTUEOUS FOR ARUMAIAN MULTIFOCAL		#20.00	#20.00				
92353	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MULTIFOCAL		\$39.00 \$29.00	\$39.00 \$29.00				
92370	REPAIR AND REFITTING SPECTACLES; EXCEPT FOR APHAKIA		\$29.00	\$29.00				
00074	REPAIR AND REFITTING SPECTACLES; SPECTACLE PROSTHESIS		00.40	040.04				
92371	FOR APHAKIA		\$8.40	\$16.31	#0.00	#0.00	-	
92499	UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
00500	OTOLABYALOOLOOLO SVANINATION LINDER OFNERAL ANEOTUEOLA		477.07	477.07				
92502	OTOLARYNGOLOGIC EXAMINATION UNDER GENERAL ANESTHESIA		\$77.27	\$77.27				
00504	DINIONIII AD MIODOGODY (OFDADATE DIA OMOGTIO DEGOFERIDE)		***	0.40.74				
92504	BINOCULAR MICROSCOPY (SEPARATE DIAGNOSTIC PROCEDURE)		\$9.25	\$12.74				
00500	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION,		000 40	0.40.40				
92506	AND/ OR AUDITORY		\$33.42	\$40.40				
	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/		400.44					
92507	OR AUDITORY		\$20.41	\$24.84				
	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/							
92508	OR AUDITORY		\$10.53	\$12.94				
	NASOPHARYNGOSCOPY WITH ENDOSCOPE (SEPARATE		***					
92511	PROCEDURE)		\$38.23	\$49.63				
92512	NASAL FUNCTION STUDIES (EG, RHINOMANOMETRY)		\$23.66	\$29.96				
00515								
92516	FACIAL NERVE FUNCTION STUDIES (EG, ELECTRONEURONOGRAPHY)		\$18.82	\$24.05				
	LARYNGEAL FUNCTION STUDIES (IE, AERODYNAMIC TESTING AND							
92520	ACOUSTIC TESTI		\$30.62	\$37.73				
92521	EVALUATION OF SPEECH FLUENCY		\$89.06	\$89.06				
92522	EVALUATE SPEECH PRODUCTION		\$72.62	\$72.62				

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
92523	SPEECH SOUND LANG COMPREHEN		\$150.38	\$150.38				
92524	BEHAVRAL QUALIT ANALYS VOICE		\$75.32	\$75.32				
92532	POSITIONAL NYSTAGMUS TEST		\$5.83	\$5.83				
	CALORIC VESTIBULAR TEST, EACH IRRIGATION (BINAURAL,							
92533	BITHERMAL STIMULAT		\$6.69	\$6.69				
92534	OPTOKINETIC NYSTAGMUS TEST		\$2.76	\$2.76				
92537	CALORIC VESTIBULAR TEST WITH RECORDING		\$31.70	\$31.70	\$6.19	\$25.52		Added Effective 1/1/2016
	MONOTHEMAL ONE IRRIGATION IN EACH EAR FOR A TOTAL OF TWO							
92538	IRRIGATIONS		\$16.10	\$16.10	\$3.34	\$12.76		Added Effective 1/1/2016
92540	BASIC VESTIBULAR EVALUATION		\$80.25	\$80.25	\$19.29	\$67.94		
	SPONTANEOUS NYSTAGMUS TEST, INCLUDING GAZE AND FIXATION							
92541	NYSTAGMUS, WIT		\$31.41	\$31.41	\$6.39	\$25.02		
	POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH							
92542	RECORDING		\$27.75	\$27.75	\$7.43	\$20.31		
	OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL, FOVEAL OR							
92544	PERIPHERAL		\$21.45	\$21.45	\$5.85	\$15.60		
92545	OSCILLATING TRACKING TEST, WITH RECORDING		\$18.45	\$18.45	\$5.85	\$12.60		
92546	SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING		\$23.94	\$23.94	\$6.65	\$17.29		
	USE OF VERTICAL ELECTRODES (LIST SEPARATELY IN ADDITION TO							
92547	CODE FOR PR		\$15.67	\$15.67				
92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY		\$66.72	\$66.72	\$10.88	\$27.85		
92549	CDP-SOT 6 COND W/I&R MCT&ADT		\$49.50	\$49.50	\$13.47	\$36.03		Added Effective 01/01/2020
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS	1	\$15.61	\$15.61	+	7	†	
92551	SCREENING TEST, PURE TONE, AIR ONLY		\$12.24	\$12.24			†	
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY		\$12.24	\$12.24		1	1	
92553	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE		\$18.60	\$18.60		1	1	
92555	SPEECH AUDIOMETRY THRESHOLD;		\$10.63	\$10.63		+		

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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
92556	SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION		\$15.94	\$15.94				
	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND							
92557	SPEECH RECOGNITION (\$33.50	\$33.50				
	EVOKED OTOACOUSTIC EMMISSIONS, SCREENING(QUALITATIVE							
	MEASUREMENT OF DISTORTION PRODUCT OR TRANSIENT EVOKED							
92558	OTOACOUSTIC EMMISSIONS) AUTO. ANALYSIS		\$6.98	\$7.77				Rate updated 1/1/2018
92559	AUDIOMETRIC TESTING OF GROUPS		\$22.26	\$22.26				
92560	BEKESY AUDIOMETRY; SCREENING		\$14.21	\$14.21				
92561	BEKESY AUDIOMETRY; DIAGNOSTIC		\$19.94	\$19.94				
92562	LOUDNESS BALANCE TEST, ALTERNATE BINAURAL OR MONAURAL		\$11.43	\$11.43				
92563	TONE DECAY TEST		\$10.63	\$10.63				
92564	SHORT INCREMENT SENSITIVITY INDEX (SISI)		\$13.28	\$13.28				
92565	STENGER TEST, PURE TONE		\$6.07	\$11.16				
92567	TYMPANOMETRY (IMPEDANCE TESTING)		\$14.87	\$14.87				
92568	ACOUSTIC REFLEX TESTING; THRESHOLD		\$10.63	\$10.63				
	ACOUSTIC IMMITTANCE TESTING, INCL TYMPANOMETRY, ACOUSTIC							
92570	REFLEX THRESHOLD TESTING & ACOUSTIC REFLEX DECAY TESTING		\$22.58	\$23.85				
92571	FILTERED SPEECH TEST		\$5.93	\$10.90				
92572	STAGGERED SPONDAIC WORD TEST		\$2.39	\$2.39				
92575	SENSORINEURAL ACUITY LEVEL TEST		\$4.62	\$8.51				
92576	SYNTHETIC SENTENCE IDENTIFICATION TEST		\$6.85	\$12.48				
92577	STENGER TEST, SPEECH		\$11.06	\$20.18				
92579	VISUAL REINFORCEMENT AUDIOMETRY (VRA)		\$20.21	\$20.21				
92582	CONDITIONING PLAY AUDIOMETRY		\$10.95	\$20.21				

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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered t	or physiciai	ns T					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	l
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
92583	SELECT PICTURE AUDIOMETRY		\$24.99	\$24.99				
92584	ELECTROCOCHLEOGRAPHY		\$69.37	\$69.37				
	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE							
92585	AUDIOMETRY AND/OR TESTI		\$109.38	\$109.38	\$51.34	\$58.04		
	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE							
92586	AUDIOMETRY AND/OR TESTI		\$50.49	\$50.49				
	EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS							
92587	LEVEL, EITHER		\$43.18	\$43.18	\$36.17	\$7.01		
	EVOKED OTOACOUSTIC EMISSIONS; COMPREHENSIVE OR							
92588	DIAGNOSTIC EVALUATION		\$60.05	\$60.05	\$40.95	\$19.10		
92590	HEARING AID EXAMINATION AND SELECTION; MONAURAL		\$33.75	\$45.00				
92591	HEARING AID EXAMINATION AND SELECTION; BINAURAL		\$23.75	\$65.00				
92592	HEARING AID CHECK; MONAURAL		\$18.75	\$25.00				
92593	HEARING AID CHECK; BINAURAL		\$18.75	\$25.00				
92594	ELECTROACOUSTIC EVALUATION FOR HEARING AID; MONAURAL		\$14.17	\$14.17				
92595	ELECTROACOUSTIC EVALUATION FOR HEARING AID; BINAURAL		\$28.34	\$28.34				
92596	EAR PROTECTOR ATTENUATION MEASUREMENTS		\$16.48	\$16.48				
	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC							
92597	DEVICE TO SUPPLE		\$62.33	\$62.33				
	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7							
92601	YEARS OF AGE;		\$91.49	\$91.49				
	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7							
92602	YEARS OF AGE;		\$64.26	\$64.26				
	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YEARS OR							
92603	OLDER; WITH	<u> </u>	\$61.69	\$61.69				
	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YEARS OR							
92604	OLDER; SUBSEQU		\$42.16	\$42.16				

Physician	Fee Schedule 2020							
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The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING							
92605	AUGMENTATIVE AND		\$70.76	\$73.63				
00000	THERAPEUTIC SERVICE(S) FOR THE USE OF NON-SPEECH-		450.70	005.40				
92606	GENERATING DEVICE,		\$56.76	\$65.12				
00007	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING		Φ 7 0 00	Φ 7 0 00				
92607	AUGMENTATIVE AND EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING		\$76.32	\$76.32				
92608	AUGMENTATIVE AND		\$15.17	\$15.17				
92000	THERAPEUTIC SERVICES FOR THE USE OF SPEECH-GENERATING		φ13.17	φ13.17				
92609	DEVICE, INCLUDIN		\$41.38	\$41.38				
32003	DEVICE, INCOMIN		Ψ+1.50	Ψ+1.50				
92610	EVALUATION OF ORAL AND PHARYNGEAL SWALLOWING FUNCTION		\$29.57	\$29.57				
020.0	MOTION FLUOROSCOPIC EVALUATION OF SWALLOWING FUNCTION		Ψ20.01	Ψ20.0.				
92611	BY CINE OR VIDEO		\$32.14	\$32.14				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING		7	7				
92612	BY CINE OR VID		\$51.22	\$124.70				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING		·					
92613	BY CINE OR VID		\$32.31	\$32.57				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION, LARYNGEAL							
92614	SENSORY TESTING B		\$51.22	\$97.21				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION, LARYNGEAL							
92615	SENSORY TESTING B		\$28.92	\$28.92				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING							
92616	AND LARYNGEAL		\$74.68	\$133.52				
	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING							
92617	AND LARYNGEAL		\$35.96	\$35.96				

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	se lab fee schedule for covered codes not listed below in the 80000-89249	range	+					
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OCCION III		Priyolola						
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	EACH ADDITIONAL 30 MINUTES (LIST SEPARAETLY IN ADDITION TO			1				
92618	CODE FOR PRIMARY PROCEDURE		\$26.11	\$26.63				
	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT;							
92620	INITIAL 60 MINUT		\$30.64	\$30.64				
	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT;							
92621	EACH ADDITIONAL		\$7.93	\$7.93				
	ASSESSMENT OF TINNITUS (INCLUDES PITCH, LOUDNESS							
92625	MATCHING, AND MASKING		\$30.13	\$30.13				
				*				
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR		\$60.81	\$70.93				
	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH							
92627	ADDITIONAL 15 MINUT		\$14.30	\$16.89				
92630	AUDITORY REHABILITATION; PRE-LINGUAL HEARING LOSS		\$0.00	\$0.00				
92633	AUDITORY REHABILITATION; POST-LINGUAL HEARING LOSS		\$0.00	\$0.00				
92640	AUDITORY BRAINSTEM IMPLANT PROGRAMMING, PER HOUR		\$35.77	\$35.77				
00700	LINE LOTED OTODIUNIOLADIALIONI COLONI CERVICE OD DECETIVE			0.00				
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE	R	\$0.00	\$0.00				
92920	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIO		\$435.20	\$435.20				
92924	PERCUTANEOUS TRANSLUMINAL CORONARY ATHER		\$517.11	\$517.11				
92928	PERCUTANEOUS TRANSCATHETER PLACEMENT OF INTRA		\$483.06	\$483.06				
92933	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY		\$540.51	\$540.51				
92937	PERCUTANEOUS TRANSLUMINAL REVASCULARIZATION OF		\$482.77	\$482.77				
92941	PERCUTANEOUS TRANSLUMINAL REVASCULARIZATION OF		\$541.56	\$541.56				
92943	PERCUTANEOUS TRANSLUMINAL REVASCULARIZATION OF		\$541.56	\$541.56				
92950	CARDIOPULMONARY RESUSCITATION (EG, IN CARDIAC ARREST)		\$176.52	\$176.52				
92953	TEMPORARY TRANSCUTANEOUS PACING		\$28.10	\$28.10				
92960	CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA; EXTERNAL		\$120.34	\$120.34				

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Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns T					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	l., .
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF			4.70 7.4				
92961	ARRHYTHMIA; INTERNAL		\$179.74	\$179.74				
92970	CARDIOASSIST-METHOD OF CIRCULATORY ASSIST; INTERNAL		\$206.32	\$206.32				
92971	CARDIOASSIST-METHOD OF CIRCULATORY ASSIST; EXTERNAL		\$83.65	\$83.65				
	PERCUTANEOUS TRANSLUMINAL CORONARY THROMBECTOMY (LIST							
92973	SEPARATELY IN		\$134.01	\$134.01				
	TRANSCATHETER PLACEMENT OF RADIATION DELIVERY DEVICE							
92974	FOR SUBSEQUENT		\$148.34	\$148.34				
	THROMBOLYSIS, CORONARY; BY INTRACORONARY INFUSION,							
92975	INCLUDING SELECTIVE		\$376.10	\$376.10				
92977	THROMBOLYSIS, CORONARY; BY INTRAVENOUS INFUSION		\$219.11	\$219.11				
	INTRAVASCULAR ULTRASOUND (CORONARY VESSEL OR GRAFT)							
92978	DURING DIAGNOSTIC		\$200.09	\$200.09	\$118.96	\$81.13		
	INTRAVASCULAR ULTRASOUND (CORONARY VESSEL OR GRAFT)							
92979	DURING DIAGNOSTIC		\$124.47	\$124.47	\$59.61	\$64.86		
92986	PERCUTANEOUS BALLOON VALVULOPLASTY; AORTIC VALVE		\$941.65	\$941.65				
92987	PERCUTANEOUS BALLOON VALVULOPLASTY; MITRAL VALVE		\$956.46	\$956.46				
92990	PERCUTANEOUS BALLOON VALVULOPLASTY; PULMONARY VALVE		\$750.43	\$750.43				
	ATRIAL SEPTECTOMY OR SEPTOSTOMY; TRANSVENOUS METHOD,							
92992	BALLOON (EG, RASH		\$799.78	\$799.78				
	CATHETER BASED ENLARGEMENT OF OPENING BETWEEN TWO							
92993	UPPER HEART CHAMBERS		\$850.00	\$865.00		1		
	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON							
92997	ANGIOPLASTY; SINGLE		\$716.27	\$716.27				
	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON							
92998	ANGIOPLASTY; EACH		\$281.67	\$281.67				

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R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	าร					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS;							
93000	WITH INTERPRETA		\$21.79	\$21.79				
	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS;							
93005	TRACING ONLY,		\$12.26	\$12.26				
00040	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS;		00.50	40.50				
93010	INTERPRETATION		\$9.52	\$9.52				
00045	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL		000.05	# 00.05		644.55		
93015	TREADMILL OR BI		\$89.95	\$89.95		\$41.55		
02046	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL		ФО4 20	#04.20				
93016	TREADMILL OR BI CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL		\$24.39	\$24.39				
93017	TREADMILL OR BI		\$45.83	\$45.83				
93017	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL		\$4 5.65	ֆ43.03				
93018	TREADMILL OR BI		\$19.72	\$19.72				
93024	ERGONOVINE PROVOCATION TEST		\$108.58	\$108.58	\$30.89	\$77.70		+
93025	MICROVOLT T-WAVE ASSESS		\$139.31	\$139.31	\$124.91	\$32.64		
33023	RHYTHM ECG, ONE TO THREE LEADS; WITH INTERPRETATION AND		Ψ100.01	ψ100.01	Ψ124.51	Ψ02.04		
93040	REPORT		\$12.15	\$12.15				
00010	RHYTHM ECG, ONE TO THREE LEADS; TRACING ONLY WITHOUT		Ψ12.10	Ψ12.10				
93041	INTERPRETATION AN		\$4.00	\$4.00				
	RHYTHM ECG, ONE TO THREE LEADS; INTERPRETATION AND		V	ψσσ				
93042	REPORT ONLY		\$8.16	\$8.16				
	ARTERAIL PRESSURE WAVEFORM ANALYSIS FOR ASSESSMENT OF							
93050	CENTRAL ARTERIAL PRESSURES		\$13.54	\$13.54	\$6.45	\$7.09		Added Effective 1/1/2016
	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY							
93224	CONTINUOUS ORIGINAL EC		\$128.20	\$128.20				

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	olumn indicates Prior Auth is required		1					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered f	or physiciai	<u>is</u>					
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D			loos of Dota	0-44 0-4-	T	D	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	l
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY		400.04					
93225	CONTINUOUS ORIGINAL EC		\$33.84	\$33.84				
	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY							
93226	CONTINUOUS ORIGINAL EC		\$59.68	\$59.68				
	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY							
93227	CONTINUOUS ORIGINAL EC		\$34.69	\$34.69				
93228	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY		\$21.07	\$21.07				
93229	WEARABLE MOBILE CARCIOVASULAR TELE TECH SUP		\$539.05	\$539.05				Rate updated 1/1/2018
	PROGRAMMING DEVICE EVALUATION OF HEART MONITORING							
	SYSTEM WITH ADJUSTMENT OF PROGRAMMED VALUES WITH							
93260	ANALYSIS, REVIEW AND REPORT		\$52.04	\$52.04	\$16.28	\$35.76		Added effective 1/1/2015
	EVALUATION OF DEFIBRILLATOR WITH ANALYSIS, REVIEW, AND							
93261	REPORT		\$47.48	\$47.48	\$16.28	\$31.20		Added effective 1/1/2015
93264	REM MNTR WRLS P-ART PRS SNR		\$29.03	\$40.00				Effective 1/1/2019
	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH							
93268	PRESYMPTOM MEMO		\$126.73	\$126.73	\$99.53	\$27.20		
	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH							
93270	PRESYMPTOM MEMO		\$33.84	\$33.84				
	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH							
93271	PRESYMPTOM MEMO		\$65.69	\$65.69				
	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH							
93272	PRESYMPTOM MEMO		\$27.20	\$27.20				
	SIGNAL-AVERAGED ELECTROCARDIOGRAPHY (SAECG), WITH OR							
93278	WITHOUT ECG		\$56.22	\$56.22	\$32.42	\$23.80		
93279	PROGRAMMING DEVICE EVALUATION		\$47.18	\$47.18	\$17.21	\$29.97		
93280	DUAL LEAD PACEMAKER SYSTEM		\$54.30	\$54.30	\$18.69	\$35.61		
93281	MULTIPLE LEAD PACEMAKER SYSTEM		\$63.49	\$63.49	\$21.96	\$41.53		

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	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	e lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		าร					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
93282	SINGLE LEAD IMPLANTABLE CARDIOVERTER		\$59.04	\$59.04	\$19.58	\$39.46		
93283	DUAL LEAD IMPLANTABLE CARDIOVERTER		\$71.50	\$71.50	\$22.55	\$48.95		
93284	MULTIPLE LEAD IMPLANTABLE CARDIOVERTER		\$83.67	\$83.67	\$25.52	\$58.15		
93285	IMPLANTABLE LOOP RECORDER		\$39.76	\$39.76	\$15.43	\$24.33		
93286	PER-PROCEDURAL DEVICE EVALUATION AND PROGRAM		\$22.55	\$22.55	\$10.09	\$12.46		
93287	SINGLE, DUAL, OR MULT LEAD IMPLANTABLE		\$29.67	\$29.67	\$11.57	\$18.10		
93288	INTERROGATION DEVICE EVAL (IN PERSON) WITH PHYS		\$35.60	\$35.60	\$15.73	\$19.87		
93289	SINGLE, DUAL, OR MULT LEAD IMPLANTABLE		\$54.59	\$54.59	\$18.69	\$35.90		
93290	IMPLANTABLE CARDIOVASCULAR MONITOR SYSTEM		\$26.41	\$26.41	\$8.90	\$17.51		
93291	IMPLANTABLE LOOP RECORDER SYSTEM		\$34.12	\$34.12	\$13.94	\$20.18		
93292	WEARABLE DEFIBRILLATOR SYSTEM		\$30.86	\$30.86	\$10.98	\$19.88		
93293	TRANSTELEPHONIC RHYTHM STRIP PACEMAKER		\$53.11	\$53.11	\$38.57	\$14.54		
93294	INTERROGATION DEVICE EVALUATIONS(S) (REMOTE)		\$30.26	\$30.26				
93295	SINGLE,DUAL, OR MULT LEAD IMPLANTABLE CARDIOVERTER		\$54.59	\$54.59				
93296	SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYS		\$29.97	\$29.97				
93297	INTERROGATION DEVICE EVALUATION(S), REMOTE) UP TO 30		\$21.07	\$21.07				
93298	IMPLANTABLE LOOP RECORDER SYSTEM		\$24.33	\$24.33				
93299	ICM/ILR REMOTE TECH SERV		\$0.00	\$0.00				enddated 12/31/19
	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC							
93303	ANOMALIES; COMPL		\$166.87	\$166.87	\$101.44	\$65.42		
	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC							
93304	ANOMALIES; FOLLO		\$91.46	\$91.46	\$51.10	\$40.35		
93306	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME (2D)		\$220.15	\$220.15	\$161.11	\$59.04		
	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE							
93307	DOCUMENTATION (2		\$157.16	\$157.16	\$105.26	\$51.90		
	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE							
93308	DOCUMENTATION (2		\$88.03	\$88.03	\$53.02	\$35.01		

Physician	Fee Schedule 2020					1	1	1
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Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE		(1 3.5.11.5)	(
93312	DOCUMENTATION		\$189.77	\$189.77	\$104.58	\$85.19		
	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE							
93313	DOCUMENTATION		\$47.30	\$47.30				
	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE							
93314	DOCUMENTATION		\$151.88	\$151.88	\$104.58	\$47.30		
	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL							
93315	CARDIAC ANOMALIES;		\$218.65	\$218.65	\$100.84	\$117.81		
	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL							
93316	CARDIAC ANOMALIES;		\$46.10	\$46.10				
	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL							
93317	CARDIAC ANOMALIES; IMA		\$172.29	\$172.29	\$100.84	\$71.45		
	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL (TEE) FOR MONITORING							
93318	PURPOSES, INCLU		\$203.83	\$203.83	\$109.26	\$94.56		
	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR							
93320	CONTINUOUS WAVE WITH SPEC		\$72.12	\$72.12	\$46.88	\$25.24		
	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR							
93321	CONTINUOUS WAVE WITH SPEC		\$40.60	\$40.60	\$30.62	\$9.98		
	DOPPLER ECHOCARDIOGRAPHY COLOR FLOW VELOCITY MAPPING							
93325	(LIST SEPARATELY		\$83.23	\$83.23	\$79.86	\$3.37		
	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE							
93350	DOCUMENTATION (2		\$126.08	\$126.08	\$48.46	\$77.62		
93351	STRESS TTE COMPLETE		\$178.09	\$178.09	\$110.13	\$67.90		Rate updated 1/1/2018
93352	USE OF ECHOCARDIOGRAPHIC CONTRAST AGENT		\$31.75	\$31.75				
	INSERTION OF PROBE IN ESOPHAGUS FOR HEART ULTRASOUND							
93355	EXAMINATION		\$183.32	\$183.32				Added effective 1/1/2015

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						e for the service	omary char	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	
							T	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	
							range.	se lab fee schedule for covered codes not listed below in the 80000-89249	Please us
						S	or physicia	ted on the lab fee schedule that begin with a P or Q are currently non-covered	Codes list
	Notes	Base Unit Value	Prof.	Tech. Comp.	Outpat. Rate (NonFacility)	Inpat. Rate (Facility)	PA Ind	Procedure Description	Proc Code
					(**************************************	(* 0.000.0)			
Effective 01/01/2020	Added E				\$30.07	\$9.58		MYOCRD STRAIN IMG SPCKL TRCK	93356
								RIGHT HEART CATHETERIZATION INCLUDING MEASURMENT(S) OF	
			\$129.66	\$537.03	\$666.68	\$666.68		OXYGEN SATURATION AND CARDIAC OUTPUT	93451
								LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL	
								INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING	
			\$227.27	\$512.99	\$740.27	\$740.27		SUPERVISION AND INTERPRETATION	93452
								COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING	
								INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY,	
			\$297.89	\$670.84	\$968.73	\$968.73		IMAGING SUPERVISION AND INTERPRETATION	93453
								CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY	
			#000 0F	050400	4700.44	4700.44		ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR	00454
			\$229.05	\$534.36	\$763.41	\$763.41		CORONARY ANGIOGRAPHY	93454
								WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) INCLUDING	
			¢004.00	#COC 00	# 000 00	#000.00		INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT	00455
			\$264.36 \$293.14	•	\$890.69 \$955.37	\$890.69 \$955.37		ANGIOGRAPHY WITH RIGHT HEART CATHETERIZATION	93455
			\$293.14	\$662.23	\$955.37	\$955.37			93456
								` '	
			¢229 74	¢752 01	¢1 092 66	¢1 092 66		` '	03457
			φ320.74	φ133.91	φ1,002.00	φ1,002.00		ANGIOGRAFIII AND RIGHT HEART CATHETERIZATION	93431
								WITH LEET HEART CATHETERIZATION INCLUDING	
			\$279.49	\$641.76	\$921.25	\$921.25			93458
_			\$328.74		\$1,082.66 \$921.25	\$1,082.66 \$921.25		WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY AND RIGHT HEART CATHETERIZATION WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY	93457

Physician	Fee Schedule 2020							
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	les in Red;							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	ne for the service	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		+		
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	T TOT THE SCIVICE	<u>'</u>		+		
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns		+		1	
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	WITH LEFT HEART CATHETERIZATION INCLUDING	1 7 1 1 1 1 1	(1 4 5 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(italii daiiit)			1	
	INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY,							
	CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) WITH BYPASS							
93459	GRAFT ANGRIOGRAPHY '		\$1,017.38	\$1,017.38	\$702.88	\$314.50		
	WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING							
93460	INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY		\$1,088.89	\$1,088.89	\$738.49	\$350.40		
	WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING							
	INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY,							
	CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) WITH BYPASS							
93461	GRAFT ANGIOGRAPHY ` ´		\$1,247.62	\$1,247.62	\$861.02	\$386.60		
	LEFT HEART CATHETERIZATION BY TRANSSEPTAL PUNCTURE							
93462	THROUGH INTACT SEPTUM OR BY TRANSAPICAL PUNCTURE		\$178.02	\$178.02				
	PHARMACOLOGIC AGENT ADMINISTRATION, INCLUDING ASSESSING							
	HEMODYNAMIC MEASUREMENTS BEFORE, DURING, AFTER, AND							
93463	REPEAT PHARMCOLOGIC AGENT ADMINISTRATION		\$94.35	\$94.35				
	PHYSIOLOGIC EXERCISE STUDY INCLUDING ASSESSING							
93464	HEMODYNAMIC MEASUREMENTS BEFORE AND AFTER		\$220.15	\$220.15	\$137.08	\$83.08		
	INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG,							
93503	SWAN-GANZ) FOR		\$143.62	\$143.62				
93505	ENDOMYOCARDIAL BIOPSY		\$276.95	\$276.95	\$55.07	\$221.88		
	RIGHT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC							
93530	ANOMALIES	<u> </u>	\$668.63	\$668.63	\$445.27	\$223.36		
	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE							
93531	LEFT HEART		\$1,663.32	\$1,663.32	\$1,272.51	\$390.81		

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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ae for the service	,				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL							
93532	LEFT HEART		\$1,723.23	\$1,723.23	\$1,238.55	\$484.67		
	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL							
93533	LEFT HEART		\$1,512.60	\$1,512.60	\$1,238.55	\$274.05		
00=04	INDICATOR DILUTION STUDIES SUCH AS DYE OR THERMAL		A 74.40			4 =0.0=		
93561	DILUTION, INCLUDING		\$71.16	\$71.16	\$15.11	\$56.05		
00500	INDICATOR DILUTION STUDIES SUCH AS DYE OR THERMAL		#00 07	000.07	00.00	004.05		
93562	DILUTION, INCLUDING		\$33.67	\$33.67	\$9.02	\$24.65		+
	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION							
	INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SELECTIVE CORONARY ANGIOGRAPHY DURING CONGENTIAL							
93563	HEART CATHETERIZATION		\$48.96	\$48.96				
93303	FOR SELECTIVE OPACIFICATION OF AORTOCORONARY VENOUS OR		φ40.90	φ40.90				+
	ARTERIAL BYPASS GRAFT(S), WHETHER NATIVE OR USED FOR							
	BYPASS TO ONE OR MORE CORONARY ARTERIES DURING							
93564	CONGENTIAL HEART CATHETERIZATION		\$49.85	\$49.85				
00001	OCHOENTINE HEART OF THE PERIOD TO		Ψ10.00	Ψ 10.00				+
93565	FOR SELECTIVE LEFT VENTRICULAR OR LEFT ATRIAL ANGIOGRAPHY		\$37.68	\$37.68				
	FOR SELECTIVE RIGHT VENTRICULAR OR RIGHT ATRICAL		+ + + + + + + + + + + + + + + + + + + 	+ -				
93566	ANGIOGRAPHY		\$37.68	\$147.76				
93567	FOR SUPRAVALVULAR AORTOGRAPHY		\$42.43	\$121.94				
93568	FOR PULMONARY ANGIOPGRAPHY		\$38.57	\$133.52	1			
	INTRAVASCULAR DOPPLER VELOCITY AND/OR PRESSURE DERIVED							
93571	CORONARY FLOW		\$198.80	\$198.80	\$127.92	\$70.87		
	INTRAVASCULAR DOPPLER VELOCITY AND/OR PRESSURE DERIVED							
93572	CORONARY FLOW		\$182.19	\$182.19	\$125.29	\$56.90		

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ne for the service					
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	se lab fee schedule for covered codes not listed below in the 80000-89249	range			1	1		
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns		1	1		
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	PERCUTANEOUS TRANSCATHETER CLOSURE OF CONGENITAL		(* 3.5	(00000000000000000000000000000000000000				
93580	INTERATRIAL COMMUNICA		\$736.30	\$736.30				
	PERCUTANEOUS TRANSCATHETER CLOSURE OF A CONGENITAL		·	·				
93581	VENTRICULAR SEPTAL		\$985.59	\$985.59				
93582	PERQ TRANSCATH CLOSURE PDA		\$543.81	\$543.81				
93583	PERQ TRANSCATH SEPTAL REDUXN		\$605.33	\$605.33				
93590	PERQ TRANSCATH CLS MITRAL		\$971.38	\$971.38				Added Effective 1/1/2017
93591	PERQ TRANSCATH CLS AORTIC		\$806.07	\$806.07				Added Effective 1/1/2017
93592	PERQ TRANSCATH CLOSURE EACH		\$355.43	\$355.43				Added Effective 1/1/2017
93600	BUNDLE OF HIS RECORDING		\$194.02	\$194.02	\$53.29	\$140.73		
93602	INTRA-ATRIAL RECORDING		\$143.46	\$143.46	\$30.37	\$113.08		
93603	RIGHT VENTRICULAR RECORDING		\$170.67	\$170.67	\$45.83	\$124.84		
	INTRAVENTRICULAR AND/OR INTRA-ATRIAL MAPPING OF							
93609	TACHYCARDIA SITE(S) WI		\$479.37	\$479.37	\$74.09	\$405.29		
93610	INTRA-ATRIAL PACING		\$191.74	\$191.74	\$37.03	\$154.71		
93612	INTRAVENTRICULAR PACING		\$199.73	\$199.73	\$44.22	\$155.51		
	INTRACARDIAC ELECTROPHYSIOLOGIC 3-DIMENSIONAL MAPPING							
93613	(LIST SEPARATELY		\$286.47	\$286.47		\$286.47		
	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR							
93615	WITHOUT VENTRICULAR		\$47.46	\$47.46	\$8.53	\$38.92		
	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR							
93616	WITHOUT VENTRICULAR		\$90.68	\$90.68	\$8.53	\$82.14		
93618	INDUCTION OF ARRHYTHMIA BY ELECTRICAL PACING		\$390.33	\$390.33	\$108.19	\$282.14		
	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT							
93619	ATRIAL PACING A		\$697.01	\$697.01	\$209.99	\$487.01		
	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION INCLUDING							
93620	INSERTION AND		\$969.71	\$969.71	\$243.64	\$726.07		
93621	ELECTROPHYSIOLOGY EVALUATION		\$0.00	\$0.00	\$0.00	\$102.06		

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	and the Daniel							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	<u>18</u>					
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D			I	0		D	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
93622	ELECTROPHYSIOLOGY EVALUATION		\$0.00	\$0.00	\$0.00	\$150.72		
93623	STIMULATION PACING HEART					\$139.15		
	ELECTROPHYSIOLOGIC FOLLOW-UP STUDY WITH PACING AND		4000 = 4	4000 = 4	4-4-00			
93624	RECORDING TO TEST		\$280.54	\$280.54	\$54.09	\$226.44		
	INTRA-OPERATIVE EPICARDIAL AND ENDOCARDIAL PACING AND							
93631	MAPPING TO LOCAL		\$567.97	\$567.97	\$174.18	\$393.79		
	ELECTROPHYSIOLOGIC EVALUATION OF SINGLE OR DUAL CHAMBER							
93640	PACING		\$438.49	\$438.49	\$195.12	\$243.37		
	ELECTROPHYSIOLOGIC EVALUATION OF SINGLE OR DUAL CHAMBER					1		
93641	PACING		\$571.97	\$571.97	\$195.12	\$376.85		
	ELECTROPHYSIOLOGIC EVALUATION OF SINGLE OR DUAL CHAMBER							
93642	PACING		\$521.07	\$521.07	\$195.12	\$325.95		
93644	EVALUATION IMPLANTABLE DEFIBRILLATOR		\$230.29	\$230.29	\$77.31	\$152.98		Added effective 1/1/2015
	INTRACARDIAC CATHETER ABLATION OF ATRIOVENTRICULAR NODE							
93650	FUNCTION,		\$701.98	\$701.98		\$908.07		
93653	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION		\$657.32	\$657.32				
93654	WITH TREATMENT OF VENTRICULAR TACHYCARDIA OR		\$877.11	\$877.11				
93655	INTRACARDIAC CATHETER ABLATION OF A DISCRETE MECH		\$328.68	\$328.68				
93656	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION		\$877.43	\$877.43				
93657	ADDITIONAL LINEAR OR FOCAL INTRACARDIAC CATHETER AB		\$328.90	\$328.90				
	EVALUATION OF CARDIOVASCULAR FUNCTION WITH TILT TABLE		1	1	1	1.		
93660	EVALUATION, WITH		\$125.57	\$125.57	\$43.61	\$81.96		
	INTRACARDIAC ECHOCARDIOGRAPHY DURING				1.			
93662	THERAPEUTIC/DIAGNOSTIC INTERVENTI		\$219.37	\$219.37	\$104.55	\$114.82		
	PERIPHERAL ARTERIAL DISEASE (PAD) REHABILITATION, PER							
93668	SESSION		\$36.51	\$36.51	1			
93701	BIOIMPEDANCE, THORACIC, ELECTRICAL		\$25.35	\$25.53	\$18.58	\$6.95		

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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	<u>ns</u>					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
02702	LYMPHEDEMA ACCECCMENT FOR EVERACELLIH AR FILLIR ANALYCIC		\$82.77	\$82.77				Add ad affactive 1/1/2015
93702	LYMPHEDEMA ASSESSMENT FOR EXTRACELLULAR FLUID ANALYSIS		\$82.77	\$82.77				Added effective 1/1/2015
02704	ELECTRONIC ANALYSIS OF ANTITACHYCARDIA PACEMAKER SYSTEM		фоод 4 О 7	#224.07	¢400.40	#226 A8		
93724	(INCLUDES TEMPERATURE GRADIENT STUDIES		\$334.27 \$17.74	\$334.27 \$17.74	\$108.19 \$4.27	\$226.08 \$13.47		
93740	TEMPERATURE GRADIENT STUDIES		\$17.74	\$17.74	\$4.27	\$13.47		
93745	INITIAL SET-UP AND PROGRAMMING BY A PHYSICIAN OF WEARABLE	R	\$0.00	\$0.00	\$0.00	\$0.00		
93743	INTERROGATION OF FENTRICULAR ASSIST DEVICE, IN PERSON,	I.V.	φυ.υυ	φυ.υυ	\$0.00	φυ.υυ		
93750	W/PHYSICIAN ANALYSIS OF DEVICE PARAMETERS		\$34.88	\$39.47				
93770	DETERMINATION OF VENOUS PRESSURE		\$10.55	\$10.55	\$0.80	\$9.74		
93770	AMBULATORY BLOOD PRESSURE MONITORING, UTILIZING A SYSTEM		\$10.55	\$10.55	\$0.60	ф9.74		
02704			\$35.18	ФЭ <i>Б</i> 40				Undeted Effective 04/04/2020
93784	SUCH AS MAGNE AMBULATORY BLOOD PRESSURE MONITORING, UTILIZING A SYSTEM		\$35.18	\$35.18				Updated Effective 01/01/2020
02706	SUCH AS MAGNE		¢16 50	\$16.59				Undeted Effective 01/01/2020
93786			\$16.59	\$16.59				Updated Effective 01/01/2020
02700	AMBULATORY BLOOD PRESSURE MONITORING, UTILIZING A SYSTEM		фо co	фо co				Undeted Effective 04/04/2020
93788	SUCH AS MAGNE		\$3.62	\$3.62				Updated Effective 01/01/2020
00700	AMBULATORY BLOOD PRESSURE MONITORING, UTILIZING A SYSTEM		¢44.00	¢44.00				Hardete d Effective 04/04/0000
93790	SUCH AS MAGNE		\$14.98	\$14.98				Updated Effective 01/01/2020 Added Effective 1/1/2018
93792	PT/CAREGIVER TRAINJ HOME INR		\$39.91	\$39.91				
93793	ANTICOAG MGMT PT WARFARIN	-	\$9.36	\$9.36	+			Added Effective 1/1/2018
00707	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION;		# 0.00	фо 7 7				
93797	WITHOUT	ļ	\$2.06	\$8.77	+			ļ
00700	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION;		(ma 00	044.04				
93798	WITH CONTINU		\$3.09	\$11.61	00.00	φο οο		ļ
93799	UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
00000	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL		0.407.66	0.4.07.00	0444.00	400 44		
93880	STUDY	<u> </u>	\$167.80	\$167.80	\$144.36	\$23.44	<u> </u>	

Physician	Fee Schedule 2020	I	1			1		
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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1	T					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR							
93882	LIMITED STUDY		\$89.06	\$89.06	\$69.62	\$19.44		
	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES;							
93886	COMPLETE STUD		\$158.82	\$158.82	\$118.76	\$40.06		
	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES;							
93888	LIMITED STUDY		\$105.85	\$105.85	\$79.42	\$26.43		
00000	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES;		0.477.44	0.477.44	* 400 00	0.47.44		
93892	EMBOLI DETECT		\$177.44	\$177.44	\$130.03	\$47.41		
02002	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES;		¢474.40	¢474.40	¢406.74	\$47.41		
93893	EMBOLI DETECT EVALUATION OF THICKNESS OF COMMON CAROTID ARTERY (NECK)		\$174.12	\$174.12	\$126.71	\$47.41		
93895	BOTH SIDES		\$0.00	\$0.00	\$0.00	\$0.00		Added effective 1/1/2015
93093	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER		φυ.υυ	\$0.00	\$0.00	φυ.υυ		Added effective 1/1/2015
93922	EXTREMITY ARTERIES,		\$48.97	\$48.97	\$32.91	\$16.06		
93922	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER		ψ40.91	ψ40.91	ψ32.91	φ10.00		+
93923	EXTREMITY ARTERIES,		\$91.18	\$91.18	\$62.11	\$29.07		
00020	NON-INVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY		ΨΟΤ.ΤΟ	ΨΟ1.10	ΨΟΖ.ΤΤ	Ψ20.01		+
93924	ARTERIES, AT REST		\$100.05	\$100.05	\$67.66	\$32.39		
	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL		V 100100		 	402.00		
93925	BYPASS GRAFTS; COM		\$133.93	\$133.93	\$105.47	\$28.45		
	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL				1			
93926	BYPASS GRAFTS;		\$89.54	\$89.54	\$70.40	\$19.15		
	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL							
93930	BYPASS GRAFTS; COM		\$137.03	\$137.03	\$111.86	\$25.17		
	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL							
93931	BYPASS GRAFTS;		\$91.19	\$91.19	\$74.39	\$16.80		

Physician	Fee Schedule 2020							
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R" in PA	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	stomary char	ge for the service	Э				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-8924	9 range.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS,							
93965	COMPLETE BILATERA		\$54.85	\$54.85	\$31.05	\$23.80		
	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO							
93970	COMPRESSION AND		\$171.77	\$171.77	\$145.38	\$26.39		
00074	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO		***	400.00		***		
93971	COMPRESSION AND		\$98.98	\$98.98	\$77.81	\$21.18		
00075	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF		0407.04	0.407.04	# 400.04	005.00		
93975	ABDOMINAL, PELVIC		\$197.61	\$197.61	\$132.31	\$65.30		
02076	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF		\$132.20	\$132.20	\$88.46	\$43.74		
93976	ABDOMINAL, PELVIC DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC		\$132.20	\$132.20	\$88.40	\$43.74		
93978	VASCULATURE, OR BYPASS		\$139.39	\$139.39	\$108.64	\$30.75		
93976	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC		क् १३७.३७	φ139.39	\$100.04	φ30.73		
93979	VASCULATURE, OR BYPASS		\$92.86	\$92.86	\$72.25	\$20.61		
93919	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF		ψ92.00	ψ92.00	Ψ12.23	φ20.01	+	+
93980	PENILE VESSELS;		\$175.65	\$175.65	\$98.55	\$77.10		
00000	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF		ψ170.00	ψ170.00	Ψ00.00	Ψίτιιο		+
93981	PENILE VESSELS;		\$121.33	\$121.33	\$91.09	\$30.24		
00001	1 2.112 12.0223,		Ψ121.00	ψ121.00	ψο 1.00	Ψου.Σ :	+	
93985	DUP-SCAN HEMO COMPL BI STD		\$197.78	\$197.78	\$166.76	\$31.02		Added Effective 01/01/2020
						,		
93986	DUP-SCAN HEMO COMPL UNI STD		\$114.85	\$114.85	\$94.92	\$19.94		Added Effective 01/01/2020
	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL						1	
93990	INFLOW, BODY OF		\$83.31	\$83.31	\$70.40	\$12.92		
94002	VENTILATION MANAGEMENT, INPATIENT, INITIAL DAY		\$68.19	\$68.19				
94003	VENTILATION MANAGEMENT, INPATIENT, SUBSEQUENT DAY		\$49.33	\$49.33				
94004	VENTILATION MANAGEMENT, NURSING FACILITY, PER DAY		\$35.89	\$35.89				

Physician	Fee Schedule 2020		1	<u> </u>	Ι			T
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED							
94010	VITAL CAPACITY,		\$24.44	\$24.44	\$11.46	\$12.98		
	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN							
94011	AN INFANT OR CHILD THROUGH 2 YRS OF AGE		\$74.48	\$74.48				
	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS,							
0.40.40	BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD							
94012	THROUGH 2 YRS OF AGE		\$114.60	\$114.60				
0.40.40	MEASUREMENT OF LUNG VOLUMES IN AN INFANT OR CHILD		004.45	0.4.45				
94013	THROUGH 2 YRS OF AGE		\$24.15	\$24.15				
04044	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD		#40.00	¢40.00				
94014	OF TIME; INC PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD		\$12.62	\$12.62				
94016	OF TIME:		\$4.89	\$4.89				
94016	BRONCHODILATION RESPONSIVENESS, SPIROMETRY AS IN 94010,		ֆ4.09	Φ4.09				
94060	PRE- AND		\$45.35	\$45.35	\$25.33	\$20.02		
94000	BRONCHOSPASM PROVOCATION EVALUATION, MULTIPLE		φ43.33	φ45.55	φ20.00	φ20.02		
94070	SPIROMETRIC DETERMINATIO		\$68.24	\$68.24	\$39.71	\$28.53		
94150	VITAL CAPACITY, TOTAL (SEPARATE PROCEDURE)		\$9.08	\$9.08	\$2.39	\$6.69		
54150	MAXIMUM BREATHING CAPACITY, MAXIMAL VOLUNTARY		Ψ5.00	ψ3.00	Ψ2.00	ψ0.00		
94200	VENTILATION		\$14.15	\$14.15	\$6.92	\$7.23		
01200	EXPIRED GAS COLLECTION, QUANTITATIVE, SINGLE PROCEDURE		Ψ11.10	Ψ11.10	Ψ0.02	ψ1.20		
94250	(SEPARATE PROCE		\$10.96	\$10.96	\$3.73	\$7.23		
94375	RESPIRATORY FLOW VOLUME LOOP		\$28.04	\$28.04	\$13.07	\$14.97		
94400	BREATHING RESPONSE TO CO2 (CO2 RESPONSE CURVE)		\$37.01	\$37.01	\$9.50	\$27.50		†
			•					
94450	BREATHING RESPONSE TO HYPOXIA (HYPOXIA RESPONSE CURVE)		\$29.31	\$29.31	\$10.65	\$18.66		

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	HIGH ALTITUDE SIMULATION TEST (HAST), WITH PHYSICIAN							
94452	INTERPRETATION AN		\$36.26	\$36.26	\$24.25	\$12.01		
	HIGH ALTITUDE SIMULATION TEST (HAST), WITH PHYSICIAN							
94453	INTERPRETATION AN		\$51.43	\$51.43	\$35.99	\$15.45		
04640			\$48.89	\$48.89				
94610 94617	INTRAPULMONARY SURFACTANT THROUGH ENDOTRACHEAL TUBE EXERCISE TST BRNCSPSM		\$72.36	\$72.36	\$45.66	\$26.70		Added Effective 1/1/2018
94618	PULMONARY STRESS TESTING		\$26.61	\$26.61	\$8.34	\$18.27		Added Effective 1/1/2018
94010	PULMONARY STRESS TESTING PULMONARY STRESS TESTING; SIMPLE (EG, PROLONGED EXERCISE		φ20.01	φ20.01	φ0.34	φ10.21		Added Effective 1/1/2018
94620	TEST FOR		\$84.45	\$84.45	\$38.64	\$45.81		
34020	PULMONARY STRESS TESTING; COMPLEX (INCLUDING		Ψ04.43	ψ04.43	ψ50.04	ψ+3.01		
94621	MEASUREMENTS OF CO2		\$126.01	\$126.01	\$70.98	\$55.03		Rate updated 1/1/2018
3 4 021	PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR		Ψ120.01	Ψ120.01	ψ10.50	ψ00.00		reace appeared 17172010
94640	ACUTE AIRWAY		\$11.19	\$11.19				
0.0.0	AEROSOL INHALATION OF PENTAMIDINE FOR PNEUMOCYSTIS		4	4				
94642	CARINII PNEUMONIA		\$43.41	\$43.41				
	CONTINUOUS AEROSOL INHALATION TREATMENT FOR ACUTE		7	+ 12111				
94644	AIRWAY OBST, FIRST HOUR		\$23.85	\$23.85				
	CONTINUOUS AEROSOL INHALATION TREATMENT FOR ACUTE							
94645	AIRWAY OBST, SUBSEQ. HOUR		\$9.13	\$9.13				
	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP),							
94660	INITIATION AND		\$42.80	\$42.80				
	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION							
94662	AND MANAGEM		\$30.83	\$30.83		<u> </u>		
	DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF							Rate change effective
94664	AN AEROSOL		\$12.65	\$12.65				7/1/2015

Physician	Fee Schedule 2020			1				
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND							
94667	VIBRATION TO		\$15.97	\$15.97				
	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND							
94668	VIBRATION TO		\$9.85	\$9.85				
94669	MECHANICAL CHEST WALL OSCILL		\$25.58	\$25.58				
	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST AND EXERCISE,							
94680	DIRECT, SIMPLE		\$32.05	\$32.05	\$14.84	\$17.21		
	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; INCLUDING CO2 OUTPUT,							
94681	PERCENTAGE		\$52.38	\$52.38	\$38.56	\$13.81		
	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST, INDIRECT							
94690	(SEPARATE PROCEDUR		\$18.05	\$18.05	\$14.65	\$3.40		
	PLETHYSMOGRAPHY FOR DETERMINATION OF LUNG VOLUMES AND							
94726	, WHEN PERFORMED, AIRWAY RESISTANCE.		\$41.50	\$41.50	\$36.20	\$10.68		
	GAS DILUTION OR WASHOUT FOR DETERMINATION OF LUNG							
	VOLUMES AND , WHEN PERFORMED, DISTRIBUTION OF VENTILATION							
94727	AND CLOSING VOLUMES.		\$32.75	\$32.75	\$26.11	\$10.68		
94728	AIRWAY RESISTANCE BY IMPULSE OSCILLOMETRY		\$30.66	\$30.66	\$20.48	\$10.18		Updated Effective 01/01/2020
	DIFFUSING CAPACITY (EG, CARBON MONOXIDE, MEMBRANE) LIST					·-		
94729	SEPARAELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE.		\$41.01	\$41.01	\$39.46	\$7.12		
0.4750	PULMONARY COMPLIANCE STUDY (EG, PLETHYSMOGRAPHY,		400.47	400.47	A 4 5 7 C	044.75		
94750	VOLUME AND PRESSURE		\$30.47	\$30.47	\$15.72	\$14.75		
0.4700	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION;		Φ7.40	67.40				
94760	SINGLE		\$7.19	\$7.19				
0.4704	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION;		# 40.00	040.00				
94761	MULTIPLE		\$18.62	\$18.62				

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	column indicates Prior Auth is required		1		_			
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	าร					
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Proc		L	Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	l., .
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0.4700	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION;		004.40	404.40				
94762	BY CONTINUOUS		\$31.40	\$31.40				
	CARBON DIOXIDE, EXPIRED GAS DETERMINATION BY INFRARED							
94770	ANALYZER		\$19.27	\$19.27	\$9.72	\$9.55		
1	CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC				1			
94772	PNEUMOGRAM), 12 TO		\$207.47	\$207.47	\$77.76	\$129.71		
94775	PED HOME APNEA REC HK-UP		\$0.00	\$0.00				
94776	PED HOME APNEA REC DOWNLD		\$0.00	\$0.00				
94777	PED HOME APNEA REC REPORT		\$0.00	\$0.00				
	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH							
	CONTINUAL NURSING OBSERVATION AND RECORDING OF PULSE							
	OXIMETRY, HEART RATE, RESPIRATORY RATE, WITH							
94780	INTERPRETATION AND REPORT; 60 MINUTES		\$19.15	\$39.82				
	EACH ADDITIONAL 30 MINUTES (LIST SEPARAETLY IN ADDITION TO							
94781	CODE FOR PRIMARY PROCEDURE)		\$6.67	\$15.46				
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE	R	\$0.00	\$0.00	\$0.00	\$0.00		
	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) WITH							
95004	ALLERGENIC EXTRACTS		\$2.82	\$2.82				
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION		\$12.43	\$12.43				
95017	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS		\$3.02	\$65.30				
95018	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS		\$5.81	\$22.60				
	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC				1			
95024	EXTRACTS, IMMEDIATE		\$4.10	\$4.10				
	INTRACUTANEOUS (INTRADERMAL) TESTS, SEQUENTIAL AND							
95027	INCREMENTAL, WITH		\$4.00	\$4.00				
	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC							
95028	EXTRACTS, DELAYED T		\$6.14	\$6.14				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	es in Red;							
Refer to C	PT book for descriptions							
R" in PA c	olumn indicates Prior Auth is required							
Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
The Anest	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	e lab fee schedule for covered codes not listed below in the 80000-89249 in	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
95044	PATCH OR APPLICATION TEST(S) (SPECIFY NUMBER OF TESTS)		\$5.34	\$5.34				
95052	PHOTO PATCH TEST(S) (SPECIFY NUMBER OF TESTS)		\$6.68	\$6.68				
95056	PHOTO TESTS		\$2.52	\$4.80				
95060	OPHTHALMIC MUCOUS MEMBRANE TESTS		\$9.34	\$9.34				
95065	DIRECT NASAL MUCOUS MEMBRANE TEST		\$2.79	\$5.34				
	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING							
95070	NECESSARY PULMON		\$58.69	\$58.69				
	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING							
95071	NECESSARY PULMON		\$75.05	\$75.05				
	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL							
95076	INGESTION OF TEST		\$58.54	\$92.66				
95079	EACH ADDITIONAL 60 MIN OF TESTING		\$54.05	\$66.20				
	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT							
95115	INCLUDING PROVISI		\$10.54	\$10.54				
	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT							
95117	INCLUDING PROVISI		\$13.37	\$13.37				
	PREPARATION AND PROVISION OF SINGLE-DOSE VIALS OF							
95144	ALLERGEN ANTIGENS FOR ALLERGY IMMUNOTHERAPY		\$2.47	\$8.41				
	PREPARATION AND PROVISION OF SINGLE STINGING INSECT VENOM							
95145	FOR ALLERGEN IMMUNOTHERAPY		\$2.47	\$10.47				
	PREPARATION AND PROVISION OF 2 SINGLE STINGING INSECT							
95146	VENOM FOR ALLERGEN IMMUNOTHERAPY		\$2.47	\$13.27				
	PREPARATION AND PROVISION OF 3 SINGLE STINGING INSECT							
95147	VENOM FOR ALLERGEN IMMUNOTHERAPY		\$2.47	\$14.76				
	PREPARATION AND PROVISION OF 4 SINGLE STINGING INSECT							
95148	VENOM FOR ALLERGEN IMMUNOTHERAPY		\$2.47	\$16.84				

Notes	Physiciar	n Fee Schedule 2020	1	1		<u> </u>	<u> </u>	1	T
Refer to CPT book for descriptions (R) in PA column indicates Prival with is required (Codes listed as \$30.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute incremented time unit. Please use lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PSEAP VENOM FOR ALLERGEN IMMUNOTHERAPY Security PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF WHOLE BODY EXTRACT OF PSI40									
Refer to CPT book for descriptions (R) in PA column indicates Prival with is required (Codes listed as \$30.00' pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute incremented time unit. Please use lab fee schedule for covered codes not listed below in the 8000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PSEAP VENOM FOR ALLERGEN IMMUNOTHERAPY Security PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF SINGLE OF MULTIPLE ANTIGENS PSI40 PREPARATION AND PROVISION OF WHOLE BODY EXTRACT OF PSI40	2020 Co	des in Red;							
Codes listed as \$5.00° pay 45% of billed amount not to exceed provider's usual and customary charge for the service The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit. Please use lab fee schedule for covered codes not listed below in the 80000-89249 range. Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians Proc Code Procedure Description PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT 95149 VENOM FOR ALLERGEN IMMUNOTHERAPY 95149 SPERPARATION AND PROVISION OF SINGLE OR MULTIPLE ANTIGENS 95165 FOR ALLERGEN IMMUNOTHERAPY 95170 BITING INSECT OR ARTHROPOD ANTIGENS 95180 RAPID DESENSTIZATION PROCEDURE, EACH HOUR 95249 CONT GLUC MNITR PT PROV EGP 95180 AMBULATORY CONTINUOUS GLUCOSE MONITORING OF INTERSTITIAL ITSSUE FILLID 95250 INTERSTITIAL ITSSUE FILLID 95251 INTERSTITIAL ITSSUE FILLID 95706 EEG WO VID 2-12HR INMINTR 9500 \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG WO VID 2-12HR INMINTR 9500 \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID 2-12HR INMINTR 9500 \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG WO VID 2-12HR INMINTR 9500 \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG WO VID 2-12HR INMINTR 9500 \$0.00 Added Effective 01/01/2020		•							
The Anesthesia Base Rate is \$15,20. Each 15 minute incremented time unit.									
The Anesthesia Base Rate is \$15,20. Each 15 minute incremented time unit.			omary char	ge for the service)				
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians PA Ind Inpat. Rate PA Ind Facility (NonFacility) Comp.			T						
Proc Procedure Description	Please u	ise lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Procedure Description	Codes lis	sted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
Inpat. Rate Code Procedure Description PA Ind Inpat. Rate (RoofFacility) Comp. Comp. Unit Value Notes									
Procedure Description									
PREPARATION AND PROVISION OF 5 SINGLE STINGING INSECT \$2.47 \$22.45 PREPARATION AND PROVISION OF SINGLE OR MULTIPLE ANTIGENS PREPARATION AND PROVISION OF SINGLE OR MULTIPLE ANTIGENS \$2.73 \$7.15 PREPARATION AND PROVISION OF SINGLE OR MULTIPLE ANTIGENS \$2.73 \$7.15 PREPARATION AND PROVISION OF WHOLE BODY EXTRACT OF \$2.47 \$8.67 PST170 BITING INSECT OR ARTHROPOD ANTIGENS \$2.47 \$8.67 PST180 RAPID DESENSITIZATION PROCEDURE, EACH HOUR \$82.99 \$100.00 PSC49 CONT GLUC MITR PT PROVEOP \$40.68 \$40.68 \$40.68 AMBULATORY CONTINUOUS GLUCOSE MONITORING OF \$37.42 \$37.42 \$37.42 \$37.42 \$0.00 PSC50 INTERSTITIAL TISSUE FLUID \$20.79 \$20.79 PSC70 EEG CONT REC W/VID EEG TECH \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12 HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID 2-12HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG W/O VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG W/O VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG W/O VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 PSC70 EEG W/O VID EA 12-26HR UNMNTR \$0.00 Added E	Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
95149 VENOM FOR ALLERGEN IMMUNOTHERAPY \$2.47 \$22.45	Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
PREPARATION AND PROVISION OF SINGLE OR MULTIPLE ANTIGENS FOR ALLERGEN IMMUNOTHERAPY \$2.73 \$7.15									
95165 FOR ALLERGEN IMMUNOTHERAPY \$2.73 \$7.15	95149			\$2.47	\$22.45				
PREPARATION AND PROVISION OF WHOLE BODY EXTRACT OF									
95170 BITING INSECT OR ARTHROPOD ANTIGENS \$2.47 \$8.67	95165			\$2.73	\$7.15				
Section Sect									
95249 CONT GLUC MNTR PT PROV EQP									
AMBULATORY CONTINUOUS GLUCOSE MONITORING OF		,			I *				
95250 INTERSTITIAL TISSUE FLUID \$37.42 \$	95249			\$40.68	\$40.68				Added Effective 1/1/2018
AMBULATORY CONTINUOUS GLUCOSE MONITORING OF									
95251 INTERSTITIAL TISSUE FLUID \$20.79 \$20.79 95700 EEG CONT REC W/VID EEG TECH \$0.00 \$0.00 Added Effective 01/01/2020 95705 EEG W/O VID 2-12 HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95250			\$37.42	\$37.42	\$37.42	\$0.00		
95700 EEG CONT REC W/VID EEG TECH \$0.00 \$0.00 Added Effective 01/01/2020 95705 EEG W/O VID 2-12 HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	l								
95705 EEG W/O VID 2-12 HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95251	INTERSTITIAL TISSUE FLUID		\$20.79	\$20.79				
95705 EEG W/O VID 2-12 HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	05700	FEO CONT DEC MAND FEO TECH		00.00	00.00				Add at Effective 04/04/0000
95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95700	EEG CONT REC W/VID EEG TECH		\$0.00	\$0.00				Added Effective 01/01/2020
95706 EEG WO VID 2-12HR INTMT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	05705	EEC MIO VID 2 42 HD HAMAITD		¢0.00	60.00				Added Effective 04/04/2020
95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95/05	EEG W/O VID 2-12 HR UNIMIN I R		\$0.00	\$0.00				Added Effective 01/01/2020
95707 EEG W/O VID 2-12HR CONT MNTR \$0.00 \$0.00 Added Effective 01/01/2020 95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	05706	EEC WO VID 2 12HD INTMT MNTD		\$0.00	\$0.00				Added Effective 01/01/2020
95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95700	EEG WO VID 2-12HK INTINIT WINTK		\$0.00	\$0.00				Added Effective 01/01/2020
95708 EEG WO VID EA 12-26HR UNMNTR \$0.00 \$0.00 Added Effective 01/01/2020 95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95707	EEG W/O VID 2-12HD CONT MNTD		\$0.00	\$0.00				Added Effective 01/01/2020
95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	93707	LEG W/O VID 2-121IK CONT WINTK		φυ.υυ	φυ.υυ				Added Effective 01/01/2020
95709 EEG W/O VID EA 12-26HR INTMT \$0.00 \$0.00 Added Effective 01/01/2020	95708	FEG WO VID FA 12-26HR LINMNTR		\$0.00	\$0.00				Added Effective 01/01/2020
	00100	EEG WO VID EA 12 2011K OKIMIKTIK		ψ0.00	ψ0.00				Added Effective 61/61/2020
	95709	EEG W/O VID EA 12-26HR INTMT		\$0.00	\$0.00				Added Effective 01/01/2020
95710 FEG W/O VID EA 12-26HR CONT \$0.00 \$0.00 Added Effective 01/01/2020				+3.00	Ţ3. 00				
1337 TO TELO 1870 VID LA TE-20111 OOMT	95710	EEG W/O VID EA 12-26HR CONT		\$0.00	\$0.00				Added Effective 01/01/2020

Physician	Fee Schedule 2020	Τ		Τ	1			
Note:								
2020 Co	des in Red;							
Refer to	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciar	ns .					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	Frocedure Description	FAIIIU	(i acility)	(Nom acmity)	Comp.	Comp.	Value	Notes
95711	VEEG 2-12 HR UNMONITORED		\$0.00	\$0.00				Added Effective 01/01/2020
			70.00	V 0.00				
95712	VEEG 2-12 HR INTMT MNTR		\$0.00	\$0.00				Added Effective 01/01/2020
95713	VEEG 2-12 HR CONT MNTR		\$0.00	\$0.00				Added Effective 01/01/2020
95714	VEEG EA 12-26 HR UNMNTR		\$0.00	\$0.00				Added Effective 01/01/2020
95715	VEEG EA 12-26HR INTMT MNTR		\$0.00	\$0.00				Added Effective 01/01/2020
95716	VEEG EA 12-26HR CONT MNTR		\$0.00	\$0.00				Added Effective 01/01/2020
957 10	VEEG EA 12-20HR CONT WINTR		\$0.00	\$0.00				Added Effective 01/01/2020
95717	EEG PHYS/QHP 2-12 HR W/O VID		\$81.61	\$82.64				Added Effective 01/01/2020
00111	ELECTIFICAÇIII 2 IZTIIC WIG VID		ψοτ.στ	ψ02.04				Added Effective 6 176 172020
95718	EEG PHYS/QHP 2-12 HR W/VEEG		\$106.76	\$108.32				Added Effective 01/01/2020
			· · · · · · · · · · · · · · · · · · ·	Ţ · · · · ·				
95719	EEG PHYS/QHP EA INCR W/O VID		\$126.26	\$127.55				Added Effective 01/01/2020
95720	EEG PHY/QHP EA INCR W/VEEG		\$165.29	\$167.62				Added Effective 01/01/2020
95721	EEG PHY/QHP>36<60 HR W/O VID		\$165.81	\$168.92				Added Effective 01/01/2020
95722	EEG PHY/QHP>36<60 HR W/VEEG		\$201.66	\$205.03				Added Effective 01/01/2020
05700	EEC DUVIOUDS CO COA LID MIO VID		COOF 47	¢200.20				Added Effective 04/04/0000
95723	EEG PHY/QHP>60<84 HR W/O VID	1	\$205.17	\$209.32				Added Effective 01/01/2020

Physician	Fee Schedule 2020							
Note:	The content of the co						+	
	des in Red;							
	CPT book for descriptions				1	+		
	column indicates Prior Auth is required				1	+		
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	rge for the service	<u>, </u>				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T Trial y Orlan	ge for the service	<u> </u>				+
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.				+		
	ted on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
0 0 0.00		1					 	
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
			,					
95724	EEG PHY/QHP>60<84 HR W/VEEG		\$257.15	\$261.82				Added Effective 01/01/2020
05705	EEO DUNGUDS OF THE MAIO MID		4000 40	*****				A 1 1 2 1 555 2 1 2 2 0 1 (0 1 (0 0 0 0
95725	EEG PHY/QHP>84 HR W/O VID		\$233.42	\$238.87				Added Effective 01/01/2020
95726	EEG PHY/QHP>84 HR W/VEEG		\$324.93	\$330.89				Added Effective 01/01/2020
95782	YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE		\$816.85	\$816.85	\$712.58	\$104.27		114404 211001110 0110 112020
95783	YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE		\$855.64	\$855.64	\$741.97	\$113.67		
-	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART		7	7000101	**********		 	
	RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS AND SLEEP							
95800	TIME		\$179.50	\$179.50	\$128.77	\$50.74		
	MINIMUM OF HEART RATE, OXYGEN SATURATION, AND							
95801	RESPIRATORY ANYALYSIS		\$84.56	\$84.56	\$39.76	\$44.80		
95803	ACTIGRAPHY TESTING		\$128.09	\$128.09	\$105.92	\$38.27		
	MULTIPLE SLEEP LATENCY OR MAINTENANCE OF WAKEFULNESS							
95805	TESTING, RECORDIN	R	\$213.89	\$213.89	\$142.00	\$71.89		
	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION,							
95806	RESPIRATORY EFFORT	R	\$246.64	\$246.64	\$130.92	\$115.72		
	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION,							
95807	RESPIRATORY EFFORT	R	\$299.68	\$299.68	\$180.64	\$119.04		
	POLYSOMNOGRAPHY; SLEEP STAGING WITH 1-3 ADDITIONAL							
95808	PARAMETERS OF SLEEP	R	\$328.73	\$328.73	\$180.64	\$148.09		
	POLYSOMNOGRAPHY; SLEEP STAGING WITH 4 OR MORE							
95810	ADDITIONAL PARAMETERS OF	R	\$542.42	\$542.42	\$412.30	\$130.12		
	POLYSOMNOGRAPHY; SLEEP STAGING WITH 4 OR MORE					1		
95811	ADDITIONAL PARAMETERS OF	R	\$597.83	\$597.83	\$458.16	\$139.67		

Physician	Fee Schedule 2020							
Note:							1	
	es in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ae for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING; 41-60							
95812	MINUTES		\$84.96	\$84.96	\$38.88	\$46.07		
	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING;							
95813	GREATER THAN ONE HOUR		\$304.78	\$304.78	\$234.96	\$69.82		Updated Effective 01/01/2020
	ELECTROENCEPHALOGRAM (EEG); INCLUDING RECORDING AWAKE					1		
95816	AND DROWSY		\$173.06	\$173.06	\$131.80	\$41.27		
0.5040	ELECTROENCEPHALOGRAM (EEG); INCLUDING RECORDING AWAKE		* 400 = 0	4400 50		.		
95819	AND ASLEEP		\$189.58	\$189.58	\$148.32	\$41.27		
05000	ELECTROENCEPHALOGRAM (EEG); RECORDING IN COMA OR SLEEP		#07.00	#07.00	040.54	Φ47.C0		
95822	ONLY		\$97.22	\$97.22	\$49.54	\$47.68	1	
05004	ELECTROENCEPHALOGRAM (EEG); CEREBRAL DEATH EVALUATION ONLY		\$49.70	\$49.70	C11 1C	\$38.24		
95824 95827	ELECTROENCEPHALOGRAM (EEG); ALL NIGHT RECORDING		\$119.60	\$119.60	\$11.46 \$62.60	\$57.00		
93021	ELECTROENCEPHALOGRAM (EEG), ALL NIGHT RECORDING		\$119.00	\$119.00	\$0∠.00	\$57.00		
95829	ELECTROCORTICOGRAM AT SURGERY (SEPARATE PROCEDURE)		\$199.26	\$199.26	\$4.24	\$195.02		
	INSERTION BY PHYSICIAN OF SPHENOIDAL ELECTRODES FOR							
95830	ELECTROENCEPHALOGR		\$72.51	\$72.51				
0.5004	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT;			440 =0				
95831	EXTREMITY		\$12.83	\$16.72				
05000	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT;		040.05	045.70				
95832	HAND, WITH OR		\$12.35	\$15.70	+			
05000	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT;		#20.40	#05.00				
95833	TOTAL EVALUAT		\$20.10	\$25.20	+		1	+
05024	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT;		¢07.04	¢25 42				
95834	TOTAL EVALUAT RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE		\$27.24	\$35.43				
95851	PROCEDURE); EACH		\$11.92	\$15.14				

Physician	Fee Schedule 2020							
Note:						+		
	es in Red;							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	marv chai	rae for the service	;				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		T					
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE							
95852	PROCEDURE); HAND, WI		\$8.07	\$10.08				
95857	TENSILON TEST FOR MYASTHENIA GRAVIS		\$23.23	\$29.93				
	NEEDLE ELECTROMYOGRAPHY; ONE EXTREMITY WITH OR WITHOUT							
95860	RELATED PARASPI		\$59.59	\$59.59	\$10.38	\$49.21		
	NEEDLE ELECTROMYOGRAPHY; TWO EXTREMITIES WITH OR							
95861	WITHOUT RELATED PARAS		\$101.92	\$101.92	\$20.23	\$81.68		
	NEEDLE ELECTROMYOGRAPHY; THREE EXTREMITIES WITH OR							
95863	WITHOUT RELATED		\$120.94	\$120.94	\$25.57	\$95.36		
	NEEDLE ELECTROMYOGRAPHY; FOUR EXTREMITIES WITH OR							
95864	WITHOUT RELATED		\$157.49	\$157.49	\$48.76	\$108.73		
95865	NEEDLE ELECTROMYOGRAPHY; LARYNX		\$86.43	\$86.43	\$18.13	\$68.30		
95866	NEEDLE ELECTROMYOGRAPHY; HEMIDIAPHRAGM		\$59.07	\$59.07	\$5.88	\$53.19		
	NEEDLE ELECTROMYOGRAPHY; CRANIAL NERVE SUPPLIED							
95867	MUSCLE(S), UNILATERAL		\$50.69	\$50.69	\$15.72	\$34.96		
05000	NEEDLE ELECTROMYOGRAPHY; CRANIAL NERVE SUPPLIED		***	400.40		400.04		
95868	MUSCLES, BILATERAL		\$99.16	\$99.16	\$18.92	\$80.24		
05000	NEEDLE ELECTROMYOGRAPHY; THORACIC PARASPINAL MUSCLES		#00.00	¢00.00	фг ог	COO 44		
95869	(EXCLUDING T1 OR NEEDLE ELECTROMYOGRAPHY; LIMITED STUDY OF MUSCLES IN ONE		\$26.29	\$26.29	\$5.85	\$20.44		+
05070	· · · · · · · · · · · · · · · · · · ·		COE EC	фо <i>Б Б</i> С	ΦE GE	\$19.91		
95870	EXTREMITY OR NEEDLE ELECTROMYOGRAPHY USING SINGLE FIBER ELECTRODE,		\$25.56	\$25.56	\$5.65	\$19.91		
95872	WITH QUANTITATIV		\$80.22	\$80.22	\$16.50	\$63.71		
9001Z	ELECTRICAL STIMULATION FOR GUIDANCE IN CONJUNCTION WITH		φου.∠∠	φου.∠∠	φ10.50	φυσ./ Ι	1	+
95873	CHEMODENERVATI		\$21.20	\$21.20	\$5.62	\$15.28		
33013	NEEDLE ELECTROMYOGRAPHY FOR GUIDANCE IN CONJUNCTION		ψ∠ 1.∠U	Ψ21.20	ψυ.υ∠	ψ13.20		+
95874	WITH CHEMODENERVAT		\$21.45	\$21.45	\$5.62	\$15.83		
33074	WITH OHLINODLINLINATI		Ψ <u></u> ∠ 1. 1 .3	Ψ∠ 1. 1 J	ψυ.υ∠	ψ10.00		

Physician	Fee Schedule 2020							
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	des in Red;						+	+
	CPT book for descriptions						+	+
	column indicates Prior Auth is required							+
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	rge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	oniary chai	T The service	,				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range					+	+
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Oodes iis	The lab lee solicadic that begin with a 1-of Q are currently non-covered in	or priyatolal					+	+
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Jour	ISCHEMIC LIMB EXERCISE TEST WITH SERIAL SPECIMEN(S)	I A IIIu	(i dointy)	(Nom domey)	Jonny.	Comp.	Value	110103
95875	ACQUISITION FOR		\$57.84	\$57.84	\$11.65	\$46.19		
00070	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED		ψ07.04	φ07.0-1	ψ11.00	ψ-10.10	+	+
	PARASPINAL AREAS, WHEN PREFORMED, DONE WITH NERVE							
	CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY; LIMITED							
	(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY							
95885	PROCEDURE.		\$43.35	\$43.35	\$33.23	\$15.43		
33003	I NOCEDONE.		ψ+3.33	Ψ43.33	ψ00.20	ψ13.43		
	COMPLETE, FIVE OR MORE MUSCLES STUDIED, INNERVATED BY							
	THREE OR MORE NERVES OR FOUR OR MORE SPINAL LEVELS. LIST							
95886	SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE		\$69.00	\$69.00	\$35.01	\$41.24		
93000	SEPARATEET IN ADDITION TO CODE FOR PRIMARY PROCEDURE		φυθ.υυ	ψ09.00	φυυ.υ ι	ψ41.24		+
	NEEDLE ELECTROMYOGRAPHY, NON-EXTREMITY, (CRANIAL NERVE							
	SUPPLIED OR AXIAL) MUSCLES DONE WITH NERVE CONDUCTION,							
	AMPLITUDE AND LATENCY/VELOCITY STUDY. LIST SEPARAETLY IN							
95887	ADDITION TO CODE FOR PRIMARY PROCEDURE.		\$61.24	\$61.24	\$35.60	\$32.34		
95905	MOTOR/SENS NRVE CONDUCT TEST		\$51.25	\$51.25	\$56.37	\$2.37		
95907	NERVE CONDUCTION STUDIES; 1-2 STUDIES		\$74.60	\$74.60	\$32.46	\$42.14	+	+
95908	3-4 STUDIES		\$92.10	\$92.10	\$39.17	\$52.93		
95909	5-6 STUDIES		\$110.35	\$110.35	\$47.12	\$63.23	+	+
95910	7-8 STUDIES		\$145.32	\$145.32	\$60.78	\$84.54		+
95911	9-10 STUDIES		\$175.90	\$175.90	\$70.53	\$105.37	+	+
95912	11-12 STUDIES		\$206.48	\$206.48	\$79.79	\$126.68		
95913	13 OR MORE STUDIES		\$239.30	\$239.30	\$89.29	\$150.02		+
90910	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION;		Ψ203.00	Ψ203.30	ψυσ.Δσ	ψ100.02	+	+
95921	CARDIOVAGAL INNERVATION		\$64.30	\$64.30	\$28.18	\$36.12		Rate updated 1/1/2018
303Z I	TOULD A VAGAL INITELY A LION		ψ04.30	φυ4.υυ	ψ20.10	ψυυ. ΙΖ		Trate upuateu 1/1/2010

Physician	Fee Schedule 2020		T			<u> </u>		
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	les in Red;							
	CPT book for descriptions							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Base Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION;					1		
95922	VASOMOTOR ADRENERGIC		\$74.91	\$74.91	\$36.27	\$38.64		Rate updated 1/1/2018
	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION;							
95923	SUDOMOTOR, INCLUDING ONE		\$98.75	\$98.75	\$62.12	\$36.62		Rate updated 1/1/2018
95924	COMBINED PARASYMPATHETIC AND SYMPATHETIC ADREN		\$116.71	\$116.71	\$46.22	\$70.49		
05005	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY,		450.00	450.00	***	00400		
95925	STIMULATION OF ANY		\$59.26	\$59.26	\$25.04	\$34.23		
05000	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY,		# 50.00	450.00	Φ05.04	004.00		
95926	STIMULATION OF ANY		\$59.26	\$59.26	\$25.04	\$34.23	_	
05007	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY,		ΦE0.00	ΦE0.00	ΦΩΕ Ω4	ma 4 00		
95927	STIMULATION OF ANY		\$59.26	\$59.26	\$25.04	\$34.23		
05000	CENTRAL MOTOR EVOKED POTENTIAL STUDY (TRANSCRANIAL		¢400.00	# 400.00	# 04.05	¢c0.64		
95928	MOTOR STIMULATION); CENTRAL MOTOR EVOKED POTENTIAL STUDY (TRANSCRANIAL		\$123.90	\$123.90	\$61.25	\$62.64		
95929	MOTOR STIMULATION);		\$128.74	\$128.74	\$66.10	\$62.64		
95929	VISUAL EVOKED POTENTIAL (VEP) TESTING CENTRAL NERVOUS		φ120.74	φ120.74	\$00.10	\$02.04		
95930	SYSTEM, CHECKERB		\$33.75	\$33.75	\$6.95	\$26.80		
95950	ORBICULARIS OCULI (BLINK) REFLEX, BY ELECTRODIAGNOSTIC		φ33.73	φ33.73	φ0.95	φ20.00		
95933	TESTING		\$53.27	\$53.27	\$21.57	\$31.70		
90900	NEUROMUSCULAR JUNCTION TESTING (REPETITIVE STIMULATION,		ψυυ.Ζ1	ψυυ.Ζ1	ΨΖ1.31	ψ51.70		
95937	PAIRED STIMULI		\$39.96	\$39.96	\$9.31	\$30.65		
95938	IN UPPER AND LOWER LIMBS		\$226.88	\$226.88	\$219.85	\$37.98		
95939	IN UPPER AND LOWER LIMBS		\$357.61	\$357.61	\$303.52	\$99.99	+	+
95940	CONTINUOUS INTRAOPERATIVE NEUROPHYSIOLOGY MON		\$25.71	\$25.71	Ψ000.02	Ψ00.00	+	+
95943	SIMULTANEOUS, INDEPENDENT, QUANTITATIVE MEASURES		\$0.00	\$0.00	\$0.00	\$0.00	+	+
300.10	MONITORING FOR IDENTIFICATION AND LATERALIZATION OF		140.00	***************************************	Ψ0.00	Ψ3.30	+	+
95950	CEREBRAL SEIZURE F		\$253.35	\$253.35	\$174.15	\$79.19		

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
_							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
0.5054	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY		****	4000	4000 40			
95951	CABLE OR RADI		\$363.89	\$363.89	\$209.48	\$154.41	1	
05050	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY		0000 40	# 000 40	047445	\$405.00		
95953	COMPUTERIZED PHARMACOLOGICAL OR PHYSICAL ACTIVATION REQUIRING		\$299.42	\$299.42	\$174.15	\$125.26		
05054			¢440.00	¢440.00	¢42.52	\$127.39		
95954	PHYSICIAN ATTENDANCE ELECTROENCEPHALOGRAM (EEG) DURING NONINTRACRANIAL		\$140.92	\$140.92	\$13.53	\$127.39	1	-
95955	SURGERY (EG, CAROTID		\$114.71	\$114.71	\$54.77	\$59.94		
90900	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY		φ114./1	φ114.71	Φ 34.77	φυ9.94	+	
95956	CABLE OR RADI		\$307.44	\$307.44	\$174.15	\$133.28		
33330	DIGITAL ANALYSIS OF ELECTROENCEPHALOGRAM (EEG) (EG, FOR		Ψ507.44	Ψ507.44	ψ174.13	ψ100.20	+	
95957	EPILEPTIC SPIK		\$122.82	\$122.82	\$46.61	\$76.21		
33337			Ψ122.02	Ψ122.02	ψ+0.01	Ψ1 0.21		
95958	WADA ACTIVATION TEST FOR HEMISPHERIC FUNCTION, INCLUDING		\$268.50	\$268.50	\$47.93	\$220.58		
00000	FUNCTIONAL CORTICAL AND SUBCORTICAL MAPPING BY		Ψ200.00	Ψ200.00	ψ 11.00	Ψ220.00	†	
95961	STIMULATION AND/OR RECO		\$163.62	\$163.62	\$35.20	\$128.42		
	FUNCTIONAL CORTICAL AND SUBCORTICAL MAPPING BY							
95962	STIMULATION AND/OR RECO		\$170.67	\$170.67	\$35.20	\$135.46		
	MAGNETOENCEPHALOGRAPHY (MEG), RECORDING AND ANALYSIS;			·			1	
95965	FOR SPONTANEOUS		\$317.58	\$317.58		\$317.58		
	MAGNETOENCEPHALOGRAPHY (MEG), RECORDING AND ANALYSIS;							
95966	FOR EVOKED MAGNE		\$45.80	\$45.80		\$45.80		
	MEASUREMENT AND RECORDING OF EXTERNALLY EVOKED BRAIN							
95967	PROCESSING FUNCTION USING MAGNETIC FIELDS		\$40.39	\$40.39		\$157.25		
	ELECTRONIC ANALYSIS OF IMPLANTED BRAIN SPINAL CORD OR							
95970	PERIPHERAL NEUROSTIMULATOR GENERATOR SYSTEM	<u> </u>	\$17.56	\$17.56				

Physician	n Fee Schedule 2020							
Note:	Trice Contiduite 2020							+
	des in Red;							+
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	column indicates Prior Auth is required							+
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	rge for the service	2				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	That y Chai		,				
	ise lab fee schedule for covered codes not listed below in the 80000-89249	range						+
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		<u> </u>					+
Codes lis	sted on the lab lee schedule that begin with a 1- of Q are currently hon-covered to	л рнузісіа Т	113					
							Base	+
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Jour	1 Toocdare Description	I A IIIu	(r donity)	(Norm domey)	Comp.	Joinp.	Value	110100
	ELECTRONIC ANALYSIS AND PROGRAMMING OF IMPLANTED SIMPLE							
	SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR GENERATOR							
95971	SYSTEM DURING OR AFTER SURGERY, FIRST HOUR		\$32.30	\$31.43		\$29.88		
00011	CTOTE IN BOTHING ONLY IN TENEDON CONTROL TO		Ψ02.00	ψοο		Ψ20.00	+	
	ELECTRONIC ANALYSIS AND PROGRAMMING OF IMPLANTED							
	COMPLEX SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR							
95972	GENERATOR SYSTEM DURING OR AFTER SURGERY, FIRST HOUR		\$62.88	\$63.68		\$61.61		
95976	ALYS SMPL CN NPGT PRGRMG		\$32.24	\$32.76		*		Effective 1/1/2019
95977	ALYS CPLX CN NPGT PRGRMG		\$42.98	\$43.50				Effective 1/1/2019
95980	IO ANAL GAST N-STIM INIT		\$26.57	\$29.52				
95981	IO ANAL GAST N-STIM SUBSQ		\$13.05	\$22.55				1
95982	IO GA N-STIM SUBSQ W/REPROG		\$26.11	\$34.71				1
95983	ALYS BRN NPGT PRGRMG 15 MIN		\$40.66	\$41.18				Effective 1/1/2019
95984	ALYS BRN NPGT PRGRMG ADDL 15		\$35.60	\$35.86				Effective 1/1/2019
	REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR							
95990	RESERVOIR FOR DRUG		\$39.59	\$39.59				
	REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR							
95991	RESERVOIR FOR DRUG		\$28.60	\$62.00				
	REPOSITIONING MANEUVERS FOR TREATMENT OF VERTIGO, PER							
95992	DAY		\$30.26	\$33.53				
	UNLISTED NEUROLOGICAL OR NEUROMUSCULAR DIAGNOSTIC							
95999	PROCEDURE	R	\$0.00	\$0.00				
96020	FUNCTIONAL BRAIN MAPPING					\$124.86		
	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE							
96105	AND RECEPTIVE		\$72.45	\$72.45				
		-	-	_	-	-	-	•

Physician	n Fee Schedule 2020							
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	CPT book for descriptions							
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cu	istomary cha	ge for the service	е				
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					
Please u	se lab fee schedule for covered codes not listed below in the 80000-8924	19 range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL							
96110	SCREENING TEST II, E		\$32.19	\$32.19				
96112	DEVEL TST PHYS/QHP 1ST HR		\$108.86	\$108.86				Updated Effective 01/01/2019
96113	DEVEL TST PHYS/QHP EA ADDL		\$48.65	\$48.65				Updated Effective 1/1/2019
	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF							
96116	THINKING, REASONIN		\$64.24	\$68.22				
96121	NUBHVL XM PHY/QHP EA ADDL HR		\$63.65	\$66.52				Effective 1/1/2019
96125	COGNITIVE TEST BY HC PRO		\$80.63	\$80.63				
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT		\$3.86	\$3.86				Added effective 1/1/2015
96130	PSYCL TST EVAL PHYS/QHP 1ST		\$89.87	\$95.10				Effective 1/1/2019
96131	PSYCL TST EVAL PHYS/QHP EA		\$68.47	\$72.39				Effective 1/1/2019
96132	NRPSYC TST EVAL PHYS/QHP 1ST		\$88.32	\$105.82				Effective 1/1/2019
96133	NRPSYC TST EVAL PHYS/QHP EA		\$67.69	\$80.74				Effective 1/1/2019
96136	PSYCL/NRPSYC TST PHY/QHP 1ST		\$20.18	\$36.63				Effective 1/1/2019
96137	PSYCL/NRPSYC TST PHY/QHP EA		\$15.96	\$33.72				Effective 1/1/2019
96138	PSYCL/NRPSYC TECH 1ST		\$28.18	\$28.18				Effective 1/1/2019
96139	PSYCL/NRPSYC TST TECH EA		\$28.18	\$28.18				Effective 1/1/2019
96146	PSYCL/NRPSYC TST AUTO RESULT		\$1.55	\$1.55				Effective 1/1/2019
								From 1/1/14 to 6/27/14 use
								14.51 for Inpat rate and 14.73
								for outpat rate. For 6/27/14
96150	HEALTH AND BEHAVIOR ASSESSMENT EACH 15 MINUTES		\$15.52	\$15.75				on use rates listed
								From 1/1/14 to 6/27/14 use
								for 14.00 Inpat rate and 14.22
								for outpat rate. For 6/27/14
96151	HEALTH AND BEHAVIOR RE-ASSESSMENT EACH 15 MINUTES		\$14.98	\$15.21				on use rates listed

Physician	Fee Schedule 2020							
Note:	The content of the co							
	des in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service					
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
_					l	_ ,	Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
96152	HEALTH AND BEHAVIOR INTERVENTION, INDIVIDUAL EACH 15 MINUTES		\$17.99	\$18.24				
96152	MINOTES		\$17.99	\$18.24			_	
96153	HEALTH AND BEHAVIOR INTERVENTION, GROUP EACH 15 MINUTES		\$3.99	\$4.25				
90100	TIEALTH AND BEHAVIOR INTERVENTION, GROUP EACH 13 MINUTES		φυ.99	φ4.23				
96156	HLTH BHV ASSMT/REASSESSMENT		\$71.86	\$78.61				Added Effective 01/01/2020
30100	TETT BIT ACCITIVEACCECUIENT		Ψ11.00	ψ10.01	+			Added Effective 6 1/6 1/2020
96158	HLTH BHV IVNTJ INDIV 1ST 30		\$49.04	\$53.71				Added Effective 01/01/2020
			V 1010 1	Ţ COLL				7 14404 21100410 0110 112020
96159	HLTH BHV IVNTJ INDIV EA ADDL		\$16.91	\$18.73				Added Effective 01/01/2020
96160	PT-FOCUSED HLTH RISK ASSMT		\$3.38	\$3.38				Added Effective 1/1/2017
96161	CAREGIVER HEALTH RISK ASSMT		\$3.38	\$3.38				Added Effective 1/1/2017
96164	HLTH BHV IVNTJ GRP 1ST 30		\$7.16	\$7.94				Added Effective 01/01/2020
96165	HLTH BHV IVNTJ GRP EA ADDL		\$3.18	\$3.70				Added Effective 01/01/2020
96167	HLTH BHV IVNTJ FAM 1ST 30		\$52.46	\$57.65				Added Effective 01/01/2020
00400	LILTU DUNANAT LEAM EA ADDI		640.64	000 45				Add ad Effective 04/04/0000
96168	HLTH BHV IVNTJ FAM EA ADDL		\$18.64	\$20.45			_	Added Effective 01/01/2020
96170	HLTH BHV IVNTJ FAM WO PT 1ST		\$61.56	\$64.42				Added Effective 01/01/2020
90170	HEIR BRY IVINIS FAIN WO FI 151		φ01.50	904.42	+	+	+	Added Effective 01/01/2020
96171	HLTH BHV IVNTJ FAM W/O PT EA		\$22.45	\$23.49				Added Effective 01/01/2020
96360	INTRAVENOUS INFUSION, HYDRATION, INITIAL, 31 MIN		\$45.40	\$45.40	+			7.0000 211000170 0170172020
96361	EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION		\$13.05	\$13.05				
96365	THER/PROPH/DIAG IV INF, INIT		\$55.19	\$55.19	+			+

Physician	Fee Schedule 2020	1						
Note:	1 00 001104410 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omarv char	ge for the service	!				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
96366	THER/PROPH/DIAG IV INF, ADD ON		\$17.51	\$17.51				
96367	TX/PROPH/DG ADDL SEQ IV INF		\$27.00	\$27.00				
96368	THER/DIAG CONCURRENT INF		\$16.32	\$16.32				
96369	SC THER INFUSION, UP TO 1 HR		\$122.54	\$122.54				
96370	SC THER INFUSION, ADDL 1 HR		\$13.05	\$13.05				
96371	SC THER INFUSION, RESET PUMP		\$60.82	\$60.82				
96372	THER/PROPH/DIAG INJ, SC/IM		\$18.10	\$18.10				
96373	THER/PROPH/DIAG INJ, IA		\$14.54	\$14.54				
96374	THER/PROPH/DIAG INJ, IV PUSH		\$44.51	\$44.51				
96375	TX/PRO/DX INJ NEW DRUG ADD ON		\$18.99	\$18.99				
								Rate updated 1/1/2018
96377	APP ON-BODY SUB INJ		\$15.60	\$15.60	\$0.00	\$0.00		Added Effective 1/1/2017
96379	THER/PROP/DIAG INJ/INF PROC		\$0.00	\$0.00				
	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR							
96401	INTRAMUSCULAR; NON-HORMON		\$56.43	\$56.43				
	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR							
96402	INTRAMUSCULAR; HORMONAL		\$35.81	\$35.81				
	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, UP TO AND							
96405	INCLUDING 7 LESIONS		\$23.22	\$118.26				
	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, MORE THAN 7							
96406	LESIONS		\$37.64	\$135.56				
	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH							
96409	TECHNIQUE, SINGLE OR IN		\$103.07	\$103.07				
	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH							
96411	TECHNIQUE, EACH ADDITIO		\$59.17	\$59.17				
	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION							
96413	TECHNIQUE; UP TO 1 H		\$139.44	\$139.44				

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Note:	ree Scriedule 2020							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary cnar	ge for the service		-			
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
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Droo			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Proc	Dragodyna Dogoriation	DAInd	•	•			Value	Notes
Code	Procedure Description CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
06415			\$31.66	\$31.66				
96415	TECHNIQUE; EACH		\$31.00	\$31.00				<u> </u>
00440	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION		¢450.04	Φ450 04				
96416	TECHNIQUE; INITIATIO CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION		\$150.81	\$150.81				<u> </u>
00447	· ·		¢60.00	фсо oo				
96417	TECHNIQUE; EACH CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH	-	\$68.92	\$68.92				
00400	•		¢00.70	#00 70				
96420	TECHNIQUE	-	\$96.79	\$96.79				
00400	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION		¢400.40	0400 40				
96422	TECHNIQUE, UP TO CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION	1	\$160.12	\$160.12				
00400			# 00 04	Ф00 C4				
96423	TECHNIQUE, EACH CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION	-	\$69.61	\$69.61				
00405			0457.40	0457.40				
96425	TECHNIQUE, INITI		\$157.18	\$157.18				
00440	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY,		¢400.00	0007.7				
96440	REQUIRING AND INCLUDI	 	\$120.39	\$307.75	-			
00440	CHEMOTHERAPY ADMINISTRATION INTO THE PERITONEAL CAVITY		040.00	045450				
96446	VIA INDWELLING PORT OR CATHETER		\$18.69	\$154.58				
00450	CHEMOTHERAPY ADMINISTRATION INTO SPINAL CANAL REQUIRING		# 00.00	0040.07				
96450	SPINAL TAP REFILLING AND MAINTENANCE OF PORTABLE PUMP		\$88.60 \$121.52	\$248.87 \$121.52				<u> </u>
96521		-	\$121.52	\$121.52				
00500	REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR		¢07.03	¢07.03				
96522	RESERVOIR FOR DRUG		\$97.03	\$97.03				<u> </u>
00500	IRRIGATION OF IMPLANTED VENOUS ACCESS DEVICE FOR DRUG		\$00.00	#00.00				
96523	DELIVERY SYSTEMS	 	\$23.68	\$23.68				
00540	CHEMOTHERAPY INJECTION, SUBARACHNOID OR		040.44	Φ454 45				
96542	INTRAVENTRICULAR VIA SUBCUTANE		\$43.14	\$154.45				

Physician	n Fee Schedule 2020							
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	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	nmary char	ne for the service	7				+
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	T	ge for the service	<u>′</u>				+
	se lab fee schedule for covered codes not listed below in the 80000-89249	range						+
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
96549	UNLISTED CHEMOTHERAPY PROCEDURE	R	\$0.00	\$0.00			1 0.1.0.0	11000
	PHOTODYNAMIC THERAPY BY EXTERNAL APPLICATION OF LIGHT TO			*				1
96567	DESTROY		\$94.17	\$94.17				
	PHOTODYNAMIC THERAPY BY ENDOSCOPIC APPLICATION OF LIGHT			T -				
96570	TO ABLATE ABNO		\$56.77	\$56.77				
	PHOTODYNAMIC THERAPY BY ENDOSCOPIC APPLICATION OF LIGHT							
96571	TO ABLATE ABNO		\$30.57	\$30.57				
96573	PDT DSTR PRMLG LES PHYS/QHP		\$141.49	\$141.49				Added Effective 1/1/2018
96574	DBRDMT PRMLG LES W/PDT		\$183.40	\$183.40				Added Effective 1/1/2018
96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)		\$10.92	\$10.92				
	PHOTOCHEMOTHERAPY; TAR AND ULTRAVIOLET B (GOECKERMAN							
96910	TREATMENT) OR		\$15.72	\$15.72				
96912	PHOTOCHEMOTHERAPY; PSORALENS AND ULTRAVIOLET A (PUVA)		\$18.11	\$18.11				
	PHOTOCHEMOTHERAPY (GOECKERMAN AND/OR PUVA) FOR SEVERE							
96913	PHOTORESPONSIVE		\$37.03	\$37.03				
	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS);							
96920	TOTAL AREA	R	\$47.00	\$109.44				
	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS);							
96921	250 SQ CM T	R	\$47.83	\$112.07				
	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS);							
96922	OVER 500 SQ	R	\$85.67	\$156.07				
	REFLECTANCE CONFOCAL MICROSCOPY FOR CELLULAR AND SUB-							Rate updated 1/1/2018
96931	CELLULAR IMAGING OF SKIN		\$126.94	\$126.94				Added Effective 1/1/2016
								Rate updated 1/1/2018
96932	IMAGE ACQUISITION ONLY FIRST LESION		\$90.56	\$90.56				Added Effective 1/1/2016

Physician	Fee Schedule 2020	I	1	1				
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	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Tinary Criar	T	7			+	
	se lab fee schedule for covered codes not listed below in the 80000-89249	rango						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered for		ne					
Codes lis	ted on the lab lee scriedule that begin with a F of Q are currently hon-covered to	л рнузісіаі Т	15					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Code	Frocedure Description	FAIIIU	(i acility)	(Non acinty)	Comp.	Comp.	Value	Rate updated 1/1/2018
96933	INTERPRETTION AND REPORT ONLY FIRST LESION		\$32.43	\$32.43				Added Effective 1/1/2016
30333	INTERCITION AND RELORD ONE FIRST ELSION		Ψ02.40	ψ32.43				Added Effective 1/1/2010
	IMAGE ACQUISITION AND INTERPRETATION AND REPORT FACIL							Data wadatad 4/4/2019
00004	IMAGE ACQUISITION AND INTERPRETATION AND REPORT, EACH		ΦEC 0C	# EC 0C				Rate updated 1/1/2018
96934	ADDITIONAL LESION		\$56.86	\$56.86			_	Added Effective 1/1/2016
00005	IMA OF A COLUCITION ONLY FACIL APPLITIONAL LEGION		#05.00	005.00				Rate updated 1/1/2018
96935	IMAGE ACQUISITION ONLY , EACH ADDITIONAL LESION		\$25.83	\$25.83				Added Effective 1/1/2016
00000	INTERPRETATION AND REPORT ONLY FACIL APPLITIONAL LEGION		004.04	004.04				Rate updated 1/1/2018
96936	INTERPRETATION AND REPORT ONLY EACH ADDITIONAL LESION		\$31.01	\$31.01			_	Added Effective 1/1/2016
00000	LINILIATED OPEOLAL DEPMATOLOGICAL OFFICIAL OF PROCEDURE		00.00	00.00				
96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE OR PROCEDURE	R	\$0.00	\$0.00			_	
07040	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR		00.05	00.05				
97010	COLD PACKS APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION,		\$9.35	\$9.35			_	
07040	MECHANICAL		#40.00	¢40.00				
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;		\$12.92	\$12.92				
07044	,		044.40	C44.40				
97014	ELECTRICAL STIMULATION		\$11.13	\$11.13			_	
07040	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;		040.47	040.47				
97016	VASOPNEUMATIC DEVICES		\$12.47	\$12.47			_	
07040	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN		¢40.20	¢40.20				
97018	BATH		\$10.39	\$10.39				
07000	ADDITION OF A MODALITY TO ONE OD MODE ABEAG MURE BOOK		#40.00	¢40.00				
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL		\$12.92	\$12.92				
07004	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY		40.05	40.05				
97024	(EG, MICROWA	<u> </u>	\$9.35	\$9.35				

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	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.					-		
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Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
	Dracedove Decements on	DA Ind	•	•		Comp.	Value	Notes
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	value	Notes
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED		\$8.81	\$8.81				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;							
97028	ULTRAVIOLET		\$11.21	\$11.21				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;							
97032	ELECTRICAL STIMULATION		\$11.33	\$11.33				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;							
97033	IONTOPHORESIS, EACH 15		\$11.87	\$11.87				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST							
97034	BATHS, EACH 1		\$9.09	\$9.09				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS;							
97035	ULTRASOUND, EACH 15 MI		\$9.36	\$9.36				
	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD							
97036	TANK, EACH 15		\$17.27	\$17.27				
	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT							
97039	ATTENDANCE)	R	\$15.68	\$15.68				
	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15							
97110	MINUTES; THERAPEUTIC		\$20.90	\$20.90				
	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15							
97112	MINUTES; NEUROMUSCUL		\$21.66	\$21.66				
	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15							
97113	MINUTES; AQUATIC THE		\$18.76	\$18.76				
	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15			1				
97116	MINUTES; GAIT TRAINI	<u> </u>	\$14.93	\$14.93				
	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15			1.				
97124	MINUTES; MASSAGE,		\$13.46	\$13.46				
97127	THER IVNTJ W/FOCUS COG FUNCJ		\$0.00	\$0.00				Added Effective 1/1/2018

Physician	Fee Schedule 2020							
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	se lab fee schedule for covered codes not listed below in the 80000-89249 r	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
97129	THER IVNTJ 1ST 15 MIN		\$18.99	\$19.25				Added Effective 01/01/2020
97130	THER IVNTJ EA ADDL 15 MIN		\$18.41	\$18.41				Added Effective 01/01/2020
97139	UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)	R	\$0.00	\$0.00				
	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION,							
97140	MANUAL LYMP		\$13.89	\$17.52				
07450	THE DADELITIC PROCEDURE (C), CROHR (2 OR MORE INDIVIDUAL C)		ф40 7 7	¢42.77				
97150 97151	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS) BHV ID ASSMT BY PHYS/QHP		\$13.77	\$13.77 \$0.00				Effortive 4/4/2040
			\$0.00		_			Effective 1/1/2019
97152	BHV ID SUPRT ASSMT BY 1 TECH ADAPTIVE BEHAVIOR TX BY TECH		\$0.00	\$0.00	+			Effective 1/1/2019
97153 97154			\$0.00	\$0.00 \$0.00	_			Effective 1/1/2019
	GRP ADAPT BHV TX BY TECH		\$0.00	· ·	_			Effective 1/1/2019
97155	ADAPT BEHAVIOR TX PHYS/QHP		\$0.00	\$0.00	_			Effective 1/1/2019
97156 97157	FAM ADAPT BHV TX GDN PHY/QHP		\$0.00	\$0.00 \$0.00				Effective 1/1/2019
	MULT FAM ADAPT BHV TX GDN		\$0.00		_			Effective 1/1/2019
97158 97161	GRP ADAPT BHV TX BY PHY/QHP PT EVAL LOW COMPLEX 20 MIN		\$0.00 \$63.47	\$0.00 \$63.47	_			Effective 1/1/2019 Added Effective 1/1/2017
97161	PT EVAL LOW COMPLEX 20 MIN PT EVAL MOD COMPLEX 30 MIN		\$63.47	\$63.47				Added Effective 1/1/2017 Added Effective 1/1/2017
97162								
97163	PT EVAL HIGH COMPLEX 45 MIN PT RE-EVAL EST PLAN CARE	-	\$63.47	\$63.47 \$42.90	1	+	+	Added Effective 1/1/2017 Added Effective 1/1/2017
97164	OT EVAL LOW COMPLEX 30 MIN		\$42.90	\$42.90 \$61.65		+	+	Added Effective 1/1/2017 Added Effective 1/1/2017
			\$61.65			+	+	
97166 97167	OT EVAL MOD COMPLEX 45 MIN	-	\$61.65 \$61.65	\$61.65 \$61.65	1	+	+	Added Effective 1/1/2017 Added Effective 1/1/2017
	OT EVAL HIGH COMPLEX 60 MIN					+	+	
97168	OT RE-EVAL EST PLAN CARE AT EVAL LOW COMPLEX 15 MIN	-	\$40.58	\$40.58	ΦΩ ΩΩ	<u> </u>	+	Added Effective 1/1/2017
97169 97170	AT EVAL LOW COMPLEX 15 MIN AT EVAL MOD COMPLEX 30 MIN	-	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	+	Added Effective 1/1/2017 Added Effective 1/1/2017
		-	•	· ·			+	
97171	AT EVAL HIGH COMPLEX 45 MIN		\$0.00	\$0.00	\$0.00	\$0.00		Added Effective 1/1/2017

Physician	Fee Schedule 2020							
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Refer to 0	CPT book for descriptions							
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Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
The Anes	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
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Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
97172	AT RE-EVAL EST PLAN CARE		\$0.00	\$0.00	\$0.00	\$0.00		Added Effective 1/1/2017
	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT							
97530	CONTACT BY THE PRO		\$21.61	\$21.61				
	DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION,							
97532	MEMORY, PROBLEM		\$14.98	\$18.85				
	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY							
97533	PROCESSING AND PROMO		\$14.98	\$20.40				
	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF							
97535	DAILY LIVING (AD		\$14.73	\$14.73				
	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING),							
97542	EACH 15 MIN		\$12.38	\$12.38				
	REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S), SELECTIVE							
97597	DEBRIDEMENT, WI		\$35.34	\$35.34				
	REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S), SELECTIVE							
97598	DEBRIDEMENT, WI		\$45.19	\$45.19				
	REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S), NON-							
97602	SELECTIVE DEBRIDEMENT		\$8.26	\$8.26				
.==	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA LESS		***	400.00				
97605	THAN 50 SQUARE CENTIMETERS, PER SESSION		\$21.77	\$32.36				
.=	NEGATIVE PRESSURE WOUND THERAPY, SURFACE AREA GREATER		400.04	400.07				
97606	THAN 50 SQUARE CENTIMETERS, PER SESSION		\$23.91	\$29.07				
07007	NEGATIVE PRESSURE WOUND THERAPY SURFACE AREA LESS THAN		040.00	0047.07				Eff. 11: 04/04/2022
97607	OR EQUAL TO 50 SQUARE CENTIMETERS PER SESSION		\$18.08	\$247.67				Effective 01/01/2020
07000	NEGATIVE PRESSURE WOUND THERAPY SURFACE AREA GREATER		000.04	0040.00				Eff. 1/10 04/04/2022
97608	THAN 50 SQUARE CENTIMETERS		\$20.31	\$248.60				Effective 01/01/2020

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	CPT book for descriptions							
	column indicates Prior Auth is required							
	sted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	;				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I III	1					
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	sted on the lab fee schedule that begin with a P or Q are currently non-covered for		 ns					
		Τ΄ ΄						
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND		7/		'	•		
	WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE,							
97610	PER DAY		\$12.95	\$87.98				Added Effective 1/1/2016
	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG,							
97750	MUSCULOSKELETAL, FUNCTIO		\$20.37	\$20.37				
	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING							
97760	ASSESSMENT AND FITTING		\$19.23	\$22.80				
	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S),							
97761	EACH 15 MINUTES		\$18.72	\$21.01				
97763	ORTHC/PROSTC MGMT SBSQ ENC		\$37.07	\$37.07				Added Effective 1/1/2018
	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR							
97799	PROCEDURE	R	\$0.00	\$0.00				
	MEDICAL NUTRITION THERAPY; INITIAL ASSESSMENT AND							
97802	INTERVENTION, INDIVI		\$11.87	\$11.87				
	MEDICAL NUTRITION THERAPY; RE-ASSESSMENT AND							
97803	INTERVENTION, INDIVIDUAL,		\$11.87	\$11.87				
	MEDICAL NUTRITION THERAPY; GROUP (2 OR MORE INDIVIDUAL(S)),							
97804	EACH 30 MI		\$4.64	\$4.64				
	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); ONE TO TWO							
98925	BODY REGIONS INVO		\$20.40	\$20.40				
	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); THREE TO FOUR							
98926	BODY REGIONS		\$30.53	\$30.53				
	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); FIVE TO SIX BODY							
98927	REGIONS INV		\$36.45	\$36.45				
	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); SEVEN TO EIGHT							
98928	BODY REGIONS	<u> </u>	\$42.46	\$42.46				

Physician Fee Schedule 2020 Note: 2020 Codes in Red; Refer to CPT book for descriptions					+
,		-		1	
Refer to CPT book for descriptions					
R" in PA column indicates Prior Auth is required					
Codes listed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and customary charge for the ser	vice				
The Anesthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.					
Please use lab fee schedule for covered codes not listed below in the 80000-89249 range.					
Codes listed on the lab fee schedule that begin with a P or Q are currently non-covered for physicians					
				Dana	
Proc Inpat. Rate	Outpot Boto	Tech.	Prof.	Base Unit	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Outpat. Rate (NonFacility)	Comp.	Comp.	Value	Notes
Code Procedure Description PA Ind (Facility)	(NonFacility)	Comp.	Comp.	value	Notes
98929 BODY REGIONS INV \$46.11	\$46.11				
φτο.11	Ψ+0.11				+
98940 CHIROPRACTIC MANIPULATIVE TREATMENT, 1-2 SPINAL REGIONS \$17.06	\$20.68				
Control of the contro	Ψ20.00				
98941 CHIROPRACTIC MANIPULATIVE TREATMENT, 3 TO 4 SPINAL REGIONS \$25.08	\$26.45				
98942 CHIROPRACTIC MANIPULATIVE TREATMENT, 5 SPINAL REGIONS \$33.23	\$32.78				
CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL,					
98943 ONE OR MORE RE \$0.00	\$19.24				
98960 SELF MANAGEMENT EDUCATION AND TRAINING INDIVIDUAL PATIENT \$20.39	\$20.39				Added Effective 7/1/2015
98966 HC PRO PHONE CALL 5-10 MIN \$10.39	\$11.17				Added Effective 02/04/2020
ACC TO	004.00				Add at Effective 00/04/0000
98967 HC PRO PHONE CALL 11-20 MIN \$20.76	\$21.80				Added Effective 02/04/2020
98968 HC PRO PHONE CALL 21-30 MIN \$30.90	\$31.94				Added Effective 02/04/2020
98900 INC PRO PHONE CALL 21-30 WIIN	ψ31.94				Added Effective 02/04/2020
98970 QNHP OL DIG E/M SVC 5-10MIN \$0.00	\$0.00				Added Effective 01/01/2020
GOSTO QUELLO CA O GALONINA	ΨΟ.ΟΟ				Added Effective 01/01/2020
98971 QNHP OL DIG EM SVC 11-20MIN \$0.00	\$0.00				Added Effective 01/01/2020
VIII.	\$5.55				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
98972 QNHP OL DIG E/M SVC 21+ MIN \$0.00	\$0.00				Added Effective 01/01/2020
SERVICES PROVIDED IN THE OFFICE AT TIMES OTHER THAN	i i				
99050 REGULARLY SCHEDULE \$7.50	\$10.00				
					1
99082 UNUSUAL TRAVEL (EG, TRANSPORTATION AND ESCORT OF PATIENT) R \$0.00	\$1.00				

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	Fee Schedule 2020						_	
Note:	2 to Book					_	+	
2020 Code	,						_	
	PT book for descriptions						_	
	olumn indicates Prior Auth is required							
	d as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	nesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							
Codes liste	d on the lab fee schedule that begin with a P or Q are currently non-covered for	r physiciar	ns .					
							D	
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SPECIAL ANESTHESIA SERVICES < ONE YEAR AND >THAN 70		\$25.00	\$25.00				
	MOD SED SAME PHYS/QHP <5 YRS		\$19.15	\$58.40				Added Effective 1/1/2017
	MOD SED SAME PHYS/QHP 5/>YRS		\$9.98	\$38.57				Added Effective 1/1/2017
	MOD SED SAME PHYS/QHP EA		\$8.04	\$8.04				Added Effective 1/1/2017
	MOD SED OTH PHYS/QHP <5 YRS		\$75.00	\$75.00				Added Effective 1/1/2017
	MOD SED OTH PHYS/QHP 5/>YRS		\$61.64	\$61.64				Added Effective 1/1/2017
	MOD SED OTHER PHYS/QHP EA		\$46.74	\$46.74				Added Effective 1/1/2017
	ANOGENITAL EXAMINATION WITH COLPOSCOPIC MAGNIFICATION IN							
	CHILDHOOD FOR		\$100.19	\$100.19				
	VISUAL FUNCTION SCREENING, AUTOMATED OR SEMI-AUTOMATED							
	BILATERAL		\$15.64	\$15.64	\$12.37	\$3.27		
	SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BILATERAL		\$45.00	\$60.00				
	OCULAR PHOTOSCREENING		\$21.93	\$21.93				
	IPECAC OR SIMILAR ADMINISTRATION FOR INDIVIDUAL EMESIS AND							
	CONTINUED		\$38.10	\$38.10				
	NSTRUMENT BASED OCULAR SCR BI W/ONSITE ANALYSIS		\$3.64	\$3.64				Added Effective 1/1/2018
	PHYSICIAN ATTENDANCE AND SUPERVISION OF HYPERBARIC							
	OXYGEN THERAPY, PER		\$116.13	\$116.13				
	INITIATION OF LOWERING HEAD OR TOTAL BODY TEMPERATURE IN							
	NEONATE		\$187.45	\$187.45				Added effective 1/1/2015
99188	APPLICATION OF TOPICAL FLUORIDE		\$15.00	\$15.00				Added effective 1/1/2015
	ASSEMBLY AND OPERATION OF PUMP WITH OXYGENATOR OR HEAT							
	EXCHANGER (WITH/WITHOUT ECG AND/OR PRESSURE							
	MONITORING); EACH HOUR		\$88.74	\$88.74				
	ASSEMBLY AND OPERATION OF PUMP WITH OXYGENATOR OR HEAT							
	EXCHANGER (WITH/WITHOUT ECG AND/OR PRESSURE							
99191	MONITORING); 45 MINUTES		\$54.76	\$54.76				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	1				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	ASSEMBLY AND OPERATION OF PUMP WITH OXYGENATOR OR HEAT							
	EXCHANGER (WITH/WITHOUT ECG AND/OR PRESSURE							
99192	MONITORING); 30 MINUTES		\$40.41	\$40.41				
99195	PHLEBOTOMY, THERAPEUTIC (SEPARATE PROCEDURE)		\$11.99	\$11.99				
99201	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 10 MINUTES		\$20.92	\$29.66				
99202	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 20 MINUTES		\$39.73	\$53.00				
99203	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 30 MINUTES		\$60.57	\$79.04				
99204	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 45 MINUTES		\$102.79	\$112.27				
99205	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 60 MINUTES		\$131.98	\$143.29				
99211	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 5 MINUTES		\$7.48	\$16.98				
99212	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 10 MINUTES		\$20.41	\$31.08				
99213	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 15 MINUTES		\$40.36	\$42.63				
99214	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 25 MINUTES		\$61.98	\$67.10				
99215	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 40 MINUTES		\$87.17	\$98.39				
99217	OBSERVATION CARE DISCHARGE DAY MANAGEMENT (THIS CODE IS TO BE UTILIZED		\$53.44	\$53.44				
99218	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT O		\$51.39	\$51.39				
99219	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT O		\$85.09	\$85.09				
99220	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT O		\$119.51	\$119.51				

Physician	Fee Schedule 2020				Ι		1	
Note:	T de delleurie 2020							
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							1
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	2				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249 i	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND							
99221	MANAGEMENT OF A		\$51.66	\$51.66				
	INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND							
99222	MANAGEMENT OF A		\$85.60	\$85.60				
	INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND							
99223	MANAGEMENT OF A		\$119.25	\$119.25				
	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVAL &		404.00	404.00				
99224	MGMT OF PT		\$24.33	\$24.33				
00005	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVAL &		# 40.00	0.40.00				
99225	MGMT OF PT		\$43.02	\$43.02				
00000	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVAL &		004.00	004.00				
99226	MGMT OF PT SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND		\$64.38	\$64.38				
99231	MANAGEMENT O		\$25.89	\$25.89				
99231	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND		\$25.69	\$25.69				
99232	MANAGEMENT O		\$42.24	\$42.24				
99232	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND		Ψ42.24	Ψ42.24				
99233	MANAGEMENT O		\$60.07	\$60.07				
33233	OBSERVATION OR INPATIENT HOSPITAL CARE, FOR THE		Ψ00.07	Ψ00.07				
99234	EVALUATION AND MANAGEM		\$102.79	\$102.79				
00201	OBSERVATION OR INPATIENT HOSPITAL CARE, FOR THE		Ψ102.70	Ψ102.70				
99235	EVALUATION AND MANAGEM		\$135.67	\$135.67				
	OBSERVATION OR INPATIENT HOSPITAL CARE, FOR THE			,				
99236	EVALUATION AND MANAGEM		\$169.32	\$169.32				
99238	HOSPITAL DISCHARGE DAY MANAGEMENT; 30 MINUTES OR LESS		\$53.44	\$53.44				

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	Fee Schedule 2020						_	
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2020 Cod	•							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service)				
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	e lab fee schedule for covered codes not listed below in the 80000-89249 i							
Codes liste	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	or physiciar	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
99239	HOSPITAL DISCHARGE DAY MANAGEMENT; MORE THAN 30 MINUTES		\$72.89	\$72.89				
99241	PATIENT OFFICE CONSULTATION, TYPICALLY 15 MINUTES		\$26.20	\$36.55				
99242	PATIENT OFFICE CONSULTATION, TYPICALLY 30 MINUTES		\$54.91	\$67.83				
99243	PATIENT OFFICE CONSULTATION, TYPICALLY 40 MINUTES		\$76.53	\$90.43				
99244	PATIENT OFFICE CONSULTATION, TYPICALLY 60 MINUTES		\$121.37	\$128.22				
99245	PATIENT OFFICE CONSULTATION, TYPICALLY 80 MINUTES		\$150.75	\$166.18				
	INITIAL INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED							
99251	PATIENT, WHICH		\$35.76	\$35.76				
	INITIAL INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED							
99252	PATIENT, WHICH		\$55.73	\$55.73				
	INITIAL INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED							
99253	PATIENT, WHICH		\$74.75	\$74.75				
	INITIAL INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED							
99254	PATIENT, WHICH		\$107.50	\$107.50				
	INITIAL INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED							
99255	PATIENT, WHICH		\$148.20	\$148.20				
	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND							
99281	MANAGEMENT OF A PATI		\$15.97	\$15.97				
	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND							
99282	MANAGEMENT OF A PATI		\$24.71	\$24.71				
	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND							
99283	MANAGEMENT OF A PATI		\$47.40	\$47.40				
	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND							
99284	MANAGEMENT OF A PATI		\$74.05	\$74.05			1	
	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND							
99285	MANAGEMENT OF A PATI		\$116.04	\$116.04				

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	Fee Schedule 2020					-		
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	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
99288	DIRECT ADVANCED LIFE SUPPORT		\$0.00	\$0.00				
	CRITICAL CARE DELIVERY CRITICALLY ILL OR INJURED PATIENT,							
99291	FIRST HOUR		\$157.68	\$215.02				
	CRITICAL CARE DELIVERY CRITICALLY ILL OR INJURED PATIENTADDL							
99292	30 MIN		\$88.74	\$96.75				
	INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION							
99304	AND MANAGEM		\$49.40	\$49.40				
	INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION							
99305	AND MANAGEM		\$65.66	\$65.66				
99306	NURSING FACILITY CARE INIT		\$130.50	\$130.50				
99307	NURSING FAC CARE SUBSEQ		\$34.42	\$34.42				
	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE							
99308	EVALUATION AND		\$42.19	\$42.19				
	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE							
99309	EVALUATION AND		\$59.51	\$59.51				
	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE							
99310	EVALUATION AND		\$74.49	\$74.49				
	NURSING FACILITY DISCHARGE DAY MANAGEMENT; 30 MINUTES OR		,					
99315	LESS		\$46.70	\$46.70				
	NURSING FACILITY DISCHARGE DAY MANAGEMENT; MORE THAN 30		7 10110	7				
99316	MINUTES		\$81.26	\$81.26				
333.5	EVALUATION AND MANAGEMENT OF A PATIENT INVOLVING AN		V 0	 				
99318	ANNUAL NURSING FAC		\$74.50	\$74.50				
300.10	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND		,	7				+
99324	MANAGEMENT OF A		\$45.98	\$45.98				
50021	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND		Ψ 10.00	ψ .0.00				+
99325	MANAGEMENT OF A		\$67.35	\$67.35				
00020	THE TAXACTERITIES OF TA	1	Ψ07.00	Ψ07.00				

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	des in Red;					+		
	CPT book for descriptions					+		
	column indicates Prior Auth is required							
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomary char	ne for the service	,				
	sthesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	lomary onar	1	^ 				
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
								1
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND	1	<u> </u>	,				
99326	MANAGEMENT OF A		\$93.42	\$93.42				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99327	MANAGEMENT OF A		\$128.47	\$128.47				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99328	MANAGEMENT OF A		\$159.03	\$159.03				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99334	MANAGEMENT OF AN		\$35.60	\$35.60				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99335	MANAGEMENT OF AN		\$56.37	\$56.37				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99336	MANAGEMENT OF AN		\$86.93	\$86.93				
	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND							
99337	MANAGEMENT OF AN		\$127.87	\$127.87				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW							
99341	PATIENT, WHICH		\$74.38	\$74.38				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW							
99342	PATIENT, WHICH		\$98.05	\$98.05				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW							
99343	PATIENT, WHICH		\$128.50	\$128.50				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW							
99344	PATIENT, WHICH		\$171.60	\$171.60				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW		4000 ==	4000 = 5				
99345	PATIENT, WHICH		\$203.79	\$203.79				
	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN							
99347	ESTABLISHED PATIENT		\$53.11	\$53.11				

Physician	Fee Schedule 2020							
Note:	1 00 001104410 2020							
2020 Cod	les in Red;							
	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes list	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	Э				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	se lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
00040	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN		4=0.40	470.40				
99348	ESTABLISHED PATIENT		\$78.48	\$78.48				
00040	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN		0445.70	0445.70				
99349	ESTABLISHED PATIENT		\$115.76	\$115.76				
00250	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN		¢467.07	¢467.07				
99350	ESTABLISHED PATIENT		\$167.27	\$167.27				+
99354	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE FIRST HOUR		\$72.83	\$71.96				
00004	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE EACH 30		Ψ12.00	ψ11.00				+
99355	MINUTES BEYOND FIRST HOUR		\$71.54	\$70.67				
-	PROLONGED INPATIENT OR OBSERVATION HOSPITAL SERVICE		ψ .	4. 6.6.				
99356	FIRST HOUR		\$68.88	\$68.88				
	PROLONGED PHYSICIAN SERVICE IN THE INPATIENT SETTING,							
99357	REQUIRING DIRECT		\$67.00	\$67.00				
	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION INFANT							
99381	YOUNGER THAN 1 YEAR		\$60.43	\$78.58				
99382	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION AGE 1-4		\$64.38	\$89.90				
	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION, AGE 5 -							
99383	11		\$68.26	\$89.90				
	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION, AGE 12-							
99384	17		\$80.42	\$101.22				
00005	INITIAL NEW DATIENT DREVENTIVE MEDICINE STALLIATION ASS. 42.22		077.00	#05.04				
99385	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION AGE 18-39		\$77.60	\$95.21				
00000	INITIAL NEW DATIENT DREVENTIVE MEDICINE EVALUATION AGE 40.04		¢02.00	¢446.70				
99386	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION AGE 40-64		\$93.99	\$116.70				

Physician	Fee Schedule 2020							
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	lles in Red;	+					+	
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	column indicates Prior Auth is required	_						
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary cnar	ge for the service)				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.						_	
	se lab fee schedule for covered codes not listed below in the 80000-89249						_	
Codes list	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	or physicia	ns					
		_					Dana	
_					l		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION, AGE 65							
99387	YEARS AND OLDER		\$101.40	\$127.74				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99391	EXAMINATION INFANT YOUNGER THAN 1 YEAR		\$55.17	\$67.57				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99392	EXAMINATION, AGE 1-4		\$60.43	\$78.58				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99393	EXAMINATION, AGE 5-11		\$60.43	\$78.58				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99394	EXAMINATION, AGE 12-17		\$68.26	\$89.90				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99395	EXAMINATION AGE 18-39		\$70.22	\$84.80				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99396	EXAMINATION AGE 40-64		\$76.54	\$100.83				
	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE							
99397	EXAMINATION AGE 65 YEARS AND OLDER		\$81.19	\$106.26				
	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT;							
99406	INTERMEDIATE, GREATER THAN 3 MINUTES UP TO 10 MINUTES		\$9.77	\$11.34				Added Effective 1/1/2018
	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT;							
99407	INTENSIVE, GREATER THAN 10 MINUTES		\$20.38	\$21.95				Rate updated 1/1/2018
	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND							<u> </u>
99408	INTERVENTION, 15-30 MINUTES		\$20.00	\$20.98				Added Effective 1/1/2014
	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND							
99409	INTERVENTION, > THAN 30 MINUTES		\$53.20	\$53.20				Added Effective 7/1/2016
99415	PROLONGED CLINICAL STAFF SERVICE		\$6.45	\$6.45				Added Effective 1/1/2016
99416	EACH ADDITIONAL 30 MINUTES		\$0.49	\$0.49				Added Effective 1/1/2016

Physician	Fee Schedule 2020							
Note:								
2020 Cod	les in Red;							
Refer to 0	CPT book for descriptions							
R" in PA	column indicates Prior Auth is required							
Codes lis	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cust	omary char	ge for the service)				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please u	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
Codes lis	ted on the lab fee schedule that begin with a P or Q are currently non-covered f	for physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
								Outpatient Rate of \$7.05
99420	HEALTH RISK ASSESS TEST		\$36.97	\$7.05				effective 01/01/2014
99421	OL DIG E/M SVC 5-10 MIN		\$10.39	\$11.94				Added Effective 01/01/2020
99422	OL DIG E/M SVC 11-20 MIN		\$21.28	\$23.87				Added Effective 01/01/2020
99422	OL DIG E/M SVC 11-20 MIN		\$21.28	\$23.87				Added Effective 01/01/2020
99423	OL DIG E/M SVC 21+ MIN		\$33.89	\$38.56				Added Effective 01/01/2020
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	R	\$0.00	\$0.00				
			·					
99441	PHONE E/M PHYS/QHP 5-10 MIN		\$40.36	\$42.63				Updated Effective 01/01/2020
99442	PHONE E/M PHYS/QHP 11-20 MIN		\$61.98	\$67.10				Updated Effective 01/01/2020
99443	PHONE E/M PHYS/QHP 21-30 MIN		\$87.17	\$98.39				Updated Effective 01/01/2020
99444	ONLINE E/M BY PHYS/QHP		\$0.00	\$0.00				Effective 1/1/2019
99446	NTRPROF PH1/NTRNET/EHR 5-10		\$14.53	\$14.53				Effective 1/1/2019
99447	NTRPROF PH1/NTRNET/EHR 11-20		\$28.79	\$28.79				Effective 1/1/2019
99448	NTRPROF PH1/NTRNET/EHR 21-30		\$43.32	\$43.32				Effective 1/1/2019
99449	NTRPROF PH1/NTRNET/EHR 31/>		\$57.58	\$57.58				Effective 1/1/2019
99451	NTRPROF PH1/NTRNET/EHR 5/>		\$29.56	\$29.56				Effective 1/1/2019
99452	NTRPROF PH1/NTRNET/EHR RFRL		\$29.56	\$29.56				Effective 1/1/2019
99453	REM MNTR PHYSIOL PARAM SETUP		\$14.08	\$14.08				Effective 1/1/2019
99454	REM MNTR PHYSIOL PARAM DEV		\$46.46	\$46.46				Effective 1/1/2019
								Rate Change Effective
99457	REM PHYSIOL MNTR 1ST 20 MIN		\$25.53	\$39.02				01/01/2020

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	CPT book for descriptions					-	+	
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	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	stomary chai	rae for the service				-	
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	I		; 			-	
	se lab fee schedule for covered codes not listed below in the 80000-8924	9 rango						
	ted on the lab fee schedule that begin with a P or Q are currently non-covered		ne					
Codes lis	The lab fee scriedule that begin with a 1 of Q are currently horr-covered	Tor priyacia	113					
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech.	Prof.	Base Unit Value	Notes
			(1 0.0 1.1 0)	(10111111111111111111111111111111111111				
99458	REM PHYSIOL MNTR EA ADDL 20		\$25.53	\$32.28				Added Effective 01/01/2020
99460	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY		\$45.99	\$45.99				
99461	INITIAL CARE, PER DAY, FOR EVALUATION AND MANAGEME		\$51.92	\$75.36				
99462	SUBSEQUENT HOSPITAL CARE PER DAY		\$24.63	\$24.63				
99463	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY		\$61.12	\$61.12				
99464	ATTENDANCE AT DELIVERY (WHEN REQ BY DEL PHY)		\$57.26	\$57.26				
99465	DELIVERY/BIRTHING ROOM RESUSCITATION		\$119.57	\$119.57				
99466	CRITICAL CARE SERVICES DELIVERED BY A PHY		\$190.18	\$190.18				
99467	EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY		\$94.05	\$94.05				
99468	INITIAL INPATIENT NEONATAL CRITICAL CARE, PER DAY		\$707.33	\$707.33				
99469	SUBSEQUENT INPATIENT NEONATAL CRITICAL CARE		\$308.57	\$308.57				
99471	INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY		\$636.72	\$636.72				
99472	SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER		\$313.91	\$313.91				
99473	SELF-MEAS BP PT EDUCAJ/TRAIN		\$8.03	\$8.03				Added Effective 01/01/2020
99475	INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY		\$441.19	\$441.19				
99476	SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER DAY,		\$261.99	\$261.99				
99477	INT DAY HOSP NEONATE CARE		\$275.93	\$275.93				
99478	SUBSEQUENT INTENSIVE CARE, PER DAY		\$113.34	\$113.34				
99479 99480	SUBSEQUENT INTENSIVE CARE, PER DAY SUBSEQUENT INTENSIVE CARE, PER DAY		\$98.50 \$94.65	\$98.50 \$94.65				
	·		\$139.00	\$94.65				Added Effective 1/1/2018
99483 99484	ASSMT & CARE PLN PT COG IMP CARE MGMT SVC BHVL HLTH COND		\$139.00	\$36.88				Added Effective 1/1/2018 Added Effective 1/1/2018
99484	SUPERVISION BY A CONTROL PHYSICIAN OF INTERFAC		\$25.39	\$36.88				Added Effective 1/1/2018
99485	EACH ADDITIONAL 30 MIN		\$52.68	\$52.68				
99486	CMPLX CHRON CARE W/O PT VSIT		\$41.76	\$71.39				Added Effective 1/1/2017
99487	CMPLX CHRON CARE W/O PT VSTT		\$41.76	\$35.83				Added Effective 1/1/2017 Added Effective 1/1/2017
99469	OMELY OURON CAKE ADDE 30 MIN		⊅∠1.∪1	ტა ნ.ია		_1		Auded Ellective 1/1/2017

Physician	Fee Schedule 2020							
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Codes list	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service	Э				
The Anes	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
Please us	e lab fee schedule for covered codes not listed below in the 80000-89249 r	ange.						
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physicia	ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	CHRONIC CARE MANAGEMENT SERVICES AT LEAST 20 MINUTES PER							
99490	CALENDAR MONTH		\$26.00	\$33.25				Added Effective 1/1/2015
99491	CHRNC CARE MGMT SVC 30 MIN		\$65.84	\$65.84				Effective 1/1/2019
99492	1ST PSYC COLLAB CARE MGMT		\$70.08	\$121.51				Added Effective 1/1/2018
99493	SBSQ PSYC COLLAB CARE MGMT		\$63.35	\$97.56				Added Effective 1/1/2018
99494	1ST/SBSQ PSYC COLLAB CARE		\$33.79	\$50.50				Added Effective 1/1/2018
	ADVANCE CARE PLANNING BY THE PHYSICIAN OR OTHER QUALIFIED							
99497	HEALTH CARE PROFESSIONAL		\$62.90	\$67.56				Added Effective 1/1/2016
	ADVANCE CARE PLANNING BY THE PHYSICIAN OR OTHER QUALIFIED							
99498	HEALTH CARE PROFESSIONAL		\$58.90	\$59.16				Added Effective 1/1/2016
	PERMANENT IMPLANTABLE CONTRACEPTIVE INTRATUBAL	_						POS 11 to pay \$1,400
A4264	OCCLUSION DEVICE(S) AND DELIVERY SYSTEM	R		\$1,400.00				effective 1/1/2011
A9500	TECHNETIUM TC-99M SESTAMIBI, DIAGNOSTIC, PER STUDY DOSE		\$103.45	\$103.45				Added Effective 07/01/2020
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH			\$18.75				Updated Effective 01/01/2020
D 1200	TO TOAL ALT EIGATION OF TEGORIDE VARIABILITY			ψ10.73				Opdated Effective 01/01/2020
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH			\$18.75				Updated Effective 01/01/2020
								Added Effective 1/1/2017 -
								May bill up to 2 times per six
D1354	SILVER DIAMINE FLUORIDE			\$12.00				months per quardrannt
D1526	REMOVE BILAT SPACE MAIN, MAX		\$190.00	\$190.00				Add Effective 01/01/2019
D1527	REMOVE BILAT SPACE MAIN, MAN		\$190.00	\$190.00				Add Effective 01/01/2019
	COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL							
G0105	AT HIGH RISK		\$255.86	\$255.86				
G0108	Diabetes Training IND SELF MAN 30 min		\$50.50	\$50.50				
G0109	Diabetes Training Group SELF MAN 30 min (2 or more IND.)		\$13.92	\$13.92				

Physician	Fee Schedule 2020		I					
Note:	1 00 001100010 2020							
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	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	stomary char	rae for the service	;				
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	e lab fee schedule for covered codes not listed below in the 80000-89249	9 range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered		ns					
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							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
G0121	COLON CA SCRN NOT HI RSK IND		\$150.28	\$243.75	•			Rate updated 1/1/2018
G0127	TRIM NAIL(S)		\$19.88	\$19.88				
G0202	SCREENING MAMMOGRAPHY, DIGITAL, BILATERIAL		\$91.56	\$91.56	\$66.30	\$25.26		
G0204	DIAGNOSTIC MAMMOGRAPHY, DIGITAL, BILATERIAL		\$99.65	\$99.65	\$68.35	\$31.30		
G0206	DIAGNOSTIC MAMMOGRAPHY, DIGITAL, UNILATERIAL		\$80.34	\$80.34	\$55.04	\$25.26		
G0279	TOMOSYNTHESIS DIGITAL BREAST, UNI/BI		\$43.04	\$43.04	\$18.61	\$24.44		Added Effective 1/1/2015
G0296	VISIT TO DETERM IDCT ELIG		\$42.85	\$42.85				Added Effective 1/1/2016
G0297	LOW DOSE CT SCREENING FOR CANCER		\$148.32	\$148.32	\$21.31	\$127.01		Added Effective 1/1/2017
G0365	Vessel mapping for dialysis access		\$143.36	\$143.36	\$133.38	\$9.97		Added Effective10/11/19
G0453	CONTINUOUS INTRAOPERATIVE NEUROPHYSIOLOGY MON		\$21.28	\$21.28				
G0455	PREPARATION WITH INSTILLATION OF FECAL MICROBIOTA		\$94.27	\$94.27				
G0463	OUTPAITENT HOSPITAL CLINIC VISIT		\$102.79	\$112.79				ADDED EFFECTIVE 1/1/2015
G2010	REMOT IMAGE SUBMIT BY PT		\$7.32	\$9.40				Added Effective 2/4/2020
G2012	BRIEF CHECK IN BY MD/QHP		\$10.39	\$11.43				Added Effective 2/4/2020
G2061	QUAL NONMD EST PT 5-10M		\$9.62	\$9.62				Added Effective 2/4/2020
G2062	QUAL NONMD EST PT 11-20M		\$16.98	\$16.98				Added Effective 2/4/2020
G2063	QUAL NONMD EST PT 21>MIN		\$26.34	\$26.60				Added Effective 2/4/2020
G6001	ECHO GUIDANCE RADIOTHERAPY		\$39.39	\$39.39	\$15.76	\$23.63		Added effective 1/1/2015
G6002	STEREOSCOPIC X-RAY GUIDANCE		\$55.74	\$55.74	\$39.56	\$16.18		Added effective 1/1/2015
G6003	RADIATION TREATMENT DELIVERY		\$116.92	\$116.92				Added effective 1/1/2015
G6004	RADIATION TREATMENT DELIVERY		\$90.53	\$90.53				Added effective 1/1/2015
G6005	RADIATION TREATMENT DELIVERY		\$101.14	\$101.14				Added effective 1/1/2015
G6006	RADIATION TREATMENT DELIVERY		\$100.62	\$100.62				Added effective 1/1/2015
G6007	RADIATION TREATMENT DELIVERY		\$186.00	\$186.00				Added effective 1/1/2015
G6008	RADIATION TREATMENT DELIVERY		\$125.20	\$125.20				Added effective 1/1/2015
G6009	RADIATION TREATMENT DELIVERY		\$138.65	\$138.65				Added effective 1/1/2015
G6010	RADIATION TREATMENT DELIVERY		\$138.65	\$138.65				Added effective 1/1/2015

Physician	Fee Schedule 2020							
Note:	00 001104410 2020							
2020 Code	es in Red:							
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	olumn indicates Prior Auth is required							
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	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.		1					
	e lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo		าร					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
G6011	RADIATION TREATMENT DELIVERY		\$198.93	\$198.93				Added effective 1/1/2015
G6012	RADIATION TREATMENT DELIVERY		\$164.78	\$164.78				Added effective 1/1/2015
G6013	RADIATION TREATMENT DELIVERY		\$185.48	\$185.48				Added effective 1/1/2015
G6014	RADIATION TREATMENT DELIVERY		\$185.48	\$185.48				Added effective 1/1/2015
G6015	RADIATION TX DELIVERY IMRT		\$289.42	\$289.42				Added effective 1/1/2015
G6016	DELIVERY COMP IMRT		\$288.71	\$288.71				Added effective 1/1/2015
G6017	INTRAFRACTION TRACK MOTION		\$0.00	\$0.00				Added effective 1/1/2015
H0049	ALCOHOL AND/OR DRUG SCREENING		\$24.06	\$24.06				Added Effective 7/1/2016
J0696	INJ, CEFTRIAXONE SODIUM, PER 250 MG			\$14.78				
J1380	INJ, ESTRADIOL VALERATE, UP TO 10 MG			\$0.51				
J7296	Kyleena		\$953.51	\$953.51				Updated Effective 01/01/2020
J7298	Mirena		\$953.51	\$953.51				Updated Effective 01/01/2020
J7300	INTRAUTERINE COPPER CONTRACEPTIVE			\$775.95				
	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE							
J7301	SYSTEM (SKYLA), 13.5 MG		\$793.96	\$793.96				Updated Effective 01/01/2020
J7303	CONTRACEPTIVE SUPPLY, HORMONE VAGINAL RING, EACH			\$0.00				
J7307	ETONOGESTREL IMPLAN SYSTEM			\$934.82				New Price Effective 06/01/2019
J7321	HYALGAN/SUPARTZ INJ PER DOSE			\$130.50				
J7323	EUFLEXXA INJ PER DOSE			\$131.21				
J7324	ORTHOVISC INJI PER DOSE			\$225.00	1			
J9000	DOXORUBICIN HCL, 10 MG			\$11.84				
J9015	ALDESLEUKIN, PER SINGLE USE VIAL			\$730.35				
J9017	ARSENIC TRIOXIDE, 1MG			\$36.00				
J9020	ASPARAGINASE, 10,000 UNITS			\$59.32				
J9031	BCG (INTRAVESICAL) PER INSTILLATION			\$152.19				

Physician	Fee Schedule 2020							
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2020 Code	as in Rad:							
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Thai y Chai						
	e lab fee schedule for covered codes not listed below in the 80000-89249	range						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		 ne					
Codes list		л риузісіаі Т	13					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
J9035	BEVACIZUMAB INJECTION	I A IIIQ	(i dointy)	\$61.87	Comp.	Comp.	Value	Added Effective 1/1/2016
J9040	BLEOMYCIN SULFATE, 15 UNITS			\$219.80				/ tagga Engotive 1/ 1/2010
J9041	INJECTION, BORTEZOMIB, 0.1 MG			\$31.27				
J9050	CARMUSTINE, 100 MG			\$147.14				
J9060	CISPLATIN, POWDER OR SOLUTION, PER 10 MG			\$26.87				
J9065	INJECTION, CLADRIBINE, PER 1 MG			\$48.60				
J9070	CYCLOPHOSPHAMIDE, 100 MG			\$2.75				
J9098	CYTARABINE LIPOSOME, 10 MG			\$380.34				
J9100	CYTARABINE, 100 MG			\$4.03				
J9130	DACARBAZINE, 100 MG			\$12.02				
J9150	DAUNORUBICIN, 10 MG			\$74.57				
J9151	DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION, 10 MG			\$61.20				
J9160	DENILEUKIN DIFTITOX, 300 MCG			\$1,374.30				
J9165	DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG			\$5.57				
J9178	INJECTION, EPIRUBICIN HCL, 2 MG			\$26.97				
J9181	ETOPOSIDE, 10 MG			\$4.15				
J9185	FLUDARABINE PHOSPHATE, 50 MG			\$330.32				
J9190	FLUOROURACIL, 500 MG			\$3.38				
J9200	FLOXURIDINE, 500 MG			\$131.40				
J9201	GEMCITABINE HCL, 200 MG			\$122.67				
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG			\$422.99				
J9206	IRINOTECAN, 20 MG			\$148.41				
J9208	IFOSFAMIDE, 1 GM			\$148.41				
J9209	MESNA, 200 MG			\$33.70				
J9211	IDARUBICIN HYDROCHLORIDE, 5 MG			\$397.84				
J9212	INJECTION, INTERFERON ALFACON-1, RECOMBINANT, 1 MCG			\$4.80				
J9213	INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS			\$33.05				
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS			\$14.66				

Physician	Fee Schedule 2020							
Note:	1 00 001104410 2020							+
	es in Red;							
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	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service					
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	1						
	se lab fee schedule for covered codes not listed below in the 80000-89249	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered f		าร					
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech.	Prof.	Base Unit Value	Notes
-	- Toolada Dood Iption	1 7 1 11 1 4	(i domey)	(itoin domey)		- Compi	7 4.145	110100
J9215	INTERFERON, ALFA-N3, (HUMAN LEUKOCYTE DERIVED), 250,000 IU			\$7.74				
J9216	INTERFERON, GAMMA 1-B, 3 MILLION UNITS			\$318.74				
J9219	LEUPROLIDE ACETATE IMPLANT, 65 MG			\$5,115.60				
	MECHLORETHAMINE HYDROCHLORIDE, (NITROGEN MUSTARD), 10					i		
J9230	MG			\$11.38				
J9245	INJECTION, MELPHALAN HYDROCHLORIDE, 50 MG			\$397.99		i		
J9250	METHOTREXATE SODIUM, 5 MG			\$0.34				
J9260	METHOTREXATE SODIUM, 50 MG			\$3.75				
J9268	PENTOSTATIN, PER 10 MG			\$2,117.34				
J9270	PLICAMYCIN, 2.5 MG			\$88.87				
J9280	MITOMYCIN, 5 MG			\$77.23				
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG			\$326.82				
J9300	GEMTUZUMAB OZOGAMICIN, 5MG			\$2,291.65				
J9305	INJECTION, PEMETREXED, 10 MG			\$43.87				
J9320	STREPTOZOCIN, 1 GM			\$167.63				
J9340	THIOTEPA, 15 MG			\$119.99				
J9355	TRASTUZUMAB, 10 MG			\$55.71				
J9357	VALRUBICIN, INTRAVESICAL, 200 MG			\$498.96				
J9360	VINBLASTINE SULFATE, 1 MG			\$2.47				
J9370	VINCRISTINE SULFATE, 1 MG			\$22.75				
J9390	VINORELBINE TARTRATE, PER 10 MG			\$82.38				
J9395	INJECTION, FULVESTRANT, 25 MG			\$84.99				
J9600	PORFIMER SODIUM, 75 MG			\$2,466.63				
Q4101	APILIGRAF, PER SQUARE CM		\$28.56	\$28.56				
Q4106	DERMAGRAFT, PER SQUARE CM		\$34.99	\$34.99				
Q4117	HYALOMATRIX		\$216.23	\$216.23				Effective 1/1/2019
Q4121	THERASKIN		\$23.21	\$23.21				

Physician	Fee Schedule 2020							
Note:	00 001104410 2020							+
2020 Code	es in Red:							+
	PT book for descriptions							
	olumn indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
The Anest	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.	Triary oriar						
	e lab fee schedule for covered codes not listed below in the 80000-89249 r	range.						
	ed on the lab fee schedule that begin with a P or Q are currently non-covered for		ns					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
Q4132	GRAPHIX CORE PER SQUARE CM		\$0.00	\$0.00				Effective 1/1/2015
Q4133	GRAPHIX PRIME PER SQUARE CM		\$0.00	\$0.00				Effective 1/1/2015
Q4160	NUSHIELD 1 SQUARE CM		\$110.62	\$110.62				Effective 11/1/2019
Q4186	EPIFIX 1 SQ CM		\$216.23	\$216.23				Effective 1/1/2019
Q4187	EPICORD 1 SQ CM		\$216.23	\$216.23				Effective 1/1/2019
Q4195	PURAPLY 1 SQ CM		\$140.00	\$140.00				Effective 7/1/2020
Q4196	PURAPLY AM 1 SQ CM		\$140.00	\$140.00				Effective 7/1/2020
V2020	FRAMES, PURCHASES		\$19.00	\$50.00			i	
V2100	SPHERE, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00, PER LENS		\$0.00	\$50.00				
	SPHERE, SINGLE VISION, PLUS OR MINUS 4.12 TO PLUS OR MINUS							
V2101	7.00D, PER		\$0.00	\$50.00				
	SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS							
V2102	20.00D, PE		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D							
V2103	SPHERE, .1		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D							
V2104	SPHERE, 2.		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D							
V2105	SPHERE, 4.		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D							
V2106	SPHERE, OV		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR							
V2107	MINUS 7.0		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25D TO PLUS							
V2108	OR MINUS 7.		\$0.00	\$50.00				

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	es in Red;					_		
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	olumn indicates Prior Auth is required		1					
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	mary char	ge for the service					
	hesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							<u> </u>
	e lab fee schedule for covered codes not listed below in the 80000-89249 r							<u> </u>
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered fo	r physiciar	ns T			+		
							Page	<u> </u>
D====			Innet Date	Outrot Bata	Took	Prof.	Base	
Proc	Day and the Day and of the se	DA III I	Inpat. Rate	Outpat. Rate	Tech.		Unit	Natas
Code		PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
1/0400	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR		# 0.00	# 50.00				
V2109	MINUS 7.0		\$0.00	\$50.00				
1,0440	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO 7.00D		**	450.00				
V2110	SPHERE, OVE		\$0.00	\$50.00				
1,0444	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR		40.00	450.00				
V2111	MINUS 12.		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR			450.00				
V2112	MINUS 12.		\$0.00	\$50.00				
1,0440	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR		40.00	450.00				
V2113	MINUS 12.		\$0.00	\$50.00				
	SPHEROCYLINDER, SINGLE VISION, SPHERE OVER PLUS OR MINUS			450.00				
V2114	12.00D, PER L		\$0.00	\$50.00				
V2115	LENTICULAR, (MYODISC), PER LENS, SINGLE VISION		\$0.00	\$50.00				
V2118	ANISEIKONIC LENS, SINGLE VISION		\$0.00	\$50.00				
V2121	LENTICULAR LENS, PER LENS, SINGLE		\$0.00	\$50.00				
V2199	NOT OTHERWISE CLASSIFIED, SINGLE VISION LENS		\$0.00	\$50.00				
V2200	SPHERE, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS		\$0.00	\$50.00				
	SPHERE, BIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D,							
V2201	PER LENS		\$0.00	\$50.00				
	SPHERE, BIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D,							
V2202	PER LENS		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D			1.				
V2203	SPHERE, .12 TO 2		\$0.00	\$50.00		1		
	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D			1.				
V2204	SPHERE, 2.12 TO		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D							
V2205	SPHERE, 4.25 TO		\$0.00	\$50.00				

Dhysisian	Fee Schedule 2020	1						
Note:	T Tee Scriedule 2020							
	les in Red;							
	CPT book for descriptions							
	column indicates Prior Auth is required	<u> </u>						
	ted as '\$0.00" pay 45% of billed amount not to exceed provider's usual and custo	omary char	ge for the service	9				
	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered for	or physiciai	ns					
							Dane	
_					L .		Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Code	Procedure Description	PA Ind	(Facility)	(NonFacility)	Comp.	Comp.	Value	Notes
	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D							
V2206	SPHERE, OVER 6.0		\$0.00	\$50.00				
1	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR							
V2207	MINUS 7.00D		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR							
V2208	MINUS 7.00D SPH		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR							
V2209	MINUS 7.00D SPH		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR							
V2210	MINUS 7.00D SPH		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR							
V2211	MINUS 12.00D SP		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR							
V2212	MINUS 12.00D SP		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR							
V2213	MINUS 12.00D SP		\$0.00	\$50.00				
	SPHEROCYLINDER, BIFOCAL, SPHERE OVER PLUS OR MINUS 12.00D,							
V2214	PER LENS		\$0.00	\$50.00				
V2215	LENTICULAR (MYODISC), PER LENS, BI		\$0.00	\$50.00				
V2218	ANISEIKONIC, PER LENS, BIFOCAL		\$0.00	\$50.00				
V2219	BIFOCAL SEG WIDTH OVER 28MM		\$0.00	\$50.00				
V2220	BIFOCAL ADD OVER 3.25D		\$0.00	\$50.00				
V2221	LENTICULAR LENS, PER LENS, BIFOCAL		\$0.00	\$50.00				
V2299	SPECIALTY BIFOCAL (BY REPORT)	R	\$0.00	\$50.00				
V2410	VARIABLE ASPHERICITY LENS, SINGLE VISION, FULL FIELD, GLASS OR PLASTIC		\$0.00	\$50.00				

Physician	Fee Schedule 2020							
Note:								
2020 Cod	es in Red;							
Refer to C	CPT book for descriptions							
R" in PA c	column indicates Prior Auth is required							
	ed as '\$0.00" pay 45% of billed amount not to exceed provider's usual and cus	tomary char	ge for the service					
The Anest	thesia Base Rate is \$15.20. Each 15 minute increment=1 time unit.							
	se lab fee schedule for covered codes not listed below in the 80000-89249							
Codes list	ed on the lab fee schedule that begin with a P or Q are currently non-covered	for physiciar	ıs					
							Base	
Proc			Inpat. Rate	Outpat. Rate	Tech.	Prof.	Unit	
Proc Code	Procedure Description	PA Ind	Inpat. Rate (Facility)	Outpat. Rate (NonFacility)	Tech. Comp.	Prof. Comp.		Notes
	Procedure Description VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR	PA Ind		•			Unit	Notes
		PA Ind		•			Unit	Notes
Code	VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR	PA Ind	(Facility)	(NonFacility)			Unit	Notes
Code V2430	VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC, PER VARIABLE SPHERICITY LENS, OTHER TYPE ANTERIOR CHAMBER INTRAOCULAR LENS	PA Ind	(Facility) \$0.00	(NonFacility) \$50.00			Unit	Notes
V2430 V2499	VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC, PER VARIABLE SPHERICITY LENS, OTHER TYPE	PA Ind	\$0.00 \$0.00	(NonFacility) \$50.00 \$50.00			Unit	Notes
V2430 V2499 V2630	VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC, PER VARIABLE SPHERICITY LENS, OTHER TYPE ANTERIOR CHAMBER INTRAOCULAR LENS	PA Ind	\$0.00 \$0.00 \$180.00	(NonFacility) \$50.00 \$50.00 \$234.00			Unit	Notes