RESERVE

MONTANA ADMINISTRATIVE REGISTER

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N O T I C E

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A D M I N I S T R A T I V E R U L E S O F M O N T A N A

The Administrative Rules of Montana are being recodified and will be available in September, 1980. A set is comprised of the rules of the executive agencies of Montana which have been designated by the Montana Administrative Procedure Act for inclusion in the code. There are 17 loose leaf binders to a set housing approximately 7000 pages. Cost, per set, is $175.00. An additional charge of $15.00 will be made for the September and December 1980 replacement pages to the recodified set. If you are interested in purchasing a set please use the order blank below and submit prior to June 1, 1980.

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To: FRANK MURRAY
Secretary of State
Capitol Bldg, Rm 202
Helena, MT 59601

Please place my order for Administrative Rules of Montana as indicated below. I understand a statement for this order will be sent July 15, 1980, and must be paid before my order will be shipped in September, 1980.

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NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules or amendment or repeal of existing rules filed with the Secretary of State. Proposals of the Department of Revenue are reviewed only in regard to the procedural requirements of the Montana Administrative Procedure Act. The Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a Joint Resolution directing an agency to adopt, amend, or repeal a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with existing or proposed rules. The address is Room 138, State Capitol, Helena, Montana 59601.

NOTICE: The July 1977 through June 1979 Montana Administrative Register have been placed on microfiche. For information, please contact the Secretary of State, Room 202, Capitol Building, Helena, Montana, 59601.

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 12

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BEFORE THE MERIT SYSTEM COUNCIL
OF THE STATE OF MONTANA

In the matter of the adoption and amendment of rules governing the operation of the Montana Merit System	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT OF RULES GOVERNING THE OPERATION OF THE MONTANA MERIT SYSTEM

TO: All Interested Persons:

1. On Thursday, July 17, 1980, at 9:00 a.m. a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, at Helena, Montana, to consider the adoption and amendment of rules governing the operation of the Montana Merit System.

2. The proposed adoption and amendment of rules would generally update and revise the rules governing the operation of the Montana Merit System.

3. The rules proposed to be adopted and amended are as follows:

Rule I. Definitions As used in this chapter, the following definitions apply:

(1) "Agency" means a division of state government operating under the merit system council.

(2) "Appointing authority" means the person or group of persons authorized by law or to whom authority has been delegated to make appointments to positions.

(3) "Bureau" means the merit system bureau.

(4) "Chief" means the chief of the merit system bureau.

(5) "Class" means a group of positions sufficiently similar in all important characteristics to be given the same title and salary schedule.

(6) "Council" means the merit system council.

(7) "Demotion, involuntary" means a change in title of an employee for disciplinary reasons from one class to another having a lower entrance salary. "Voluntary demotion" means a change in title of an employee for other than disciplinary reasons from one class to another having a lower entrance salary.

(8) "Disadvantaged persons" means persons participating in employment or rehabilitation programs authorized by congress or the state legislature.

(9) "Dismissal" means the termination of employment for cause.

(10) "Eligible" means a person who has qualified under these rules for a specific class and has been placed on a register.

(11) "Emergency appointment" means an appointment during an emergency without regard to minimum qualifications or eligibility of appointees.

(12) "Employee" means any person hired by an appropriate appointing authority who has commenced working in a pay status and who has not resigned, been terminated or severed employment as a result of an extended unapproved leave of absence without pay.

(13) "Exempt position" means a position specifically excluded from coverage by the rules of the merit system council.

(14) "Minimum qualifications" means the requirements of training and experience as outlined in the specifications for a class.

(15) "Permanent employee" means an employee approved for permanent tenure after serving a probationary period.

(16) "Personnel officer" means the person designated responsibility for personnel administration within an agency.

(17) "Position" means any office or employment composed of specific duties.

(18) "Probationary period" means a period ranging from 6 months to 12 months of employment following appointment from a register for a permanent position.

(19) "Promotion" means a change in title of an employee from one class to another having a higher entrance salary.

(20) "Provisional appointment" means an appointment of a person possessing minimum qualifications for the position to which he is appointed but who has not completed the examination for the position.

(21) "Reappointment" means a return to employment in an agency in a different class or without previously accrued rights.

(22) "Reassignment" means a change in title of an employee for other than disciplinary reasons from one class to another.

(23) "Reclassification" means a change in title of an employee from one class to another having the same entrance salary.

(24) "Reduction in force" means the termination of employment resulting from lack of funds, curtailment of work, or reinstatement of employees who are on leave of absence.

(25) "Register" means a list of eligibles who have qualified for the same class of position.

(26) "Reinstatement" means a return to employment in an agency in the same class, or a closely related lower class, with all previously accrued rights.

(27) "Resignation" means the termination of employment at the request of the employee.

(28) "Salary adjustment" means a change in rate of pay as a result of revisions in the compensation plan or a transfer, demotion, or promotion of an employee. Salary increases of one step or more in the salary range resulting from promotions will be considered as salary advancements in determining eligibility for further advancements.

(29) "Salary advancement" means an increase in salary from one step in the salary range for a class to a higher step in the range.

(30) "Status" means the type of tenure earned by an employee, such as provisional, probationary, or permanent.

(31) "Suspension" means an enforced leave of absence for cause.

(32) "Temporary appointment" means an appointment from a register for a period of 9 months or less.

(33) "Terminition" means the termination of employment during or at the end of a period of employment of specified maximum duration, other than by resignation, reduction in force, or dismissal.

(34) "Transfer" means a change of assignment of an employee from one position to another in the same class.

Rule II. Other Leaves (1) Agencies shall follow any other leave policies adopted by the department of administration under 2-18-102, MCA.

Rule III. Training (1) The executive officer of the agency will insure that employees receive training which will give them the skills, knowledges, and abilities which they must have to efficiently and effectively perform the job to which they are assigned.

2-3.34(38)-S34300 PURPOSE OF THE MONTANA STATE MERIT SYSTEM (1) Basic Principles. ~~The Montana State Merit System of personnel administration is established to assure fair treatment to all applicants, eligibles, and employees in all personnel actions. It provides for induction of new employees through competitive examinations in order to assure the selection of the best qualified personnel available for employment. It establishes quality of performance as the basic consideration in determining salary advancements and promotions. It aims to provide equality of opportunity for qualified persons who wish to enter public employment. The cooperative efforts of Merit System and program agency personnel offices in providing comprehensive personnel for analyzing and classifying jobs, establishing adequate and equitable salary, fringe benefit, and retirement plans, projecting~~

~~manpower needs and planning to meet them; developing effective recruitment, selection, placement, training, employee evaluation and promotion programs; assuring equal opportunity and providing affirmative action programs to achieve that end; protecting employees from discrimination, arbitrary removal, and political pressures; conducting positive employee--management relations and communications; and providing research to improve personnel methods.~~ The Montana State Merit System is established to provide a fair and objective system of personnel administration for state and local agencies receiving grants-in-aid from the federal government. The goal of the Merit System is to serve citizens of Montana, State agencies and their employees by developing and administering policies and procedures that assure recruitment, selection, compensation, training, separation and other aspects of personnel administration are based on merit. The merit system strives to provide equality of opportunity for all persons wishing to enter public employment and to enhance those opportunities for handicapped and disadvantaged persons. In cooperation with agencies, the merit system will continually strive to improve personal programs in the State of Montana.

(2) The cooperative efforts of the Merit System Bureau and program agency personnel offices in providing comprehensive personnel programs are essential.

~~(2)~~ (3) Prohibition of Discrimination. Discrimination against any person in ~~recruitment, examination, appointment, training, promotion retention, discipline, or any other aspect of personnel administration because of political or religious opinions or affiliations or because of race, national origin, or other nonmerit factors will be prohibited. except where specific age, sex, or physical requirements constitute a bona fide occupational qualification necessary to proper and efficient administration. However, any person who is shown to adhere to any organization advocating the overthrowing or undermining of the government of the United States shall be barred from employment~~ recruitment, examination, appointment, assignment, training, evaluation, promotion, retention, discipline, or any other aspect of personnel administration because of race, color, religion, creed, political ideas, political belief, sex, age, marital status, physical or mental handicap, national origin, ancestry, or other nonmerit factors will be prohibited except where specific age, sex, or physical requirements constitute a bona fide occupational qualification necessary to proper and efficient administration.

~~(3)~~ (4)(a) Political Activity. Every employee will have the right to freely express his/her views as a citizen and to cast his or her vote. A state or local officer or an

employee who is subject to the provisions of the Federal Hatch Political Activities Act, as amended, may not:

(i) Use his or her official authority to influence for the purpose of interfering with or affecting the result of an election or nomination for office;

(ii) Directly or indirectly coerce, attempt to coerce, command, or advise a state or local officer or employee to pay, lend, or contribute anything of value to a party, committee, organization, agency, or person for political purposes; or

(iii) Be a candidate for public elective office in a partisan election (Candidacy for political party office is not prohibited).

(b) A state or local officer or employee who is subject to the provisions of the Hatch Act may:

(i) express his or her opinions in political subjects and candidates;

(ii) take an active part in political and management and political campaigns, and

(iii) be a candidate for political party office.

(c) Further state allowances and restrictions are found in Title 13, Chapters 35 and 37, MCA as amended, 1975.

~~(4)~~(5) Employee-Management Relations. Employees covered by the Montana State Merit System shall have the right to organize and join or refrain from joining an organization for purposes of representation pursuant to Title 39, chapters 31 and 32, MCA. ~~The matters on which such employees may negotiate and in which management agrees to meet and confer will be designated, along with other employee rights and obligations and management rights and obligations. Means should be established for the resolution of impasses.~~ The maintenance of a system of personnel administration based on the merit principles as outlined in these rules must be assured.

2-3.34(38)-S34310 MONTANA STATE MERIT SYSTEM RULES

(1) Development, Adoption, Amendment. The Montana State Merit System Council will be responsible for developing, adopting, and amending rules, regulations, and policies for meeting the needs of the participating agencies in complying with Federal Standards in order to receive federal funds. Notwithstanding any other provisions of law or rule, wherever federal merit system standards are applicable, rules shall be established by the Montana state merit system council to the extent necessary to apply such standards to personnel administration in the federally-funded programs served by the Montana state merit system council and the positions and employees therein.

(2) Same as text (found on ARM page 5, 2-55 and 2-56).

2-3.34(38)-S34330 ~~MONTANA STATE MERIT SYSTEM ADMINISTRATOR~~ CHIEF OF THE MERIT SYSTEM BUREAU

~~(1) Qualifications.--The administrator chief of the Merit System Bureau must have the training and experience in a field related to Merit System administration, and shall be known to favor the merit principle in government service.--During his or her term as administrator and for three (3) years prior to appointment, the administrator may not hold or have held a political office, or an office in a political organization nor may the administrator hold or have held a position as an employee of one of the participating agencies during his or her term for one year prior to appointment.~~

~~(2)~~ (1) Duties. The ~~administrator~~ chief shall be responsible for administering the rules and policies of the Montana State Merit System and the Merit System Council. ~~The administrator will develop and maintain effective policies and procedures with respect to employee management relations, political activity, classification, compensation, recruitment, selection, appointment, career advancement, layoffs and separations, cooperation between merit system, equal employment opportunity and personnel records and reports.~~ The chief, under the direction and approval of the merit system council and the administrator of the personnel division, will develop and maintain personnel policies and procedures that are in consonance with federal merit system standards. The ~~administrator~~ chief will develop effective policies and procedures with respect to publicizing of examinations; preparation, custody, and maintenance of registers of eligibles, determination of availability of eligibles for appointment, certification for appointments, determination of adequacy of existing registers; and other duties prescribed by these rules, ~~and~~ the Council, and the administrator of the personnel division.

~~(3)~~ (2) ~~Office~~. Bureau. The Montana State Merit System ~~office~~ Bureau will be established ~~and operated separate and distinct from the offices of the participating agencies.~~ within the Personnel Division to effectivate the statutorily mandated efficiency and avoidance of duplication and overlapping of statewide personnel administration. The ~~administrator~~ chief and the ~~assistants~~ staff selected by the ~~administrator~~ chief must be appointed in accordance with these rules.

2-3.34(38)-S34340 COOPERATION WITH OTHER AGENCIES

(1) With Agencies under the Montana Merit System. The Montana State Merit System Council will focus the

majority of its activities on providing the best possible personnel for the agencies it serves. The Merit System ~~Office~~ Bureau will work with the agencies to set up an effective program of statewide recruitment; will conduct its examination and related programs in such a way as to select for certification the ~~best~~ most qualified of available applicants; and will assist the agencies in a continuous evaluation of their personnel policies to promote high standards of personnel procedures in accordance with the basic principles embodied in these rules.

(2) With Other Civil Service Agencies. The Montana State Merit System Council will cooperate with other Civil Service agencies in conducting examinations and related procedures. The ~~Council~~ chief of the Merit System Bureau may recognize and accept certification from registers of eligibles in other Civil Services agencies operating under the same standards as the Montana State Merit System.

2-3.34(42)-S34350 POSITIONS TO WHICH THE MONTANA MERIT SYSTEM APPLIES (1) Same as existing text (found on ARM page 2-59).

(2) Exemptions. Only the following employees may be exempted from Merit System coverage, provided that such exemption would not have an undesirable impact on proper and efficient administration or on the achievement of equal employment opportunities:

(a) ~~The executive head of a state agency.~~ appropriate numbers of top level positions which are given independent responsibility by a politically elected or appointed superior to determine and publicly advocate substantive program policy which governs the essential mission of the grantee agency;

(b) ~~One deputy director appointed by the executive head of a state agency.~~ confidential assistant(s) to the executive head of a state agency or top level position defined in (a) above;

(c) ~~One confidential secretary or assistant to each the executive head of a state agency and his appointed deputy director~~ the administrator of the disaster and emergency services division or the director of an independent local civil defense/disaster and emergency service agency;

(d) ~~The appointed director of the Civil Defense agency or of an independent local Civil Defense agency.~~ members of policy, advisory, review, and appeals boards or similar bodies who do not perform administrative duties as individuals;

(e) ~~The executive head of an independent local Public Health agency.~~ bona fide part-time employees who work less than 20 hours per week, and bona fide part-time county disaster and emergency services/civil defense employees who work less than 40 hours per week;

(f) ~~Members of policy, advisory, review, appeals boards or similar bodies who do not perform administrative duties as individuals.~~ attorneys serving as legal counsel;

(g) ~~Part-time professional health and related personnel.~~ time limited positions established for the purpose of conducting a special study or investigation;

(h) ~~Attorneys serving as legal counsel.~~ severely handicapped persons recommended by the department of social and rehabilitation services;

(i) ~~Time limited positions established for the purpose of conducting a special study or investigation.~~ personnel working under personal service contracts; and

(j) ~~Examination monitors employed to conduct Merit System examinations and examination subject matter consultants.~~ unskilled laborers.

(k) ~~Unskilled labor such as janitors and custodians. (history: See. 59-914, R.C.M., 1947; NEW, MAC Notice No. 2-3-34-1, MAC Order No. 2-3-34-2, Adp. 3/17/76, Eff. 4/5/76.)~~

(3) Requests for exemptions under (2) (a) above must be presented to the merit system council for approval. All other requests for exemptions under this rule will be handled by the chief of the Merit System Bureau. Decisions made by the chief may be reviewed by the merit system council upon the request of an agency director.

(4) Job related qualification requirements should be established for positions exempted.

(5) Career management employees assigned to exempt policy determining and advocacy, confidential, and other key positions may be reinstated to the employees former class of position or a comparable position under the following conditions:

(a) The position must be vacant.

(b) The employee must meet current minimum qualifications for the position.

(6) Upon exemption of a position from the career service, incumbants with permanent status retain their career service tenure or will be appropriately compensated for its loss.

2-3.34(42)-S34360 CLASSIFICATION PLAN. (1) Delete subsection (1) in its entirety. Renumber subsequent subsections accordingly.

(2) Same as existing text (found on ARM page 2-60).

2-3.34(42)-S34370 COMPENSATION PLAN (1) Delete subsection (1) in its entirety. Renumber subsequent subsections accordingly.

(2) Same as existing text (found on ARM page 2-60).

2-3.34(46)-S34380 RECRUITMENT (1) Basis for the Plan. An active recruiting program will be conducted, based upon a plan to meet current and projected manpower needs. The recruiting efforts of the Merit System and program agencies will be coordinated and carried out in a timely manner. Recruitment will be tailored to the various classes of positions to be filled and will be directed to all appropriate sources of applicants in order to attract an adequate number of candidates for consideration and to permit successful competition with other employees. Special emphasis will be placed on recruiting efforts to attract minorities, women, or other groups that are substantially under represented in the agency work force to help assure they will be among the candidates from which appointments are made. Recruiting publicity will be carried out ~~through all appropriate media~~ for a sufficient period to assure open opportunity for the public to apply and be considered for public employment on the basis the agency is an equal opportunity employer.

(2) Notices. The ~~administrator~~ chief of the merit system bureau will give adequate public announcements of all entrance examinations and make every reasonable effort to attract qualified persons to compete in the examination and will provide an adequate period for filing of applications.

(3) Positions Requiring Announcement. When an agency wishes to fill a position that has not been recruited for on a continuous basis, the agency will notify the ~~Administrator~~ chief of the merit system bureau. The ~~Administrator~~ chief will contact those individuals whose names have been filed in a suspense file for the position. ~~If a register of three or more names cannot be developed the Merit System Administrator shall~~ The chief of the merit system bureau or the agency shall also advertise the position for at least seven (7) calendar days in such mass media as the ~~Administrator~~ chief or agency deems necessary. The ~~Administrator~~ chief or agency will provide a sufficient number of additional days, not less than three (3), for the filing of applications. Newly created classes will be advertised for in the same manner and time frame. The Merit System ~~Office~~ Bureau will pay the cost of advertising and will bill the involved agency for reimbursement.

(4) Examination Announcements. Examination announcements distributed will include the following items of information:

(a) Class title.

(b) Grade level.

(c) A description of duties and responsibilities of the class.

(d) Minimum and additional desirable qualifications.

(e) Starting salary.

(f) Hiring agency's title.

(g) Deadline for filing of applications.

(h) Selection procedure and weights.

(i) A statement directing the applicant to ~~forward his~~ make application ~~to~~ at the ~~Merit System Office~~ nearest job service office.

(5) Disqualification from Competition. The ~~administration~~ chief of the merit system bureau may, at the request of an agency or upon ~~its~~ the chief's own motion, disqualify an applicant from competition, remove the applicant's name from the register, or refuse to certify the applicant if the applicant:

(a) Lacks the announced requirements for the class.

(b) Where physical ability is a bona fide class requirement, the applicant is not physically able to perform the duties of the class with reasonable accommodation.

(c) Has been convicted of a felony and is currently under court jurisdiction.

(d) Has ever been dismissed from public service for delinquency or misconduct.

(e) Has used or attempted to use political pressure or bribery to secure an appointment under jurisdiction of the Montana State Merit System.

(f) Has failed to submit an application correctly filled out within announced time limits.

(g) Has made deliberate misstatements in an application in attempting to qualify for a class.

2-3.34(46)-S34390 EXAMINATIONS (1) Character of Examinations.

(a) For entrance to positions under Merit System jurisdiction, examinations will be conducted on an open competitive basis. They will be practical job related tests designed to reveal the applicant's ability to perform the duties of the particular position, and to determine general background and related knowledge.

(b) Written examinations will be utilized whenever they can adequately measure a significant portion of the skills, knowledges, and abilities needed to do the job. Examinations other than written may be used at the discre-

tion of the ~~Administrater~~ chief of the merit system bureau for positions for which state licensing or registration is required or where the ~~Administrater~~ chief determines that adequate written examination material does not exist.

(c) Performance tests will be used for stenographic and typing positions and may be required for other positions whenever the skills, knowledges, or abilities needed to do the job are most readily measurable with the performance test.

(d) Oral examinations may be used for positions requiring frequent contact with the public or involving important supervisory or administrative duties or whenever the skills, knowledge, or abilities needed to do the job are most readily measurable with an oral examination. Oral boards will consist of three or more members, each of whom are knowledgeable concerning the required knowledges, skills, and abilities. ~~interested in improving public administration.~~ At least one member must be technically familiar with the work performed in the classes for which oral examinations are being given. Persons holding political office or known to be active in political management may not serve as oral board members. Oral board rating format criteria must be developed in advance of the oral examination of applicants. Each applicant must be examined and rated on identical criteria. ~~An~~ Whenever possible, an oral board member will not rate competitors that are personally known.

(e) Training and experience may be rated as a part of the examination for positions where it is an appropriate measure of fitness for the class. Appropriate recognition will be given recency and quality of experience and pertinency of training. The ~~Administrator will promptly~~ chief of the merit system bureau may, at the request of an agency or upon the chief's own motion, investigate training and experience claimed by applicants who are successful in other parts of the examination. Information from these investigations will be used to rerate competitors whenever misstatements are uncovered, and to change their place on the register accordingly. When an investigation of training and experience discloses misstatements the applicant may be excluded from further examination or register placement. Such applicant may be barred from taking future merit examinations. When professional entry level classes call for a Bachelor's degree, additional numerical credit will not be extended for graduate course work and degrees.

(f) Where written examinations are required and there is no developed alternate form of the examination, an applicant failing the written examination may not reapply for the same class for a period of ~~ninety (90) calendar days~~ 6 months.

(2) Veterans' and Disabled Civilian Preference. In accordance with ~~Section 77-501, Revised Codes 1947~~ 10-2-201 through 10-2-206, MCA as amended, veterans' preference will be granted to persons who served in the armed forces during a war period or who served on active military duty for more than 180 days after January 31, 1955, or who were discharged or released because of a service connected disability, including but not limited to those veterans serving because of the Viet Nam conflict; who were honorably discharged therefrom, who have been residents of Montana for at least a 1 year, and who make a passing grade in the examination. To the final score of all such veterans, points will be added as follows: veterans, their ~~wives~~ spouses, and dependents, 5 points; veterans with a service connected disability certified by the U. S. Veterans' Administration, their ~~wives and widows~~, spouses, surviving spouses, and other dependents, 10 points. Applicants who wish to receive preference must indicate so on the application form and will be required to supply the necessary proofs on additional forms which will be furnished by the ~~Merit System Administrator~~ chief of the merit system bureau.

(3) Same as existing text (found on ARM page (2-60.B).

(4) Conduct of Examinations.

(a) Written tests will be conducted simultaneously in as many places as necessary for the convenience of applicants and as practicable for proper administration. The ~~Administrator~~ chief of the merit system bureau will make arrangements for time and place, using monitors who are qualified to give the type of examination required.

(b) The anonymity of examinees will be protected throughout the entire examination process until final grades have been established.

(c) All scoring of applicants will be done objectively and in accordance with approved testing techniques and final ratings will be established on the basis of announced weights for the separate parts of the examination. Failure in any part of the examination ~~will~~ may disqualify a competitor from participation in subsequent parts of the examination and from securing a place on the register, except for clerical performance tests. Clerical performance tests may be taken as many times and as often as is necessary to secure a passing grade. In determining the

system for establishing final ratings on an examination, the ~~Administrator~~ chief of the merit system bureau. must give due regard to the number of candidates and the number of vacancies likely to occur during the life of the register.

(d) Competitors will be allowed to review their examination papers in the presence of a Merit System ~~Office~~ Bureau staff member and within the confines of the Merit System ~~Office~~ Bureau. Only ~~those~~ the examination ~~questions~~ answer sheet ~~which were marked incorrectly~~ may be reviewed. Test booklets and test questions may not be reviewed. Answer sheets or other materials which could reveal the contents of the examination may not leave the possession of the Merit System ~~Office~~ Bureau or be copied. If a covered position has only one (1) written examination or structured oral interview, the competitor may not retake the examination until ~~ninety (90) calendar days~~ 6 months after the date of the examination or answer sheet review.

(5) Same as existing text (found on ARM page 2-60.3b).

(6) Reratings. Reratings of numerical scores based on training and experience evaluation will not be made for a period of six (6) months following the date the applicant was issued a numerical score. After six (6) months from the date of issuance of a score for a specific class, a competitor may seek a new rating. The competitor must take a written examination if one is required for the class. The most recent score will be used to place the individual on the class register. Requests for reratings must be in writing from the applicant wishing the rerating.

(7) Same as existing text (found on ARM page 2-60Bb).

2-3.34(46)-S34400 REGISTERS (1) through (3) same as existing text (found on ARM page 2-60C).

(4) Conditions of Suspension from Register. Except under extenuating circumstance(s) approved by the chief ~~Administrator~~ an eligible's suspension from the register will be final. Individuals wishing to be ~~reestablished~~ reinstated on the register will be treated as a new applicant. If no alternate form of examination exists the individual must wait a period of ~~ninety (90) calendar days~~ 6 months.

(5) and (6) Same as existing text (found on ARM pages 2-60C and 2-60Cc).

2-3.34(50)-S34410 CERTIFICATION (1) State Office Certification.

(a) Certification of eligibles will be made following receipt of a written request stating the number of positions

to be filled, the class title, salary, location of the work, and other pertinent information. For a single vacancy the ~~Administrator~~ chief will certify ~~all individuals who are ranked in the top three whole scores~~ the 5 highest names plus all ties with the fifth eligible using the register set up for the class of position to be filled. For ~~two or more vacancies in a class, the same certification used for a single vacancy will apply~~ multiple vacancies, two names for each additional vacancy will be certified.

(b) If a register is exhausted, closely related registers of the same or higher level may be used. In certifying eligibles for a position, the ~~Administrator~~ chief may use the register for that position and higher registers in the same series, if the persons certified rank among the number to be certified when eligibles on both registers are considered in order of their ratings on the two registers.

(c) When an eligible is given probationary appointment the eligible's name will be suspended from all other registers at the same or lower salary level subject to reinstatement at the eligible's written request.

(d) If an eligible has been certified three times to the same appointing authority from one register and passed over for three appointments, the appointing authority may request the ~~Administrator~~ chief in writing to omit the name of the eligible from further certifications from this register. Reasons of justification must be included in the request. Under extenauting conditions, to be approved by the ~~Administrator~~ chief, agencies may request, in writing with justification(s) the ~~Administrator~~ chief to remove the name of an eligible after one (1) certification from subsequent registers. Following the receipt of such a request, the ~~Administrator~~ chief may determine the facts and decide whether to certify the eligible again from the register to the appointing authority who has made the request.

(e) Within three days of the appointing authority's decision to appoint an eligible, those available eligibles interviewed and not appointed to a position will be notified in writing that another eligible was appointed to the position.

(f) The appointing authority may consider an eligible to be not available if the eligible fails to respond to a written inquiry within five (5) days of the mailing of the inquiry. The agency must submit proof to the Merit System ~~Administrator~~ chief that a written attempt was made to contact the eligible. Eligibles not responding to inquiries may be removed from the register.

(g) The life of a certification will be twenty-one (21) calendar days. Certification will be returned to the Merit System ~~Office~~ Bureau at the end of the twenty-one (21) days and no appointment may be made from the register thereafter.

(h) Race (sex) conscious certification of qualified applicants is permissable for occupations in which a utilization analysis indicates underutilization of minorities or women. In such cases, the chief will ensure that up to five minorities or women on the register are certified to the agency.

(2) Same as existing text (found on ARM page 2-60.D).

(3) Promotional Certification ~~from Promotional Registers. When competitive promotion is requested registers established will be used only for certification to the requesting agency. Permanent employees who apply and meet the minimum qualifications for the promotional vacancy are not subject to written examination. Upon certification by the Administrator that a permanent employee meets the minimum qualifications for the involved position, the employee's name will automatically be placed on the promotional register. Names on promotional registers will be unranked. The appointing authority shall have the right to appoint any individual whose name appears on the promotional register to the position involved. For non-competitive promotions any permanent employee of the agency who is on an appropriate or open-competitive register may be certified.~~ When promotional examinations are given, the registers established will be used only for certifications to the agency for which the examinations were given. In using a promotional register, the chief will certify the five most qualified available eligibles when competitive promotion is requested. All ties with the fifth eligible will also be referred. For non-competitive promotions, any permanent employee of the agency who is on an appropriate promotional or open-competitive register may be certified.

(4) Selective Certification. Certification of eligibles will normally be in the order of their ranking on eligible registers. For some positions approved by the chief wherein the duties and responsibilities of a position require job related qualifications in addition to, or more specific than, those measured in the examination for the class of position, the chief may identify and selectively certify fully qualified eligibles for these positions.

~~(4)~~ (5) Information Concerning Eligibles. When it is requested, all information that the ~~Administrator~~ chief has on file concerning eligibles who are certified will be made available to appointing authorities who are considering the

eligibles for appointment. When information is not specifically requested the only information to be forwarded with the certificate will be a photocopy of the eligible's application and the most recent availability inquiry.

2-3.34(50)-S34420 SELECTION (1) Basis for Plan. Selection for entrance to Merit System positions will be through open competition. The selection process will maximize reliability, objectivity, and validity through a practical and normally multipart assessment of the applicant's attributes necessary for successful job performance and career development. Applicants will meet the minimum requirements of the job class. The parts of the total examination may consist in various combinations, as appropriate to the class and to available manpower resources, of such devices as work-sample and performance tests, practical written tests, individual and group oral examinations, ratings of training and experience, physical examinations, and background and reference inquiries. Credit checks or inquiries are prohibited. In determining ranking of candidates those combinations utilized will be appropriately weighted. To facilitate employment of disadvantaged persons, ~~in aide or similar positions,~~ competition for appropriate positions may be limited to such individuals.

2-3.34(54)-S34430 APPOINTMENTS (1) Basis for Plan. Appointments to positions not herein exempted will be made on the basis of merit by selection from among the ~~highest available~~ most qualified eligibles on appropriate registers established in accordance with the provisions on recruitment and selection. Permanent appointment will be based upon satisfactory performance of employees during a ~~fixed~~ time limited probationary period. In the absence of an appropriate register, individuals appointed to temporary or other non-status positions or given provisional appointments to permanent positions pending establishment of a register will be certified by the Merit System ~~Administrator~~ chief as meeting at least the minimum qualifications established for the class of position. Such appointments will be time limited. Provisional appointments will not be continued beyond the established time limit unless compelling extenuating circumstances exist and are a matter of record. Provisional appointments will be terminated within a specified reasonable period following establishment of an appropriate list of eligibles. Emergency appointments may be made for a specified limited period to provide for maintenance of essential services in an emergency situation where normal employment procedures are impracticable.

(2) Probationary Appointments.

(a) All appointments in Merit System agencies exclusive of exempt positions will be made from appropriate registers whenever there are ~~three~~ five or more eligibles available. Selection will be made from names certified in accordance with these rules. Appointments to county or local positions will be reviewed by the administrative officer of the state agency involved to make sure that Merit System rules and regulations are strictly followed. In selecting persons from among those certified, the appointing authority will be entitled to receive and consider all information about them which has been secured by the Merit System ~~Office~~ Bureau. ~~and the appointing authority must interview all available eligibles.~~

(b) In making appointments, veterans' and disabled civilian preference must be granted in accordance with ~~Section 77-501, Revised Codes of Montana, 1947,~~ 10-2-201 through 10-2-206, MCA, ~~as amended~~.

(c) Eligibles who accept appointment and fail to report for duty at the time and place specified by the agency, except under extenuating circumstance(s) approved by the Council, will be permanently suspended from the register for a period of two (2) years from the date of establishing their numerical ratings. No reinstatements to the register will be made.

(d) All probationary appointees will work on a probationary basis for a period ranging from a minimum of six (6) months to a maximum of twelve (12) months as predetermined for each class of position by the agency, with the approval of the Merit System ~~Administrator~~ chief. Upon completion of the probationary period, the status of an employee will be changed automatically from probationary to permanent if the agency failed to prepare the written evaluation as outlined in paragraph (e) below.

(e) The services of a probationary employee serving a six (6) month probationary period will be given a written ~~evaluation~~ performance appraisal at the end of the fifth month. Employees not performing satisfactorily may be given thirty (30) days to improve their performance. The services of an employee serving a twelve (12) month probationary period will be given a written ~~evaluation~~ performance appraisal at the end of the sixth month and again at the end of the eleventh month. If the ~~evaluation(s)~~ appraisal(s) is/are satisfactory, the employee is given permanent status at the end of the probationary period. Written ~~evaluations must be signed by the employee.~~ appraisals must conform to the Performance Appraisal Policy adopted by the department of administration. ~~If an employee refuses to sign a written evaluation the evaluator will attest to the fact by signing the evaluator's~~

~~name, date, time, and reasons given by the employee for not signing the evaluation sheet. The employee will have the right to a written rebuttal of any written evaluation. Copies~~ Notification of written negative evaluations and rebuttals will be forwarded to the Merit System ~~Office~~ Bureau upon request and will be filed in the employee's personnel jacket. After the probationary period, employees must be evaluated at least on an annual basis.

(f) Probationary appointees ~~who have been selected from a county or local area certification~~ may not be transferred to another ~~office~~ position during the probationary period unless they are eligible for certification for the position to which they are transferred.

(g) Probationary appointments may be terminated by the executive officer of the agency at any time during the probationary period and the employee will have no right of appeal or hearing before the Merit System Council unless the employee alleges discrimination as defined in Sub-Chapter 38, Rule 2-3.34(38)-S34300, Paragraph (2).

(3) Same as existing text (found on ARM page 2-60.8e).

(4) Provisional Appointments. A person certified by the Merit System Administrator as meeting the minimum qualifications for a class of position may be appointed to it on a provisional basis subject to examination within six (6) months if there are fewer than ~~three~~ five persons available for appointment from the register for this class and closely related classes and providing the position has been properly advertised according to the rules of Sub-Chapter 46, Rule 2-3.34(46)-S34380, paragraphs (3) and (4). The duration of a provisional appointment may never exceed six (6) months nor may it exceed thirty (30) days after the appropriate register has been established. Successive provisional appointments of the same person may not be made and a full time equivalent position (FTE) may not be filled by repeated provisional appointments. The period of provisional appointment will be considered as part of the probationary period for persons who are given a probationary appointment within six (6) months of the provisional appointment. All provisional appointments must have prior approval of the ~~Merit System Administrator~~ chief of the Merit System Bureau.

(5) Emergency Appointments. When additional employees are urgently needed and cannot be secured from appropriate registers, emergency appointments may be made without regard to other provisions of these rules with respect to appointments. An emergency appointment is limited to forty (40) ~~calendar~~ working days during any twelve (12) month period. A full time equivalent position (FTE) will not be filled by successive emergency appointments, and successive emergency appointments of the same person may not be made.

(6) Same as existing text (found on ARM page 2-60.F)

(7) Congressionally Authorized Employment and Training Program Appointments. Congressionally authorized employment and training program appointments may be made notwithstanding other provisions of these rules in order to hire persons certified by the program operator who meet eligibility requirements established in federal legislation for special employment and training programs in effect at the time of such appointment. Such appointments may be made of persons meeting the federally established eligibility requirements from lists established through open competition, ~~on~~ or competition limited to persons meeting those requirements, or persons found by the ~~Merit System Administrator~~ chief of the Merit System Bureau to meet the minimum qualification requirements for the position. Authority to determine that appointees meet minimum qualification requirements and applicable employment requirements may be delegated by the Merit System ~~Administrator~~ chief to the employing agency. Such appointments may be made for up to one (1) year~~, and may be renewed at the discretion of the Merit System Administrator during the duration of the federally authorized program~~. Recipients of appointments under this Rule will not be given any type of Merit System status and may not be converted to probationary or permanent status appointments except under the following conditions;

(a) When original appointment under this Rule was made from lists established on an open competitive or limited competitive bases, or

(b) When, during the term of appointments under this Rule, the individual comes within reach on an appropriate open competitive register; or, ~~for aide and similar positions~~ on an appropriate register established through limited competition.

An appointee who has not earned Merit System status must be terminated at the end of the program date.

(8) Non-Competitive Appointments. In those occasional instances where there is evidence that open or limited competition is not practical, non-competitive appointments may be made. All non-competitive appointments must have prior approval by the chief of the merit system bureau. The nature of the tenure, if any, to be granted, and the promotion rights, if any, to be granted to non-competitive appointed employees will be determined by the chief.

2-3.34(54)-S34440 CAREER ADVANCEMENT. (1) Basis for Plan. Employee performance and potential should be evaluated systematically in order to improve individual effectiveness, to assess training needs and plan training opportunities, and to provide a basis for decisions on placements, promotions, separations, salary advancements and other personnel actions. When in the best interest of the service it is determined to fill a position by promotion, consideration will be given to the eligible permanent employees in the agency or in the career service and the selection will be based upon demonstrated capacity, and quality and length of service. Promotions will require certification of eligibility by the ~~Administrator~~ chief. Authority to certify permanent employee eligibility for non-competitive promotions may be delegated by the chief to the executive officer of the agency or a staff employee designated as personnel officer of the agency. Non-competitive promotions certified by the agency will be subject to a post audit by the merit system bureau.

(2) ~~Open~~ Competitive Promotions. Whenever practical, promotions should be made on ~~an open~~ a competitive basis. Vacancies may be filled by promotion of permanent or probationary employees who are qualified for the higher class of position. Promotional vacancy announcements should be posted on all employee bulletin boards for a period of not less than seven (7) days.

(3) Non-competitive Promotions. An agency may promote a permanent status employee upon certification ~~by the Merit System Administrator~~ that the employee has passed an ~~appropriate~~ examination and meets the current minimum qualifications for the position involved. Probationary employees may be promoted only if they can be certified on a competitive bases. Employees who are promoted must serve a ~~new probationary~~ trial period. A promoted employee serving a ~~new probationary~~ trial period will not lose the rights and privileges to the position held just prior to promotion.

(4) and (5) Same as existing text (found on ARM page 2-60.G).

2-3.34(54)-S34450 DEMOTIONS. (1) Agency Initiated Demotions. Permanent Employees may be demoted for cause. When an agency demotes an employee it must follow the Discipline Handling Policy set forth in ARM 2-2.14(40)-S14650 through ARM 2-2.14(40)-S14680, as amended. Salary adjustments will be made according to ~~rules, regulations, and policies developed in conjunction with House Joint Resolution Thirty Seven (37) which implements Section Six (6), Chapter 440, Session Laws of Montana, 1973.~~ the Pay Plan Rules adopted by the department of administration under 2-18-301,MCA.

(2) Voluntary Demotions. When an employee requests demotion or agrees to a demotion for non-disciplinary reasons the employee will be paid according to the Pay Plan Rules ~~at a step in the new salary range. The employees salary will be adjusted downward step for step or, at the option of the agency, to any step in the new range that does not exceed his currently held rate of pay or does not exceed the maximum of the new pay range.~~

2-3.34(54)-S34460 REASSIGNMENTS (1) Approval. Employees may not be temporarily reassigned to a higher class of position than that class currently held by the employee except for acting appointments as defined in the Pay Plan Rules adopted under 2-15-301, MCA without prior approval of the merit System Council Reassignments may not exceed twelve (12) months in duration.

(2) Reassignments. ~~An employee who is reassigned to a different class of position will be paid at the same rate of pay as before reassignment, except that in cases of added responsibilities and duties the employee's salary may be increased not to exceed the maximum of his current range or one step of the new range of reassignment, whichever is greater. Upon termination of the temporary assignment the employee will return to his original rate of pay or at the discretion of the agency to a step to which an employee would have earned had the employee not been reassigned.~~ Salary adjustments that result from reassignment will be made according to the Pay Plan Rules.

2-3.34(54)-S34470 TRANSFERS AND RECLASSIFICATIONS.

(1) Transfers. Inter and intra-agency transfers without change in title or salary may be made at any time.

(2) Reclassifications. Reclassification to another class of position having the same entrance level salary requires certification by the ~~Merit System Administrator~~ chief concerning eligibility for appointment to the new position. The ~~Administrator~~ chief may require a qualifying examination. Authority to certify eligibility for appointment to the new position may be delegated to the agency subject to post audit by the merit system bureau.

2-3.34(58)-S34480 LAYOFFS AND SEPARATIONS (1) and (2) Same as existing text (found on ARM page 2-60.Gg).

(3) Resignations. Resignations made to an agency in writing, stating the reasons for leaving, will be made a part of the agency's personnel record for the employee. A ~~photocopy of such resignation~~ copy of the payroll termination form shall be forwarded to the Merit System Office and made a part of the employee's permanent record.

(4) Reduction of Force. The executive officer of the agency may separate employees without prejudice because of lack of funds, curtailment of work, or to permit reinstatements following leave of absence. The order of separations according to status within a class will be emergency provisional, temporary, probationary, and permanent employees. When employees of the same status are separated, service ratings and seniority will be considered. Agencies shall follow the Reduction in Work Force Policy and Procedure set forth in ARM 2-2.14(24) through ARM 2-2.14(24)-S14500, as amended.

(5) Suspensions. After written notice outlining the reasons for suspension, the executive officer of the agency may suspend an employee, without pay, for cause, for a period not to exceed ~~thirty (30)~~ 10 calendar days in any one calendar year. Dismissal may follow the suspension period. A photocopy of the letter of suspension will be forwarded to the Merit System ~~Office~~ Bureau and become a part of the employee's record. Agencies ~~will~~ shall follow the Discipline Handling Policy set forth in ARM 2-2.14(40)-S14650 through ARM 2-2.14(40)-S14680, as amended.

(6) Dismissal. After written notice outlining the reasons for dismissal, the executive officer of the agency may dismiss an employee for cause. Permanent employees will have the right of appeal and hearing before the Merit System Council. Agencies ~~will~~ shall follow the

Discipline Handling and Grievance Procedures set forth in ARM 2-2.14(40)-S14650 through ARM 2-2.14(40)-S14680, as amended, and in ARM 2-2.14(64)-S14890 through ARM 2-2.14(64)-S14930, as amended.

(7) Retirement. All conditions of retirement will be according to the ~~agency's retirement policy and the Revised Codes of Montana, if applicable.~~ applicable provisions of the MCA and the rules adopted thereunder.

(8) and (9) Same as existing text (found on ARM page 2-60.H).

2-3.34(58)-S34490 GRIEVANCES (1) Each Agency participating in the Montana State Merit System will have a standardized procedure for processing grievances that conforms with the Grievance Policy and Procedure set forth in ARM 2-2.14(64)-S14890 through ARM 2-2.14(64)-S14930, as amended. No employee will be allowed to file an appeal ~~or request a hearing~~ before the Merit System Council until such employee has exhausted the remedies as outlined in the agency grievance procedure ~~developed by the agency.~~ In the grievance procedure the agency will stipulate a time frame for completion of each step that is not unreasonable or would present a hardship to an employee attempting to resolve a grievance.

(2) Employees covered under a contractual grievance procedure offering binding arbitration have the right to use either the agency grievance procedure or the contractual grievance procedure, but not both. Whichever grievance procedure is selected, the employee waives the right to the other procedure. Decisions resulting from binding arbitration are final and can not be appealed to the Merit System Council.

2-3.34(58)-S34500 APPEALS (1) Employees. Permanent employees who have been reclassified, demoted, suspended, dismissed, ~~retired,~~ separated through a reduction in force, denied reinstatement when the employee's previous class of position is open, or ~~allege~~ any employee who alleges that ~~they have~~ he or she has been subject to discrimination as defined in Sub-Chapter 38, Rule 2-3.34(38)-S43400, paragraph (2), may appeal to the Montana State Merit System Council. Such appeals must be made in writing stating the basis of the appeal within thirty (30) calendar days after the effective date of ~~exhaustion of the grievance~~

~~procedure~~ exhausting the agency grievance procedure. ~~on which the appeal is based. The appeal must be in writing and must state the basis and facts surrounding the alleged grievance.~~ A ~~formal~~ hearing before the merit system council will be arranged by the ~~Merit System Administrator~~ chief within fifteen (15) calendar days upon receipt of the written appeal. The attorney general's model ~~Rule 14 is~~ rules are modified to this extent. ~~The executive officer of the agency will be furnished a copy of the appeal in advance of the hearing.~~ The council will review the record of the grievance and consider oral and written statements presented by the parties. The council reserves the right to conduct an evidentiary hearing on the merits of the grievance. The employee ~~the employee's immediate supervisor~~ and the ~~appointing authority~~ agency director will be notified reasonably in advance of the hearing and will have the right to ~~bring witnesses, give evidence, and/or~~ have someone represent ~~them~~ him/her. The decision of the council in all appeals will be final and binding upon the agency and employee, but does not preclude the agency's or employee's right to appeal the council's decision before a Montana District Court as provided under the montana administrative ~~Procedures~~ procedure act, ~~Section 82 4216, R.C.M. 1947~~. Any action taken by the council is without prejudice to the employee's right to timely file a complaint of discrimination with the montana human rights commission after the alleged unlawful discrimination occured or was discovered.

(2) Applicants and Eligibles. Applicants and eligibles who allege discrimination as defined in Sub-Chapter 38, Rule 2-3.34(38)-S34300, paragraph (2), who have been found ineligible to take examinations, who fail examinations, or who have been removed from a register, may also appeal to the montana state merit system council. Such appeal is without prejudice to the applicant's or eligible's right to timely file a complaint with the montana human rights commission alleged unlawful discrimination occurred or was discovered. With the exception of discrimination as defined in Subchapter 38, Rule 2-3.34(38)-S34300, paragraph (2), hearings will be informal; the council need not meet as a body. The following procedures will apply:

(a) When rejected for examination the council will review the applicant's qualifications and make a determination as to whether or not the individual will be admitted to the examination. The individual will not be admitted to any part of the examination pending the council's decision.

(b) In hearing any appeal of a rating the council will determine whether or not an error was made in scoring the candidate. If the merit system ~~Administrator~~ chief is ordered to correct the applicant's rating it will be done immediately. However, the correction will not affect certifications or appointments that have already been made from the register.

(c) When an eligible appeals a removal from a register the ~~Administrator~~ chief will furnish the council all facts relating to the action. After investigation the council will render a decision. The council's decision will not affect certifications on appointments that have already been made from the register.

2-3.34(62)-S34510 COOPERATION (1) Basis for Plan. To facilitate public service mobility and maximum utilization of ~~manpower~~ human resources provision should be made for: cooperational interjurisdictional recruiting, examining, certifying, training and other personnel functions; adding to registers of eligibles, applicants with eligibility on comparable examinations in other jurisdictions; appointing on the basis of their permanent Merit System status in another jurisdiction, with maximum protection of their retirement and other benefits.

(2) Same as existing text (found on ARM page 2-60.I).

2-3.34(66)-S34520 EXTENSION (1) Basis for Plan. As determined by the ~~state~~ agency, upon initial extension of the Merit System to a program or position(s), an incumbent may obtain permanent status through an open competitive or qualifying examination; or if the incumbent has a specified period of service in the agency, at its discretion ~~the incumbent may attain permanent status if the incumbent passes a non-competitive qualifying examination.~~ permanent status may be conferred on the incumbent. ~~If the incumbent does not pass, such an employee~~ If an examination is required, incumbents who do not pass the examination may be retained in the position in which the employee has incumbency preference without acquiring the rights of Merit System status.

(2) Qualifying Examinations.

(a) When the Merit System is extended to include an agency or positions which ~~has~~ have not been previously covered, an employee of the agency may obtain status in the employee's position through an appropriate qualifying examination. Upon recommendation of the agency the employee will be automatically admitted to the examination for the position in which the employee has incumbency.

(b) In order to obtain permanent status, the employee must receive a passing grade in such examination and must be certified by the agency as having given satisfactory service in the position for six (6) months prior to the effective date of obtaining status. Qualifying examinations must meet the same standards as all other merit examinations.

(c) If the employee does not pass the qualifying examination the employee may be retained in the position in which the employee has incumbency preference without acquiring the rights of Merit System status.

(3) Same as existing text (found on ARM page 2-60.Ii).

2-3.34(70)-S34530 PERSONNEL RECORDS (1) Basis for Plan. Such personnel records as are necessary for the proper administration of a Merit System and related agency personnel programs will be maintained according to the Employee Recordkeeping Policies set forth in ARM 2-2.14(48)-S14760 through ARM 2-2.14(48)-S14760, as amended. Periodic reports will be prepared as necessary to indicate compliance with applicable state and local requirements and these standards.

(2) and (3) Same as existing text (found on ARM page 2-60.J).

2-3.34(74)-S34540 ANNUAL VACATION LEAVE (1) Same as existing text (found on ARM pages 2-60.J and 2-60.Jj).

(2) Agencies ~~will~~ shall follow the Annual Vacation Leave Policy set forth in ARM 2-2.14(14)-S14090 through ARM 2-2.14(14)-S14240, as amended.

2-3.34(74)-S-34550 SICK LEAVE (1) Same as existing text (found on ARM page 2-60.Jj).

(2) Agencies ~~will~~ shall follow the Sick Leave Policy set forth in ARM 2-2.14(20)-S14250 through ARM 2-2.14(20)-S14460, as amended, and ARM 2-2.14(28)-S14510 through ARM 2-2.14(28)-S14540, as amended.

2-3.34(74)-S34560 MILITARY LEAVE (1) Same as existing text (found on ARM page 2-60Jj).

(2) Agencies ~~will~~ shall follow the Military Leave Policy set forth in ARM 2-2.14(2)-S1430 through ARM 2-2.14(2)-S14000, as amended.

2-3.34(74)-S34570 JURY DUTY (1) Same as existing text (found on ARM page 2-60.Jj).

(2) Agencies ~~will~~ shall follow the Jury Duty Leave Policy set forth in ARM 2-2.14(6)-S14010 through ARM 2-2.14(6)-S14070, as amended.

2-3.34(74)S34580 CONFERENCE OR EDUCATIONAL LEAVE (1) and (2) same as existing text (found on ARM Page 2-60.Jj).

2-3.34(78)-S34600 CLASSIFICATION PLAN (1) Basis for the Plan. Each local government agency will provide a position classification plan based upon analysis of the duties and responsibilities of each position required to be covered under the merit system and maintained on a current basis. The classification plan will include an appropriate title for each class of position, a description of the duties and responsibilities of positions in the class, and minimum requirements of training, experience, skills, knowledges, abilities, and other qualifications necessary for entry into the class. Position classification will group together under common titles those positions having approximately the same duties and responsibilities and the same requirements of training and experience. Whenever possible, identical specifications will be used for similar positions in two or more agencies.

(2) Adoption, Maintenance and Revision of Plan.

(a) The developed position classification plan will be referred to the ~~Montana State Merit System Council~~ chief for review and comment. If the ~~Council~~ chief finds the plan acceptable, ~~it~~ then the plan will be formally adopted ~~the plan~~.

(b) The agency will keep the plan up to date by making required changes from time to time. Class specifications will be revised to reflect the current duties and responsibilities of the position. Positions will be reclassified when there is a significant change in duties and responsibilities. Revisions will be submitted to the ~~Council~~ chief for approval and formal adoption.

(c) Amendments to the original position classification plan will be prepared and submitted by the agency to the ~~Council~~ chief for review, comment, and formal adoption in the same manner as the original plan.

(d) When the ~~Council~~ chief makes recommendations to revise a job specification submitted to the ~~Council~~ chief for formal adoption the agency will comply with the ~~Council's~~ chief's recommendation(s).

(3) Allocation of Positions.

(a) All except specifically exempted positions will be allocated to the most appropriate class under the plan, and proper class titles will be used in payroll and personnel records of the agency. The classification plan will be the basis for examination announcements and admission to examinations.

(b) No appointments or promotions can be made to positions that have not been properly classified except in emergency situations approved by the ~~Council~~ chief.

(c) When the classification plan is revised, positions will be reallocated if they are found to belong in a different class or if the old class has been abolished. Incumbents of reallocated positions will be reassigned to the appropriate class with an equivalent rate of pay. If the pay they are now receiving is less than the minimum of the new range the salary will be adjusted to the minimum. If the employee's salary is not within an established rate of the new class the salary will be adjusted to the nearest rate in the new class which is above the employee's current rate of pay.

2-3.34(78)-S34610 COMPENSATION PLAN (1) Same as existing text (found on ARM pages 2-60.Kk and 2-60.L).

(2) Adoption of Plan. If a local government agency is granted the authority to develop its own compensation plan it must submit that plan to the appropriate state agency for consideration and approval. If the compensation plan is approved it will be forwarded to the ~~Merit System Council~~ chief ~~of the Merit System Bureau~~ for formal adoption. In setting up the plan the agency will consider the amount of funds available, the prevailing rates of pay in government and private employment, the cost of living, the state's financial policies, the level of each class of position in the overall classification plan, and other relevant factors.

(3) through (10) Same as existing text (found on ARM pages 2-60.L through 2-60.M).

4. The Merit System Council is proposing the adoption and amendment of the above rules, as the case may be, in order to generally revise and update the rules governing the operation of the Montana State Merit System.

5. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Mr. James A. Silberberger, Chief, Merit System Bureau, Capital Station, Helena, Montana 59601, no later than Friday, July, 25, 1980.

6. Mr. James A. Silberberger, Chief, Merit System Bureau, Capital Station, Helena, Montana 59601, has been designated to preside over and conduct the hearing.

7. The authority of the agency to make the proposed rules and amendments is based on section 2-18-105, MCA, and the rules and amendments implement section 2-18-105, MCA.

By: Joseph D. Harrington
Reverend Joseph D. Harrington,
Chairman Merit System Council

Certified to the Secretary of State June 16, 1980.

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the amendment of rules 16-2.14(1)-S1415 (air quality permits) and 16-2.14(10)-S14460 (water quality permits), to allow special public comment procedure for applications for air and water permits under the Major Facility Siting Act	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULE 16-2.14(1)-S1415, Permits, Construction and Operation of Air Contaminant Sources, AND RULE 16-2.14(10)-S14460, Montana Pollutant Discharge Elimination System

TO: All Interested Persons

1. On July 18, 1980, at 9:30 a.m., a public hearing will be held in the auditorium of the Highway Department Building, 2701 Prospect, Helena, Montana, to consider the amendment of rules 16-2.14(1)-S1415 and 16-2.14(10)-S14460.

2. The proposed amendments would except Major Facility Siting Act applications from the time and procedural requirements of the air and water permit rules.

3. The rules as proposed to be amended provide as follows:

16-2.14(1)-S1415 Permits, Construction and Operation of Air Contaminant Sources

(1) through (5) same

(6) Public review of permit applications.

(a) same

(b) With the exception of those permit applications subject to paragraph (d) below, where the application for a permit does not require the compilation of an environmental impact statement, an application shall be deemed to be complete and filed on the date the department received it unless the department notifies the applicant in writing within 30 days thereafter that it is incomplete. The notice shall list the reasons why the application is considered incomplete and shall specify the date by which any additional information requested shall be submitted. If the information is not submitted as required, the application shall be considered withdrawn unless the applicant requests in writing an extension of time for submission of the additional information. The application is complete and filed on the date the required additional information is received.

(i) through (iii) same

(c) same

(d) If an application for an air quality permit is also an application for certification under the terms of the Major Facility Siting Act, public review is governed by the terms of [Rules I through III, MAR Notice No.16-2-147].

16-2.14(10)-S14460 Montana Pollutant Discharge Elimination System

(1) through (4) same

(5) Processing procedures for MPDES permit applications.

(a) through (b) same

(c) Unless (j) below applies, a public notice of every completed MPDES permit application shall be circulated by the department in accordance with the procedures described in section (9) of this rule to inform interested and potentially interested persons of the proposed discharge and of the tentative determination. The contents of the public notice shall include the equivalent of information contained in the EPA example published in the Federal Register, December 22, 1972, Vol. 37, Number 247, Part III, Appendix A, or any subsequent revisions.

(d) through (e) same

(f) The applicant, any affected state, any affected interstate agency, any affected country, the regional administrator, or any interested agency, person or group of persons may request or petition for a public hearing with respect to the MPDES application. Any such request or petition for public hearing shall be filed within the period prescribed in subsection (e) above and shall indicate the interest of the party filing such request and the reasons why a hearing is warranted. The department shall hold a hearing if there is significant public interest (including the filing of requests or petitions for such hearings) in holding such a hearing. Instances of doubt shall be resolved in favor of holding the hearing. Any hearing pursuant to this section shall be held in the geographical area of the proposed discharge or other appropriate area, at the discretion of the department and may, as appropriate, consider related groups of permit applications.

Public notice of any hearing held pursuant to this rule, unless (j) below applies, shall be in accordance with procedures described in section (9) of this rule. The contents of the public notice shall include the equivalent of the information contained in the EPA example published in the Federal Register, December 22, 1972, Vol. 37, Number 247, Part III, Appendix C or any subsequent revisions.

(g) through (i) same

(j) If the MPDES application is also an application for certification under the Major Facility Siting Act, [Rules I through III, MAR Notice No.16-2-147] apply.

(6) through (8) same

(9) Public notice procedures.

(a) through (b) same

(c) If an MPDES application is also an application under the Major Facility Siting Act, public review is pursuant to [Rules I through III, MAR Notice No.16-2-147] rather than this subsection.

(10) through (13) same

4. The board is proposing to amend the air and water quality permit rules to allow substitution of a special public review and hearing procedure in the event that such permits are requested as part of an application under the Major Facility Siting Act.

5. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written date, views or arguments may also be submitted to C. W. Leaphart, 1 North Last Chance Gulch, Helena, Montana, 59601, no later than July 25, 1980.

6. C. W. Leaphart, 1 North Last Chance Gulch, Helena, Montana, has been designated to preside over and conduct the hearing.

7. The authority of the agency to make the proposed amendment is based on sections 75-2-111, 75-5-201, and 75-20-216(3), and the amendments implement section 75-20-216(3).

John F. McGregor M.D.
JOHN F. McGREGOR M.D., Chairman

By Rita Ann Sheehy
RITA ANN SHEEHY

Certified to the Secretary of State June 17, 1980

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the adoption of rules establishing procedures for public comment on applications for air and water permits under the Major Facility Siting Act	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF RULES SETTING PROCEDURE FOR PUBLIC COMMENT ON MAJOR FACILITY SITING ACT APPLICATIONS

TO: All Interested Persons

1. On July 18, 1980, at 9:30 a.m., a public hearing will be held in the auditorium of the Highway Department Building, to consider the adoption of rules which set procedure for public comment on applications for air or water permits pursuant to the Major Facility Siting Act.

2. The proposed rules do not replace or modify any sections currently found in the Administrative Rules of Montana and establish procedure and time frames for public comment on Major Facility Siting Act applications.

3. The proposed rules provide as follows:

RULE I DEFINITIONS

"Department" means the department of health and environmental sciences.

"Application" means a written request for a certificate of environmental compatability and public need from the board of natural resources and conservation and for any air or water permits necessary under Title 75, Chapters 2 and 5, MCA, for a facility defined in Section 75-20-104(10), MCA.

RULE II OPPORTUNITY FOR PUBLIC COMMENT AFTER APPLICATION COMPLETE

(1) Within one month after an application is declared complete pursuant to section 75-20-216, MCA, the department shall publish notice of the following:

(a) the name and address of the applicant; a general description of the size, purpose and pollutants discharged from the proposed facility; and the location of the alternative sites;

(b) if a water quality permit must be obtained, the name of the state water receiving the discharge, a brief description of the discharge's location, and whether the discharge is new or existing.

(c) that the department will accept written public comment on the application;

(d) the deadlines by which the above comments must be submitted, which must be no less than 30 days after the date the notice is first published in a legal advertisement pursuant to (2)(a) below;

(e) the name, address and phone number of the department and the person within each bureau from whom information on the application may be obtained;

(f) the name and address of the person to whom comments may be submitted;

(g) the fact that a public hearing will be held after a preliminary decision to grant or deny the relevant air or water quality permits is made.

(2) Notice of the opportunity for public comment described in (1) above must be published as follows:

(a) publishing legal notice in a newspaper of general circulation in Butte, Missoula, Helena, Great Falls, Miles City, Kalispell, and Billings 2 times within one week;

(b) submitting the notice to a state-wide wire service;

(c) mailing to any person, group, or agency upon request.

RULE III PUBLIC HEARING AFTER PRELIMINARY DECISION

(1) Within 7 months after an application is accepted as complete, the department shall:

(a) make a preliminary decision whether to grant or deny air or water permits for the primary site and each alternative site for which approval is sought; and

(b) hold a hearing to receive public comments on those decisions.

(2) The notice of public hearing shall be published as follows:

(a) publishing legal notice in a newspaper of general circulation in Butte, Missoula, Helena, Great Falls, Miles City, Kalispell, and Billings two times within one week;

(b) submitting the notice to a state-wide wire service;

(c) mailing to any person or group upon request at least 30 days prior to the date of hearing, and, in the case of an application for a water quality permit, those listed in ARM 16-2.14(10)-S14460(10)(a).

(3) The notice of public hearing shall contain the following:

(a) the name and address of the applicant, a general description of the size, purpose, and pollutants discharged from the proposed facility, the location of the alternative sites, the preliminary decision for each site to grant or deny an air or water quality permit, and the fact that only one site will be approved by the board of natural resources;

(b) if a water quality permit is applied for, the name and address of the discharger if different from the applicant.

(c) if a water quality permit must be obtained, the name of the state water receiving the discharge and a brief description of the discharge's location;

(d) the name, address and phone number of the department;

(e) the time, date and location of the public hearing, the date to be at least 30 days after the notice is first published; and the fact that written comments may be submitted until that date.

(f) the name and address of the presiding officer and the fact that written comments should be submitted to him;

(g) the name, address and phone number of the person from whom information concerning each relevant permit may be obtained, including, if a water quality permit is applied for, a draft permit, a fact sheet as required by ARM 16-2.14(10)-S14460(5)(d), and copies of MPDES forms and related documents.

(h) a brief description of the nature and purpose of the hearing, including the rules and procedure to be followed.

(4) The presiding officer shall accept information, comments and data from members of the public relevant to air or water quality at the primary and alternative sites orally or in writing at the hearing and in writing prior to the hearing. The hearing is not subject to the contested case procedure of the Montana Administrative Procedure Act, and no cross-examination will be allowed. The presiding officer has the discretion to limit repetitive testimony and prescribe rules to ensure orderly submission of statements.

(5) All written and oral comments submitted to the department from the date the above notice is issued until the termination of the public hearing must be retained by the department and considered in the formation of its final decision on relevant air or water permits. The department shall issue a response to all significant comments.

4. The board is proposing these rules in order to implement an amendment to the Major Facility Siting Act requiring the board to adopt rules providing an opportunity for public review and comment prior to issuance of a preliminary decision by the department of health and environmental sciences on air or water permits which are requested as a part of an application under the Major Facility Siting Act.

5. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to C. W. Leaphart, 1 North Last Chance Gulch, Helena, Montana, 59601, no later than July 25 1980.

6. C. W. Leaphart, 1 North Last Chance Gulch, Helena, Montana, has been designated to preside over and conduct the hearing.

7. The authority of the board to make the proposed rules is based on sections 75-2-111, 75-5-201, and 75-20-216(3), MCA, and the rules implement section 75-20-216(3), MCA.

John F. McGregor, M.D.
JOHN F. McGREGOR, M.D., Chairman

By Rita Ann Sheehy
RITA ANN SHEEHY

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF INSTITUTIONS
OF THE STATE OF MONTANA

In the matter of the adoption of rules for the certification of Alcohol and Drug Abuse personnel.	)))))	NOTICE OF PUBLIC HEARING FOR PROPOSED ADOPTION OF RULES FOR CERTIFICATION OF ALCOHOL AND DRUG ABUSE PERSONNEL.

TO: All Interested Persons.

1. On the following dates, times and places public hearings will be held in;

July 21, 1980 at 10:00 A.M. in Billings at Eastern Montana College, Petro Hall, Petro West Room.

July 21, 1980 at 3:00 P.M. in Glendive at Dawson County Courthouse, Community Room.

July 22, 1980 at 9:00 A.M. in Havre at Hilltop Recovery Center 1020 Assiniboine.

July 23, 1980 at 10:00 A.M. at Galen State Hospital, Gymnasium to consider the adoption of rules for the certification of alcohol and drug abuse counselors.

2. The proposed rules provide as follows:

Rule I. The Department will establish a certification system. Certification will be a two tier structure based upon point system. Tier one is a general chemical dependency certification with given points for work experience, college course work, structured workshop training, performance on a written examination and performance ratings on taped work samples. Tier two will provide endorsements in the four fields of (a) alcoholism counseling, (b) drug counseling, (c) education and prevention, (d) management and supervision.

Rule II. Point system. To become certified, a person must accumulate 200 points in accordance with the system rules for the accumulation of points.

Rule III. Work experience. Five points will be awarded for every documentable year of full time equivalent work experience completed as a counselor, educator, supervisor or administrator in an approved program. A maximum of 65 points can be earned from such documented work experience. One point will be given for each FTE of work in a state approved program in any other job title. To a maximum of 5 points. One point will be given for every documentable year of service as an active volunteer assisting a state approved program. Twelve step work with Alcoholics Anonymous or outreach programs targeted to drug or alcohol programs, sponsored by charitable, religious or medical groups. One point will be given for each year of service on the governing board of a state approved program. Up to 10 points will be earned for such volunteer

service plus service on a board. No more than 65 points can be counted toward the basic certificate from all types of work experience combined.

Work experience claims cannot be duplicated. That is, the same experience claimed in two places. Neither can one claim volunteer points for any period in which he was employed full time by a drug or alcohol program. There are no minimum point requirements in this area.

Table 2. Work Experience Summary

Criteria*	Point Formula	Maximum
Employment in professional position	5 per FTE year	65*
Employment in non-custodial, non-professional position	1 per FTE year	5
Active volunteer work	1 per year)	10
Governing Board Service	1 per year)	
Combined maximum experience points allowed		65
Required minimum		-0-

* For registry, data only needs to be reported. For certification it must be documented.

Rule IV. Academic work. One (1) point will be given for each documentable academic quarter hour of credit earned for coursework, subject only to the limit of sixty-five (65) points for academic coursework on the general certificate in the areas of: psychology, social work, sociology, counseling, and specific drug/alcohol coursework. One (1) point will be given for each documentable academic quarter hour of credit, but not to exceed a total of six (6) points for each area, or fifteen (15) for all areas, in the areas of: pharmacy, biology, anthropology, educational methods, and business administation (including economics and accounting).

Table 3. Coursework Summary

Criteria	Point Formula	Maximum
College coursework in approved fields - documented Psychology Social Work Counseling Sociology Specific Drug/Alcohol Courses	1 per academic quarter hour without area limits	65

Rule V. Structured Workshop Training. One (1) point will be granted for each day of approved structured workshop training. To qualify for credit, such workshops must be at least one day (six hours minimum), the workshop must be approved as appropriate for DAP by the ADAD Training and Certification Section. ADAD currently approves essentially all: 1) NIAAA/NCAE Titles and Trainers; 2) NIDA Titles and Trainers; and 3) CEDS Trainers, (and most CEDS Titles). Other workshops and trainers will be considered ona case-by-case basis.

Training must be documented by supplying an original (or a certified copy of a) certificate of completion signed by the trainer and/or an official of the training organization. All workshop training completed after implementation of certification must be approved in advance by the ADAD Training and Certification Section to gain certification points.

Local in-service training qualified for points only when it is: 1) structured training one or more days in length; 2) offered in a continuous block; 3) is an approvable topic; 4) is offered by an approved trainer. Other types of in-service offerings are credited as part of the work experience points earned. (If an in-service offering is granted credit by an academic institution the quarter hours may be counted under the academic study category when it otherwise meets requirements for such points.)

Up to forty (40) points may be granted for any approved workshop training. An additional sixty (60) points can be earned for taking workshops from a "preferred" list established by ADAD as part of the certification system.

Table 4. Structured Workshop Summary

Criteria	Point Formula	Maximum
Any structured workshop with title, descirpton, outcome objectives, and training on the ADAD approved list.	1 for each calendar day of training	40

Criteria	Point Formula	Maximum
Any structured workshop the ADAD preferred list.	1 for each calendar day of training.	60
Required Minimum		-0-

Rule VI. Written Examination. Each year a written examination will be offered by ADAD. Fifty (50) points are available on this exam. To be certified a minimum of 35 points must be earned. Each applicant may attempt this exam three times to either meet the minimum or to increase overall point total. However, the exam score of record is the most recent score. Should someone fail three times to either meet the minimum of 35 points, they must wait at least two years at which time one final attempt may be made.

Examination questions cover counseling in general, community resource use, pharmacology, first aid, and general drug and alcohol treatment knowledge.

Table 5. Written Examination Summary

Criteria	Point Formula		Maximum
Score on written exam	$\frac{\text{Earned Score}}{\text{Possible Score}}$	X	50
Required Minimum			35

Rule VII. Work Sample. Up to fifty (50) points are granted for performance on a work sample. The work-sample will consist of two tapes of real (preferred) or simulated counseling sessions. These will be reviewed and rated for performance by a panel of three experienced professionals on various dimensions of counseling process. Thirty-five (35) points are required on the work sample. (Tapes are rated separately by each judge and points averaged across tapes and judges). Of the 50 points, 45 come from the tape rating with 5 added if it is an actual session with a drug, alcohol, or impacted family member client. Since applicants may select the tape they submit, they will be able to submit what they see as their "best" work. (This is a more advantageous than a set-up with a requirement to perform in a certain way on a certain day.)

Criteria	Point Formula		Maximum
Taped Session Quality	$\frac{\text{Score Earned}}{\text{Possible Score}}$	X	45

Actual Client Taped	5 or 0	5
Required Minimum		35

Rule VIII Endorsement Areas. Endorsement area points derive from two sources. An oral examination can earn up to forty (40) points. A further ten (10) points are available from any combination of: 1) Work experience (5 points per FTE year in the area); 2) Structured workshop training drawn from the "preferred list" in the topic area (1 point per training day) or; 3) Five points also derive from an advanced counseling area degree (counting toward DAP certification or economics bachelors or advanced degree (toward the management and supervision area). Similarly a teaching certificate earns 5 points (within the 10) toward an education endorsement. (Note that only degree, certificates, and preferred workshops may be used in the endorsement area.)

Anyone in registry categories A or B is eligible to take the endorsement area examination.

Up to 50 endorsement area points may be counted toward the basic certificate.

Table 7. Endorsement Areas

Area	Criteria	Formula	Allowed Maximum	Required Minimum
Alcoholism Counseling	Oral Examination	Score X 40 / Possible Score	40	
	Work Experience Designated Degree	5 points per FTE year		35
	Area workshop from perferred list	1 point per day		
Drug Counseling	Same as alcohol	———	———	———
Education Prevention	Same as alcohol	———	———	———
		(except a teaching certificate earns 5 points)		

Minimum Points to be endorsed in each area	35
Maximum Endorsement Points toward initial certification	50

Rule IX. Basic certification. Basic certification requies earning the minimum of 200 points from a rather unlimited

pool of sources. Of these 200 points, 35 points must come from the written examination, 35 points from an endorsement area, and 35 points from performance ratings. See table 7 above.

Table 8. Overall Points Summary

	Available	Maximum Can Count	Minimum Required
Work Experience	Unlimited	65	-0-
College Course Work	Unlimited	65	-0-
Structured Workshops-General	Unlimited	40	-0-
Structured Workshops-Preferred	75	60	-0-
Written Examination	50	50	35
Work Performance Sample	50	50	35
Endorsement Areas	200	50	35

Rule X. Registry Process. The first step in the certification process is going on a registry. A registry is developed in steps.

(1) Announcements are sent to each State Approved alcohol and drug program asking that each employee send in a form reporting his full legal name, job title, mailing address, and telephone number. Others may register, but will not be solicited.

(2) A complete set of forms and instructions are sent to each respondent for submitting documentation or experience, education, and training necessary to place him/her into the proper registry category. These are the same forms needed for certification.

(3) Registry categories are assigned as follows:

Category A. Shows a total of 100 points or more before exams. With minimum exam and performance scores, will be certified. Top candidate.

Category B. Shows 70 points or more before exams. With top exam scores could be certifiable. Realistic Candidate. Those close to the 70 level should also give serious thought to strengthening their position through training, coursework, etc.

Category C. Shows less than 70 points. Will need preparation yielding more points over and above those that will probably accrue from examinations. These applicants are Doubtful Candidates and must earn more points before sitting exams or submitting work samples.

Category D. This category means "category unassigned". Most common reason for being in this category is an incomplete file.

Category AG, BG, and CG. On grace period. These were persons actively employed in the field, either on salary or by contract, between initiation of Registry (March 17, 1980) and formal initiation of full certification process (expected July 1, 1981). This category ceases to exist as of July 1, 1983.

The registry: 1) allows for some catagorization of Manpower; 2) gives applicants feedback on where they stand; 3) indicates

directions to take to strengthen their position via the certification process; 4) provides an "eligibility roster" for taking certification examinations; and yet 5) can be operated by currently available resources (whereas certification requires additional resources).

Rule XI. Written Examination. A person with experience in drug and alcohol programs, testing and evaluation, and with a solid academic knowledge of counseling should be contracted to develop an item pool, testing procedures and processes, and the actual examination for the first year. It is suggested that the field be involved by the contractor by soliciting questions from the field and paying $5 for each question actually used in the pool. (The contractor would use such questions as deemed appropriate from this source and develop the balance of needed questions.) Exam length would probably be about 150 questions, all objective.

The examination will be given once each year simultaneously in several locations during good driving weather (e.g. last Saturday in September). Applicants are responsible for their own expenses. Colleges and college staff with experience in such testing could be contracted or ADAD staff could be trained and sent to each location to administer the test.

Rule XII. Performance on Work Samples. Applicants will submit two tapes of not less than 25 nor more than 45 minutes in length. These must be continuous segments of actual counseling sessions or of a counseling role play where the client (real or role played) is dealing with either a drug or alcohol concern as addict or impact family member.

Applicants should make every effort to submit a tape of an actual counseling session with a real client as five (5) points will be added to the scores of all tapes with actual clients. All tapes from persons employed in the field must be sent in by the Director of the applicant's program by certified mail along with a signed and notarized statement from the Program Director attesting the nature of the submitted tapes (role play or real clients) and that the counslor named is the counslor executing the session on the tape. Each tape (can be one physical tape with a different session on each side) must be clearly labeled with the applicant's name, program where taped, the session number (1st, 10th, etc.) with the client if a real client or with "role play" if not a true client, nd the type of client (drug, alcohol, impacted family member) and the type of session (individual, couples, family). If role played, the name of the person playing the client should be given. Security will be maintained and confidentiality assured.

Persons not currently employed in the field should contact the Director of any State Approved program, (a list is available from ADAD) and ask either to be allowed to sign on as a volunteer and execute actual counseling sessions for submission, or to have a role play set up with a staff member playing the client. Program Directors are under no obligation to assist in this fashion. If local arrangements cannot be made, applicants should contact ADAD in Helena, Training and Certification

Section, and a role play will be set up in Helena.

Work samples must be mailed from a Program Director by certified mail in the same way as described above or persons employed in the field. Outside applicants must reimburse the local program for the mailing, notary, and other costs. The exception would be where the session was role-played at ADAD in Helena. In this case, the supervising staff would attest the validity of the tapes.

Tapes are rated by three Judges on a rating sheet covering a range of "desirable" counselor characteristics. One judge is an ADAD staff professional with a counseling background, two judges from the field, usually one of these judges will have a background primarily derived from experience and workshop training, and the other a background primarily derived from formal higher education. Judges rate each tape separately. Judges travel to Helena and rate work samples periodically (e.g. semi-monthly or quarterly) as the flow of applications demands. Judges do not have access to other judges ratings of tapes and do not meet as a group in any formal or official way.

The score is the average score across judges and tapes showing the proportional positive rating multiplied by 45 plus 5 if a "real" session. Judges only rate. ADAD staff socre, average, and record ratings.

Internal ADAD judges serve one year terms. They may, however, be reappointed. External judges serve two year terms except during the first year one judge will serve a one year term. This way there is always one external judge with experience to provide continuity. (2 consecutive term limit.)

Rule XIII. Endorsement Areas Certification. Endorsement area attainment is through a combination of education, experience, and performance on an oral examination. Points for background derive from file review.

Each area panel is composed of three persons. On person is the ADAD "resident expert" in the endorsement field.

Additionally, two panel members will be selected from the field. Again, it is recommended that one be a judge whose skills derive largely from experience and workshop training and the other someone who has considerable academic background. They are to be selected by ADAD. Nominations, including self nomination, should be sought from the field (forms to be provided), but the decision is with ADAD exclusively.

Designated ADAD staff serve one year terms on the panel. Field panelists serve two years. In the first year one field panelist serves a one year term. In the first year the ADAD staff member chairs the panel. In subsequent years the field panelist who is in his/her second year of service chairs.

A master list of 15/25 questions and model answers is developed for each area. Panelists question the applicant for 15 minutes drawing questions from this list. For 30 minutes panelists can ask any follow-up questions they wish of any type regardless

of the list, providing it relates to the endorsement field, in an open discussion format. The applicant is excused and panelists may then discuss the applicant among themselves prior to each panelist making their own private ratings. Applicants may apply for only one endorsement area each year. This is a practical rule to keep costs and manpower commitments within bounds. (Even this probably will be tight for the alcohol area in the first year.)

Eight field panelists are required.

The alcoholism counseling panel would sit twice each year and the others once each. In the first year the alcohol panel would probably sit for two weeks, might need to sit four different times (or each week every other month), depending upon number of endorsement applicants.

Rule XIV. Continuing Education. Once certified, DAP will be required to earn ten (10) points per year on the average; averages being run three years. Points can come from any source where the individual has not already earned his/her maximum points. If all experience points have not been earned, full-time work in the field will provide half of the points.

Rule IV. Loss of Certification. Certification may be lost or suspended in three ways:

(a) By not meeting continuing education requirements. In this case a warning is given with a one year period to make up any deficiencies. If not made up in one year, the certificate is suspended until the requirements are brought up to date.

(b) Violation of a code of professional ethics to be published by the Department. The Director of the Department will appoint a panel of three peers and one Department employee to investigate any formal breach of ethics charges directed to the Department. The panel will have the power to either recommend that the accused person be cleared of any charges or recommend suspension of the certification for a period ranging from 6 months up to 10 years. If the person losing certification wishes to make a formal appeal to the Director of the Department he may do so pursuant to the other administrative rules of contested cases already adopted by this Department.

Rule XVI. Definitions

Full-time Equivalent (FTE). A half-time DAP working two years equals one full-time equivalent, etc.

Document (able) (ed). A person who by position is found credible by ADAD (e.g. A Program Director, Personnel Manager Program Board Officer) will sign a form attesting the dates, hours, and job titles reported for salaried employment or annual clock hours of service per year for volunteers etc., as required. For academic work this would be an official transcript.

State Approved Program. A program reviewed and approved for offering drug or alcohol services by Montana, JCAH, or any other

source credible to ADAD. (Proof of program approval must be supplied for out-of-state experience.)

Active Volunteer. One who acts on behalf of the object organization(s), without payment, at least 50 hours per year.

Duplication. Counting the same point earning activity in more than one point category. (e.g. Counting a year of work experience both toward general certificate and an endorsement area.)

Governing Board. Persons legally responsible for operation of a corporate entity as defined in the Articles of Incorporation and By Laws.

Training Day. A training day is six-to-eight hours of continuous training. Where dates and hours are available points will be granted for each full day provided days average at least six hours. Where hours alone are given days will be established by division by seven (7).

Approved List. The listings of structured workshops and trainers that have been reviewed and approved by ADAD as, respectively, relevant for drug/alcohol personnel and as having the necessary qualifications to train such personnel.

The Field. Refers to all persons currently employed in a State Approved program, serving as a Board Member of such a program, serving on any State level Advisory Board for ADAD, or employed directly or on contract by ADAD.

Judges. Persons rating work performance tapes.

Panel. The group of three persons who conduct oral examinations for an endorsement area.

Panelist. A person serving on an endorsement panel.

3. Rationale: The National Institute of Alcohol and Drug Abuse has recommended that statewide plans and programs develope and implement certification for substance abuse counselors. In 1979, the Legislature in Chapter 711 passed legislation requiring the department to develop and inplement certification standards by giving specific statutory authority to the department.

4. Interested persons may present their data, views or arguments either orally or in writing at any of these hearings. Further, written data, viewes or arguments may also be submitted to Michael Murray, Adminstrator, Alcohol and Drug Abuse Division, Department of Institutions, 1539 11th Avenue, Helena, Montana 59601 no later than August 1, 1980.

5. Nick A. Rotering, Legal Counsel for the Department of Institutions has been designated to preside over and conduct the hearings.

6. The authority of the agency to make the proposed rules is based upon Sections 53-24-105 MCA and its implementing Section 53-24-205 MCA.

LAWRENCE M. ZANTO, Director
Department of Institutions

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF COMMUNITY AFFAIRS
OF THE STATE OF MONTANA

In the matter of the amendment of Rules 22-2.4B(1)-S400 through 22-2.4B(30)-S4100 prescribing minimum requirements for subdivision regulations and regulating the form, accuracy, and descriptive content of records of survey	NOTICE OF PUBLIC HEARING FOR ADOPTION OF AMENDMENTS FOR RULES (Montana Subdivision and Platting Act)

TO: All Interested Persons:

(1) On Wednesday, July 23, 1980, at 2:00 p.m. a public hearing will be held in the Scott Hart Building (old Highway Department) at 303 Roberts Street, Helena, Montana to consider adoption of amendments to rules relating to the administration of the Montana Subdivision and Platting Act (Title 76 Chapter 3 Montana Codes Annotated).

(2) The proposed amendments would modify present rules 22-2.4B(6)-S420, 2202.4B(10)-S4010, 22-2.4B(30)-S4080, 22-2.4B (30)-S4090, and 22-2.4B(30)-S4100 to bring them into conformance with 1979 amendments to the Subdivision and Platting Act, to eliminate possible conflicts with the Act, and to reflect currently accepted professional standards for monumentation and the preparation of survey documents.

(3) The rules as proposed to be amended are shown below. Language to be stricken is interlined and new language is underlined. The rationale for each proposed amendment is shown following the proposal.

A. Subparagraphs 22-2.4B(6)-S420(3) and (4) concerning condominium developments and divisions of land exempted from subdivision review, are proposed to be deleted in their entirety as follows:

~~(3)--Procedures for condominium developments.--Local regulations shall provide that:~~

~~(a)--The construction of condominium buildings or installations of related public improvements is not subject to subdivision review and approval procedures where the condominiums or improvements are to be constructed in an approved and filed subdivision, the approval of which was based on the anticipated construction of the condominiums and related public improvements. The public improvements in such a condominium development are, however, subject to inspection by the governing body to insure conformance with the approved subdivision plan and specifications.~~

~~(b)--Where no division of land is created by a condominium subdivision, surveying requirements shall not apply.~~

~~(c)--Where no division of land is created by a condominium subdivision, the subdivision shall be reviewed under the procedures contained in local regulations for review of subdivisions created by lease or rent.~~

~~(d)--Where no division of land is created by a condominium subdivision and an adopted zoning ordinance permits multiple family use of the density proposed in the plan for the condominium, the condominium subdivision is exempt from public review and approval.~~

~~(4)--Procedures for divisions of land exempted from local review as subdivisions.~~

~~(a)--Determining when the exemptions listed in sections 11-3862(6) and 11-3862(9) are being used for the purpose of evading the subdivision law.--The governing body shall, by March 1, 1978, adopt criteria for determining when the exemptions contained in sections 11-3862(6) and 11-3862(9) are being used for the purpose of evading the act.--As a minimum these criteria shall address:--the number of parcels created through use of the exemptions, the disposition of prior exempted parcels, the length of time since previous exempted divisions of land from the original tract, and the number, size and configuration of remainders created by the use of the exemptions.~~

~~(b)--In addition to any criteria adopted by the local officials the following provisions shall govern the use of exemptions.~~

~~(i)--For an occasional sale exemption authorized under section 11-3862(6)(d), only one occasional sale may be made within any 12-month period from any tract of record or from contiguous tracts of land created of public record on or after July 1, 1973, and held in single or undivided ownership.--No portion or a tract or parcel of land may be the subject of an occasional sale more than once within any 12-month period.~~

~~(ii)--For a gift or sale to any member of the immediate family authorized under section 11-3862(6)(b), one conveyance of a parcel of land to each member of the landowner's immediate family is eligible for exemption from the review and approval of the governing body, providing that the exemption creates no more than one remaining parcel of less than 20 acres in size. A second or subsequent proposed gift or sale to the same family member must be reviewed by the governing body to determine if the use of the exemption is intended to evade the purpose of the act.~~

Rationale:

Repeal of Rules Relating to Condominiums

The Subdivision and Platting Act specifies that the term "subdivision" includes "any condominium", but goes on to provide that:

Condominiums constructed on land divided in compliance with the Act are exempt from it.

To facilitate the administration of these provisions, DCA, in 1974 adopted the above regulations.

The effect of the provisions is at once to subject to subdivision review condominiums which may be exempted from review by the broader language of the statute and to exclude from review other condominiums which may not be exempted by the statute. Although the practical consequences of these regulations may be desirable and reasonable, the Department is concerned that they are susceptible to the charges leveled in

the Swart v. Casne (172 Mont. 302, 564 P.2d 983) case, that they modify statutory provisions.

Repeal of Rules Relating to Use of Exemptions

Section 76-3-207, MCA, of the Montana Subdivision and Platting Act provides certain exemptions from the law "unless the method of disposition is adopted for the purpose of evading" the law. In July, 1977, DCA formally proposed repeal of its rules which had been adopted in 1974 to provide consistent direction to local officials in determining when use of the exemptions for an occasional sale or transfer to a member of the immediate family constitute an evasion of the law. Repeal of the rules was proposed for three reasons. First, May, 1977, the Montana Supreme Court ruled invalid a Department rule which prohibited the use of the exemptions within platted subdivisions. That ruling placed in doubt the validity of two other rules which restricted use of the exemptions. Second, the 1977 Legislature, in rejecting all legislative proposals to specify proper use of the exemptions, reduced support for DCA's argument that the administrative definition of evasion of the law was consistent with legislative intent. Third, DCA questioned the effectiveness of the rules inasmuch as more than 70% of the total land area divided into parcels less than 20 acres in size was not being reviewed.

A public hearing on the proposals was held August 17, 1977. Written and oral testimony was almost unanimously opposed to the proposed repeal of the DCA rules which define the proper use of the occasional sale and family conveyance exemptions.

In September 1977 the Attorney General issued to DCA an opinion that the Department's rule on the occasional sale would probably be held valid by a court, but that the limitation of only one exempted transfer to each member of the immediate family would likely be overturned. However, the opinion also stated that adopting less restrictive limitations might be within DCA's rule-making authority. In response to the public sentiment against repeal of the rules and in keeping with the reasoning of the Attorney General's opinion DCA delayed taking action on any of the rule changes for one month. During that time a large number of people interested or involved in land division were asked to comment on an alternative proposal regarding the exemptions. Most of the individuals and organizations contacted recommended that the Department not take any immediate action regarding the administrative rules. Instead, many suggested that the agency work together with the Interim Subcommittee on Subdivision Laws established by the 1977 Legislature to develop reasonable controls on the use of the exemptions which could be considered in the 1979 session.

In response to this apparent consensus and in light of the Attorney General's opinion DCA decided to retain its rule relating to the occasional sale exemption and also made several changes in the rules governing transfers to family members. First, the certificate of survey had to indicate the name of the family member to receive the parcel, the relationship of that family member to the landowner and the parcel to be transferred. Second, each member of the landowner's immediate family was eligible to receive one parcel under this exemption,

provided that use of the exemption did not leave more than one remainder less than 20 acres in size. Third, a second or subsequent parcel could be transferred to the same family member under this exemption if the governing body determined that the landowner was not using the exemption to evade the purpose of the subdivision law. Fourth, local governing bodies were directed to adopt criteria by March 1, 1978, for determining when the use of the exemptions was intended to evade the law. The purpose of the determination made under this rule was not to review the parcel but to ascertain whether the use of the exemption conformed to local criteria.

In hindsight and after considerable discussion the Department has concluded that the arguments for repeal of the administrative rules three years ago were valid and since that time have become more so. The Montana Supreme Court, in the 1977 case, Swart v. Casne (172 Mont. 302, 564 P.2d 983), held that the Department's rules may not impose substantive requirements on the use of the exemptions beyond those contained in the subdivision act itself. The Swart decision, viewed in light of the 1979 Legislature's subsequent rejection of proposals made by its interim subcommittee to restrict the use of exemptions from subdivision review, has led the Department to the conclusion that the law's exemption provisions accurately reflect legislative intent and must stand by themselves. The Department also fears that its administrative rules which mandate local adoption of criteria for determining when evasion takes place, while intended only to assure proper use of the exemptions, could still be construed by the courts as attaching requirements or restrictions in contravention of legislative intent.

In addition, the agency seriously questions the practical effectiveness of the rules proposed for repeal. In 1977 DCA conducted a detailed study of the implementation of the law in nine counties. This research revealed that six out of every ten new parcels less than twenty acres in size were being created by use of the exemptions has increased. Estimates by planning directors of the number of such parcels undergoing local review range from one in 11 in Flathead County to one in 100 in Cascade County. Given the limited effectiveness of the rules and the difficulties they may pose for private parties and local officials who must deal with them, DCA feels that their continued existence can no longer be justified.

The repeal of the requirement that local governing bodies adopt criteria for determining when exemptions are being used for evading the subdivision act would have little, if any, practical effect. First, only about 10 counties have complied with this requirement to date. Second, the Attorney General has recognized that under the Act cities and counties already have implicit authority to adopt such criteria. In a 1977 opinion he stated:

The Act...places a burden upon the local governing body to determine whether the arrangement was entered for the purpose of evasion. Therefore, it would be a legitimate and proper exercise of the local body's duties to require anyone wishing to claim the exemption...to provide some justification

for entitlement thereto.

Finally, drafting and filing requirements for use of the exemptions would be retained in the Uniform Standards for Certificates of Survey.

B. The following new sub-paragraph is proposed to be added to Rule 22-2.4B(10)-S4010 concerning park and open space requirements:

(c) The park dedication and cash in lieu requirements of subsections (a) and (b) do not apply to any division that creates only one additional lot.

Rationale:

The 1977 Legislature provided this exemption in the park land requirement.

C. Rule 22-2.4B(30)-S4080 is proposed to be amended to read as follows and appropriately renumbered:

(a) The terms "Monument" and "Permanent Monument" as used in these regulations shall mean any structure of masonry, metal or other permanent material placed in the ground, which is exclusively identifiable as a monument to a survey point, expressly placed for surveying reference.

Rationale:

The definition of "monument" is currently contained in the definition section of the Minimum Requirements for Local Subdivision Regulations. Since the Minimum Requirements have normally been published separately from the Uniform Standards for Monumentation, a number of surveyors have proposed that the definition of "monument" also be incorporated within the Uniform Standards to prevent any confusion as to what a monument must be constructed of.

(b) ~~(a)~~ All permanent control monuments or monuments set to control or mark the boundaries of any division shall be of not less than one-half inch (1/2") diameter by twenty-four inches (24") in length with a cap of not less than one and one-quarter inch (1-1/4") diameter marked in a permanet manner with the name and/or registration number of the registered land surveyor in charge of the survey. A cap of the above dimensions may be set firmly in concrete.

(c) [present subsection (b) unchanged]

~~(c) All monuments must be set prior to the filing of a plat or certificate of survey except those monuments which will be disturbed by the installation of improvements. Such monuments may be set subsequent to filing if the surveyor certifies that they will be set before a specified date.~~

(d) All monuments must be set prior to the filing of a plat or certificate of survey except those monuments which will be disturbed by the installation of improvements or where, due to unusual circumstances, monuments cannot be set prior to filing. All monuments, other than those which would be disturbed by installation of improvements, must be set within six months of filing the plat or certificate of survey. The monuments not set prior to filing shall be shown by a distinct symbol noted on the face of the plat or certificate of survey together with

a specified date by which the monuments will be set.

[present sub-paragraphs (d) through (f), renumbered but unchanged]

Rationale:

We have received a request from a Billings engineering and surveying firm to amend the existing requirement for setting monuments to allow greater flexibility. The proposed language would allow survey documents to be filed with the County Clerk and Recorder's Office before the monuments are set in the field where conditions, such as winter weather, would prevent setting monuments. The proposal would put a six month time limit on setting the monuments in these circumstances but, as at present, allows additional time for those monuments that would be disturbed during construction of improvements.

D. Rule 22-2.4B(30)-S4090, concerning certificates of survey is proposed to be amended as follows and appropriately renumbered:

22-2.4B(30)-S4090 UNIFORM STANDARDS FOR CERTIFICATES OF SURVEY. ~~(1)~~ A certificate of survey may not be filed by the county clerk and recorder unless it complies with the following requirements:

(1) Certificates of survey shall be legibly drawn with permanent ink or printed or reproduced by a process guaranteeing a permanent record and shall be 18 inches by 24 inches overall to include a 1½ inch margin on the binding side.

(2) ~~(b)~~ One signed cloth-backed or opaque mylar copy and one signed reproducible copy on a stable base polyester film or equivalent shall be submitted.

Rationale:

We have received a request for this amendment. The commentary for adding opaque mylar is as follows:

A few years ago it became hard to obtain cloth-backed material. Some of the counties of the state started accepting opaque mylar in the place of cloth-backed material. Consequently the surveyors in these counties have gotten into the habit of using this material and when they go into counties that do not accept anything other than cloth-backed material they are in a hardship situation. Also opaque mylar appears to be quite as durable as cloth-backed material.

By inserting the word signed should eliminate confusion whether to sign or leave blank the reproducible copy.

(3) ~~(c)~~ Whenever more than one sheet must be used to accurately portray the land subdivided, each sheet must show the number of that sheet and the total number of sheets included. All certifications shall be shown or reference on one sheet.

(4) ~~(2)~~ The certificate of survey shall show on its face or on separate sheets referenced on its face the following information only:

[Sub-paragraphs (2)(a) through (2)(k) unchanged]

(l) ~~A metes and bounds legal description of the perimeter boundary of the tract surveyed.~~ A legal description of the tract(s) surveyed.

Rationale:

The above lanugage was proposed by a Missoula engineering

and surveying firm. Their commentary, in part, follows:

Section 22-2.4B(30)-S4090(2)(l) requires "A metes and bounds legal description of the perimeter boundary of the tract surveyed." We would suggest that this be changed to read "A legal description of the tract surveyed". A metes and bounds legal description is a necessary and proper legal description for an irregular shaped tract; however, if the tract you surveyed is actually the Northwest one-quarter of a Section, then the proper legal description is "the Northwest one-quarter (NW¼), Section whatever and township and range, Principal Meridian, Montana and whatever County. . . . period. This would also apply to a survey of an existing subdivision lot or tract. . . . the property legal description would be whatever lot, block and subdivision name. In these instances, a metes and bounds legal description is not only not necessary, it is not the proper legal description. . . .

Our suggested working would require the surveyor to use the proper legal description and yet not require that he use a superfluous description as is not the case.

[Sub-paragraph (2)(m) unchanged]

(n) Certification by the State Department of Health and Environmental Sciences that sanitary restrictions are lifted, where required.

Rationale:

The above language is proposed to bring the survey requirements within the requirements of the Sanitation in Subdivision Act.

[Present sub-paragraphs (2)(n) and (2)(o) unchanged but renumbered]

(3) Procedures for divisions of land exempted from public review as subdivision. Certificates of survey for divisions of land meeting the criteria set out in section 11-3862(6), R.C.M. 1947, must meet the following requirements:

(a) Certificates of survey of a division of land which would otherwise be a subdivision but which is exempted from public review under section 11-3862(6), R.C.M. 1947, may not be filed by the county clerk and recorder unless it bears the acknowledged certificate of the property owner stating that the division of land in question is exempted from review as a subdivision and citing the applicable exemption.

(b) Where the exemption relied upon requires that the property owner enter into a covenant running with the land, the certificate of survey may not be filed unless it bears a signed and acknowledged copy of the covenant.

~~(c) For an exemption as an "occasional sale," the certificate of survey must bear a certificate of the property owner that the exempted division of land meets the criteria specified in local regulations* and the following provisions:~~

~~(i) For an occasional sale exemption authorized under section 11-3862(6)(d), only one occasional sale may be made within any 12-month period from any tract of record or from~~

~~contiguous tracts of land created of public record on or after July 1, 1973, and held in single or undivided ownership. No portion of a tract or parcel of land may be the subject of an occasional sale more than once within any 12 month period.~~

(c) ~~(d)~~ For an exemption as a gift or sale to a member of the immediate family, ~~the certificate of survey must bear a certificate of the property owner that the exempted division of land meets the criteria for use of the exemption specified in local regulations and the following provisions: T~~the certificate of survey must indicate the name of the grantee, the relationship of the grantee to the landowner, and the parcel to be conveyed to the grantee.

~~(i) For a gift or sale to any member of the immediate family authorized under section 11-3862(6)(b), one conveyance of a parcel of land to each member of the landowner's immediate family is eligible for exemption from review and approval of the governing body, providing that the exemption creates no more than one remaining parcel of less than 20 acres in size. A second or subsequent proposed gift or sale to the same family member must be reviewed by the governing body to determine if the use of the exemption is intended to evade the purpose of the act.~~

[Present sub-paragraph (3)(e) unchanged but renumbered]

Rationale:

Because the department proposes to repeal MAC 22-2.4B(6)-S420(4) in the Minimum Requirements for Subdivision Regulations, these requirements should also be deleted from the Uniform Standards.

E. Rule 22-2.4B(30)-S4100, concerning standards for final subdivision plats, is proposed to be amended as follows:

1. Sub-paragraph (1)(b) would be amended to read:

(1)

(b) One signed cloth-backed or opaque mylar copy and one signed reproducible copy on a stable based polyester film or equivalent shall be submitted.

Rationale:

We have received a request for this amendment. The commentary for adding opaque mylar is as follows:

A few years ago it became hard to obtain cloth-backed material. Some of the counties of the state started accepting opaque mylar in the place of cloth-backed material. Consequently the surveyors in these counties have gotten into the habit of using this material and when they go into counties that do not accept anything other than cloth-backed material they are in a hardship situatin. Also opaque mylar appears to be quite as durable as cloth-backed material.

By inserting the word signed should eliminate confusion whether to sign or leave blank the reproducible copy.

2. Sub-paragraph (2)(o) would be amended to read:

(o) ~~A metes and bounds legal description of the permimeter boundary of the tract surveyed.~~ A legal description of the tract(s) surveyed.

Rationale:

The above language was proposed by a Missoula engineering and surveying firm. Their commentary, in part, follows:

Section 22-2.4B(30)-S4090(2)(l) requires "A metes and bounds legal description of the perimeter boundary of the tract surveyed." We would suggest that this be changed to read "A legal description of the tract surveyed". A metes and bounds legal description is a necessary and proper legal description for an irregular shaped tract; however, if the tract you surveyed is actually the Northwest one-quarter of a Section, then the proper legal description is "the Northwest one-quarter (NW¼), Section whatever and township and range, Principal Meridian, Montana and whatever County. . . . period. This would also apply to a survey of an existing subdivision lot or tract. . . . the property legal description would be whatever lot, block and subdivision name. In these instances, a metes and bounds legal description is not only not necessary, it is not the proper legal description. . . .

(4) Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Community Development Division, DCA, Capitol Station, Helena, MT 59601, no later than July 24, 1980.

(5) Richard M. Weddle has been designated to preside over and conduct the hearing.

(6) The authority of the agency to make the proposed amendments is based on sections 76-3-504 and 76-3-403, MCA, and the rules implementing sections 76-3-504 and 76-3-403 MCA.

Harold A. Fryslie, Director
Department of Community Affairs

Certified to the Secretary of State 6-16-80.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 23-2.6AI(6)-S6183 specifying who is eligible for the Driver Rehabilitation Program	))))))	NOTICE OF PROPOSED AMENDMENT OF RULE 23-2.6AI(6)-S6183 (Persons Eligible For Driver Rehabilitation Program) NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On July 28, 1980, the Department of Justice proposes to amend rule 23-2.6AI(6)-S6183 (to be recodified as rule 23.3.203) specifying who is eligible for the Driver Rehabilitation Program. Rule 23-2. 6A(6)-S6183 was proposed as Rule I of MAR Notice No. 23-2-43, 1979 MAR pp. 1585-86, and adopted at 1980 MAR p.580.

2. The rule as proposed to be amended provides as follows:

23.3.203 PERSONS ELIGIBLE FOR DRIVER REHABILITATION PROGRAM (1) A person whose license is suspended because of the accumulation of 15 or more Driver Rehabilitation ~~Habitual Offender Act~~ points must be referred to a Driver Rehabilitation Program.

(2) A person whose license is suspended for any reason other than refusal to submit to a chemical test of his blood, breath, or urine is eligible to participate in the Driver Rehabilitation Program.

(3) A person whose license has been revoked for 3 months of a 1 year revocation or 1 year of a 3 year revocation is eligible to participate in the Driver Rehabilitation Program if he complies with all requirements for reobtaining a license after revocation.

3. The rule is proposed to be amended to conform to the amendment of rule 23-2.6AI(6)-S6180, at 1980 MAR pp. 576-77. That amendment eliminated reference to the Habitual Offender Act point system because the Habitual Offender Act point system is detailed in statute (§61-11-203, MCA) and repetition in rules would be redundant.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Assistant Attorney General Dennis J. Dunphy, State Capitol, Room 225, Helena, Montana 59601, no later than July 24, 1980.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Assistant Attorney General Dennis J. Dunphy, State Capitol, Room 225, Helena, Montana 59601, no later than July 24, 1980.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the Administrative Code Committee of the legislature, from a governmental subdivison or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 61,000 persons based on the 610,000 licensed drivers in Montana.

7. The authority of the agency to make the proposed amendment is based on section 61-2-302(1), MCA, and the rule implements section 61-2-301, MCA.

By: MIKE GREELY
Attorney General

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of the Proposed Adoption of New Rules for Rate Information to be Provided by Electric Utilities.	NOTICE OF PUBLIC HEARING ON NEW RULES REGARDING RATE INFORMATION TO BE PROVIDED BY ELECTRIC UTILITIES

TO: All Interested Persons

1. On July 22, 1980, in the Senate Chambers, State Capitol Building, Helena, Montana, immediately following the hearing beginning at 10:00 a.m. on proposed rules regarding master meters in new buildings, a public hearing will be held to consider the proposed adoption of new rules for rate information to be provided by electric utilities.

2. The proposed rules do not replace or modify any section currently found in the Administrative Rules of Montana.

3. The proposed rules provide as follows:

Rule I. EXISTING RATE INFORMATION (1) Each electric utility shall transmit to each of its consumers a clear and concise statement containing the existing rate schedule.

(2) The statement shall be sent to existing consumers within 90 days of adoption of this rule. New consumers must receive a rate statement within 60 days after commencement of service.

(3) Each electric utility shall transmit to each of its electric consumers not less frequently than once each year a clear and concise explanation of the existing rate schedules applicable to each of the major classes of its electric consumers for which there is a separate rate and shall identify each class of consumer whose rates are not summarized.

(4) The summary may be transmitted with the consumer's bill or in such other manner that each electric utility deems appropriate.

Rule II. PROPOSED RATE CHANGES INFORMATION (1) Each electric utility shall send a statement within 60 days of an application for any change in a rate schedule applicable to a consumer.

Rule III. OPTIONAL OR ALTERNATIVE RATE INFORMATION (1) Whenever optional or alternative rate schedules are established and annually thereafter, the utility shall furnish each consumer who may be affected by them, a summary of the applicable rate schedules, together with a notice calling the attention of the consumer to the availability of alternative rate schedules for the consumer's particular class of service and stating that, upon request, the utility will assist the consumer in determining the billing for such service as is specified by the consumer under the various rate schedules.

Rule IV. INDIVIDUAL CONSUMPTION INFORMATION (1) Each electric utility, upon request of its consumers, shall deliver to the consumer a clear and concise statement of the actual consumption or degree day adjusted consumption of electric energy by the consumer during each billing period of the previous 12 months if such data is reasonably ascertainable by

the utility.

Rule V. INFORMATION TO BE KEPT IN UTILITY OFFICES (1) Each electric utility shall keep on file in every office of the utility where payments are received, copies of its rate schedules and rules and regulations applicable thereto. Reasonable notice shall be given consumers as to where this information is available.

Rule VI. BILLING DISPUTE INFORMATION (1) Each electric utility shall assign to one or more of its personnel in each of its offices where it transacts business with the public, the duty of hearing, in person, any dispute by a consumer. Such personnel shall consider the consumer's allegations and shall explain the consumer's account and the utility's contentions in connection therewith. Such personnel shall be authorized to act on behalf of the utility in resolving the complaint and shall be available during all business hours for the duty hereinbefore described.

4. Rationale. The Commission is proposing these rules to implement the requirements of the federal Public Utility Regulatory Policies Act and help assure that consumers understand the basis upon which they are charged for electric energy usage.

5. Interested persons may submit their data, views, or arguments concerning the proposed adoption at the hearing or in writing to Eileen E. Shore, 1227 11th Avenue, Helena, Montana 59601, no later than July 24, 1980.

6. The Montana Consumer Counsel, 34 West Sixth Avenue, Helena, Montana 59601 (Telephone 449-2771) is available and may be contacted to represent consumer interests in this matter.

7. Authority for the Commission to make these rules is based on Sections 2-4-303 and 69-3-103, MCA. IMP, Section 69-3-102, MCA.

Eileen E. Shore

EILEEN E. SHORE
Chief Legal Counsel

CERTIFIED TO THE SECRETARY OF STATE June 17, 1980.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE STATE ELECTRICAL BOARD

IN THE MATTER of the Proposed Amendment of ARM 40-3.38(6)-S3875 Apprentice Registration	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF ARM 40-3.38(6)-S3875 APPRENTICE REGISTRATION

TO: All Interested Persons:

1. On Wednesday, July 23, 1980 at 1:30 p.m. a public hearing will be held in Rooms 413-415, State Capitol Building, Helena, Montana, to consider the amendment of Rule ARM 40-3.38(6)-S3875 Apprentice Registration.

2. The State Electrical Board published a notice of proposed amendment on February 14, 1980 at pages 480-482 Montana Administrative Register, issue number 3 on the same rule. No action was taken regarding that amendment.

3. The rule as proposed to be amended will delete all the existing subsections in their entirety and in lieu thereof will read as follows: (deleted material is located at pages 40-153 and 40-153.1, Administrative Rules of Montana)

"40-3.38(6)-S3875 APPRENTICES (1) Section 37-68-303 MCA states that the licensing requirements for doing electrical work do not prohibit a person from working as an apprentice in the trade of electrician with an electrician licensed under the act and under rules made by the board. Pursuant to this authorization, the board specifies, in the remainder of this rule, the conditions under which persons may employ and work as apprentices.

(2) All master electricians, (and residential journeymen electricians in the case of residential construction) shall be responsible for assuring that all apprentices under their general direction and supervision comply with the requirements of this rule.

(3) Any person desiring to work as an apprentice, shall first make application to the state electrical board on forms provided by the board.

(4) In order to qualify for an apprenticeship program, the applicant apprentice shall either:

(a) present evidence that (s)he is enrolled in an apprentice training program registered by the apprenticeship bureau, department of labor and industry, state of Montana; or

(b) present evidence directly to the board that (s)he is enrolled in an apprentice training program which is equivalent to programs of the Montana department of labor and industry.

(5) For purposes of determining whether a program is equivalent within the meaning of (4)(b) above, the board will consider and apply the current apprenticeship bureau standards. If the applicant employer's proposed program meets or exceeds the apprenticeship bureau

then equivalency will be determined to have been met. In determining whether a proposed program meets or exceeds the apprenticeship bureau standards, the board will consider all factors used by the apprenticeship bureau. Interpretation of existence of these factors will be made with an overall expectation that proper safety standards for the apprentice are met and that the consumer is receiving proper and adequate electrical installation services from the apprentice and his/her employer.

(6) With respect to apprenticeship programs established directly through the board, the board reserves the right to monitor said programs and to demand and receive any and all necessary progress reports.

(7) Compliance with federal and state law administered by the department of labor and industry, labor standards division, apprenticeship bureau, where such compliance is applicable shall be a condition to registering apprentices with the state electrical board. "

3. The State Electrical Board has in the past made several attempts at implementing rules for regulating apprentices. Under the existing rule, virtually any person or any employer could list a person as an apprentice by filing his name with the board and submitting a quarterly report. Virtually no training standards are imposed under the existing rule and determinations as to the quality and extent to the apprentice's training are not made until the apprentice applies for journeyman licensure.

The board has found that the current rule allows extensive abuse of the licensing requirements and of the exemption from licensure for apprentices. The board has found in numerous instances that employers are using the simple listing requirements under the existing rule to obtain employees to do electrical work without any intention, or implementation of electrical training.

To correct such abuse, the board proposes this rule. As an existing apprenticeship training certifying program is administered by the state apprenticeship bureau, department of labor, it is the board's expectation that employers where possible will certify their program through that bureau. However, the board recognizes a legal need for an alternative to the apprenticeship bureau program, the board proposes in this rule the alternative to register a program through the electrical board.

4. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the State Electrical Board, Lalonde Building, Helena, Montana 59601 no later than July 24, 1980.

5. The board or its designee will preside over and conduct the hearing.

6. The authority of the board to make the proposed amendment is based on section 37-68-201 MCA and implements section 37-68-303 MCA.

STATE ELECTRICAL BOARD
KENNETH OLSEN, PRESIDENT

BY: 
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPATIONAL LICENSING

Certified to the Secretary of State, June 17, 1980.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF HORSE RACING

IN THE MATTER of the Proposed Amendment of ARM 40-3.46(6)-S46010 subsection (63)(k) concerning general conduct of racing.	NOTICE OF PROPOSED AMENDMENT OF ARM 40-3.46(6)-S46010 SUBSECTION (63)(k) GENERAL CONDUCT OF RACING

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 26, 1980 the Board of Horse Racing proposes to amend subsection (63)(k) of ARM 40-3.46(6)-S46010 concerning general conduct of racing.

2. The proposed amendment will read as follows:

"40-3.46(6)-S46010 GENERAL CONDUCT OF RACING

.....

(63)...

(k) In the event of mechanical failure or interference during the running of a race which affects ~~the majority~~ one or more of the horses in such race, the stewards may declare the race as no contest. Any wagers on such races called off, cancelled, or declared as no contest shall be refunded, and no purse, prize or stakes shall be awarded. A race shall be cancelled if no horse covers the course.

...."

3. The board has amended the rule through the emergency amendment process on June 11, 1980. The board has determined that the existing wording of the rule places excessive and unreasonable restrictions on the discretion of the stewards. As now written it is questionable whether the stewards can declare a race called off unless a majority of the horses are affected. A race might have to be declared official even through up to one half of the horses in the field have been affected by mechanical failure. In the interests of fairness to the horsemen and to the wagering public the board feels that the stewards must have discretion to declare a race no contest if in their judgement one or more horses are determined to have been detrimentally affected by a mechanical failure.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Horse Racing, Lalonde Building, Helena, Montana 59601 no later than July 24, 1980.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to the Board of Horse Racing, Lalonde Building, Helena, Montana 59601 no later than July 24, 1980.

6. If the board receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the

proposed amendment; from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

7. The authority of the board to make the proposed amendment is based on section 23-4-202 MCA and implements section 23-4-104 MCA.

BOARD OF HORSE RACING
JOSEPH MURPHY, D.D.S., CHAIRMAN

BY: 
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPTIONAL LICENSING

Certified to the Secretary of State, June 17, 1980.

BEFORE THE BOARD OF EXAMINERS
OF THE STATE OF MONTANA

In the matter of the repeal of rules ARM 2-3.26(2)-P2620 through ARM 2-3.26(2)-P2660, specifying the procedure to be followed in applying for the Vietnam veterans' bonus	)))))))	NOTICE OF THE REPEAL OF RULES ARM 2-3.26(2)-P2620 through ARM 2-3.26(2)-P2660, specifying the procedure to be followed in applying for the Vietnam veteran's bonus

TO: All Interested Persons:

1. On May 15, 1980, the Board of Examiners published notice of a proposed repeal of rules ARM 2-3.26(2)-P2620 through ARM 2-3.26(2)-P2660, specifying the procedure to be followed in applying for the Vietnam veterans' bonus, at page 1287 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

By: M. Wm. McEnaney
M. Wm. McEnaney, Executive Secretary
Board of Examiners

Certified to the Secretary of State June 16, 1980.

BEFORE THE MERIT SYSTEM COUNCIL
OF THE STATE OF MONTANA

In the matter of the repeal of rule ARM 2-3.34(74)-S34590, concerning retirement	)))	NOTICE OF THE REPEAL OF RULE ARM 2-3.34(74)-S34590, concerning retirement

TO: All Interested Persons:

1. On May 15, 1980, the Merit System Council published notice of a proposed repeal of rule ARM 2-3.34(74)-S34590, concerning retirement, at page 1291 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

By: Joseph D. Harrington
Reverend Joseph D. Harrington
Chairman, Merit System Council

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the repeal of rules ARM 2-3.22(1)-02200 and ARM 2-3.22(2)-P2210, specifying the organization and procedure of the now defunct State Depository Board	))))))	NOTICE OF THE REPEAL OF RULES ARM 2-3.22(1)-02200 and ARM 2-3.22(2)-P2210, specifying the organization and procedure of the now defunct State Depository Board

TO: All Interested Persons:

1. On May 15, 1980, the Department of Administration published notice of a proposed repeal of rules ARM 2-3.22(1)-02200 and ARM 2-3.22(2)-P2210, specifying the organization and procedure of the now defunct State Depository Board, at page 1289 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

By: _____
J. Michael Young
Acting Director
Department of Administration

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the repeal of Rules 4.2.070, 4.2.080, 4.2.090, 4.2.100, 4.2.110, 4.2.120, 4.2.140, 4.2.150 pertaining to the implementation of the Montana Environmetal Policy Act; and the adoption of new rules implementing MEPA.	NOTICE OF THE REPEAL OF THE PRESENT RULES IMPLEMENTING THE MONTANA ENVIRONMENTAL POLICY ACT; AND ADOPTION OF REVISED RULES IMPLEMENTING MEPA

TO: All Interested Persons.

1. On May 15, 1980, the Department of Agriculture published notice of a proposed repeal of rules 4.2.070, 4.2.080, 4.2.090, 4.2.100, 4.2.110, 4.2.120, 4.2.140, 4.2.150 and the adoption of rules 4.2.301 thru 4.2.310 concerning the Repeal of the Present Rules implementing the Montana Environmental Policy Act; and Adoption of Revised Rules implementing MEPA, at page 1292 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed and adopted the rules as proposed.

3. No comments or testimony were received.

W. Gordon McOmber, Director
Department of Agriculture

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the amendment of rules 16-2.18(10)-S18070, 16-2.18(10)-S18071, 16-2.18(10)-S18072, 16-2.18(10)-S18075, 16-2.18(10)-S18077, 16-2.18(10)-S18078, establishing immunization requirements for public ad private schools	NOTICE OF AMENDMENT OF RULES 16-2.18(10)-S18070, 16-2.18(10)-S18071, 16-2.18(10)-S18072, 16-2.18(10)-S18075, 16-2.18(10)-S18077, and 16-2.18(10)-S18078 (Immunization Standards for Schools)

TO: All Interested Persons

1. On May 15, 1980, the Department of Health and Environmental Sciences published notice of proposed amendments to rules 16-2.18(10)-S18070, -S18071, -S18072, -S18075, -S18077, and -S18078, concerning immunization requirements for public and private schools, at page 1302 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rules as proposed.

3. No comments or testimony were received concerning the proposed amendments.

A. C. KNIGHT, M.D., Director

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the repeal of rules relating to licensing and construction of hospitals and related facilities (ARM 16-2.22(1)-S2200 through ARM 16-2.22(2)-S2261 except 16-2.22(1)-S2210 (2) and (3) and 16-2.22(1)-S2220(3)(j) and the adoption of rules relating to licensing and construction of health care facilities	NOTICE OF CORRECTION TO NOTICE OF ADOPTION OF RULES ARM 16.32.301 through 16.32.396 except 16.32.346, 16.32.361 and 16.32.362 AND REPEAL OF RULES ARM 16-2.22(1)-S2200 through ARM 16-2.22(2)-S2261 except ARM 16-2.22(1)-S2210 (2) and (3) and ARM 16-2.22(1)-S2220(3)(j)

TO: All Interested Persons

1. On April 24, 1980, the Department of Health and Environmental Sciences published notice of a proposed adoption of rules concerning licensing and construction of health care facilities and repeal of rules ARM 16-2.22(1)-S2200 through ARM 16-2.22(2)-S2261 concerning the licensing and construction of hospitals and related facilities at page 1225 of the 1980 Montana Administrative Register, issue number 8.

2. On June 12, 1980, the Department of Health and Environmental Sciences published "NOTICE OF ADOPTION . . . AND REPEAL OF RULES . . . " as above-captioned, at page 1587 of the 1980 Montana Administrative Register, issue no. 11. In that Notice, on pages 1587 and 1595, the Department erroneously cited subsection (3)(j) of ARM 16-2.22(1)-S2220 as an exception to the repeal of rules relating to licensing and construction of hospitals and related facilities. There is, in fact, no subsection (3)(j) to that rule; the correct citation for the exception to the repeal of the rules is 16-2.22(1)-S2220(6)(j), and the Department therefore submits this NOTICE OF CORRECTION for publication in the rule section of issue no. 12, 1980 Montana Administrative Register.

A. C. KNIGHT, M.D., Director

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Repeal of Rules 23-2.6AVI (1)-S600, 23-2.6AVI(2)-S610, and 23-2.6AVI(2)-S690 concerning the enforcement of traffic laws by the Highway Patrol;	))))))	NOTICE OF THE REPEAL OF RULES 23-2.6AVI(1)-S600, 23-2.6AVI(2)-S610, AND 23-2.6AVI(2)-S690

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed repeal of rules 23-2.6AVI(1)-S600, 23-2.6AVI(2)-S610, and 23-2.6AVI(2)-S690 concerning the enforcement of traffic laws by the Highway Patrol at pages 1320-21 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Amendment of Rule 23-2.6AVI (2)-S620 concerning authorized emergency vehicles.	)))))	NOTICE OF THE AMENDMENT OF RULE 23-2.6AVI(2)-S620

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed amendment of rule 23-2.6AVI(2)-S620 concerning authorized emergency vehicles at pages 1316-19 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Amendment of Rule 23-2.6AVI (2)-S6010 concerning the posting of bond monies by an alleged traffic violator) cited by the Highway Patrol	)))))	NOTICE OF THE AMENDMENT OF RULE 23-2.6AVI(2)-S6010

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed amendment of rule 23-2.6AVI(2)-S6010 concerning the posting of bond monies by an alleged traffic violator cited by the Highway Patrol at pages 1314-15 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Repeal of Rules 23-2.6AII(1)-S600 and 23-2.6AII(2)-S610 concerning operations of the Highway Patrol Bureau	)))))	NOTICE OF THE REPEAL OF RULES 23-2.6AII(1)-S600 AND 23-2.6AII(2)-S610 Highway Patrol Bureau.

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed repeal of rules 23-2.6AII(1)-S600 and 23-2.6AII(2)-S610 concerning operations of the Highway Patrol Bureau at pages 1312-13 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Repeal of Rules 23-2.6B(1)-0600, 23-2.6B(2)-S610, 23-2.6B(2)-S620, 23-2.6B(2)-S650, and 23-2.6B(2)-S670 concerning the Registrar's Bureau	))))))	NOTICE OF THE REPEAL OF RULES 23-2.6B(1)-0600, 23-2.6B(2)-S610, 23-2.6B(2)-S620, 23-2.6B(2)-S650, AND 23-2.6B(2)-S670

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed repeal of rules 23-2.6B(1)-0600, 23-2.6B (2)-S610, 23-2.6B(2)-S620, 23-2.6B(2)-S650, and 23-2.6B (2)-S670 concerning the Registrar's Bureau at pages 1322-23 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the repeal of rule 23-2.10B(1)-S1000 providing for the duties of the Public Safety Division	)))	NOTICE OF REPEAL OF RULE AND 23-2.10B(1)-S1000

TO: All Interested Persons.

1. On May 15, 1980, the Department of Justice published notice of a proposed repeal of rule 23-2.10B(1)-S1000 providing for the duties of the Public Safety Division at pages 1328-29 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the Amendment of Rule 23-2.6B(2) -S680 concerning the payment of fees while a vehicle is owned and held for sale.	))))	NOTICE OF THE AMENDMENT OF RULE 23-2.6B(2)-S680

TO: All Interested Persons:

1. On May 15, 1980 the Department of Justice published notice of a proposed amendment of rule 23-2.6B(2)-S680, concerning the payment of fees while a vehicle is owned and held for sale at pages 1324-25 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule with the following changes:

23-2.6B(2)-S680 DEALER LOT EXEMPTIONS

~~(1) If a motor vehicle, subject to anniversary date registration, is owned and held for sale by a new or used motor vehicle dealer on the 25th day of the anniversary registration period assigned to that particular motor vehicle, the requirement for registration and payment of taxes shall abate until such time as the motor vehicle is sold.~~

~~(2) The purchaser of a motor vehicle for which registration and taxes have abated as set forth in (1) above shall register the motor vehicle within ten (10) days of purchase and shall pay such prorated property taxes as are required by the Department of Revenue.~~ "If the anniversary date for reregistration of a vehicle passes while the vehicle is owned and held for sale by a licensed new or used car dealer, property taxes or the fee in lieu of property taxes abate on such vehicle properly reported with the Department of Revenue until the vehicle is sold and thereafter the purchaser shall pay the pro rata balance of the taxes or the fee in lieu of tax due and owing on the vehicle." § 61-3-501 MCA.

(2) While under section 61-3-501, MCA, property taxes or the fee in lieu of property taxes are prorated for a purchaser of a vehicle that has been sold by a licensed car dealer all

Other fees, ~~IN ADDITION TO THE PRORATED TAXES PAID, SHALL BE~~ are computed on a yearly basis and are not prorated. ~~The anniversary registration period assigned to such motor vehicle shall remain the same as that period first assigned to it under anniversary date registration.~~

~~(3) The exemption from registration and payment of fees and taxes as set forth in (1) above shall apply~~

~~to new or used motor vehicle dealers in Montana only if,~~

~~(a) they are duly registered and licensed as new or used motor vehicle dealers by the State of Montana, and,~~

~~(b) the motor vehicle for which the exemption is sought has been duly reported to the Department of Revenue in the manner required by such department.~~

3. The Staff of the Legislative Council commented orally that the quoting of a statute was unnecessary and in violation of section 2-4-305(2), MCA, which states: "Rules may not unnecessarily repeat statutory language." Accordingly, the rule has been modified to refer to the statute rather than repeat it.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the repeal of rules 23-2.10B(2)-S1030, and 23-2.10B(10)-S10390 concerning the Fire Marshal Bureau	))))	NOTICE OF PROPOSED REPEAL OF RULES 23-2.10B(2)-S1030 AND 23-2.10B(10)-10390

TO: All Interested Persons.

1. On May 15, 1980, the Department of Justice published notice of a proposed repeal of rules 23-2.10B(2)-S1030, and 23-2.10B(10)-S10390 concerning the Fire Marshal Bureau at pages 1326-27 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. Staff of Legislative Council commented orally, questioning the authority of the Department of Justice to repeal these rules, when the statute grants that authority to the State Fire Marshal. See section 50-3-102(2)(a), MCA. The Department of Justice responded that Executive Reorganization transferred all functions of the State Fire Marshal to the Department of Justice. Section 82-A-1202(5), R.C.M., 1947, states:

> The office of state fire marshal, created in Title 82, chapter 12, R.C.M. 1947, is abolished, and its functions are transferred to the department. Unless inconsistent with this act, any reference in the Revised Codes of Montana, 1947, to the office of state fire marshal means the department of justice.

When made aware of this provision, the commenter agreed that the Department of Justice has authority to repeal these rules.

MIKE GREELY
Attorney General

Certified to the Secretary of State June 17, 1980.

BEFORE THE HUMAN RIGHTS COMMISSION
OF THE STATE OF MONTANA

In the matter of the adoption of a rule regarding the time at which a decision of a hearing examiner may be reviewed by the Commission	NOTICE OF THE ADOPTION OF 24-3.9(2)-P9117, TIME FOR REVIEW OF HEARING EXAMINER DECISIONS

TO: All Interested Persons.

1. On April 10, 1980, the Commission published a notice of a public hearing regarding the adoption of a new rule concerning the time at which a decision of a hearing examiner may be reviewed by the Commission, appearing at page 1129 of the 1980 Montana Administrative Register, issue number 7.

2. The Commission has adopted the rule as proposed.

3. No comments or testimony were received at the public hearing held on May 14, 1980.

Karen S. Townsend, Chair

BY: Raymond D. Brown
Raymond D. Brown, Administrator
Human Rights Division

Certified to the Secretary of State June 17, 1980.

BEFORE THE HUMAN RIGHTS COMMISSION
OF THE STATE OF MONTANA

In the matter of the adoption of amendments to 24-3.9(14)-S9330 relating to guidelines on employee selection procedures	NOTICE OF ADOPTION OF AMENDMENTS OF 24-3.9(14)-S9330, ADOPTION OF EEOC UNIFORM GUIDELINES ON EMPLOYEE SELECTION PROCEDURES

TO: All Interested Persons.

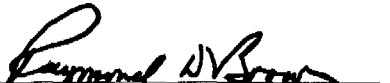
1. On April 10, 1980, the Commission published a notice of a public hearing regarding the adoption of amendments relating to Guidelines on Employee Selection procedures, appearing at page 1137 of the 1980 Montana Administrative Register, issue number 7.

2. The Commission has adopted the amended rule as proposed. The rule has been brought up to date with EEOC guidelines in this area and makes it consistent with ARM 24-3.9(14)-S9350. The Commission finds that the amendment implements the intent of Montana's Human Rights Act and the Governmental Code of Fair Practices by giving to employers the same guidance as to allowable employee selection procedures as does federal law.

3. At the public hearing held on May 12, 1980, at 7:30 p.m. in Suite 300, Steamboat Block Building, Helena, Montana 59601, the Commission heard testimony from Joyce Brown, EEOC Coordinator from the Montana Department of Administration. Ms. Brown stated that the rule was desirable insofar as it addressed the question of affirmative action in that it would make Montana's guidelines the same as federal guidelines in this area. This consistency in the laws would be advantageous for employers. Furthermore, it would benefit both employers and those who have traditionally suffered discrimination in the past by allowing affirmative action to be more effectively taken. There was no other testimony received.

The Commission was advised that its staff attorney had met with the Administrative Code Committee to explain the amendments and the related new rule concerning affirmative action. The Committee submitted a letter to the Commission stating that it had no objections to the adoption of the amendments or the new rule. Except for a memorandum from the staff, no other written comments were received.

Karen S. Townsend, Chair

BY: 
Raymond D. Brown, Administrator
Human Rights Division

Certified to the Secretary of State June 17, 1980.

BEFORE THE HUMAN RIGHTS COMMISSION
OF THE STATE OF MONTANA

In the matter of the adoption of a rule regarding the adoption of EEOC Affirmative Action Guidelines	NOTICE OF ADOPTION OF 24-3.9(14)-S9350, ADOPTION OF EEOC AFFIRMATIVE ACTION GUIDELINES

TO: All Interested Persons.

1. On April 10, 1980, the Commission published a notice of a public hearing regarding the adoption of a new rule adopting the EEOC Affirmative Action Guidelines, appearing at page 1128 of the 1980 Montana Administrative Register, issue number 7.

2. The Commission had adopted the rule as proposed in order to enable employers to undertake voluntary affirmative action in accordance with federal guidelines without violating state law. The Commission finds that the intent of the Montana Human Rights Act and the Governmental Code of Fair Practices is the same as the intent of Title VII, federal regulations concerning affirmative action.

3. At a public hearing held on May 12, 1980, at 7:30 p.m. in Suite 300, Steamboat Block Building, Helena, Montana 59601, the Commission heard testimony from Joyce Brown, EEOC Coordinator from the Montana Department of Administration. Ms. Brown stated that the rule was desirable in that it would make Montana's guidelines the same as federal guidelines in this area. This consistency in the laws would be advantageous for employers. Furthermore, it would benefit both employers and those who have traditionally suffered discrimination in the past by allowing affirmative action to be more effectively taken. There was no other testimony received.

The Commission was advised that its staff attorney had met with the Administrative Code Committee to explain this new rule and the related amended rule concerning affirmative action. The Committee submitted a letter to the Commission stating that it had no objections to the adoption of the new rule or the related amendments of the existing rule. Except for a memorandum from the staff, no other written comments were received.

Karen S. Townsend, Chair

BY: Raymond D. Brown
Raymond D. Brown, Administrator
Human Rights Division

Certified to the Secretary of State June 17, 1980.

BEFORE THE BOARD OF LIVESTOCK
STATE OF MONTANA

In the matter of the amendment of rule 32-2.6A(78)-S6330 to clarify horse import requirements.	)))	NOTICE OF THE AMENDMENT OF RULE 32-2.6A(78)-S6330

TO: All Interested Persons

1. On May 15, 1980 the Department of Livestock published notice of the proposed amendment on rule 32-2.6A(78)-S6330 clarifying horse import requirements at page 1330 of the 1980 Montana Administrative Register, Issue No. 9.

2. The agency has amended rule 32-2.6A(78)-S6330 as proposed.

3. No comments or testimony were received.

ROBERT G. BARTHELMESS
Chairman, Board of Livestock

By:
JAMES W. GLOSSER, D.V.M.
Administrator & State Veterinarian

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF
NATURAL RESOURCES AND CONSERVATION OF THE
STATE OF MONTANA

In the matter of the repeal of rule 36-2.6(1)-S600 that describes Grass Conservation and Soil Conservation Bureau Rules	))))	NOTICE OF REPEAL OF RULE 36-2.6(1)-S600 RELATING TO GRASS CONSERVATION AND SOIL CONSERVATION BUREAU RULES

TO: ALL INTERESTED PERSONS

1. On May 15, 1980, the Department of Natural Resources and Conservation (Department) published notice of a proposed repeal of rule 36-2.6(1)-S600 concerning Grass Conservation and Soil Conservation Bureau rules at page 1359 of the 1980 Montana Administrative Register, issue number 9.
2. The Department has repealed the rules as proposed.
3. No comments or testimony were received.

Ted J. Doney, Director
Department of Natural Resources
and Conservation

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF
NATURAL RESOURCES AND CONSERVATION OF THE
STATE OF MONTANA

In the matter of the repeal of rules 36-2.14(1)-S1400 and 36-2.14(1)-S1410 designating a controlled groundwater area	))))	NOTICE OF REPEAL OF RULES 36-2.14(1)-S1400 AND 36-2.14 (1)-S1410 RELATING TO THE DESIGNATION OF A CONTROLLED GROUNDWATER AREA

TO: ALL INTERESTED PERSONS

1. On May 15, 1980, the Department of Natural Resources and Conservation (Department) published notice of a proposed repeal of rules 36-2.14(1)-S1400 and 36-2.14(1)-S1410 concerning the designation of a controlled groundwater area at page 1360 of the 1980 Montana Administrative Register, issue number 9.

2. The Department has repealed the rules as proposed.

3. No comments or testimony were received.

Ted J. Doney, Director
Department of Natural Resources
and Conservation

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF
NATURAL RESOURCES AND CONSERVATION OF THE
STATE OF MONTANA

In the matter of the repeal of rules 36-2.14N(1)-S1400 through 36-2.14N(1)-S14220 relating to renewable resource development loans to ranchers and farmers	NOTICE OF REPEAL OF RULES 36-2.14N(1)-S1400 THROUGH 36-2.14N(1)-S14220 RELATING TO RENEWABLE RESOURCE DEVELOPMENT LOANS TO RANCHERS AND FARMERS

TO: ALL INTERESTED PERSONS

1. On May 15, 1980, the Department of Natural Resources and Conservation (Department) published notice of a proposed repeal of rules 36-2.14N(1)-S1400 through 36-2.14N(1)-S14220 concerning renewable resource development loans to ranchers and farmers at page 1358 of the 1980 Montana Administrative Register, issue number 9.
2. The Department has repealed the rules as proposed.
3. No comments or testimony were received.

Ted J. Doney, Director
Department of Natural Resources
and Conservation

Certified to the Secretary of State June 16, 1980.

BEFORE THE DEPARTMENT OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

IN THE MATTER of the Proposed Adoption of Rules Implementing Minimum Operations Requirements for Class D Motor Carriers.	NOTICE OF THE ADOPTION OF RULES IMPLEMENTING MINIMUM OPERATIONS REQUIREMENTS FOR CLASS D MOTOR CARRIERS

TO: All Interested Persons

1. On February 14, 1980, the Montana Public Service Commission published notice of a proposed adoption of rules implementing legislative changes in Sections 69-12-314 and 69-12-407, MCA, at page 472 of the 1980 Montana Administrative Register, issue number 3.

2. The Commission has adopted the rules with the following changes:

Rule I. (38-2.6(6)-S6210) USUAL BUSINESS OPERATION No change.

Rule II. (38-2.6(6)-S6220) REGULAR BASIS No change.

Rule III. (38-2.6(6)-S6230) RETAINING CLASS D CERTIFICATE (1) A motor carrier who possesses a Class D motor carrier certificate and who can show that its Class D service is used by at least 20 customers per month during each month of the calendar year, or can show that its Class D service generates not less than $5,000 gross revenue per calendar year, is presumed to meet the requirements of actually engaging in the transportation of Class D materials on a regular basis as part of the motor carrier's usual business operation as those requirements are set out in Section 69-12-314(2) and is, therefore, further presumed to be entitled to possess a Class D motor carrier certificate. No further showing will be required from such carrier unless the Commission specifically requests additional information pursuant to Rule VI.

(2) Failure of any Class "D" motor carrier to show either at least 20 customers per month or at least $5,000 in annual gross revenues raises no presumption either in favor of or against that carrier retaining its certificate in light of the requirements of Section 69-12-314(2). Rather, each such carrier will be evaluated on a case-by-case basis as set out in Rule IV.

Rule IV. (38-2.6(6)-S6240) OTHER CIRCUMSTANCES ALLOWING RETENTION OF CLASS D CERTIFICATE (1) A motor carrier who possesses a Class D motor carrier certificate but who because of seasonal operations or other circumstances cannot meet either of the conditions stated in Rule III(1), must submit to the Commission a signed and verified statement describing in detail those circumstances which lead the carrier to believe that it should be allowed to retain its Class D certificate consistent with the requirements of Section 69-12-314(2).

(2) No change.

Rule V. (38-2.6(6)-S6250) REPORTS No change.

Rule VI. (38-2.6(6)-S6260) ADDITIONAL INFORMATION REQUIRED BY THE COMMISSION (1) At any time, the Commission

may in its discretion require any Class D carrier to submit additional supporting evidence beyond that received in accordance with Rules IV or V.

(2) No change.

Rule VII. (38-2.6(6)-S6270) SHOW CAUSE ORDER No change.

3. A public hearing was held to consider the proposed rules on March 28, 1980. Several members of the Montana Solid Waste Contractors Association appeared at the hearing. Their attorney, Gary Zadick, reiterated several comments made in an earlier written statement submitted to the Commission.

In connection with Rule I, Mr. Zadick argued that it should contain language specifically prohibiting the holding of a Class "D" certificate for purposes of speculation. The Commission feels that it is possible for a carrier to hold a Class "D" certificate for speculation while still operating on a regular basis and as part of the motor carrier's usual business operation. Merely because one of the reasons for holding a certificate may be speculation does not mean the carrier would not be in compliance with Section 69-12-314, MCA. Therefore, no such language was included.

Concerning Rule II, Mr. Zadick proposed that the rule should require service on at least a weekly basis. Mr. Zadick pointed out that ARM 16-2.14(8)-S14315 requires that Group 2 wastes be picked up weekly. However, an examination of that Department of Health rule shows that it is applicable only when refuse containers are utilized and that Group 2 wastes are more narrowly defined than materials authorized by a Class "D" certificate. The Commission can foresee legitimate Class "D" operations who do not operate on a strict weekly basis.

Concerning Rule III, Mr. Zadick urged the Commission to increase the standards contained therein to 100 customers per month and raise the $5,000 gross revenue figure. Mr. Zadick points out that carriers operating in a community of 500 persons or less are exempt from regulation under Section 69-12-102(d), MCA, anyway. Again the Commission can foresee legitimate Class "D" operations in cities larger than 500 in population but which operation has less than 100 customers, especially if they are large customers. Admittedly, the standards set out in Rule III are somewhat arbitrary. However, their purpose is to establish some general guidelines by which the Commission can avoid having to closely scrutinize every Class "D" carrier on a case-by-case basis. The Commission believes this purpose is better served without increasing those standards.

In regards to Rule IV, Mr. Zadick urged the use of language clarifying that seasonal operations are seasonal because of the needs of the customer and not the discretion of the operator. Seasonal operations are mentioned in Rule IV primarily by way of example. The intent of Rule IV was to establish a case-by-case examination and not to set general standards or limiting definitions for seasonal operations or otherwise. Mr. Zadick's concern can be handled on a case-by-

case basis.

Mr. William O'Leary appeared on behalf of Marvin Mintyala and some other members of the Solid Waste Contractors Association. Mr. O'Leary argued that the rules should not address operating for a profit because that is not a requirement for obtaining Class "D" authority. The Commission believes that intent to operate at a level above costs is necessary to prevent the holding of certificates for the purposes of speculation only. Purposely operating at a loss would not be consistent with the intent of 69-12-314.

In connection with Rule I, Mr. O'Leary also argued that whether Class "D" service is incidental is immaterial. Again the Commission believes that the "on a regular basis" and "as part of the motor carrier's usual business operation" requirements of 69-12-314, require more than just an "incidental" service.

Mr. O'Leary submitted that inclusion of any numbers concerning customers or revenues is entirely arbitrary. It is the Commission's position that some numbers are necessary to establish guidelines by which the Commission may avoid a detailed examination of every single Class "D" carrier for compliance with the statute. The numerical guidelines do not constitute an exclusive test and any carrier may, in the alternative, choose to be treated on a case-by-case basis.

Mr. O'Leary and several others at the hearing expressed concern with respect to the constitutionality of the Commission revoking any existing Class "D" authority on the basis of 69-12-314. The Commission feels that the statute does require it to revoke noncomplying authorities. The matter of the constitutionality of such action is a question for the courts to decide and not the Commission in this proceeding.

Mr. Dennis Lopach appeared on behalf of the Montana Motor Carrier Association. He expressed concern that the verified statement in Rule IV may be measured against the numerical standards contained in Rule III. Paragraph (2) has been added to Rule III to further clarify the Commission's intention to judge each Rule IV verified statement on a case-by-case basis.

Mr. Lopach also recommended that Rule III standards be declared to be "interpretive" or "adjective." The Commission feels that this is not necessary since Rule III is clearly not the exclusive test for compliance with 69-12-304, MCA, and therefore does not in and of itself restrict the rights of any existing Class "D" carrier.

GORDON E. BOLLINGER, Chairman

CERTIFIED TO THE SECRETARY OF STATE JUNE 17, 1980.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF ARCHITECTS

IN THE MATTER of the Amendments of ARM 40-3.10(6)-S1040 subsection (1)(a) concerning reciprocity rules; ARM 40-3.10(6)-S10010 subsection (2) concerning reciprocity; and ARM 40-3.10(6)-S10040 subsection (1)(a) concerning qualification required of architects registered outside of Montana	NOTICE OF AMENDMENT OF ARM 40-2.10(6)-S1040 RULES AND REGULATIONS - RECIPROCITY; ARM 40-3.10(6)-S10010 RECIPROCITY; and ARM 40-3.10(6)-S10040 QUALIFICATIONS REQUIRED OF ARCHITECTS REGISTERED OUTSIDE OF MONTANA

TO: All Interested Persons:

1. On May 15, 1980, the Board of Architects published a notice of amendment of ARM 40-3.10(6)-S1040 subsection (1)(a) concerning reciprocity rules; ARM 40-3.10(6)-S10010 subsection (2) concerning reciprocity and ARM 40-3.10(6)-S10040 subsection (1)(a) concerning qualifications required of architects registered outside of Montana at pages 1362 and 1363, Montana Administrative Register, issue number 9.

2. The board has amended the rules exactly as proposed.

3. No comments or testimony were received.

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF PHARMACISTS

In the matter of the amendment of ARM 40-3.78(6)-S78030 concerning statutory rules and regulations - dangerous drugs, subsection (5)(b)	NOTICE OF AMENDMENT OF ARM 40-3.78(6)-S78030 STATUTORY RULES AND REGULATIONS - DANGEROUS DRUGS

TO: All Interested Persons:

1. On May 15, 1980, the Board of Pharmacists published a notice of proposed amendment of ARM 40-3.78(6)-S78030 concerning statutory rules and regulations for dangerous drugs at pages 1364 and 1365, Montana Administrative Register, issue number 9.

2. The board has amended the rule exactly as proposed.

3. No comments or testimony were received.

BY: 
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPATIONAL LICENSING

Certified to the Secretary of State, June 17, 1980.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF HORSE RACING

In the matter of the proposed) Emergency amendment of ARM) 40-3.46(6)-S46010 subsection) (63)(k) concerning general) conduct of racing.)	NOTICE OF EMERGENCY AMENDMENT OF SUBSECTION (63)(k) of ARM 40-3.46(6)-S46010 GENERAL CONDUCT OF RACING

TO: All Interested Persons:

1. The Board of Horse Racing has determined that the existing wording of the rule places excessive and unreasonable restrictions on the discretion of the stewards. As now written it is questionable whether the stewards can declare a race called off unless a majority of the horses are affected. A race might have to be declared official even though up to one half of the horses in the field have been affected by mechanical failure. In the interests of fairness to the horsemen and to the wagering public the board feels that the stewards must have discretion to declare a race no contest if in their judgement one or more horses are determined to have been detrimentally affected by a mechanical failure.

a. Race meets are, as of the day of this filing, being conducted. Each time a race is run a possibility of a mechanical failure in the starting gate exists. If and when a mechanical failure should occur, under the current rule, the stewards cannot declare a no contest unless a majority of the horses are affected. To remain under this wording of the rule might very well expose the Board of Horse Racing, the Department of Professional and Occupational Licensing, and the state of Montana to serious liability generated by action of claimants who have an interest in a horse affected by mechanical failure and at the same time subject to a race which must be declared official under the current rule, and generated by claimants who have a wagering interest which may suffer detriment thereunder. To prevent this potentially imminent liability, the board finds it necessary to make the amendment effective immediately.

The board intends on filing a notice of proposed amendment on the most immediate filing deadline following this date and through the regular rule adoption process therein offering an opportunity for a hearing.

3. The text of the proposed amendment is as follows:

"40.3.46(6)-S46010 GENERAL CONDUCT OF RACING.....

(63)..

(k) In the event of mechanical failure or interference during the running of a race which affects ~~the majority~~ one or more of the horses in such race, the stewards may declare the race as no contest. Any wagers on such races called off, cancelled, or declared as no contest shall be refunded, and no purse, prize or stakes shall be awarded. A race shall be cancelled if no horse

covers the course.
...."

4. The rationale for the proposed rule is as set forth in the statement of reasons for the emergency.

5. The emergency amendment will become effective on June 11, 1980.

6. Interested persons may comment in writing to the Board of Horse Racing, Lalonde Building, Helena, Montana 59601.

7. The authority of the board to make the proposed amendment is based on section 23-4-202 MCA and implements section 23-4-104 MCA.

BOARD OF HORSE RACING
JOSEPH MURPHY, D.D.S., CHAIRMAN

BY: 
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPATIONAL LICENSING

Certified to the Secretary of State, June 11, 1980.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF PSYCHOLOGISTS

In the matter of the Amendment of ARM 40-3.90(6)-S90040 concerning the code of professional conduct) NOTICE OF AMENDMENT OF ARM 40-3.90(6)-S90040 CODE OF PROFESSIONAL CONDUCT

TO: All Interested Persons:

1. On May 15, 1980, the Board of Psychologists published a notice of proposed amendment of ARM 40-3.90(6)-S90040 concerning the code of professional conduct at page 1366, Montana Administrative Register, issue number 9.

2. The board has amended the rule exactly as proposed.

3. No comments or testimony were received.

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF PUBLIC ACCOUNTANTS

In the matter of the repeal of ARM 40-3.94(6)-S94010 concerning examinations and applications and ARM 40-3.94(6)-S94060 concerning fees and inactive list.) NOTICE OF REPEAL OF ARM 40-3.94(6)-S94010 EXAMINATIONS - APPLICATIONS AND ARM 40-3.94(6)-S94060 FEES, INACTIVE LIST

TO: All Interested Persons:

1. On May 15, 1980, the Board of Public Accountants published a notice of proposed repeal of ARM 40-3.94(6)-S94010 concerning examinations and applications and ARM 40-3.94(6)-S94060 concerning fees and inactive list at pages 1367 and 1368, Montana Administrative Register, issue number 9.

2. The board has repealed the rules exactly as proposed.

3. No comments or testimony were received.

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BEFORE THE BOARD OF WATER WELL CONTRACTORS

In the matter of the Repeal of ARM 40-3.106(6)-S10670 concerning duplicate or lost licenses) NOTICE OF REPEAL OF ARM 40-2.106(6)-S10670 DUPLICATE OR LOST LICENSES

TO: All Interested Persons:

1. On May 15, 1980, The Board of Water Well Contractors published a notice of proposed repeal of ARM 40-3.106(6)-S10670 concerning duplicate or lost licenses at page 1639, Montana Administrative Register, issue number 9.

2. The board has repealed the rule exactly as proposed.
3. No comments or testimony were received.

BY: 
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPATIONAL LICENSING

Certified to the Secretary of State, June 17, 1980.

BEFORE THE DEPARTMENT OF REVENUE

OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT OF RULE 42-2.8(1)-S8660, relating to adjusted gross income of spouses on separate returns.	NOTICE OF DEPARTMENT DECISION ON PROPOSED AMENDMENT OF RULE 42-2.8(1)-S8660, relating to the adjusted gross income of spouses on separate returns.

TO: All Interested Persons:

1. On January 31, 1980, the Department of Revenue published notice of a public hearing on a proposed amendment to rule 42-2.8(1)-S8660, relating to the adjusted gross income of spouses on separate returns, at pages 398 and 399 of the Montana Administrative Register, issue no. 2. On March 17, 1980, the public hearing was held.

2. The Department has decided not to adopt the proposed amendment.

3. The rule-making proceeding in this instance was initiated by a petition from the Revenue Oversight Committee requesting that the amendment noticed in 1980 MAR, issue no. 2, be adopted. At the hearing several parties appeared in support of the proposal. The Department, at the hearing, expressed its reluctance to promulgate the amendment because of questionable authority to make the changes and because of recent legislative history indicating the reluctance of the Legislature to make the desired changes by statute. The hearing examiner, Mr. Ross Cannon, felt that the Department's concerns relating to lack of authority were not valid, and he recommended adoption of the amendments. After carefully reviewing the arguments of the proponents and of the hearing examiner, the Department has determined it lacks authority to make the proposed amendment and consequently declines to adopt the amendment. The rationale for the Department's decision, as presented in a letter to the Revenue Oversight Committee, is as follows:

The Department's decision is not based on the question of whether the amendment is "good" or "bad", but rather on the question of whether the Department has authority to promulgate the suggested amendment. In reviewing the proposed amendment, it is necessary to examine the underlying statutes. In particular, Section 15-30-111, MCA, provides in relevant part:

> "15-3--111. Adjusted gross income. (1) Adjusted gross income shall be the taxpayer's federal income tax adjusted gross income as defined in section 62 of the Internal Revenue Code of 1954. . . ."

In essence, the Committee's proposal would enable a taxpayer to report as the taxpayer's Montana adjusted gross income an

amount that would not correspond to the taxpayer's federal adjusted gross income, and this would violate 15-30-111, MCA. The fact that income splitting is achievable under the federal code by means of a joint return does not provide a solution. It is a well-established principle that the use of a federal joint return does not convert the income of one spouse into the income of the other spouse. Another factor indicating that adoption of the amendment would not be appropriate is the legislative history of proposals to accomplish similar results. During the 1979 Legislature, no legislation related to income splitting was submitted. During the 1977 Legislature, two Senate bills and one House Joint Resolution were introduced. All three were killed in committee. In 1975, a House Joint Resolution was also killed in committee. Given this expression of legislative intent, it seems inappropriate that the Department implement a rule which the Legislature has declined to implement as a statute.

MARY L. CRAIG, Director
Department of Revenue

Certified to the Secretary of State 6/16/80

BEFORE THE DEPARTMENT OF REVENUE

OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT OF RULES 42-2.22(2)-S22000 Assessment of Heavy Equipment and 42-2.22(2)-S22020 Assessment of Manufacturing and Mining Equipment.	))))))	NOTICE OF AMENDMENT OF RULES 42-2.22(2)-S22000 Assessment of Heavy Equipment and 42-2.22(2)-S22020 Assessment of Manufacturing and Mining Equipment.

TO: All Interested Persons:

1. On December 27, 1979, the Department of Revenue published notice of the proposed amendment of rules 42-2.22(2)-S22000, relating to assessment of heavy equipment, and 42-2.22(2)-S22020, relating to assessment of manufacturing and mining equipment, at pages 1635 through 1640 of the 1979 Montana Administrative Register, issue no. 24.

2. The Department has amended rules 42-2.22(2)-S22000 and 42-2.22(2)-S22020 with the following changes (deletions interlined and additions underlined and capitalized):

42-2.22(2)-S22000 ASSESSMENT OF HEAVY EQUIPMENT (1) (a) The ~~minimum assessed~~ market value of heavy equipment ~~shall be the wholesale value~~ is the average resale value of such property as shown in "Green Guides", Volumes I and II, ~~or~~ "Green Guides Older Equipment Guide", "Green Guides Life Trucks", or "Green Guides Off Highway Trucks and Trailers", ~~The~~ using the current volumes of the year of assessment~~, Equipment Guide Book Company, 3980 Fabian Way, P. O. Box 10113, Palo Alto, California 94303~~. This guide may be reviewed in the Department or purchased from the publisher: Equipment Guide Book Company; 3980 Fabian Way; P. O. Box 10113; Palo Alto, California 94303.

(b) If the above-named publications cannot be used to value these properties then a trended depreciation schedule established by the Department of Revenue shall be used to determine the average market value. The schedule is found in subsection (2).

(2)(a)(i) For the calendar year commencing January 1, 1979, the following schedule is used for heavy equipment:

TABLE 1A

AGE	~~R-3~~ PERCENTAGE DEPRECIATION	TREND FACTOR	PERCENTAGE TRENDED DEPRECIATION
1 Year Old	92%	1.000	92%
2 Years Old	84%	1.053	88%
3 Years Old	76%	1.119	85%
4 Years Old	67%	1.248	84%
5 Years Old	58%	1.446	84%
6 Years Old	49%	1.497	73%
7 Years Old	39%	1.547	60%
8 Years Old	30%	1.639	49%
9 Years Old	24%	1.744	42%
10 Years Old and Older	20%	1.820	36%

(ii) For 1979 models, a percentage trended depreciation figure of 95% is used.

(b)(i) For the calendar year commencing January 1, 1980, the following schedule is used for heavy equipment:

~~TABLE 1B~~

~~AGE~~	~~R-3 PERCENTAGE DEPRECIATION~~	~~TREND FACTOR~~	~~PERCENTAGE TRENDED DEPRECIATION~~
~~1 Year Old~~	~~92%~~	~~1.000~~	~~92%~~
~~2 Years Old~~	~~84%~~	~~1.058~~	~~89%~~
~~3 Years Old~~	~~76%~~	~~1.144~~	~~87%~~
~~4 Years Old~~	~~67%~~	~~1.223~~	~~82%~~
~~5 Years Old~~	~~58%~~	~~1.310~~	~~76%~~
~~6 Years Old~~	~~49%~~	~~1.370~~	~~67%~~
~~7 Years Old~~	~~39%~~	~~1.677~~	~~65%~~
~~8 Years Old~~	~~30%~~	~~1.758~~	~~53%~~
~~9 Years Old~~	~~24%~~	~~1.823~~	~~44%~~
~~10 Years Old and Older~~	~~20%~~	~~1.900~~	~~38%~~

~~(ii) For 1980 models, a percentage trended depreciation figure of 95% is used.~~

TABLE IB WHEEL LOADERS LIFT TRUCKS CRAWLER TRACTORS LOG SKIDDERS CONCRETE EQUIPMENT BELT LOADERS HYDRAULIC CRANES CRAWLER CRANES AND SHOVELS TRUCK MOUNTED CRANES AND SHOVELS OFF HIGHWAY HAUL UNITS		TABLE IIB CRUSHING EQUIPMENT ROAD MAINTENANCE EQUIPMENT MOTOR GRADERS CRAWLER LOADERS ASPHALT FINISHERS ALL OTHER MISC. EQUIPMENT NOT INCLUDED IN TABLE IB OR IIIB		TABLE IIIB AIR EQUIPMENT HYDRAULIC EXCAVATORS MOTOR SCRAPERS WHEEL TRACTORS DITCHERS ROLLERS OTHER COMPACTION EQUIPMENT	
YEAR OF PURCHASE	R.C.L.N.D. MARKET VALUE	YEAR OF PURCHASE	R.C.L.N.D. MARKET VALUE	YEAR OF PURCHASE	R.C.L.N.D MARKET VALUE
1980	100%	1980	100%	1980	100%
1979	96%	1979	78%	1979	74%
1978	93%	1978	75%	1978	72%
1977	89%	1977	72%	1977	68%
1976	86%	1976	66%	1976	64%
1975	81%	1975	65%	1975	59%
1974	78%	1974	59%	1974	57%
1973	86%	1973	66%	1973	63%
1972	77%	1972	60%	1972	56%
1971	74%	1971	52%	1971	52%
1970	69%	1970	52%	1970	46%
1969	65%	1969	51%	1969	36%
1968	61%	1968	51%	1968	33%
1967	57%	1967	49%	1967	30%
1966	56%	1966	48%	1966	28%
1965	50%	1965	45%	1965	24%
1964	46%	1964	44%	1964	22%
1963	44%	1963	44%	1963	22%
1962	40%	1962	40%	1962	17%
1961	34%	1961	34%	1961	17%
1960 & Older	34%	1960 & Older	32%	1960 & Older	14%
R.C.L.N.D. - REPLACEMENT COST LESS NORMAL DEPRECIATION					

(II) IN ADDITION TO THE SCHEDULE IN SUBSECTION (2)(B)(I), THE DEPARTMENT MULTIPLIES THE R.C.L.N.D. MARKET VALUE PERCENTAGES IN TABLES IB, IIB, AND IIIB BY A FACTOR BASED ON EQUIPMENT USE. THE MULTIPLIER IS DETERMINED FROM THE FOLLOWING TABLE:

ANNUAL HOURS OF USE (T)	MULTIPLIER
$0 \leq T \leq 3,120$	1
$3,120 < T \leq 4,680$	.8
$4,680 < T$	.667

(3) The tables IN SUBSECTION (2) (A) were compiled using ~~R-3~~ depreciation schedules with a residual valve of 20%. THE TABLES IN SUBSECTION (2)(B)(I) WERE COMPILED TO APPROXIMATE DEPRECIATION AS GIVEN BY THE RESALE VALUES OF THE GREEN GUIDES. The trend factors were compiled using comparative cost multipliers based on data published by the Marshall and Swift Publication Company. More detailed information concerning the table entries can be obtained from the department.

42-2.22(2)-S22020 ~~ASSESSMENT OF MANUFACTURING AND MINING EQUIPMENT~~ ASSESSMENT OF MINING MACHINERY AND EQUIPMENT. (1)(a) ~~The minimum assessed value of manufacturing and mining machinery, equipment and supplies shall be forty percent (40%) of the original installed cost. (This is in lieu of an annual depreciation.)~~ The average market value for the mobile equipment used in mining, including coal and ore haulers, shall be the average resale value of such property as shown in "Green Guides", Volumes I and II, Older Equipment, Off Highway Trucks, and Trailers and Lift Trucks, using the current volumes of the year of assessment. This guide may be reviewed in the Department or purchased from the publisher: Equipment Guide Book Company; 3980 Fabian Way; P. O. Box 10113; Palo Alto, California 94303.

(b) If the above-named guides cannot be used to value these properties, then trended depreciation tables established by the Department of Revenue shall be used to determine the average market value. The tables are found in subsection (2).

(2)(a)(i) For the calendar year commencing January 1, 1979, the following table is used for mobile mining equipment:

TABLE 1A

AGE	~~R-3~~ PERCENTAGE DEPRECIATION	TREND FACTOR	PERCENTAGE TRENDED DEPRECIATION
1 Year Old	92%	1.000	92%
2 Years Old	84%	1.053	88%
3 Years Old	76%	1.119	85%
4 Years Old	67%	1.248	84%
5 Years Old	58%	1.446	84%
6 Years Old	49%	1.497	73%
7 Years Old	39%	1.547	60%
8 Years Old	30%	1.639	49%
9 Years Old	24%	1.744	42%
10 Years Old and Older	20%	1.820	36%

(ii) For 1979 models, a percentage trended depreciation figure of 95% is used.

(b)(i) For the calendar year commencing January 1, 1980, the following table is used for mobile mining equipment:

~~TABLE 1B~~

~~AGE~~	~~R-3 PERCENTAGE DEPRECIATION~~	~~TREND FACTOR~~	~~PERCENTAGE TRENDED DEPRECIATION~~
~~1 Year Old~~	~~92%~~	~~1.000~~	~~92%~~
~~2 Years Old~~	~~84%~~	~~1.058~~	~~89%~~
~~3 Years Old~~	~~76%~~	~~1.144~~	~~87%~~
~~4 Years Old~~	~~67%~~	~~1.223~~	~~82%~~
~~5 Years Old~~	~~58%~~	~~1.310~~	~~76%~~
~~6 Years Old~~	~~49%~~	~~1.370~~	~~67%~~
~~7 Years Old~~	~~39%~~	~~1.677~~	~~65%~~
~~8 Years Old~~	~~30%~~	~~1.758~~	~~53%~~
~~9 Years Old~~	~~24%~~	~~1.823~~	~~44%~~
~~10 Years Old and Older~~	~~20%~~	~~1.900~~	~~38%~~

~~(ii) For 1980 models, a percentage trended depreciation figure of 95% is used.~~

TABLE IB WHEEL LOADERS LIFT TRUCKS CRAWLER TRACTORS LOG SKIDDERS CONCRETE EQUIPMENT BELT LOADERS HYDRAULIC CRANES CRAWLER CRANES AND SHOVELS TRUCK MOUNTED CRANES AND SHOVELS OFF HIGHWAY HAUL UNITS		TABLE IIB CRUSHING EQUIPMENT ROAD MAINTENANCE EQUIPMENT MOTOR GRADERS CRAWLER LOADERS ASPHALT FINISHERS ALL OTHER MISC. EQUIPMENT NOT INCLUDED IN TABLE IB OR IIIB		TABLE IIIB AIR EQUIPMENT HYDRAULIC EXCAVATORS MOTOR SCRAPERS WHEEL TRACTORS DITCHERS ROLLERS OTHER COMPACTION EQUIPMENT	
YEAR OF PURCHASE	R.C.L.N.D. MARKET VALUE	YEAR OF PURCHASE	R.C.L.N.D. MARKET VALUE	YEAR OF PURCHASE	R.C.L.N.D MARKET VALUE
1980	100%	1980	100%	1980	100%
1979	96%	1979	78%	1979	74%
1978	93%	1978	75%	1978	72%
1977	89%	1977	72%	1977	68%
1976	86%	1976	66%	1976	64%
1975	81%	1975	65%	1975	59%
1974	78%	1974	59%	1974	57%
1973	86%	1973	66%	1973	63%
1972	77%	1972	60%	1972	56%
1971	74%	1971	52%	1971	52%
1970	69%	1970	52%	1970	46%
1969	65%	1969	51%	1969	36%
1968	61%	1968	51%	1968	33%
1967	57%	1967	49%	1967	30%
1966	56%	1966	48%	1966	28%
1965	50%	1965	45%	1965	24%
1964	46%	1964	44%	1964	22%
1963	44%	1963	44%	1963	22%
1962	40%	1962	40%	1962	17%
1961	34%	1961	34%	1961	17%
1960 & Older	34%	1960 & Older	32%	1960 & Older	14%
R.C.L.N.D. - REPLACEMENT COST LESS NORMAL DEPRECIATION					

(II) IN ADDITION TO THE SCHEDULE IN SUBSECTION (2)(B)(I), THE DEPARTMENT MULTIPLIES THE R.C.L.N.D. MARKET VALUE PERCENTAGES IN TABLES IB, IIB, AND IIIB BY A FACTOR BASED ON EQUIPMENT USE. THE MULTIPLIER IS DETERMINED FROM THE FOLLOWING TABLE:

ANNUAL HOURS OF USE (T)	MULTIPLIER
$0 \leq T \leq 3,120$	1
$3,120 < T \leq 4,680$	.8
$4,680 < T$	.667

(3) The average market value for stationary machinery and equipment used in mining shall be determined using trended depreciation tables established by the Department of Revenue. These are 10-year tables and reflect the average life of these properties. The tables are found in subsection (4).

(4)(a) For the calendar year commencing January 1, 1979, the following table is used for stationary mining machinery and equipment:

TABLE 2A

AGE	~~R-3~~ PERCENTAGE DEPRECIATION	TREND FACTOR	PERCENTAGE TRENDED DEPRECIATION
1 Year Old	92%	1.000	92%
2 Years Old	84%	1.078	91%
3 Years Old	76%	1.140	87%
4 Years Old	67%	1.216	81%
5 Years Old	58%	1.392	81%
6 Years Old	49%	1.610	79%
7 Years Old	39%	1.667	65%
8 Years Old	30%	1.725	52%
9 Years Old	24%	1.829	44%
10 Years Old and Older	20%	1.949	39%

(b) For the calendar year commencing January 1, 1980, the following table is used for stationary mining machinery and equipment:

TABLE 2B

AGE	~~R-3~~ PERCENTAGE DEPRECIATION	TREND FACTOR	PERCENTAGE TRENDED DEPRECIATION
1 Year Old	92%	1.000	92%
2 Years Old	84%	1.053	88%
3 Years Old	76%	1.145	87%
4 Years Old	67%	1.232	83%
5 Years Old	58%	1.324	77%
6 Years Old	49%	1.416	69%
7 Years Old	39%	1.746	68%
8 Years Old	30%	1.821	55%
9 Years Old	24%	1.885	45%
10 Years Old and Older	20%	1.966	39%

(5) The tables IN SUBSECTIONS (2)(A) AND (4) were compiled using ~~R-3~~ depreciation schedules with a residual value of 20%. THE TABLES IN SUBSECTION (2)(B)(I) WERE COMPILED TO APPROXIMATE DEPRECIATION AS GIVEN BY THE RESALE VALUES OF THE GREEN GUIDES. The trend factors were compiled using comparative cost multipliers based on data published by the Marshall and Swift Publication Company. More detailed information concerning the table entries can be obtained from the department.

3. On March 4, 1980, a rule-making hearing was held concerning proposed amendments to Rules 42-2.22(2)-S22000 (Heavy Equipment) and 42-2.22(2)-S22020 (Manufacturing and Mining Equipment). This hearing was in essence a continuation of a rule-making proceeding on these rules that had its origin in 1978. Numerous parties appeared at the hearing and presented testimony.

The principal points raised by those appearing at the hearing concerned:

(1) The use of the Green Guides to value property.

(2) The use of wholesale versus resale in computing value.

(3) The use of trend factors in depreciation tables.

Additionally a report was presented by an advisory committee appointed by the Director.

Concerning the use of the Green Guides, testimony was presented by the Montana Contractors Association urging the use of actual sales data as opposed to the use of the Green Guide or other valuation manuals. To the extent that publications such as the Green Guide utilize sales data in compiling tables, the use of a valuation manual accomplishes what the Contractors Association requests. In a relatively small market such as Montana, there will be a lack of sales data for many of the types of equipment, and this will necessitate the use of manuals in any

case. Moreover, the Department lacks the resources to carry out the complete sales analysis that would be required to implement the Contractors Association proposal. However, the Department will continue to examine the feasibility of valuation based on sales data for possible future implementation. In a similar fashion, the Advisory Committee advocated the development of depreciation tables for all heavy equipment (including mobile mining equipment). The problem with this approach is again one of resources. A substantial number of tables would be needed to adequately value the multitude of properties concerned. Moreover, a considerable portion of the tables would be computed from data taken from valuation manuals such as the Green Guide. Consequently, given the resources available to the Department, it is felt that the most practical approach is the use of a valuation manual coupled with tables for that equipment that is not listed in the selected manual. Because of familiarity with the manual, the Department proposes to continue the use of the Green Guides at this time. The Department will, however, examine other manuals, such as the statement of sales by Forke Brothers, for possible adoption at a future date.

Turning to the question of wholesale versus resale price in the Green Guides as a standard of value, the Department maintains that in view of the legislative history of House Bill 70, which implemented the market value concept, the appropriate measure of value is the resale price. In establishing the various percentages to convert market value to taxable value, the Legislature relied on data supplied by the Department that was phrased in terms of resale value. It was not the Legislature's intent to alter the tax base but rather to simplify the computation of taxable value. Those who advocate the use of wholesale price as the proper measure of market value should present their arguments to the 1981 Legislature, as that is the proper body to change the law. As a consequence the Department proposes to retain the reference to resale price in the rules.

Responding to comments that a single depreciation table is not adequate to treat the various types of heavy equipment and mobile mining equipment, the Department has prepared three depreciation tables designed to yield resale value as given by the Green Guides. The Department will continue to study the tables and will make refinements, including additional tables if necessary, to reflect the resale value with reasonable accuracy, within the confines of available manpower and other resources. The new tables can be found in subsection (2)(B)(I) of both rules.

In addition to the tables, the Department also proposes to utilize a factor to reflect the usage of the equipment. The Department is aware that a piece of equipment that has been used 24 hours a day for every day of the year will have a lower market value than a similar piece of equipment used 8 hours a day. On a basis of 8-12 hours a day for 260 days (52 weeks of 5 days), a

single shift is considered to be up to 3,120 hours a year. A double shift is 12-18 hours a day or from 3,120 hours to 4,680 hours a year. A triple shift is more than 18 hours a day or more than 4,680 hours a year. A piece of equipment that has averaged single shift operation for each year of operation is valued by the percentage figure given in the table. A piece of equipment that has averaged double shift operation for each year of operation is valued by taking 80% of the figure shown in the table. A piece of equipment that has averaged triple shift operation for each year of operation is valued by taking 66 2/3% of the value shown in the table. Thus, for example, the resulting figures for Table IB in Subsection (2)(B)(I) of rule 42-2.22(2)-S22000 would look like:

TABLE IB

YEAR OF PURCHASE	R. C. L. N. D. MARKET VALUE		
	SINGLE SHIFT	DOUBLE SHIFT	TRIPLE SHIFT
1980	100%	80%	67%
1979	96%	77%	64%
1978	93%	74%	62%
1977	89%	71%	59%
1976	86%	69%	57%
.	.	.	.
.	.	.	.
.	.	.	.

The use of the shift concept will permit the Department to take into account the degree of use in ascertaining market value.

The Montana Contractor's Association has voiced its opposition to the use of trend factors in deriving depreciation tables. The Department considers the use of trend factors to be in accord with the legislative mandate of employing market value. The nature of the data found in the Green Guides required the use of trend factors to obtain the tables shown in Tables I, II and III above.

It was necessary to convert original costs from earlier years to present day dollars in order to derive a table that could be multiplied times original cost and yield present market value.

The trend factors utilized are as follows:

YEAR PURCHASED	TREND FACTOR
1979	1.000
1978	1.105
1977	1.199
1976	1.289
1975	1.373
1974	1.470
1973	1.840
1972	1.937
1971	2.005
1970	2.079
1969	2.229
1968	2.337
1967	2.468
1966	2.552
1965	2.653
1964	2.722
1963	2.768
1962	2.838
1961	2.844
1960 & Older	2.865

The trend factors were based on the comparative cost multipliers for construction equipment published by the Marshall-Swift Valuation Service. The Advisory Committee stated its support for the concept of replacement cost less depreciation as the measure of market value.

The Tables were developed to reflect the resale values given by the Green Guides. In order to accomplish this, trend factors were employed. The Department makes no claim that the tables are perfect and admits that in a particular case the table may overvalue or undervalue a specific piece of equipment. A taxpayer who anticipates an incorrect valuation should contact the county assessor prior to valuation in order to informally try and resolve any differences. Such informal contact is still possible after valuation, but the initiative remains with the taxpayer. An example of such a situation would be inoperable equipment. The state of the equipment should be brought to the assessor's attention. When the informal process is of no avail, the taxpayer has the formal appeal process of the County Tax Appeal Board available. The Department considers the approach detailed above to be both workable and equitable.

It was suggested at the hearing that the taxpayer's depreciation schedule for income tax purposes be utilized. The Department considers this approach inappropriate. Income tax depreciation is designed to permit the recovery of capital

investment via a deduction against income. Property tax depreciation is designed to reflect present market value. To the extent these figures differ, the use of income tax depreciation schedules is inappropriate for property tax valuation. It would also be inappropriate to permit the taxpayer to pick and choose methods of valuation. Under Montana's present method of taxation, it is proper that the same piece of equipment be valued the same independent of the owner of the property. This is best accomplished by a single method of valuation, that does not depend on a particular taxpayer's method of accounting or bookkeeping.

In addition to the comments received at the hearing and from various interested persons, the Department received a report from the hearing officer, Mr. Ross Cannon, based on his analysis of the proposed amendments. The Department must respectfully disagree with the hearing officer's conclusions. The hearing officer would require the Department (via county offices in most cases) to have assessors and appraisers personally observe and value each piece of property to be valued unless the taxpayer elects another method of valuation. While such an approach might be viable in a perfect and fully-funded world, the use of individual valuations is simply not possible in the real, fiscal world. An army of appraisers would be required; for if Mr. Cannon is correct with respect to heavy equipment and mining equipment, the same principles apply to automobiles, boats, motors, bowling alleys, etc., etc. It is the Department's contention that the Legislature did not intend to create a greater bureaucracy in passing House Bill 70. It is the Department's contention that the proposal adopted by the Department is a valid means of determining market value within the definition established by the Legislature and consistent with the legislative intent underlying House Bill 70. It is not a matter of expediency and convenience that leads the Department to use valuation manuals and depreciation tables. The methods adopted by the Department were chosen to enable the Department to determine market value within the constraints imposed by the legislative appropriation.

The hearing officer also challenged the use of trend factors. The Department continues to maintain that the use of trend factors is not only proper, but is in fact mandated by the concept of market value. A trend factor is designed to translate dollars from a prior year to dollars in the present year. Market value as defined must be expressed in present dollars, and trend factors accomplish this task. The validity of trend factors is based on the validity of the concept of present value and not on the existence of precedent in federal or state law. A depreciation table takes into account wear and use, but used alone pure depreciation values the property in terms of original cost in the dollars at the time of purchase. Multiplication by a trend factor brings this valuation to present value.

MARY L. CRAIG, Director
Department of Revenue

Certified to the Secretary of State 6-16-80.

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of the repeal of rules relating to the rule numbering method and breakdown of ARM before recodification and the revision of rules relating to specific recodification procedures	)))))	NOTICE OF THE REPEAL AND REVISION OF PROCEDURAL RULES IN TITLE 1, CHAPTER 2, GENERAL PROVISIONS

TO: All Interested Persons:

1. On May 15, 1980, the Secretary of State published notice of a proposed repeal of rules and revision of rules in Title 1, Chapter 2, General Provisions, at page 1370 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed and revised the rules as proposed.

3. No comments or testimony were received.

Dated this 17th day of June, 1980.

Frank Murray

FRANK MURRAY
Secretary of State

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(a)(i) (ii)(iii)(b) and (2) and the adoption of Rules 46-2.10(18)-S11532 and 46-2.10(18)-S11533 pertaining to physician services	)))))	NOTICE OF AMENDMENT OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES 46-2.10(18)-S11532 AND 46-2.10(18)-S11533

TO: All Interested Persons

1. On April 24, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment of Rule 46-2.10(18)-S11440(1)(a)(i)(ii)(iii)(b) and (2) and the adoption of Rules 46-2.10(18)-S11532 (RULE I) PHYSICIAN SERVICES, DEFINITION and 46-2.10(18)-S11533 (RULE II) PHYSICIAN SERVICES, REQUIREMENTS pertaining to physician services at page 1258 of the 1980 Montana Administrative Register, issue number 8.

2. The agency has amended 46-2.10(18)-S11440 as proposed.

3. The agency has adopted 46-2.10(18)-S11532 PHYSICIAN SERVICES, DEFINITION and 46-2.10(18)-S11533 PHYSICIAN SERVICES, REQUIREMENTS as proposed.

4. No comments or testimony were received.

Kell P. Colby
Director, Social and Rehabilitation Services

CERTIFIED TO THE SECRETARY OF STATE June 13, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules and the repeal of rules 46-2.10(14)-S11170 through 46-2.10 (14)-S11200 pertaining to evaluating income of applicants and recipients in the AFDC program	NOTICE OF THE ADOPTION OF RULES 46-2.10(14)-S11381, 46-2.10(14)-S11382, 46-2.10(14)-S11383, 46-2.10(14)-S11384, 46-2.10(14)-S11385, 46-2.10(14)-S11386, 46-2.10(14)-S11387, 46-2.10(14)-S11388, 46-2.10(14)-S11389, 46-2.10(14)-S11394, AND 46-2.10(14)-S11395 AND THE REPEAL OF RULES 46-2.10(14)-S11170 THROUGH 46-2.10(14)-S11200

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed adoption of Rules 46-2.10(14)-S11381, S11382, S11383, S11384, S11385, S11386, S11387, S11388, S11389, S11394 and S11395, and the repeal of 46-2.10(14)-S11170 through 46-2.10(14)-S11200 pertaining to evaluating income of applicants and recipients in the AFDC program at page 1465 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. The agency has adopted the rules with the following changes.

46-2.10(14)-S11381 ~~RULE-I~~ UNEARNED INCOME, DEFINITION

(1) "Unearned Income" means all income that is not earned income as defined in ~~Rule-V~~ ARM 46-2.10(14)-S11385. Unearned income includes, but is not limited to social security income benefits, veteran's benefits or payments, ~~workmen's~~ workers' compensation payments, unemployment compensation payments, and returns from capital investments with respect to which the individual is not actively engaged.

(2) Unearned income shall be treated as provided in ~~Rules II through IV~~ ARM 46-2.10(14)-S11382 through 46-2.10(14)-S11384.

46-2.10(14)-S11382 ~~RULE II~~ DISREGARDED UNEARNED INCOME

(1) In determining need and amount of assistance, the following unearned income shall be disregarded:

(a) complementary assistance from other agencies and organizations which consists of:

(i) goods and services not included in or duplicated by the AFDC payment,

(ii) a supplement to AFDC payments, for a different purpose.

(b) home produce utilized for household consumption;

(c) undergraduate student loans and grants for educational purposes made or insured under any program administered by the commissioner of education;

(d) extension of OASDI benefits for 18 to 22 year olds who are fulltime students;

(e) the value of the food stamp coupon allotment;

(f) the value of U.S. department of agriculture donated foods;

(g) any benefits received under Title VII of the Nutrition Program for the Elderly of the Older Americans Act of 1965 as amended;

(h) the value of supplemental food assistance received under the Child Nutrition Act of 1966, and the special food services program for children under the National School Lunch Act (PL 92-433 and PL 93-150);

(i) all monies awarded to Indian tribes by the Indian claims commission or Court of Claims shall be disregarded as authorized by PL 93-134, 92-254, 94-540, and 94-114;

(j) payments received under Title II of the uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(k) any contribution furnished by relatives or others which is unavailable directly to the recipient;

(l) the tax exempt portions of payments made pursuant to PL 92-203, the Alaska Native Claims Settlement Act;

(m) all payments under Title I of the elementary and secondary Education Act;

(n) all weekly incentive allowances paid under PL 93-203, the Comprehensive Employment and Training Act of 1973;

(o) incentive payments or reimbursement of training-related expenses made to WIN participants by the manpower agency;

(p) payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in service corps of the retired executives and active corps of executives, and any other program under Titles II and III of PL 93-113;

(q) payments to individual volunteers under Title I (VISTA) of PL 93-113, pursuant to section 404(g) of that law;

(r) individuals receiving supplemental security income shall not be considered as a member of the assistance unit unless they choose to relinquish their SSI grant.

46-2.10(14)-S11383 ~~RULE III~~ COUNTABLE UNEARNED INCOME (1) All unearned income, not specifically disregarded by rule II shall be counted.

(2) The amount of the assistance payment shall be determined by estimating the income reasonably expected to exist during the month of application and the month immediately following the month of application. Any income received prior to the date of application is not counted. Unearned income of a recipient is counted from the first to the last day of the second month prior to grant determination.

46-2.10(14)-S11384 ~~RULE IV~~ SPECIALLY TREATED UNEARNED INCOME (1) The types of income listed below shall be treated as follows:

(a) Lump sum payments are considered as income for only the month after the ten-day notification to the recipient of grant amount change. After this month, any sum that is retained will be considered against the property resources limitation. The following are examples of lump sum payments: social security, veteran's benefits, unemployment compensation, railroad retirement or disability, workmen's compensation.

(b) Income tax refunds shall be considered toward the property resources limitation and not treated as income.

(c) Indian per capita payments may be considered toward the property resources limitation.

(d) Income from leased land, land sale, and other accrued income may be considered as income available to meet need when received, prorated over the year, or programmed for special needs, such as, but not limited to: housing and home repair, household furnishings and equipment, financial institution debts, education and/or training, recreation equipment, medical debts, bedding and clothing, necessary repair or replacement of a vehicle. Programming must have the approval of the recipient, paying agent, and the county welfare department.

46-2.10(14)-S11385 ~~RULE V~~ EARNED INCOME (1) "Earned income" means all income earned by an individual through the receipt of wages, salary, commissions, tips, or any other ~~for~~ profit from activity in which he is actively engaged.

(2) Earned income from self-employment means the total profit from business enterprise, farming, etc., resulting from a comparison of the gross income received with the business expenses or total cost of the production of the income. Returns from capital investments are earned income when produced as a result of the individual's own efforts, including managerial responsibilities.

(3) Earned income shall be treated as provided in ~~Rules VI through IX~~ ARM 46-2.10(14)-S11386 through 46-2.10(14)-S11389.

46-2.10(14)-S11386 ~~RULE VI~~ DISREGARDED EARNED INCOME

(1) In determining need and amount of assistance, the following earned income shall be disregarded:

(a) earned income of a child under 14 years of age;

(b) earned income of a child over 14 years of age who is a full or part-time student; and

~~(c) earned income of an AFDC family member conserved for future educational needs of a child, if the department has given prior approval for the use of this income;~~

~~(d)~~ (c) income received under Title II of CETA "youth employment demonstration programs," of PL 95-93. These programs include the youth incentive pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs.

46-2.10(14)-S11387 ~~RULE VII~~ TREATMENT OF EARNED INCOME

(1) The following are methods and treatment of earned income:

(a) The income reasonably expected to exist during the month of application and the month immediately following the month of application shall be estimated. Any income received prior to the date of application shall not be considered.

(b) Business expenses such as materials, labor, tools, rental equipment, supplies and utilities shall be subtracted from the gross self-employment income to arrive at gross income for disregard purposes. Personal employment expenses and work related expenses are not business expenses.

46-2.10(14)-S11388 ~~RULE VIII~~ EARNED INCOME DISREGARDS

(1) The following disregards are applied to earned income of applicants for and recipients of AFDC, except as provided in ~~Rule IX~~ ARM 46-2.10(14)-S11389:

(a) $30 from the gross monthly income;

(b) one-third ~~(1/3)~~ of the remainder;

(c) the mandatory deductions as determined by the employer's tax guide tables for the maximum number of exemptions the individual is entitled under the law. Mandatory deductions are state, federal, FICA taxes, and other deductions over which the individual has no control;

(d) work related expenses of $25 per month or more if the need is documented;

(e) the full cost of public transportation or $.12 per mile if the individual's own vehicle is used to and from work;

(f) child care as a work expense in determining initial eligibility of an applicant. When a suitable placement is not available under Title XX, day care expenses may be allowed as a work related expense.

46-2.10(14)-S11389 ~~RULE IX~~ EARNED INCOME NOT DISREGARDED

(1) Disregards of mandatory deductions, work related expenses, transportation, and child care shall be allowed.

The $30 + 1/3 disregards outlined in ~~Rule VIII~~ ARM 46-2.10(14)-S11388 shall not be allowed as follows:

(a) to the children's natural or adoptive parents in stepparent cases when the natural or adoptive parents are not included in the AFDC payment;

(b) to any individual whose needs are not included in the AFDC payment;

(c) to new applicants (those who have not received AFDC within any of the previous four months prior to application);

(d) to any person included in the AFDC payment who reduced his/her income, or terminated or refused employment, within the preceding ~~thirty~~ (30) days without good cause;

(e) to income from public service employment under WIN.

46-2.10(14)-S11394 ~~RULE X~~ TERMINATION OF INCOME When unearned or earned income terminates, the AFDC payment shall be adjusted the month immediately after the income terminates.

46-2.10(14)-S11395 ~~RULE XI~~ SUPPLEMENTAL PAYMENTS When earned or unearned income terminates, the AFDC payment may be adjusted and a supplemental payment made to eligible recipients who request such payment in the month of termination. The recipient is eligible for a supplemental payment if his income is less than 80% of the amount the department would pay for a similar family with no income.

4. No comments or testimony were received. The Department has repealed the old and adopted these new rules to update its AFDC rules to comply with current practice.

Keith L. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(j)(k)(l) and the adoption of Rules 46-2.10(18)-S11558, 46-2.10(18)-S11559 and 46-2.10(18)-S11560 pertaining to medical assistance, dental services.	))))))	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES 46-2.10(18)-S11558, 46-2.10(18)-S11559 and 46-2.10(18)-S11560

TO: All Interested Parties:

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46-2.10(18)-S11440 and the adoption of rules pertaining to medical assistance, dental services at page 1416 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended 46-2.10(18)-S11440 as proposed.

3. The agency has adopted the rules with the following changes:

46-2.10(18)-S11558 ~~RULE I~~ DENTAL SERVICES, DEFINITION

Dental service is the treatment of the teeth and associated structures of the oral cavity and treatment of disease, injury or impairment which may effect the oral and general health of the individual. The services must be provided by a licensed dentist or a licensed dental hygienist under the direct supervision of a licensed dentist. The services must be within the scope of their professions, as defined by law.

46-2.10(18)-S11559 ~~RULE II~~ DENTAL SERVICES, REQUIREMENTS

These requirements are in addition to those contained in ARM 46-2.10(18)-S11516 through 46-2.10(18)-S11522. (See MAR Notice No. 46-2-223 in the 1980 Register, Issue No. 5. These rules will be adopted in June.)

(1) Emergency dental care for covered services does not need prior authorization when an emergency exists.

(2) The following diagnostic and preventive dental services are covered by the program:

(a) simple extractions;

(b) annual fluoride treatments;

(c) full mouth x-rays, or panorex, or cephalometric radiograms, the foregoing allowed at three year intervals;

(d) annual bite-wing x-rays;

(e) single periapical radiograms;

(f) intra-oral occulsal maxillary or mandibular;

(g) extra-oral radiograms, maxillary or mandibular lateral films;

(h) examinations at six month intervals;
(i) prophylaxis at six month intervals;
(j) full mouth x-rays on edentulous patients allowed when determined medically necessary by the designated peer review organization;
(k) house calls;
(l) vitality tests;
(m) consultation, written justification for consultation must be provided;
(n) hospital and nursing home calls;
(o) palliative emergency treatment of dental pain, including minor procedures, temporary fillings, incisions and drainage, topical medicaments, irrigation for pericoronitis;
(3) The following dental services for the restoration of carious and fractural teeth are benefits of the medicaid program:
(a) amalgam restorations on deciduous and permanent teeth;
(b) retention pins, up to 2 per tooth;
(c) silicate restorations;
(d) composite and resin restorations;
(e) acrylic jacket for immediate treatment of fractured anterior tooth;
(f) treatment fillings;
(g) recementing of inlays;
(h) pulpotomys.
(4) The following oral surgery services are benefits of the medicaid program: extensive oral surgery must be prior authorized by the designated professional review organization.
(a) general anesthesia in a dental office. This service must be prior authorized by the designated peer review organization;
(b) nitrous oxide, when prior authorized by the designated peer review organization for specific reasons such as disability or age of patient, etc;
(c) Oral premedication for sedation of patient for whom dental treatment under normal circumstances is not possible, but who does not require general anesthesia, or parenteral premedication; when prior authorized by the designated peer review organization.
(d) Parenteral premedication for sedation of patient for whom dental treatment under normal circumstances is not possible, but who does not require general anesthesia; when prior authorized by the designated peer review organization.
(e) hospital dental treatment, when prior authorized by the designated peer review organization;
(f) I and D of extra-oral abcess;
(g) removal of tooth (includes shaping of ridge bone);
(h) surgical removal of tooth, soft tissue impaction;
(i) surgical removal of tooth, partial bone impaction;

(j) surgical removal of tooth, complete bone impaction;
(k) alveolectomy, not in conjection with extractions;
(l) excision of hyperplastic tissue;
(m) removal of retained or residual roots, foreign bodies in bony tissue;
(n) removal of cyst;
(o) removal of retained or residual roots, foreign bodies in maxillary sinus;
(p) frenectomy;
(q) removal of exostosis, torus, maxillary or mandibular;
(r) biopsy;
(s) maxilla, open reduction;
(t) fracture, simple, maxilla, treatment and care;
(u) mandible, open reduction;
(v) fracture, simple, mandible, treatment and care;
(w) facial surgery.

(5) The following endodontic services are benefits of the medicaid program: All nonemergency endodontics must be authorized by the designated peer review organization.

(a) root canal treatment on upper or lower six anterior teeth (chemotherapy and mechanical preparation, and filling);

(b) root canal treatment on posterior teeth except third molars (chemotherapy and mechanical preparation, and filling), maximum of three roots per tooth;

(c) emergency root canal, a finished x-ray must be attached to claim;

(d) root canal and apicoectomy combined operation;

(e) apicoectomy not in conjunction with root canal.

(6) The following full denture services are benefits of the medicaid program: All full dentures must be prior authorized by the designated peer review organization. Requests for full dentures must show the approximate date of the most recent extractions, and/or the age of the present dentures. Dentures less than ten years old must be considered for relining or jumping. Tissue conditioners are considered a part of treatment.

(a) replacement of lost dentures. A caseworker must investigate thoroughly and send a written evaluation to the recipient's dentist. Social worker's evaluation is to accompany dentist's prior authorization request;

(b) cured and resin relines, upper and lower, on immediate dentures three months after placement of denture;

(c) cured and resin relines, upper and lower, at three year intervals;

(d) duplicate (jump) upper and/or lower complete denture when prior authorized by the peer review organization;

(e) complete maxillary denture, acrylic, plus necessary adjustment;

(f) complete mandibular denture, acrylic, plus necessary adjustment;

(g) broken denture repair, no teeth or metal involved;
(h) denture adjustment as a separate service when dentist did not make dentures;
(i) replacing broken teeth on denture;
(j) placing name on a new, full or partial denture.
(7) The following partial denture services are benefits of the medicaid program: All partial dentures must be prior authorized by the designated peer review organization.
(a) acrylic upper or lower partial denture with two chrome or gold clasps and rests and adjustments, a minimum of 4 posterior teeth;
(b) maxillary or mandibular cast chrome partial denture replacing any number of posterior teeth but must include one or more anterior teeth and adjustments;
(c) acrylic denture, without clasps, supplying 1 to 4 teeth (flipper);
(d) additional teeth, permanent - on acrylic denture (flipper);
(e) adding teeth to partial to replace extracted natural teeth;
(f) replacing clasp, new clasp;
(g) repairing (welding or soldering) palatal bars, lingual bars, metal connectors, etc. on chrome partials.
(8) The following periodontal services are benefits of the medicaid program: all periodontia must be prior authorized by the designated peer review organization.
(a) deep scaling and currettage up to four (4) quadrants;
(b) gingival resection for the treatment of gingival hyperplasia due to medication reactions. Treatment shall cover posterior and anterior teeth on uppers and lowers (sextants).
(9) The following services for crowns and fixed bridges are benefits of the medicaid program: These services must be prior authorized by the designated peer review organization.
(a) porcelain or acrylic crowns are limited to upper and lower 6 anterior teeth;
(b) chrome, gold, or semiprecious crowns on posterior teeth not restorable by conventional filling material;
(c) fixed bridges on anterior teeth only;
(d) bridges replacing no more than 2 teeth;
(e) three-quarter cast crown;
(f) full cast crown;
(g) cured acrylic jacket crown, laboratory processed;
(h) porcelain jacket;
(i) porcelain veneer (microbond, ceramco, etc.);
(j) full cast crown with acrylic facing;
(k) pontic, ceramic only;
(l) steele's facing type;
(m) cured acrylic, laboratory processed, veneer.

(10) The following pedodontic services including spacers and crowns are benefits of the medicaid program:

(a) amalgam restorations;

(b) chrome crown, prior authorization by the designated peer review organization required;

(c) immediate treatment of fractured anterior permanent tooth, including pulp testing, pulp capping and use of metal band or crown form with sedative filling;

(d) chrome crown and loop spacer or other types (space maintainers) prior authorization by the designated peer review organization required;

(e) bilateral space maintainer or lingual arch, prior authorization by the designated peer review organization required, at least one tooth must be missing on each side of the mouth;

(f) chrome wire clasps, adams, T or ball;

(g) stainless steel band.

(11) The following orthodontic services are benefits of the medicaid program: All orthodontia must be prior authorized by the designated peer review organization. There shall be written documentation submitted with all prior authorization requests for orthodontia that the recipient and/or his family understands that once the treatment is started, it must be followed to completion and if medicaid eligibility ceases, the recipient and/or his family will be responsible for the payment for the balance of the treatment.

(a) orthodontia related to post maxillo-facial intervention when the injuries are caused by trauma. The treatment shall be limited to stabilization and movement to accommodate prosthesis;

(b) orthodontia for movement of teeth to accommodate post cleft palate treatment, the treatment shall be limited to those procedures necessary for the retention of prosthesis for swallowing, breathing, and mastication;

(c) examination;

(d) records and diagnosis;

(e) full treatment - initial service. The prior authorization request will include a statement on the maximum length of treatment;

(f) full treatment monthly service;

(g) full treatment retention service;

(h) serial extractions, supervision;

(i) partial treatment, expansion appliance;

(j) partial treatment - head gear appliance;

(k) special appliance, bilateral space maintainer (when not part of full treatment);

(l) special appliance, unilateral space maintainer;

(m) special appliance, removable space maintainer, upper and lower;

(n) special appliance, expansion appliance;

(o) special appliance, retainer;
(p) special appliance, habit appliance.
(12) X-rays are required with requests for the following dental services:
(a) all crowns, stainless steel, gold, others;
(b) endodontic cases;
(c) any case where pulp chamber is involved;
(d) removal of impacted teeth.
(13) Cosmetic dentistry is not a benefit of the medicaid program.

46-2.10(18)-S11560 ~~RULE III~~ DENTAL SERVICES, REIMBURSEMENT Payment for dental services shall be limited to the lowest of usual and customary charges which are reasonable; the maximum amount payable by medicare, or the following fee schedule:
(1) preventive and diagnostic services;
(a) examination and execution of forms - 7.80;
(b) complete intra-oral radiograms, minimum 14 films - 26.00;
(c) single periapical radiograms, first film - 5.20;
(d) each additional film, periapical - 2.60;
(e) bite-wing radiograms, 2 films - 7.80;
(f) intra-oral occlusal maxillary or mandibular - 6.50;
(g) cephalometric radiograms or panorex, diagnostic only - 26.00;
(h) extra-oral radiograms, maxillary or mandibular lateral film -19.50;
(i) allowable charges for x-rays in a single visit shall not exceed the allowable charges for a full mouth x-ray;
(j) consultation fee (necessity to be shown) per session -13.00;
(k) hospital calls - 19.50;
(l) simple operations under general anesthesia in hospital - 39.00;
(m) house calls and nursing home calls - 9.10;
(n) vitality tests one tooth or per quadrant - 7.80;
(o) palliative (emergency treatment of dental pain (includes only minor procedures, i.e., temporary fillings, incision and drainage, topical medicaments, irrigation, pericoronitis, etc.) - 7.80;
(p) stannus flouride 8%, one treatment, including prophylaxis - 22.10;
(q) flouride - 7.70;
(r) prophyliaxis, includes routine scaling and polishing/adults and children - 16.90;
~~(s) prophylaxis, includes routine scaling and polishing/children - 16.90~~.
(2) Amalgam restorations:
(a) deciduous, one surface - 12.32;

(b) deciduous, two surface - 20.16;
(c) deciduous, three surface - 28.16;
(d) each additional surface, deciduous - 3.30;
(e) one surface, permanent - 12.32;
(f) two surface, permanent - 20.16;
(g) three surface, permanent - 28.16;
(h) each additional surface (includes cusp restoration, veneer, groove extension, etc.) permanent - 4.80;
(i) pins for retention (maximum 2) each pin - 3.90.
(3) Silicates and fiberglass restorations (per surface):
(a) silicate - 13.00;
(b) compost resin (addent, dakor, adaptic, concise, prestige, etc.) - 19.20.
(c) composite fillings for posterior teeth will be paid at the rate of a similar amalgam restoration except for buccal surfaces.
(4) Additional operative procedures:
(a) acrylic jacket, immediate treatment for fractured anterior - 26.00;
(b) treatment filling (emergency) - 6.50;
(c) recement inlay - 6.50;
(d) pulpotomy - need authorization - 19.20;
(e) No extra fee for pulp capping or bases.
(5) Crown and bridge:
(a) three-quarter cast crown - 125.45;
(b) full cast crown - 125.45;
(c) cured acrylic jacket crown, laboratory processed - 104.00;
(d) porcelain jacket - 143.00;
(e) porcelain veneer (microbond, ceramco, etc.) - ~~175.50~~ 184.00;
(f) full cast crown with acrylic facing - 184.00;
(g) gold and semi-precious crowns will be reimbursed at the same rate.
(6) Pedodontics, spacers, crowns, etc. amalgam restorations same as permanent teeth:
(a) chrome crown - 40.00;
(b) immediate treatment of fractured anterior permanent tooth, includes pulp testing, pulp capping and use of metal band or crown form with sedative filling - 20.80;
(c) chrome crown and loop spacer or other types (space maintainer) - 52.00;
(d) bilateral space maintainer or lingual arch - 82.50;
(e) acrylic denture, without clasps, supplying 1 to 4 (flipper) - 65.00;
(f) each additional tooth, permanent on acrylic denture (flipper) - 6.50;
(g) chrome wire clasps, adams, t or ball, each - 6.50;
(h) stainless steel band - 12.00.
(7) Prosthodontics:

(a) complete maxillary denture, acrylic, plus necessary adjustment - 336.00;
(b) complete mandibular denture, acrylic, plus necessary adjustment - 336.00;
(c) acrylic upper or lower partial denture with cast chrome clasps and rests replacing at least 4 posterior teeth plus adjustments - 260.00;
(d) maxillary cast chrome partial denture, acrylic saddles, 2 clasps and rests, replacing missing posterior teeth and one or more anterior teeth, plus adjustments - 325.00.
(8) Relines and repairs, etc.:
(a) cured resin reline, lower - 86.45;
(b) cured resin reline upper - 86.45;
(c) broken denture repair, no teeth or metal involved - 32.00;
(d) denture adjustment - only where dentist did not make dentures - 7.80;
(e) replacing broken tooth on denture, first tooth - 24.00;
(f) each additional tooth after procedure (e) or (g) - 6.50;
(g) adding teeth to partial to replace extracted natural teeth, first tooth - 32.50;
(h) replacing clasp, new clasp - 45.50;
(i) repairing (welding or soldering) palatal bars, lingual bars, metal connectors, etc. on chrome partials - 84.50;
(j) duplicate (jump) upper complete denture - 110.50;
(k) lower jump or duplicate - 110.50;
(l) placing name on new, full or partial dentures - 10.00.
(9) Pontics:
(a) steele's facing type, each - 97.50;
(b) pontic - ceramic only - 147.50;
(c) cured acrylic, laboratory processed, veneer - 97.50;
(10) Repairs:
(a) recement bridge - 13.00;
(b) recement crown - 6.50;
(c) porcelain facing - 26.00;
(d) replace broken Steele's facing, post intact - 22.00;
(e) gold Post - 55.00;
(f) steel post or dowel with amalgum buildup - 26.00;
(g) replace broken Steel's facing, post broken - 32.50.
(11) Oral surgery:
(a) I and D of abcess intra-oral - 50.00;
(b) removal of tooth (includes shaping of ridge bone) - 14.88;
(c) surgical removal of tooth, soft tissue impaction - 32.50;
(d) surgical removal of tooth, partial bone impaction - 58.50;

(e) surgical removal of tooth, complete bone impaction - 97.50;
(f) alveolectomy, not in conjection with extractions, per quadrant - 32.50;
(g) excision of hyperplastic tissue/each quad - 32.50;
(h) removal of retained, residual roots, foreign bodies in bony tissue - 32.50;
(i) removal of cyst - 50.00;
(j) removal of retained, residual roots, foreign bodies in maxillary sinus - 97.50;
(k) frenectomy - 45.50;
(l) removal of exostosis torus, maxillary or mandibular - 65.00;
(m) biopsy, including pathology lab charges - 26.00;
(n) maxilla, open reduction - 326.30;
(o) fracture, simple, maxilla, treatment and care - 253.50;
(p) mandible, open reduction - 436.80;
(q) fracture, simple, mandible, treatment and care - 253.50;
(r) facial surgery - usual and customary charges which are reasonable.
(12) Endodontics:
(a) root canal chemotherapy and mechanical preparation, scaling and filing) - 112.00;
(b) root canal, each additional root up to two - 30.00;
(c) root canal and apicoectomy combined operation - 97.50;
(d) apicoectomy not in conjunction with root canal - 58.50.
(13) Anesthesia:
(a) General anesthesia administered in office - 39.00;
(b) nitrous oxide - 4.00;
(c) Oral premedication - $10.00;
(d) Parenteral premedication - $39.00
(14) Periodontal services:
(a) periodontal prophylaxis per quadrant - 16.90;
(b) gingival resection - 32.50;
(15) Dentist examining more than one Medicaid recipient in a long-term care facility on the same day shall be allowed payment for one (1) nursing home call over the examination fees. Examination is considered a recorded evaluation.
(16) Reimbursement - orthodontia:
(a) examination - 7.80;
(b) full treatment - records and diagnosis - 45.50;
(c) full treatment, initial fee - includes appliances - 315.00;
(d) full treatment, monthly fee (prior authorization will state maximum number at months) - 31.50;
(e) full treatment, retention service - 3.50;

(f) serial extractions, supervision - 3.50;
(g) partial treatment, expansion appliance - 175.00;
(h) partial treatment - head gear appliance - 175.00;
(i) special appliance, bilateral space maintainer, upper and lower - 82.50;
(j) special appliance, unilateral space maintainer - 52.00;
(k) special appliance, expansion appliance - 175.00;
(l) special appliance, retainer - 87.50;
(m) special appliance, habit appliance - 87.50.

4. The Department has thoroughly considered all verbal and written commentary received:

Comment:

Under Rule II, section 4, proposal to follow part (b) $N_2 0$-0_2 etc...

(c) Oral premedication for sedation of patient for whom dental treatment under normal circumstances is not possible, but who does not require general anesthesia, or parenteral premedication; when prior authorized by the designated peer review organization.

(d) Parenteral premedication for sedation of patient for whom dental treatment under normal circumstances is not possible, but who does not require general anesthesia; when prior authorized by the designated peer review organization.

Response:

These services have been previously covered and budgeted for and the Department agress to change the rule in this respect. The Department does not feel this is a substantive change.

Comment:

(Several additional proposed changes were offered by the Montana Academy of Pediatric Dentists. Several dental procedures and fees were proposed and are too numerous to reproduce here.)

Response:

The Department has initially determined that the adoption of these proposals would cause significant program expansion.

In the future the Department would consider proposals of this nature if the Montana Academy of Pediatric Dentists could also propose effective prior authorization procedures that would restrict these services to those who really need them. These procedures could limit the budget impact and cause the Department to reconsider its present decision.

Comment:

Why is an acrylic to gold crown valued at 184.00 while ceramco, which is not allowed, valued at 175.50? Rule III, section (5) (e) should be amended to read:

(e) Porcelain veneer (microbond, ceramco, etc.) - (184.00)

Response:

The Department agrees to change the fee to make it uniform for both services. The dentist may choose the service he considers most appropriate, it still must be prior authorized.

Keith L. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(m) and the adoption of Rules 46-2.10(18)-S11503, 46-2.10(18)-S11504, 46-2.10(18)-S11506, and 46-2.10(18)-S11507 pertaining to medical assistance program, optometric services	))))))	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES 46-2.10(18)-S11503, 46-2.10(18)-S11504, 46-2.10(18)-S11506, AND 46-2.10(18)-S11507

TO: All Interested Persons

1. On April 10, 1980, the Department of Social and Rehabilitation Services published notice of the amendment of Rule 46-2.10(18)-S11440(1)(m) and the adoption of rules pertaining to medical assistance program, optometric services at page 1152 of the 1980 Montana Administrative Register, issue number 7.

2. The agency has amended Rule 46-2.10(18)-S11440 as proposed.

3. The agency has adopted the rules as proposed with the following changes:

46-2.10(18)-S11503 ~~RULE-I~~ OPTOMETRIC SERVICES, DEFINITION Optometric services are those services provided by an optometrist who is licensed and which are within the scope of his practice as defined by law. Optometric services include visual training.

(1) Visual training is the therapeutic approach to altering the relationship between the pointing system and the focusing system by means other than conventional glasses.

46-2.10(18)-S11504 ~~RULE-II~~ OPTOMETRIC SERVICES, REQUIREMENTS (1) Optometric services shall be provided only when they are medically necessary and shall be subject to review by the designated professional review organization.

(2) Each medicaid recipient shall be allowed one eye examination ~~for visual acuity~~ per fiscal year unless one of the following circumstances exist:

(a) Following cataract surgery there may be more than one examination per fiscal year.

(b) The provider determines by screening that a loss of one line acuity has occurred with present glasses.

(3) Visual training - limitations:

(a) Visual training must be prior authorized by the designated professional review organization.

(b) Visual training shall be limited to two (2) one-hour sessions per week up to a maximum of twenty-four (24) sessions

per fiscal year.

46-2.10(18)-S11506 ~~RULE III~~ EYEGLASSES, DEFINITION Eyeglasses are lens and/or frames prescribed by a physician skilled in the diseases of the eye or by an optometrist, whichever the patient may select, to aid and improve vision.

46-2.10(18)-S11507 ~~RULE IV~~ EYEGLASSES, REQUIREMENTS (1) Each recipient 21 years old or younger is limited to one pair of eyeglasses per fiscal year and each recipient over 21 years old is limited to one pair of eyeglasses every two fiscal years unless one of the following circumstances exists:

(a) A recipient has had cataract surgery.

(b) When there is:

(i) a .50 diopter change in correction in can sphere, cylinder, vertical prism or near heading power; or

(ii) a minimum of a 5 degree change in any cylinder axis of .50 diopters or more; or

(iii) any 1 degree or more prism change in lateral prism.

(c) A recipient is unable to wear bifocals due to medical necessity.

(2) Contact lenses may be provided only when they are medically necessary. They shall not be allowed for cosmetic reasons. Claims for contact lenses must be accompanied by a statement explaining the medical reason for them.

(3) A recipient shall be allowed repairs on a pair of glasses during the fiscal year not to exceed the amount of an additional pair of glasses.

4. The Department has thoroughly considered all verbal and written commentary received:

Comment

Referring to Rule 46-2.10(18)-S11504, subsection (2), which says, "Each Medicaid recipient shall be allowed one eye examination for visual acuity per fiscal year....." The words "for visual acuity" should not be there. Visual acuity happens to be just one of a number of different visual dysfunctions that could be present. So rather than have a whole list of technical visual diagnosis terms, it would be best just to drop "for visual acuity."

Response

The words "for visual acuity" have been eliminated from the rule. This has been done to more accurately reflect the

services being purchased for Medicaid recipients.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440 (1) (i) and the adoption of rules pertaining to home health services	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES PERTAINING TO HOME HEALTH SERVICES

TO: All Interested Parties:

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of an amendment to Rule 46-2.10(18)-S11440 and the adoption of rules pertaining to home health services at page 1430 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. The agency has adopted the rules with the following changes:

46-2.10(18)-S11555 ~~RULE I~~ HOME HEALTH SERVICES, DEFINITION (1) Home health services are the following services provided by a licensed home health care agency on a part-time or intermittent basis to a recipient in his place of residence:

(a) nursing services;
(b) home health aide services;
(c) physical therapy;
(d) occupational therapy;
(e) speech therapy;
(f) medical supplies and equipment suitable for use in the home.

(2) Nursing service may be provided by a licensed registered nurse in geographic areas not covered by a licensed home health agency.

46-2.10(18)-S11556 ~~RULE II~~ HOME HEALTH SERVICES, REQUIREMENTS (1) A home health agency must be licensed by the Montana department of health and environmental sciences and be medicare certified.

(2) Home health services are available only through those home health agencies that have a contract with the department.

(3) Home health services must be prescribed by the recipient's attending physician and be part of a written plan of care.

(4) Home health services must be reviewed and renewed by the recipient's attending physician at a minimum of 60 day intervals.

(5) Written physician orders and care plans must be current and available upon request of the department or its designated representative.

(6) Home health services are limited to a maximum of 200 visits per recipient per fiscal year.

46-2.10(18)-S11557 ~~RULE III~~ HOME HEALTH SERVICES, REIMBURSEMENT (1) Reimbursement for home health services will be at cost, subject to upper limits defined in (3), as determined by an audit conducted according to Title XVIII of the Social Security Act definition of allowable costs, except that payment by the home health agency for contracted therapy services may not exceed the Montana state medicaid therapy fee schedule as an allowable cost for the contracted service.

(2) Reimbursement will be paid through interim rates during a cost report period as determined by the home health agencies' Title XVIII of the Social Security Act fiscal intermediary, with retroactive settlement for actual allowable costs at the conclusion of the report period.

(3) Reimbursement for home health services will be the lesser of usual and customary charges which are reasonable or the maximum amount payable by medicare.

(4) Total payment for home health services will not exceed $400.00 per recipient per month without prior authorization of the department.

(5) Reimbursement for nursing service provided by a licensed registered nurse in geographic areas not covered by a home health agency will be $7.50 per hour.

(6) These rules take precedence over any other home health service reimbursement rules found in this title.

4. The Department has thoroughly considered all verbal and written commentary received:

Comment

Rule I should include respiratory therapy.

Response

42 CFR 440.70 does not include respiratory therapy as a medicaid reimbursable home health service. The Department must follow the requirements of Federal rules to receive continued Federal financial participation.

Comment

Rule II (1) should be amended by adding that those home health agencies which are not medicare certified have the ability to negotiate a contract with the Department.

Response

To receive a license from the Montana Department of Health and Environmental Sciences, a home health agency must meet Medicare "conditions of participation" which also give Medicare certification. The Department cannot contract with an unlicensed home health agency. The Department contracts with one home health agency which has elected not to participate in Medicare. However, this provider is licensed and Medicare certified. With the adoption of these rules, Medicaid reimbursement for home health services will be determined by an audit conducted according to Medicare definition of allowable costs. The provider which does not participate in Medicare will still have the ability to negotiate a contract with Medicaid if they conduct this audit. Without the audit, Medicaid will not be able to establish reimbursement rates.

Comment

Rule II should be amended by deleting section (6) - the 200 visit limitation.

Response

Medicaid coverage, like all other insurance programs, has limits. At this time, the Department cannot expand the program past present limits due to budget considerations.

Comment

Rule III should be amended by deleting section (4) - the prior authorization for cases which may exceed $400.00 per month per recipient.

Response

The Department believes that the requirement allows a necessary tool for program monitoring while not creating an unnecessary hardship on either the provider or the Department.

Keith E. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(o) and the adoption of rules pertaining to medical assistance, ambulance services	)))))	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11440(1)(o) AND THE ADOPTION OF RULES 46-2.10(18)-S11561, 46-2.10(18)-S11562, AND 46-2.10(18)-S11563

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment of Rule 46-2.10(18)-S11440(1)(o) and the adoption of new rules 46-2.10(18)-S11561, AMBULANCE SERVICES, DEFINITION; 46-2.10(18)-S11562, AMBULANCE SERVICES, REQUIREMENTS; and 46-2.10(18)-S11563, AMBULANCE SERVICES, REIMBURSEMENT, at page 1458 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. The agency has adopted the proposed rules with the following changes:

46-2.10(18)-S11561 ~~RULE I~~ AMBULANCE SERVICES, DEFINITION

(1) Ambulance means any vehicle that is specially designed, equipped with customary patient care equipment and supplies as required by state or local law and maintained for the medical care and transportation of the sick or injured.

(2) Emergency ambulance service means ~~immediate response~~ services provided by a licensed ambulance provider in the ground or air transportation of a sick or injured person in a specially designed and equipped vehicle as defined above, which includes a trained ambulance attendant who has current advanced American red cross first aid training or its equivalent.

(3) Nonemergency ambulance service means services provided by a licensed ambulance provider in the ground or air transportation of a ~~patient to obtain medical service when such transportation is medically necessary and~~ sick or injured person in a specially designed and equipped vehicle as defined above, which includes a trained ambulance attendant who has current advanced American red cross first aid training or its equivalent, that does not require immediate action.

46-2.10(18)-S11562 ~~RULE II~~ AMBULANCE SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46-2.10(18)-S11516 through 46-2.10(18)-S11522 ~~(See MAR Notice No. 46-2-223 in the 1980 Register, issue No. 5. These rules will be adopted in June.)~~

(2) Medicaid payment for ambulance service will be made

only to a licensed ambulance provider.

(3) No payment will be made for ambulance service in cases where some means of transportation other than the ambulance could be utilized without endangering the patients health, whether or not such other transportation is actually available.

(4) Medicaid benefits cease at the time of death. When a recipient is pronounced dead after an ambulance is called but before pickup, the ambulance service provided to the point of pickup is covered at the base rate. If a recipient is pronounced dead by a legally authorized individual before the ambulance is called, no payment will be made.

(5) Ambulance claims will be screened for medical necessity and appropriateness by the designated professional review organization.

46-2.10(18)-S11563 ~~RULE III~~ AMBULANCE SERVICES, REIMBURSEMENT (1) Ambulance attendant services are included in the providers base rate.

(2) Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the ambulance service and are included in the providers base rate.

(3) Nonreusable items and disposable supplies such as oxygen, gauze and dressings, are reimbursable as a separate charge.

(4) Medicaid reimbursement for mileage is allowed for patient loaded miles only outside the city limits.

(5) Medicaid reimbursement will be the lesser of usual and customary charges which are reasonable, the individual providers medicare rate or the individual providers January 1980 medicaid rate plus 10 percent. ~~except that the base rate for nonemergency ambulance service shall not exceed $30.00.~~

4. The Department has thoroughly reviewed all verbal and written commentary received:

Comment

The method of claims payment should be investigated before any rule changes are made.

Response

One of the purposes of this rule change is to clarify procedures so that claims processing will proceed smoother. There is no reason why future changes cannot be developed as needed when refinements are made known.

Comment

Ambulance providers have been told they would get no raise; now there is a 10% raise; can it be retroactive?

Response

Budgetary limitations now allow for a 10% increase for reimbursements from the date of implementation only. Retroactive increases are not feasible.

Comment

The type of requirement found in Rule II(5) causes great hardship to ambulance providers. Often after providing service in good faith, we find out that a physician or police ordered ambulance call is denied due to lack of medical necessity.

Response

The Medicaid program is based on the philosophy of paying for medically necessary services. If the Department changed that policy it would not have sufficient funds to pay for all the medically necessary services we now pay for. The Department recognizes that ambulance providers are not responsible for who orders an ambulance and why they do it, but we cannot assume that responsibility.

Comment

Rule II(5) requires a designated professional review organization. An ambulance service operator should be a member.

Response

Ambulance operators have been requested to designate 3 members for an organization. Hopefully they soon will so that this concept may be worked out and adopted.

Comment

The designated professional review organization needs to have firm guidelines written into the rules so they will screen consistently.

Response

The Department believes the rules are clear and firm, and would appreciate hearing about any inconsistent interpretation of them.

Comment

Rule II(3) is objectionable in communities with no public transportation; ambulances must answer calls. Medicaid should reimburse such services at the rate the general public must pay for the same service.

Response

Medicaid can only pay for medically necessary services. Unfortunately, where ambulance services is not medically indicated, Medicaid may not pay, no matter what other transportation may or may not be available.

Comment

Rule II(3) should be changed to read that ambulance service will be reimbursed if immediate transportation is indicated and if no other transportation is available.

Response

As pointed out above, Medicaid is responsible for covering (paying for) medically necessary service. In addition, this is a Medicare coverage limitation.

Comment

Rule III(2) causes Medicaid to pay for, in the base rate, for items an individual didn't use. The general public is charged for what they use. This is how Medicaid should pay.

Response

We have received comments pro and con over this issue. The fact that we use the Medicare system weighs heavily in our decision not to change as it is illegal for us to pay higher than they allow.

Comment

Medicaid is trying to tell us it doesn't cost as much to serve a Medicaid recipient as it does to serve the general public. These rules are being adopted disregarding ambulance owner input and expense records.

Response

This is incorrect. To the best of our knowledge we have never in the past two years claimed that ambulance rates paid by Medicaid were adequate. It is a budget problem and must be solved by adequate legislative appropriations. Note that in Rule III(5) the Department has struck part of the last line that apparently held nonemergency service to $30.00.

Comment

One 10% increase in two years does not match inflation.

Response

The Department agrees, the inflation rate rose much faster than the Legislature or the Department anticipated. The Department simply doesn't have any additional funds for any greater increase.

Comment

Is the prior "wheel chair" ambulance service now included under nonemergency ambulance service?

Response

No. "Wheel chair" transportation is analogous to Rule II(3) as transportation by ambulance is not medically indicated. This type of transportation is found under transportation rules of the Department. The Agency has redrafted Rule I(3) to better clarify nonemergency ambulance services.

Comment

Air ambulance services need to be clarified and written up so as not to be left up to individual interpretation.

Response

Air ambulance is not addressed in the Department of Health and Environmental Services rules, therefore we cannot directly pay for it. What we can do and are doing is paying for ambulance services and also paying for air charter services where medically necessary. The agency plans to better address these services in the near future.

Comment

Rather than being included in the base rate, attendant services should be additionally reimbursed both at the scene and for any additional services rendered at the hospital.

Response

We appreciate this comment and will be studying the budget of this proposal as we gather more data.

Comment

In the initial notice for this rule, the Department indicated it received input from the Emergency Medical Services Association. This should be clarified since the Department utilized so few suggestions of the Association.

Response

The Department merely wished to indicate that input had been sought and received. The Department does not mean to indicate that the Association supported the final draft of this rule.

Keith L. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(q)(i)(ii)(iii)(iv)(aa) and the adoption of rules 46-2.10(18)-S11536, 46-2.10(18)-S11537 and 46-2.10(18)-S11538 pertaining to physical therapy except the proposed amendment also pertains to occupational therapy services.	NOTICE OF AMENDMENT OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES 46-2.10(18)-S11536 46-2.10(18)-S11537 AND 46-2.10(18)-S11538

TO: All Interested Persons

1. On May 15, 1980, the Department published notice of the proposed amendment to Rule 46-2.10(18)-S11440 (1)(q)(i)(ii)(iii)(iv)(aa) and the proposed adoption of Rules 46-2.10(18)-S11537, OUTPATIENT PHYSICAL THERAPY SERVICES, REQUIREMENTS; and 46-2.10(18)-S11538, OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT pertaining to physical therapy services at page 1440 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended 46-2.10(18)-S11440 as proposed.

3. The agency has adopted the rules with the following changes:

46-2.10(18)-S11536 ~~RULE I~~ OUTPATIENT PHYSICAL THERAPY SERVICES, DEFINITION (1) Outpatient physical therapy means the evaluation, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain, injury, and any bodily or mental disability. Treatment employs, for therapeutic effects, physical measures, activities and devices, for preventive and therapeutic purposes, exercises, rehabilitative procedures, massage, mobilization, and physical agents including but not limited to mechanical devices, heat, cold, light, water, electricity, and sound. Physical therapy also includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structures, the establishment and modification of treatment, and consultative, educational, and other advisory services, and instruction and supervision of supportive personnel.

(2) Outpatient physical therapy applies only to services provided by other than a hospital.

46-2.10(18)-S11537 ~~RULE II~~ OUTPATIENT PHYSICAL THERAPY SERVICES, REQUIREMENTS (1) These requirements are in

addition to those contained in ARM 46-2.10(18)-S11516 through 46-2.10(18)-S11522. (See MAR NOTICE No. 46-2-223 Register Issue No. 5. Rules will be adopted in June.)

(2) All physical therapy must be provided by a licensed physical therapist.

(3) Outpatient physical therapy service is limited to a maximum of 200 visits per fiscal year.

(4) All physical therapy must be prescribed by a physician.

(5) Prescription for physical therapy is valid for 90 days except physical therapy prescription for nursing home resident is only valid for 30 days.

(6) Written physicians' ~~prescription~~ orders and physical therapy reports must be current and available upon request of the department or its designated representative.

(7) Outpatient physical therapy will be subject to review by the designated professional review organization.

(8) Physical therapy services provided through a home health care agency shall be part of the agencies 200 visit limitation.

(9) A physical therapy assistant, student or aide may assist in the practice of physical therapy under direct supervision of the licensed physical therapist who is responsible for and participates in the patients treatment program.

46-2.10(18)-S11538 ~~RULE III~~ OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT Medicaid payment for outpatient physical therapy services will be the lesser of usual and customary charges which are reasonable, the maximum allowed by Medicare, or the following physical therapy fee schedule:

A. D. L.	16.50
Consultation	27.50
Electrophysiological evaluation	27.50
Electromyography	55.00
Physical Therapy Evaluation	27.50
Home Instruction	27.50
Muscle Testing	27.50
Hubbard Tub	22.00
Hubbard Tub + 1 modality	22.00
Hubbard Tub + 2 modalities	25.30
Hubbard Tub + 3 modalities	27.50
Isolation Hubbard Tub	22.00
Whirlpool	13.20
Whirlpool + 1 modality	14.30
Whirlpool + 2 modalities	22.00
Whirlpool + 3 modalities	33.00
Gait Training	22.00
Postural Drainage	14.30

Therapeutic Exercise	16.50
One Modality	11.00
Two Modalities	12.10
Three Modalities	16.50
Four Modalities	16.50
Five Modalities	19.80

4. The Department has thoroughly considered all written and oral commentary and responds to those comments as follows:

Comment:

The world "prescription should be replaced with the word "referral" to keep the wording consistent with 37-11-104 MCA, our Practice Act.

Response:

42 CFR 440.110(a)(1) requires physical therapy services to be prescribed by a physician. Webster's New World Dictionary, Second College Edition does not define "prescription" and "referral" identically. The word prescription is apparently a more narrow written order for services and, therefore, more specific. Medicaid rules require more specificity than what is required by a practice act that includes many services Medicaid is unable to reimburse.

Comment:

The Medical Assistance Bureau agreed verbally to utilize a relative value system in the future as a reimbursement tool. Will this increase jeopardize either that conversion or another increase during the next legislative session?

Response:

Due to comments received about Relative Value Schedules composed by provider groups during two earlier hearings, the department will be unable to accept a fee schedule from any provider group. The department has been instructed that utilizing such a fee schedule may be a violation of the Sherman Anti-Trust Act and 30-15-205.

The department cannot predict with any accuracy what increases may be forthcoming until after the next legislative session.

Comment:

The fee schedule (reimbursement tool) should reflect all modalities and procedures allowed under the Physical Therapy Practice Act.

Response:

The department realized that there may have been new procedures and added modalities since the time Physical Therapy Services were first paid for. However, our funding prevents any program expansion at the present time.

Comment:

The fee schedule should be increased 10% according to the following revision of the schedule proposed by the department:

A. D. L.	15.00
Consultation	26.50
Electrophysiological evaluation	27.50
Electromyography	55.00
Evaluation	27.50
Home Instruction	25.00
Muscle Testing	26.50
Hubbard Tub	22.00
Hubbard Tub + 1 modality	22.00
Hubbard Tub + 2 modalities	25.30
Hubbard Tub + 3 modalities	27.50
Isolation Hubbard Tub	21.00
Whirlpool	13.20
Whirlpool + 1 modality	14.30
Whirlpool + 2 modalities	22.00
Whirlpool + 3 modalities	27.50
Gait Training	20.00
One Modality	12.51
Two Modalities	13.51
Three Modalities	17.51
Four Modalities	19.42
Five Modalities	20.51

Response:

The fee schedule proposed in the rule offers a uniform 10% increase. The alternative schedule offered here was evaluated for budget impact by Gary Blewett, an Administrative Officer with the Medical Assistance Unit of the department. The alternative schedule would increase the budget for Physical Therapy by 26.1%.

Another alternative offered prior to the hearing would be to increase reimbursement for the five modalities. They could be raised by 30.5% if nothing else was raised and still keep within the 10% increase. One drawback to this method is that some rarely used services might become unattractive to the provider if the reimbursement was kept abnormally low.

Representatives of the Montana Chapter of the American Physical Therapy Association indicated at the hearing that they might offer some further alternatives to the schedule as adopted to better reflect current needs and practice. This was not done but the department will be receptive to keeping its options open regarding further changes at a later date after receiving further input from the Association.

Comment:

All Physical Therapy (inpatient and outpatient) should be totally covered in only one rule.

Response:

It is not possible to apply one rule to both inpatient and outpatient physical therapy because:

1. Federal regulation makes medical necessity the only limitation on inpatient services, which is a mandatory service under the Medical Assistance Program.

2. Reimbursement for inpatient hospital service is based on reasonable cost so there is no fee schedule applied to hospital providers.

The department will be updating the hospital rules and there is a strong possibility that outpatient physical therapy requirements will be referenced in the outpatient hospital rules.

Comment:

Rule II (8) limits Physical Therapy services in the home to a Physical Therapist employed by a certified home health agency. This seems like a restraint of trade.

Response:

Physical Therapy services in the home are allowed by any physical therapist. Rule II (8) was meant to clarify limits

on home health care. The department believes this section is quite clear and will be glad to cooperate in further clarification should that become necessary.

Comment:

Outpatient physical therapy should include those services provided in a nursing facility. If there is a rule which only allows physical therapy to those who warrant skilled nursing care this rule should be removed.

Response:

The Former Rule (46-2.10(18)-S11440(1) (g)(iii) did limit physical therapy to recipients receiving skilled nursing care but has now been deleted.

The term "outpatient" does apply to any service and/or patient who is not a hospital inpatient. For clarification the department has added Section (2) to Rule I:

(2) Outpatient physical therapy applies only to services provided by other than a hospital.

COMMENT:

Any retroactive denial of reimbursement after review by the designated professional review organization should be prohibited. Medicaid should utilize the mechanism Medicare uses, i.e., a Waiver of Liability letter so that physical therapists, patients and physicians are not jeopardized.

Response:

The department has no experinece with the manner in which Medicare applies the Waiver of Liability. We will obtain information and background on the Medicare policy and see if it would be feasible for the Medicaid Program to adopt a similar mechanism in the future. Without extensive study and consideration of impact on Medicaid, we cannot adopt this recommendation.

Keith F. Cobb
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46-2.10(18)-S11451B, 46-2.10 (18)-S11451D, and 46-2.10(18)-S11451E pertaining to the reimbursement for skilled nursing and intermediate care services, reimbursement method and procedures	NOTICE OF THE AMENDMENT OF RULES 46-2.10(18)-S11451B, 46-2.10(18)-S11451D, AND 46-2.10(18)-S11451E

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the amendment of Rules 46-2.10(18)-S11451B, 46-2.10(18)-S11451D, and 46-2.10(18)-S11451E pertaining to the reimbursement for skilled and intermediate care services, reimbursement method and procedures at page 1372 of the 1980 Montana Administrative Register, issue 9.

2. The agency has amended the rules as proposed.

3. The Department has thoroughly considered all verbal and written commentary received:

Comment:

In the statement of position relative to the need for the amendment of the rules, it was indicated the Department concurred with the federal requirement that the rules had to change to address the recapture of depreciation provision. Do these proposed rule changes exceed federal requirements?

Response:

It is a fact that we definitely concur with the federal government's response to our current rules regarding recapture of depreciation. The rules for allowable costs for the Medicaid program are defined by the Medicare Provider Reimbursement Manual (HIM-15) with the exceptions, clarifications, and additions included in the rule. For the protection of providers against retroactive implementation of any revisions of this manual, no revisions made subsequent to March 20, 1979, are recognized by the Department in determining allowable costs. The current rule states that there is an exception to HIM-15 relative to depreciation recapture. By eliminating this exception in the proposed rule change, we are defining allowable depreciation costs under the criteria presented in HIM-15, sections 100 through 136.16 specifically sections 132 and 136 through 136.16.

Comment:

Is it not true that under HIM-15, the only depreciation to be recaptured under Medicare is the difference between straight-line and accelerated?

Response:

HIM-15 addresses both the recapture of excess straight-line depreciation on gains due to a sale (sections 130-136.16) and recovery of excess accelerated depreciation upon termination (sections 136-136.16). Both will be recaptured to the extent determined under HIM-15 formulas.

Comment:

The Department has hampered our efforts to respond to these rules by failing to make available the results of the rate reviews conducted by Medical Services Consultants, Inc.

Response:

These rule changes have not been predicated on data from rate reviews. Therefore, rate review results are not essential for any analysis of the amendments. Furthermore, none of the rate reviews are completed and could not be made available as yet in any case.

Comment:

The Department has failed to keep the Nursing Home Advisory Committee informed on matters of vital interest to it in terms of providing meaningful input to the development of the reimbursement plan.

Response:

The proposed amendments were first referenced as being worked on at the Nursing Home Advisory Committee meeting of February 22, 1980. This information was then sent to all nursing home administrators and others on the nursing home reimbursement mailing list as part of reimbursement planning memo number 4, dated March 7, 1980. At the March 28, 1980 meeting of the Nursing Home Advisory Committee, a summary of the proposed amendments and the written rule amendments themselves, as they were to be published by the Secretary of State,

were distributed and reviewed with committee members. This same information was then enclosed in reimbursement planning memo number 5, dated April 10, 1980, and mailed to all nursing home administrators and others on the nursing home reimbursement mailing list. All this was done in addition to the public notice by the Secretary of State. The Department believes it has adequately informed both the Committee and others affected by the rule amendments.

Comment:

We object to the amendment of Section S11451D(2)(k) which deletes reference to the determination of property costs for a new provider in a sale or lease situation according to the Certificate of Need process.

Response:

The amended rules call for a budget for an initial rate with justification for costs that would be different from the prior provider. One item of justification could be Certificate of Need determinations. The determination of the initial rate does not, therefore, preclude consideration of the Certificate of Need.

Comment:

The Department's opening testimony substantially changed the nature, character, and extent of this hearing. Therefore, this hearing is ineffective and not proper because of inadequate and improper notice.

Response:

The Department provided explanatory information in its opening comments. In no way were the rule amendments revised by these comments.

Comment:

We urge the inclusion of the following provision in the amended rule: Any recapture of depreciation will be limited to depreciation taken after the effective date of the amended rules.

Response:

Recapture of depreciation is to be undertaken at the time of sale and will be determined in accordance with HIM-15. No specific period of depreciation payment will be excluded from this determination as recapture provisions are to apply to the entire time during which the seller participated in the Medicaid program.

Comment:

The Department should develop a complete plan for amending the reimbursement rules, rather than implement the amendments in a piecemeal fashion.

Response:

A complete plan has been developed. It is being implemented in series. Each part of the series is a building block to the next and will not result in contradiction or ambiguity. Each part of the series requires research before it can be implemented. As research is completed, the new part will be introduced. This is a logical and orderly progression of amendments to perfect the reimbursement rules, and not a piecemeal approach at all.

Comment:

The rule appears to provide reimbursement for the purchases of an ongoing facility for the cost of the facility in excess of depreciation on the remaining undepreciated costs of previous owner.

Response:

Reimbursement of depreciation to a new provider is based on the market value or depreciated reproduction cost of the building, whichever is lower; the HIM-15 manual is incorporated into our rule with noted exceptions. This amended rule does not make any exception to Paragraph 104.14, which states the cost basis of facility transferred to a new provider.

Comment:

Medicare does not pay for ICF/MR services, therefore, the amendment stating: "However such payments will not exceed the

amount that would be paid under the Medicare principles of provider reimbursement," should be excluded from these amendments.

Response:

The Medicare upper limit is based on skilled nursing service costs for a market area using a market basket approach to determining the limit. It is the Department's discretion to establish upper limits for any class of facility provided that such limits are reasonably cost related. The Department has set ICF/MR's as a class, has determined that the Medicare limit is reasonably cost related, and has determined that the ICF/MR costs should not exceed the maximum cost of skilled care as determined by Medicare.

Comment:

The Department has amended the rules to delete the 120% upper limit on interim rates for facilities under rate review.

Response:

This statement is incorrect. Section S11451D(6)(c) of the existing rules includes this provision. The portion of this section involving the 120% interim limit was not amended.

Comment:

The January 16, 1980 letter from the federal government regarding required changes in the state plan for Medicaid states the profit factor must be deleted from the rule, but they do not state that performance incentive can be included for facilities under rate review.

Response:

The federal letter identifies problems with the current rule. It does not attempt, in every instance, to identify solutions to the problems; that is up to the Department. In this instance, the Department believes that the provision of an incentive factor under rate review procedures is discretionary. The Department has chosen to add an incentive to costs under

rate review within the 90th percential framework just as it is being added to prospective rates under formula procedures.

Comment:

The Department, through use of the 90th percentile as the basis of setting incentives, is in fact stating that facilities with costs above the 90th percentile are operated inefficiently and uneconomically.

Response:

The 90th percentile is used in two ways: it sets an upper limit on costs that will be reimbursed under the formula method of rate determination, and it sets the limit for facilities that can receive an incentive factor for containing costs. The payment of the incentive factor is for efficient and economical facilities that are below the 90th percentile. There may be efficient and economical facilities above the 90th percentile, which were so defined under the rate review procedures, for example, that do not qualify for the incentive factor. Qualifying for the incentive factor is not a method of differentiating the effective and efficient from the ineffective and the inefficient. Instead, it is a method of encouraging those who are motivated by incentives, and who can and are willing to contain costs and/or accept a patient mix that allows for lower costs.

Comment:

The rule states that the Department will pay one-half of the difference between the 90th percentile cost and a facility's actual cost. I challenge the Department to prove that facilities have been able to receive the maximum incentive of $1.50 per patient day.

Response:

Under the rates issued as of January, 1980, 38 of the 51 facilities receiving formula rates received the maximum incentive of $1.50.

Comment:

Is it the Department's understanding that by definition any difference between book value and the sales price constitutes, in effect, excess depreciation?

Response:

The difference between book value and sales price is defined as a gain or loss. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in Medicaid allowable costs. The extent to which such gains are included is calculated by prorating the basis for depreciation in accordance with the proportion of the depreciable assets' useful life for which the provider participated in Medicaid.

Comment:

If it is determined that the Department's interpretation of Medicaid regulations regarding a profit factor is incorrect would you readjust the rules?

Response:

If our understanding was incorrect, we would adjust the rules to be in compliance with HIM-15.

Comment:

It is my understanding that all facilities enrolled in the Medicaid program would receive their costs that were determined to be actually expended and related to patient care even though those costs were above the 90th percentile.

Response:

Facilities which apply for a rate review may receive a rate above the 90th percentile cost if their costs are deemed by the Department to be reasonable and necessary. Facilities receiving the formula rate will not receive a rate above the 90th percentile.

Comment:

I urge SRS to defer implementing these rules until there is a direct face-to-face meeting with those federal officials which have advised the State Medicaid program that sections of the current rule are not acceptable.

Response:

The Department does not believe that there is any need for further meetings with federal officials on this matter because we endorse their position on the changes we have included in these amendments.

Comment:

S11451B1 states in part that rates shall be set at a level adequate to reimburse in full actual allowable cost of providers having no deficiences. I feel that the phrase "no deficiencies" should be replaced with the phrase "having substantial compliance".

Response:

The portion of S11451B1 to which this comment pertains has not been amended. The department may consider this comment in its review of future possible amendments.

Comment:

The trend factor which is based on changes in the CPI, all Items is not appropriate.

Response:

The section of the rule pertaining to the trend factor was not amended. The department may consider this comment in its review of future possible amendments.

Comment:

Is the Department suggesting that facilities cut patient services in order to be eligible to receive payment in excess of their costs?

Response:

No. If a facility's costs are above the 90th percentile and the owner has evidence that the facility is being operated efficiently and effectively given the patient mix, then cutting costs would be inappropriate. The only realistic opportunity

for an incentive payment over cost would be if the patient mix were such that the cost of care would be less than the 90th percentile.

Comment:

If property is sold at a loss, is there a provision for reimbursement for inadequate depreciation?

Response:

The amount of loss (book value - sales price) to be included in calculation of allowable costs shall be limited to the undepreciated basis of the asset permitted under the program. The extent to which such losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the asset's useful life for which the provider participated in the Medicaid program.

Comment:

The per diem cost in nursing homes has increased less than any other provider in the health field. The primary cause of the increase in the Medicaid budget has been due to the proliferation of eligible clients.

Response:

Between fiscal year 1975 and fiscal year 1979, the number of patient days paid has increased 21.42%. During the same period the per diem cost to Medicaid has been 74.22%. The increase in the Consumer Price Index during that period was 37.37%. This data indicates that the primary cause of the increase in the Medicaid budget has been due to increased per diem costs.

Comment:

I would like to show for the record that the State of Wyoming has a reimbursement system which allows for a specific add-on incentive for facilities under the maximum rate allowed.

Response:

The State of Wyoming has a maximum reimbursement limit set at the allowable cost per day of the 84th percentile facility. The incentive is calculated in a manner similar to the method

used by the Department; facilities approaching the 84th percentile will receive less and less incentive. For facilities with low costs, there is a maximum allowable incentive. The federal Medicaid officials would most assuredly deem an 84th percentile upper limit to be more reasonable than a 90th percentile limit. However, it is the Department's contention that statistical analysis of cost report data indicates that, under our current rules as proposed today, the 90th percentile is the most equitable upper limit.

Comment:

The Hearing Officer is an internal employee of SRS, under the Montana Administrative Procedure Act provision of both the United States and State Constitution, this is inappropriate and improper.

Response:

In accordance with Section 2-4-611 of the Montana Administrative Procedure Act, the decision to disqualify a hearing officer is committed to the agency's discretion and is subject to judicial review only as the decision may taint the final order in the case (hearing). In addition the affidavit stating facts and reasons "for the belief that the hearing examiner should be disqualified must be filed not less than 10 days before the original date set for the hearing." Withrow v. Larkin, 421 U.S. 35 (1975) contains a thorough discussion of Constitutional standards for an unbiased hearing before a state agency. It is the Department's position that the selection of Mr. Scott as hearing officer is neither inappropriate nor improper after evaluation of the above cited act, section, and case.

Comment:

The Fifth Circuit Court specifcally set forth certain guidelines in relation to a percentile approach in limiting profit and other reimbursements in connection with U.S. Court of Appeals for the Fifth Circuit Case No. 79-1694 (May 7, 1980).

Response:

The Fifth Circuit Court remanded this case back to the District Court for rehearing after the federal government has

clarified its policies regarding state plans for reimbursement under the Medicaid program. Since the case has not been settled, there are apparently no guidelines set forth regarding the use of percentiles. It is doubtful that any decisions on Alabama's use of a 60th percentile as upper limit on reimbursement would have much impact on Montana's rule since we have both a 90th percentile limit and an opportunity for rate review.

Keith L. Colt
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.10(18)-S11511 pertaining to medical assistance, services provided, amount, duration -- transportation and per diem, additional requirements	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11511

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment to Rule 46-2.10(18)-S11511 pertaining to medical assistance, services provided, amount, duration -- transportation and per diem, at page 1405 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

In the matter of the amendment of Rule 46-2.10(18)-S11512 pertaining to medical assistance, services provided, amount, duration -- transportation and per diem, reimbursement	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11512

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment to Rule 46-2.10(18)-S11512 pertaining to medical assistance, services provided, amount, duration -- transportation and per diem, reimbursement, at page 1405 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to occupational therapy services	)))))	NOTICE OF THE ADOPTION OF RULES 46-2.10(18)-S11539, 46-2.10(18)-S11540, AND 46-2.10(18)-S11541

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed adoption of new rules, 46-2.10(18)-S11539, OUTPATIENT OCCUPATIONAL THERAPY SERVICES, DEFINITIONS; 46-2.10(18)-S11540, OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REQUIREMENTS; and 46-2.10(18)-S11541, OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT, at page 1428 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rules as proposed.

3. No comments or testimony were received.

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(f) and the adoption of rules pertaining to the medical assistance program, private duty nursing services	)))))	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11440(1)(f) AND THE ADOPTION OF RULES 46-2.10(18)-S11542, 46-2.10(18)-S11543, AND 46-2.10(18)-S11544

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46-2.10(18)-S11440(1)(f) and the adoption of new rules 46-2.10(18)-S11542, PRIVATE DUTY NURSING SERVICE, DEFINITION; 46-2.10(18)-S11543, PRIVATE DUTY NURSING SERVICE, REQUIREMENTS; and 46-2.10(18)-S11544, PRIVATE DUTY NURSING SERVICE, REIMBURSEMENT, at page 1412 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. The agency has adopted the rules as proposed.

4. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of a rule pertaining to medical assistance, services provided	))))	NOTICE OF THE ADOPTION OF RULE 46-2.10(18)-S11545

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rule 46-2.10(18)-S11545, SERVICES PROVIDED, at page 1435 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rule as proposed.

3. No comments or testimony were received.

In the matter of the amendment of Rule 46-2.10(18)-S11440(1)(s) and the adoption of rules pertaining to medical assistance, home dialysis for end stage renal disease	)))))	NOTICE OF THE AMENDMENT OF OF RULE 46-2.10(18)-S11440 AND THE ADOPTION OF RULES 46-2.10(18)-S11546, 46-2.10(18)-S11547, AND 46-2.10(18)-S11548

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46-2.10(18)-S11440(1)(s) and the adoption of new rules 46-2.10(18)-S11546, HOME DIALYSIS FOR END STAGE RENAL DISEASE, DEFINITION; 46-2.10(18)-S11547, HOME DIALYSIS FOR END STAGE RENAL DISEASE, REQUIREMENTS; and 46-2.10(18)-S11548, HOME DIALYSIS FOR END STAGE RENAL DISEASE, REIMBURSEMENT, at page 1437 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. The agency has adopted the rules as proposed.

4. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to medical assistance, early periodic screening diagnosis and treatment	NOTICE OF THE ADOPTION OF OF RULES 46-2.10(18)-S11552, 46-2.10(18)-S11553, AND 46-2.10(18)-S11554

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed adoption of new rules 46-2.10(18)-S11552, EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT, DEFINITION; 46-2.10(18)-S11553, EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT, REQUIREMENTS; and 46-2.10(18)-S11554, EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT, REIMBURSEMENT, at page 1456 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rules as proposed.

3. No comments or testimony were received.

In the matter of the amendment of Rule 46-2.10(18)-S11502 pertaining to medical assistance, psychological services, reimbursement	NOTICE OF THE AMENDMENT OF RULE 46-2.10(18)-S11502

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment to Rule 46-2.10(18)-S11502 pertaining to medical assistance, psychological services, reimbursement, at page 1433 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to medical assistance, audiology services	))))	NOTICE OF THE ADOPTION OF RULES 46-2.10(18)-S11549, 46-2.10(18)-S11550, AND 46-2.10(18)-S11551

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed adoption of rules 46-2.10(18)-S11549, AUDIOLOGY SERVICES, DEFINITION; 46-2.10(18)-S11550, AUDIOLOGY SERVICES, REQUIREMENTS; and 46-2.10(18)-S11551, AUDIOLOGY SERVICES, REIMBURSEMENT, at page 1453 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rules as proposed with the following changes:

46-2.10(18)-S11549 ~~RULE I~~ AUDIOLOGY SERVICES, DEFINITION Audiology services means hearing aid evaluation (HAE) and basic audio assessment (BAA) provided by a licensed audiologist, upon physician referral, to individuals with hearing disorders.

46-2.10(18)-S11550 ~~RULE II~~ AUDIOLOGY SERVICES, REQUIREMENTS (1) Audiology services must be physician referred.

(2) Medicaid coverage for audiology services is limited to those services medically required preliminary to the purchase or obtaining of a hearing aid/device.

(3) Written physicians orders, diagnostic and evaluative reports must be current and available upon request of the Department or its designated representative.

(4) Audiology services will be subject to review by the designated professional review organization.

(5) Basic audio assessment (BAA) under ear phones must include as a minimum a speech discrimination test, a speech reception threshold, a pure tone air threshold, and either a pure tone bone threshold or one of the following: tympanogram, acoustic reflex, tympanometry for tubal function, static compliance.

(6) Hearing aid evaluation (HAE) must be in a sound attenuated room in a free field setting ~~with comparison of representative makes and models of hearing aids~~ to determine those acoustical specifications most appropriate for clients hearing loss, and will include at least one follow-up visit.

46-2.10(18)-S11551 ~~RULE III~~ AUDIOLOGY SERVICES, REIMBURSEMENT Payment for audiology services shall not ex-

ceed the lowest of; usual and customary charges which are reasonable, actual charges, or the rates allowed by the audiology fee schedule:

AUDIOLOGY FEE SCHEDULE

Basic Audio Assessment (BAA)	$40.00
Hearing Aid Evaluation (HAE)	20.00
Speech Discrimination Test	8.00
Speech Reception Threshold	8.00
Pure Tone Air Threshold	8.00
Pure Tone Bone Threshold	8.00
Tympanogram (unilateral)	3.00
Tympanogram (bilateral)	6.00
Acoustic Reflex (bilateral)	8.00
Static Compliance	6.00
Bekesy	10.00
SISI (two or more frequency)	10.00
Loudness Balance or ABLB	10.00
Stenger	10.00
Doefler - Stewart	10.00
Lombard	10.00

3. The Department has thoroughly considered all verbal and written commentary received:

Comment

Rule II(6) provides for a hearing aid evaluation that is in a free field setting with comparison of representative-makes and models of hearing aids. This does not provide for the most effective hearing aid for each patient evaluated.

Response

The Department has modified Rule II(6) to read:

(6) Hearing aid avaluation (HAE) must be in a sound attenuated room in a setting to determine those acoustical specifications most appropriate for clients hearing loss, and will include at least one follow-up visit.

4. These changes should clarify the problems raised by the comment without substantively changing the effect or scope of the rule.

Keith F. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rule 46-2.10(18)-S11535 listing excluded services under the medicaid program	))))	NOTICE OF THE ADOPTION OF RULE 46-2.10(18)-S11535

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed adoption of a rule pertaining to listing excluded services under the Medicaid program at page 1407 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rule, 46-2.10(18)-S11535, with the following changes:

46-2.10(18)-S11535 SERVICES NOT PROVIDED BY THE MEDICAID PROGRAM (1) Items or medical services not specifically included within defined benefits of the medicaid program are not reimbursable under the medicaid program.

(2) The following medical and nonmedical services are explicitly excluded from the Montana medicaid program except for those services covered under the ~~institutional~~ health care facility licensure rules of the Montana department of health and environmental sciences when provided as part of a prescribed regimen of care to the inpatient of a licensed health care facility:

(a) chiropractic services;
(b) acupuncture services;
(c) naturopathic services;
~~(d) inhalation or respiratory therapy service;~~
~~(e)~~ (d) dietician service;
~~(f)~~ (e) nurse practitioner service;
~~(g)~~ (f) psychiatric social work service;
~~(h)~~ (g) mid-wifery;
~~(i)~~ (h) social work service;
~~(j)~~ (i) physical therapy aide service;
~~(k)~~ (j) physician assistant service;
~~(l)~~ (k) nonphysician surgical assistance service;
~~(m)~~ (l) nutritional service;
~~(n)~~ (m) masseur or masseuse services;
~~(o)~~ (n) dietary supplements;
~~(p)~~ (o) homemaker service;
~~(q)~~ (p) telephone service in home, remodeling of home, plumbing service, car repair, and/or modification of automobile.

3. The Department has thoroughly considered all verbal and written commentary received:

Comment
Although this rule was noticed up to "inform providers" it actually excludes many services now paid for that are important functions of a hospital.

Response
The first notice of this rule inadvertantly appeared to exclude services which were currently being reimbursed when prescribed for inpatient care in a licensed medical institution. The second notice cleared up the problem by stating that "services covered under the institutional licensure rules" would be reimbursed. The Department wishes to further clarify that only licensed medical institutions may provide some services by changing Rule I(2) to read:

(2) The following medical and nonmedical services are explicitly excluded from the Montana medicaid program except for those services covered under the health care facility licensure rules of the Montana department of health and environmental sciences when provided as part of a prescribed regimen of care to the inpatient of a licensed health care facility.

Comment
Respiratory or inhalation therapy is very important; Medicaid should cover those services.

Response
Inhalation or respiratory therapy services have been deleted from the list of excluded services. The Department intends to address those services in greater detail in a later rule on hospital services. Since these services are covered under institutional licensure rules of the Department of Health and Environmental Sciences, they will continue to be reimbursable when rendered by a licensed medical institution.

Comment
Will the Montana recipient being served by the practitioner of an excluded service be reimbursable if that service is not excluded in another state.

Response
No.

Comment

The wording in Rule I (2) is unclear and should read:

The following medical and nonmedical services are explicitly excluded from the Montana Medicaid program except for those services furnished by a health care facility licensed by the Montana department of health and environmental sciences.

Response

The Department must often reimburse out-of-state providers who are not licensed by the Montana Department of Health and Environmental Sciences.

Comment

The Department should cover any services furnished by a health care facility licensed by the state licensing agency in the state where the facility is located.

Response

The Department cannot allow reimbursement for services rendered out of state that are not reimbursable in state.

Comment

Licensed medical institution should be changed to licensed health care facility to be more in tune with the Montana Department of Health and Environmental Sciences.

Response

The Department has changed the wording.

Comment

Why are certified dieticians services, nurse practitioner services and inhalation or respiratory therapy services excluded outside of licensed health care facilities.

Response

The Montana Medicaid program must live within its budget. Exporting the program to cover these services would require a legislative budget appropriation.

Keith I Colbo

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules and the repeal of 46-2.10 (18)-S11430 pertaining to medical assistance, eligibility	))))	NOTICE OF THE ADOPTION OF RULE 46-2.10(18)-S11564

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed adoption of rules and the proposed repeal of Rule 46-2.10(18)-S11430 at page 1444 of the 1980 Montana Administrative Register, issue number 9. The notice was incorrectly typed in that the Department intended to propose to repeal 46-2.10(18)-S11420 which is the medical assistance eligibility requirements rule.

2. The Department has adopted only Rule VI(3), 46-2.10(18) -S11564, of the proposed rules with the following change, and has chosen not to repeal Rule 46-2.10(18)-S11420:

46-2.10(18)-S11564 ~~(RULE-VI(3))~~ MEDICALLY NEEDY, PERSONAL NEEDS All persons in a medical institution which participates in the medicaid program shall ~~have~~ be allowed to retain up to $40.00 per month of their income ~~proceeds~~ for personal needs.

3. No comments or testimony were received. The Department intends to adopt a more detailed version of the initially proposed rule at a later date. It is imperative that the portion adopted be implemented quickly to alleviate the severe pinch in personal needs funds of recipients.

Keith T. Colbo
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rule 46-2.10(30)-S11880 pertaining to emergency assistance, food stamps	))))	NOTICE OF THE REPEAL OF RULE 46-2.10(30)-S11880

TO: All Interested Persons

1. On April 24, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.10(30)-S11880 pertaining to emergency assistance, food stamps at page 1254 of the 1980 Montana Administrative Register, issue number 8.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

In the matter of the repeal of Rules 46-2.10(46)-S103000 through 46-2.10(46)-S103050 all pertaining to medical assistance provisions for emergency situations	)))))	NOTICE OF THE REPEAL OF RULES 46-2.10(46)-S103000 THROUGH 46-2.10(46)-S103050

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rules 46-2.10(46)-S103000 through 46-2.10(46)-S103050 pertaining to medical assistance provisions for emergency situations at page 1391 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rule 46-2.10(18)-S11444 pertaining to personal care home services	))))	NOTICE OF THE REPEAL OF RULE 46-2.10(18) -S11444

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.10(18)-S11444 pertaining to personal care home services, at page 1393 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

In the matter of the repeal of Rule 46-2.6(6)-S6505 (46.5.9911) pertaining to obsolete miscellaneous programs dealing with social services	)))))	NOTICE OF THE REPEAL OF RULE 46-2.6(6)-S6505

To: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.6(6)-S6505 pertaining to obsolete miscellaneous programs dealing with social services at page 1403 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rule 46-2.6(6)-S6440 (46.5.9910) pertaining to obsolete miscellaneous programs dealing with social services	)))))	NOTICE OF THE REPEAL OF RULE 46-2.6(6)-S6440

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.6(6)-S6440 pertaining to obsolete miscellaneous programs dealing with social services, at page 1401 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

In the matter of the repeal of Rules 46-2.6(6)-S6360 (46.5.9907)) 46-2.6(6)-S6370 (46.5.9908) and 46-2.6(6)-S6380 (46.5.9909) all pertaining to obsolete miscellaneous programs dealing with social services	)))))	NOTICE OF THE REPEAL OF RULES 46-2.6(6)-S6360, 46-2.6(6)-S6370 AND 46-2.6(6)-S6380

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed repeal of Rules 46-2.6(6)-S6360, 46-2.6(6)-S6370, and 46-2.6(6)-S6380, all pertaining to obsolete miscellaneous programs dealing with social services, at page 1399 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rules 46-2.6(6)-S6300 (46.5.9904)) 46-2.6(6)-S6310 (46.5.9905), and 46-2.6(6)-S6320 (46.5.9906), all pertaining to obsolete miscellaneous programs dealing with social services	NOTICE OF THE REPEAL OF RULES 46-2.6(6)-S6300, 46-2.6(6)-S6310, AND 46-2.6(6)-S6320

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed repeal of Rules 46-2.6(6)-S6300, 46-2.6(6)-S6310, and 46-2.6(6)-S6320, all pertaining to obsolete miscellaneous programs dealing with social services, at page 1397 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

In the matter of the repeal of Rules 46-2.6(2)-S6030 (46.5.9901)) 46-2.6(2)-S6040 (46.5.9902), and 46-2.6(2)-S6050 (46.5.9903) all pertaining to obsolete miscellaneous programs dealing with social services	NOTICE OF THE REPEAL OF RULES 46-2.6(2)-S6030, 46-2.6(2)-S6040, AND 46-2.6(2)-S6050

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of the proposed repeal of Rules 46-2.6(2)-S6030, 46-2.6(2)-S6040, and 46-2.6(2)-S6050, all pertaining to obsolete miscellaneous programs dealing with social services, at page 1395 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rules as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rule 46-2.10(18)-S11460 pertaining to medical assistance, providers of services	))))	NOTICE OF THE REPEAL OF RULE 46-2.10(18)-S11460

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.10(18)-S11460, pertaining to medical assistance, providers of services, at page 1461 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testiomny were received.

In the matter of the repeal of Rule 46-2.10(18)-S11490 pertaining to medical assistance, third party liability cases	))))	NOTICE OF THE REPEAL OF RULE 46-2.10(18)-S11490

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed repeal of Rule 46-2.10(18)-S11490, pertaining to medical assistance, third party liability cases, at page 1463 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has repealed the rule as proposed.

3. No comments or testimony were received.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46-2.6(2)-S680(2)(g) extending eligibility for day care assistance	))))	NOTICE OF AMENDMENT OF RULE 46-2.6(2)-S680(2)(g)

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment to Rule 46-2.6(2)-S680(2)(g), pertaining to extending eligibility for day care assistance, at page 1472 of the 1980 Montana Administrative Register.

2. On the original MAR Notice No. 46-2-263 to amend the above enumerated rule, the subsection was inadvertently typed as (2)(f) rather than (2)(g) as indicated in this notice.

3. The agency has amended the rule as proposed.

4. No comments or testimony were received.

In the matter of the amendment of Rule 46-2.6(2)-S680(2)(g) extending eligibility for day care assistance	))))	NOTICE OF THE AMENDMENT OF RULE 46-2.6(2)-S680(2)(g)

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of an amendment to Rule 46-2.6(2)-S680(2)(g), at page 1472 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

Keith E. Colby
Director, Social and Rehabilitation Services

CERTIFIED TO THE SECRETARY OF STATE June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rule 46-2.22(1)-S2226 pertaining to the certification of persons assisting in the administration of medication	))))	NOTICE OF THE ADOPTION OF RULE 46-2.22(1)-S2226

TO: All Interested Persons

1. On May 15, 1980, the Department of Social and Rehabilitation Services published notice of a proposed adoption of a rule pertaining to certification of persons assisting in the administration of medication at page 1409 of the 1980 Montana Administrative Register, issue number 9.

2. The agency has adopted the rule with the following changes:

46-2.22(1)-S2226 ~~RULE I~~ CERTIFICATION OF PERSONS ASSISTING IN THE ADMINISTRATION OF MEDICATION (1) This rule establishes procedures under which an employee or an agent of a provider may assist and supervise a client in taking medication. Such assistance and supervision may only be given where a medication which is normally self-administered has been prescribed for a client and where the physician who prescribed the medication also prescribed assistance or supervision in the administration of the medication.

(2) For the purposes of this rule, the following definitions apply:

(a) "Assistance" means providing any degree of support or aid to a client who independently performs at least one component of medication-taking behavior;

(b) "Supervision" means critically observing and directing a client engaging in medication-taking behavior.

(3) No agent or employee of a provider may assist or supervise in the administration of medication to clients unless certified by the department as herein provided unless otherwise authorized by law to provide such assistance or supervision. Every provider shall maintain a current list of provider employees and agents certified to administer medication on file with the division.

(4) Certification to provide such assistance will be determined by the department upon written application to the Developmental Disabilities Division, Department of Social and Rehabilitation Services, P. O. Box 4210, Helena, MT 59601. To be certified, an employee or agent of a provider must demonstrate knowledge of epilepsies and of use and side effects of medications by achieving a score of at least 90% on a comprehensive test administered by the department.

(5) Any provider may receive, free of charge, an instructional and reference aid entitled epilepsies and medications individualized instruction manual, which shall have been approved by the board of nursing.

(6) The department will administer the comprehensive test to a qualified applicant within thirty (30) days of receipt of a written application for certification. Notice of certification or noncertification will be mailed within ten (10) days of the date of testing. The notice will designate an effective date and an expiration date for the certification. Certification will in no event be longer than for a period of two years.

(7) Any assistance provided under this rule which occurs after the client has been enrolled in the program for thirty (30) days and which must be administered for a longer period than ten (10) consecutive days must be the subject of a written individual habilitation plan. ~~The~~ An individual ~~program~~ medication plan must be prepared which describes a program to train the client to self-administer the medication and must specify at least:

(a) the target medication-taking behavior;

(b) the conditions (e.g., times and places) in which such behavior should occur;

(c) the conditions (e.g., times and places) in which such behavior will be trained;

(d) criteria for completion of the individual program plan~~,~~ in accordance with section (9) herein;

(e) written strategies for training the target behavior;

(f) a data recording system which accounts for each prescribed medication dosage, and;

(g) a data recording system which specifies progress or lack of progress toward the target behavior on a daily basis.

(8) Every instance of assistance or supervision provided under this rule must be recorded and must include at least the name of the person who receives medication, the name of the person who assists or supervises the taking of medication, the date and time the medication was taken, and the type of medication taken.

(9) A client is considered to be capable of self-administering medication when it has been documented that the client has self-administered all (100%) of prescribed medication dosages ~~within~~ for a consecutive thirty (30) day period.

(10)(a) ~~(8)~~ The department may revoke certification by notifying the certified person of the reason for revocation in writing at least ten (10) days prior to the effective date of revocation. The certified person may request, in writing, within the ten (10) days prior to revocation, a hearing from the division administrator, who will issue a decision no later than thirty (30) days from the date the request for hearing was received. When a request for a hearing is made, the

revocation will not be effective until the division administrator's decision is made.

(b) The department may, for cause, suspend a certified person's right to assist or supervise in the administration of medication for a period no longer than fifteen (15) days, after which the suspension must be removed or notice of revocation issued. If notice of revocation is issued, suspension may continue until the effective date of revocation or until the division administrator's decision is made.

3. The Department has thoroughly considered all verbal and written commentary received:

Comment

A provision should be made to allow emergency relief staff or staff not certified due to frequent staff turnover to assist clients in taking medication.

Response

The law states that a "properly trained staff member" may assist and supervise a client in taking medication. The assisting staff must be certified.

Comment

Training for certification procedures should include behavioral control medication.

Response

Commonly used medication, including neuroleptics (used to calm upset individuals), anxiolytics (used to counteract tension and anxiety), as well as other types of medication are included in the individualized instructional manual.

Comment

The level of training that a provider staff member will receive is not adequate to cover medical responsibility.

Response

The provider staff member is responsible for assisting in medication prescribed by the physician. The staff person will contact the physician if the client indicates in any way that he needs additional or modified medical treatment.

Comment

What procedure will be followed for clients who need "totally administered" drugs?

Response

Any individual who requires more than assistance in taking medication should have a properly licensed person to administer the medication.

Comment

The requirement for training each individual to self-administer medication may not be in every client's best interest.

Response

The Division's philosophy is to train individuals with developmental disabilities to learn independent living skills. Training in medication-taking behavior is one of the skills necessary to become independent.

Comment

Why is certification of persons necessary at this time?

Response

The law, Section 53-20-204(2), MCA, states that the department shall adopt rules under which a properly trained staff may assist and supervise a client in taking medication.

Comments

A staff member should be taught the signs and symptoms of medication.

Response

The "Epilepsies and Medications" individualized instruction manual addresses possible drug side effects.

Comment

Will someone who is certified to assist and supervise a client taking medication be able to perform this responsibility in another setting such as a nursing home?

Response

The certification of persons assisting in the administration of medication applies only to those individuals certified who are assisting and supervising clients who are in services which have a contractual agreement with the department through the Developmental Disabilities Division.

Keith P. Colby
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 17, 1980.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rule 46-2.10(18)-S11534 pertaining to reimbursement for physician services	))))	NOTICE OF THE ADOPTION OF 46-2.10(18)-S11534

TO: All Interested Persons

1. On April 24, 1980, the Department of Social and Rehabilitation Services published notice of a proposed adoption of a rule pertaining to reimbursement for physician services at page 1256 of the 1980 Montana Administrative Register, issue number 8.

2. The agency has adopted the rule with the following changes: (THE RULE WILL BE BROKEN DOWN INTO APPROXIMATELY FIVE RULES UNDER RECODIFICATION. SUBSECTIONS WILL BE IDENTIFIED BY THE NUMBERING SYSTEM AT THAT SAME TIME. THIS IS BEING DONE TO MAKE THE RULE MORE READABLE FOR THE PUBLIC. IT WILL AVOID UNNECESSARY SUBHEADINGS AND PROVIDE A LOGICAL BREAKDOWN FOR EASE OF LOCATING SPECIFIC SERVICES AND FEES.) (THE FOLLOWING HAS BEEN ADDED.)

~~RULE I~~ 46-2.10(18)-S11534 PHYSICIAN SERVICES, REIMBURSEMENT (1) Payments for physician services will be the lesser of usual and customary charges which are reasonable, the amount payable by Medicare, or the following fee schedule. Services paid by report (BR) will be paid at 94.6000% of the fees which are comparable to usual and customary charges established by the provider in 1976. ~~or the amounts determined by applying the following conversion factors to the 1974 Montana medicaid association relative value schedule:~~

~~Surgery~~	~~29.8290~~
~~Medicine~~	~~0.7781~~
~~Radiology~~	~~3.8910~~
~~Anesthesia~~	~~7.7810~~
~~Pathology~~	~~0.3289~~
~~By report codes~~	~~94.6000 of the fees which are comparable to the usual and customary charges established by the provider in 1976~~

~~(2) The 1974 Montana medical association relative value schedule is hereby incorporated and made a part of this rule.~~

REIMBURSEMENT SCHEDULE

MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which is a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, the "Multiple Modifiers" code placed first after the procedure code indicates that one or more additional modifier codes will follow. All procedures where a modifier is used may be paid By Report (BR). Modifiers commonly used are as follows:

-22 Unusual Services: When the service(S) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-2' to the usual procedure number. A report may also be appropriate. (Pertains to Medicine, Anesthesia, Surgery, Radiology, and Pathology and Laboratory.)

-23 Unusual Anesthesia: Periodically, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service. (Pertains to Anesthesia, Surgery.)

-26 Professional Component: Certain procedures (eg, laboratory, radiology, electrocardiogram, specific diagnostic services) are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number. (Pertains to Medicine, Surgery, Radiology, and Pathology and Laboratory.)

-30 Anesthesia Service: The anesthesia service may be identified by adding the modifier '-30' to the usual procedural code number of the basic service. (Pertains to Anesthesia.)

-47 Anesthesia by Surgeon: When regional or general anesthesia is provided by the surgeon, it may be reported by adding the modifier '-47' to the basic service. (This does not include local anesthesia.) (Pertains to Anesthesia, and Surgery.)

-50 Multiple or Bilateral Procedures: When multiple or bilateral procedures are provided at the same operative session, the first major procedure may be report-

ed as listed. The secondary or lesser procedure(s) may be identified by adding the modifier '-50' to the usual procedure number(s). (Pertains to Surgery, and Radiology.)

-52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. (Pertains to Medicine, Anesthesia, Surgery, Radiology, and Pathology and Laboratory.)

-54 Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier '-54' to the usual procedure number. (Pertains to Surgery.)

-55 Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier '-55' to the usual procedure number. (Pertains to Medicine, and Surgery.)

-56 Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier '-56' to the usual procedure number. (Pertains to Medicine, and Surgery.)

-66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the 'surgical team' concept. Such circumstances may be identified by each participating physician with the addition of the modifier '-66' to the basic procedure number used for reporting services. (Pertains to Surgery.)

-75 Concurrent Care. Services Rendered by More than One Physician: When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '-75' to the basic service performed. (Pertains to Medicine, Anesthesia, Surgery, and Radiology.)

-76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This may be reported by adding the modifier '-76' to the procedure code of the repeated service (Pertains to Medicine, Surgery, and Radiology.)

-77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This may be reported by adding modifier '-77' to the repeated service. (Pertains to Medicine, Surgery, and Radiology.)

-80 Assistant Surgeon: Surgical assistant services may be identified by addint the modifier '-80' to the usual procedure number(s). (Pertains to Surgery.)

-81 Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding the modifier '-81' to the usual procedure number. (Pertains to Surgery.)

-90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number. (Pertains to Medicine, Surgery, Radiology, and Pathology and Laboratory.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as a part of the description of the service. (Pertains to Medicine, Anesthesia, Surgery, and Radiology.)

MEDICINE PROCEDURES

OFFICE MEDICAL SERVICES

New Patient

90000 Brief service - $15.57

90010 Limited service - $23.34

90015 Intermediate service - $38.91

90020 Comprehensive service - $54.49

Established Patient

90030 Minimal service - $6.23

90040 Brief service - $9.34

90050 Limited service - $12.45

90060 Intermediate service - $15.57

90070 Extended service - $23.34

90080 Comprehensive service - $38.91

HOME MEDICAL SERVICES

New Patient

90100 Brief service - $23.34

90110 Limited service - $31.12

90115 Intermediate service - $38.90

90117 Extended service - 46.68

Established Patient

90130 Minimal service - $11.67

90140 Brief service - $15.56

90150 Limited service - $23.34

90160 Intermediate service - $27.23

90170 Extended service - $31.12

HOSPITAL MEDICAL SERVICES

New and Established Patient

Initial Hospital Care

90200 Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records - $23.34

90215 Intermediate history and examination, initiation of diagnosis and treatment programs, and preparation of hospital records - $33.73

90220 Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records - $54.47

Subsequent Hospital Care

90240 Brief service - $9.34

90250 Limited service - $11.80

90260 Intermediate service - $23.34

90270 Extended service - $31.13

90280 Comprehensive service - $31.13

90285 Routine newborn care in hospital, including physical examination of baby and conference(s) with parent(s) - $46.68

SKILLED NURSING, INTERMEDIATE CARE, AND LONG-TERM CARE FACILITIES

New or Established Patient

Initial Care

90300 Brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records - $23.34

90315 Intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records - $38.91

90320 Comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records - $54.46

Subsequent Care

90340 Brief service - $9.34

90350 Limited service - $15.57

90360 Intermediate service - $23.34

90370 Extended service - $31.12

NURSING HOME, BOARDING HOME, DOMICILIARY, OR CUSTODIAL CARE MEDICAL SERVICES

New Patient

90400 Brief services - $23.34

90410 Limited service - $31.13

90415 Intermediate service - $38.91

90420 Comprehensive service - BR

Established Patient

90430 Minimal service - $11.67

90440 Brief service - $15.57

90450 Limited service $23.34

90460 Intermediate service - $23.34

90470 Extended service - $31.13

EMERGENCY DEPARTMENT SERVICES

New Patient

90500 Minimal service - $6.22

90505 Brief service - $15.57

90510 Limited service - $23.34

90515 Intermediate service - $38.91

90517 Extended service - $46.68

Established Patient

90530 Minimal service - $6.22

90540 Brief service - $9.33

90550 Limited service - $12.24

90560 Intermediate service - $15.55

90570 Extended service - $23.34

CONSULTATIONS

90600 Limited consultation - $23.34

90605 Intermediate consultation - $31.13

90610 Extensive consultation - $33.74

90620 Comprehensive consultation - $54.47

90630 Complex consultation $54.47

Other Procedures

90699 Unlisted medical service, general - BR

IMMUNIZATION INJECTIONS

90720 Immunizations, each (includes supply of materials); DPT DT, tetanus toxoid, oral polio, typhoid, typhus, influenza, or colera - $4.40

90721 single virus vaccine (ie, measles, mumps, rubella, or smallpox) - $13.75

90722 double virus vaccine (ie, measles and rubella, mumps and rebella, or measles and mumps) - $13.75

90723 triple virus vaccine (ie, measles, mumps and rubella) - $13.75

90749 Unlisted immunization procedure - BR

INFANT, CHILD AND ADOLESCENT CARE

Preventive Health Care

New Patient

90751 Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years) - $38.91

90752 late childhood (age 5 through 11 years) - $31.13

90753 early childhood (age 1 through 4 years) - $23.34

90754 infant (age under 1 year) - $19.45

90755 Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DPT and oral polio - BR

Established Patient

90761 Interval history and examination related to the healthy individual, including anticipatory guidance, periodic type of examination; adolescent (age 12 through 17 years) -$31.13

90762 late childhood (age 5 through 11 years) - $23.34

90763 early childhood (age 1 through 4 years) - $19.45

90764 infant (age under 1 year) - $15.57

90774 Administration and medical interpretation of developmental tests (eg, Denver, Sprigle) - $26.46

THERAPEUTIC INJECTIONS

90782 Therapeutic injection of medication (specify); subcutaneous or intramuscular - $6.23

90784 intravenous - $11.12

90788 Intramuscular injection of antibiotic (specify) - $6.23

90790 Chemotherapy for malignant disease; parenteral - $11.12

90791 infusion (continuous or intermittent) - $11.12

90792 perfusion - $11.12

90793 intracavitary - $11.12

90796 Injection of an intrathecal chemotherapeutic agent administered by the physician - BR

90798 Intravenous therapy for severe or intractable allergic disease in physician's office or institution with theophyllines, corticosteriods, antihistamines - BR

90799 Unlisted therapeutic injection - BR

PSYCHIATRY

General Clinical Psychiatric Diagnosis or Evaluative Interview Procedures

90801 Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies; in certain circumstances other informants will be seen in lieu of the patient) - BR

Special Clinical Psychiatric Diagnostic Or Evaluative Procedures

90825 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes (without other informants or patient interview) - $18.68

90831 Telephone consultation with or about patient for psychiatric therapeutic or diagnostic purposes - BR

90835 Narcosynthesis for psychiatric diagnostic and therapeutic purposes, eg, sodium amobarbital (Amytal) interview - BR

Psychiatric Therapeutic Procedures

Medical Psychotherapy

90841 Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; time unspecified - $15.57

90843 approximately 20 TO 30 minutes - $23.34

90844 approximately 45 OR 50 minutes - $38.91

90847 Family medical psychotherapy (conjoint psychotherapy) with continuing medical diagnostic evaluation, and drug management when indicated; of two family members - BR

90848 of three or more members of one family - BR

90849 Multiple-family group medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated - BR

90853 Group medical psychotherapy (other than of a multiple-family group) with continuing medical diagnostic evaluation, and drug management when indicated - $15.57

Psychiatric Somatotherapy

90862 Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy - BR

90870 Electroconvulsive therapy - $38.91

90872 Subconvulsive electric shock treatment - BR

Other Psychiatric Therapy

90880 Medical hypnotherapy - BR

90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions - BR

90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient - BR

90889 Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers -BR

Other Procedures

90899 Unlisted psychiatric service or procedure - BR

DIALYSIS

Hemodialysis

90941 Hemodialysis, initial or acute (eg, acute renal failure or intoxication); patient over 40 kg - $264.96

90942 patient 21-40 kg - $264.69

90943 patient 11-20 kg - $264.96

90944 patient under 10 kg - $264.96

90951 Hemodialysis, for chronic irreversible renal insufficiency, initial stabilizing therapy via shunt or fistula, up to 4-6 weeks; patient over 40 kg - $163.02

90852 patient 21-40 kg - $163.02

90853 patient 11-20 kg - $163.02

90954 patient under 10 kg - $163.02

90955 Hemodialysis, for chronic irreversible renal insufficiency, maintenance for stabilized condition, more than 4-6 weeks, hospital; patient over 40 kg - $61.16

90956 patient 21-40 kg - $61.16

90957 patient 11-20 kg - $61.16

90958 patient under 10 kg - $61.16

Peritoneal Dialysis

90966 Peritoneal dialysis for acute renal failure and/or intoxication, excluding catheter/cannula insertion; patient more than 40 kg - $61.16

90967 patient 21-40 kg - $61.16

90968 patient 11-20 kg - $61.16

90969 patient under 10 kg - $61.16

90976 Peritoneal dialysis for chronic renal failure; patient more than 40 kg - $163.02

90977 patient 21-40 kg - $163.02

90978 patient 11-20 kg - $163.02

90979 patient under 10 kg - $163.02

Miscellaneous Dialysis Procedures

90990 Hemodialysis training and/or counseling - BR

90991 Home hemodialysis care, outpatient, for those services either provided by the physician primarily responsible for total hemolysis care or under his direct supervision, and excludes care for complicating illnesses unrelated to hemodialysis - BR

90999 Unlisted dialysis procedure - BR

GASTROENTEROLOGY

91000 Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure) - $24.43

91010 Esophageal motility study; - $105.05

91011 with mecholyl or similar stimulant - BR

91012 with acid perfusion studies - BR

91030 Esophagus, acid perfusion (Bernstein) test for esophagitis - BR

91032 Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux - BR

91052 Gastric analysis test with injection of stimulant of gastric secretion (eg, histamine, insulin, pentagastrin) - BR

91055 Gastric intubation, washings, and preparing slides for cytology (separate procedure) - $23.43

91060 Gastric saline load test - $20.38

91090 Fluorescein-string test for upper gastrointestinal bleeding - $40.77

91100 Intestinal bleeding tube, passage, positioning and monitoring - BR

91299 Unlisted diagnostic gastroenterology procedure - BR

OPHTHALMOLOGY

Ophthalmological Diagnostic and Treatment Services

General Ophthalmological Services - New Patient

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient - $28.29

92004 comprehensive, new patient, one or more visits - $35.37

General Ophthalmological Services - Established Patient

92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient - $19.45

92014 comprehensive, established patient, one or more visits - $23.13

Special Ophthalmological Services

92018 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; initial - $31.12

92019 subsequent - $21.00

92020 Gonioscopy with medical diagnostic evaluation (separate procedure) - $15.15

92060 Sensorimotor examination with medical diagnostic evaluation (separate procedure) - $12.06

92065 Orthoptic and/or pleoptic training, with continuing medical direction and evaluation - $10.81

92070 Fitting of contact lens for treatment of disease, including supply of lens - BR

92081 Visual field examination with medical diagnostic evaluation; tangent screen, Autoplot or equivalent - $15.57

92082 quantitative perimetry, eg, several isopters on Goldmann perimeter, or equivalent - BR

92083 static and kinetic perimetry, or equivalent - BR

92100 Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day - $11.67

92120 Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method - $23.34

92130 Tonography with water provocation - BR

92140 Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography - $15.55

Ophthalmoscopy

92225 Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; initial - $23.34

92226 subsequent - $15.00

92230 Ophthalmoscopy, including medical diagnostic evaluation; with fluorescein angioscopy (observation only) - $38.91

92235 with fluorescein angiography (includes multiframe photography and medical interpretation) - $35.79

92250 with fundus photography - $27.24

92260 with ophthalmodynamometry - $31.13

Other Specialized Services

92265 Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation - BR

92270 Electro-oculography, with medical diagnostic evaluation - $13.07

92275 Electroretinography, with medical diagnostic evaluation - BR

92280 Visually evoked potential (response) study, with medical diagnostic evaluation - BR

92283 Color vision examination, extended, eg, anamaloscope or equivalent - BR

92284 Dark adaptation examination, with medical diagnostic evaluation - BR

92285 External ocular photography for documentation of medical progress - BR

Contact Lens Services

92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia - BR

92311 corneal lens for aphakia, one eye - BR

92312 corneal lens for aphakia, both eyes - BR

92313 corneoscleral lens - BR

92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia - BR

92315 corneal lens for aphakia, one eye - BR

92316 corneal lens for aphakia, both eyes - BR

92317 corneoscleral lens - BR

92325 Modification of contact lens (separate procedure), with medical supervision of adaptation - BR

92326 Replacement of contact lens - BR

Ocular Prosthetics, Artificial Eye

92330 Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation - BR

92335 Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation - BR

92340 Fitting of spectacles, except for aphakia; monofocal - BR

92341 bifocal - BR

92342 miltifocal, other than bifocal - BR

92352 Fitting of spectacle prosthesis for aphakia; monofocal - BR

92353 multifocal - BR

92354 Fitting of spectacle mounted low vision aid; single element system - BR

92355 telescopic or other compound lens system - BR

92358 Prosthesis service for aphakia, temporary (disposable or loan, including materials) - BR

92370 Repair and refitting spectacles; except for aphakia - BR

92371 spectacle prosthesis for aphakia - BR

Supply of Materials

92390 Supply of spectacles, except prosthesis for aphakia and low vision aids - BR

92391 Supply of contact lenses, except prosthesis for aphakia - BR

92392 Supply of low vision aids (A low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction. Conventional spectacle correction includes reading additions up to 4 D.) - BR

92393 Supply of ocular prosthesis (artificial eye) - BR

92395 Supply of permanent prosthesis for aphakia; spectacles - BR

92396 contact lenses - BR

Other Procedures

92499 Unlisted ophthalmological service or procedure - BR

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

92502 Otolaryngologic examination under general anesthesia - BR

92504 Binocular microscopy (separate diagnostic procedure) - $10.12

92506 Medical evaluation speech, language and/or hearing problems - BR

92507 Speech, language or hearing therapy, with continuing medical supervision; individual - BR

92508 group - BR

92511 Nasopharyngoscopy with endoscope (separate procedure) - BR

92512 Nasal function studies, eg, rhinomanometry - BR

92516 Facial nerve function studies - BR

92520 Laryngeal function studies - BR

Vestibular Function Tests, With Observation and Evaluation By Physician, Without Electrical Recording

92531 Spontaneous nystagmus, including gaze - BR

92532 Positional nystagmus - BR

92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) - $23.34

92534 Optokinetic nystagmus - BR

Vestibular Function Tests, With Recording, eg, ENG, PENG, And Medical Diagnostic Evaluation

92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording - BR

92542 Positional nystagmus test, minimum of 4 positions, with recording - BR

92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording - BR

92544 Optokinetic nystagmus test, biderectional, foveal or peripheral stimulation, with recording - BR

92545 Oscillating tracking test, with recording - BR

92546 Torsion swing test, with recording - BR

92547 Use of vertical electrodes in any or all of above tests counts as one additional test - BR

Audiologic Function Tests With Medical Diagnostic Evaluation

Basic Audiometry

92551 Screening test, pure tone, air only $7.78

92552 Pure tone audiometry (threshold); air only - $11.67

92553 air and bone - $15.57

92555 Speech audiometry; threshold only - $23.34

92556 threshold and discrimination - $23.34

92557 Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination) -$23.34

92558 Hearing aid evaluation and selection - BR

92559 Audiometric testing of groups - BR

Pure Tone Audiometry, Extended

92560 Bekesy audiometry; screening - BR

92561 diagnostic - BR

92562 Loudness balance test, alternate binaural or monaural - BR

92563 Tone decay test - $3.65

92564 Short increment sensitivity index (SISI) - BR

92565 Stenger test, pure tone - BR

92566 Impedance testing - $10.97

92567 Tympanometry - BR

92568 Acoustic reflex testing - BR

Speech Audiometry, Extended

92571 Filtered speech test - BR

92572 Staggered spondaic word test - BR

92573 Lombard test - BR

92574 Swinging story test - BR

92575 Sensorineural acuity level test - BR

92576 Synthetic sentence identification test - BR

92577 Stenger test, speech

92578 Delayed auditory feedback test - BR

Special Audiometric Function Tests

92580 Electrodermal audiometry - BR

92581 Evoked response (EEG) audiometry - BR

92582 Conditioning play audiometry - BR

92583 Select picture audiometry - BR

92584 Electrocochleography - BR

Other procedures

92599 Unlisted otorhinolaryngological service or procedure - BR

CARDIOVASCULAR

Therapeutic Services

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest) - BR

92960 Cardioversion, elective, electrical conversion of arrhythmia, external - $77.81

92970 Cardioassist-method of circulatory assist; internal - BR

92971 external - BR

Cardiography

93000 Electrocardiogram, with interpretation and report; routine ECG with at least 12 leads - $23.34

93005 tracing only, without interpretation and report - $15.57

93010 interpretation and report only - $11.67

93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report - $61.16

93017 tracing only, without interpretation and report - $20.38

93018 interpretation and report only - $31.12

93040 Rhythm ECG, one to three leads; with interpretation - $6.53

93041 tracing only without interpretation and report - $3.27

93042 interpretation and report only - $3.27

93045 esophageal lead (includes placement and interpretation) - $24.43

93201 Phonocardiogram with ECG lead; with supervision during recording with interpretation and report (when equipment is supplied by the physician) - $25.44

93202 tracing only, without interpretation and report (when equipment is supplied by the hospital, clinic, etc.) - $10.97

93204 interpretation and report - $7.32

93205 Phonocardiogram with ECG lead, with indirect carotid artery and/or jugular vein tracing, and/or apex cardiogram; with interpretation and report - $46.68

93208 tracing only, without interpretation and report - $14.71

93209 interpretation and report only - $22.41

93210 Phonocardiogram, intracardiac - BR

93220 Vectorcardiogram (VCG), with or without ECG; with interpretation and report - $38.91

93221 tracing only, without interpretation and report - $13.46

93222 interpretation and report only - $18.13

93240 Ballistocardiogram - BR

93255 Apexcardiography - BR

93270 Electrocardiographic monitoring utilizing a system such as magnetic tape, for up through 12 hours; includes recording, scanning analysis, interpretation and report - $99.61

93271 recording only - $22.41

93272 scanning analysis with report - BR

93273 physician review and interpretation, with report - BR

93274 Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis, interpretation and report - $119.83

93275 recording only - $30.58

93276 scanning analysis with report - BR

93277 physician review and interpretation, with report - BR

Echocardiography

(See 76601-76628)

Cardiac Fluoroscopy

93280 Cardiac fluoroscopy - BR

Cardiac Catheterization

93501 Right heart catheterization; only - $272.35

93503 placement of flow directed catheter (e.g., Swan-Ganz), with or without balloon tip, when placed for monitoring purpose, collection of blood, and/or angiography - $81.54

93505 Endocardial biopsy - $142.64

93510 Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous - $155.63

93511 by cutdown - $163.02

93514 by left ventricular puncture - $163.02

93515 by transseptal venous catheterization - $155.63

93524 Combined transseptal and retrograde left heart catheterization - $203.80

93526 Combined right heart catheterization and retrograde left heart catheterization - $285.34

93527 Combined right heart catheterization and transseptal left heart catheterization (with or without retrograde left heart catheterization) - $305.66

93528 Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization) - $305.66

93541 Injection procedure during cardiac catheterization; for pulmonary angiography - $61.16

93542 for selective right ventricular or right atrial angiography - $61.16

93543 for selective left ventricular or left atrial angiography - $81.54

93544 for aortography - $101.86

93545 for selective coronary angiography (injection of radiopaque material may be by hand) - $115.72

93546 Combined left heart catheterization and left ventricular angiography - $183.40

93547 Combined left heart catheterization, selective coronary angiography and selective left ventricular angio-

graphy (this code number is to be used when procedure 93510 is combined with procedures 93543 and 93545) - $285.34

93548 Combined left heart catheterization, selective coronary angiography, selective left ventriculography, and aortic root aortography - $326.04

93549 Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography (this code number is to be used when procedure 93547 is combined with right heart catheterization) - $407.59

93561 Indicator dilution studies such as dye or thermal dilution including arterial and/or venous catheterization; with cardiac output measurement (separate procedure) - $38.91

93562 subsequent measurement of cardiac output - $15.57

Intracardiac Electrophysiological Procedures

93600 Bundle of His recording - BR

93602 Intra-atrial recording - BR

93604 Intraventricular recording - BR

93606 Combined intracardiac recording - BR

93610 Intra-atrial pacing - BR

93612 Intraventricular pacing - BR

93614 Bundle of His pacing - BR

Other Vascular Studies

93700 Peripheral vascular disease studies - BR

93720 Plethysmography; total body - BR

93725 regional - BR

93730 Phleborheography - BR

93740 Temperature gradient studies - BR

93750 Oscillometry - BR

93760 Thermogram; cephalic - BR

93762 peripheral - BR

93770 Determination of venous pressure - $7.78

93780 Circulation time; one test - $7.78

93781 two or more test materials - $15.57

93795 Electronic analysis of internal pacemaker system; to include analysis of pulse, amplitude, duration, configuration of wave form, and testing of sensing function of pacemaker - $28.48

93796 telephonic analysis of rate - $8.17

Other Procedures

93799 Unlisted cardiovascular service or procedure - BR

PULMONARY

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation - $23.34

94060 Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise - $38.50

94070 Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010 - BR

94150 Vital capacity, total (separate procedure) - $4.66

94160 Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate - $7.78

94200 Maximum breathing capacity, maximal voluntary ventilation -$15.55

94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method (specify) - $19.45

94250 Expired gas collection, quantitative, single procedure (separate procedure) - $4.05

94260 Thoracic gas volume - $12.22

94350 Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time - $8.17

94360 Determination of resistance to airflow, oscillatory or plethysmographic methods - BR

94370 Determination of airway closing volume, single breath tests - BR

94375 Respiratory flow volume loop - BR

94400 Breathing response to CO_2 (CO_2 response curve) - BR

94450 Breathing response to hypoxia (hypoxia response curve) - $6.23

94620 Pulmonary stress testing, simple or complex - BR

94650 Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation - BR

94651 subsequent - BR

94652 newborn infants - BR

94656 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day - BR

94657 subsequent days - BR

94660 Continuous positive airway pressure ventilation (CPAP), initiation and management - BR

94662 Continuous negative pressure ventilation (CNP), initiation and management - BR

94664 Aerosol or vapor inhalations for sputum mobilization or bronchodialation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation - BR

94665 subsequent - BR

94667 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation - BR

94668 subsequent - BR

94680 Oxygen uptake, expired gas analysis; rest and exercise, direct, simple - $38.91

94681 including CO_2 output, percentage oxygen extracted - $77.81

94690 rest, indirect (separate procedure) - $12.45

94700 Analysis of arterial blood gas (oxygen saturation, pO_2, pCO_2, CO_2, pH); rest only - $54.46

94705 rest and exercise (including cannulization of artery) - $101.16

94710 three or more (O_2 administration, IPPB, exercise) - $171.19

94715 Hemoglobin-oxygen affinity (pO_2 for 50% hemoglobin saturation with oxygen) - BR

94720 Carbon monoxide diffusing capacity, any method - $24.43

94725 Membrane diffusion capacity - BR

94750 Pulmonary compliance study, any method - $12.30

94770 Carbon dioxide, expired gas determination by infrared analyzer - $4.05

94799 Unlisted pulmonary service or procedure - BR

ALLERGY AND CLINICAL IMMUNOLOGY

Special Diagnostic Procedures

Allergy Testing

95000 Percutaneous tests (scratch, puncture, prick) with allergic extracts; up to 30 tests - $7.78

95001 31-60 tests $0.78

95002 61-90 tests - BR

95003 more than 90 tests - BR

95005 Percutaneous tests (scratch, puncture, prick) with antibiotics, biologicals, stinging insects; 1-5 tests - BR

95006 6-10 tests - BR

95007 11-15 tests - BR

95011 more than 15 tests - BR

95014 Intracutaneous (intradermal) tests, with antibiotics, biologicals, stinging insects, immediate reaction 15-20 minutes; 1-5 tests - BR

95016 6-10 tests - BR

95017 11-15 tests - BR

95018 more than 15 tests - BR

95020 Intracutaneous (intradermal) tests with allergenic extracts, immediate reaction -- 15 to 20 minutes; up to 10 tests - $11.67

95021 11-20 tests - $1.17

95022 21-30 tests - BR

95023 more than 30 tests BR

95030 Intracutaneous (intradermal) tests with allergenic extracts, delayed reaction -- 24 to 72 hours, including reading; 2 tests - BR

95031 3-4 tests - BR

95032 5-6 tests - BR

95033 7-8 tests - BR

95034 more than 8 tests - BR

95040 Patch or application tests; up to 10 tests - $7.78

95041 11-20 tests - $1.55

95042 21-30 tests - BR

95043 more than 30 tests - BR

95050 Photo patch tests; up to 10 tests - $7.78

95051 more than 10 tests - $3.11

95056 Photo tests - $7.78

95060 Ophthalmic mucous membrane tests - $7.78

95065 Direct nasal mucous membrane test - BR

95070 Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similiar compounds - BR

95071 with antigens, specify - BR

95080 Passive transfer tests; up to 10 tests - $77.81

95081 11-20 tests - $1.55

95082 more than 20 tests BR

95105 Medical conference services (eg, use of mechanical and electronic devices, climatotherapy, breathing exercises and/or postural drainage) - BR

95120 Immunotherapy, in prescribing physician's office or institution, allergenic extract; single antigen - BR

95125 multiple antigens - BR

95130 stinging insect antigens, single dose vials - BR

95135 Professional services performed in the supervision and provision of antigens for immunotherapy in other than the providing physician's office or institution; single antigen, single dose vial - BR

95140 multiple antigens, single dose vials - BR

95145 stinging insect antigens, single dose vials - BR

95150 Professional services performed in the supervision and provision of antigens for immunotherapy in other than the providing physician's office or institution; single antigen, single dose vial - BR

95155 multiple antigens, multiple dose vials - BR

95160 stinging insect antigens, multiple dose vials - BR

95180 Rapid desensitization procedure, each hour (eg, insulin, penicillin, horse serum) - BR

95199 Unlisted allergy/clinical immunologic service or procedure - BR

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

95819 Electroencephalogram (EEG); standard or portable, same facility - $54.47

95821 portable, to an alternate facility - $61.16

95822 sleep - $61.16

95823 physical or pharmacological activation - $61.16

95824 cerebral death evaluation recording - BR

95826 intracerebral (depth) EEG - BR

95827 all night sleep recording - BR

95828 Polysomnography (recording, analysis and interpretation of the multiple simultaneous physiological measurements of sleep) - BR

95829 Electrocorticogram at surgery (separate procedure) - BR

95831 Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report - $12.45

95832 hand (with or without comparison with normal side) - BR

95833 total evaluation of body, excluding hands - BR

95834 total evaluation of body, including hands - $49.80

95842 Muscle testing, electrical: reaction of degeneration, chronaxy, galvanic/tetanus ratio, one or more extremities, one or more methods - BR

95845 Strength duration curve, each nerve - $18.68

95851 Range of motion measurements and report (separate procedure); each extremity, excluding hand - $12.45

95852 hand, with or without comparison with normal side - BR

95857 Tensilon test for myasthenia gravis; - $20.38

95858 with electromyographic recording - BR

95860 Electromyography; one extremity and related paraspinal areas - $62.25

95861 two extremities and related paraspinal areas - $93.37

95863 three extremities and related paraspinal areas - BR

95864 four extremities and related paraspinal areas - $155.63

95867 Electromyography, cranial nerve supplied muscles; unilateral - BR

95868 bilateral - BR

95869 Electromyography, limited study of specific muscles (eg, external anal sphincter, thoracic spinal muscles) - BR

95875 Ischemic forearm exercise test - BR

95880 Assessment of higher cerebral function with medical interpretation; aphasia testing - BR

95881 developmental testing - BR

95882 cognitive testing and others - BR

95900 Nerve conduction, velocity and/or latency study; motor, each nerve - $24.89

95904 sensory, each nerve - $24.89

95925 Somatosensory testing (eg, cerebral evoked potentials), one or more nerves - BR

95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing - BR

95935 "H" reflex, by electrodiagnostic testing - BR

95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method - BR

95999 Unlisted neurological or neuromuscular diagnostic procedure - BR

SPECIAL DERMATOLOGICAL PROCEDURES

96900 Actinotherapy (ultraviolet light) - $1.55

96999 Unlisted special dermatological service or procedure - BR

PHYSICAL MEDICINE

Modalities

97000 Office visit with one of the following modalities to one area: - $9.34

a. Hot or cold packs
b. Traction, mechanical
c. Electrical stimulation (unattended)
d. Vasopneumatic devices
e. Paraffin bath
f. Microwave
g. Whirlpool
h. Diathermy
i. Infrared
j. Ultraviolet

97050 Office visit with two or more modalities to same area - $10.11

Procedures

97100 Office visit with one of the following procedures to one area: - $12.45

a. Therapeutic exercises
b. Neuromuscular reeducation
c. Functional activities
d. Gait training

e. Electrical stimulation (manual)
f. Iontophoresis
g. Traction, manual
h. Massage
i. Contrast baths
j. Ultrasound;

initial 30 minutes

97101 each additional 15 minutes - $3.89

97200 Office visit, including combination of any modality(s) and procedure(s); initial 30 minutes - $12.45

97201 each additional 15 minutes - $3.89

97220 Hubbard tank; initial 30 minutes - $18.58

97221 each additional 15 minutes, up to one hour - $3.89

97240 Pool therapy or Hubbard tank with therapeutic exercises; initial 30 mintues - $23.34

97241 each additional 15 minutes; up to one hour - $4.66

97260 Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area - $12.45

97261 each additional area - $6.22

97500 Orthotics training (dynamic bracing, splinting), upper extremities; initial 30 minutes - $18.68

97501 each additional 15 minutes - $9.34

97520 Prosthetic training; initial 30 minutes - $18.68

97521 each additional 15 minutes - $9.34

97540 Activities of daily living (ADL) and diversional activities; initial 30 mintues - $18.67

97541 each additional 15 minutes - $9.34

Tests and Measurements

97700 Office visit, including one of the following tests or measurements, with report - $18.68

a. Orthotic "check-out"
b. Prosthetic "check-out"
c. Activities of daily living "check-out";

initial 30 minutes

97701 each additional 15 minutes - $9.34

97720 Extremity testing for strength, dexterity, or stamina; initial 30 minutes - $18.68

97721 each additional 15 minutes - $9.34

97740 Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes - $18.67

97741 each additional 15 minutes - $9.34

Other Procedures

97799 Unlisted physical medicine service or procedure - BR

SPECIAL SERVICES AND REPORTS

Administrative Services

99000 Collection, handling, and/or conveyance of specimen for transfer from the physician's office to a laboratory - $4.66

99001 Collection, handling, and/or conveyance of specimen for transfer from the patient's home to a laboratory (distance may be indicated) - $9.33

99002 Collection, handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician. - BR

99012 Telephone calls, phone consultations or repeated or lengthy phone calls may need to be separately identified - BR

99025 Initial (new patient) visit when asterisk (*) surgical procedure constitutes major service at that visit - BR

99050 Services requested after office hours in addition to basic service - BR

99052 Services requested between 10:00 pm and 8:00 am in addition to basic service - BR

99054 Services requested on Sundays and holidays in addition to basic service - BR

99056 Services provided at request of patient in a location other than physician's office which are normally provided in the office - BR

99062 Emergency care facility services: when the nonhospital-based physician is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services - BR

99064 Emergency care facility services: when the non-hospital-based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours - BR

99065 during regular office hours - BR

99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided) - BR

99071 Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician - BR

99075 Medical testimony - BR

99078 Physician educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions) - BR

99080 Special reports as insurance forms, or the review of medical data to clarify a patient's status -- more than the information conveyed in the usual medical communications or standard reporting form - BR

99082 Usual travel (eg, transportation and escort of patient) - BR

99090 Analysis of information data stored in computers (eg, ECGs, blood pressures, hematologic data) - BR

Prolonged Services

99150 Prolonged physician attendance requiring physician detention beyond usual service (eg, operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour - $38.91

99151 more than one hour - BR

99155 Medical conference by physician regarding medical management with patient, and/or relative, guardian or other (may include counseling by a physician); approximately 25 minutes - BR

99156 approximately 50 minutes - BR

Critical Care

99160 Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour - BR

99162 additional 30 minutes - BR

99165 Monitoring respiration - BR

99166 Monitoring temperature - BR

Other Services

99170 Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons) - BR

99175 Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison - BR

99180 Hyperbaric oxygen pressurization; initial - BR

99182 subsequent - BR

99185 Hypothermia; regional - BR

99186 total body - BR

99190 Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour - BR

99191 3/4 hour - BR

99192 1/2 hour - BR

99195 Phlebotomy, therapeutic (separate procedure) - BR

99199 Unlisted special service or report - BR

ANESTHESIA

Qualifying Circumstances for Anesthesia

99100 Anesthesia for patient under one year or over 70 years - BR

99105 Anesthesia risk as when patient has incapacitating systemic disease that is constant threat to life - BR

99110 Anesthesia complicated by prone position and/or intubation to avoid surgical field - BR

99115 Anesthesia complicated by total body hypothermia; above 30°C - BR

99120 below 30°C - BR

99125 Anesthesia complicated by extracorporeal circulation, eg, heart pump oxygenator bypass or pump assist, with or without hypothermia - BR

99130 Anesthesia complicated by hyperbaric or compression chamber pressurization - BR

99135 Anesthesia employed in controlled hypotension - BR

SURGERY PROCEDURES

INTEGUMENTARY SYSTEM

Skin, Subcutaneous and Areolar Tissues

Incision

10000 Incision and drainage of infected or noninfected sebaceous cyst; one lesion - $11.92

10001 second lesion - $5.46

10002 more than two lesions - $2.98

10003 Incision and drainage of infected or noninfected epithelial inclusion cyst ("sebaceous cyst") with complete removal of sac and treatment of cavity - BR

10020 Incision and drainage of furuncle - $11.94

10040 Acne surgery (eg, marsupialization, opening, or removal of multiple milia, comedones, cysts, pustules) - $8.95

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple - $11.94

10061 complicated - BR

10080 Incision and drainage of pilonidal cyst; simple - BR

10081 complicated - BR

10100 Incision and drainage of onychia or paronychia; single or simple - BR

10101 multiple or complicated - BR

10120 Incision and removal of foreign body, subcutaneous tissues; simple - $11.94

10121 complicated - BR

10140 Incision and drainage of hemotoma; simple - $11.94

10141 complicated - BR

10160 Puncture aspiration of abscess, hematoma, bulla, or cyst - $8.95

Excision -- Debridement

11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface - BR

11001 each additional 10% of the body surface - BR

11040 Debridement of abrasions - BR

Paring or Curettement

11050 Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion - BR

11051 two to four lesions - BR

11052 more than four lesions - BR

Excision and Simple Closure

(Not reconstructive surgery)

Biopsy

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); one lesion - $17.90

11101 each additional lesion - BR

Excision -- Benign Lesions

Excision (including simple closure) of benign lesions of skin or subcutaneous tissues (eg, cicatrical, fibrous, inflammatory, congenital, cystic lesions), including local anesthesia. See appropriate size and area below.

11200 Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 - $11.92

11201 each additional ten lesions - $5.96

11400 Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 cm - $17.90

11401 lesion diameter 0.5 to 1.0 cm - $23.86

11402 lesion diameter 1.0 to 2.0 cm - $29.82

11403 lesion diameter 2.0 to 3.0 cm - BR

11404 lesion diameter 3.0 to 4.0 cm - BR

11406 lesion diameter over 4.0 cm - BR

11420 Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 cm - $23.86

11421 lesion diameter 0.5 to 1.0 cm - $29.82

11422 lesion diameter 1.0 to 2.0 cm - $35.80

11423 lesion diameter 2.0 to 3.0 cm - BR

11424 lesion diameter 3.0 to 4.0 cm - BR

11426 lesion diameter over 4.0 cm - BR

11440 Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 cm - $29.82

11441 lesion diameter 0.5 to 1.0 cm - $35.79

11442 lesion diameter 1.0 to 2.0 cm - $41.76

11443 lesion diameter 2.0 to 3.0 cm - BR

11444 lesion diameter 3.0 to 4.0 cm - BR

11446 lesion diameter over 4.0 cm - BR

Excision -- Malignant Lesions

11600 Excision, malignant lesion, trunk, arms, or legs; lesion diameter up to 0.5 cm - $35.79

11601 lesion diameter 0.5 to 1.0 cm - $47.73

11602 lesion diameter 1.0 to 2.0 cm - $59.65

11603 lesion diameter 2.0 to 3.0 cm - BR

11604 lesion diameter 3.0 to 4.0 cm BR

11606 lesion diameter over 4.0 cm - BR

11620 Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 cm - $35.79

11621 lesion diameter 0.5 to 1.0 cm - $47.73

11622 lesion diameter 1.0 to 2.0 cm - $59.65

11623 lesion diameter 2.0 to 3.0 cm - BR

11624 lesion diameter 3.0 to 4.0 cm - BR

11626 lesion diameter over 4.0 cm - BR

11640 Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter up to 0.5 cm - $35.79

11641 lesion diameter 0.5 to 1.0 cm $47.73

11642 lesion diameter 1.0 to 2.0 cm - $59.65

11643 lesion diameter 2.0 to 3.0 cm - BR

11644 lesion diameter 3.0 to 4.0 cm - BR

11646 lesion diameter over 4.0 cm - BR

Nails

11700 Debridement of nails, manual; five or less - $8.95

11701 each additional, five or less - $4.48

11710 Debridement of nails, electric grinder; five or less - $11.92

11711 each additional, five or less - $5.96

11730 Avulsion of nail plate, partial or complete, simple; single - $11.94

11731 second nail plate - $5.96

11732 each additional nail plate - $2.98

11740 Evacuation of subungual hematoma - BR

11750 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal - $59.65

11760 Reconstruction of nail bed; simple - BR

11762 complicated - BR

Miscellaneous

11770 Excision of pilonidal cyst or sinus; simple - $59.65

11771 extensive - $208.80

11772 complicated - BR

Introduction

11900 Injection, intralesional; up to and including seven lesions -$11.94

11901 more then seven lesions - $21.47

11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; up to 6.0 sq cm - BR

11921 6.0 to 20.0 sq cm - BR

11922 each additional 20.0 sq cm - BR

11950 Subcutaneous injection of "filling" material (eg, silicone); up to 1 cc - BR

11951 1 to 5 cc - BR

11952 5 to 10 cc - BR

11953 over 10 cc - BR

Repair -- Simple

(Sum of lengths of repairs)

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); up to 2.5 cm - $11.94

12002 2.5 cm to 7.5 cm - $23.86

12004 7.5 cm to 12.5 cm - $29.83

12005 12.5 cm to 20.0 cm - BR

12006 20.0 cm to 30.0 cm - BR

12007 over 30.0 cm - BR

12011 Simple repair of superficial wounds to face, ears, eyelids, nose, lips and/or mucous membranes; up to 2.5 cm - $17.90

12013 2.5 cm to 5.0 cm - $29.84

12014 5.0 cm to 7.5 cm - BR

12015 7.5 cm to 12.5 cm - BR

10216 12.5 cm to 20.0 cm - BR

10217 20.0 cm to 30.0 cm - BR

12018 over 30.0 cm - BR

Repair -- Intermediate

12031 Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); up to 2.5 cm - $20.88

12032 2.5 cm to 7.5 cm - BR

12034 7.5 cm to 12.5 cm - BR

10235 12.5 cm to 20.0 cm - BR

12036 20.0 cm to 30.0 cm - BR

12037 over 30.0 cm - BR

12041 Layer closure of wounds of neck, hands, feet and/or external genitalia; up to 2.5 cm - BR

12042 2.5 cm to 7.5 cm - BR

12044 7.5 cm to 12.5 cm - BR

12045 12.5 cm to 20.0 cm - BR

12046 20.0 cm to 30.0 cm - BR

12047 over 30.0 cm - BR

12051 Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; up to 2.5 cm - $35.79

12052 2.5 cm to 5.0 cm - BR

12053 5.0 cm to 7.5 cm - BR

12054 7.5 cm to 12.5 cm - BR

12055 12.5 cm to 20.0 cm - BR

12056 20.0 cm to 30,0 cm - BR

12057 over 30.0 cm - BR

Repair -- Complex

13100 Repair, complex, trunk; 1.0 cm to 2.5 cm - $35.79

13101 2.5 cm to 7.5 cm - BR

13120 Repair, complex, scalp, arms, and/or legs; 1.0 cm to 2.5 cm - $53.69

13121 2.5 cm to 7.5 cm - BR

13131 Repair, complex, forehead, cheeks, chin, mouth, neck, asillae, genitalia, hands and/or feet; 1.0 cm to 2.5 cm - BR

13132 2.5 cm to 7.5 cm - BR

13150 Repair, complex, eyelids, nose, ears and/or lips; up to 1.0 cm - $178.97

13151 1.0 cm to 2.5 cm - BR

13152 2.5 cm to 7.5 cm - BR

13300 Repair, unusual, complicated, over 7.5 cm, any area - BR

Adjacent Tissue Transfer or Rearrangement

14000 Adjacent tissue transfer or rearrangement, trunk; defect up to 10 sq cm - BR

14001 defect 10 sq cm to 30 sq cm - $178.97

14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect up to 10 sq cm - $178.97

14021 defect 10 sq cm to 30 sq cm - $238.63

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect up to 10 sq cm - $238.63

14041 defect 10 sq cm to 30 sq cm - $298.29

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect up to 10 sq cm - $298.29

14061 defect 10 sq cm to 30 sq cm - $417.60

14300 Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area - BR

14350 Filleted finger or toe flap, including preparation of recipient site - BR

Free Skin Grafts

15000 Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft) - BR

15050 Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter - $35.79

15100 Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); up to 100 sq cm, or each one percent of body area of infants and children (except 15050) - $178.97

15101 each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof - $35.79

15120 Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; up to 100 sq cm, or each one percent of body area of infants and children (except 15050) - $328.11

15121 each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof - $35.79

15200 Full thickness graft, free, including direct closure of donor site, trunk; up to 20 sq cm - $119.29

15201 each additional 20 sq cm - $59.65

15220 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; up t0 20 sq cm - $178.97

15221 each additional 20 sq cm - $89.47

15240 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; up to 20 sq cm - $238.64

15241 each additional 20 sq cm - $119.29

15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; up to 20 sq cm - $298.29

15261 each additional 20 sq cm - $149.15

15350 Homograft, skin - BR

15400 Hetergraft, skin - BR

15410 Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; up to 100 sq cm - BR

15412 between 101 and 160 sq cm - BR

15414 between 161 and 230 sq cm - BR

15416 over 230 sq cm - BR

Pedicle Flaps (Skin and Deep Tissues)

15500 Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk - $208.80

15505 on scalp, arms, or legs - $208.80

15510 on forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet - $208.80

15515 on eyelids, nose, ears, or lips - $208.80

15540 Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to trunk - $268.46

15545 to scalp, arms, or legs - $268.46

15550 to forehead, cheeks, chin, mouth, neck, axillae, genitalia, or hands (except 15580), feet - $268.46

15555 to eyelids, nose, ears, or lips - $268.46

15580 cross finder pedicle flap, including free graft to donor site - BR

15600 Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at trunk - $119.29

15610 at scalp, arms, or legs - $149.15

15620 at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet - $176.97

15625 section pedicle of cross finger flap - BR

15630 at eyelids, nose, ears, or lips - $178.97

15650 Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, "Walking" tube), any location - BR

15700 Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; trunk - $208.80

15710 scalp, arms, or legs - $328.12

15720 forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet - $477.26

15730 eyelids, nose, ears, or lips - $477.26

Other Grafts

15740 Graft; island pedicle flap - $298.89

15750 neurovascular pedicle flap - $298.89

15760 composite (full thickness of external ear or nasal ala), including primary closure, donor area - $298.89

15770 derma-fat-fascia - $357.94

15775 Punch graft for hair transplant; 1 to 15 punch grafts - $14.91

15776 more than 15 punch grafts - BR

Miscellaneous Procedures

15780 Abrasion of skin for removal of scars, tattoos, actinic changes (keratoses), primary or secondary; total face - $357.94

15785 regional (1/4 face, cheeks, chin, forehead, or elsewhere) - $119.29

15786 Abrasion; single lesion (eg, keratosis, scar) - BR

15787 each additional four lesions or less - BR

15790 Superficial chemosurgery (acid peel); total face and neck - BR

15791 regional, face, neck, or elsewhere - BR

15800 Abrasion of skin, total face, combined with superficial chemosurgery (acid peel) of remaining face (eyelids, neck, shoulders) - $477.26

15810 Salabrasion; up to 20 sq cm - BR

15811 20 sq cm and over - BR

15820 Blepharoplasty, lower eyelids; - $357.94

15821 with extensive herniated fat pads - BR

15822 Rhytidectomy, upper eyelids; - $238.63

15823 with excessive skin weighting down lids - BR

15824 Rhytidectomy; forehead - $298.29

15826 glabellar frown - $238.63

15827 submetal fat pad - BR

15828 cheeks, chin, neck - $894.87

15831 Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen - BR

15832 thighs - BR

15833 legs - BR

15834 hips - BR

15835 buttocks - BR

15836 arms - BR

15837 forearms - BR

15840 Graft for facil nerve paralysis; free fascia graft (including obtaining fascia) - $894.86

15841 free muscle graft (including obtaining graft) - BR

15842 free muscle graft by microsurgical technique - BR

15845 reanimation, muscle transfers - BR

Decubitus Ulcers (Pressure Sores)

15920 Coccygectomy; primary suture - BR

15922 with flap closure - BR

15930 Excision, sacral decubitus ulcer; with skin flap closure - BR

15932 with ostectomy - BR

15933 with ostectomy and primary suture - BR

15940 Excision, ischial decubitus ulcer; direct suture - BR

15941 with ostectomy (ischiectomy) - BR

15942 skin and muscle flap closure - BR

15943 skin and muscle flap closure, with ostectomy - BR

15950 Excision, trochanteric decubitus ulcer; direct suture - BR

15951 with ostectomy - BR

15952 skin flap closure - BR

15953 skin flap closure, with ostectomy - BR

Burns, Local Treatment

16000 Initial treatment, first degree burn, when no more than local treatment is required - $8.95

16010 Dressings and/or debridement, initial or subsequent; under anesthesia, small - $23.86

16015 under anesthesia, medium or large, or with major debridement - $59.65

16020 without anesthesia, office or hospital, small - $10.12

16025 without anesthesia, medium (eg, whole face or whole extremity) - $17.88

16030 without anesthesia, large (eg, more than one extremity) - $23.86

16035 Escharotomy - BR

Destruction

17000 Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion - $23.86

17001 second and third lesions, each - $8.94

17002 over three lesions, each additional lesion - $4.48

17010 complicated lesion(s) - BR

17100 Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion - $11.94

17101 second lesion - $5.96

17102 over two lesions, each additional lesion up to 15 lesions -$2.98

17104 15 or more lesions - BR

17015 complicated lesions - BR

17110 Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions - $11.94

17200 Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions - $11.94

17201 each additional ten lesions - $5.96

17300 Chemosurgery (Mohs type technique), malignancies of skin, including removal of lesion and microscopic delineation of margins and base; first stage -- fulguration and application of chemicals -$149.15

17301 subsequent treatment, up to five microscopic sections - $47.73

17302 subsequent treatment, over five additional microscopic sections - $5.96 (per section)

17340 Cryotherapy (CO2 slush, liquid N2) - $8.95

17360 Chemical exfoliation for acne (eg, acne paste, acid) - $8.95

17380 Electrolysis epilation, each 1/2 hour - $17.90

17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue - BR

Breast

Incision

19000 Puncture aspiration of cyst; - $11.94

19001 each additional cyst - BR

19020 Mastotomy with exploration or drainage of abscess, deep - $77.55

Excision

19100 Biopsy of breast; needle (separate procedure) - $17.90

19101 incisional - $107.36

19120 Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140 -19161), male or female, one or more lesions; unilateral - $149.14

19121 bilateral - $178,97

19140 Mastectomy for gynecomastia through circumareolar or other incision; unilateral - $238.63

19141 bilateral - $298.29

19160 Mastectomy, partial (quadrectomy or more); unilateral - $178.97

19161 bilateral - $238.63

19180 Mastectomy, simple, complete; unilateral - $238.63

19181 bilateral - BR

19182 Mastectomy, subcutaneous; unilateral - BR

19183 bilateral - BR

19184 Mastectomy, subcutaneous, with immediate prosthetic implant; unilateral - $417.60

19185 bilateral - BR

19186 Mastectomy, subcutlaneous, with delayed prosthetic implant; unilateral - $3,579.40

19187 bilateral - $477.26

19200 Mastectomy, radical, including breast, pectoral muscles, axillary lymph nodes; unilateral - $536.92

19205 bilateral - BR

19210 including internal mammary lynph nodes (Urban type operation - $775.55

19240 Mastectomy, modified radical, with modified axillary dissection but leaving pectoral muscles; unilateral - $77.26

19245 bilateral - BR

19260 Excision of chest wall tumor including ribs - BR

19271 Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy - BR

19272 with mediastinal lymphadenectomy - BR

Repair

19300 Mammoplasty, reduction or repositioning; one stage operation, unilateral - $1,193.15

19301 one stage operation, bilateral - BR

19303 two stage operation, unilateral - BR

19304 two stage operation, bilateral - BR

19310 Mammoplasty, augmentation, prosthetic (not including implants); unilateral - $536.92

19311 bilateral - $894.80

19330 Removal of mammary implant material; unilateral - BR

19331 bilateral - BR

19350 Reconstruction of nipple and/or areola, including labial or other grafts; unilateral - BR

19351 bilateral - BR

19499 Unlisted procedure, breast - BR

MUSCULOSKELETAL SYSTEM

General

Incision

20000 Incision of soft tissue abscess, secondary to osteomyelitis; superficial - $11.94

20005 deep or complicated - BR

20010 with suction irrigation - $17.90

Excision

20200 Biopsy, muscle; superficial - $35.79

20205 deep - $71.57

20220 Biopsy, bone, trocar or needle; superficial (eg, ilium, sternum, spionous process, ribs) - $35.79

20225 deep (vertebral body, femur) - $119.29

20240 Biopsy, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur) - $89.47

20245 deep (el, humerus, ishium, femur) - $149.15

20250 Biopsy, vertebral body, open; thoracic - BR

20251 lumbar or cervical - BR

Introduction or Removal

20500 Injection of sinus tract; therapeutic (separate procedure) - $11.94

20501 diagnostic (sinogram) (separate procedure) - BR

20520 Removal of foreign body in muscle; simple - $35.79

20525 deep or complicated - BR

20550 Injection, tendon sheath, ligament or trigger points - $11.92

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes) - $8.94

20605 intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) - $11.90

20610 major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) - $17.90

20650 Insertion of wire or pin for skeletal traction, including removal (separate procedure) - $35.79

20660 Application of tongs or caliper, including removal (separate procedure) - $89.47

20661 Application of halo; cranial - BR

20662 pelvic - BR

20663 femoral - BR

20665 Removal of tongs or halo applied by another physician - $8.94

20670 Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure) - $17.90

20680 deep, (eg, buried wire, pin, screw, metal band, nail, rod or plate) - $107.38

Reimplantation

20802 Reimplantation, arm; complete - BR

20804 incomplete (nonviable extremity with soft tissue pedicle) - BR

20808 Reimplantation, hand; complete - BR

20812 incomplete (nonviable extremity with soft tissue pedicle) - BR

20816 Reimplantation, digit; complete - BR

20820 incomplete (nonviable extremity with soft tissue pedicle) - BR

Grafts (or Implants)

20900 Bone graft, any donor area; minor or small (eg, dowel or button) - $71.57

20902 major or large - $143.18

20910 Cartilage graft, costochondral - $143.18

20920 Fascia lata graft; by stripper - $59.65

20922 by incision and area exposure, complex or sheet - $119.29

20924 Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris) - BR

20926 Tissue grafts, other (eg, paratenon, fat, dermis, etc) - BR

Miscellaneous

20999 Unlisted procedure, musculoskeletal system, general - BR

Head

Incision

21010 Arthrotomy, temporomandibular joint; unilateral - BR

21011 bilateral - BR

Excision

21020 Craniectomy or sequestrectomy for osteomyelitis - BR

21030 Excision of benign tumor or cyst of facial bone other than mandible - BR

21034 Excision of malignant tumor of facial bone other than mandible - BR

21040 Excision of benign cyst or tumor of mandible; simple - $149.15

21041 complex - BR

21044 Excision of malignant tumor of mandible; - BR

21045 radical resection - BR

21050 Arthrectomy, temporomandibular joint; unilateral - $536.92

21051 bilateral - BR

21060 Meniscectomy, temporomandibular joint; unilateral - $536.92

21061 bilateral - BR

21070 Coronoidectomy (separate procedure); unilateral - BR

21071 bilateral - BR

Introduction Or Removal

21100 Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure) - $59.65

21110 Application of interdental fixation device for conditions other than fracture or dislocation - BR

Repair, Revision, Or Reconstruction

21200 Osteoplasty for prognathism, micrognathism, or apertognathism; mandible, total - $233.22

21202 mandible, segmental - BR

21204 maxilla, total - BR

21206 maxilla, segmental - BR

21210 Graft, bone; nasal, maxillary and malar areas (includes obtaining graft) - $596.57

21215 mandible (includes obtaining graft) - $596.57

21230 Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft) - $539.92

21235 ear cartilage to nose or ear (includes obtaining graft) - $35.79

21239 Implant, chin, homologous, heterologous, or alloplastic - BR

21240 Arthroplasty, temporomandibular joint; unilateral - BR

21241 bilateral - BR

21250 Osteoplasty of maxilla and/or other facial bones for midface hypoplasia or retrusion (LeFort type operation); without bone graft - BR

21254 with bone graft - BR

21260 Orbital hypertelorism correction (periorbital) osteotomies, bilateral, with bone grafts, extracranial approach - BR

21261 combined intra- and extracranial approach - BR

21263 with forehead advancement - BR

21267 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach - BR

21268 combined intra- and extracranial approach - BR

21270 Reconstruction for Treacher Collins syndrome (periorbital and zygomatic reconstruction with multiple bone grafts) - BR

21275 Secondary revision for orbitocraniofacial reconstruction - BR

Fracture and/or Dislocation

21300 Treatment of closed skull fracture without operation - BR

21310 Treatment of closed or open nasal fracture without manipulation - BR

21315 Manipulation, digital, uncomplicated nasal fracture - $32.81

21320 Manipulation, instrumental, complicated nasal fracture - $89.50

21325 Open treatment of nasal fracture; uncomplicated - $119.29

21330 complicated, with internal and/or external skeletal fixation - $283.37

21335 with concomitant open treatment of fractured septum - $507.09

21340 Treatment of closed or open nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus - BR

21345 Treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint - BR

21346 Open treatment of nasomaxillary complex fracture (Lefort II type); with wiring and/or local fixation - BR

21347 with multiple approaches - BR

21350 Treatment of closed or open fracture of malar area, including zygomatic arch and malar tripod without manipulation - BR

21355 Manipulative treatment of closed or open fracture of malar area, including zygomatic arch and malar tripod, towel clip technique - $35.79

21360 Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod - $208.80

21365 Open treatment of closed or open complicated (eg, multiple fractures), of malar area, including zygomatic arch and malar tripod, with internal skeletal fixation and multiple surgical approaches - $387.77

21380 Treatment of orbital floor "blowout" fracture without manipulation - BR

21385 Open treatment of orbital floor "blowout" fracture; transantral approach (Caldwell-Luc type operation) - $357.94

21386 periorbital approach - BR

21387 combined approach - BR

21390 periorbital approach, with alloplastic or other implant - $307.00

21395 periorbital approach with bone graft (includes obtaining graft) - $536.92

21400 Treatment of fracture of orbit, except "blowout"; without manipulation - BR

21401 with manipulation - BR

21406 Open treatment of fracture of orbit, except "blowout"; without implant - BR

21407 with implant - BR

21420 Treatment of closed or open maxillary fracture without manipulation - BR

21421 Treatment of palatal or alveolar ridge fractures (Lefort I type); closed manipulation with interdental wire fixation or fixation of denture or splint - $208.80

21422 open treatment - $357.94

21431 Treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint - BR

21432 Open treatment of craniofacial separation (LeFort III type); with wiring and/or local fixation - BR

21433 complicated (eg, multiple approaches) - BR

21435 complicated, fixation by head cap, halo device, multiple surgical approaches, internal fixation, and/or wiring teeth - BR

21440 Manipulative treatment of alveolar ridge fracture (separate procedure) - BR

21445 Open treatment of alveolar ridge fracture (separate procedure) - BR

21450 Treatment of closed or open mandibular fracture without manipulation - BR

21455 Closed manipulative treatment by interdental fixation of closed or open mandibular fracture - $238.62

21461 Open treatment of closed or open mandibular fracture; without interdental fixation - BR

21462 with interdental fixation - BR

21470 Open reduction of complicated closed or open mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints - BR

21480 Uncomplicated treatment of temporomandibular dislocation, initial or subsequent - BR

21485 Complicated manipulative treatment of temporomandibular dislocation, initial or subsequent - BR

21490 Open treatment of temporomandibular dislocation - BR

21493 Treatment of closed or open hyoid fracture; without manipulation - BR

21494 with manipulation - BR

21495 Open treatment of closed or open hyoid fracture - BR

21497 Interdental wiring, for condition other than fracture - BR

21499 Unlisted procedure, head - BR

Neck (Soft Tissues) and Thorax

Incision

21501 Incision and drainage, deep abscess or hemotoma; - BR

21502 with partial rib ostectomy - BR

21510 Incision, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

21511 with suction irrigation - BR

Excision

21550 Excisional biopsy, soft tissues - BR

21555 Excision benign tumor; subcutaneous - BR

21556 deep, subfascial, intramuscular - BR

21600 Excision of rib, partial - $178.97

21610 Costotransversectomy (separate procedure) - BR

21615 Excision first and/or cervical rib for outlet compression syndrome or other cause; - BR

21616 with sympathectomy - BR

21620 Ostectomy of sternum, partial - BR

21630 Radical resection of sternum for tumor; - BR

21632 with mediastinal lymphadenectomy - BR

21700 Division of scalenus anticus; without resection of cervical rib - $298.29

21705 with resection of cervical rib - $357.94

21720 Division of sternocleidomastoid for torticollis, open operation; without cast application - $238.63

21725 with cast application - $268.46

21740 Reconstructive repair of pectus excavatum or carinatum - $775.54

21741 Xiphoid resection pectus excavatum - BR

Fracture and/or Dislocation

21800 Treatment of rib fracture; closed, uncomplicated, each - BR

21805 open or complicated, each - BR

21810 closed or open requiring external fixation ("flail chest") - BR

21820 Treatment of sternum fracture; closed - BR

21825 open - BR

Miscellaneous

21899 Unlisted procedure, neck or thorax - BR

Spine (Vertebral Column)

Excision

22010 Biopsy, soft tissues; superficial - BR

22011 deep - BR

22030 Excision, benign tumor, subcutaneous - BR

22031 Excision, benign tumor, deep, subfacial, intramuscular; cervical - BR

22032 thoracic - BR

22033 lumbar - BR

22100 Partial resection of vertebral component, spinous processes (eg, "kissing" spines); cervical - $238.63

22101 thoracic - BR

22102 lumbar - BR

22105 Partial resection of vertebral component for tumor (eg, partial facetectomy without primary grafting); cervical - $357.94

22106 thoracic - BR

22107 lumbar - BR

22110 Partial excision of vertebrae (craterization, saucerization) for osteomyelitis, cervical; - BR

22111 with suction irrigation - BR

22112 Partial excision of vertebrae (craterization, saucerization) for osteomyelitis, lumbar; - BR

22113 with suction irrigation - BR

22114 Partial excision of vertebrae (craterization, saucerization) for osteomyelitis, lumbar; - BR

22115 with suction irrigation - BR

22120 Radical resection of vertebral body or component with primary grafting, includes obtaining graft; cervical - BR

22121 thoracic - BR

22122 lumbar - BR

Repair, Revision and Reconstruction

22200 Osteotomy of spine for correction fixed deformity (not scoliosis); anterior OR posterior, lumbar - $954.51

22201 thoracic or cervical - BR

22202 Osteotomy of spine for correction fixed deformity (not scoliosis); anterior AND posterior, lumbar - BR

22203 cervical - BR

22206 Osteotomy of spine for correction fixed deformity, single or multiple (including vertebral body resection), for scoliosis with or without internal fixation; transthoracic - BR

22207 transabdominal or retroperitoneal - BR

Fracture and/or Dislocation

22305 Treatment of vertebral process fracture, each - BR

22310 Treatment of vertebral body fracture and/or dislocation; without reduction, each - BR

22315 with or without anesthesia by manipulation or traction, each - $208.80

22325 Open treatment of vertebral body fracture and/or dislocation; lumbar, each - $715.89

22326 cervical, each - BR

22327 thoracic, each - BR

22330 Open treatment and fusion, cervical spine; posterior approach, with local bone graft and/or internal fixation for fracture $835.21

22335 posterior approach, with iliac or other autogenous bone graft (includes obtaining graft), for fracture - $924.69

22345 anterior approach, with iliac or other autogenous bone graft (includes obtaining graft) for fracture - $894.86

22355 Open treatment and fusion, posterior approach, with local bone graft and/or internal fixation for fracture; lumbar - $775.54

22356 thoracic - BR

22360 Open treatment and fusion, posterior approach with iliac or other autogenous bone graft (includes obtaining graft), for fracture; lumbar - $894.86

22361 thoracic - BR

22370 Open treatment and fusion, posterolateral or anterolateral approach, with iliac or other autogenous bone graft (includes obtaining graft) for fracture; lumbar - BR

22371 thoracic - BR

Manipulation

22500 Manipulation of spine, any region - $8.95

22505 requiring anesthesia - $41.76

Arthrodesis with Diskectomy (Intervertebral disk excision, laminotomy or laminectomy and fusion)

22550 Arthrodesis with diskectomy, cervical, posterior approach; local bone graft and/or internal fixation - $835.21

22552 with iliac or other autogenous bone graft (includes obtaining grafts) - $954.51

22555 Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) - $835.21

22560 Arthrodesis with diskectomy, lumbar or thoracic, posterior posterolateral or posterior interbody approach; local bone graft and/or internal fixation - $775.54

22561 with iliac or other autogenous bone graft (includes obtaining graft) - $894.86

22565 Arthrodesis with diskectomy, lower lumbar spine, anterior interbody approach, (includes obtaining graft) - $715.89

Arthrodesis, Primary or Repair of Pseudarthrosis

22600 Cervical fusion, posterior approach, below C1 level; local bone graft and/or internal fixation - $715.89

22605 with iliac or other autogenous bone graft (includes obtaining graft) - $835.21

22615 Cervical fusion, anterior approach (C3-T1) with iliac or other autogenous bone graft (includes obtaining graft) - $835.21

22617 Atlas-axis fusion (C1-C2 or C3) with iliac or other autogenous bone graft (includes obtaining graft) (posterior or anterior approach) - BR

22620 Cervicocranial fusion (occiput through C2) with iliac or other autogenous bone graft) (includes obtaining graft) - BR

22640 Thoracic or lumbar fusion, posterior or posterolateral approach; local bone graft and/or internal fixation - $715.89

22645 with iliac or other autogenous bone graft (includes obtaining graft) - $835.21

22655 Thoracic or lumbar fusion; posterior interbody technique, with iliac or other autogenous bone graft, (includes obtaining graft) - $954.51

22670 lateral approach (transverse process to transverse process and/or sacrum) with iliac or other autogenous bone graft and/or internal fixation (includes obtaining graft) - $954.51

22680 anterolateral or anterior interbody fusion, transthoracic approach (includes obtaining graft) - BR

22700 Lumbar spine fusion; anterior interbody fusion (includes obtaining graft) - $715.89

22720 posterior approach, Harrington or Knodt rod distraction fusion, with iliac or other autogenous bone graft (includes obtaining graft) - $894.86

22730 Arthrodesis, primary or repair of pseudarthrosis; two levels (list separately in addition to code for single level arthrodesis, 22600-22720) - $178.97

22735 more than two levels (list separately in addition to code for single level arthrodesis, 22600-22720) - BR

Arthrodesis, Primary for Scoliosis

22800 Arthrodesis, primary for scoliosis (includes first postoperative cast), 6 or less vertebrae; local bone graft - $865.03

22801 with iliac or other autogenous bone graft - BR

22802 Arthrodesis, primary for scoliosis (includes first postoperative cast), seven or more vertebrae; local bone graft - BR

22803 with iliac or other autogenous bone graft - BR

22840 Harrington rods technique (list separately in addition to procedures 22800-22803) - $1491.45

22845 Dwyer instrumentation technique (list separately in addition to procedures 22800-22803) - BR

22850 Harrington rod removal - BR

22855 Dwyer instrument removal - BR

Miscellaneous

22899 Unlised procedure, spine - BR

Abdomen

Excision

22900 Excision, abdominal wall tumor, subfascial (eg, desmoid) - BR

22910 Abdominal fascial transplants, bilateral (Lowman type procedure) (includes obtaining fascia) - $596.58

Miscellaneous

22999 Unlisted procedure, abdomen - BR

Shoulder

Incision

23000 Removal of subdeltiod (or intratendinous) calcareous deposits - $178.97

23020 Capsular contracture release (Sever type procedure) for Erb's palsy - $328.12

23030 Incision and drainage; deep abscess or hematoma - BR

23031 infected bursa BR

23035 Incision, deep, with opening of cortex for osteomyelitis or bone abscess; - BR

23036 with suction irrigation - BR

23040 Arthrotomy with exploration, drainage or removal of foreign body, glenohumeral joint; - $328.12

23042 with suction irrigation - BR

23044 Arthrotomy with exploration, drainage or removal of foreign body, acromioclavicular joint - BR

Excision

23065 Biopsy, soft tissues; superficial - BR

23066 deep - BR

23075 Excision, benign tumor; subcutaneous - BR

23076 deep, subfascial or intramuscular - BR

23100 Arthrotomy for biopsy, glenohumeral joint - $328.12

23101 Arthrotomy for biopsy or for excision of torn cartilage, acromioclavicular, sternoclavicular joint - BR

23105 Arthrotomy for synovectomy; glenohumeral joint - BR

23106 acromioclavicular, sternoclavicular joint - BR

23110 Excision, subacromial (subdeltoid) bursa - $178.97

23120 Claviculectomy; partial - $253.54

23125 total - BR

23130 Acromionectomy, partial or total - $253.54

23140 Excision or curettage of bone cyst or benign tumor of clavicle or scapula; - $178.97

23145 with primary autogenous graft (includes obtaining graft) - $268.46

23146 with homogenous or other nonautogenous graft - BR

23150 Excision or curettage of bone cyst or benign tumor of proximal humerus; - BR

23155 with primary autogenous graft (includes obtaining graft) - BR

23156 with homogenous or toher nonautogenous graft - BR

23170 Suquestrectomy for osteomyelitis or bone abscess, clavicle; - BR

23171 with suction irrigation - BR

23172 Sequestrectomy for osteomyelitis or bone abscess, scapula; - BR

23173 with suction irrigation- BR

23174 Sequestrectomy for osteomyelitis or bone abscess, humeral head to surgical neck; - BR

23175 with suction irrigation - BR

23180 Partial excision of bone (craterization, saucerization, or diaphysectomy) for osteomyelitis, clavicle; - $149.15

23181 with suction irrigation - BR

23182 Partial excision of bone (craterization, saucerization or diaphysectomy) for osteomyelitis, scapula;- BR

23183 with suction irrigation - BR

23184 Partial excision of bone (craterization, saucerization, or diaphysectomy) ofr osteomyelitis, proximal humerus; - BR

23185 with suction irrigation - BR

23190 Ostectomy of scapula, partial (eg superior medial angle) - $208.80

23195 Resection humeral head - BR

23200 Radical resection for tumor; clavicle - BR

23210 scapula - BR

23220 Radical resection for tumor, proximal humerus; - BR

23221 with autogenous bone graft, (includes obtaining graft) - BR

23222 with prosthetic replacement - BR

Introduction or Removal

23330 Removal of foreign body; subcutaneous - BR

23331 deep (eg, prosthetic removal) - $328.12

23350 Injection procedure for shoulder arthrography - $17.90

Repair, Revision or Reconstruction

23395 Muscle transfer, any type for paralysis of shoulder or upper arm; single - BR

23397 multiple - BR

23400 Scapulopexy (eg, Sprengel's deformity or for paralysis) - $656.23

23405 Tenomyotomy; single - BR

23406 multiple through same incision - BR

23410 Repair of ruptured supraspinatus tendon or musculotendinous cuff; acute - $417.60

23412 chronic - BR

23415 Coracoacromial ligament release for chronic ruptured supraspinatus tendon - BR

23420 Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) - $536.92

23430 Tenodesis for rupture of long tendon of biceps - $357.94

23440 Resection or transplantation of long tendon of biceps, for chronic tenosynovitis - $357.94

23450 Capsulorrhaphy for recurrent dislocation, anterior, any type; with bone block - $596.57

23462 with coracoid process transfer - BR

23465 Capsulorrhaphy for recurrent dislocation, posterior, with or without bone block - $507.09

23470 Arthroplasty with proximal humeral implant (eg, Neer type operation) - $596.57

23472 Arthroplasty with glenoid and proximal humeral replacement (eg, total shoulder) - BR

23480 Osteotomy, clavicle, with or without internal fixation; - $298.29

23485 with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation) - $387.77

Fracture and/or Dislocation

23500 Treatment of closed clavicular fracture; without manipulation - BR

23505 with manipulation - $89.49

23510 Treatment of open clavicular fracture, with uncomplicated soft tissue closure - $149.15

23515 Open treatment of closed or open clavicular fracture, with or without internal or external skeletal fixation - $268.46

23520 Treatment of closed sternoclavicular dislocation; without manipulation - BR

23524 with manipulation - BR

23530 Open treatment of closed or open sternoclavicular dislocation, acute or chronic; - $304.89

23532 with fascial graft (includes obtaining graft) - BR

23540 Treatment of closed acromioclavicular dislocation; without manipulation - BR

23545 with manipulation - BR

23550 Open treatment of closed or open acromioclavicular dislocation, acute or chronic; - $357.95

23552 with fascial graft (includes obtaining graft) - BR

23570 Treatment of closed scapular fracture; without manipulation - BR

23575 with manipulation (with or without shoulder joint involvement) - BR

23580 Treatment of open scapular fracture, with uncomplicated soft tissue closure - $357.94

23585 Open treatment of closed or open scapular fracture juxta-articular - $357.94

23600 Treatment of closed humeral (surgical or anatomical neck) fracture, with uncomplicated soft tissue closure - $208.79

23615 Open treatment of closed or open humeral (surgical or anatomical neck) fracture, with or without internal or external skeletal fixation - $357.94

23620 Treatment of closed greater tuperosity fracture; without manipulation - BR

23630 Open treatment of closed or open greater tuberosity fracture, with or without internal or external skeletal fixation - BR

23650 Treatment of closed shoulder dislocation, with manipulation; without anesthesia - BR

23655 requiring anesthesia - BR

23658 Treatment of open shoulder dislocation, with uncomplicated soft tissue closure - BR

23660 Open treatment of closed or open shoulder dislocation - $357.94

23665 Treatment of closed shoulder dislocation, with fracture of greater tuberosity, with manipulation - BR

23670 Open treatment of closed or open shoulder dislocation, with fracture of greater tuberosity - $357.94

23675 Treatment of closed shoulder dislocation, with surgical or anatomical neck fracture, with manipulation - BR

23680 Open treatment of closed or open shoulder dislocation, with surgical or anatomical neck fracture - $417.60

Manipulation

23700 Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded) - $35.79

Arthrodesis

23800 Arthrodesis, shoulder joint; with or without local bone graft - $596.57

23802 with primary autogenous graft (includes obtaining graft) - BR

Amputation

23900 Interthoracoscapular amputation (forequarter) - $715.89

23920 Disarticulation of shoulder; - $536.92

23921 secondary closure or scar revision - BR

Miscellaneous

23929 Unlisted procedure, shoulder - BR

Humerus (Upper Arm) and Elbow

Incision

23930 Incision and drainage; deep abscess or hematoma - BR

23931 infected bursa - BR

23935 Incision, deep, with opening of cortex for osteomyelitis or bone abscess; - BR

23936 with suction irrigation - BR

24000 Arthrotomy, elbow, with exploration, drainage or removal of foreign body; - $298.29

24001 with suction irrigation - BR

Excision

24065 Biopsy, soft tissues; superficial - BR

24066 deep - BR

24075 Excision, benign tumor; subcutaneous - BR

24076 deep, subfascial or intramuscular - BR

24100 Arthrotomy, elbow; for synovial biopsy only - $298.29

24101 with joint exploration, with or without biopsy, with or without removal of foreign body - BR

24102 for synovectomy - $417.60

24105 Excision, olecranon bursa - $143.18

24110 Excision or curettage of bone cyst or benign tumor, humerus; - $283.37

24115 with primary autogenous graft (includes obtaining graft) - $372.86

24116 with homogenous or other nonautogenous graft - BR

24120 Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; - $238.63

24125 with primary autogenous graft (includes obtaining graft) - $298.29

24126 with homogenous or other nonautogenous graft - BR

24130 Excision, radial head - $238.63

24134 Suquestrectomy for osteomyelitis or bone abscess, shaft or distal humerus; - BR

24135 with suction irrigation - BR

24136 Sequestrectomy for osteomyelitis or bone abscess, radial head or neck; - BR

24137 with suction irrigation - BR

24138 Suquestrectomy for osteomyelitis or bone abscess, olecranon process; - BR

24139 with suction irrigation - BR

24140 Partial excision of bone (craterization, saucerization or diaphysectomy) for osteomyelitis, humerus; - $208.80

24144 with suction irrigation - BR

24145 Partial excision of bone (craterization, saucerization or diaphysectomy) for osteomyelitis, radial head or neck; - BR

24146 with suction irrigation - BR

24147 Partial excision of bone (craterization, saucerization or diaphysectomy) for osteomyelitis, olecranon process; - BR

24148 with suction irrigation - BR

24150 Radical resection for tumor, shaft or distal humerus; - BR

24151 with autogenous bone graft (includes obtaining graft) - BR

24152 Radical resection for tumor, radial head or neck; - BR

24153 with autogenous bone graft (includes obtaining graft) - BR

24155 Resection of elbow joint (arthrectomy) - BR

Introduction or Removal

24160 Implant removal; elbow joint - BR

24164 radial head - BR

24200 Removal of foreign body; subcutaneous - BR

24201 deep - BR

24220 Injection procedure for elbow arthrography - BR

Repair, Revision and Reconstruction

24301 Muscle or tendon transfer, any type, single (excluding 24330) - BR

24305 Tendon lengthening; single, each - BR

24310 Tenotomy, open, elbow to shoulder; single, each - BR

24320 Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure) - BR

24330 Flexor-plasty, elbow, (eg, Steindler type advancement); - $238.63

24331 with extensor advancement - BR

24340 Tenodesis for rupture of biceps tendon at elbow - $307.60

24342 Reinsertion of ruptured biceps tendon, distal, with or without tendon graft (includes obtaining graft) - BR

24350 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis); - $178.97

24351 with extensor origin detachment - BR

24352 with annular ligament resection - BR

24354 with stripping - BR

24360 Arthroplasty, elbow; with membrane - BR

24361 with distal humeral prosthetic replacement - BR

24362 with implant and fascia lata ligament reconstruction - BR

24363 with distal humerus and proximal ulnar prosthetic replacement ("total elbow") - BR

24365 Arthroplasty, radial head; - BR

24366 with implant - BR

24400 Osteotomy, humerus, with or without internal fixation - $357.94

24410 Multiple osteotomies with realignment on intramedullary rod (Sofield type procedure) - $417.60

24420 Osteoplasty, humerus (eg, shortening or lengthening) - BR

24430 Repair of nonunion or malunion, humerus; without graft (eg, compression technique, etc.) - $507.09

24435 with iliac or other autogenous bone graft (includes obtaining graft) - $596.57

24470 Hemiepiphyseal arrest (eg, for cubitus varus or valgus, distal humerus) - $208.80

24495 Decompression fasciotomy, forearm, with brachial artery exploration. - BR

Fracture and/or Dislocation

24500 Treatment of closed humeral shaft fracture; without manipulation - BR

24505 with manipulation - $149.15

24510 Treatment of open humeral shaft fracture, with uncomplicated soft tissue closure - $269.61

24515 Open treatment of closed or open humeral shaft fracture, with or without internal or external skeletal fixation - $328.12

24530 Treatment of closed supracondylar or transcondylar fracture, without manipulation; - BR

24531 with traction (pin or skin) - BR

24535 Treatment of closed supracondylar or transcondylar fracture, with manipulation; - $149.15

24536 with traction (pin or skin) - BR

24538 with percutaneous skeletal fixation - BR

24540 Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure; - $208.80

24542 with traction (pin or skin) - BR

24545 Open treatment of closed or open supracondylar or transcondylar fracture, with or without internal or external skeletal fixation - $298.29

24560 Treatment of closed epicondylar fracture, medial or lateral; without manipulation - BR

24565 with manipulation - BR

24570 Treatment of open epicondylar fracture, medial or lateral, with uncomplicated soft tissue closure - $178.97

24575 Open treatment of closed or open epicondylar fracture, medial or lateral, with or without internal or external skeletal fixation - $268.46

24576 Treatment of closed condylar fracture, medial or lateral; without manipulation - BR

24577 with manipulation - BR

24578 Treatment of open condylar fracture, medial or lateral, with uncomplicated soft tissue closure - BR

24579 Open treatment of closed or open condylar fracture, medial or lateral, with or without internal or external skeletal fixation - BR

24580 Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); without manipulation - BR

24581 with manipulation - BR

24583 Treatment of open comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), with traction, (pin or skin); without manipulation - BR

24585 Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal ulna/radius), with or without internal or external skeletal fixation; - BR

24586 with elbow resection - BR

24587 with implant - BR

24588 with implants and fascia lata ligament reconstruction - BR

24600 Treatment of closed elbow dislocation; without anesthesia - BR

24605 requiring anesthesia - BR

24610 Treatment of open elbow dislocation, with uncomplicated soft tissue closure - $178.97

24615 Open treatment of closed or open elbow dislocation - $357.94

24620 Treatment of closed Monteggis type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head) - $119.31

24625 Treatment of open Monteggis type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with uncomplicated soft tissue closure - $178.97

24635 Open treatment of closed or open Monteggia type of fracture dislocation at elbow (fracture proximal end

of ulna with dislocation of radial head), with or without internal or external skeletal fixation - $357.94

24640 Treatment of radial head subluxation in child, "nursemaid elbow", with manipulation - BR

24650 Treatment of closed radial head or neck fracture; without manipulation - BR

24655 with manipulation - BR

24660 Treatment of open radial head or neck fracture, with uncomplicated soft tissue closure - $119.31

24665 Open treatment of closed or open radial head or neck fracture, with or without internal fixation or radial head excision; -$238.63

24666 with implant - BR

24670 Treatment of closed ulnar fracture, proximal end (olecranon process); without manipulation - BR

24675 with manipulation - BR

24680 Treatment of open ulnar fracture, proximal end (olecranon process), with uncomplicated soft tissue closure - $119.31

24685 Open treatment of closed or open ulnar fracture proximal end (olecranon process), with or without internal or external skeletal fixation - $238.63

Manipulation

24700 Manipulation under general anesthesia (includes application of traction or other fixation device) - $29.83

Arthrodesis

24800 Arthrodesis, elbow joint; with or without local or homogenous bone graft - $477.26

24802 with primary autogenous bone graft (includes obtaining graft) - BR

Amputation

24900 Amputation, arm through humerus; with primary closure - $298.29

24920 open, flap or circular (guillotine) - $268.46

24925 secondary closure or scar revision - $89.48

24930 reamputation - $298.29

24931 with implant - BR

24935 Stump elongation - BR

24940 Cineplasty, upper extremity, complete procedure - BR

Miscellaneous

24999 Unlisted procedure, humerus or elbow - BR

Forearm And Wrist

Incision

25000 Tendon sheath incision; at radial styloid for deQuervain's disease - $131.24

25005 at wrist for other stenosing tenosynovitis - BR

25020 Decompression fasciotomy, flexor and/or extensor compartment; - BR

25023 with debridement of nonviable muscle and/or nerve - BR

25028 Incision and drainage; deep abscess or hematoma - BR

25031 infected bursa - BR

25035 Incision, deep, with opening of cortex for osteomyelitis or bone abscess; - BR

25036 with suction irrigation - BR

25040 Arthrotomy with exploration, drainage, or removal of loose or foreign body, infection, radiocarpal or mediocarpal joint; - BR

25041 with suction irrigation - BR

Excision

25065 Biopsy, soft tissues; superficial - BR

25066 deep - BR

25075 Excision, benign tumor; subcutaneous - BR

25076 deep, subfascial or intramuscular - BR

25085 Capsulotomy, wrist (eg, for contracture) - BR

25100 Arthrotomy, wrist joint; for biopsy - $149.15

25101 with joint exploration, with or without biopsy, with or without removal of foreign body - BR

25105 for synovectomy - $238.63

25107 Arthrotomy, distal radioulnar joint for excision triangular cartilage - BR

25110 Excision, lesion of tendon sheath - $89.48

25111 Excision of ganglion, wrist (dorsal or volar); primary - $122.29

25112 recurrent - BR

25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors - $298.29

25116 extensors (with or without transposition of dorsal retinaculum) - BR

25118 Synovectomy, extensor tendon sheath, wrist, single compartment; - $298.29

25119 with resection of distal ulna - BR

25120 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); - $208.80

25125 with primary autogenous graft (includes obtaining graft) - $298.29

25126 with homogenous or other nonautogenous graft - BR

25130 Excision or curettage of bone cyst or benign tumor of carpal bones - $149.15

25135 with primary autogenous graft (includes obtaining graft) - $208.80

25136 with homogenous or other nonautogenous graft - BR

25145 Sequestrectomy for osteomyelitis or bone abscess; - BR

25146 with suction irrigation - BR

25150 Partial excision of bone (craterization, saucerization or diaphysectomy) for osteomyelitis; ulna - $149.15

25151 radius - BR

25153 radius or ulna, with suction irrigation - BR

25170 Radical resection for tumor, radius or ulna - BR

25210 Carpectomy; one bone - $208.80

25215 all bones or proximal row - $298.29

25230 Radial styloidectomy (separate procedure) - $149.15

25240 Excision distal ulna (Darrach type procedure) - $178.97

Introduction or Removal

25246 Injection procedure for wrist arthrography - BR

25248 Exploration for removal of deep foreign body - BR

Repair, Revision or Reconstruction

25260 Repair, tendon or muscle, flexor; primary, single, each tendon or muscle - BR

25263 secondary, single, each tendon or muscle - BR

25265 secondary, with free graft (includes obtaining graft), each tendon or muscle - BR

25270 Repair, tendon or muscle, extensor; primary, single, each tendon or muscle - BR

25272 secondary, single, each tendon or muscle - BR

25274 Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), each tendon - BR

25280 Lengthening or shortening of flexor or extensor tendon, single, each tendon - BR

25290 Tenotomy, open, single, flexor or extensor tendon, each tendon - BR

25295 Tenolysis, single flexor or extensor tendon, each tendon - BR

25300 Tenodesis at wrist; flexors of fingers - $238.63

25301 extensors of fingers - BR

25310 Tendon transplantation or transfer, flexor or extensor, single; each tendon - $283.37

25312 with tendon graft(s) (includes obtaining graft), each tendon - BR

25315 Flexor origin slide for cerebral palsy; - BR

25316 with tendon(s) transfer - BR

25317 Flexor origin slide for Volkmann contracture; - BR

25318 with tendon(s) transfer - BR

25320 Capsulorrhaphy or reconstruction, capsulectomy, wrist (includes synovectomy, resection of capsule, tendon insertions) - BR

25330 Arthroplasty, wrist; $238.63

25331 with implant - BR

25332 pseudarthrosis type with internal fixation - BR

25335 Transposition and realignment of hand over ulna with or without removal of bone or bones, and with or without tendon transfer or advancement (Riordon type operation) - BR

25350 Osteotomy, radius; distal third - $298.29

24355 middle or proximal third - $357.94

25360 Osteotomy; ulna - $298.29

25365 radius and ulna - $417.60

25370 Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna - $357.94

25375 radius AND ulna - $536.92

25390 Osteoplasty, radius OR ulna; shortening - BR

25391 lengthing with autogenous bone graft - BR

25392 Osteoplasty, radius AND ulna; shortening - BR

25393 lengthening with autogenous bone graft - BR

25400 Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique, etc) - $417.60

25405 with iliac or other autogenous bone graft (includes obtaining graft) - $507.09

25415 Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique, etc) - $596.57

25420 with iliac or other autogenous bone graft (includes obtaining graft) - $686.06

25425 Repair of defect with autogenous bone graft; radius OR ulna - BR

25426 radius AND ulna - BR

25440 Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation) - $417.60

25441 Arthroplasty with prosthetic replacement; distal radius - BR

25442 distal ulna - BR

25443 scaphoid (navicular) - BR

25444 lunate - BR

25445 trapezium - BR

25446 distal radius and partial or entire carpus ("total wrist") - BR

25449 Arthroplasty with removal of implant - BR

25450 Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna - $178.97

25455 distal radius AND ulna - $238.63

Fracture and/or Dislocation

25500 Treatment of closed radial shaft fracture; without manipulation - BR

25505 with manipulation - BR

25510 Treatment of open radial shaft fracture, with uncomplicated soft tissue closure - $149.15

25515 Open treatment of closed or open radial shaft fracture, with or without internal or external skeletal fixation - $238.63

25530 Treatment of closed ulnar shaft fracture; with manipulation - BR

25535 with manipulation - BR

25540 Treatment of open ulnar shaft fracture, with uncomplicated soft tissue closure - $149.15

25545 Open treatment of closed or open ulnar shaft fracture, with or without internal or external skeletal fixation - $238.63

25560 Treatment of closed radial and ulnar shaft fractures; without manipulation - BR

25565 with manipulation - $161.07

25570 Treatment of open radial and ulnar shaft fractures, with uncomplicated soft tissue closure - $178.97

25575 Open treatment of closed or open radial and ulnar shaft fractures, with or without internal or external skeletal fixation - $357.94

25600 Treatment of closed distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation - BR

25605 with manipulation - $119.31

25610 Treatment of closed, complex, distal radial fracture (Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manip-

ulation; without external skeletal fixation or percutaneous pinning - $178.97

25611 with external skeletal fixation or percutaneous pinning - BR

25615 Treatment of open distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with uncomplicated soft tissue closure - $149.14

25620 Open treatment of closed or open distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external skeletal fixation - $238.63

25622 Treatment of closed carpal scaphoid (navicular) fracture, without manipulation - BR

25624 with manipulation - BR

25626 Treatment of open carpal scaphoid (navicular) fracture, with uncomplicated soft tissue closure - BR

25628 Open treatment of closed or open carpal scaphoid (navicular) fracture, with or without skeletal fixation - BR

25630 Treatment of closed carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone - BR

25635 with manipulation, each bone - BR

25640 Treatment of open carpal bone fracture (excluding carpal scaphoid (navicular)), with uncomplicated soft tissue closure, each bone - $149.15

25645 Open treatment of closed or open carpal bone fracture (excluding carpal scaphoid (navicular), each bone - 178.97

25660 Treatment of closed radiocarpal or intercarpal dislocation, one or more bones, with manipulation - $35.79

25665 Treatment of open radiocarpal or intercarpal dislocation, one or more bones, with uncomplicated soft tissue closure - $119.31

25670 Open treatment of closed or open radiocarpal or intercarpal dislocation, one or more bones - $238.63

25675 Treatment of closed distal radioulnar dislocation with manipulation - BR

25676 Open treatment of closed or open distal radioulnar dislocation, acute or chronic - BR

25680 Treatment of closed trans-scaphoperilunar type of fracture dislocation, with manipulation - $178.97

25685 Open treatment of closed or open trans-scaphoperilunar type of fracture dislocation - $357.90

25690 Treatment of lunate dislocation, with manipulation - BR

25695 Open treatment of lunate dislocation - BR

Manipulation

25700 Manipulation of joint under general anesthesia - $29.83

Arthrodesis

25800 Arthrodesis, wrist joint; without bone graft - $357.94

25805 with sliding graft - BR

25810 with iliac or other autogenous distant bone graft (includes obtaining graft) - $477.26

Amputation

25900 Amputation, forearm, through radius and ulna; - $268.46

25905 open flap or circular (guillotine) - $238.63

25907 secondary closure or scar revision - $89.48

25909 reamputation - $268.46

25915 Krukenberg procedure - BR

25920 Disarticulation through wrist; - $238.63

25922 secondary closure or scar revision - BR

25924 reamputation - BR

25927 Transmetacarpal amputation; BR

25929 secondary closure or scar revision - BR

25931 reamputation - BR

Miscellaneous

25999 Unlisted procedure, forearm or wrist - BR

Hand And Fingers

Incision

26010 Drainage of finger abscess; simple - $21.47

26011 complicated (eg, felon, etc) - BR

26020 Drainage of tendon sheath, one digit and/or palm - $119.31

26025 Drainage of palmar bursa; single ulnar or radial - $149.15

26030 multiple or complicated - BR

26032 with suction irrigation - BR

26034 Incision, deep, with opening of cortex for osteomyelitis or bone abscess - BR

26035 Decompression fingers and/or hand, injection injury (eg, grease gun, etc) - BR

26040 Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous) - $107.38

26045 open, partial - $149.15

26055 Tendon sheath incision for trigger finger - $149.15

26060 Tenotomy, subcutaneous, single, each digit - $35.79

26070 Arthrotomy with exploration, drainage or removal of loose or foreign body; carpometacarpal joint - $149.15

26075 metacarpophalangeal joint - $149.15

26080 interphalangeal joint, each - $119.31

Excision

26100 Arthrotomy for synovial biopsy; carpometacarpal joint - $149.15

26105 metacarpophalangeal joint - $149.15

26110 interphalangeal joint, each $119.31

26115 Excision of benign tumor; subcutaneous - BR

26116 deep, subfascial, intramuscular - BR

26120 Fasciectomy, palmar, simple, for Dupuytren's contracture; partial excision - $178.97

26122 up to one-half palmar fascia, with single digit involvement, with or with Z-plasty or other local tissue rearrangement - $298.29

26124 Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); with single digit involvement - BR

26126 each additional digit - BR

26128 each finger joint release - BR

26130 Synovectomy, carpometacarpal joint - $298.29

26135 Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit - $149.15

26140 Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint - $149.19

26145 Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit - $298.29

26160 Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion(- $71.59

26170 Excision of tendon, palm, flexor, single (separate procedure), each - BR

26180 Excision of tendon, finger, flexor (separate procedure) - BR

26200 Excision or curettage of bone cyst or benign tumor of metacarpal; - $178.20

26205 with autogenous graft (includes obtaining graft) $208.80

26206 with homogenous or other nonautogenous graft - BR

26210 Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx; - $149.15

26215 with autogenous graft (includes obtaining graft) - $178.97

26216 with homogenous or other nonautogenous graft - BR

26230 Partial excision of bone (craterization, saucerization, or diaphysectomy) for osteomyelitis; metacarpal - $178.97

26235 proximal or middle phalanx - $149.15

26236 distal phalanx - BR

26250 Radical resection (ostectomy) for tumor, metacarpal; - $357.94

26255 with autogenous graft (includes obtaining graft) - BR

26260 Radical resection (ostectomy) for tumor, proximal or middle phalanx; - $298.29

26261 with autogenous graft (includes obtaining graft) - BR

26262 Radical resection (ostectomy) for tumor, distal phalanx - BR

Introduction of Removal

26320 Removal of implant from finger or hand - BR

Repair, Revision or Reconstruction

26350 Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon - BR

26352 secondary with free graft (includes obtaining graft), each tendon - BR

26356 Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon - BR

26358 secondary with free graft (includes obtaining graft), each tendon - BR

26370 Profundus tendon repair or advancement, with intact sublimis; primary - BR

26372 secondary with free graft (includes obtaining graft) - BR

26373 secondary without free graft - BR

26390 Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft - BR

26392 Removal of tube or rod and insertion of tendon graft (includes obtaining graft) - BR

26410 Extensor tendon repair, dorsum or hand, single, primary or secondary; without free graft, each tendon - $89.48

26412 with free graft (includes obtaining graft), each tendon - BR

26418 Extensor tendon repair, dorsum of finger, single primary or secondary; without free graft, each tendon - $119.31

26420 with free graft (includes obtaining graft) each tendon - BR

26426 Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues - BR

26428 with free graft (includes obtaining graft) - BR

26432 Extensor tendon repair, distal insertion ("mallet finger"), closed splinting with or without percutaneous pinning - BR

26433 Extensor tendon repair, open, primary or secondary repair; without graft - BR

26434 with free graft (includes obtaining graft) - BR

26440 Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon - $146.95

26442 palm AND finger, each tendon - BR

26445 Tenolysis, extensor tendon, dorsum of hand or finger; each tendon - $146.95

26449 Tenolysis, complex, extensor tendon, dorsum of hand or finger, including hand and forearm - BR

26450 Tenotomy, flexor, single, palm, open, each - $119.31

26455 Tenotomy, flexor, single, finger, open, each - $149.14

26460 Tenotomy, extensor, hand or finger, single each - BR

26471 Tenodesis; for proximal interphalangeal joint stabilization - BR

26474 for distal joint stabilization - BR

26476 Tendon lengthening, extensor, single, each - BR

26477 Tendon shortening, extensor, single each - BR

26480 Tendon transfer or transplant, carpometacarpal area or dorsum of hand, single; without free graft, each - $238.63

26483 with free tendon graft (includes obtaining graft), each tendon - $328.12

26485 Tendon transfer or transplant, palmar, single, each tendon; without free tendon graft - $298.29

26489 with free tendon graft (includes obtaining graft), each tendon - $328.12

26490 Opponens plasty; sublimis tendon transfer type - $283.37

26492 tendon transfer with graft (includes obtaining graft) - $328.12

26494 hypothenar muscle transfer - $357.94

26496 other methods - BR

26497 Sublimis transfer to correct claw finger; IV and V - BR

26498 II, III, IV and I - BR

26499 Correction claw finger, other methods - BR

26500 Tendon pulley reconstruction; with local tissues (separate procedure) - $178.97

26502 with tendon of fascial graft (includes obtaining graft) (separate procedure) - $238.63

26508 Thenar muscle release for thumb contracture - BR

26516 Capsulodesis for M-P joint stabilization; single digit - BR

26517 two digits - BR

26518 three or four digits - BR

26520 Capsulectomy for contracture; metacarpophalangeal joint, single, each - $208.80

26525 interphalangeal joint, single each - $208.80

26530 Arthroplasty, metacarpophalangeal joint; single, each - $208.80

26531 with prosthetic implant, single, each - $268.46

26535 Arthroplasty interphalangeal joint; single, each - $238.63

26536 with prosthetic implant, single, each - BR

26540 Reconstruction, collateral ligament, metacarpophalangeal joint; - $298.29

26541 with tendon or fascial graft (includes obtaining graft) - BR

26545 Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint - $238.63

26550 Pollicization of a digit - BR

26552 Reconstruction thumb with toe - BR

26555 Positional change of other finger - BR

26557 Toe to finger transfer; first stage - BR

26558 each delay - BR

26559 second stage - BR

26560 Repair of syndactyly (web finger) each web space; with skin flaps - $283.37

26561 with skin flaps and grafts - $357.94

26562 complex, involving bone, nails, etc - BR

26565 Osteotomy for correction of deformity; metacarpal - $238.63

26567 phalanx - $149.15

26570 Bone graft, (includes obtaining graft); metacarpal - $298.29

26574 phalanx - $208.80

26580 Repair cleft hand - BR

26585 Repair bifid digit - BR

26590 Repair amcrodactylia - BR

Fractures and/or Dislocations

26600 Treatment of closed metacarpal fracture, single; without manipulation, each bone - BR

26605 with manipulation, each bone - $71.59

26610 Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone - $89.48

26615 Open treatment of closed or open metacarpal fracture, single with or without internal or external skeletal fixation, each bone - $208.80

26641 Treatment of carpometacarpal dislocation, thumb, with manipulation - BR

26645 Treatment of closed carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation; - BR

26650 with skeletal fixation - $178.97

26655 Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with uncomplicated soft tissue closure; - $298.29

26660 with skeletal fixation - $208.80

26665 Open treatment of closed or open carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external skeletal fixation - $298.29

26670 Treatment of closed carpometacarpal dislocation, other than Bennett fracture, single, with manipulation; with anesthesia - $21.47

26675 requiring anesthesia - $59.65

26680 Treatment of open carpometacarpal dislocation, other than Bennett fracture, single with uncomplicated soft tissue closure - $89.48

26685 Open treatment of closed or open carpometacarpal dislocation, other than Bennett fracture; single, with or without internal or external skeletal fixation - $178.97

26686 complex, multiple or delayed reduction - BR

26700 Treatment of closed metacarpophalangeal dislocation, single, with manipulation; without anesthesia - $21.47

26705 requiring anesthesia - $59.65

26710 Treatment of open metacarpophalangeal dislocation, single, with uncomplicated soft tissue closure - $89.48

26715 Open treatment of closed or open metacarpophalangeal dislocation, single, with or without internal or external skeletal fixation - $178.97.

26720 Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each - BR

26725 with manipulation, each - $47.73

26727 Treatment of open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, requiring traction or fixation, each - BR

26730 Treatment of open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with uncomplicated soft tissue closure, each - $65.62

26735 Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external sheletal fixation, each - BR

26740 Treatment of closed articular fracture, involving metacarpophalangeal or proximal interphalangeal joint; without manipulation, each - BR

26742 with manipulation, each - BR

26743 with manipulation requiring traction for fixation, each - BR

26744 Treatment of open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint, with uncomplicated soft tissue closure, each - BR

26746 Open treatment of closed or open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint, each - BR

26750 Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each - BR

26755 with manipulation, each - $21.51

26760 Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each - $35.79.

26765 Open treatment of closed or open distal phalangeal fracture, finger or thumb, each - $71.57

26770 Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia - $21.51

26775 requiring anesthesia - $35.79

26780 Treatment of open interphalangeal joint dislocation, single, with uncomplicated soft tissue closure - $47.73

26785 Open treatment of closed or open interphalangeal joint dislocation, single - $71.57

Arthrodesis

26820 Fusion in opposition, thumb, with autogenous graft (includes obtaining graft) - BR

26841 Arthrodesis, carpometacarpal, joint, thumb, with or without internal fixation; - $238.63

26842 with autogenous graft (includes obtaining graft) - $298.29.

26843 Arthrodesis, carpometacarpal joint, digits, other than thumb; - BR

26844 with autogenous graft (includes obtaining graft) - BR

26850 Arthrodesis, metacarpophalangeal joint, with or without internal fixation; - $208.80

26852 with autogenous graft (includes obtaining graft) - $238.63.

26860 Arthrodesis, interphalangeal joint, with or without internal fixation; - $149.15

26861 each additional interphalangeal joint - BR

26862 with autogenous graft (includes obtaining graft) - $178.97

26863 with autogenous graft (includes obtaining graft), each additional joint - BR

Amputation

26910 Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer - $208.80

26951 Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neuroectomies; with direct closure - BR

26952 with local advancement flaps (V-Y, hood) - BR

Miscellaneous

26989 Unlisted procedure, hands or fingers - BR

Pelvis and Hip Joint

Incision

26990 Incision and drainage; deep abscess or hematoma - BR

26991 infected bursa - BR

26992 Incision, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

26995 with suction irrigation - BR

27000 Tenotomy, adductor, subcutaneous, closed (separate procedure) - $29.83

27001 Tenotomy, adductor, subcutaneous, open; unilateral - $89.47

27002 bilateral - BR

27003 Tenotomy, adductor, subcutaneous, open; with obturator neurectomy; unilateral - BR

27004 bilateral - BR

27005 Tenotomy, iliopsoas, open (separate procedure) - $178.97

27006 Tenotomy, abductors, open (separate procedure) - BR

27010 Gluteal-iliotibial fasciotomy (Ober type procedure) - $178.97

27015 Iliac crest fasciotomy (Soutter or Campbell type procedure), stripping of ilium - $238.63

27025 Ober-Yount fasciotomy, combined with spica cast, pins in tibia, wedging the case, etc; unilateral - $298.29

27026 bilateral - $357.94

27030 Arthrotomy, hip, for drainage; - $417.60

27031 with suction irrigation - BR

27033 Arthrotomy, hip, for exploration or removal of loose or foreign body - BR

27035 Hip joint denervation, intrapelvic or extrapelvic intra-articular brances of sciatic, femoral or obturator nerves - $507.09

Excision

27040 Biopsy, soft tissues; superficial - BR

27041 deep - BR

27047 Excision, benign tumor; subcutaneous - BR

27048 deep, subfascial, intramuscular - BR

27050 Arthrotomy, for biopsy; sacroiliac joint - $178.97

27052 hip joint - $417.60

27054 Arthrotomy for synovectomy, hip joint - $596.58

27060 Excision; ischial bursa - $149.15

27062 trochanteric bursa or calcification - $119.29

27065 Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autogenous bone graft - $149.15

27066 deep, with or without bone graft - $283.37

27067 with bone graft requiring separate incision - BR

27070 Partial excision of bone (craterization, saucerization), for osteomyelitis; superficial (eg, wing of ilium, symphysis pubis or greater trochanter of femur) - $178.97

27071 deep - $357.94

27075 Radical resection for tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis - BR

27076 ilium, including acetabulum, both pubic rami, or ischium and acetabulum - BR

27077 innominate bone, total - BR

27078 ischial tuberosity and greater trochanter of femur - BR

27079 ischial tuberosity and greater trochanter of femur, with skin flaps - BR

27080 Coccygectomy, primary - $178.97

Introduction and/or Removal

27086 Removal of foreign body; subcutaneous tissue - BR

27087 deep - BR

27088 deep, complicated - BR

27090 Removal of hip prosthesis; (separate procedure) - $417.60

27091 complicated, including "total hip" - BR

27093 Injection procedure for hip arthrography; without anesthesis - BR

27095 with anesthesia - BR

Repair, Revision or Reconstruction

27097 Hamstring recession, proximal - BR

27098 Adductor transfer to ischium - BR

27100 Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft) - $447.44

27105 Transfer paraspinal muscle to hip (icludes fascial or tendon extension graft) - $477.26

27110 Transfer iliopsoas; to greater trochanter - $536.92

27111 to femoral neck - BR

27115 Muscle release, complete (hanging hip operation) - BR

27120 Acetabuloplasty; (Whitman or Colonna type procedure) - $715.89

27122 resection femoral head (Girdlestone procedure) - $596.57

27125 Arthrophasty; prosthesis - $835.21

27126 cup - BR

27127 cup with acetabuloplasty - $1014.18

27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement); simple - $1,193.15

27131 complex - BR

27135 Secondary reconstruction or revision of arthroplasty, any type - BR

27140 Osteotomy and transfer of greater trochanter (separate procedure) - $357.94

27146 Osteotomy, iliac or acetabular; (Pemberton or Salter type procedure) - $715.89

27147 with open reduction of hip - BR

27151 with femoral osteotomy - $805.38

27156 with femoral osteotomy and with open reduction of hip - $805.38

27157 Acetabular augmentation (Wilson procedure) - BR

27158 Osteotomy, pelvis, bilateral for congenital malformation - BR

27161 Osteotomy, femoral neck (separate procedure) - $596.57

27165 Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast - $715.89

27170 Bone graft for nonunion, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft) - $715.89

27175 Treatment of slipped femoral epiphysis; by traction, without reduction - BR

27176 by single or multiple pinning, in situ - BR

27177 Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft) - $656.23

27178 closed manipulation with single or multiple pinning - BR

27179 osteophasty of femoral neck (Heyman type procedure) - $477.26

27181 osteotomy and internal fixation - $715.89

27185 Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter - $149.15

Fractures and/or Dislocations

27190 Treatment of closed sacral fracture; without manipulation - BR

27191 with manipulation - BR

27192 Open treatment of closed or open sacral fracture - BR

27195 Treatment of sacroiliac and/or symphysis pubis dislocation, without manipulation - BR

27196 Treatment of sacroiliac and/or symphysis pubis dislocation, with anesthesia and with manipulation - BR

27200 Treatment of closed coccygeal fracture - BR

27201 Treatment of open coccygeal fracture - BR

27202 Open treatment of closed or open coccygeal fracture - BR

27210 Treatment of closed iliac, pubic or ischial fracture, without manipulation; single - BR

27211 more than one - BR

27212 Treatment of open iliac, pubic of ischial fracture, with uncomplicated soft tissue closure - BR

27214 Open treatment of closed or open iliac, public or ischial fracture, with or without internal or external skeletal fixation - BR

27220 Treatment of closed acetabulum (hip socket) fracture(s); without manipulation - BR

27222 with manipulation with or without skeletal traction - $238.63

27224 Open treatment of closed or open acetabulum (hip socket) fracture(s), with or without internal or external skeletal fixation; simple - $656.23

27225 complicated, intrapelvic approach - BR

27230 Treatment of closed femoral fracture, proximal end, neck; without manipulation - BR

27232 with manipulation including skeletal traction - $283.37

27234 Treatment of open femoral fracture, proximal end, neck, with uncomplicated soft tissue closure, with manipulation (including skeletal traction) - $357.94

27235 Treatment of closed or open femoral fracture, proximal end, neck, in situ pinning of undisplaced or impacted fracture - BR

27236 Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement - $656.23

27238 Treatment of closed intertrochanteric or pertrochanteric femoral fracture; without manipulation - BR

27240 with manipulation (including skeletal traction) - $283.37

27242 Treatment of open intertrochanteric or pertrochanteric femoral fracture, with uncomplicated soft tissue closure (including traction) - $357.94

27244 Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation - $596.57

27246 Treatment of closed greater trochanteric fracture, without manipulation - BR

27248 Open treatment of closed or open greater trochanteric fracture, with or without internal or external skeletal fixation - $208.80

27250 Treatment of closed hip dislocation, traumatic; without anesthesia - BR

27252 requiring anesthesia - $143.18

27253 Open treatment of closed or open hip dislocation, traumatic, without internal fixation - BR

27254 Open treatment of closed or open hip dislocation, traumatic, with acetabular lip fixation, with or without internal or external skeletal fixation; - $507.09

27255 complicated or late - BR

27256 Treatment of congenital hip dislocation, by abduction, splint or traction; any method - BR

27257 with manipulation requiring anesthesia - BR

27258 Open treatment of congenital hip dislocation; replacement of femoral head in acetabulum (including tenotomy, etc) - $507.09

27259 with femoral shaft shortening - BR

Manipulation

27275 Manipulation, hip joint, requiring general anesthesia - $35.79

Arthrodesis

27280 Arthrodesis, sacroiliac joint (including obtaining graft); unilateral - $417.60

27281 bilateral - BR

27282 Arthrodesis, symphysis pubis (including obtaining graft) - BR

27284 Arthrodesis, hip joint (includes obtaining graft); - $715.89

27286 with subtrochanteric osteotomy - $775.54

Amputation

27290 Interpelviabdominal amputation (hind quarter amputation) - $868.33

27295 Disarticulation of hip - $715.89

Miscellaneous

27299 Unlisted procedure, pelvis or hip joint - BR

Femur (Thigh Region) and Knee Joint

Incision

27301 Incision and drainage of deep abscess, infected bursa or hematoma - BR

27303 Incision, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

27304 with suction irrigation - BR

27305 Fasciotomy, iliotibial (tenotomy), open - $178.97

27306 Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); single - BR

27307 Multiple - BR

27310 Arthrotomy, knee, with exploration, drainage or removal of foreign body; - $357.94

27311 with suction irrigation - BR

27315 Neurectomy, hamstring muscle - $328.11

27320 Neurectomy, popliteal (gastrocnemius) - $378.12

Excision

27323 Biopsy, soft tissues; superficial - BR

27324 deep - BR

27327 Excision, benign tumor; subcutaneous - BR

27328 deep, subfascial, or intramuscular - BR

27330 Arthrotomy, knee; for synovial biopsy only - $357.94

27331 with joint exploration, with or without biopsy, with or without removal of loose bodies - BR

27332 Anthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial OR lateral - $417.59

27333 medial AND lateral - BR

27334 Arthrotomy, knee, for synovectomy; anterior OR posterior - $507.09

27335 Anterior AND posterior including popliteal area - BR

27340 Excision, prepatellar bursa - $149.15

27345 Excision of synovial cyst of popliteal space (Baker's Cyst) -$238.63

27350 Patellectomy or hemipatellectomy - $357.94

27355 Excision or currettage of bone cyst or benign tumor of femur; - $328.12

27356 with hemogenous graft - BR

27357 with primary autogenous graft (includes obtaining graft) - $417.60

27358 with internal fixation - BR

27360 Excision of bone, partial (craterization, saucerization or diaphysectomy), for osteomyelitis, femur, proximal tibia and/or fibula; - $298.29

27361 with suction irrigation - BR

27365 Radical resection for tumor (bone or soft tissue) - BR

Introduction and/or Removal

27370 Injection procedure for knee arthrography - $17.90

27372 Removal foreign body, deep - BR

27375 Arthroscopy, knee (separate procedure); - BR

27376 with synovial biopsy - $196.87

27377 with removal of loose body - BR

27378 with partial meniscectomy - BR

Repair, Revision or Reconstruction

27380 Suture of infrapatellar tendon; primary - $328.12

27381 secondary reconstruction, including fascial or tendon graft - BR

27385 Suture of quadriceps or hamstring muscle rupture; primary - $387.77

27386 secondary reconstruction, including fascial or tendon graft - BR

27390 Tenotomy, open, hamstring, knee to hip; single - $178.97

27391 multiple, one leg - BR

27392 multiple, bilateral - BR

27393 Lengthening of hamstring tendon; single - BR

27394 multiple, one leg - BR

27395 multiple, bilateral - $477.26

27396 Transplant, hamstring tendon to patella; single - $477.26

27397 multiple - BR

27400 Tendon or muscle transfer, hamstrings to femur (Eggers type procedure) - $477.26

27405 Suture, primary, torn, ruptured or severed ligament, with or without meniscectomy, knee; collateral - $417.60

27407 cruciate - $477.26

27408 collateral, with pes anserinus transfer - BR

27409 collateral and cruiciate ligaments - $536.92

27410 Suture, secondary repair, torn, ruptured, or severed ligament, with or without meniscectomy, knee; collateral OR cruciate ligament - BR

27411 medial ligament and capsule - BR

27413 collateral or cruciate ligament, with pes anserinus transfer or fascial or tendon graft - $566.74

27414 Suture, secondary repair, torn, ruptured, or severed ligament with or without meniscectomy, knee, collateral AND cruciate ligaments; - $686.06

27415 with pes anserinus transfer or fascial or tendon graft - BR

27416 Advancement, pes anserinus, Slocum type procedure, (separate procedure) - BR

27420 Reconstruction for recurrent dislocating patella; (Hauser type procedure) - $447.44

27422 with extensor realignment and/or muscle advancement or release (Campbell, Goldwaite, etc, type procedure) - $447.43

27424 with patellectomy - $507.09

27430 Quadriceps plasty (Bennett or Thompson type) - $447.44

27435 Capsulotomy, knee, posterior capsular release - $417.60

27438 Arthroplasty, patella, prosthetic - BR

27440 Arthroplasty, knee, tibial plateau; - $596.57

27441 with debridement and partial synovectomy - BR

27442 Arthroplasty, knee, femoral condyles or tibial plateaus; - $715.89

27443 with debridement and partial synovectomy - BR

27444 Arthroplasty, knee, total; fascial - $835.21

27445 prosthetic (eg, Walldius type) - BR

27446 Arthroplasty, knee, condyle and plateau ("total knee" replacement); medial OR lateral compartment - BR

27447 medial AND lateral compartments ("total knee") - BR

27448 Osteotomy, femur, shaft or supracondylar, without fixation; unilateral - BR

27449 bilateral - BR

27450 Osteotomy, femur, shaft or supracondylar, with fixation; unilateral - $566.75

27452 bilateral - BR

27454 Osteotomy, multiple, femoral shaft, with realignment on intramedullary rod (Sofield type procedure) - $596.58

27455 Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bow-leg) or genu valgus (knock-knee)), unilateral; before epiphyseal closure - $417.60

27457 after epiphyseal closure - BR

27460 Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)), bilateral; before epiphyseal closure - $626.41

27462 after epiphyseal closure - BR

27465 Osteoplasty, femur; shortening - $596.57

27466 lengthening - $775.54

27468 combined, lengthening and shortening with femoral segment transfer - BR

27470 Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique, etc) - $596.57

27472 with iliac or other autogenous bone graft (includes obtaining graft) - $686.06

27475 Epiphyseal arrest by epiphysiodesis or stapling; distal femur - $417.60

27477 tibia and fibula, proximal - $477.26

27479 combined distal femur, proximal tibia and fibula - $596.58

27485 Arrest, hemiepiphyseal, distal femur or proximal leg (eg, for genu varus or valgus) - $328.11

Fractures and/or Dislocations

27500 Treatment of closed femoral shaft fracture (including supracondylar); without manipulation (includes traction) - BR

27502 with manipulation - $208.80

27504 Treatment of open femoral shaft fracture (including supracondylar), with uncomplicated soft tissue closure - $328.12

27506 Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation - $566.74

27508 Treatment of closed femoral fracture, distal end, medial or lateral condyle; without manipulation - BR

27510 with manipulation - $238.63

27512 Treatment of open femoral fracture, distal end, medial or lateral condyle, with uncomplicated soft tissue closure - $357.94

27514 Open treatment of closed or open femoral fracture, distal end, medial or lateral condyle, with or without internal or external skeletal fixation - $596.57

27516 Treatment of closed distal femoral epiphyseal separation; without manipulation (includes traction) - BR

27517 with manipulation - BR

27518 Treatment of open distal femoral epiphyseal separation, with uncomplicated soft tissue closure - BR

27519 Open treatment of closed or open distal femoral epiphyseal separation, with or without internal or external skeletal fixation - BR

27520 Treatment of closed patellar fracture, without manipulation - BR

27522 Treatment of open patellar fracture, with uncomplicated soft tissue closure - $119.29

27524 Open treatment of closed or open patellar fracture, with repair and/or excision - $357.94

27530 Treatment of closed tibial fracture, proximal (plateau); without manipulation - BR

27532 with manipulation - $149.15

27534 Treatment of open tibial fracture, proximal (plateau), with uncomplicated soft tissue closure - $239.63

27536 Open treatment of closed or open tibial fracture, proximal (plateau), with of without internal or external skeletal fixation; - $417.60

27537 with autogenous graft (includes obtaining graft) - BR

27538 Treatment of closed intercondylar spine(s) fracture(s) - BR

27540 Open treatment of closed or open intercondylar spine(s) fracture(s), with internal fixation - $417.60

27550 Treatment of closed knee dislocation; without anesthesia - BR

27552 requiring anesthesia - $107.38

27554 Treatment of open knee dislocation, with uncomplicated soft tissue closure - $208.80

27556 Open treatment of closed or open knee dislocation, with or without internal or external skeletal fixation; without primary ligamentous repair - $447.44

27557 with primary ligamentous repair - BR

27560 Treatment of closed patellar dislocation; without anesthesia - BR

27562 requiring anesthesia - $107.38

27564 Treatment of open patellar dislocation, with uncomplicated soft tissue closure - $149.15

27566 Open treatment of closed or open patellar dislocation, with or without partial or total patellectomy - $357.94

Manipulation

27570 Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices) - $35.79

Arthrodesis

27580 Fusion of knee, any technique - $596.57

Amputation

27590 Amputation, thigh, through femur, any level; - $432.52

27591 immediate fitting technique including first cast - BR

27592 open, flap or circular (guillotine) - $417.60

27594 secondary closure or scar revision - BR

27596 reamputation - BR

27598 Disarticulation at knee - $417.60

Miscellaneous

27599 Unlisted procedure, femur or knee - BR

Leg (Tibia and Fibula) and Ankle Joint

Incision

27600 Fasciotomy, leg, anterior compartment, for closed space decompression; - $149.15

27602 including posterior compartment decompression - $208.80

27603 Incision and drainage; deep abscess or hematoma - BR

27604 infected bursa - BR

27605 Tenotomy, Achilles tendon, subcutaneous (separate procedure); local anesthesia - $29.83

27606 general anesthesia - BR

27607 Incicion, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

27608 with suction irrigation - BR

27610 Arthrotomy, ankle, with exploration, drainage or removal of loose or foreign body; - $268.46

27611 with suction irrigation - BR

27612 Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening - $298.29

Excision

27613 Biopsy, soft tissues; superficial - BR

27614 deep - BR

27618 Excision, benign tumor; subcutaneous - BR

27619 deep, subfascial or intramuscular - BR

27620 Arthrotomy, ankle, for biopsy - $268.40

27625 Arthrotomy, ankle, for synovectomy; - $357.94

27626 including tenosynovectomy - BR

27630 Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion, etc) - $107.38

27635 Excision or curettage of bone cyst or benign tumor, tibia or fibula; - $298.29

27635 with primary autogenous graft (includes obtaining graft) - $387.77

27638 with primary homogenous graft - BR

27640 Excision of bone, partial, (craterization, saucerization, or diaphysectomy) for osteomyelitis; tibia - $357.94

27641 fibula - BR

27645 Resection for tumor, radical; tibia - BR

27646 fibula - BR

27647 talus or calcaneus - BR

Introduction or Removal

27648 Injection procedure for ankle arthrography - BR

Repair, Revision or Reconstruction

27650 Suture, primary, ruptured Achilles tendon; - $328.12

27652 with graft (includes obtaining graft) - $417.60

27654 Suture, secondary, ruptured Achilles tendon, with or without graft - BR

27656 Repair, fascial defect of leg - $178.97

27658 Repair or suture of flexor tendon of leg; primary, without free graft, single, each - $178.97

27659 secondary with or without free graft, single tendon, each - $238.63

27664 Repair or suture of extensor tendon of leg; primary, without free graft, single, each - BR

27665 secondary with or without free graft, single tendon, each - $178.97

27675 Repair for dislocating peroneal tendons; without fibular osteotomy - BR

27676 with fibular osteotomy - BR

27680 Tenolysis, including tibia, fibula and ankle flexor; single - $149.15

27681 multiple (through same incision), each - $178.97

27685 Lengthening or shortening of tendon; single (separate procedure - $208.80

27686 multiple (through same incision), each - BR

27687 Gastrocnemius recession (eg, Strayer procedure) - BR

27690 Transfer or transplant of single tendon (with muscel redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot) - $238.63

27691 anterior tibial or posterior tibial through interosseous space - $298.29

27692 each additional tendon - BR

27695 Suture, primary, torn, ruptured or severed ligament, ankle; collateral - $298.29

27696 both collateral ligaments - $417.60

27698 Suture, secondary repair, torn, ruptured or severed ligament, ankle, collateral (eg, Watson-Jones procedure) - $417.60

27700 Arthroplasty, ankle: - BR

27702 with implant ("total ankle") - BR

27704 Removal of ankle implant - BR

27705 Osteotomy; tibia - $357.94

27707 fibula - $208.80

27709 tibia and fibula - $417.60

27712 multiple, with realignment on intramedullary rod (Sofield type procedure) - $304.87

27715 Osteoplasty, tibia and fibula, lengthening - $715.89

27720 Repair of nonunion or malunion, tibia; without graft, (eg, compression technique, etc) - $536.92

27722 with sliding graft - $596.57

27724 with iliac or other autogenous bone graft (includes obtaining graft) - $656.23

27725 by synostosis, with fibula, any method - BR

27727 Repair of congenital pseudarthrosis, tibia - BR

27730 Epiphyseal arrest by epiphysiodesis or stapling; distal tibia - $357.94

27732 distal fibula - $178.97

27734 distal tibia and fibula - $417.60

27740 Epiphyseal arrest by epiphysiodesis or stapling, combined, proximal and distal tibia and fibula; - $536.92

27742 and distal femur - $656.23

Fractures and/or Dislocations

27750 Treatment of closed tibial shaft fracture; without manipulation - BR

27752 with manipulation - $149.15

27754 Treatment of open tibial shaft fracture, with uncomplicated soft tissue closure - $193.89

27756 Open treatment of closed or open tibial shaft fracture, with internal or external skeletal fixation; simple - $357.94

27758 complicated - BR

27760 Treatment of closed distal tibial fracture (medial malleolus); without manipulation - BR

27762 with manipulation - $89.47

27764 Treatment of open distal tibial fracture (medial malleolus), with uncomplicated soft tissue closure - $131.24

27766 Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation - $268.46

27780 Treatment of closed proximal fibula or shaft fracture; without manipulation - BR

27781 with manipulation - BR

27782 Treatment of open proximal fibula or shaft fracture, with uncomplicated soft tissue closure - $119.29

27784 Open treatment of closed or open proximal fibula or shaft fracture, with or without internal or external skeletal fixation - $238.63

27786 Treatment of closed distal fibular fracture (lateral malleolus); without manipulation - BR

27788 with manipulation - $89.47

27790 Treatment of open distal fibular fracture (lateral malleolus), with uncomplicated soft tissue closure - $119.29

27792 Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation - $268.46

27800 Treatment of closed tibia and fibula fractures, shafts; without manipulation - BR

27802 with manipulation - $193.89

27804 Treatment of open tibia and fibula fractures, shafts, with uncomplicated soft tissue closure (eg, "pins above and below") - $238.63

27806 Open treatment of closed or open tibia and fibula fractures, shafts, with or without internal or external skeletal fixation - $432.52

27808 Treatment of closed bimalleolar ankle fracture, (including Potts); without manipulation - BR

27810 with manipulation - $149.15

27812 Treatment of open bimalleolar ankle fracture, with uncomplicated soft tissue closure - $193.89

27814 Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation - $357.94

27816 Treatment of closed trimalleolar ankle fracture; without manipulation - BR

27818 with manipulation - $178.97

27820 Treatment of open trimalleolar ankle fracture, with uncomplicated soft tissue closure - $208.80

27822 Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial and/or lateral malleolus; only - $432.52

27823 including internal skeletal fixation of posterior lip (malleolus) - BR

27830 Treatment of proximal tibiofibular joint dislocation; without anesthesia - BR

27831 requiring anesthesia - BR

27832 Open treatment of proximal tibiofibular joint doslocation with fixation or excision - $238.63

27840 Treatment of ankle dislocation; without anesthesia - BR

27842 requiring anesthesia - $59.65

27844 Treatment of open ankle dislocation, with uncomplicated soft tissue closure - $95.45

27846 Open treatment of closed or open ankle dislocation - $357.94

27848 with fixation - $278.46

Manipulation

27860 Mnaipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus) - $29.83

Arthrodesis

27870 Arthrodesis, ankle, any method - $507.09

27871 Arthrodesis, tibiofibular joint, proximal or distal - BR

Amputation

27880 Amputation leg, through tibia and fibula; - $357.94

27881 with immediate fitting technique including application of first cast - BR

27882 open, flap or circular (guillotine) - $313.20

27884 secondary closure or scar rivision - BR

27886 reamputation - BR

27888 Amputation, ankle, through malleoli of tibia and fibula (Syme, Pirogoff type procedures), with plastic closure and resection of nerves - $357.94

27889 Ankle disarticulation - BR

Miscellaneous

27899 Unlisted procedure, leg or ankle - BR

Foot

Incision

28001 Incision and drainage, infected bursa - BR

28002 Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; single bursal space, specify - BR

28003 multiple areas - BR

28004 multiple areas with suction irrigation - BR

28005 Incision, deep, with opening of bone cortex for osteomyelitis or bone abscess; - BR

28006 with suction irrigation - BR

28008 Fasciotomy, plantar and/or toe, subcutaneous - BR

28010 Tenotomy, subcutaneous, toe; single - $23.86

28011 multiple - $35.79

28020 Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint - $178.97

28022 metatarsophalangeal joint - $107.38

28024 interphalangeal joint - $71.58

28030 Neurectomy of intrinsic musculature of foot - BR

28035 Tarsal tunnel release (posterior tibial nerve decompression) - BR

Excision

28043 Excision, benign tumor; subcutaneous - BR

28045 deep, subfascial, intramuscular - BR

28050 Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint - $178.97

28052 metatarsophalangeal joint - $107.38

28054 interphalangeal joint - $71.58

28060 Fasciectomy, excision of plantar fascia; partial (separate procedure) - $178.97

28062 radical (separate procedure) - BR

28070 Synovectomy; intertarsal or tarsometatarsal joint, each - $178.97

28072 metatarsophalangeal joint, each - $107.38

28080 Excision of Morton neuroma, single, each - $107.38

28086 Synovectomy, tendon sheath; flexor - BR

28088 extensor - BR

28090 Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot - $107.38

28092 toes - $71.58

28100 Excision or curettage of bone cyst or benign tumor, talus or calcaneus; - $178.97

28102 with illiac or other autogenous bone graft (includes obtaining graft) - $208.80

28103 with homogenous bone graft - BR

28104 Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus; - $143.18

28106 with illiac or other autogenous bone graft (includes obtaining graft) - BR

28107 with homogenous bone graft - BR

28108 Excision or curettage of bone cyst or benign tumor, phalanges; - BR

28109 with homogenous bone graft - BR

28110 Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure) - $71.57

28111 Ostectomy; complete excision of first metatarsal head - BR

28112 other metatarsal head (second, third or fourth) - $119.29

28113 fifth metatarsal head - BR

28114 all metatarsal heads with partial proximal phalangectomies (Clayton type procedure) - $357.94

28116 Ostectomy, excision of tarsal coalition - $208.80

28118 Ostectomy, calcaneus; partial (Cotton scoop type procedure) - $208.80

28119 for spur, with or without plantar fascial release - BR

28120 Partial excision of bone (craterization, saucerization, sequestrectomy, or diaphysectomy) for osteomyelitis, talus, or calcaneus; - $178.97

28121 with suction irrigation - BR

28122 Partial excision of bone (craterization, sauceriation, or diaphysectomy) for osteomyelitis, tarsal or metatarsal bone, except talus or calcaneus; - $143.18

28123 with suction irrigation - BR

28124 Partial excision of bone (craterization, saucerization, or diaphysectomy) for osteomyelitis, phalanx - $107.36

28126 Condylectomy, phalangela base, single toe, each - BR

28130 Talectomy (astragalectomy) - $298.29

28135 Calcanectomy - BR

28140 Metatarsectomy - $178.97

28150 Phalangectomy, single, each - $107.36

28153 Resection, head of phalanx - BR

28160 Hemiphalangectomy or interphalangeal joint excision, single each - $89.47

28170 Radical resection for tumor - BR

Introduction and/or Removal

28190 Remove foreign body; subcutaneous - BR

28192 deep - BR

28193 complicated - BR

Repair, Revision or Reconstruction

28200 Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon - $178.97

28202 secondary with free graft, each tendon (includes obtaining graft) - BR

28208 Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon - $83.50

28210 secondary with free graft, each tendon (includes obtaining graft) - $119.29

28220 Tenolysis, flexor; single - $149.12

28222 multiple (through same incision), each - $178.94

28225 Tenolysis, extensor; single - $83.50

28226 multiple (through same incision), each - BR

28230 Tenotomy, open, flexor; foot, single or multiple (separate procedure) - $89.47

28232 toe, single (separate procedure) - $41.76

28234 Tenotomy, open, extensor, foot or toe - $29.83

28236 Transfer of tendon, anterior tibial into tarsal bone (eg, Lowman-Young type procedure) - BR

28238 Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure) - BR

28240 Tenotomy or release, abductor hallucis muscle (McCauley type procedure) - $107.36

28250 Division of plantar fascia and muscle ("Steindler stripping") (separate procedure) - $178.97

28260 Capsulotomy, midfoot; medial release only (separate procedure) - BR

28261 with tendon lengthening - BR

28262 extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity - BR

28264 Capsulotomy, midtarsal (Heyman type procedure) - $357.94

28270 Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure) - $89.47

28272 interphalangeal joint, single, each joint (separate procedure) - $41.75

28280 Webbing operation (create syndactylism of toes) for soft corn (Kelikian type procedure) - $107.36

28285 Hammertoe operation; one toe (eg, interphalangeal fusion, filleting, phalangectomy) (separate procedure) - $143.18

28286 for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure) - BR

28288 Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, second through fifth, each metatarsal head, (separate porcedure) - BR

28290 Hallux valgus (bunion), correction by exostectomy; (Silver type procedure) - $143.18

28292 (Keller, McBride or Mayo type procedure) - $208.80

28293 resection of joint with implant - BR

28294 with tendon transplants (Joplin type procedure) - $283.37

28296 with metatarsal osteotomy (Mitchell or Lapidus type procedure) - $283.37

28298 Halix valgus (bunion) correction; by phalanx osteotomy - BR

28299 by other methods (eg, double osteotomy) - BR

28300 Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation - $283.37

28302 talus - BR

28304 Osteotomy, midtarsal bones, other than calcaneus or talus; - $238.63

28305 with autogenous graft (includes obtaining graft) (Fowler type) - BR

28306 Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal - $208.80

28308 other than first metatarsal - $167.04

28309 Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure) - BR

28310 Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure) - BR

28312 other phalanges, any toe - $59.65

28320 Repair of nonunion or malunion; tarsal bones (calcaneus, talus, etc) - BR

28322 metatarsal, with or without bone graft (includes obtaining graft) - $143.18

Fracture and/or Dislocation

28400 Treatment of closed calcaneal fracture; without manipulation - BR

28405 with manipulation including Cotton or Bohler type reductions - BR

28406 with manipulation and skeletal fixation - BR

28410 Treatment of open calcaneal fracture, with uncomplicated soft tissue closure - BR

28415 Open treatment of closed or open calcaneal fracture, with or without internal or external skeletal fixation; - $298.29

28420 with primary iliac or other autogenous bone graft (includes obtaining graft) - $432.52

28430 Treatment of closed talus fracture; without manipulation - BR

28435 with manipulation - BR

28440 Treatment of open talus fracture, with uncomplicated soft tissue closure - BR

28445 Open treatment of closed or open talus fracture, with or without internal or skeletal fixation - $298.29

28450 Treatment of closed tarsal bone fracture (except talus and calcaneus); without manipulation, each - BR

28455 with manipulation, each - BR

28460 Treatment of open tarsal bone fracture (except talus and calcaneus), with uncomplicated soft tissue closure, each - $89.47

28465 Open treatment of closed or open tarsal bone fracture (except talus and calcaneus), with or without internal or external skeletal fixation, each - $178.97

28470 Treatment of closed metatarsal fracture; without manipulation, each - BR

28475 with manipulation, each - $65.62

28480 Treatment of open metatarsal fracture, with uncomplicated soft tissue closure, each - $89.47

28485 Open treatment of closed or open metatarsal fracture, with or without internal or external skeletal fixation, each - $178.97

28490 Treatment of closed fracture great toe, phalanx or phalanges; without manipulation - BR

28495 with manipulation - $35.79

28500 Treatment of open fracture great toe, phalanx or phalanges, with uncomplicated soft tissue closure - $53.69

28505 Open treatment of closed or open fracture great toe, phalanx or phalanges, with or without internal or external skeletal fixation - BR

28510 Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each - BR

28515 with manipulation, each - $29.83

28520 Treatment of open fracture, phalanx or phalanges, other than great toe, with uncomplicated soft tissue closure, each - $47.72

28525 Open treatment of closed or open fracture, phalanx or phalanges, other than great toe, with or without internal or external skeletal fixation, each - BR

28540 Treatment of closed tarsal bone dislocation; without anesthesia - BR

28545 requiring anesthesia - $59.65

28546 Treatment of closed tarsal bone dislocation, with percutaneous skeletal fixation - BR

28550 Treatment of open tarsal bone dislocation, with uncomplicated soft tissue closure - $83.50

28555 Open treatment of closed or open tarsal bone dislocation, with or without internal or external skeletal fixation - $178.97

28570 Treatment of closed talotarsal joint dislocation; with anesthesia - BR

28575 requiring anesthesia - $71.57

28580 Treatment of open talotarsal joint dislocation, with uncomplicated soft tissue closure - BR

28585 Open treatment of closed or open talotarsal joint dislocation, with or without internal or external skeletal fixation - $298.29

28600 Treatment of closed tarsometatarsal joint dislocation; without anesthesia - $21.47

28605 requiring anesthesia - $59.65

28606 Treatment of closed tarsometatarsal joint dislocation, with percutaneous skeletal fixation - BR

28610 Treatment of open tarsometatarsal joint dislocation, with uncomplicated soft tissue closure - $83.50

28615 Open treatment of closed or open tarsometatarsal joint dislocation, with or without internal or external skeletal fixation - $178.97

28630 Treatment of closed metatarsophalangeal joint dislocation; without anesthesia - BR

28635 requiring anesthesia - BR

28640 Treatment of open metatarsophalangeal joint dislocation, with uncomplicated soft tissue closure - $59.65

28645 Open treatment of closed or open metatarsophalangeal joint dislocation - $119.29

28660 Treatment of closed interphalangeal joint dislocation; without anesthesia - $21.47

28665 requiring anesthesia - $35.79

28670 Treatment of open interphalangeal joint dislocation, with uncomplicated soft tissue closure - $47.73

28675 Open treatment of closed or open interphalangeal joint dislocation - $71.57

Arthrodesis

28705 Pantalar arthrodesis - $566.74

28715 Triple arthrodesis - $447.43

28725 Subtalar arthrodesis (includes Grice type procedure) - $357.94

28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse - $328.12

28735 with osteotomy as for flatfoot correction - $417.60

28737 Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure) - BR

28740 Arthrodesis, midtarsal or tarsometatarsal, single joint - $268.46

28750 Arthrodesis, great toe; metatarsophalangeal joint - $208.80

28755 interphalangeal joint - $119.31

28760 Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure) - $178.97

Amputation

28800 Amputation, foot; midtarsal (Chopart type procedure) - $298.29

28805 transmetatarsal - $298.29

28810 Amputation, metatarsal, with toe, single - $178.97

28820 Amputation, toe; metatarsophalangeal joint - $178.97

28825 interphalangeal joint - $59.65

Miscellaneous

28899 Unlisted procedure, foot or toes - BR

Application of Casts and Strapping

Body and Upper Extremity Casts

29000 Application of halo type body cast (see 20661-20663 for insertion) - 149.15

29010 Application of Risser jacket, localizer, body; only - $89.47

29015 including head - $107.38

29020 Application of turnbuckle jacket, body; only - $89.47

29025 including head - $107.36

29035 Application of body cast, shoulder to hips; - $47.72

29040 including head, Minerva type - $65.62

29044 including one thigh - $59.65

29046 including both thighs - $65.42

29049 Application; plaster figure of eight - BR

29055 shoulder spica - $53.69

29058 plaster Velpeau - BR

29065 shoulder to hand (long arm) - $23.86

29075 elbow to finger (short arm) - $17.90

29085 hand and lower forearm (guantlet) - $17.90

Splints

29105 Application of long arm splint (shoulder to hand) - $17.90

29125 Application of short arm splint (forearm to hand); static - $14.92

29126 dynamic - BR

29130 Application of finger splint; static - BR

29131 dynamic - BR

Strapping - Any Age

29200 Strapping; thorax - $11.94

29220 low back - $14.92

29240 shoulder (eg, Velpeau) - $17.90

29260 elbow or wrist - $7.16

29280 hand or finger - BR

Lower Extremity Casts

29305 Application of hip spica cast; unilateral - BR

29325 bilateral, or one and one-half spica - BR

29345 Application of long leg cast (thigh to toes); - $32.80

29355 walker or ambulatory type - $38.78

29358 Application of long leg cast brace - BR

29365 Application of cylinder cast (thigh to ankle) - $29.83

29405 Application of short leg cast (below knee to toes); - $23.86

29425 walking or ambulatory type - $29.83

29435 Application of patellar tendon bearing (PTB) cast - BR

29440 Adding walker to previously applied cast - $8.95

29450 Application of clubfoot cast with molding or manipulation, long or short leg; unilateral - $11.94

29455 bilateral - $23.86

Splints

29505 Application of long leg splint (thigh to ankle or toes) - $21.47

29515 Application of short leg splint (calf to foot) - $17.90

Strapping - Any Age

29520 Strapping; hip - $14.92

29530 knee - $11.94

29540 ankle - $8.95

29550 toes - BR

29580 Unna boot - $11.94

29590 Denis-Browne splint strapping - BR

Removal or Repair

29700 Removal or bivalving; gauntlet, boot or body cast - $11.94

29705 full arm or full leg cast - BR

29710 shoulder or hip spica, Minerva, or Risser jacket, etc - $14.92

29715 turnbuckle jacket - BR

29720 Repair of spica, body cast or jacket - $7.16

29730 Windowning of cast - $7.16

29740 Wedging of cast (except clubfoot casts) - $8.95

29750 Wedging of clubfoot cast; unilateral - $8.95

29751 bilateral - $11.94

Miscellaneous

29799 unlisted procedure, casting or strapping - BR

RESPIRATORY SYSTEM

Nose

Incision

30000 Drainage abscess or hematoma, nasal, internal approach - $35.79

30020 Drainage abscess or hematoma, nasal septum - $41.76

Excision

30100 Biopsy, intranasal - $17.90

30110 Excision, nasal polyp(s); office type procedure - $41.76

30115 extensive, requiring hospitalization - $119.29

30117 Excision, intranasal lesion; internal approach - BR

30118 external approach (lateral rhinotomy) - BR

30120 Excision or surgical planing of skin of nose for rhinophyma - $298.29

30124 Excision dermoid cyst, nose; simple, skin, subcutaneous - BR

30125 complex, under bone or cartilage - BR

30130 Excision turbinate, partial or complete - $59.65

30140 Submucous resection turbinate, partial or complete - $178.97

30150 Rhinectomy; partial - BR

30160 total - BR

Introduction

30200 Injection into turbinate(s), therapeutic - $14.32

30210 Displacement therapy (Proetz type) - BR

Removal Foreign Body

30300 Removal foreign body, intranasal; office type procedure - $11.92

30310 requiring general anesthesia - BR

30320 by lateral rhinotomy - BR

Repair

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip - $357.94

30410 complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip - $536.92

30420 including major septal repair - $596.57

30430 Rhinoplasty, secondary; minor revision - $89.47

30450 major revision - $335.50

30500 Submucous resection nasal septum, classic - $238.63

30520 Septoplasty with or without cartilage implant (separate procedure) - $298.28

30540 Repair choanal atresia; intranasal - $328.12

30545 transpalatine - BR

30560 Lysis intranasal synechia - BR

30580 Repair fistula; oromaxillary (combine with 31030 if antrotomy is included) - $298.29

30600 oronasal - BR

30620 Reconstruction, functional, internal nose (septal or other intranasal dermatoplasty) (does not include obtaining graft) - $298.29

30630 Repair nasal septal perforations - BR

Destruction

30800 Cauterization turbinates, unilateral or bilateral (separate procedure); superficial - $11.92

30805 intramural - $41.76

Other Procedures

30900 Control hemorrhage, nasal, with or without cauterization or anterior packs; anterior, unilateral or bilateral - $17.90

30905 posterior, initial, with posterior nasal packs - BR

30906 posterior, subsequest, with posterior nasal packs - $47.73

30915 Ligation arteries; ethmoidal - BR

30920 internal maxillary artery, transantral - BR

30999 Unlisted procedure, nose - BR

Accessory Sinuses

Incision

31000 Lavage by cannulation; maxillary sinus, unilateral (antrum puncture or natural ostium) - $11.92

31001 maxillary sinuses, bilateral - $17.90

31002 sphenoid sinus - BR

31020 Sinusotomy, maxillary (antrotomy); intranasal, unilateral - $89.47

31021 intranasal, bilateral - $178.97

31030 radical, unilateral (Caldwell-Luc) - $357.34

31031 radical, bilateral (Caldwell-Luc) - $477.26

31040 Surgery on pterygomaxillary fossa contents by transantral approach - BR

31050 Sinusotomy, sphenoid - $328.12

31070 Sinusotomy frontal; external, simple (trephine operation) - $289.29

31075 transorbital, unilateral (for mucocele or osteoma, Lynch type) - $477.26

31080 obliterative without osteoplastic flap, brow incision - $715.89

31081 obliterative, without osteoplastic flap, coronal incision - BR

31084 obliterative, with osteoplastic flap, brow incision - BR

31085 obliterative, with osteoplastic flap, coronal incision - BR

31090 Sinusotomy combined, three or more sinuses - $775.54

Excision

31200 Ethmoidectomy; intranasal, anterior - $178.97

31201 intranasal, total - BR

31205 extranasal, total - $387.77

31225 Maxillectomy; without orbital exenteration - BR

31230 with orbital exenteration (en bloc) - BR

Other Procedures

31245 Transnasal pituitary procedure other than hypophysectomy - BR

31299 Unlisted procedure, accessory sinuses - BR

Larynx

Excision

31300 Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy - $477.26

31320 diagnostic - $238.59

31360 Laryngectomy; total, without radical neck dissection - $775.54

31365 total, with radical neck dissection - $1,014.18

31367 subtotal supraglottic, without radical neck dissection - BR

31368 subtotal supraglottic, with radical neck dissection - BR

31370 Partial laryngectomy (hemilaryngectomy); horizontal - $894.70

31375 laterovertical - $596.50

31380 anterovertical - $596.50

31382 antero-latero-vertical - BR

31390 Pharyngolaryngectomy, with radical neck dissection; without reconstruction - BR

31395 with reconstruction - BR

31400 Arytenoidectomy or arytenoidopexy, external approach - $596.57

31420 Epiglottidectomy - $477.26

Introduction

31500 Intubation, endotracheal, emergency procedure - $41.76

Endoscopy

31505 Laryngoscopy, indirect (separate procedure); diagnostic - BR

31510 with biopsy - $41.76

31511 with removal of foreign body - BR

31512 with removal of lesion - BR

31515 Laryngoscopy direct; for aspiration - $17.90

31520 diagnostic, newborn - $71.57

31525 diagnostic, except newborn - $119.31

31526 diagnostic, with operating microscope - BR

31530 Laryngoscopy, operative, with foreign body removal; - $178.97

31531 with operating microscope - BR

31535 Laryngoscopy, operative, with biopsy; - $178.97

31536 with operating microscope - BR

31540 Laryngoscopy, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; - $178.97

31541 with operating microscope - BR

31560 Laryngoscopy, operative, with arytenoidectomy; - BR

31561 with operating microscope - BR

31570 Laryngoscopy with injection into vocal cord(s), therapeutic; - $178.97

31571 with operating microscope - BR

Repair

31580 Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal - BR

31582 for laryngeal stenosis, with graft or core mold, including tracheotomy - BR

31584 withopen reduction of fracture - BR

31585 Treatment of closed laryngeal fracture; without manipulation - BR

31586 with closed manipulative reduction - BR

Other Procedures

31599 Unlisted procedure, larynx - BR

Trachea and Bronchi

Incision

31600 Tracheostomy (separate procedure); - $161.07

31601 under two years - $178.97

31605 Cricothyroidostomy (separate procedure) - BR

31610 Tracheostomy, fenestration procedure with skin flaps - $208.80

31612 Tracheal puncture, percutaneous for aspiration of mucus (transtracheal aspiration) - BR

Endoscopy

31615 Tracheoscopy through established tracheostomy incision - BR

31620 Bronchoscopy; diagnostic, rigid bronchoscope - $107.38

31621 diagnostic, fiberoptic bronchoscope (flexible) - BR

31625 with biopsy, rigid bronchoscope - $149.15

31626 with biopsy, fiberoptic bronchoscope (flexible) - BR

31627 with brushing, fiberoptic bronchoscope (flexible) - BR

31630 with tracheal or bronchial dilation or closed reduction of fracture - $178.97

31635 with removal of foreign body - $167.05

31640 with excision of tumor - $149.14

31645 with therapeutic aspiration of tracheobronchial tree, intiial - $119.29

31646 with therapeutic aspiration of tracheobronchial tree, subsequent - $77.55

31650 with drainage of lung abscess or cavity, initial - $119.29

31651 with drainage of lung abscess or cavity, subsequent - $77.55

31656 with injection of contrast material for segmental bronchography (fiberscope only) - BR

31659 with other bronchoscopic procedures - BR

Introduction

31700 Catheterization, transglottic (separate procedure) - BR

31708 Installation of contrast material for laryngography or bronchography, without catheterization - BR

31710 Catheterization for bronchography, with or without instillation of contrast material - $23.86

31715 Transtracheal injection for bronchography - BR

31717 Catheterization with bronchial brush biopsy - BR

31719 Transtracheal (percutaneous) introduction of indwelling tube for therapy (tickle tube) - BR

31720 Catheter aspiration (separate procedure); nasotracheobronchial - BR

31725 tracheobronchial with fiberscope, bedside - BR

Repair

31750 Tracheoplasty; cervical - BR

31755 tracheopharyngeal fistulization (Asai technique), each stage - BR

31760 intrathoracic - BR

31770 Bronchoplasty; graft repair - BR

31775 excision stenosis and anastomosis - BR

31780 Excision tracheal stenosis and anastomosis; cervical - BR

31781 cervicothoracic - BR

31785 Excision of tracheal tumor or carcinoma; cervical - BR

31786 thoracic - BR

Suture

31800 Suture of external tracheal wound or injury; cervical - BR

31805 intrathoracic - BR

31820 Surgical closure tracheostomy or fistula; without plastic repair - $119.29

31825 with plastic repair - $178.97

31830 Revision of tracheostomy scar - BR

31899 Unlisted procedure, trachea, bronchi - BR

Lungs and Pleura

Incision

32000 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent - $21.47

32020 Tube thoracostomy with water seal, pneumothorax, hemothorax, empyema (separate procedure) - $35.79

32035 Thoracostomy; with rib resection for empyema - BR

32036 with open flap drainage for empyema - BR

32095 Thoracotomy limited, for biopsy of lung or pleura - BR

32100 Thoracotomy, major; with exploration and biopsy - $357.34

32110 with control of traumatic hemorrhage and/or repair of lung tear - $477.26

32120 for postoperative complications - $477.26

32124 with open intrapleural pheumonolysis - BR

32140 with cyst(s) removal with or without a pleural procedure - $477.26

32141 with excision-plication of bullae, with or without any pleural procedure - BR

32150 with removal of intrapleural foreign body or fibrin deposit - $417.60

32151 with removal of intrapulmonary foreign body - BR

32160 with cardiac massage - BR

32200 Pneumonostomy, with open drainage of abscess or cyst - $417.60

32215 Pleural scarification for repeat pneumothorax - BR

32220 Decortication, pulmonary, (separate procedure); total - $596.57

32225 partial - $417.60

Excision

32310 Pleurectomy; parietal (separate procedure) - BR

32315 partial - BR

32320 Decortication and parietal pleurectomy - BR

32400 Biopsy, pleura; needle - $35.79

32402 open - BR

32405 Biopsy, lung, percutaneous, needle - BR

32420 Pneumonocentesis, puncture of lung for aspiration - $35.79

32440 Pneumonectomy, total - $894.86

32445 Pneumonectomy, extrapleural; without empyemectomy - BR

32450 with empyemectomy - BR

32480 Lobectomy, total or segmental; - $775.54

32485 with bronchoplasty - $894.86

32490 with concomitant decortication - $894.86

32500 Wedge resection of lung, single or multiple - $656.23

32520 Resection of lung; with resection of chest wall - BR

32522 with reconstruction of chest wall, without prosthesis - BR

32525 with major reconstruction of chest wall, with prosthesis - BR

32540 Extrapleural enucleation of empyema (empyemectomy); - $596.58

32545 with lobectomy - $894.86

Endoscopy

32700 Thoracoscopy, exploratory (separate procedure); - $119.31

32705 with biopsy - $119.31

Repair

32800 Repair lung hernia through chest wall - BR

32810 Closure of chest wall following open flap drainage for empyema (Clagett type procedure) - BR

32815 Open closure of major bronchial fistula - BR

32820 Major reconstruction, chest wall (post-traumatic) - BR

Surgical Collapse Therapy; Thoracoplasty

32900 Resection of ribs, extrapleural, all stages - $417.60

32905 Thoracoplasty, Schede type or extrapleural (all stages); - BR

32906 with closure of bronchopleural fistula - BR

32940 Pneumonolysis, extraperiosteal, including filling or packing procedures - $417.60

32960 Pneumothorax, therapeutic, intrapleural injection of air - $29.83

32999 Unlisted procedure, lungs and pleura - BR

CARDIOVASCULAR SYSTEM

Heart and Pericardium

Pericardium

33010 Pericardiocentesis; initial - $35.79

33011 subsequent - BR

33015 Tube pericardiostomy - BR

33020 Pericardiotomy for removal of clot or foreign body (primary procedure) - $596.57

33025 Creation of pericardial window or partial resection for drainage - BR

33030 Partial resection for chronic constrictive pericarditis, without bypass - BR

33035 Complete ventricular decortication, with bypass - BR

33050 Excision of pericardial cyst or tumor - BR

33100 Pericardiectomy (separate procedure) - $1,014.18

Cardiac Tumor

33120 Excision of intracardiac tumor, resection with bypass - $1,491.44

33130 Resection of external cardiac tumor - BR

Pacemaker

33200 Insertion of permanent pacemaker with epicardial electrode; by thoracotomy - $715.89

33201 by xiphoid approach - BR

33205 Insertion of permanent pacemaker with transvenous electrodes - BR

33210 Insertion of temporary transvenous cardiac electrode, or pacemaker catheter (separate procedure) - $208.80

33212 Insertion or replacement of pulse generator only - BR

33216 Insertion, replacement, or repositioning of permanent transvenous electrodes only (15 days or more after initial insertion) - BR

33218 Repair of pacemaker; electrodes only - BR

33219 with replacement of pulse generator - BR

Wounds of the Heart and Great Vessels

33300 Repair of cardiac wound; without bypass - $715.89

33305 with bypass - BR

33310 Cardiotomy, exploratory (includes removal of foreign body); without bypass - BR

33315 with bypass - BR

33320 Suture repair of aorta or great vessels; without bypass - BR

33322 with bypass - BR

33330 Insertion of graft; without bypass - BR

33350 Great vessel repair with other major procedure - BR

Cardiac Valves
Aortic Valve

33400 Valvuloplasty, aortic valve, open, with bypass - $1,491.44

33405 Replacement, aortic valve - $1,551.09

33407 Valvotomy, aortic valve (commissurotomy); with bypass - BR

33408 with inflow occlusion - BR

33415 Resection of aortic valve for subvalvular stenosis - BR

33417 Aortoplasty (gusset) for supravalvular stenosis - BR

Mitral Valve

33420 Valvotomy, mitral valve (commissurotomy); closed - $954.51

33422 open, with bypass - BR

33425 Valvuloplasty, mitral valve, with bypass - $1,551.09

33430 Replacement, mitral valve, with bypass - $1,551.09

Tricuspid Valve

33450 Valvotomy, tricuspid valve (commissurotomy); closed - BR

33452 open, with bypass - BR

33460 Valvuloplasty or valvectomy, tricuspid valve, with bypass; - $1491.45

33465 replacement - $1,551.09

33468 Tricuspid valve repositioning and plication for Ebstein anomaly - BR

Pulmonary Valve

33470 Valvotomy, pulmonary valve (commissurotomy); closed (transventricular) - $954.51

33472 open, with inflow occlusion - $954.51

33474 open, with bypass - BR

33476 Right ventricular resection for infundibular stenosis, with or without commissurotomy - $1,491.44

33478 Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection - BR

Multiple Valve Procedures

33480 Replacement and/or repair, double valve procedure, by methods 33400-33465 - $2,088.01

33481 Single valve replacement; with commissurotomy or valvuloplasty of another valve - BR

33482 with commissurotomy or valvuloplasty of two valves - BR

33483 Double valve replacement; - BR

33485 with commissurotomy or valvuloplasty of one valve - BR

33490 Replacement and/or repair, triple valve procedure, by methods 33400-33465 - $2,386.30

33492 Triple valve replacement - BR

Coronary Artery Procedures

33502 Anomalous coronary artery; ligation - BR

33503 graft, without bypass - BR

33504 graft, with bypass - BR

33510 Coronary artery bypass, autogenous graft, eg, saphenous vein or internal mammary artery; single artery - BR

33515 two coronary arteries - BR

33518 three or more coronary arteries - BR

33520 Coronary artery bypass, nonautogenous graft (eg, synthetic or cadaver); single artery - BR

33525 two coronary arteries - BR

33528 three or more coronary arteries - BR

33532 Myocardial implantation, one or more systemic arteries (Vineberg type operation) - BR

Postinfarction Myocardial Procedures

33542 Myocardial resection (eg, ventricular aneurysmectomy) - BR

33545 Repair of postinfarction ventricular septal defect, with or without myocardial resection - BR

33560 Myocardial operation combined with coronary bypass procedure - BR

33570 Coronary angioplasty (endarterectomy with or without gas, arterial implantation or anastomosis), with bypass; - $1789.74

33575 combined with vascularization - $2028.37

Septal Defect

33640 Repair atrial septal defect, secundum; without bypass - $954.51

33641 with bypass - $1,372.12

33643 patch closure, with or without anomalous pulmonary venous drainage - BR

33645 Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage - BR

33649 Repair of tricuspid atresia (eg, Fontan, Gago procedures) - BR

33660 Patch closure, endocardial cushion defect, with or without repair of mitral and/or tricuspid cleft; - $1,491.44

33665 with repair of separate ventricular septal defect - BR

33670 Repair of complete atrioventricular canal, with or without prosthetic valve - BR

33681 Closure ventricular septal defect; direct - BR

33682 patch - BR

33684 with pulmonary valvotomy or infundibular resection (acyanotic) - BR

33688 with removal of pulmonary artery band, with or without gusset - BR

33690 Banding of pulmonary artery - $715.89

33692 Total repair tetralogy of Fallot; intact outflow tract - BR

33694 with outflow tract gusset - $1,491.44

33696 with closure or previous shunt - BR

Sinus of Valsalva

33702 Repair sinus of Valsalva fistula, with bypass; - $1,491.44

33710 with repair of ventricular septal defect - BR

33720 Repair sinus of Valsalva aneurysm, with bypass - BR

Total Anomalous Pulmonary Venous Drainage

33730 Complete repair of anomalous venous return (supra-cardiac, intracardiac, or infracardiac types) - BR

Shunting Procedures

33735 Atrial septectomy; closed (Blalock-Hanion type operation) - BR

33737 open, with inflow occlusion - BR

33738 transvenous method, balloon, Rashkind type (includes cardiac catheterization) - BR

33750 Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation) - BR

33755 ascending aorta to pulmonary artery (Waterston type operation) - BR

33762 descending aorta to pulmonary artery (Potts-Smith type operation) - BR

33766 vena cava to pulmonary artery (Glenn type operation) - BR

Transposition of the Great Vessels

33782 Repair transposition of great vessels, atrial baffle procedure (Mustard type); with bypass - BR

33783 with removal of pulmonary artery band, with or without gusset - BR

33784 with closure of ventricular septal defect - BR

Truncus Arteriosus

33786 Total repair, truncus arteriosus (Rastelli type operation) - BR

33788 Replant pulmonary artery for hemitruncus - BR

Aortic Anomalies

33802 Division of aberrant vessel (vascular ring); - $715.89

33803 with reanastomosis - BR

33810 Creation of aortoplumonary window; without bypass - BR

33812 with bypass - BR

33820 Patent ductus arteriosus; ligation (primary procedure) - BR

33822 division, under 18 years - $715.89

33824 division, 18 years and older - $1,073.83

33830 ligation or division when performed with another procedure - BR

33840 Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis - BR

33845 with graft - BR

33850 with shunt, left subclavian to descending aorta (Blalock-Park type operation) - BR

Thoracic Aortic Aneurysm

33860 Ascending aorta graft, with bypass; with or without valve suspension - BR

33865 with valve replacement - BR

33870 Transverse arch graft, with bypass - BR

33875 Descending thoracic aorta graft, with or without bypass - BR

Pulmonary Artery

33910 Pulmonary artery embolectomy; with bypass - BR

33915 without bypass - BR

Miscellaneous

33950 Cardiac transplantation, including removal of donor heart - BR

33960 Prolonged extracorporeal circulation for cardiopulmonary insufficiency - BR

33970 Intra-aortic balloon counterpulsation; insertion and removal - BR

33972 monitoring only - BR

33999 Unlisted procedure, cardiac surgery - BR

Arteries and Veins

Arterial Embolectomy or Thrombectomy, with or without Catheter

34001 Embolectomy or thrombectomy, with or without catheter; carotid, subclavian artery, by neck incision - BR

34051 innominate, subclavian artery, by thoracic incision - BR

34101 axillary, brachial, innominate, subclavian artery, by arm incision - BR

34151 renal, celiac, mesentery, aortoiliac artery, by abdominal incision - BR

34201 femoropopliteal, aortoiliac artery, by leg incision - BR

Venous Thrombectomy, Direct or With Catheter

34401 Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision - BR

34421 vena cava, iliac, femoropopliteal vein, by leg incision - BR

34451 vena cava, iliac, femoropopliteal vein, by abdominal and leg incision - BR

34471 subclavian vein, by neck incision - BR

34490 axillary and subclavian vein, by arm incision - BR

Direct Repair of Aneurysm or Excision (Partial or Total) and Graft Insertion for Aneurysm, False Aneurysm, or Occlusive Disease

35001 Direct repair of aneurysm or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm or occlusive disease; carotid, subclavian artery, by neck incision - $835.21

35011 axillary-brachial artery, by arm incision - $835.21

35021 innominate, subclavian artery, by thoracic incision - BR

35081 abdominal aorta - BR

35091 abdominal aorta involving visceral vessels (mesenteric, celiac, renal) - BR

35102 Abdominal aorta involving iliac vessels (common, hypogastric, external) - BR

35111 splenic artery - BR

35121 hepatic, celiac, renal, or mesenteric artery - BR

35131 iliac artery (common, hypogastric, external) - BR

35141 common femoral artery (profunda femoris, superficial femoral) - BR

35151 popliteal artery - BR

35161 other arteries (eg, radial, brachial, ulnar) - BR

Repair Blood Vessel or Arteriovenous Fistula, with or without Patch Graft

35201 Repair blood vessels or A-V fistula, direct; neck - BR

35206 upper extremity - BR

35211 intrathoracic, with bypass - BR

35216 intrathoracic, without bypass - BR

35221 intra-abdominal - BR

35226 lower extremity - BR

35231 Repair blood vessel or A-V fistula with vein graft; neck - BR

35236 upper extremity - BR

35241 intrathoracic, with bypass - BR

35246 intrathoracic, without bypass - BR

35251 intra-abdominal - BR

35256 lower extremity - BR

35261 Repair blood vessel or A-V fistula with graft other than vein; neck - BR

35266 upper extremity - BR

35271 intrathoracic, with bypass - BR

35276 intrathoracic, without bypass - BR

35281 intra-abdominal - BR

35286 lower extremity - BR

Thromboendarterectomy

35301 Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision - $894.86

35311 subclavian, innominate, by thoracic incision - BR

35321 axillary-brachial - $894.86

35331 abdominal aorta - $1,193.15

35341 mesenteric, celiac, or renal - BR

35351 iliac - $954.51

35361 combined aortoiliac - $1,193.15

35371 common and/or deep (profunda) femoral - $835.21

35381 femoral and/or popliteal, and/or tibioperoneal - $835.21

Bypass Graft--Vein

35501 Bypass graft, vein; carotid - BR

35506 carotid-subclavian - $894.86

35507 subclavian-carotid - BR

35509 carotid-carotid - BR

35511 subclavian-subclavian - BR

35516 subclavian-axillary - $894.86

35521 axillary-femoral - $894.86

35526 aortosubclavian or carotid - $954.51

35531 aortoceliac, mesenteric, or renal - BR

35536 splenorenal - $954.51

35541 aortoiliac - $1,193.15

35546 aortofemoral - $1,193.15

35548 aortoiliofemoral, unilateral - BR

35549 aortoiliofemoral, bilateral - BR

35551 aortofemoral-popliteal - $1,193.15

35556 femoral-popliteal - BR

35558 femoral-femoral - BR

35563 ilioiliac - BR

35565 iliofemoral - BR

35566 femoral-anterior tibial, posterior tibial, or peroneal artery - BR

35571 popliteal-tibial - BR

Bypass Graft--with Other than Vein Including Mandril Grown Graft

35601 Bypass graft, with other than vein; carotid - BR

35606 carotid-subclavian - BR

35612 subclavian-subclavian - BR

35616 subclavian-axillary - BR

35621 axillary-femoral - BR

35626 aortosubclavian or carotid - BR

35631 aortoceliac, mesenteric, renal - BR

35636 splenorenal - BR

35641 aortoiliac - BR

35646 aortofemoral - BR

35651 aortofemoral-popliteal - BR

35656 femoral-popliteal - BR

35661 femoral-femoral - BR

35663 ilioiliac - BR

35665 iliofemoral - BR

35666 femoral-anterior tibial, posterior tibial, or peroneal artery - BR

35671 popliteal-tibial - BR

Exploration (Not Followed by Surgical Repair), with or without Lysis of Artery

35701 Exploration; carotid artery - $298.29

35721 femoral artery - $238.63

35741 popliteal artery - $238.63

35761 other vessels - BR

Exploration for Postoperative Hemorrhage or Thrombosis

35800 Exploration for postoperative hemorrhage or thrombosis; neck - BR

35820 chest - BR

35840 abdomen - BR

35860 extremity - BR

Excision of Graft

35900 Excision of infected graft; - BR

35910 with revascularization - BR

Vascular Injection Procedures

Intravenous

36000 Introduction of needle or intracatheter, vein; unilateral - $29.80

36001 bilateral - $41.76

36010 Introduction of catheter; in superior or inferior vena cava, right heart or pulmonary artery - $59.65

36020 by selective catheterization of renal, adrenal, hepatic, and other veins - $119.29

Intraosseous

36030 Introduction of needle, intraosseous - BR

Intra-Arterial--Intra-Aortic

36100 Introduction of needle or intracatheter, carotid or vertebral artery; unilateral - $149.14

36101 bilateral - $179.42

36120 Introduction of needle or intracatheter; retrograde brachial artery - $164.06

36140 extremity artery - BR

36145 Arteriovenous shunt for dialysis (cannula, fistula or graft) - BR

36160 Introduction of needle or intracatheter, aortic, translumbar - BR

36200 Introduction of catheter; aorta (arch, abdominal, midstream renal, aortoiliac run-off) - $119.31

36210 cerebral artery, selective, single - $173.00

36220 multiple cerebral arteries, with or without midstream arch injection - $208.79

36230 coronary artery, selective, unilateral or bilateral - $178.97

36240 renal, celiac, mesenteric or other artery, selective, single with or without midstream injection - $149.15

36250 bilateral renal or multiple arteries - $178.97

36299 Unlisted procedure, vascular injection - BR

Venous

36400 Venipuncture, under age 3 years; femoral, jugular or sagittal sinus - $11.94

36405 scalp vein - $17.90

36410 Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for venography (upper extremity, vena cava, adrenal, renal, iliac, femoral, poplieal, tibial, saphenous, jugular, innominate vein). Not to be used for routine venipuncture. - $5.96

36420 Venipuncture, cutdown; under age 1 year - $29.82

36425 age 1 or over - $21.47

36430 Transfusion, blood or blood components; indirect - $11.94

36431 direct - $35.79

36440 Push transfusion, blood, 2 years or under - $35.79

36450 Exchange transfusion, blood; newborn - $208.80

36455 other than newborn - BR

36460 Transfusion, intrauterine, fetal - BR

36470 Injection of sclerosing solution; single vein - $8.35

36471 multiple veins, same leg - $11.94

36480 Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous - $23.86

36485 by cutdown - $23.86

36490 Cutdown placement of central venous catheter for hyperalimentation; age 2 years or under - BR

36491 over age 2 - BR

36500 Venous catheterization for selective organ blood sampling - BR

36510 Catheterization of umbilical vein for diagnosis or therapy, newborn - $17.90

Arterial

36600 Arterial puncture, withdrawal of blood for diagnosis - $5.96

36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous - $29.82

36625 cutdown - $41.76

36640 Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown - BR

36660 Catheterization, umbilical artery, newborn, for diagnosis or therapy - $29.83

Intervascular Cannulization or Shunt (Separate Procedure)

36800 Insertion of cannula for hemodialysis, other purpose; vein to vein - BR

36810 arteriovenous, external (Scribner type) - $268.46

36815 arteriovenous, external revision or closure - $178.97

36820 arteriovenous, internal (Cimino type) - BR

36821 Arteriovenous anastomosis, direct, any site - BR

36825 Arteriovenous fistula; autogenous graft - BR

36830 nonautogenous graft - BR

36835 Thomas shunt - BR

36840 Insertion mandril - BR

36845 Anastomosis mandril - BR

36860 Cannula declotting; without balloon catheter - BR

36861 with balloon catheter - BR

37140 Anastomosis; portacaval - $954.51

37145 renoportal - BR

37160 caval-mesenteric - $954.51

37180 splenorenal - $954.51

37190 Plastic repair of arteriovenous aneurysm - BR

Repair, Ligation and other Procedures

37400 Arteriorrhaphy, suture of major artery, wound or injury (separate procedure); neck - $357.94

37420 chest - $596.57

37440 abdomen - $596.57

37460 extremity - $298.29

37470 Repair multiple arteries and/or veins - BR

37500 Phleborrhaphy, suture of major vein, wound or injury (separate procedure); neck - $298.29

37520 chest - $596.57

37540 abdomen - $596.57

37560 extremity - $238.63

37565 Ligation of internal jugular vein - BR

37600 Ligation; external carotid artery - $298.29

37605 internal or common carotid artery - $298.29

37606 internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp - BR

37609 Ligation or biopsy, temporal artery - BR

37615 Ligation, major artery (eg, post-traumatic, rupture); neck - BR

37616 chest - BR

37617 abdomen - BR

37618 extremity - BR

37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device) - $477.26

37650 Interruption, partial or complete, of femoral vein, by ligature, intravascular device; unilateral - $238.63

37651 bilateral - BR

37660 Interruption, partial or complete, of common iliac vein by ligature, intravascular device - $357.94

37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions; unilateral - $143.18

37701 bilateral - BR

37720 Ligation and division and complete stripping of long or short saphenous veins; unilateral - $208.80

37721 bilateral - $357.94

37730 Ligation and division and complete stripping of long and short saphenous veins; unilateral - $298.29

37735 Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia; unilateral - BR

37737 bilateral - BR

37760 Ligation of perforators, subfascial, radical (Linton type), with or without skin graft - $298.29

37780 Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure); unilateral - $59.65

37781 bilateral - BR

37785 Ligation and division of minor varicose vein of leg - $35.79

37799 Unlisted procedure, vascular surgery - BR

HEMIC AND LYMPHATIC SYSTEMS

Spleen

Excision

38090 Puncture spleen - BR

38100 Splenectomy - $432.52

Introduction

38200 Injection procedure for splenoportography - $59.65

Lymph Nodes and Lymphatic Channels

Incision

38300 Drainage of lymph node abscess or lymphadenitis; simple - $17.90

38305 extensive - BR

38308 Lymphangiotomy or other operations on lymphatic channels - BR

38380 Suture and/or ligation of thoracic duct; cervical approach - BR

38381 thoracic approach - BR

Excision

38500 Biopsy or excision of lymph node; unspecified (separate procedure) - $41.76

38510 deep, cervical node - $101.41

38520 deep, cervical node with excision scalene fat pad - $149.15

38530 internal mammary node (separate procedure) - BR

38550 Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; simple - $178.97

38555 complex - BR

Radical Lymphadenectomy (Radical Resection of Lymph Nodes)

38700 Suprahyoid lymphadenectomy; unilateral - $357.94

38701 bilateral - $447.44

38720 Cervical lymphadenectomy (complete); unilateral - $566.74

38721 bilateral - BR

38740 Axillary lymphadenectomy; supervicial - $238.63

38745 complete - $417.60

38760 Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure); unilateral - $238.63

28761 bilateral - BR

28765 Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure); unilateral - $596.58

38766 bilateral - $715.89

38770 Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure); unilateral - BR

38771 bilateral - BR

38780 Retroperitoneal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure) - $835.21

Introduction

38790 Injection procedure for lymphangiography; unilateral - $89.47

38791 bilateral - $119.29

38794 Cannulation, thoracic duct - BR

38999 Unlisted procedure, hemic or lymphatic system - BR

MEDIASTINUM AND DIAPHRAGM

Mediastinum

Incision

39000 Mediastinotomy with exploration or drainage; cervical approach - $178.97

39010 transthoracic - $357.94

39020 sternal split - $656.23

39050 Removal of foreign body, mediastinum; cervical approach - $238.59

39060 transthoracic - $357.94

39070 sternal split - $656.23

Excision

39200 Excision of mediastinal cyst - $536.92

39220 Excision of mediastinal tumor - $536.92

Endoscopy

39400 Mediastinoscopy, with or without biopsy - $298.29

Repair

39499 Unlisted procedure, mediastinum - BR

Diaphragm

Repair

39500 Repair, diaphragmatic hernia (esophageal hiatal), transabdominal, including fundoplasty; except neonatal - $507.08

39510 neonatal - $656.23

39520 Repair, diaphragmatic hernia (esophageal hiatal); transthoracic - $507.09

39530 combined, thoracicoabdominal - $566.74

39531 combined, thoracicoabdominal, with dilation of stricture (with or without gastreotomy) - BR

39540 Repair, diaphragmatic hernia (other than neonatal), traumatic; acute - BR

39541 chronic - BR

39545 Imbrication of diaphragm for eventration; paralytic - BR

39547 nonparalytic - BR

39599 Unlisted procedure, diaphragm - BR

DIGESTIVE SYSTEM

Lips

Excision

40490 Biopsy lip - BR

40500 Vermilionectomy (lip peel), with mucosal advancement - $313.20

40510 Excision lip; transverse wedge excision - $313.20

40520 V-excision with primary direct linear closure - $178.97

40530 Resection lip, more than one-fourth, without reconstruction - $178.97

Repair (Cheiloplasty)

40650 Repair lip, full thickness; vermilion only - BR

40652 up to half vertical height - BR

40654 over one half vertical height, or complex - BR

40700 Plastic repair of cleft lip; primary, partial or complete, unilateral - $477.26

40701 primary bilateral, one stage procedure - $596.57

40702 primary bilateral, one of two stages - $417.60

40720 secondary, unilateral, by recreation of defect and reclosure - $477.26

40740 secondary, bilateral (per major stage) - $417.60

40760 with cross lip pedicle flap (Abbe-Estlander type) - BR

40761 with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle - BR

Other Procedures

40799 Unlisted procedure, lips - BR

Vestibule of Mouth

Incision

40800 Drainage of abscess, cyst, hematoma, vestibule of mouth; simple - BR

40801 complicated - BR

40804 Removal of embedded foreign body; simple - BR

30805 complicated - BR

30806 Incision of labial frenum (frenotomy) - BR

Excision, Destruction

40808 Biopsy, vestibule of mouth - BR

40810 Excision of lesion of mucosa and submucosa; without repair - BR

40812 with simple repair - BR

40814 with complex repair - BR

40816 Excision of lesion of mucosa, submucosa, and underlying muscle - BR

40818 Excision of mucosa as donor graft - BR

40819 Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy) - BR

40820 Destruction of lesion or scar by physical methods (eg, thermal, cryo, chemical) - BR

Repair

40830 Closure of laceration; up to 2 cm - BR

40831 over 2 cm or complex - BR

40840 Vestibuloplasty; anterior - BR

40842 poster, unilateral - BR

40843 posterior, bilateral - BR

40844 entire arch - BR

40845 complex (including ridge extension, muscle repositioning) - BR

Other Procedures

40899 Unlisted procedure, vestibule of mouth - BR

Tongue, Floor of Mouth

Incision

41000 Incision and drainage of intraoral abscess, cyst, or hematoma of tongue or floor of mouth; lingual - $11.94

41005 sublingual, superficial - $11.94

41006 sublingual, deep, supramylohyoid - BR

41007 submental space - BR

41008 submandibular space - BR

41009 masticator space - BR

41010 Incision of lingual frenum (frenotomy) - BR

41015 Incision and drainage of extraoral abscess, cyst, or hematoma of floor of mouth; sublingual - BR

41016 submental - BR

41017 submandibular - BR

41018 masticator space - BR

Excision

41100 Biopsy tongue; anterior two-thirds - $17.89

41105 posterior one-third - $29.82

41108 Biopsy, floor of mouth - BR

41110 Excision lesion of tongue; without closure - BR

41112 with closure, anterior two-thirds - BR

41113 with closure, posterior one-third - BR

41115 Excision of lingual frenum (frenectomy) - BR

41116 Excision lesion of floor of mouth - BR

41120 Glossectomy; less than one-half tongue - $238.63

41130 hemiglossectomy - $356.94

41135 partial, with unilateral radical neck dissection - BR

41140 complete or total, with or without tracheostomy, without radical neck dissection - $536.92

41145 complete or total, with or without tracheostomy, with unilateral radical neck dissection - $775.54

41150 composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection - BR

41155 composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type) - BR

Repair

41250 Repair laceration up to 2 cm; floor of mouth and/or anterior two-thirds of tongue - BR

41251 posterior one-third of tongue - BR

41252 Repair laceration of tongue, floor of mouth, over 2 cm or complex - BR

Other Procedures

41500 Fixation tongue, mechanical, other than suture (eg, K-wire) - $149.15

41510 Suture tongue to lip for micrognathia (Douglas type procedure) - $298.29

41520 Frenoplasty (surgical revision of frenum, eg, with Z-plasty) - BR

41599 Unlisted procedure, tongue, floor of mouth - BR

Dentoalveolar Structures

Incision

41800 Drainage abscess, cyst, hematoma - $11.94

41805 Removal embedded foreign body; from soft tissues - BR

41806 from bone - BR

Excision, Destruction

41820 Gingivectomy, excision gingiva, each quadrant - BR

41821 Operculectomy, excision pericoronal tissues - BR

41822 Excision fibrous tuberosities - BR

41823 Excision osseous tuberosities - BR

41825 Excision of lesion or tumor (except listed above); without repair - BR

41826 with simple repair - BR

41827 with complex repair - BR

41828 Excision of hyperplastic alveolar mucosa, each sextant or quadrant (specify) - BR

41830 Alveolectomy, including curettage of osteitis or sequestrectomy - BR

41850 Destruction of lesion (except excision) - BR

Other Procedures

41870 Periodontal mucosal grafting - BR

41872 Gingivoplasty - BR

41874 Alveoplasty - BR

41899 Unlisted procedure, dentoalveolar structures - BR

Palate, Uvula

Incision

42000 Drainage of abscess of palate, uvula - BR

Excision, Destruction

42100 Biopsy of palate, uvula - $17.90

42104 Excision lesion of palate, uvula; without closure - BR

42106 with closure - BR

42120 Resection palate or extensive resection of lesion - BR

42140 Uvulectomy, excision of uvula - $17.90

42150 Removal exostosis bony palate - BR

42160 Destruction of lesion, palate or uvula (thermal, cryo or chemical) - BR

Repair

42180 Repair laceration of palate; up to 2 cm - BR

42182 over 2 cm or complex - BR

42200 Palatoplasty for cleft palate, soft and/or hard palate only - $477.26

42205 Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only - $596.57

42210 with bone graft to alveolar ridge - BR

42215 Palatoplasty for cleft palate; major revision - $477.26

42220 secondary lengthening procedure - $507.09

42225 attachment pharyngeal flap - $507.09

42235 Repair anterior palate, including vomer flap - BR

42250 Repair oroantral or oronasal fistula, up to 1 cm - BR

42260 Repair nasolabial fistula - BR

Other Procedures

42299 Unlisted procedure, palate, uvula - BR

Salivary Gland and Ducts

Incision

42300 Drainage abscess; parotid, simple - $41.76

42305 parotid, complicated - BR

42310 submaxillary or sublingual, intraoral - $29.83

42320 submaxillary, external - $89.48

42325 Fistulization sublingual salivary cyst (ranula); - BR

42326 with prosthesis - BR

42330 Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral - $17.90

42335 submandibular (submaxillary) or sublingual, complicated - $71.58

42340 parotid, extraoral or complicated intraoral - $178.97

Excision

42400 Biopsy salivary gland; needle - $23.86

42405 incisional - $59.65

42408 Excision sublingual salivary cyst (ranula) - BR

42409 Marsupialization sublingual salivary cyst (ranula) - BR

42410 Excision parotid tumor or parotid gland; lateral lobe, without nerve dissection - $178.97

42415 lateral lobs, with dissection and preservation of facial nerve - $432.52

42420 total, with dissection and preservation of facial nerve - $536.92

42425 total, en bloc removal with sacrifice of facial nerve - $357.94

42426 total, with unilateral radical neck dissection - BR

42440 Excision submandibular (submaxillary) gland - $298.29

42450 Excision sublingual gland - BR

Repair

42500 Plastic repair salivary duct, sialodochoplasty; primary or simple - $208.80

42505 secondary or complicated - BR

42507 Parotid duct diversion, bilateral (Wilke type procedure); - BR

42508 with excision of one submandibular gland - BR

42509 with excision of both submandibular glands - BR

Other Procedures

42550 Injection procedure for sialography - $11.94

42600 Closure salivary fistula - BR

42650 Dilation salivary duct - $8.94

42660 Dilation and catheterization of salivary duct, with or without injection - BR

42665 Ligation salivary duct, intraoral - BR

42699 Unlisted procedure, salivary glands or ducts - BR

Pharynx, Adenoids, and Tonsils

Incision

42700 Incision and drainage abscess; peritonsillar - $17.90

42720 retropharyngeal or parapharyngeal, intraoral approach - $71.58

42725 retropharyngeal or parapharyngeal, external approach - BR

Excision

42800 Biopsy; oropharynx - $23.86

42802 hypopharynx - $41.76

42804 nasopharynx, visible lesion, simple - $29.83

42806 nasopharynx, survey for unknown primary lesion - BR

42808 Excision of lesion of pharynx - BR

42809 Removal of foreign body from pharynx - BR

42810 Excision branchial cleft cyst or vestige; confined to skin and subcutaneous tissues - $119.31

42815 extending beneath subcutaneous tissues - $298.29

42820 Tonsillectomy and adenoidectomy; under age 12 - $119.31

42821 age 12 or over - $143.18

42825 Tonsillectomy, primary or secondary; under age 12 - BR

42826 age 12 or over - BR

42830 Adenoidectomy, primary; under age 12 - BR

42831 age 12 or over - BR

42835 Adenoidectomy, secondary; under age 12 - BR

42836 age 12 or over - BR

42860 Excision of tonsil tags - BR

42870 Excision lingual tonsil (separate procedure) - $143.17

42880 Excision nasopharyngeal lesion (e.g., fibroma) - BR

42890 Limited pharyngectomy; without radical neck dissection - BR

42895 with radical neck dissection - BR

Repair

42900 Suture pharynx for wound or injury - BR

42950 Pharyngoplasty (plastic or reconstructive operation on pharynx) - BR

Other Procedures

42955 Pharyngostomy (fistulization of pharynx, external for feeding) - BR

42960 Control oropharyngeal hemmorrhage (primary or secondary, e.g., posttonsillectomy); simple - BR

42961 complicated, requiring hospitalization - BR

42962 with scondary surgical intervention - BR

42970 Control of nasopharyngeal hemorrhage (primary or secondary, eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cauterization - BR

42971 complicated, requiring hospitalization - BR

42972 with secondary surgical intervention - BR

42999 Unlisted procedure, pharynx, adenoids, or tonsils - BR

Esophagus

Incision

43000 Esophagotomy, cervical approach; without removal of foreign body - $417.60

43020 with removal of foreign body - $417.60

43030 Cricopharyngeal myotomy - BR

43040 Esophagotomy, thoracic approach; without removal of foreign body - BR

43045 with removal of foreign body - $566.75

Excision

43100 Excision of local lesion, esophagus, with primary repair, cervical approach - $566.74

43101 thoracic approach - BR

43105 Wide excision of malignant lesion of cervical esophagus, with or without laryngectomy; - BR

43106 with radical neck dissection (Wookey type procedure) - BR

43110 Esophagectomy (at upper two-thirds level) and gastric anastomosis; with or without pyloroplasty - $894.86

43111 with second stage pyloroplasty - BR

43115 Esophagectomy (at upper two-thirds level) with segment replacement of bowel - $1,193.15

43120 Esophagogastrectomy (lower third), combined thoracicoabdominal with or without pyloroplasty - $865.03

43130 Diverticulectomy hypopharynx or esophagus, with or without myotomy; cervical approach - $417.60

43135 thoracic approach - $596.58

43136 Diverticulopexy, hypopharynx, with or without myotomy - BR

Endoscopy

43200 Esophagoscopy, rigid or fiberoptic (specify); diagnostic - $119.31

43202 with biopsy and/or collection of specimen by brushing or washing for cytology - $143.18

43215 with removal of foreign body - $178.97

43217 with removal of polyp(s) - BR

43218 with irrigation - BR

43219 with insertion of plastic tybe or stent - BR

43220 with dilation, direct - $143.18

43221 Esophagogastroscopy, fiberoptic; diagnostic - BR

43222 with biopsy and/or collection of specimen by brushing or washing for cytology - BR

43223 with removal of foreign body - BR

43224 with removal of polyp(s) - BR

43225 with repair of hypopharyngeal diverticulum (Dohlman procedure) - BR

43226 with insertion of wire to guide dilation - BR

43227 for control of hemorrhage - BR

43228 with fulguration of mucosal lesion - BR

43235 Esophagogastroduodenoscopy; diagnostic - BR

43239 with biopsy and/or collection of specimen by brushing or washing for cytology - BR

43247 with removal of foreign body - BR

43251 with removal of polyp(s) - BR

43255 for control of hemorrhage - BR

43258 with fulguration of mucosal lesion - BR

43260 with cannulation of ampulla of Vater for radiographic studies and/or specimen collection for cytology - BR

43262 with electrosurgical sphincterotomy (Oddi) - BR

43264 with extraction of stone from common bile duct - BR

Repair

43300 Esophagoplasty, (plastic repair or reconstruction) cervical approach; without repair of tracheoesophageal fistula - BR

43305 with repair of tracheoesophageal fistula - $656.23

43310 Esophagoplasty, (plastic repair or reconstruction) thoracic approach; without repair of tracheoesophageal fistula - $894.87

43312 with repair of tracheoesophageal fistula - BR

43320 Esophagogastrostomy (cardioplasty) with or without vagotomy and pyloroplasty; abdominal approach - $656.23

43321 thoracic approach - BR

43324 Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures) - BR

43325 Esophagogastric fundoplasty with fundic patch (Thal-Nissen Procedure) - BR

43330 Esophagomyotomy (Heller type) with or without hiatal hermia repair); abdominal approach - $566.74

43331 thoracic approach - BR

43340 Esophagojejunostomy (without total gastrectomy); abdominal approach - $715.89

43341 thoracic approach - BR

43350 Esophagostomy, fistulization of esophagus, external; abdominal approach - $417.60

43351 thoracic approach - BR

43352 cervical approach - BR

Suture

43400 Ligation, direct, esophageal varices - $596.57

43410 Suture esophageal would or injury; cervical approach - BR

43415 thoracic approach - $566.74

43420 Closure esophagostomy or fistula; cervical approach - $417.60

43425 thoracic approach - $775.54

Manipulation

43450 Dilation esophagus, by unguided sound(s) or bougie(s) indirect; initial session - $17.90

43452 subsequent session - $17.90

43453 Dilation esophagus, over guide wire or string - BR

43455 Brusque esophageal dilation by balloon or Start dilator; - $119.31

43456 retrograde - BR

43460 Esophagogastric tamponade, with balloon (sengstaaken type) - BR

43499 Unlisted procedure, esophagus - BR

Stomach

Incision

43500 Gastrotomy with exploration of foreign body removal; - $357.94

43510 with esophageal dilation and insertion of plastic tubes - BR

43520 Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation) - $298.29

Excision

43600 Biopsy of stomach; by capsulte, tube, peroral (one or more specimens) - $89.48

43605 by laparotomy - $357.94

43610 Excision, local, of ulcer or tumor - $432.52

43620 Gastrectomy, total; including intestinal anastomosis - $835.21

43625 with repair by intestinal transplant - $1,014.18

43630 Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; without vagotomy - $566.74

43635 with vagotomy, any type - $626.41

43638 Hemigastrectomy or proximal subtotal gastrectomy, thoracic or abdominal approach - BR

43640 Vagotomy and pyloroplasty, with or without gastrostomy - $507.09

Endoscopy

43700 Gastroscopy, fiberoptic, without esophagoscopy; diagnostic - $119.31

43702 with biopsy and/or collection of specimen by brushing or washing for cytology - BR

43709 with removal of foreign body - BR

43711 with removal of polyp(s) - BR

43712 for control of hemorrhage - BR

43714 with fulguration of mucosal lesion - BR

Suture

43800 Pyloroplasty - $387.77

43810 Gastrodudenostomy - $417.60

43820 Gastrojejunostomy; - $417.60

43825 with vagotomy, any type - $536.92

43830 Gastrostomy, temporary (tube, rubber or plastic) (separate procedure); - $387.77

43831 neonatal, for feeding - $238.64

43832 Gastrostomy, permanent, with construction of gastric tube - $477.26

43840 Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, would, or injury - $387.77

43850 Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy - $596.57

43855 with vagotomy - $686.06

43860 Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction; without vagotomy - $596.57

43865 with vagotomy - $686.06

43870 Closure of gastrostomy, surgical - $357.94

43880 Closure of gastrocolic fistula - BR

43885 Anterior gastropexy for hiatal hernia (separate procedure - BR

43999 Unlisted procedure, stomacy - BR

Intestines (Except Rectum)

Incision

44000 Enterolysis, freeing of intestinal adhesion; (separate procedure) - $298.29

44005 with acute bowel obstruction - $432.52

44010 Duodenotomy - BR

44020 Enterotomy with exploration or foreign body removal; small bowel, other than duodenum - $432.52

44025 large bowel - $447.44

44040 Exteriorization of intestine (Mikulicz resection with crushing of spur) - $536.92

44050 Reduction of volvulus, intussusception, internal hernia, by laparotomy - $417.60

44060 Sigmoid myotomy (Reilly type operation) for diverticular disease - BR

Excision

44100 Biopsy of intestine by capsule, tube, peroral (one or more specimens) - $89.47

44110 Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization, or fistulization; single enterotomy - $507.26

44111 multiple enterotomies - BR

44115 Excision colonic diverticulum - BR

44120 Enterectomy, resection of small intestine; with anastomosis - $507.08

44125 with double-barrel enterostomy - $417.60

44130 Enteroenterostomy, anastomosis of intestine; (separate procedure) - $432.52

44131 intestinal bypass for morbid obesity - BR

44140 Colectomy, partial; with anastomosis - $536.92

44141 with skin level cecostomy or colostomy - BR

44143 with end colostomy and closure of distal segment (Hartment type procedure) - BR

44144 with resection, with colostomy or ileostomy and creation of mucofistula - BR

44145 with coloproctostomy (low pelvic anastomosis) - $715.89

44146 with coloproctostomy (low pelvic anastomosis), with colostomy - BR

44150 Colectomy, total, abdominal, with ileostomy or ileoproctostomy; with proctectomy - $775.54

44155 with proctectomy and ileostomy - $894.86

44160 Colectomy with removal of terminal ileum and ileocolostomy - BR

Enterostomy-External Fistulization of Intestines (Separate Procedure)

44300 Enterostomy, tube, or cecostomy; - $253.54

44305 in conjunction with other procedures - BR

44308 Enterostomy, suture of one wall of intestine to abdominal wall, small or large intestine - BR

44310 Ileostomy - $432.52

44312 Revision of ileostomy; simple (release of superficial scar) - BR

44314 complicated (reconstruction in depth) - BR

44316 Continent ileostomy (Koch procedure) - BR

44320 Colostomy or skin level cecostomy (separate procedure) - $357.94

44340 Revision of colostomy; simple (release of superficial scar) - $35.79

44345 complicated (reconstruction in depth) - $178.97

Endoscopy, Small Bowel and Stomal

44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic - BR

44361 with biopsy and/or collection of specimen by brushing or washing for cytology - BR

44363 with removal of foreign body - BR

44364 with removal of polyps - BR

44366 for control of hemorrhage - BR

44369 with fulguration of mucosal lesion - BR

44375 Fiberoptic gastrojejunoscopy through stoma - BR

44380 Fiberoptic ileoscopy through stoma; - BR

44382 with biopsy and/or collection of specimen for cytology - BR

44385 Fiberoptic evaluation of Koch pouch - BR

44388 Fiberoptic colonoscopy through colostomy - BR

Repair

44400 Cecopexy, fixation of cecum to abdominal wall - BR

44405 Sigmoidopexy, fixation of sigmoid colon to abdominal wall - BR

Suture

44600 Suture of intestine (enterorrhaphy), large or small, for perforated ulcer, diverticulum, would, injury or rupture; single - $417.60

44605 with colostomy - $477.26

44610 multiple - BR

44620 Closure of enterostomy, large or small intestine; - $298.29

44625 with resection and anastomosis - $417.60

44640 Closure of intestinal cutaneous fistula - BR

44650 Closure of enteroenteric or enterocolic fistula - $417.60

44660 Closure of enterovesical fistula; without intestinal or bladder resection - $417.60

44661 with bowel and/or bladder resection - BR

44680 Intestinal plication, complete (Noble type operation) (separate procedure) - $596.57

44799 Unlisted procedure, intestine - BR

Meckel's Diverticulum and the Mesentery

Excision

44800 Excision of Mechel's diverticulum (diverticulectomy) or omphalomesenteric duct - $298.29

44820 Excision of lesion of mesentery (separate procedure) - BR

Suture

44850 Suture of mesentery (separate procedure) - $387.77

44899 Unlisted procedure, Mechel's diverticulum and the mesentery - BR

Appendix

Incision

44900 Incision and drainage of appendiceal abscess, transabdominal - $208.80

Excision

44950 Appendectomy; - $283.37

44955 when done for indicated purpose at time of other major procedure (not as separate procedure) - BR

44960 for ruptured appendix with abscess or generalized peritonitis - BR

Rectum

Incision

45000 Transrectal drainage of pelvic abscess - $89.48

45005 Incision and drainage of submucous abscess, rectum - BR

45020 Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess - $143.18

Excision

45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon); incisional - $119.31

45105 full thickness - $178.97

45108 Anorectal myomectomy - BR

45110 Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages - $775.54

45111 partial resection of rectum - BR

45112 Proctectomy, combined abdominoperineal, pull-through procedure, one or two stages - BR

45114 Proctectomy, partial, with anastomosis; abdominal and transacral approach, one or two stages - BR

45116 transacral approach only (Kraske type) - BR

45120 Proctectomy, complete, for congenital megacolon (Swenson, Duhamel, or Soave type operation) - $775.55

45130 Excision of rectal procidentia, with anastomosis; perineal approach - $432.52

45135 abdominal and perineal approach - $775.54

45150 Division of stricture of rectum - BR

45160 Excision of rectal tumor by proctotomy, transcral or transcoccygeal approach - $566.75

45170 Excision of rectal tumor, simple, transanal approach - $566.74

45180 Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach; palliative - BR

45181 therapeutic - BR

Endoscopy

45300 Proctosigmoidoscopy; diagnostic (separate procedure) - $17.90

45302 with collection of specimen by brushing or washing for cytology - BR

45303 with dilation, direct, instrumental - BR

45305 with biopsy - $35.79

45307 with removal of foreign body - BR

45310 with removal of polyp or papilloma - $41.76

45315 with removal of multiple excrescences, papillomata or polyps - $53.69

45317 for control of hemorrhage - BR

45319 with retrograde lavage (eg, water pik) - BR

45325 Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple - BR

45360 Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure - BR

45365 with biopsy and/or collection of specimen for cytology - BR

45367 with removal of foreign body - BR

45368 with control of hemorrhage - BR

45370 with removal of polypoid lesion(s) - BR

45371 with retrograde lavage (eg, water pik) - BR

45378 Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure - BR

45379 with removal of foreign body - BR

45380 with biopsy and/or collection of specimen for cytology - BR

45382 for control of hemorrhage - BR

45385 with removal of polypoid lesion(s) - BR

45386 with retrograde lavage (eg, water pik) - BR

Repair

45500 Proctoplasty; for stenosis - $298.29

45505 for prolapse of mucous membrane - $328.12

45520 Perirectal injection of sclerosing solution for prolapse; office - $29.83

45521 hospital - $119.31

45540 Proctopexy for prolapse; abdominal approach - $536.92

45541 perineal approach - BR

45550 Proctopexy combined with sigmoid resection, abdominal approach - $656.23

45560 Repair of rectocele (separate procedure) - BR

Suture

45800 Closure of rectovesical fistula; - $596.57

45805 with colostomy - $656.23

45820 Closure of rectourethral fistula; - $596.58

45825 with colostomy - $656.23

Manipulation

45900 Reduction of procidentia (separate procedure) under anesthesia - $17.90

45905 Dilation of anal sphincter (separate procedure) under anesthesia other than local - BR

45910 Dilation of rectal stricture (separate procedure) under anesthesia other than local - BR

45915 Removal of fecal impaction or foreign body (separate procedure) under anesthesia - BR

45999 Unlisted procedure, rectum - BR

Anus

Incision

46000 Fistulotomy, subcutaneous - $17.90

46030 Removal of seton, other marker - $17.90

46032 Undercutting for pruritus ani (modified Ball Operation) - BR

46040 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure) - BR

46045 Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia - $71.58

46050 Incision and drainage, perianal abscess, superficial - $14.32

46060 Incision and drainage of ischiorectal or intramural abscess, with fistulectomy, submuscular - $283.37

46070 Incision, anal septum (infant) - $35.79

46080 Sphincterotomy, anal, division of sphincter (separate procedure) - $35.79

Excision

46200 Fissurectomy, with or without sphincterotomy - $143.18

46210 Cryptectomy; single - $41.75

46211 multiple (separate procedure) - $208.80

46220 Papillectomy or excision of single tab, anus (separate Procedure) - $17.90

46221 Hemorrhoidectomy, by simple ligature (rubber band) - BR

46230 Excision of external hemorrhoid tabs and/or multiple papillae, office - $35.79

46250 Hemorrhoidectomy, external, complete - $143.18

46255 Hemorrhoidectomy internal and external, simple; - $208.79

46257 with fissurectomy - BR

46258 with fistulectomy, with or without fissurectomy - BR

46260 Hemorrhoidectomy, internal and external, complex or extensive; - $298.29

46261 with fissurectomy - BR

46262 with fistulectomy, with or without fissurectomy - BR

46270 Fistulectomy; subcutaneous - $71.57

46275 submuscular - $283.37

46280 complex or multiple - BR

46285 second stage - $283.37

46320 Enucleation or excision of external thrombotic hemorrhois - $21.47

Introduction

46500 Injection of sclerosing solution, hemorrhoids or mucosal prolapse - $11.94

46510 Perianal injection of alcohol or other solution for pruritus ani - BR

Endoscopy

46600 Anoscopy; diagnostic (separate procedure) - $9.55

46602 with collection of specimen by brushing or washing for cytology - BR

46604 with dilation, direct, instrumental - BR

46606 with biopsy - BR

46608 with removal of foreign body - BR

46610 with removal of polyp - BR

46612 with multiple polyp removal - BR

46614 for control of hemorrhage - BR

Repair

46700 Anoplasty, plastic operation for stricture; adult - $268.46

46705 infant - $298.29

46715 Repair of congenital anovaginal fistula ("cut-back" type procedure) - $357.94

46716 Perineal transplant of anovaginal fistula - BR

46730 Construction of anus for congenital absence; perineal or sacrococcygeal approach - $477.26

46735 combined abdominal and perineal approach - $596.57

46740 Construction of anus for congenital absence, with repair of urinary fistula - $656.23

46750 Sphincteroplasty, anal, for incontinence or prolapse; adult - $298.29

46751 child - $357.94

26753 Graft (Thiersch operation) for rectal incontinence and/or prolapse - BR

46754 Removal of Thiersch wire or suture - BR

46760 Sphincteroplasty, anal, for incontinence, adult, muscle transplant - BR

Destruction

46900 Chemosurgery of condylomata, anal, multiple, simple - $14.31

46910 Electrodesiccation of condylomata, anal, multiple, simple - $23.86

46920 Excision and electrodesiccation of condylomata, anal; simple - $29.83

46930 extensive - BR

46932 Cryosurgery of condylomata, anal; simple - BR

46933 extensive - BR

46934 Cryosurgery of condylomata, anal; simple - BR

46935 external - BR

46936 internal and external - BR

46937 Cryosurgery of rectal tumor; benign - BR

46938 malignant - BR

46940 Curettage or cauterization of anal fissure, including dilation of anal sphincter (separate procedure); initial - BR

46942 subsequent - BR

Suture

46945 Ligation of internal hemorrhoids; single procedure - BR

46946 multiple procedures - BR

Other Procedures

46999 Unlisted procedure, anus - BR

Liver

Incision

47000 Biopsy of liver, needle, percutaneous - $41.76

47010 Hepatotomy for drainage of abscess or cyst, one or two stages - BR

Excision

47100 Biopsy of liver, wedge (separate procedure) - $298.29

47120 Hepatectomy, resection of liver; partial lobectomy - $566.74

47125 total left lobectomy - BR

47130 total right lobectomy - BR

47135 total, with transplant - BR

Repair

47300 Marsupialization of cyst or abscess of liver - $432.52

Suture

47350 Hepatorrhaphy, suture of liver would or injury; simple - $417.59

47355 with common duct or gallbladder drainage - $536.92

47360 complex - BR

47399 Unlisted procedure, liver - BR

Biliary Tract

Incision

47400 Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus - $596.57

47420 Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; - $507.09

47425 with transduodenal sphincterotomy - $566.74

47440 Duodenocholedochotomy, transduodenal choledocholihotomy - $566.74

47460 Transduodenal sphincterotomy or sphincteroplasty (separate procedure) - $566.74

47480 Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure) - $357.94

Introduction

47500 Injection procedure for percutaneous transhepatic cholangiography - $47.72

Excision

47600 Cholecystectomy; - $432.51

47605 with cholangiography - $447.43

47610 Cholecystectomy with exploration of common duct; - $508.08

47611 with biliary endoscopy - BR

47620 with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography - $596.57

47630 Biliary duct stone extraction, percutaneous via t-tube trace (eg, Burhenne technique) - BR

47700 Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or with cholangiography - $432.52

Repair

47720 Cholecystoenterostomy; direct - $432.52

47721 with gastroenterostomy - BR

47740 Roux-en-y - $477.26

47760 Anastomosis, direct, or extrahepatic biliary ducts and gastrointestinal tract - $596.57

47765 Anastomosis, direct, of intrahepatic ducts and gastrointestinal tract - BR

47800 Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis - $596.57

47810 Implantation of biliary istulous tract into stomach or intestine - BR

Suture

47850 Choledochorrhaphy - BR

47855 Cholecystorrhaphy - BR

47999 Unlisted procedure, biliary tract

Pancreas

Incision

48000 Drainage of abdoment for pancreatitis - $387.77

48020 Removal of pancreatic calculus - $596.58

Excision

48100 Biopsy of pancreas (separate procedure) - $417.60

48120 Excision of lesion of pancreas (eg, cyst, adenoma) - $507.09

48140 Pancreatectomy, distal subtotal, with or without plenectomy; - $596.57

48145 with pancreaticojejunostomy - $656.23

48148 Excision of ampulla of Vater, simple - BR

48150 Pancreatectomy, proximal subtotal, with pancreaticojejunostomy or pancreaticoduodenostomy (Whipple type operation) - $1,014.18

48151 Pancreatectomy, near-total, with preservation of duodenum (Child type procedure) - BR

48155 Pancreatectomy, total; $1,014.18

48160 with transplantation - BR

48180 Pancreaticojejunostomy, side-to-side anastomosis, Peustow type operation (separate procedure) - $715.89

Repair

48500 Marsupialization of cyst of pancreas - $432.52

48520 Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct - $507.09

48540 Roux-en-y - $566.74

48999 Unlisted procedure, pancreas - BR

Abdomen, Peritoneum, and Omentum

Incision

49000 Exploratory laparotomy, exploratory celiotomy (separate procedure) - $298.28

49002 Reopening of recent laparotomy incision for exploration, removal of hematoma, control of bleeding - BR

49010 Exploration, retroperitoneal area (separate procedure) - $298.28

49020 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal - $328.12

49040 Drainage of subdiaphragmatic or subphrenic abscess - $357.94

49060 Drainage of retroperitoneal abscess - $328.12

49080 Peritoneocentesis, abdominal paracentesis; initial - $23.87

49081 subsequent - $17.90

49085 Removal of peritoneal foreign body - BR

Excision

49200 Excision of intra-abdominal or retroperitoneal tumors or cysts; - $417.60

49201 extensive - BR

49250 Umbilectomy, omphalectomy, excision of umbilicus (separate procedure) - BR

49255 Omentectomy, epiploectomy, resection of omentum (separate procedure) - BR

Endoscopy

49300 Peritoneoscopy; without biopsy - $119.31

49301 with biopsy - BR

49302 Peritoneoscopy with guided transhepatic cholangiography; without biopsy - BR

49303 with biopsy - BR

Introduction

49400 Pneumoperitoneum; initial - $29.83

49401 subsequent - $17.89

49420 Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary - $29.82

49421 permanent - BR

49430 Injection procedure for retroperitoneal pneumography - $71.58

49440 Injection procedure for pelvic pneumography - $11.93

Repair Hernioplasty, Herniorrhaphy, Herniotomy

49500 Repair inguinal hernia, under age 5 years, with or without hydrocelectomy; unilateral - $208.80

49501 bilateral - $283.37

49505 Repair inguinal hernia, age 5 or over; unilateral - $268.46

49506 bilateral - $357.94

49510 Repair inguinal hernia, age 5 or over; unilateral, with orchiectomy, with or without implantation of prosthesis - $283.37

49515 with excision of hydrocele or spermatocele - $283.37

49520 recurrent - $298.29

49525 sliding - $298.29

49530 incarcerated - BR

49535 strangulated - BR

49540 Repair lumbar hernia - $298.29

49550 Repair femoral hernia, groin incision; unilateral - $268.46

49551 bilateral - BR

49552 Repair femoral hernia, Henry approach; unilateral - BR

49553 bilateral - BR

49555 Repair femoral hernia, recurrent, any approach - $298.29

49560 Repair ventral hernia (separate procedure); - $328.11

49565 recurrent - $357.94

49570 Repair epigastric hernia, properitoneal fat (separate procedure); simple - $89.48

49575 complex - BR

49580 Repair umbilical hernia; under age 5 years - $208.80

49581 age 5 or over - $253.54

49590 Repair spigelian hernia - $268.46

49600 Repair of omphalocele; small, with primary closure - $283.37

49605 large or gastroschisis, with or without prosthesis - $432.52

49606 with staged closure of prosthesis, reduction in operating room, under anesthesia - BR

49610 Repair of omphalocele (Gross type operation); first stage - $357.94

49611 second stage - $357.94

49630 Reduction of torsion, omentum - BR

49635 Omentopexy for establishing collateral circulation in portal obstruction - BR

49640 Omentoplasty (omental flap reconstruction for transfer of omentum with intact blood supply to thorax, nect or axilla) - BR

Suture

49900 Suture, secondary, of abdominal wall for evisceration or dehiscence - $178.97

49910 Suture of omentum, omentorrhaphy for wound or injury - BR

4999 Unlisted procedure, abdoment, peritoneum and omentum - BR

Urinary System

Kidney

Incision

50010 Renal exploration, not necessitating other specific procedures - BR

50020 Drainage of perirenal or renal abscess (separate procedure) - $596.57

50040 Nephrostomy, nephrotomy with drainage - $596.57

50045 Nephrotomy, with exploration - BR

50060 Nephrolithotomy; removal of calculus - $596.57

50065 secondary surgical operation for calculus - $715.89

50070 complicated by congenital kidney abnormality - $715.89

50075 large (staghorn) calculus filling renal pelvis and calyces - $775.54

50100 Transection or repositioning of aberrant renal vessels (separate procedure) - $507.09

50120 Pyelotomy; with exploration - $596.57

50125 with drainage, pyelostomy - $596.57

50130 with removal of calculus (pyelolithotomy, pelviolithotomy) - $596.57

50135 Complicated (eg, secondary operation, congenital kidney abnormality) - $715.89

Excision

50200 Renal biopsy, percutaneous; by trocar or needle - $71.58

50205 by surgical exposure of kidney - $238.63

50220 Nephrectomy, including partial ureterectomy, any apporach including rib resection; - $596.57

50225 complicated because of previous surgery on same kidney - $715.89

50230 radical, with regional lymphadenectomy - $775.54

50234 Nephrectomy with total ureterectomy and bladder cuff; through same incision - BR

50236 through separate incision - BR

50240 Nephrectomy, partial - $715.89

50280 Excision or unroofing of cyst(s) of kidney - $536.92

50290 Excision of perinephric cyst - BR

Renal Transplantation

50300 Donor nephrectomy, with preparation and maintenance of homograft; from cadaver donor, unilateral or bilateral - BR

50320 from living donor, unilateral - $715.89

50340 Recipient nephrectomy (separate procedure); unilateral - $596.57

50341 bilateral - $894.86

50360 Renal homotransplantation, implantation of graft; excluding donor and recipient nephrectomy - $894.86

50365 with unilateral recipient nephrectomy - $1,491.44

50366 with bilateral recipient nephrectomy - $1,491.44

50370 Removal of transplanted homograft (eg, infarcted or rejected kidney) - BR

50380 Renal autotransplantation, reimplantation of kidney - $894.87

Introduction

50390 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous - BR

50392 Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous - BR

50394 Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure) - BR

50396 Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter - BR

50398 Change of nephrostomy or pyelostomy tube - BR

Repair

50400 Pyeloplasty; (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting - $656.23

50405 complicated (congenital kidney abnormality, secondary peyloplasty, solitary kidney) - $775.54

50420 Nephropexy, fixation or suspension of kidney (separate procedure) - $477.26

Suture

50500 Nephrorrhaphy, suture of kidney would or injury - $596.58

50520 Closure of nephrocutaneous or pyelocutaneous fistula - $596.58

50525 Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach - $715.89

50526 thoracis approach - BR

50540 Symphysiotomy for horeshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral bilateral (one operation) - $835.21

Endoscopy

50550 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; hospital - BR

50551 office - BR

50552 with ureteral catheterization, hospital - BR

50553 with ureteral catheterization, office - BR

50554 with biopsy, hospital - BR

50555 with biopsy, office - BR

50556 with fulguration, with or without biopsy, hospital - BR

50557 with fulguration, with or without biopsy, office - BR

50558 with insertion of radioactive substance with or without biopsy and/or fulguration, hospital - BR

50559 with insertion of radioactive substance with or without biopsy and/or fulguration, office - BR

50560 with removal of foreign body or calculus, hospital - BR

50561 with removal of foreign body or calculus, office - BR

50570 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; - BR

50572 with ureteral catheterization - BR

50574 with biopsy - BR

50576 with fulguration, with or without biopsy - BR

50578 with insertion of radioactive substance, with or without biopsy and/or fulguration - BR

50580 with removal of foreign body or calculus - BR

Ureter

Incision

50600 Ureterotomy with exploration or drainage (separate procedure) - $536.92

50610 Ureterolithotomy; upper one-third of ureter - BR

50620 middle one-third of ureter - $536.22

50630 lower one-third of ureter - BR

Excision

50650 Ureterectomy, with bladder cuff (separate procedure) - $596.57

50660 Ureterectomy, total, ectopic, ureter, combination abdominal, vaginal and/or perineal approach - BR

Introduction

50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter (separate procedure) - BR

50686 Manometric studies through ureterostomy or indwelling ureteral catheter - BR

50688 Change of ureterostomy tube - BR

50690 Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure) - BR

Repair

50700 Ureteroplasty, plastic operation on ureter (eg, stricture) - $596.57

50715 Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis; unilateral - BR

50716 bilateral - BR

50722 Ureterolysis for ovarian vein syndrome - BR

50725 Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava - $775.54

50740 Ureteropyelostomy, anastomosis of ureter and renal pelvis - $656.23

50750 Ureterocalycostomy, anastomosis of ureter to renal calyx - BR

50760 Ureteroureterostomy - $656.23

50770 Transureteroureterostomy, anastomosis of ureter to contralateral ureter - $715.89

50780 Ureteroneocystostomy, anastomosis of ureter to bladder, or other operations for correction of vesicoureteral reflux; unilateral - $656.23

50781 bilateral - $775.54

50785 Ureteroneocystostomy, with bladder flap; unilateral - $715.89

50786 bilateral - $835.21

50800 Ureteroenterostomy, direct anastomosis of ureter to intestine; unilateral - $656.23

50801 bilateral - $775.54

50810 Ureterosigmoidostomy, with creation of isgmoid bladder and establishment of abdominal or perineal colostomy, including bowel anastomosis - $894.86

50820 Ureteroileal conduit (ileal bladder), including bowel anastomosis (Bricker operation); unilateral - $894.86

50821 bilateral - $1,014.18

50840 Replacement of all or part of ureter by bowel segment, including bowel anastomosis; unilateral - $894.87

50841 bilateral - $1,193.16

50860 Ureterostomy, transplantation of ureter to skin; unilateral - $536.92

50861 bilateral - $656.23

Suture

50900 Ureterorrhaphy, suture of ureter (separate procedure) - $596.57

50920 Closure of ureterocutaneous fistula - $596.57

50930 Closure of ureterovisceral fistula (including visceral repair) - BR

50940 Deligation of ureter - BR

Endoscopy

50950 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; hospital - BR

50951 office - BR

50952 with ureteral catheterization, hospital - BR

50953 with ureteral catheterization, office - BR

50954 with biopsy, hospital - BR

50955 with biopsy, office - BR

50956 with fulguration, with or without biopsy, hospital - BR

50957 with fulguration, with or without biopsy, office - BR

50958 with insertion of radioactive substance with or without biipsy and/or fulguration, hospital - BR

50959 with insertion of radioactive substance with or without biopsy and/or fulguration, office - BR

50960 with removal of foreign body or calculus, hospital - BR

50961 with removal of foreign body or calculus, office - BR

50970 Ureteral endoscopy through ureterotomy, with or without irrigation, installation or ureteropyelography, exclusive of radilogic service; - BR

50972 with ureteral catheterization - BR

50974 with biopsy - BR

50976 with fulguration, with or without biopsy - BR

50978 with insertion of radioactive substance, with or without biopsy and/or fulguration - BR

50980 with removal of foreign body or calculus - BR

Bladder

Incision

51000 Aspiration of bladder by needle - $11.94

51005 Aspiration of bladder, by trocar or intracatheter - $29.83

51010 with insertion of suprapubic catheter - $59.65

51020 Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material - $432.52

51030 with cryosurgical destruction of intravesical lesion - $432.52

51040 Cystostomy, cystotomy with drainage - $357.94

51045 Cystotomy, with insertion of ureteral catheter (separate procedure) - BR

51050 Cystolithotomy, cystotomy with removal of calculus, without vesical nect resection - $432.52

51060 Transvesical ureterolithotomy - BR

51065 Cystotomy, with stone basket extraction of ureteral calculus - BR

51080 Drainage of perivesical or prevesical space abscess - $238.63

Excision

51500 Excision of urachal cyst or sinus, with or without umbilical hernia repair - $417.60

51520 Cystotomy; for simple excision of vesical nect (separate procedure) - $477.26

51525 for excision of bladder diverticulum, single or multiple (separate procedure) - $596.57

51530 for excision of bladder tumor - $477.26

51535 Cystotomy for excision, or repair of ureterocele; unilateral - $477.26

51536 bilateral - $536.92

51550 Cystectomy, partial; simple - BR

51555 complicated (eg, postradiation, previous surgery, difficult location) - BR

51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy) - $715.89

51570 Cystectomy, complete; (separate procedure) - $775.54

51575 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes - $1,014.18

51580 Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; - $1,014.18

51585 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes - $1,193.16

51590 Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; - $1,312.47

51595 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes - $1,491.44

51597 Pelvic exenteration, complete, for vesical, prostatic, or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof - BR

Introduction

51600 Injection procedure for cystography or voiding urethrocystography - $5.96

51605 Injection procedure and placement of chain for contrast and/or chain urethrocystography - BR

51610 Injection procedure for retrograde urethrocystography - $8.94

51700 Bladder irrigation, simple, lavage and/or instillation - $5.96

51705 Change of cystostomy tube; simple - BR

51710 complicated - BR

51720 Bladder instillation of anticarcinogenic agent (including detention time) - $23.86

51740 Cystometrogram (separate procedure) - $29.82

51750 Uroflowmetric evaluation (separate procedure) - BR

Repair

51800 Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical nect (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical nect - $596.57

51820 Cystourethroplasty with unilateral or bilateral ureteroneocystostomy - $894.86

51840 Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti type); simple - $432.51

51841 complicated (eg, secondary repair) - BR

51860 Cystorrhaphy, suture of bladder wound, injury or rupture; simple - $432.52

51865 complicated - BR

51880 Closure of cystostomy (separate procedure) - $238.63

51900 Closure of vesicovaginal fistula, abdominal approach - $656.23

51920 Closure of vesicouterine fistula; - $596.58

51925 with hysterectomy - BR

51940 Closure of exstrophy - BR

51960 Enterocystoplasty, including bowel anastomosis - $894.87

51980 Cutaneous vesicostomy - $536.92

52000 Cystourethroscopy (separate procedure), office; - $35.79

52005 with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service - $47.73

52010 with ejaculatory duct catheterization - $47.73

52100 Cystourethroscopy, hospital; - $55.00

52105 with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service - $50.59

52110 with ejaculatory duct catheterization - $107.38

52190 Differential quantitative and chemical renal function test (Howard or Stamey type) - BR

Transurethral Surgery (Urethra, Prostate, Bladder, Ureter)

52202 Cystourethroscopy, with biopsy; hospital - BR

52204 office - BR

52212 Cystourethroscopy, with fulguration (including cryosurgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands; hospital - BR

52214 office - BR

52222 Cystourethroscopy, with fulguration (including cryosurgery) or treatment of MINOR (less than 9.5 cm) lesion(s), with or without biopsy; hospital - BR

52224 office - BR

52232 Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of SMALL bladder tumor(s) (0.5 to 2.0 cm); hospital - BR

52234 office - BR

52235 Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of; MEDIUM bladder tumor(s) 2.0 to 5.0 cm) - $357.94

52240 LARGE bladder tumor(s) - $536.92

52250 Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration - $178.97

52260 Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia - $89.48

52265 local anesthesia - $41.76

52270 Cystourethroscopy, with internal urethrotomy; female - $119.31

52275 male - $119.31

52277 Cystourethroscopy, with resection of external sphincter (sphincterotomy) - BR

52280 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; hospital - $89.49

52281 office - BR

52282 Cystourethroscopy, with steroid injection into stricture; hospital - BR

52283 office - BR

52285 Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of urethral polyps, bladder neck, and trigone - BR

52290 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral - $119.31

52300 with resection of fulguration of ureterocele(s), unilateral or bilateral - $178.97

52305 with incision or resection of orifice of bladder diverticulum, single or multiple - BR

52310 Cystourethroscopy, with removal of foreign body or calculus from urethra or bladder; simple - $119.31

52315 complicated - BR

52320 Cystourethroscopy; with removal of ureteral calculus - $208.79

52330 with manipulation, without removal of ureteral calculus - $149.15

52335 Cystourethroscopy, with ureteroscopy and/or pyeloscopy - BR

52340 Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds) - $178.97

52500 Transurethral resection of bladder neck (separate procedure) - $298.29

52601 Transurethral resection of prostate, including control of postoperative bleeding during hospitalization, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) - $596.57

52605 Transurethral fulguration for postoperative bleeding after leaving hospital; (in hospital) - BR

52606 office - BR

52610 Transurethral resection of prostate; two-stage (planned or medical necessity) - $775.54

52612 first stage of two-stage resection (partial resection) - BR

52614 second stage of two-state resection (resection completed) - BR

52620 Transurethral resection; of residual obstructive tissue after 90 days postoperative - $178.97

52630 of regrowth of obstructive tissue longer than one year postoperative - $596.57

52640 of postoperative bladder neck contracture - $298.29

52650 Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue includes) - $596.57

52700 Transurethral drainage of prostatic abscess - $238.63

52800 Litholapaxy, crushing of calculus in bladder and removal of fragments; simple, small (less than 2.5 cm) - $298.29

52805 complicated or large (over 2.5 cm) - $417.60

Urethra

Incision

53000 Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra - $71.58

53010 perineal urethra, external - $178.97

53020 Meatotomy, cutting of meatus (separate procedure), except infant; office - $29.82

53021 hospital - BR

53025 Meatotomy, cutting of meatus (separate procedure), infant - $17.90

53040 Drainage of deep periurethral abscess - $89.48

53060 Drainage of Skene's gland abscess or cyst - $25.79

53080 Drainage of perineal urinary extravasation; uncomplicated (separate procedure) - $119.31

53085 complicated - BR

Excision

53200 Biopsy of urethra - $59.65

53210 Urethrectomy, total, including cystostomy; female - $417.60

53215 male - $536.92

53220 Excision or fulguration of carcinoma of urethra - BR

53230 Excision of urethral diverticulum (separate procedure); female - $298.29

53235 male - $357.94

53240 Marsupialization of urethral diverticulum, male or female - $119.31

53250 Excision of bulbourethral gland (Cowper's gland) - BR

53260 Excision or fulguration; urethral polyp(s), distal urethra - $29.83

53265 urethral caruncle - $35.79

53270 Skene's glands - $35.79

53275 urethral prolapse - $89.48

Repair

53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture, eg, Johannsen type - $298.29

53405 second stage (formation of urethra), including urinary diversion - $417.60

53410 Urethroplasty, one-stage reconstruction of male anterior urethra - $477.26

53420 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage - $596.57

53425 second stage - $596.57

53430 Urethroplasty, reconstruction of female urethra - $417.60

53440 Operation for correction of male urinary incontinence, with or without introduction of prosthesis - $596.57

53450 Urethral meatoplasty, with mucosal advancement - $119.31

53460 Urethral meatoplasty, with partial excision of distal urethral segment (Richardson type procedure) - BR

Suture

53502 Urethrorrhaphy, suture of urethral wound or injury, female - BR

53505 Urethrorrhaphy, suture of urethral wound or injury; penile - BR

53510 perineal - BR

53515 prostatomenbranous - BR

53520 Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure) - $178.97

Manipulation

53600 Dilation of urethral stricture by passage of sound, male; initial - $11.94

53601 subsequent - $8.94

53605 Dilation of urethral stricture or vesical neck by passage of urethral dilator, male, general or conduction (spinal) anesthesia, hospital - BR

53620 Dilation of urethral stricture by passage of filiform and follower, male; initial - $23.86

53621 subsequent - $17.90

53640 Passage of filiform and follower for acute vesical retention, male - $23.86

53660 Dilation of female urethra including suppository and/or instillation; initial - $11.94

53661 subsequent - $8.94

53665 in hospital, general anesthesia - BR

53670 Catheterization; simple - BR

53675 complicated (may include difficult removal of balloon catheter) - BR

53899 Unlisted procedure, urinary system - BR

MALE GENITAL SYSTEM

Penis

Incision

54000 Slitting of prepuce, dorsal or lateral, (separate procedure); newborn - $17.90

54001 except newborn - $41.76

54015 Incision and drainage of penis, deep - BR

Destruction

54050 Destruction of condylomata, penis, multiple; simple, chemical - $8.95

54055 electrodesiccation - $23.86

54060 surgical excision - $29.83

54065 extensive - BR

Excision

54100 Biopsy of penis; cutaneous (separate procedure) - $17.90

54105 deep structures - $43.74

54110 Excision of penile plaque (Peyronie disease) - BR

54115 Removal foreign body from deep penile tissue (eg, plastic implant) - BR

54120 Amputation of penis; partial - $298.29

54125 complete - $596.58

54130 Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy - $775.55

54135 in continuity with bilateral pelvis lymphadenectomy, including external iliac, hypogastric and obturator nodes - $894.87

54150 Circumcision, clamp procedure; newborn - $23.86

54152 except newborn, office - BR

54154 except newborn, hospital - BR

54160 Circumcision, surgical excision other than clamp or dorsal slit; newborn - $23.86

54161 except newborn - $89.47

Introduction

54200 Injection procedure for Peyronie disease; - $11.93

54205 with surgical exposure of plaque - BR

54220 Irrigation of corpora cavernosa for priapism - BR

Repair

54300 Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra; - $238.63

54305 with transplantation of prepuce - $417.59

54320 Urethroplasty, formation of urethra, Denis-Browne type operation (including urinary diversion); penile or penoscrotal - $417.60

54325 scrotal or perineal - $536.92

54330 Urethroplasty and straightening of chordee (including urinary diversion), complete, one stage, for hypospadias - $596.57

54380 Plastic operation on penis for epispadias distal to external sphincter; - BR

54385 with incontinence - BR

54390 with exstrophy of bladder - BR

54400 Plastic operation for insertion of penile prosthesis - BR

54420 Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral - BR

54430 Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral - BR

54440 Plastic operation of penis for injury - BR

Manipulation

54450 Foreskin manipulation including lysis of preputial adhesions and stretching - BR

Testis

Excision

54500 Biopsy, needle (separate procedure) - $11.94

54505 Biopsy, incisional (separate procedure); unilateral - $89.48

54506 bilateral - $119.31

54510 Excision of local lesion of testis - $178.97

54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; unilateral - $178.97

54521 bilateral - $238.63

54530 Orchiectomy, radical, for tumor; inguinal approach - $238.63

54535 with abdominal exploration - $357.94

54550 Exploration for undescended testis (inguinal or scrotal area); unilateral - BR

54555 bilateral - BR

54560 Exploration for undescended testis with abdominal exploration; unilateral - BR

54565 bilateral - BR

Repair

54600 Reduction of torsion of testis, surgical, with or without fixation of contralateral testis - $238.63

54620 Fixation of contralateral testis (separate procedure) - $119.31

54640 Orchiopexy, any type, with or without hernia repair; unilateral - $357.94

54641 bilateral - BR

54645 second stage (Torek type) - $59.65

54660 Insertion of testicular prosthesis (separate procedure); unilateral - $119.31

54661 bilateral - BR

54670 Suture or repair of testicular injury - $238.63

54680 Transplantation of testis(es) to thigh (because of scrotal destruction) - BR

Epididymis

Incision

54700 Incision and drainage of epididymis, testis and/or scrotal space (abscess or hematoma) - $41.76

Excision

54800 Biopsy of epididymis, needle - $11.93

54820 Exploration of epididymis, with or without biopsy - $178.97

54830 Excision of local lesion of epididymis - $178.97

54840 Excision of spermatocele, with or without epididymectomy - $238.63

54860 Epididymectomy; unilateral - $238.63

54861 bilateral - $298.29

Repair

54900 Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral - $298.29

54901 bilateral - $417.60

Tunica Vaginalis

Incision

55000 Puncture aspiration of hydrocele, with or without injection of medication - $14.32

55040 Excision of hydrocele; unilateral - $238.62

55041 bilateral - BR

Repair

55060 Repair of hydrocele (Bottle type) - $178.97

Scrotum

Incision

55100 Drainage of scrotal wall abscess - $11.93

55120 Removal of foreign body in scrotum - BR

Excision

55150 Resection of scrotum - BR

Repair

55170 Scrotoplasty, plastic operation on scrotum - BR

Vas Deferens

Incision

55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) - $107.38

Excision

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) - $107.38

Introduction

55300 Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral - $107.38

Repair

55400 Vasovasostomy, vasovasorrhaphy; unilateral - $298.29

55401 bilateral - $417.60

Suture

55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) - $35.79

Spermatic Cord

Excision

55500 Excision of hydrocele of spermatic cord, unilateral (separate procedure) - $178.97

55520 Excision of lesion of spermatic cord (separate procedure) - $178.97

55530 Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure) - $238.63

55535 abdominal approach - $283.37

55540 with hernia repair - $283.37

Seminal Vesicles

Incision

55600 Vesiculotomy; unilateral - BR

55601 bilateral - BR

55605 complicated - BR

Excision

55650 Vesiculectomy, any approach; unilateral - $596.57

55651 bilateral - BR

55680 Excision of Mullerian duct cyst - $596.57

Prostate

Incision

55700 Biopsy, prostate; needle or punch, single or multiple, any approach - $41.76

55705 incisional, any approach - $238.63

55720 Prostatotomy, external drainage of prostatic abscess, any approach; simple - $238.63

55725 complicated - $417.60

55740 Prostatolithotomy, removal of prostatic calculus (separate procedure) - $596.58

Excision

55801 Prostatectomy, including control of postoperative bleeding during initial hospitalization, complete (vasectomy, meatotomy urethral calibration and/or dilation, and internal urethrotomy are included); perineal, subtotal - BR

55810 perineal, radical - $775.54

55821 suprapubic, subtotal, one or two stages - BR

55831 retropubic, subtotal - BR

55840 retropubic, radical - $775.54

55845 retropubic, radical, with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes - BR

Other Procedures

55899 Unlisted procedure, male genital system - BR

INTERSEX SURGERY

55970 Intersex surgery; male to female - BR

55980 female to male - BR

FEMALE GENITAL SYSTEM

Perineum

Incision

56000 Incision and drainage of perineal abscess (nonobstetrical) - $17.90

Excision

56100 Biopsy of perineum (separate procedure) - $17.90

Repair

56200 Perineoplasty, repair of perineum, nonobstetrical (separate procedure) - BR

Vulva and Introitus

Incision

56400 Incision and drainage, abscess of vulva, extensive - $23.86

56420 Incision and drainage of Bartholin's gland abscess, unilateral - $29.83

56440 Marsupialization of Bartholin's gland cyst - $119.31

Destruction

56500 Destruction of condylomata, vulva, multiple; simple, chemical $14.32

56505 electrodesiccation - $23.86

56510 surgical excision - $29.82

56515 extensive - BR

56520 Cryosurgery of benign lesion, vulva; simple - BR

56521 multiple - BR

Excision

56600 Biopsy of vulva (separate procedure) - $17.90

56620 Vulvectomy; partial, unilateral or bilateral (less than 80% of vulvar area) - $357.94

56625 complete (skin and subcutaneous tissue), bilateral - $447.44

56630 Vulvectomy, radical; without skin graft - $596.57

56635 with inguinofemoral lymphadenectomy, unilateral - $715.89

56636 with inguinofemoral lymphadenectomy, bilateral - $775.55

56640 Vulvectomy, radical, with inguinofemoral, iliac, and pelvic lymphadenectomy; unilateral - $775.55

56641 bilateral - $894.87

56680 Clitoridectomy; simple - $238.63

56685 extensive - $357.94

56700 Hymenectomy, partial excision of hymen - $71.58

56710 Plastic revision of hymen - BR

56720 Hymenotomy, simple incision - $41.76

56740 Excision of Bartholin's gland or cyst - $143.18

Repair

56800 Plastic repair of introitus - $143.18

Suture

Vagina

Incision

57000 Colpotomy; with exploration - $119.31

57010 with drainage of pelvic abscess - $119.31

57020 Colpocentesis (separate procedure) - $23.86

Excision

57100 Biopsy of vaginal mucosa; simple (separate procedure) - $21.47

57105 extensive, requiring suture (including cysts) - BR

57108 Colpectomy, obliteration of vagina; partial - BR

57110 complete - $417.60

57120 Colpocleisis (Le Fort type) - $357.94

57130 Excision of vaginal septum - BR

57137 Excision of vaginal cyst or tumor - BR

Introduction

57150 Irrigation and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease - $7.16

57160 Insertion of pessary - $7.15

57170 Diaphragm fitting with instructions - BR

Repair

57200 Colporrhaphy, suture of injury of vagina (nonobstetrical) - BR

57210 Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical) - BR

57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication) (separate procedure) - BR

57230 Plastic repair of urethrocele (separate procedure) - $208.80

57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele (separate procedure) - $253.54

57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy - $208.80

57260 Combined anteroposterior colporrhaphy; - $357.94

57265 with enterocele repair - $417.60

57270 Repair of enterocele, abdominal approach (separate procedure) - $417.60

57280 Colpopexy, abdominal approach - $417.60

57288 Sling operation for stress incontinence (eg, fascia or synthetic) - BR

57289 Pereyra procedure, including anterior colporrhaphy - BR

57290 Construction of artificial vagina (vaginal atresia or absence) - BR

57300 Closure of rectovaginal fistula; vaginal approach - $432.52

57305 abdominal approach - $536.92

57307 abdominal approach, with concomitant colostomy - $596.58

57310 Closure of urethrovaginal fistula - $432.52

57320 Closure of vesicovaginal fistula; vaginal approach - $432.52

57330 transvesical and vaginal approach - BR

Manipulation

57400 Dilation of vagina under anesthesia - $21.47

57410 Pelvic examination under anesthesia - $21.47

Endoscopy

57450 Culdoscopy, diagnostic; - $119.31

57451 with biopsy and/or lysis of adhesions or tubal sterilization - BR

57452 Colposcopy; (separate procedure) - BR

57454 with biopsies, or biopsy of the cervix - $44.75

Cervix Uteri

Excision

57500 Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) - $17.90

57510 Cauterization of cervix; electro or thermal - $17.90

57511 cryocautery, initial or repeat - BR

57520 Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair - $178.97

57530 Trachelectomy (cervicectomy), amputation of cervix (separate procedure) - $143.18

57540 Excision of cervical stump, abdominal approach; - $357.94

57545 with pelvic floor repair - BR

57550 Excision of cervical stump, vaginal approach; - $357.94

57555 with anterior and/or posterior repair - $432.52

57556 with repair of enterocele - BR

Introduction

57600 Introduction of any hemostatic agent or pack for spontaneous hemorrhage (separate procedure); initial - $21.47

57620 subsequent - $7.16

Repair

57700 Tracheloplasty (Shirodkar or Lash type operation) $178.97

57720 Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach - $178.97

Manipulation

57800 Dilation of cervical canal, instrumental (separate procedure) - $17.90

57820 Dilation and curettage of cervical stump - $178.97

Corpus Uteri

Excision

58100 Endometrial biopsy, suction type (separate procedure) - $21.47

58101 Endometrial washings (eg, for cytology sampling) - BR

58102 Office endometrial curettage - BR

58103 Menstrual extration - BR

58120 Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical) - $149.15

58140 Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); abdominal approach - $417.60

58145 vaginal approach - BR

58150 Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of overy(s) - $477.26

58180 Supracervical hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of overy(s) - $477.26

58200 Total hysterectomy, extended, corpus cancer, including partial vaginectomy; - $596.57

58205 with bilateral radical pelvic lymphadenectomy - $715.89

58210 Total hysterectomy, extended, cervical cancer, with bilateral radical pelvic lymphadenectomy (Wertheim type operation) - $894.86

58240 Total hysterectomy or cervicectomy, with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof (pelvic exenteration) - BR

58260 Vaginal hysterectomy; - $477.26

58265 with plastic repair of vagina, anterior and/or posterior colporrhaphy - $436.91

58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type) - BR

58270 with repair of enterocele - $536.92

58275 Vaginal hysterectomy, with total or partial colpectomy; - $536.92

58280 with repair of enterocele - $536.92

58285 Vaginal hysterectomy, radical (Schauta type operation) - $715.89

Introduction

58300 Insertion of intrauterine device (IUD) - $29.83

58301 Removal of intrauterine device (IUD) - BR

58310 Artifical insemination - BR

58320 Insufflation of uterus and tubes with air and CO2 - $29.83

58340 Injection procedure for hysterosalpingography - $23.86

58350 Hydrotubation of oviduct, including materials - BR

Repair

58400 Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure) - $357.94

58410 with presacral sympathectomy - BR

58430 Interposition operation (Watkins type), with or without pelvic floor repair - $417.60

58500 Hysterosalpingostomy, anastomosis of tube(s) to uterus - $417.60

58520 Hysterorrhaphy, repair of ruptured uterus (nonobstetrical) - $357.94

58540 Hysteroplasty, repair of uterine anomaly (Strassman type) - $417.60

Oviduct

Incision

58600 Transection of fallopian tube, abdominal or vaginal approach, unilateral or bilateral - $357.94

58605 Transection of fallopian tube, abdominal or vaginal approach, postpartum, during same hospitalization (separate procedure) - $208.79

58610 Ligation of fallopian tube(s) - BR

Excision

58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) - $357.94

58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) - $357.94

58740 Salpingoplasty, unilateral or bilateral (separate procedure) - $417.59

Ovary

Incision

58800 Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach - $119.31

58805 abdominal approach - $357.94

58820 Drainage of ovarian abscess; vaginal approach - $119.31

58822 abdominal approach - $357.94

Excision

58900 Biopsy of ovary, unilateral or bilateral (separate procedure) - $357.94

58920 Wedge resection or bisection of ovary, unilateral or bilateral - $357.94

58925 Ovarian cystectomy, unilateral or bilateral - BR

58940 Oophorectomy, partial or total, unilateral or bilateral; - $357.94

59845 with total omentectomy - $477.26

Endoscopy-Laparoscopy

58980 Laparoscopy for visualization of pelvic viscera; - BR

58982 with fulguration of oviducts (with or without transection) - $357.94

58984 with fulguration of ovarian or peritoneal lesions - BR

58985 with lysis of adhesions - BR

58986 with biopsy (single or multiple) - BR

58987 with aspiration (single or multiple) - BR

Other Procedures

58999 Unlisted procedure, female genital system nonobstetrical - BR

Maternity Care and Delivery

Incision

59000 Amniocentesis for diagnosis, abdominal approach - $29.83

59010 Amnioscopy - BR

59011 Amnioscopy (intraovular) - BR

59020 Fetal oxytocin stress test - BR

59030 Fetal scalp blood sampling; - BR

59031 repeat - BR

59050 Initiation and/or supervision of internal fetal monitoring during labor by consultant - BR

59100 Hysterotomy, abdominal, for removal of hydatidiform mole; - $417.60

59101 with tubal ligation - BR

59105 Hysterotomy, abdominal, for legal abortion; - BR

59106 with tubal ligation - BR

Excision

59102 Surgical treatment of ectopic pregnancy; tubal, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach - $417.60

59121 tubal, without salpingectomy and/or oophorectomy - BR

59125 ovarian, requiring oophorectomy and/or salpingectomy - BR

59126 ovarian, without oophorectomy and/or salpingectomy - BR

59130 abdominal - BR

59135 interstitial, uterine pregnancy requiring hysterectomy, total or subtotal - BR

59140 cervical - BR

59160 Dilation and curettage for postpartum hemorrhage (separate procedure) - $19.31

Repair

59300 Episiotomy or vaginal repair only, by other than attending physician; simple - $59.65

59305 extensive - BR

59350 Hysterorrhaphy of ruptured uterus; (separate procedure) - BR

59351 following dilation and curettage, including both procedures - BR

Delivery, Antepartum and Postpartum Care

59400 Total obstetric care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care - $477.26

59410 Vaginal delivery only (with or without episiotomy, forceps or breech delivery including in-hospital postpartum care (separate procedure) - $298.29

59420 Antepartum care only (separate procedure) - BR

59430 Postpartum care only (separate procedure) - BR

Cesarean Section

59500 Cesarean section, low cervical, including in-hospital postpartum care; (separate procedure) - $357.94

59501 including antepartum and postpartum care - $536.92

59520 Cesarean section, classic, including in-hospital postpartum care; (separate procedure) - $357.94

59521 including antepartum and postpartum care - $536.91

59540 Cesarean section, extraperitoneal, including in-hospital postpartum care; (separate procedure) - $417.60

59541 including antepartum and postpartum care - $596.57

59560 Cesarean section with hysterectomy, subtotal, including in-hospital postpartum care; (separate procedure) - $417.60

59561 including antepartum and postpartum care - $596.57

59580 Cesarean section with hysterectomy, total, including in-hospital postpartum care; (separate procedure) - $357.94

59581 including antepartum and postpartum care - $596.57

Abortion

59800 Treatment of abortion, first trimester; completed medically - BR

59801 completed surgically (separate procedure) - $178.97

59810 Treatment of abortion, second trimester; completed medically - BR

59811 completed surgically (separate procedure) - $178.97

59820 Treatment of missed abortion, any trimester, completed medically or surgically - BR

59830 Treatment of septic abortion - BR

59840 Legal (therapeutic) abortion, completed with dilation and curettage, and/or vacuum extraction - BR

59850 Legal (therapeutic) abortion, by one or more intra-amniotic injections (amniocentesis-injections) (including hospital admission and visits, delivery of fetus and secundines); - BR

59851 with dilation and curettage - $238.63

59852 with hysterotomy (failed saline) - BR

Other Procedures

59899 Unlisted procedure, maternity care and delivery - BR

ENDOCRINE SYSTEM

Thyroid Gland

Incision

60000 Incision and drainage of thyroglossal cyst, infected - $17.90

Excision

60100 Biopsy thyroid, needle - $35.79

60200 Excision of cyst or adenoma of thyroid, or transection of isthmus - $283.37

60220 Total thyroid lobectomy, unilateral; - $417.60

60225 with contralateral subtotal lobectomy, including isthmus - BR

60240 Thyroidectomy; total or complete - $477.26

60242 near total - BR

60245 Thyroidectomy, subtotal or partial; - $432.52

60246 with removal of substernal thyroid gland, cervical - approach - BR

60252 Thyroidectomy, total or subtotal for malignancy; with limited neck dissection - BR

60254 with radical neck dissection - $835.21

60260 Thyroidectomy, secondary; unilateral - BR

60261 bilateral - $536.92

60270 Thyroidectomy, including substernal thyroid gland, sternal split or transthoracic approach - BR

60280 Excision of thyroglossal duct cyst or sinus - $328.12

Parathyroid, Thymus, Adrenal Glands, and Carotid Body

Excision

60500 Parathyroidectomy or exploration of parathyroid(s); - $536.92

60505 with mediastinal exploration, sternal split or transthoracic approach - $715.89

60510 Transplantation of parathyroid gland(s) during thyroidectomy - BR

60520 Thymectomy, partial or total (separate procedure) - $536.92

60540 Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure), unilateral; - $566.74

60545 with excision of adjacent retroperitoneal tumor - $656.23

60550 Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal, bilateral; one stage - $715.89

60555 two stages - BR

60600 Excision of carotid body tumor; without excision of carotid artery - $507.09

60605 with excision of carotid artery - $715.89

60699 Unlisted procedure, endocrine system - BR

NERVOUS SYSTEM

Skull, Meninges, and Brain

Puncture for Injection, Drainage or Aspiration

61000 Subdural tap through fontanelle, infant; unilateral or bilateral; initial - $59.65

61001 subsequent taps - $41.76

61020 Ventricular puncture through previous burr hole, fontanelle, or implanted ventricular catheter/ reservoir; without injection - $59.65

61025 with gas injection procedure for ventriculography - $149.15

61030 with injection procedure for positive contrast ventriculography - $167.04

61045 with injection procedure of dye or radioactive material for CSF flow study, including lumbar puncture - BR

61050 Cisternal puncture; (separate procedure) - $74.57

61051 with injection of dye or drug - BR

61052 with injection of gas or contrast media for myelography - BR

61053 with injection of gas or contrast media for cisternography or pneumoencephalography - $149.15

61070 Puncture of shunt tubing or reservoir for aspiration or injection procedure - BR

Burr Hole(s) or Trephine

61120 Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material); not followed by other surgery - $387.77

61130 followed by other surgery - $298.29

61140 Burr hole(s) or trephine; for biopsy of brain or intracranial lesion - BR

61150 for drainage of brain abscess or cyst - $715.89

61151 subsequent tapping (aspiration of intracranial abscess or cyst - $59.65

61154 Burr hole(s); for evacuation and/or drainage of hematoma, extradural or subdural - BR

61156 for aspiration of hematoma or cyst, intracerebral - BR

61210 for implanting ventricular catheter, reservoir, or pressure recording device - BR

61250 Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery; unilateral - BR

61251 bilateral - BR

61253 Burr hole(s) or trephine, infratentorial, unilateral or bilateral - BR

Craniectomy or Craniotomy

61304 Craniectomy or craniotomy, exploratory; supratentorial - $1,014.18

61305 infratentorial (posterior fossa) - $1,193.15

61310 Craniectomy or craniotomy, evacuation of hematomy, extradural, subdural or intracerebral; supratentorial - $954.51

61311 infratentorial - BR

61320 Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial - $835.21

61321 infratentorial - BR

61330 Exploration or decompression of orbit only, transcranial approach; unilateral - $775.55

61331 bilateral - $1,163.32

61332 Exploration or decompression of orbit (transcranial approach); with biopsy - BR

61333 with removal of lesion - BR

61334 with removal of foreign body - BR

61340 Other cranial decompression (eg, subtemporal), supratentorial; unilateral - $477.26

61341 bilateral - BR

61345 Other cranial decompression, posterior fossa - BR

61440 Craniotomy for section of tentorium cerebelli (separate procedure) - BR

61450 Craniectomy for section, compression, or decompression of sensory root of gasserian ganglion - $835.21

61460 Craniectomy, suboccipital; for section of one or more cranial nerves - $1,014.18

61470 for medullary tractotomy - $1,193.15

61480 for mesencephalic tractotomy or pedunculotomy - BR

61490 Craniotomy for lobotomy, including cingulotomy; unilateral - $715.89

61491 bilateral - BR

61500 Craniectomy, trephination, bone flap craniotomy; for tumor of skull - $477.26

61510 for excision of brain tumor, supratentorial; except meningioma - $1,133.50

61512 for excision of meningioma, supratentorial - BR

61514 for excision of brain abscess, supratentorial - BR

61516 for excision or fenestration of cyst, supratentorial - BR

61518 Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma or cerebellopontine angle tumor - $1,193.15

61519 meningioma - BR

61520 cerebellopontine angle tumor - BR

61522 Craniectomy, infratentorial or posterior fossa; for excision of brain abscess - BR

61524 for excision or fenestration of cyst - BR

61526 Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; - BR

61530 combined with middle/posterior fossa craniotomy - $1,193.15

61532 Craniectomy, trephination, bone flap craniotomy; for excision of intracranial vascular malformation - $1,193.15

61534 for excision of cerebral cortical scar - BR

61536 for excision of cerebral cortical scar, with electrocorticography during surgery - BR

61538 for lobectomy with electrocorticography during surgery, temporal lobe - $1,133.50

61539 for lobectomy with electrocorticography during surgery, other than temporal lobe, partial or total - $1,133.50

61542 for hemispherectomy - $1,431.78

61544 for excision or coagulation of choroid plexus - BR

61546 Craniectomy for hypophysectomy; intracranial approach - $1,133.50

61548 Hypophysectomy, transnasal or transseptal approach, nonstereotactic - $1,133.50

61550 Craniectomy for craniostenosis; single suture - BR

61552 multiple sutures, one stage - BR

61553 each stage of multiple stages - BR

61555 Reconstruction of skull by multiple bone flaps - BR

61570 Craniectomy or craniotomy for excision of foreign body from brain - $1,014.18

Surgery for Aneurysm or Arteriovenous Malformation

61700 Surgery of intracranial aneurysm, intracranial approach; carotid circulation - $1,193.15

61702 vertebral-basilar circulation - BR

61703 Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type) - $417.60

61705 Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery - BR

61708 by intracranial electrothrombosis - BR

61710 by intra-arterial embolization, injection procedure - BR

61711 Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries - BR

61712 Microdissection, intracranial or spinal procedure (list separately in addition to code for primary procedure) - BR

Stereotaxis

61715 Stereotactic hypophysectomy, transnasal - BR

61720 Stereotactic lesion, any method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus - $1,133.50

61735 subcortical structure(s) other than globus pallidus or thalamus - $1,133.50

61780 Stereotactic localization, including burr hole(s), ventriculography and introduction of subcortical electrodes - BR

61790 Stereotactic lesion of gasserian ganglion, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency) - BR

Neurostimulators, Intracranial

61850 Burr or twist drill hole(s) for implantation of neurostimulator electrodes; cortical - BR

61855 subcortical - BR

61860 Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical - BR

61865 subcortical - BR

61870 Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical - BR

61875 subcortical - BR

61880 Revision or removal of intracranial neurostimulator electrodes - BR

61885 Incision for subcutaneous placement of neurostimulator receiver, direct or inductive coupling - BR

61888 Revision or removal of intracranial neurostimulator receiver - BR

Repair

62000 Elevation of depressed skull fracture; simple, extradural - $536.92

62005 compound or comminuted, extradural - $715.89

62010 with debridgement of brain and repair of dura - $865.03

62100 Repair of dural/CSF leak, including surgery for rhinorrhea/ otorrhea - $1,014.18

62120 Repair of encephalocele, including cranioplasty - $894.86

62140 Cranioplasty for skull defect; up to 5 cm diameter - $596.57

62141 larger than 5 cm diameter - $745.72

62145 Cranioplasty for skull defect with reparative brain surgery - $894.86

CSF Shunt

62180 Ventriculocisternostomy (Torkildsen type operation) - $954.51

62190 Creation of shunt; subdural-atrial, -jugular, -auricular - BR

62192 subdural-peritoneal, -pleural, -other terminus - BR

62194 Replacement or irrigation, subdural catheter - BR

62200 Ventriculocisternostomy, third ventricle - $954.51

62220 Creation of shunt; ventriculo-atrial, -jugular, -auricular - $775.54

62223 ventriculo-peritoneal, -pleural, -other terminus - $775.54

62225 Replacement or irrigation, ventricular catheter - $298.29

62230 Replacement or revision of shunt, obstructed valve, or distal catheter in shunt system - $656.23

62256 Removal of complete shunt system; without replacement - $298.29

62258 with replacement by similar or other shunt at same operation - $775.54

Spine and Spinal Cord

Puncture for Injection, Drainage, or Aspiration

62270 Spinal puncture, lumbar; diagnostic - $41.76

62272 for decompression (separate procedure) - BR

62273 Injection, lumbar epidural, of blood or clot patch - BR

62274 Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, simple - BR

62276 subarachnoid or subdural, differential - BR

62277 subarachnoid or subdural, continuous - BR

62278 epidural or cauda_, simple - BR

62279 epidural or caudal, continuous - BR

62280 Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); subarachnoid - $149.15

62282 epidural or caudal - $149.15

62284 Injection procedure for myelography, spinal or posterior fossa - $89.49

62286 Injection procedure for pneumoencephalography, lumbar - BR

62288 Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure) - BR

62289 epidural or caudal - BR

62290 Injection procedure for diskography, single or multiple levels; lumbar - $95,45

62291 cervical - BR

62292 Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar - BR

62293 cervical - BR

62294 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal - BR

Laminectomy or Laminotomy, for Exploration or Decompression

62295 Laminectomy for exploration of intraspinal canal, one or two segments; cervical - BR

62296 thoracic - BR

62297 lumbar - BR

62301 Laminectomy for exploration of intraspinal canal, more than two segments; cervical - BR

62302 thoracic - BR

62303 lumbar - BR

63001 Laminectomy for decompression of spinal cord and/or cauda equina, one or two segments; cervical - $954.51

63003 thoracic - $954.51

63005 lumbar, except for spondylolisthesis - $775.54

63010 lumbar for spondylolisthesis (Gill type operation) - $835.21

63015 Laminectomy for decompression of spinal cord and/or cauda equina, more than two segments; cervical - $954.51

63016 thoracic - $954.51

63017 lumbar - $954.51

63020 Laminotomy (hemilaminectomy), for herniated intervertebral disk, and/or decompression of nerve root; one interspace, cervical, unilateral - BR

63021 one interspace, cervical, bilateral - BR

63030 one interspace, lumbar, unilateral - BR

63031 one interspace, lumbar, bilateral - BR

63035 additional interspaces, cervical or lumbar - BR

63040 Laminotomy (hemilaminectomy), for herniated intervertebral disk, and/or decompression of nerve root, any level, extensive or re-exploration; cervical - BR

63041 thoracic - BR

63042 lumbar - BR

63060 Hemilaminectomy (laminectomy) for herniated intervertebral disk, thoracic; posterior approach - BR

63064 costovertebral approach - BR

63075 Diskectomy, cervical, anterior approach, without arthrodesis; single interspace - BR

63076 additional interspaces - BR

Incision

63180 Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments - $1,133.50

63182 more than two segments - BR

63185 Laminectomy for rhizotomy; one or two segments - $835.21

63190 more than two segments - BR

63194 Laminectomy for cordotomy, unilateral, one stage; cervical - BR

63195 thoracic - BR

63196 Laminectomy for cordotomy, bilateral, one stage; cervical - BR

63197 thoracic - BR

63198 Laminectomy for cordotomy, bilateral, two stages within 14 days; cervical - BR

63199 thoracic - BR

Excision for Lesion other than Herniated Intervertebral Disk

63210 Laminectomy, one or two segments, for excision of intraspinal lesion; cervical - $1,014.18

63215 thoracic - BR

63220 lumbar - $894.86

63240 Laminectomy, more than two segments, for excision of intraspinal lesion; cervical - BR

63241 thoracic - BR

63242 lumbar - BR

63250 Laminectomy for excision or occlusion of arteriovenous malformation of cord; cervical - BR

63251 thoracic - BR

Stereotaxis

63600 Stereotactic lesion of spinal cord, percutaneous, any modality (including stimulation and/or recording) - $715.89

63610 Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery - BR

Neurostimulators, Spinal

63650 Percutaneous implantation of neurostimulator electrodes; epidural - BR

63652 intradural (spinal cord) - BR

63655 Laminectomy for implantation of neurostimulator electrodes; epidural - BR

63656 endodural - BR

63657 subdural - BR

63658 spinal cord (dorsal or ventral) - BR

63660 Revision or removal of spinal neurostimulator electrodes - BR

63685 Incision for subcutaneous placement of neurostimulator receiver, direct or inductive coupling - BR

63688 Revision or removal of spinal neurostimulator receiver - BR

Repair

63700 Repair of meningocele; less than 5 cm diameter - $596.58

63702 larger than 5 cm diameter - BR

63704 Repair of myelomeningocele; less than 5 cm diameter - BR

63706 larger than 5 cm diameter - BR

63708 Repair dural/CSF leak - BR

63710 Dural graft, spinal - BR

Shunt, Spinal CSF

63740 Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, -ureteral, -fallopian or other - $775.54

63744 Replacement, irrigation or revision of lumbar-subarachnoid shunt - BR

63746 Removal of entire lumbar-subarachnoid shunt system without placement - BR

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic Somatic Nerves

64400 Injection, anesthetic agent; trigeminal nerve, any division or branch - $17.90

64402 facial nerve - BR

64405 greater occipital nerve - $17.90

64408 vagus nerve - BR

64410 phrenic nerve - $23.86

64412 spinal accessory nerve - BR

64415 brachial plexus - $29.83

64417 axillary nerve - BR

64420 intercostal nerve, single - $21.47

64421 intercostal nerves, multiple, regional block - BR

64425 iloinguinal, iliohypogastric nerves - $21.47

64430 pudendal nerve - $29.83

64435 paracervical (uterine) nerve - $29.83

64440 paravertebral nerve (thoracic, lumbar, sacral, coccygeal), single - $29.83

64441 paravertebral nerves, multiple, regional block - BR

64445 sciatic nerve - $17.90

64450 other peripheral nerve or branch - $17.90

Sympathetic Nerves

64505 Injection, anesthetic agent; sphenopalatine ganglion - BR

64508 carotid sinus (separate procedure) - BR

64510 stellate ganglion (cervical sympathetic) $29.83

64520 lumbar or thoracic (paravertebral sympathetic) - $23.86

64530 celiac plexus, with or without radiologic monitoring - BR

Neurostimulators, Peripheral Nerve

64550 Application of surface (transcutaneous) neurostimulator - BR

64553 Percutaneous implantation of neurostimulator electrodes; cranial nerve - BR

64555 peripheral nerve BR

64560 autonomic nerve - BR

64565 neuromuscular - BR

64573 Incision for implantation of neurostimulator electrodes; cranial nerve - BR

64575 peripheral nerve - BR

64577 autonomic nerve - BR

64580 neuromuscular - BR

64585 Revision or removal of peripheral neurostimulator electrodes - BR

64590 Incision for subcutaneous placement of neurostimulator receiver, direct or inductive coupling - BR

64595 Revision or removal of peripheral neurostimulator receiver - BR

Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical, Radiofrequency) Somatic Nerves

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch - $59.65

64605 second and third division branches at foramen ovale - $119.31

64610 second and third division branches at foramen ovale under radiologic monitoring - $119.31

64620 Destruction by neurolytic agent; intercostal nerve - $119.31

64630 pudendal nerve - BR

64640 other peripheral nerve or branch - $59.65

Sympathetic Nerves

64680 Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring - BR

Exploration, Neurolysis or Nerve Decompression (Neuroplasty)

Decompression or freeing of intact nerve from scar tissue, including external neurolysis and transposition

64702 Neurolysis; digital, one or both, same digit - $143.18

64704 nerve of hand or foot - $238.63

64708 Neurolysis, major peripheral nerve, arm or leg; other than specified - BR

64712 sciatic nerve - $447.44

64713 brachial plexus - BR

64714 lumbar plexus - BR

64716 Neurolysis and/or transposition; cranial nerve (specify) - BR

64718 ulnar nerve at elbow - $357.94

64719 ulnar nerve at wrist - BR

64721 median nerve at carpal tunnel - $298.29

64722 Decompression; unspecified nerve(s) (specify) - BR

64726 plantar digital nerve - BR

64727 Internal neurolysis by dissection, with or without microdissection (list separately in addition to code for primary neuroplasty) - BR

Transection or Avulsion of Nerve

64732 Transection or avulsion of; supraorbital nerve - $208.80

64734 infraorbital nerve - BR

64736 mental nerve - BR

64738 inferior alveolar nerve by osteotomy - BR

64740 lingual nerve - BR

64742 facial nerve, differential or complete - $447.44

64744 greater occipital nerve - $208.80

64746 phrenic nerve - BR

64752 vagus nerve (vagotomy), transthoracic - $417.60

64760 vagus nerve (vagotomy), abdominal - $417.60

64761 pudendal nerve, unilateral - BR

64762 pudendal nerve, bilateral - BR

64763 Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy; unilateral - $178.97

64764 bilateral - $268.46

64766 Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy; unilateral - $298.29

64768 bilateral - BR

64772 Transection or avulsion of other spinal nerve, extradural - $298.29

Excision-Somatic Nerves

64774 Excision of neuroma; cutaneous nerve, surgically identifiable - BR

64776 digital nerve, one or both, same digit - BR

64778 digital nerve, each additional digit (list separately by this number) - BR

64782 hand or foot, except digital nerve - $178.97

64783 hand or foot, each additional nerve, except same digit (list separately by this number) - BR

64784 major peripheral nerve, except sciatic - BR

64786 sciatic nerve - BR

64787 Insertion of plastic cap on nerve end - BR

64788 Excision of neurofibroma or neurolemmoma; cutaneous nerve - $178.97

64790 major peripheral nerve - BR

64792 extensive (including malignant type) - $596.57

64795 Biopsy of nerve - BR

Excision-Sympathetic Nerves

64802 Sympathectomy, cervical; unilateral - $447.44

64803 bilateral - BR

64804 Sympathectomy, cervicothoracic; unilateral, one stage - $596.57

64806 bilateral or two stage unilateral - BR

64809 Sympathectomy, thoracolumbar; unilateral - $596.57

64811 bilateral - $894.86

64814 Sympathectomy, hypogastric or presacral neurectomy (separate procedure) - $417.60

64818 Sympathectomy, lumbar, unilateral - $447.44

64819 bilateral - $671.14

64824 periarterial - BR

Nerve Repair by Suture (Neurorrhaphy)

64830 Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair) - BR

64831 Suture of digital nerve, hand or foot; one nerve - $298.29

64832 each additional digital nerve - $35.79

64834 Suture of one nerve, hand or foot; common sensory nerve - $238.63

64835 median motor thenar - $298.29

64836 ulnar motor - $357.90

64837 Suture of each additional nerve, hand or foot - BR

64840 Suture of posterior tibial nerve - BR

64856 Suture of major peripheral nerve, arm or leg, except sciatic; including transposition - $447.43

64857 without transposition - BR

64858 Suture of sciatic nerve - $596.57

64859 Suture of each additional major peripheral nerve - BR

64861 Suture of; brachial plexus - BR

64862 lumbar plexus - BR

64864 Suture of facial nerve; extracranial - BR

64865 intratemporal, with or without grafting - BR

64866 Anastomosis; facial-spinal accessory - BR

64868 facial-hypoglossal - BR

64870 facial-phrenic - BR

64872 Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy) - BR

64874 requiring extensive proximal mobilization, or transposition of nerve (list separately in addition to code for nerve suture) - BR

64876 requiring shortening of bone of extremity (list separately in addition to code for nerve suture) - BR

Neurorrhaphy with Nerve Graft

64890 Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length - BR

64891 more than 4 cm length - BR

64892 Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length - BR

64893 more than 4 cm length - BR

64895 Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length - BR

64896 more than 4 cm length - BR

64897 Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length - BR

64898 more than 4 cm length - BR

64901 Nerve graft, each additional nerve; single strand - BR

64902 multiple strands (cable) - BR

64905 Nerve pedicle transfer; first stage - BR

64907 second stage - BR

Other Procedures

64999 Unlisted procedure, nervous system - BR

EYE AND OCULAR ADNEXA

Eyeball

Removal of Eye

65091 evisceration ocular contents; without implant - $298.29

65093 with implant - $357.94

65101 Enucleation eye; without implant - BR

65103 with implant, muscles not attached to implant - BR

65105 with implant, muscles attached to implant - $357.94

65110 Exenteration orbit (does not include skin graft), removal orbital contents; only - BR

65112 with therapeutic removal of bone - BR

65114 with temporalis muscle transplant - BR

Secondary Implant Procedures

An ocular implant is an implant inside muscular cone; an orbital implant is an implant outside muscular cone.

65130 Insertion ocular implant secondary; after evisceration, in scleral shell - BR

65135 after enucleation, muscles not attached to implant - BR

65140 after enucleation, muscles attached to implant - $417.60

65150 Reinsertion ocular implant; with or without conjunctival graft - BR

65155 with use of foreign material for reinforcement and/or attachment of muscles to implant - BR

65175 Removal ocular implant - BR

Removal of Ocular Foreign Body

65205 Removal foreign body, external eye; conjunctival superficial - $5.96

65210 conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating - $11.96

65220 corneal, without slit lamp - $11.96

65222 corneal, with slip lamp - $17.90

65230 Removal foreign body intraocular; from anterior chamber, magnetic extraction - $357.94

65235 from anterior chamber, nonmagnetic extraction - $477.26

65240 from lens (without extraction lens), magnetic extraction - BR

65245 from lens (without extraction lens), nonmagnetic extraction - BR

65260 from posterior segment, magnetic extraction, anterior or posterior route - BR

65265 from posterior segment, nonmagnetic extraction - BR

Repair of Laceration of Eyeball

65270 Repair laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure - BR

65272 conjunctiva, by mobilization and rearrangement, without hospitalization - BR

65273 conjunctiva, by mobilization and rearrangement, with hospitalization - BR

65275 cornea, nonperforating, with or without removal foreign body - BR

65280 cornea and/or sclera, perforating, not involving uveal tissue - BR

65285 cornea and/or sclera, perforating, with reposition or resection of uveal tissue - BR

65290 Repair wound extraocular muscle, tendon and/or Tenon's capsule - BR

Anterior Segment--Cornea

Incision

65300 Delimiting keratotomy - $59.65

Excision

65400 Excision lesion cornea (keratectomy, lamellar, partial), except pterygium - $238.63

65410 Biopsy cornea - BR

65420 Excision or transposition pterygium; without graft - $178.97

65426 with graft - BR

Removal or Destruction

65430 Scraping cornea, diagnostic, for smear and/or culture - BR

65435 Removal corneal epithelium; with or without chemocauterization (abrasion, curettage) - BR

65436 with application of chelating agent, eg, EDTA - BR

65445 Thermocauterization lesion of cornea - BR

65455 Cryotherapy lesion of cornea - BR

65600 Tattoo cornea, mechanical or chemical - $238.64

Keratoplasty

65710 Keratoplasty (corneal transplant) lamellar; autograft - BR

65720 homograft, fresh - BR

65725 homograft, preserved - BR

65730 Keratoplasty (corneal transplant) penetrating (except in aphakia); autograft - BR

65740 homograft, fresh - BR

65745 homograft, preserved - BR

65750 Keratoplasty (corneal transplant) penetrating, in aphakia - BR

Other Procedures

65760 Keratomeleusis (refractive keratoplasty) - BR

65765 Keratophakia - BR

65770 Keratoprosthesis - BR

Anterior Segment--Anterior Chamber

Incision

65800 Paracentesis anterior chamber eye (separate procedure); with diagnostic aspiration of aoueous - $29.83

65805 with therapeutic release of aqueous - BR

65810 with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection - BR

65815 with removal of blood, with or without irrigation and/or air injection - BR

65820 Goniotomy; without goniopuncture - $298.29

65825 with goniopuncture - BR

65830 Goniopuncture, without goniotomy - BR

65850 Trabeculotomy ab externo - BR

Other Procedures

65865 Severing adhesions anterior segment eye (with or without injection air or liquid) (separate procedure); goniosynechiae - BR

65870 anterior synechiae, except goniosynechiae - BR

65875 posterior synechiae - BR

65880 corneovitreal adhesions - BR

65900 Removal epithelial downgrowth anterior chamber eye - BR

65920 Removal implanted material anterior segment eye - BR

65930 Revomal of blood clot, anterior segment eye - BR

66020 Injection, anterior chamber (separate procedure); air or liquid - $59.65

66030 medication - BR

Anterior Segment--Anterior Sclera

Excision

66130 Excision lesion sclera - BR

66150 Fistulization sclera for glaucoma; trephination with iridectomy - BR

66155 thermocauterization with iridectomy - BR

66160 sclerectomy with punch or scissors, with iridectomy - BR

66165 iridencleisis or iridotasis - BR

66170 trabeculectomy ab externo - BR

Repair

66220 Repair scleral staphyloma; without graft - $596.58

66225 with graft - $715.89

Revision Operative Wound

66250 Revision or repair operative wound anterior segment, any type, early or late, major or minor procedure - BR

Anterior Segment--Iris, Ciliary Body

Iridotomy, Iridectomy

66500 Iridotomy by stab incision (separate procedure); except transfixion -$149.15

66505 with transfixion as for iris bombe - $149.15

66600 Iridectomy, with corneoscleral or corneal section; for removal of lesion - $417.60

66605 with cyclectomy - BR

66625 peripheral for glaucoma (separate procedure) - BR

66630 sector for glaucoma (separate procedure) - BR

66635 "optical" (separate procedure) - BR

Repair

66680 Repair of iris, ciliary body (as for iridodialysis) - $298.29

Destruction

66700 Cyclodiathermy; initial - $238.63

66701 subsequent - $119.31

66720 Cyclocryotherapy; initial - $178.97

66721 subsequent - $89.48

66740 Cyclodialysis; initial - $357.94

66741 subsequent - $178.97

66761 Coreoplasty ("iridotomy") by photocoagulation; for glaucoma - BR

66762 other than for glaucoma - BR

66770 Destruction of cyst or lesion iris or ciliary body (nonexcisional prodecure) - BR

Anterior Segment--Lens

Incision

66800 Discission lens (needling of lens); initial - $149.15

66801 subsequent - $71.58

66820 Discission of secondary membranous cataract ("after cataract") and/or anterior hyaloid (Ziegler or Wheeler knife technique) - $149.14

Removal Cataract

66830 Removal of secondary membranous cataract ("after cataract"), with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy) - BR

66840 Removal of lens material; aspiration technique, one or more stages - $357.94

66850 phacofragmentation technique (mechanical or ultrasonic, eg, phacoemulsification), with aspiration - BR

66915 Expression lens, linear, one or more stages - BR

66920 Extraction lens with or without iridectomy; intracapsular, with or without enzymes - BR

66930 intracapsular, for dislocated lens - BR

66940 extracapsular (other than 66840, 66850, 66915) - BR

66945 in presence of fistulization bleb and/or by temporal, inferior or inferotemporal route, intracapsular or extracapsular - BR

Anterior Segment--Other Procedures

66980 Insertion intraocular lens prosthesis; with cataract extraction (any technique) one stage - BR

66985 secondary, subsequent to cataract extraction - BR

66999 Unlisted procedure, anterior segment of eye - BR

Posterior Segment--Vitreous

67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal - BR

67010 subtotal removal with mechanical vitrectomy (such as VISC or rotoextractor) - BR

67015 Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy) - BR

67025 Injection of vitreous substitute, pars plana approach (separate procedure), excludes air or balanced salt solutions - BR

67030 Discission of vitreous strands (without removal), pars plana approach - BR

67035 Vitrectomy mechanical (such as VISC or roto-extractor) pars plana approach, with or without removal of lens by same technique - BR

Posterior Segment--Retinal Detachment

Repair

67102 Repair retinal detachment (one or more stages, same hospitalization); diathermy, with or without drainage of subretinal fluid and/or injection of air or saline - BR

67103 cryotherapy, with or without drainage of subretinal fluid - BR

67104 drainage of subretinal fluid with photo-coagulation (one or more stages), xenon arc - BR

67106 drainage of subretinal fluid with photo-coagulation (one or more stages), laser - BR

67107 scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant, may include procedures 67102-67106 - BR

67108 with vitrectomy, any method, with or without air tamponade, may include procedures 67102-67107 and/or removal of lens by same technique - BR

67109 by technique other than 67102-67108 - BR

67112 previously operated upon, any technique - BR

67120 Removal implanted materila, posterior segment eye - BR

Prophylaxis

67142 Prophylaxis retinal detachment (eg, retinal break, lattice degeneration), without drainage, one or more stages; diathermy - BR

67143 cryotherapy - BR

67144 photocoagulation, xenon arc - BR

67146 photocoagulation, laser - BR

Posterior Segment--Other Procedures

Destruction--Retina, Choroid

67212 Destruction of localized lesion retina or choroid (eg choroidopathy), one or more stages; diathermy - BR

67213 cryotherapy - BR

67214 photocoagulation, xenon arc - BR

67216 photocoagulation, laser - BR

67218 radiation by implantation of source (includes removal of source) - BR

67222 Destruction of progressive retinopathy (eg, diabetic), one or more stages; diathermy - BR

67223 cryotherapy - BR

67224 photocoagulation, xenon arc - BR

67226 photocoagulation, laser - BR

Scleral Repair

67250 Scleral reinforcement (separate procedure); without graft - BR

67255 with graft - BR

67299 Unlisted procedure, posterior segment - BR

Ocular Adnexa--Extraocular Muscles

67311 Strabismus surgery on patient not previously operated on, any procedure, any muscle, (may include

minor displacement, eg, for A or V pattern); one muscle - BR

67312 two muscles, one or both eyes - BR

67313 three or more muscles, one or both eyes - BR

67320 Transposition extraocular muscle (eg, for paretic muscle), one or more stages, one or more muscles, with displacement of plane of action more than 5 mm - $536.92

67331 Strabismus surgery on patient previously operated on; not involving reoperation of muscles - BR

67332 involving reoperation of muscles - BR

Other Procedures

67350 Biopsy extraocular muscle - BR

67399 Unlisted procedure, ocular muscle - BR

Ocular Adnexa--Orbit

Exploration, Exicision

67400 Orbitotomy without bone flap (frontal approach); for exploration, with or without biopsy - $357.94

67405 drainage only - $357.94

67412 with removal lesion - BR

67413 with removal foreign body - BR

67415 Transconjunctival or aspirational biopsy - BR

67420 Orbitotomy with bone flap, lateral approach (eg, Kroenlein); with removal of lesion - $656.23

67430 with removal foreign body - BR

67440 with drainage or decompression - $596.57

67450 for exploration, with or without biopsy - BR

Other Procedures

67500 Retrobulbar injection; medication (separate procedure does not include supply of medication) - $17.90

67505 alcohol - $59.65

67510 air or opaque contrast medium of radiography - $29.83

67515 Injection therapeutic agent into Tenon's capsule - BR

67550 Orbital implant (implant outside muscle cone); insertion - BR

67560 removal or revision - BR

67599 Unlisted procedure, orbit - BR

Ocular Adnexa--Eyelids

Incision

67700 Blepharotomy, drainage abscess eyelid - $11.94

67710 Severing tarsorrhaphy - BR

67715 Canthotomy (separate procedure) - BR

Excision or Removal of Lesion Involving More Than Skin (ie, Involving Lid Margin, Tarsus, and/or Palpebral Conjunctiva)

67800 Excision chalazion, single - $35.79

67801 multiple, same lid - $41.76

67805 multiple, different lids - $47.73

67808 under general anesthesia and/or requiring hospitalization, single or multiple - BR

67810 Biopsy eyelid - BR

67820 Correction trichiasis; epilation, forceps only - $11.94

67825 epilation, electrosurgical - $29.83

67830 incision lid margin - BR

67835 incision lid margin, with free mucous membrane graft - BR

67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure - BR

67850 Destruction of lesion of lid margin (up to 1 cm) - BR

Tarsorrhaphy

67880 Construction intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; - BR

67882 with transposition of tarsal plate - BR

Repair Blepharoptosis, Lid Retraction

67901 Repair blepharoptosis; frontalis muscle technique with suture - $477.26

67902 frontalis muscle technique with fascial sling (includes obtaining fascia) - $357.94

67903 (tarso)levator resection, internal approach - BR

67904 (tarso)levator resection, external approach - BR

67906 superior rectus technique with fascial sling (includes obtaining fascia) - BR

67907 superior rectus tendon transplant - BR

67908 conjunctivo-tarso-levator resection (Fasanella-Servat type) - BR

67909 Reduction of overcorrection of ptosis - BR

67911 Correction of lid retraction - BR

Repair Ectropion, Entropion

67914 Repair ectropion; suture - BR

67915 thermocauterization - BR

67916 blepharoplasty, excision tarsal wedge - BR

67917 blepharoplasty, extensive (eg, Kuhnt-Szymanowski operation) - BR

67921 Repair entropion; suture - BR

67922 thermocauterization - BR

67923 blepharoplasty, excision tarsal wedge - BR

67924 blepharoplasty, extensive (eg, Wheeler operation) - $298.29

Reconstructive Surgery, Blepharoplasty Involving More Than Skin (ie, Involving Lid Margin, Tarsus, and/or Palpebral Conjunctiva)

67930 Suture recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva) direct closure; partial thickness - BR

67935 full thickness - BR

67938 Removal embedded foreign body, eyelid - BR

67950 Canthoplasty (reconstruction of canthus) - BR

67961 Excision and repair eyelid, involving lid margin, tarsus, conjunctiva, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin - BR

67966 over one-fourth of lid margin - BR

67971 Reconstruction eyelid full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage - BR

67973 total eyelid, lower, one stage or first stage - BR

67974 total eyelid, upper, one stage or first stage - BR

67975 second stage - BR

Other Procedures

67999 Unlisted procedure, eyelids - BR

Ocular Adnexa--Conjunctiva

Incision, Drainage

68020 Incision conjunctiva, drainage cyst - $11.94

68040 Expression conjunctival follicles, eg, for trachoma - BR

Excision, Destruction

68100 Biopsy conjunctiva - $29.83

68110 Excision lesion conjunctiva; up to 1 cm - BR

68115 over 1 cm - BR

68130 with adjacent sclera - BR

68135 Destruction lesion conjunctiva - BR

Injection

68200 Subconjunctival injection - $17.90

Conjunctivoplasty

68320 Conjunctivoplasty; with conjunctival graft or extensive rearrangement - $357.94

68325 with buccal mucous membrane graft (includes obtaining graft) - $417.60

68326 Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement - BR

68328 with buccal mucous membrane graft (includes obtaining graft) - BR

68330 Repair symblepharon; conjunctivoplasty, without graft - BR

68335 with free graft conjunctiva or buccal mucous membrane (includes obtaining graft) - BR

68340 division symblepharon with or without insertion of conformer or contact lens - BR

Other Procedures

68360 Conjunctival flap; bridge or partial (separate procedure) - $149.15

68362 total (such as Gunderson thin flap or purse string flap) - BR

68399 Unlisted procedure, conjunctiva - BR

Ocular Adnexa--Lacrimal System

Incision

68400 Incision, drainage lacrimal gland - $71.58

68420 Incision, drainage lacrimal sac (dacryocystotomy or dacryocystostomy) - $59.65

68440 Snip incision lacrimal punctum - $11.94

Excision

68500 Excision of lacrimal gland (dacryoadenectomy), except for tumor; total - $357.94

68505 partial - BR

68510 Biopsy lacrimal gland - BR

68520 Excision of lacrimal sac (dacryocystectomy) - $357.94

68525 Biopsy of lacrimal sac - BR

68530 Removal of foreign body or dacryolith, lacrimal passages - BR

68540 Excision of lacrimal gland tumor; frontal approach - $447.43

68550 involving osteotomy - BR

Repair

68700 Plastic repair canaliculi - BR

68705 Correction everted punctum, cautery - BR

68720 Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity) - $417.60

68745 Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube - BR

68750 with insertion of tube or stent - BR

68760 Closure lacrimal punctum, thermocauterization - $29.82

68770 Closure lacrimal fistula (separate procedure) - BR

Probing and Related Procedures

68800 Dilation lacrimal punctum, with or without irrigation, unilateral or bilateral - $11.94

68820 Probing nasolacrimal duct, with or without irrigation, unilateral or bilateral; - $17.50

68825 requiring hospitalization - BR

68830 with insertion of tube or stent (without general anesthesia) - BR

68840 Probing lacrimal canaliculi, with or without irrigation - $11.94

68850 Injection contrast medium for dacryocystography - BR

Other Procedures

68899 Unlisted procedure, lacrimal system - BR

AUDITORY SYSTEM

External Ear

Incision

69000 Drainage external ear, abscess or hematoma; simple - $11.94

69005 complicated - BR

69020 Drainage external auditory canal, abscess - $11.94

69090 Ear piercing - $17.90

Excision

69100 Biopsy external ear - $17.90

69105 Biopsy external auditory canal - BR

69110 Excision external ear; partial, simple repair - $89.48

69120 complete amputation - $238.63

69140 Excision exostosis(es), external auditory canal - $357.94

69145 Excision soft tissue lesion, external auditory canal - BR

69150 Radical excision external auditory canal lesion; without neck dissection - BR

69155 with neck dissection - BR

Removal Foreign Body

69200 Removal foreign body from external auditory canal; without general anesthesia - $11.94

69205 with general anesthesia - $17.90

69210 Removal impacted cerumen (separate procedure), one or both ears - BR

Repair

69300 Otoplasty protruding ear, with or without size reduction; unilateral - $298.29

69301 bilateral - $477.26

69320 Reconstruction external auditory canal for congenital atresia, single stage - $477.26

Other Procedures

69399 Unlisted procedure, external ear - BR

Middle Ear

Introduction

69400 Eustachian tube inflation; with catheterization - $8.95

69401 without catheterization - BR

Incision

69420 Myringotomy including aspiration and/or eustachian tube inflation - $17.90

69431 Tympanostomy (requiring insertion of ventilating tube); in office, without operating microscope - BR

69432 in office, with operating microscope - BR

69435 in surgical suite, with or without operating microscope - $89.49

69440 Middle ear exploration through postauricular or ear canal incision - $298.29

Excision

69501 Transmastoid antrotomy ("simple" mastoidectomy) - BR

69502 Mastoidectomy; complete - BR

69505 modified radical - BR

69511 radical - BR

69530 Petrous apicectomy including radical mastoidectomy - $894.86

69535 Resection temporal bone, external approach - BR

69540 Excision aural polyp - $29.82

69550 Excision aural glomus tumor; transcanal - BR

69552 transmastoid - BR

69554 extended (extratemporal) - BR

Repair

69601 Revision mastoidectomy; resulting in complete mastoidectomy - BR

69602 resulting in modified radicla mastoidectomy - BR

69603 resulting in radicla mastoidectomy - BR

69604 resulting in tympanoplasty - BR

69605 with apicectomy - BR

69610 Tympanic membrane patching, with or without site preparation or perforation preparation for closure without patch - $17.90

69620 Myringoplasty (surgery confined to drumhead and donor area) - $17.90

69631 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction - BR

69632 with ossicular chain reconstruction, eg, post-fenestration - BR

69635 Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction - BR

69636 with ossicular chain reconstruction - BR

69641 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction - $700.98

69642 with ossicular chain reconstruction - BR

69643 with intact or reconstructed wall, without ossicular chain reconstruction - BR

69644 with intact or reconstructed canal wall, with ossicular chain reconstruction - BR

69645 radical or complete, without ossicular chain reconstruction - BR

69646 radical or complete, with ossicular chain reconstruction - BR

69650 Stapes mobilization - $357.94

69660 Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material - $596.58

69666 Repair oval window fistula - BR

69667 Repair round window fistula - BR

69670 Mastoid obliteration (separate procedure) - BR

69675 Tympanic neurectomy - BR

Other Procedures

69700 Closure postauricular fistula, mastoid (separate procedure) - $208.80

69720 Decompression facial nerve, intratemporal; lateral to geniculate ganglion - $715.89

69725 including medial to geniculate ganglion - BR

69740 Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion - $894.86

69745 including medial to geniculate ganglion - BR

69799 Unlisted procedure, middle ear - BR

Inner Ear

Incision, Destruction

69801 Labyrinthotomy, with or without cryosurgery or other nonexcisional destructive procedures or tack procedure; transcanal - BR

69802 with mastoidectomy - BR

69805 Endolymphatic sac operation; without shunt - BR

69806 with shunt - BR

69820 Fenestration semicircular canal - $656.23

69840 Revision fenestration operation - $328.11

Excision

69905 Labyrinthectomy; transcanal - BR

69910 with mastoidectomy - BR

69915 Vestibular nerve section, translabyrinthine approach - BR

69949 Unlisted procedure, inner ear - BR

Temporal Bone, Middle Fossa Approach

69950 Vestibular nerve section, transcranial approach - BR

69955 Total facial nerve decompression and/or repair (may include graft) - BR

69960 Decompression internal auditory canal - BR

69965 Eustachian tuboplasty - BR

69970 Removal of tumor - BR

Other Procedures

69979 Unlisted procedure, temporal bone, middle fossa approach - BR

RADIOLOGY

(INCLUDING NUCLEAR MEDICINE AND DIAGNOSTIC ULTRASOUND)

PROCEDURES

DIAGNOSTIC RADIOLOGY

Head and Neck

70002 Pneumoencephalography; supervision and interpretation only - $155.64

70003 complete procedure - BR

70010 Myelography, posterior fossa; supervision and interpretation only - BR

70011 complete procedure - BR

70015 Cisternography, positive contrast; supervision and interpretation only - BR

70016 complete procedure - BR

70020 Ventriculography; air contrast, supervision and interpretation only - $93.38

70021 positive contrast, supervision and interpretation only - BR

70022 Stereotactic localization, head - BR

70030 Radiologic examination, eye; for detection of foreign body - $34.24

70040 for localization of foreign body (does not include detection) - $54.47

70050 for detection and localization of foreign body - $70.03

70100 Radiologic examination, mandible; partial, less than four views - $23.34

70110 complete, minimum of four views - $38.91

70120 Radiologic examination, mastoids; less than three views per side - $23.34

70130 complete, minimum of three views per side - $46.68

70134 Radiologic examination, internal auditory meati, complete - $46.68

70140 Radiologic examination, facial bones; less than three views - $21.40

70150 complete, minimum of three views - $38.91

70160 Radiologic examination, nasal bones, complete minimum of three views - $24.89

70170 Dacryocystography, nasolacrimal duct; supervision and interpretation only - $38.91

70171 complete procedure - BR

70190 Radiologic examination; optic foramina - $23.34

70200 orbits, complete, minimum of four views - BR

70210 Radiologic examination, sinuses, paranasal, less than three views - $19.46

70220 Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies - $34.24

70230 with contrast studies, supervision and interpretation only - BR

70231 with contrast studies, complete procedure - BR

70240 Radiologic examination, sella turcica - $19.46

70250 Radiologic examination, skull; less than four views, with or without stereo - $23.34

70260 complete, minimum of four views, with or without stereo - $46.68

70300 Radiologic examination, teeth; single view - $7.78

70310 partial examination, less than full mouth - $15.57

70320 complete, full mouth - $31.13

70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral - BR

70330 bilateral - $34.24

70350 Cephalogram, orthodontic - $15.57

70355 Orthopantogram - BR

70360 Radiologic examination; neck, soft tissue - $15.57

70370 pharynx or larynx, including fluoroscopy - BR

70373 Laryngography, contrast; supervision and interpretation only - BR

70374 complete procedure - $93.38

70380 Radiologic examination, salivary gland for calculus - $24.90

70390 Sialography; supervision and interpretation only - $31.12

70391 complete procedure - BR

70400 Orbitography, air or positive contrast; supervision and interpretation only - BR

70401 complete procedure - BR

70450 Computerized tomography, head; without intravenous contrast - $157.73

70460 with intravenous contrast - BR

70470 without intravenous contrast, followed by intravenous contrast and further sections - BR

Chest

71000 Radiologic examination, chest, minifilm - $6.61

71010 Radiologic examination, chest; single view, posteroanterior - $15.57

71015 stereo, posteroanterior - BR

71020 two views, posteroanterior and lateral - $20.24

71021 apical lordotic procedure - BR

71022 oblique projections - BR

71030 minimum of four views - $31.12

71034 including fluoroscopy - $38.91

71035 Radiologic examination, chest, special views, eg, lateral decubitus, Bucky studies - BR

71036 Fluoroscopic localization for needle biopsy of intrathoracic lesion, including follow-up films - BR

71038 Fluoroscopic localization for transbronchial biopsy or brushing - BR

71040 Bronchography, unilateral; supervision and interpretation only - $54.47

71041 complete procedure - BR

71060 Bronchography, bilateral; supervision and interpretation only - $85.60

71061 complete procedure - BR

71090 Insertion pacemaker, fluoroscopy and radiography, supervision and interpretation only - BR

71100 Radiologic examination, ribs; unilateral, minimum of two views - $28.00

71110 bilateral, minimum of three views - $38.91

71120 Radiologic examination; sternum, minimum of two views - $23.34

71130 sternoclavicular joint or joints, minimum of three views - $23.34

71250 Computerized tomography, thorax; without intravenous contrast - BR

71260 with intravenous contrast - BR

71270 without intravenous contrast, followed by intravenous contrast and further sections - BR

Spine and Pelvis

72010 Radiologic examination, spine, entire, survey study, anteroposterior and lateral - $62.25

72020 Radiologic examination, spine, single view, specify level - BR

72040 Radiologic examination, spine, cervical; anteroposterior and lateral - $23.34

72050 minimum of four views - $25.30

72052 complete, including oblique and flexion and/or extension studies - $51.36

72070 Radiologic examination, spine; thoracic, anteroposterior and lateral - $27.24

72080 thoracolumbar, anteroposterior and lateral - $27.23

72090 scoliosis study, including supine and erect studies - $23.34

72100 Radiologic examination, spine, lumbosacral; anteroposterior and lateral - $25.30

72110 complete, with oblique views - $50.58

72114 complete, including bending views - $62.25

72120 Radiologic examination, spine, lumbosacral, bending views only, minimum of four views - $31.12

72170 Radiologic examination, pelvis; anteroposterior only - $19.46

72180 stereo - $24.90

72190 complete, minimum of three views - $31.12

72200 Radiologic examination, sacroiliac joints; less than three views - $19.46

72202 three or more views - $31.13

72220 Radiologic examination, sacrum and coccyx, minimum of two views - $24.90

72240 Myelography, cervical; supervision and interpretation only - BR

72241 complete procedure - BR

72255 Myelography, thoracic; supervision and interpretation only - BR

72256 complete procedure - BR

72265 Myelography, lumbosacral; supervision and interpretation only - BR

72266 complete procedure - BR

72270 Myelography, entire spinal canal; supervision and interpretation only - $116.73

72271 complete procedure - BR

72285 Diskography, cervical; supervision and interpretation only - BR

72286 complete procedure - BR

72295 Diskography, lumbar; supervision and interpretation only - BR

72296 complete procedure - BR

Upper Extremities

73000 Radiologic examination; clavicle, complete - $18.68

73010 scapula, complete - $23.34

73020 Radiologic examination, shoulder; one view - $15.55

73030 complete, minimum of two views - $23.34

73040 Radiologic examination, shoulder, arthrography; supervision and interpretation only - $38.91

73041 complete procedure - BR

73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction - $27.24

73060 humerus, minimum of two views - $16.80

73070 Radiologic examination, elbow; anteroposterior and lateral views - $18.68

73080 complete, minimum of three views - $23.34

73085 Radiologic examination, elbow, arthrography; supervision and interpretation only - BR

73086 complete procedure - BR

73090 Radiologic examination; forearm, anteroposterior and lateral views - $16.86

73092 upper extremity, infant, minimum of two views - BR

73100 Radiologic examination, wrist; anteroposterior and lateral views - $15.57

73110 complete, minimum of three views - $23.34

73115 Radiologic examination wrist arthrography; supervision and interpretation only - BR

73116 complete procedure - BR

73120 Radiologic examination, hand; two views - $15.57

73130 minimum of three views - $23.34

73140 Radiologic examination, finger or fingers, minimum of two views - $14.00

Lower Extremities

73500 Radiologic examination, hip; unilateral, one view - $19.46

73510 complete, minimum of two views - $24.29

73520 Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis - $37.35

73525 Radiologic examination, hip, arthrography; supervision and interpretation only - BR

73526 complete procedure - BR

73530 Radiologic examination, hip, during operative procedure; up to four studies - $62.25

73531 each additional study over four - $11.67

73540 Radiologic examination, pelvis and hips, infant or child, minimum of two views - $24.89

73550 Radiologic examination, femur, anteroposterior and lateral views - $23.34

73560 Radiologic examination, knee; anteroposterior and lateral views - $17.12

73570 complete, minimum of three views - $24.90

73580 Radiologic examination, knee, arthrography; supervision and interpretation only - $62.25

73581 complete procedure - BR

73590 Radiologic examination; tibia and fibula, anteroposterior and lateral views - $18.68

73592 lower extremity, infant, minimum of two views - BR

73600 Radiologic examination, ankle; anteroposterior and lateral views - $17.12

73610 complete, minimum of three views - $23.34

73615 Radiologic examination, ankle, arthrography; supervision and interpretation only - BR

73616 complete procedure - BR

73620 Radiologic examination, foot; anteroposterior and lateral views - $15.57

73630 complete, minimum of three views - $16.86

73650 Radiologic examination; calcaneus, minimum of two views - $17.12

73660 toe or toes, minimum of two views - $14.00

Abdomen

74000 Radiologic examination, abdomen; single anteroposterior view - $15.57

74010 anteroposterior and additional oblique and cone views - $23.34

74020 complete, including decubitus and/or erect views - $31.12

74150 Computerized tomography, abdomen; without intravenous contrast - BR

74160 with intravenous contrast - BR

74170 without intravenous contrast, followed by intravenous contrast and further sections - BR

Gastrointestinal Tract

74210 Radiologic examination; pharynx and/or cervical esophagus - $34.24

74220 esophagus - $31.24

74230 Cineradiography, pharynx and/or esophagus - $46.68

74240 Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB - $54.47

74241 with or without delayed films, with KUB - $59.14

74245 with small bowel, includes multiple serial films - $68.48

74250 Radiologic examination, small bowel, includes multiple serial films - $54.47

74260 Duodenography, hypotonic - BR

74270 Radiologic examination, colon; barium enema - $46.68

74275 barium enema with air contrast - $68.48

74280 air contrast only - $54.47

74285 high kilovoltage technique for polyp study - BR

74290 Cholecystography, oral contrast; - $37.35

74291 additional or repeat examination or multiple day examination - $18.67

74300 Cholangiography; operative - $38.91

74305 postoperative - $46.68

74310 intravenous - $62.25

74315 oral contrast - $46.68

74320 Cholangiography, percutaneous, transhepatic; supervision and interpretation only - $62.25

74321 complete procedure - BR

74325 Diagnostic pneumoperitoneum; supervision and interpretation only - BR

74326 complete procedure - BR

74327 Postoperative biliary duct stone removal via basket catheter - BR

74328 Endoscopic catheterization of the biliary ductal system, fluoroscopic monitoring and radiography - BR

74329 Endoscopic catheterization of the pancreatic ductal system, fluoroscopic monitoring and radiography - BR

74330 Combined endoscopic catheterization of the biliary and pancreatic ductal systems, fluoroscopic monitoring and radiography - BR

74340 Introduction of long gastrointestinal tube (eg, Miller-Abbott), with multiple fluoroscopies and films - BR

Urinary Tract

74400 Urography, intravenous, including kidneys, ureters, and bladder; - $55.00

74405 with special hypertensive contrast concentration and/or clearance studies - $62.25

74410 Urography, infusion, drip technique; - $77.81

74415 with nephrotomography - $93.38

74420 Urography, retrograde, with or without kidneys, ureters, and bladder - $46.68

74425 Urography, antegrade, (pyelostogram, nephrostogram, loopogram); supervision and interpretation only - $22.18

74426 complete procedure - BR

74430 Cystography, minimum of three views; supervision and interpretation only - $34.24

74431 complete procedure - BR

74440 Vasography, vesiculography, or epididymography; supervision and interpretation only - $34.24

74441 complete procedure - BR

74450 Urethrocystography, retrograde; supervision and interpretation only - $37.35

74451 complete procedure - BR

74455 Urethrocystography, voiding; supervision and interpretation only - $54.47

74456 complete procedure - BR

74460 Pneumography, retroperitoneal; supervision and interpretation only - $46.69

74461 complete procedure - BR

74470 Radiologic examination, renal cyst study, translumbar, contrast visualization; supervision and interpretation only - $38.91

74471 complete procedure - BR

Gynecological and Obstetrical

74710 Pelvimetry, with or without placental localization - $38.91

74720 Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view - $15.57

74725 multiple views - $23.34

74730 Placentography with contrast cystography; supervision and interpretation only - BR

74731 complete procedure - BR

74740 Hysterosalpingography; supervision and interpretation only - $42.02

74741 complete procedure - BR

74760 Pneumography, pelvic; supervision and interpretation only - $38.91

74761 complete procedure - BR

74770 Radiologic examination, fetal study, intrauterine contrast visualization; - $38.91

74771 complete procedure - BR

Vascular System - Heart

75500 Angiocardiography by cineradiography; supervision and interpretation only - BR

75501 complete procedure (including catheterization) - $77.82

75505 Angiocardiography by serialography, single plane; supervision and interpretation only - BR

75506 complete procedure (including catheterization) - BR

75507 Angiocardiography by serialography, multi-plane; supervision and interpretation only - BR

75509 complete procedure (including catheterization) - BR

75510 Angiocardiography, CO_2 or positive contrast, intravenous, for pericardial effusion or atrial wall thickness; supervision and interpretation only - $77.82

75511 complete procedure - BR

75520 Cardiac radiography, selective cardiac catheterization; right side, complete procedure - BR

75524 left side, complete procedure - BR

75528 Cardiac radiography, selective cardiac catheterization, right and left side, complete procedure - BR

Aorta and Arteries

75600 Aortography, thoracic, without serialography; supervision and interpretation only - $77.82

75601 complete procedure - BR

75605 Aortography, thoracic, by serialography; supervision and interpretation only - $155.64

75606 complete procedure - BR

75620 Aortography, abdominal, translumbar, without serialography; supervision and interpretation only - $124.51

75621 complete procedure - BR

75622 Aortography, abdominal, catheter, without serialography; supervision and interpretation only - BR

75623 complete procedure - BR

75625 Aortography, abdominal, translumbar, by serialography; supervision and interpretation only - $155.64

75626 complete procedure - BR

75627 Aortography, abdominal, catheter, by serialography; supervision and interpretation only - BR

75628 complete procedure - BR

75650 Angiography, cervicocerebral, catheter, including vessel origin; supervision and interpretation only - BR

75651 complete procedure - BR

75652 Angiography, cervicocerebral, selective catheter, including vessel origin; one vessel, supervision and interpretation only BR

75653 one vessel, complete procedure - BR

75654 two vessels, supervision and interpretation only - BR

75655 two vessels, complete procedure - BR

75656 three or four vessels, supervision and interpretation only - BR

75657 three or four vessels, complete procedure - BR

75658 Angiography, brachial, retrograde; supervision and interpretation only - BR

75659 complete procedure - BR

75660 Angiography, carotid, cerebral, unilateral, selective external; supervision and interpretation only - BR

75661 complete procedure - BR

75662 Angiography, carotid, cerebral, bilateral, selective external; supervision and interpretation only - BR

75663 complete procedure - BR

75665 Angiography, carotid, cerebral, unilateral; supervision and interpretation only - $54.08

75667 direct puncture, complete procedure - BR

75669 catheter, complete procedure - BR

75671 Angiography, carotid, cerebral, bilateral; supervision and interpretation only - $194.54

75672 direct puncture, complete procedure - BR

75673 catheter, complete procedure - BR

75676 Angiography, carotid, cervical, unilateral; supervision and interpretation only - BR

75677 direct puncture, complete procedure - BR

75678 catheter, complete procedure - BR

75680 Angiography, carotid, cervical, bilateral; supervision and interpretation only - BR

75681 direct puncture, complete procedure - BR

75682 catheter, complete procedure - BR

75685 Angiography, vertebral; supervision and interpretation only - BR

75686 direct puncture, complete procedure - BR

75687 catheter, complete procedure - BR

75690 Angiography, vertebral, cervical, unilateral; supervision and interpretation only - BR

75691 direct puncture, complete procedure - BR

75692 catheter complete procedure - BR

75695 Angiography, vertebral, cervical, bilateral; supervision and interpretation only - BR

75696 direct puncture, complete procedure - BR

75697 catheter, complete procedure - BR

75705 Angiography, spinal, selective; supervision and interpretation only - BR

75706 complete procedure - BR

75710 Angiography, extremity, unilateral; supervision and interpretation only - $70.03

75711 without serialography, complete procedure - BR

75712 by serialography, complete procedure - BR

75716 Angiography, extremity, bilateral; supervision and interpretation only - BR

75717 without serialography, complete procedure - BR

75718 by serialography, complete procedure - BR

75722 Angiography, renal, unilateral, selective (including flush aortogram); supervision and interpretation only - BR

75723 complete procedure - BR

75724 Angiography, renal, bilateral, selective (including flush aortogram); supervision and interpretation only - BR

75725 complete procedure - BR

75726 Angiography, visceral; selective or supraselective, supervision and interpretation only - BR

75727 selective (including flush aortogram), complete procedure - BR

75728 supraselective, complete procedure - BR

75731 Angiography, adrenal, unilateral, selective; supervision and interpretation only - BR

75732 complete procedure - BR

75733 Angiography, adrenal, bilateral, selective; supervision and interpretation only - BR

75734 complete procedure - BR

75736 Angiography, pelvic; selective or supraselective, supervision and interpretation only - BR

75737 selective, complete procedure - BR

75738 supraselective, complete procedure - BR

75741 Angiography, pulmonary, unilateral, selective; supervision and interpretation only - BR

75742 complete procedure - BR

75743 Angiography, pulmonary, bilateral, selective; supervision and interpretation only - BR

75744 complete procedure - BR

75746 Angiography, pulmonary; by nonselective catheter or venous injection, supervision and interpretation only - BR

75747 catheter, nonselective, complete procedure - BR

75748 venous injection, complete procedure - BR

75750 Angiography, coronary, root injection; supervision and interpretation only - BR

75751 complete procedure - BR

75752 Angiography, coronary, unilateral selective injection, including left ventricular and supravalvular

angiogram and pressure recording; supervision and interpretation only - BR

75753 complete procedure - BR

75754 Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only - BR

75755 complete procedure - BR

75756 Angiography, internal mammary; supervision and interpretation only - BR

75757 complete procedure

Veins and Lymphatics

75801 Lymphangiography, extremity only, unilateral; supervision and interpretation only - BR

75802 complete procedure - BR

75803 Lymphangiography, extremity only, bilateral; supervision and interpretation only - BR

75804 complete procedure - BR

75805 Lymphangiography, pelvic/abdominal, unilateral; supervision and interpretation only - BR

75806 complete procedure - BR

75807 Lymphangiography, pelvic/abdominal, bilateral; supervision and interpretation only - BR

75808 complete procedure - BR

75810 Splenoportography; supervision and interpretation only - BR

75811 complete procedure - BR

75820 Venography, extremity, unilateral; supervision and interpretation only - $62.25

75821 complete procedure - BR

75822 Venography, extremity, bilateral; supervision and interpretation only - BR

75823 complete procedure - BR

75825 Venography, caval, inferior, with serialography; supervision and interpretation only - $124.51

75826 complete procedure - BR

75827 Venography, caval, superior, with serialography; supervision and interpretation only - BR

75828 complete procedure - BR

75831 Venography, renal, unilateral, selective; supervision and interpretation only - BR

75832 complete procedure - BR

75833 Venography, renal, bilateral, selective; supervision and interpretation only - BR

75834 complete procedure - BR

75840 Venography, adrenal, unilateral, selective; supervision and interpretation only - BR

75841 complete procedure - BR

75842 Venography, adrenal, bilateral, selective; supervision and interpretation only - BR

75843 complete procedure - BR

75845 Venography, azygos; selective or nonselective, supervision and interpretation only - BR

75846 selective, complete procedure - BR

75847 nonselective, complete procedure - BR

75850 Venography, intraosseous; supervision and interpretation only - BR

75851 complete procedure - BR

75860 Venography, sinus or jugular, catheter; supervision and interpretation only - BR

75861 complete procedure - BR

75870 Venography, superior sagittal sinus; supervision and interpretation only - BR

75871 complete procedure, including direct puncture - BR

75880 Venography, orbital; supervision and interpretation only - BR

75881 complete procedure - BR

75885 Percutaneous transhepatic portography with hemodynamic evaluation; supervision and interpretation only - BR

75886 complete procedure - BR

75887 Percutaneous transhepatic portography without hemodynamic evaluation; supervision and interpretation only - BR

75888 complete procedure - BR

75889 Hepatic venography wedged or free, with hemodynamic evaluation; supervision and interpretation only - BR

75890 complete procedure - BR

75891 Hepatic venography, wedged or free, without hemodynamic evaluation; supervision and interpretation only - BR

75892 complete procedure - BR

75893 Venous sampling thru catheter without angiography (eg, for parathyroid hormone, renin) - BR

Transcatheter Therapy

75894 Transcatheter therapy, embolization, including angiography; supervision and interpretation only - BR

75895 complete procedure - BR

75896 Transcatheter therapy, infusion, including angiography; supervision and interpretation only - BR

75897 complete procedure - BR

75898 Angiogram through existing catheter for follow-up study for transcatheter therapy, embolization or infusion - BR

Miscellaneous

76000 Fluoroscopy (separate procedure), other then 71034 - $11.67

76020 Bone age studies - $23.34

76040 Bone length studies (orthoroentgenogram) - $38.91

76060 Radiologic examination; osseous survey (long bone or for metastases) - $58.36

76065 osseous survey, infant - BR

76080 Radiologic examination, fistula or sinus tract study; supervision and interpretation only - $46.69

76081 complete procedure - BR

76090 Mammography; unilateral - $34.24

76091 bilateral - $50.58

76100 Radiologic examination, body section (eg, tomography), other than kidney; - $51.36

76105 to complement routine examination - $27.23

76120 Cineradiography, except where specifically included - $51.36

76125 Cineradiography to complement routine examination - $27.23

76127 Procedures using Polaroid or similar photographic media - BR

76130 Radiologic examination; at bedside or in operating room, not otherwise specified - BR

76134 in home - BR

76137 after regular hours - BR

76140 Consultation on x-ray examination made elsewhere, written report - BR

76150 Xeroradiography - BR

76300 Thermography - BR

76499 Unlisted diagnostic radiologic procedure - BR

DIAGNOSTIC ULTRASOUND

Head and Neck

76500 Echoencephalography, A-mode; diencephalic midline - $27.62

76505 complete (diencephalic midline and ventricular size) - $38.91

76511 Echography, ophthalmic, spectral analysis with amplitude quantitation; A-mode - BR

76512 contact B-scan - BR

76515 tomography with or without A or M-mode - BR

76516 Echography, ophthalmic, ultrasonic biometry; A-mode - BR

76517 B-scan - BR

76529 Ophthalmic ultrasonic foreign body localization - BR

76530 Echography, thyroid; Amode - BR

76535 Bscan - BR

76550 Carotid imaging - BR

Chest

76601 echography, chest; A-mode - BR

76604 B-scan (includes mediastinum) - BR

76620 Echocardiography, M-mode; complete - $50.58

76625 limited (eg, follow-up or limited study) - $27.62

76627 Echocardiography, real-time scan; complete - BR

76628 limited - BR

76640 Echography, breast; A-mode - $32.24

76645 B-scan - $64.59

Abdomen And Retroperitoneum

76700 echography, abdominal, B-scan; complete - $77.81

76705 limited (eg, follow-up or limited study) - $50.58

76770 Echography, retroperitoneal (e.g., renal, aorta, nodes), B-scan; complete - $77.82

76775 limited - BR

76805 Echography, pelvic, B-scan (eg, obstetrics, gynecology, or transplants); complete - $54.55

76815 limited, fetal growth rate only - $32.30

76855 Echography, pelvic area (Doppler) - BR

Vascular Studies

76900 Peripheral flow study (Doppler); arterial only - $58.36

76910 venous only - $58.36

76920 arterial and venous - $70.42

76925 Peripheral imaging, B-scan, Doppler or real-time scan - BR

76930 Pericardiocentesis; supervision and interpretation - BR

76931 complete procedure - BR

Ultrasonic Guidance Procedures

76934 Ultrasonic guidance for thoracentesis; supervision and interpretation only - BR

76935 complete procedure - BR

76938 Ultrasonic guidance for cyst aspiration; supervision and interpretation only - BR

76939 complete procedure - BR

76942 Ultrasonic guidance for needle biopsy; supervision and interpretation only - BR

76943 complete procedure - BR

76946 Ultrasonic guidance for amniocentesis; supervision and interpretation only - BR

76947 complete procedure - BR

76950 Echography for placement of radiation therapy fields, B-scan - $58.36

76960 Ultrasonic guidance for placement of radiation therapy fields, except for B-scan echography - BR

Miscellaneous

76970 Ultrasound study follow-up (specify) - BR

76980 Ultrasound examination outside regular hours - BR

76985 Ultrasound examination at bedside or in operating room - BR

76990 Special ultrasonic display or imaging techniques (eg, color) - BR

76999 Unlisted ultrasound procedure - BR

RADIOTHERAPY

Treatment Planning Process (External and Internal Sources)

77260 Radiation therapy treatment planning; inclusive service (including interpretation of special testing, patient contour and localization of internal structures) - BR

77265 interpretation of special testing ordered by the radiation therapist - BR

77270 patient contour and localization of internal structures - BR

77275 setting of each treatment port - BR

77280 Radiation therapy simulator aided field setting; simple - BR

77285 intermediate - BR

77290 complex - BR

77299 Unlisted procedure, radiation therapy planning - BR

Dosimetry (External Source Fields) Radiation Physics

77300 Radiation therapy, central axis depth dose computation - BR

77305 Radiation therapy, isodose plan; simple (one or two therapy beams) - BR

77310 intermediate (three or more therapy beams) - BR

77315 complex (one or more beams plus additional procedures) - BR

77320 Radiation therapy isodose plan; wedge fields - BR

77325 arc field - BR

77330 rotation field - BR

77335 moving strip field - BR

77340 isocentric (in addition to above) - BR

77345 Radiation therapy; tissue and geometric inhomogeneity correction (in addition to above) - BR

77350 electron beam (in addition to above) - BR

77355 neutron beam (in addition to above) - BR

77360 special beam considerations (in addition to above) - BR

77399 Unlisted procedure, external radiation dosimetry - BR

Treatment Management

77400 Daily radiation therapy treatment management; simple - BR

77405 intermediate - BR

77410 complex - BR

77415 Radiation treatment port verification films - BR

77420 Weekly radiation therapy treatment management; simple - BR

77425 intermediate - BR

77430 complex - BR

77435 Course of radiation therapy treatment management; simple - BR

77440 intermediate - BR

77445 complex - BR

77450 Daily transvaginal external radiation treatment - BR

77455 Daily per oral external radiation treatment - BR

77460 Daily superficial external radiation treatment, auxiliary shielding - BR

77465 Daily orthovoltage external treatment - BR

77499 Unlisted procedure, radiation therapy treatment management - BR

Treatment Aids

77600 Radiation therapy treatment aid(s); wedge filter design and fabrication - BR

77605 bolus design and fabrication - BR

77610 field block design and fabrication - BR

77615 compensating filter design and fabrication - BR

77620 moulds or casts for immobilization - BR

77625 stents or bite blocks - BR

77630 Provision of external compensating shield; for radium sources - BR

77635 for radioisotope sources - BR

77699 Unlisted procedure, radiation therapy treatment aid - BR

Dosimetry (Internal Sources) Radiation Physics

77700 Radium therapy dosimetry and interpretation of application - BR

77705 Radioisotope therapy dosimetry and interpretation of application - BR

77749 Unlisted procedure, internal radiation dosimetry - BR

Radium and Radioisotope Therapy

77750 Infusion of radioactive materials for therapy (includes handling and loading) - BR

77755 Supervision and consultation of radioelement application only - BR

77760 Intracavitary radium application (includes handling and loading) - BR

77765 Intracavitary radioisotope application (includes handling and loading) - BR

77770 Interstitial radium application (includes handling and loading) - BR

77775 Interstitial radioisotope therapy (includes handling and loading) - BR

77780 Radium handling and loading - BR

77785 Radioisotope handling and loading - BR

77799 unlisted procedure, radium and radioisotope therapy - BR

Special Services

77800 TLD or microdosimetry - BR

77805 Consultation, computer dosimetry and isodose chart; brachytherapy - BR

77810 teletherapy - BR

77850 Professional physics consultation service - BR

77860 Continuing radiation physics consultation in support of radiation therapist - BR

77999 Unlisted procedure, radiation therapy special service - BR

NUCLEAR MEDICINE

Diagnostic

Endocrine System

78000 Thyroid uptake; single determination - $23.34

78001 multiple determinations (eg, 6 and 24 hours) - $31.13

78003 Thyroid stimulation, suppression or discharge (not including initial uptake studies) - BR

78006 Thyroid imaging, with uptake; single determination - BR

78007 multiple determinations - BR

78010 Thyroid imaging only - $38.91

78015 Thyroid carcinoma metastases, imaging, neck and chest; only - BR

78016 with additional studies (eg, imaging other body areas urinary recovery, etc) - BR

78070 Parathyroid imaging - BR

78075 Adrenal imaging - BR

78099 Unlisted endocrine procedure, diagnostic nuclear medicine - BR

Hematopoietic, Reticuloendothelial and Lymphatic System

78102 Bone marrow imaging; limited area - $116.72

78103 multiple areas - BR

78104 whole body - BR

78110 Blood or plasma volume, radioisotope technique; single sampling - $31.30

78111 multiple sampling - BR

78120 Red cell mass determination; single sampling - $46.68

78121 multiple sampling - BR

78130 Red cell survival study (eg, radiochromium); - $77.82

78135 plus splenic and/or hepatic sequestration - $116.72

78140 Red cell splenic and/or hepatic sequestration - $77.82

78160 Plasma radioiron disappearance (turnover) rate - $62.25

78170 Radioiron, red cell utilization - $93.38

78180 Radioiron, body distribution and storage pools - BR

78185 Spleen imaging only; static - BR

78186 with vascular flow - BR

78195 Lymphatics and lymph glands imaging - BR

78199 Unlisted hematopoietic, R-E and lymphatic procedure, diagnostic nuclear medicine - BR

Gastrointestinal System

78201 Liver imaging; static - BR

78202 with vascular flow - BR

78215 Liver and spleen imaging; static - BR

78216 with vascular flow of liver and/or spleen - BR

78220 Liver function (eg, with radioiodinated rose bengal); with serial images - $54.59

78221 with probe technique - BR

78225 Liver-lung study, imaging (eg, subphrenic abscess) - BR

78230 Salivary gland imaging; static - $54.59

78231 with serial views - BR

78240 Pancreas imaging - BR

78270 Vitamin B-12 absorption studies (eg, Schilling test); without intrinsic factor - BR

78271 with intrinsic factor - BR

78272 Vitamin B-12 absorption studies combined, with and without intrinsic factor - BR

78280 Gastrointestinal blood loss study - BR

78282 Gastrointestinal protein loss (eg, radiochromium albumin) - $46.68

78285 Gastrointestinal fat absorption study (eg, radioiodinated triolein) - $46.68

78286 Gastrointestinal fatty acid absorption study (eg, radioiodinated oleic acid) - BR

78290 Bowel imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus) - BR

78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine - BR

Musculoskeletal System

78300 Bone imaging; limited area (eg, skull, pelvis) - $116.73

78305 multiple areas - BR

78306 whole body - BR

78380 Joint imaging; limited area - BR

78381 multiple areas - BR

78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine - BR

Cardiovascular System

78401 Cardiac blood pool imaging; static (eg, pericardial effusion) - BR

78402 with vascular flow - BR

78403 with determination of regional ventricular function (eg, gated blood pool images) - BR

78405 Myocardium imaging; regional myocardial perfusion - BR

78406 myocardial infarction - BR

78435 Cardiac flow study, imaging (ie, angiocardiography) - BR

78445 Vascular flow study, imaging (ie, angiography, venography) - BR

78455 Venous thrombosis study (eg, radioactive fibrinogen) - BR

78470 Cardiac output - BR

78490 Tissue clearance studies - $38.91

78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine - BR

Respiratory System

78580 Pulmonary perfusion imaging; particulate - BR

78581 gaseous - BR

78582 gaseous, with ventilation, rebreathing and washout - BR

78586 Pulmonary ventilation imaging, aerosol; single projection - BR

78587 multiple projections (eg, anterior, posterior, lateral views) - BR

78591 Pulmonary ventilation imaging, gaseous, single breath, single projection - BR

78593 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection - BR

78594 multiple projections (eg, anterior, posterior, lateral views) - BR

78599 Unlisted respiratory procedure, diagnostic nuclear medicine - BR

Nervous System

78600 Brain imaging, limited procedure; static - BR

78601 with vascular flow - BR

78605 Brain imaging, complete; static - $116.72

78606 with vascular flow - BR

78610 Brain imaging, vascular flow study only - BR

78630 Cerebrospinal fluid flow, imaging; cisternography (not including introduction of material) - BR

78635 ventriculography (not including introduction of material) - BR

78640 myelography (not including introduction of material) - BR

78645 shunt evaluation - BR

78650 CSF leakage - BR

78655 Eye tumor identification with radiophosphorus - BR

78660 Dacryocystography (lacrimal flow study) - BR

78699 Unlisted nervous system procedure, diagnostic nuclear medicine - BR

Genitourinary System

78700 Kidney imaging; static - BR

78701 with vascular flow - BR

78704 with function study (ie, imaging renogram) - BR

78707 with vascular flow and function study - BR

78715 Kidney vascular flow - BR

78720 Kidney function study (ie, renogram) - BR

78725 Kidney function study, clearance - BR

78730 Urinary bladder residual study - BR

78740 Ureteral reflux study - BR

78770 Placenta imaging - $54.59

78775 Placenta localization (eg, radioiodinated HSA) - $46.68

78799 Unlisted genitourinary procedure, diagnostic nuclear medicine - BR

Miscellaneous Studies

78800 Tumor localization (eg, gallium, selenomethionine); limited area - BR

78801 multiple areas - BR

78802 whole body - BR

78990 Provision of diagnostic radionuclide(s) - BR

78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine - BR

Therapeutic

79000 Radionuclide therapy, hyperthyroidism; initial, including evaluation of patient - $186.76

79001 subsequent, each visit - $77.82

79020 Radionuclide therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient - $186.76

79030 Radionuclide ablation of gland for thyroid carcinoma - BR

79035 Radionuclide therapy for metastases of thyroid carcinoma - BR

79100 Radionuclide therapy for metastases of thyroid carcinoma - BR

79200 Intracavitary radioactive colloid therapy - $93.38

79300 Interstitial radioactive colloid therapy - $233.46

79400 Radionuclide therapy, nonthyroid, nonhematologic (eg, for metastases to bone) - BR

79420 Intravascular radionuclide therapy, particulate - BR

79440 Intra-articular radionuclide therapy - BR

79900 Provision of therapeutic radionuclide(s) - BR

79999 Unlisted radionuclide therapeutic procedure - BR

PATHOLOGY AND LABORATORY

PROCEDURES

AUTOMATED, MULTICHANNEL TESTS

80003 3 clinical chemistry tests - $9.08

80004 4 clinical chemistry tests - $10.37

80005 5 clinical chemistry tests - $11.67

80006 6 clinical chemistry tests - $12.97

80007 7 clinical chemistry tests - $14.26

80008 8 clinical chemistry tests - $15.55

80009 9 clinical chemistry tests - $16.85

80010 10 clinical chemistry tests - $18.15

80011 11 clinical chemistry tests - $19.45

80012 12 clinical chemistry tests - $20.75

80016 13-16 clinical chemistry tests - $22.04

80018 17-18 clinical chemistry tests - $22.04

80019 19 or more clinical chemistry tests (indicate instrument used and number of tests performed) - BR

URINALYSIS

81000 Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy - $3.89

81002 routine, without microscopy - $3.56

81004 components, single, not otherwise listed, specify - BR

81005 chemical, qualitative, any number of constituents - $2.60

81006 urine volume measurement - BR

81010 concentration and dilution test - $4.53

81015 microscopic only - $3.25

81020 two or three glass test - $3.25

81030 Quantitative sediment analysis and quantitative protein (Addis count) - $12.97

81099 Unlisted urinalysis procedure - BR

CHEMISTRY AND TOXICOLOGY

82000 Acetaldehyde, blood - $12.97

82003 Acetaminophen, urine - $30.80

82005 Acetoacetic acid - $12.97

82009 Acetone; qualitative - $4.21

82010 quantitative - $12.97

82011 Acetylsalicylic acid; quantitative - $10.37

82012 qualitative - $6.16

82013 Acetylcholinesterase - $12.97

82015 Acidity, titratable, urine - $6.81

82024 Adrenocorticotrophic hormone (ACTH), RIA - $43.12

82030 Adenosine; 5'-diphosphate and 5'-monophosphate (AMP, cyclic, RIA blood - $12.97

82035 5'-triphosphate, blood - $12.97

82040 Albumin; serum - $6.48

82042 urine, quantitative (specify method, eg, Esbach) - BR

82055 Alcohol (ethanol), blood; chemical - $9.72

82060 by gas-liquid chromatography - $12.97

82065 Alcohol (ethanol), urine; chemical - $9.72

82070 by gas-liquid chromatography - $12.97

82072 Alcohol (ethanol) gelation - BR

82075 Alcohol (ethanol), breath - $19.45

82076 Alcohol; isopropyl - $19.45

82078 methyl - $19.45

82085 Aldolase, blood; kinetic ultraviolet method - $8.43

82086 colorimetric - $6.49

82087 Aldosterone; double isotope technique - $77.81

82088 RIA blood - $61.60

82089 RIA urine - $73.92

82095 Alkaloids tissue; screening - $25.94

82096 quantitative - $38.91

82100 Alkaloids, urine; screening - $25.94

82101 quantitative - $38.91

82126 Amino acid nitrogen, alpha - $16.21

82128 Amino acids, qualitative - BR

82130 Amino acids, urine, chromatographic fractionation and quantitation - $111.21

82134 Aminohippurate, para (PAH) - $6.49

82135 Aminolevulinic acid, delta (ALA) - $19.45

82137 Aminophylline - $19.45

82138 Amitriptyline - $24.64

82140 Ammonia; blood - $12.97

82141 urine - $9.41

82142 Ammonium chloride loading test - BR

82143 Amniotic fluid scan (spectrophotometric) - $14.92

82145 Amphetamine or methamphetamine, chemical, quantitative - $25.94

82150 Amylase, serum; - $9.72

82155 isoenzymes, electrophoretic - BR

82156 Amylase, urine (diastase) - $9.72

82157 Androstenedione RIA - $43.12

82159 Androsterone - $24.64

82163 Angiotensin II, RIA - BR

82165 Aniline - BR

82168 Antihistamines - BR

82170 Antimony, urine - $25.94

82175 Arsenic, blood, urine, gastric contents, hair or nails, quantitative - $25.94

82180 Ascorbic acid (Vitamin C), blood - $12.97

82205 Barbiturates; quantitative - $19.45

82210 quantitative and identification - $25.94

82225 Barium - BR

82230 Beryllium, urine - $25.94

82235 Bicarbonate excretion, urine - BR

82236 Bicarbonate loading test - BR

82240 Bile acids, blood, fractionated - $38.91

82245 Bile pigments, urine - $2.60

82250 Bilirubin; blood, total OR direct - $7.78

82251 blood, total AND direct - $8.43

82252 feces, qualitative - $3.89

82260 urine, quantitative - $3.89

82265 amniotic fluid, quantitative - $9.72

82268 Bismuth - $39.88

82270 Blood; occult, feces, screening - $2.60

82273 duodenal, gastric contents, qualitative - BR

82280 Boric acid; blood - $32.43

82285 urine - $32.43

82286 Bradykinin - BR

82290 Bromides; blood - $7.78

82291 urine - $12.97

82300 Cadmium, urine - $32.43

82305 Caffeine - $24.64

82308 Calcitonin, RIA - $36.96

82310 Calcium, blood; chemical - $7.13

82315 fluorometric - $7.13

82320 emission flame photometry - $7.13

82325 atomic absorption flame photometry - $7.78

82330 fractionated, diffusible - $19.45

82335 Calcium, urine; qualitative (Sulkowitch) - $3.56

82340 quantitative, timed specimen - $10.37

82345 Calcium, feces, quantitative, timed specimen - $25.94

82355 Calculus (stone), qualitative, chemical - $12.97

82360 Calculus (stone), quantitative; chemical - $19.45

82365 infrared spectroscopy - $19.45

82370 x-ray diffraction - $16.21

82372 Carbamazepine, serum - $16.21

82374 Carbon dioxide, combining power or content - $6.16

82375 Carbon monoxide, (carboxyhemoglobin); quantitative - $15.55

82376 qualitative - $15.55

82380 Carotene, blood - $12.97

82382 Catecholamines (dopamine, norepinephrine, epinephrine); total urine - $20.75

82383 blood - $32.43

82384 fractionated - BR

82390 Ceruloplasmin (copper oxidase), blood - $12.97

82400 Chloral hydrate; blood - $19.45

82405 urine - $12.97

82415 Chloramphenicol, blood - $12.97

82418 Chlorazepate dipotassium - BR

82420 Chlordiazepoxide; blood - $19.45

82425 urine - $19.45

82435 Chlorides; blood (specify chemical or electrometric) - $6.49

82436 urine (specify chemical, electrometric or Fantus test) - $19.45

82437 sweat (without iontophoresis) - $8.76

82438 spinal fluid - $6.49

82441 Chlorinated hydrocarbons, screen - $5.51

82443 Chlorothiazide-hydrochlorothiazide - $21.40

82465 Cholesterol, serum; total - $7.13

82470 total and esters - $9.72

82480 Cholinesterase; serum - $12.97

82482 RBC - $19.45

82484 serum and RBC - $25.94

82485 Chondroitin B sulfate, quantitative - $25.94

82486 Chromatography; gas-liquid, compound and method not elsewhere specified - BR

82487 paper, 1-dimensional, compound and method not elsewhere specified - BR

82488 paper, 2-dimensional, not elsewhere specified BR

82489 thin layer, not elsewhere specified - BR

82490 Chromium; blood - $32.43

82495 urine - $32.43

82505 Chymotrypsin, duodenal contents - $9.72

82507 Citric acid - $33.72

82525 Copper; blood - $19.45

82526 urine - $19.45

82528 Corticosterone, RIA - $11.67

82529 Cortisol; fluorometric, plasma - $14.92

82531 CPB, plasma - $30.80

82532 CPB, urine - $30.80

82533 RIA, plasma - $43.12

82534 RIA, urine - $43.12

82540 Creatine; blood - $7.78

82545 urine - $12.97

82546 Creatine and creatinine - $9.41

82550 Creatine phosphokinase (CPK), blood; timed kinetic ultraviolet method - $8.43

82552 isoenzymes - $18.48

82555 colorimetric - $6.49

82565 Creatinine; blood - $6.49

82570 urine - $6.49

82575 clearance - $12.97

82585 Cryofibrinogen, blood - $12.97

82595 Cryoglobulin, blood - $12.97

82600 Cyanide; blood - $25.94

82601 tissue - $25.94

82606 Cyanocobalamin (Vitamin B-12); bioassay - $30.80

28607 RIA - $18.48

82614 Cystine, blood, qualitative - BR

82615 Cystine and homocystine, urine; qualitative - $9.72

82620 quantitative - $12.97

82624 Cystine aminopeptidase - BR

82626 Dehydroepiandrosterone, RIA - $39.88

82628 Desipramine - BR

82633 Desoxycorticosterone, 11-RIA - BR

82634 Desoxycortisol, 11-(compound S), RIA - $36.96

82635 Diacetic acid - BR

82636 Diazepam - $24.64

82638 Dibucaine number - $14.27

82639 Dicumarol - $21.40

82640 Digitoxin (digitalis); blood, RIA - $17.18

82641 urine - BR

82643 Digoxin, RIA - $14.92

82646 Dihydrocodinone - BR

82649 Dihydromorphinone, quantitative - $30.80

82651 Dihydrotestosterone (DHT) - BR

82654 Dimethadione - BR

82656 Doxepin - BR

82660 Drug screen (amphetamines, barbiturates, alkaloids) - $12.32

82662 Enzyme immunoassay technique for drugs, EMIT - $18.48

82664 Electrophoretic technique, not elsewhere specified - BR

82666 Epiandrosterone - BR

82668 Erythropoietin, bioassay - BR

82670 Estradiol, RIA (placental) - $36.96

82671 Estrogens; fractionated - $45.40

82672 total - $19.46

82673 Estriol, placental; fluorometric - $21.40

82674 GLC - $18.48

82676 Estriol, nonpregnancy; chemical - $30.80

82677 RIA - $43.12

82678 Estrone; chemical - $30.80

82679 RIA - $36.96

82690 Ethchlorvynol; blood - $19.46

82691 urine - $19.46

82692 Ethosuximide - $16.21

82694 Etiocholanolone - $51.88

82705 Fat or lipids, feces; screening - $3.23

82710 quantitative, 24 or 72 hour specimen - $32.42

82715 Fat differential, feces, quantitative - $49.28

82720 Fatty acids, blood; esterified - $12.97

82725 nonesterified - $12.97

82727 Ferric chloride, urine - BR

82730 Fibrinogen, quantitative - $12.97

82735 Fluoride; blood - $32.42

82740 urine - $32.42

82742 Flurazepam - $24.64

82745 Folic acid (folate), blood; bioassay - $12.32

82746 RIA - $18.48

82750 Formiminoglutamic acid (FIGLU), urine - $32.42

82755 Free radical assay technique for drugs (FRAT) - BR

82756 Free thyroxine index (T-7) - BR

82757 Fructose, semen - $24.64

82759 Galactokinase, RBC - BR

82760 Galactose; blood - $12.97

82763 tolerance test - $30.80

82765 urine - $12.97

82775 Galactose-1-phosphate uridyl transferase; quantitative - $19.45

28776 screen - $7.46

82780 Gallium - BR

82784 Gammaglobulin, A, D, G, M nephelometric, each - $4.86

82785 Gammaglobulin, E, RIA - $30.80

82786 Gammaglobulin, salt precipitation method - $8.76

82790 Gases, blood, oxygen saturation; by calculation from pO_2 - $2.60

82791 by manometry - $12.97

82792 by oximetry - $6.48

82793 by spectrophotometry - $12.97

82795 by calculation from pCO_2 - $2.60

82800 Gases, blood; pH only - $6.48

82801 pCO_2 - $12.97

82802 pH, oCO_2 by electrode - $12.97

82803 pH, pCO_2, pO_2 simultaneous - $32.42

82804 pO_2 by electrode - $12.97

82812 pO_2 by manometry - $12.97

82817 pH, pCO_2 by tonometry - $12.97

82926 Gastric acid, free and total; single specimen - $4.54

82927 each additional specimen - $3.56

82928 Gastric acid, free or total; single specimen - $3.56

82929 each additional specimen - $3.25

82931 Gastric acid, pH titration; single specimen - $9.72

82932 each additional specimen - $7.46

82939 Gastric analysis, tubeless (Diagnex blue) - $12.97

82941 Gastrin, RIA - $19.78

82942 Globulin, serum - $4.21

82943 Glucagon, RIA - $21.73

82944 Glucosamine - $2.60

82947 Glucose; except urine (eg, blood, spinal fluid, joint fluid) - $6.50

82948 blood, stick test - $2.60

82949 fermentation - $6.50

82950 post glucose dose (includes glucose) - BR

82951 tolerance test (GTT), three specimens (includes glucose) - $19.46

82952 tolerance test, each additional beyond three specimens - $4.21

82953 tolbutamide tolerance test - $19.46

82954 urine - $6.50

82955 Glucose-6-phosphate dehydrogenase (G6PD); quantitative - $19.46

82960 screen - BR

82965 Glutamate dehydrogenase, blood - $12.97

82975 Glutamine (glutamic acid amide), spinal fluid - $25.94

82977 Glutamyl transpeptidase, gamma (GGT) - $9.41

82978 Glutathione - $18.48

82979 Glutathione reductase, RBC - $6.16

82980 Glutethimide - $30.80

82985 Glycoprotein, electrophoresis - $19.46

82995 Gold, blood - $32.42

82996 Gonadotropin, chorionic, bioassay; qualitative - $11.02

82997 quantitative - $38.91

82998 Gonadotropin, chorionic, RIA - $13.94

83000 Gonadotropin, pituitary FSH; bioassay - $38.91

83001 RIA - $38.91

83002 (LH) (ICSH) RIA - $38.91

83003 Growth hormone (HGH), (somatotropin) RIA - $19.78

83005 Guanase, blood - $12.97

83008 Guanosine monophosphate, cyclic, RIA - BR

83010 Haptoglobin; chemical - $19.46

83011 quantitative, electrophoresis - $12.32

83012 phenotypes, electrophoresis - $24.64

83015 Heavy metal screen (arsenic, bismuth, mercury, antimony); chemical (eg, Reinsch, Gutzeit) - $9.72

83018 chromatography, DEAE column - BR

83020 Hemoglobin; electrophoresis (includes A_2, S, C, etc) - $19.46

83030 F(fetal), chemical - $12.97

83033 F(fetal), qualitative (APT) test, fecal - $6.16

83040 methemoglobin, electrophoretic separation - $25.94

83045 methemoglobin, qualitative - $6.50

83050 methemoblobin, quantitative - $12.97

83051 plasma - $16.21

83052 sickle, turbidimetric - $16.21

83053 solubility, S-D, etc - $9.72

83055 sulfhemoglobin, qualitative - $6.50

83060 sulfhemoglobin, quantitative - $12.97

83065 thermolabile - $9.41

83068 unstable, screen - $11.02

83069 urine - BR

83070 Hemosiderin, urine - $3.89

83086 Histidine; blood, qualitative - $18.81

83087 urine, qualitative - $18.81

83088 Histamine - $32.42

83093 Homogentisic acid; blood, qualitative - BR

83094 urine, qualitative - $6.50

83095 urine, quantitative - $12.97

83150 Homovanillic acid (HVA), urine - $25.94

83485 Hydroxybutyric dehydrogenase, alpha (HBD), blood; kinetic ultraviolet method - $7.13

83486 colorimetric method - $6.50

83492 Hydroxycorticosteroids, 17-(17-OHCS); gas liquid chromatography (GLC) - $33.72

83493 blood, Porter-Silber type - $18.48

83494 blood, fluorometric - $15.24

83495 urine, Porter-Silber type - $21.40

83496 urine, fluorometric - $21.40

83497 Hydroxyindolacetic acid, 5-(HIAA), urine - $19.46

83498 Hydroxyprogesterone, 17-d, RIA - $43.12

83499 Hydroxyprogesterone, 20- - BR

83500 Hydroxyproline, urine; free only - $32.42

83505 total only - $32.42

83510 free and total - $58.36

83523 Imipramine - $27.56

83524 Indican, urine - BR

83525 Insulin, RIA - $14.92

83530 Inulin clearance - $12.97

83533 iodine; protein bound (PBI) - $5.19

83534 total - $5.19

83540 Iron, serum; chemical - $6.50

83545 automated - $3.89

83546 radioactive uptake method - $9.72

83550 Iron binding capacity, serum; chemical - $6.48

83555 automated - $3.89

83565 radioactive uptake method - $9.72

83570 Isocitric dehydrogenase (IDH), blood; kinetic ultraviolet - $8.43

83571 colorimetric - $6.48

83576 Isonicotinic acid hydrazide (INH) - $43.12

83582 Ketogenic steroids, urine; 17-(17-KGS) - $19.46

83583 11-desoxy: 11-oxy ratio - $30.80

83584 Ketoglutarate, alpha - $12.97

83586 Ketosteroids, 17-(17-KS), blood; total - $32.42

83587 fractionation, alpha/beta - $64.85

83589 Ketosteroids, 17-(17-KS), urine; total - $16.21

83590 fractionation, alpha/beta - $32.42

83593 chromatographic fractionation - $64.85

83596 D/A/E ratio - $32.42

83597 11-desoxy: 11-oxy ratio - $30.80

83600 Kynurenic acid - $36.96

83605 Lactate (lactic acid) - $12.97

83615 Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method - $8.43

83620 colorimetric or fluorometric - $6.48

83624 heat or urea inhibition (total not included) - $6.81

83625 isoenzymes, electrophoretic separation and quantitation - $19.45

83626 isoenzymes, chemical separation - $6.48

83628 Lactic dehydrogenase, liver (LLDH) - BR

83629 Lactic dehydrogenase (LDH), urine - $6.48

83631 Lactic dehydrogenase (LDH), CSF - $7.46

83632 Lactogen, placental (HPL) chorionic somatomammotropin, RIA - $36.96

83633 Lactose, urine; qualitative - BR

83634 quantitative - $15.24

83645 Lead, screening; blood - $6.48

83650 urine - $6.48

83655 Lead, quantitative; blood - $19.45

83660 urine - $19.45

83661 Lecithin-sphingomyelin ratio (L/S ratio), amniotic fluid - $30.80

83670 Leucine aminopeptidase (LAP), blood; kinetic ultraviolet method - $8.43

83675 colorimetric - $6.48

83680 Leucine aminopeptidase (LAP), urine - $8.43

83685 Lidocaine - $15.24

83690 Lipase, blood - $9.72

83700 Lipids, blood; total - $9.72

83705 fractionated (cholesteral, triglycerides, phospholipids) - $19.45

83715 Lipoprotein, blood; electrophoretic separation and quantitation - $19.45

83717 ultracentrifugation, analytic, (atherogenic index) - $32.42

83725 Lithium, blood, quantitative - $19.45

83728 Lysergic acid diethylamide (LSD) RIA - $35.34

83730 Macroglobulins (Sia test) - $4.86

83635 Magnesium, blood; chemical - $6.48

83740 fluorometric - $6.48

83750 atomic absorption $12.97

83755 Magnesium, urine; chemical - $12.97

83760 fluorometric - $12.97

83765 atomic absorption - $12.97

83775 Malate dehydrogenase, kinetic ultraviolet method - $9.72

83785 Manganese, blood or urine - $19.45

83790 Mannitol clearance - BR

83795 Melanin, urine, qualitative - $19.45

83799 Meperidine, quantitative - $22.04

83805 Meprobamate, blood or urine - $19.45

83825 Mercury, quantitative; blood - $22.69

83830 urine - $22.69

83835 Metanephrines, urine - $19.45

83840 Methadone - $24.64

83842 Methapyrilene - BR

83845 Methaqualone - $36.96

83857 Methemalbumin - $10.37

83858 Methsuximide, serum - $16.21

83859 Methyprylon - $36.96

83860 Morphine; screening - $25.94

83861 quantitative - $38.91

83862 RIA - $33.72

83864 Mucopolysaccharides, acid, blood - BR

83865 Mucopolysaccharides, acid, urine; quantitative - $19.45

83866 screen - $8.76

83870 Mucoprotein, blood (seromucoid) - $12.97

83872 Mucin, synovial fluid (rope test) - $4.21

83874 Myoglobin, electrophoresis - BR

83875 Myoglobin, urine - $12.97

83880 Nalorphine - $24.64

83885 Nickel, urine - $32.42

83887 Nicotine - $30.80

83895 Nitrogen, total; urine, 24-hour specimen - $19.45

83900 feces, 24-hour specimen - $32.42

83910 Nonprotein nitrogen (NPN), blood - $6.48

83915 Nucleotidase 5'- -$13.62

83917 Organic acids; screen, qualitative - BR

83918 quantitative - BR

83920 Ornithine carbamyl transferase (OCT) - $7.78

83930 Osmolality; blood - $6.48

83935 urine - $6.48

83938 Ouabain - BR

83945 Oxalate, urine - $12.97

83946 Oxazepam - BR

83947 Oxybutyric acid, beta - BR

83948 Oxycodinone - $21.40

83949 Oxytocinase, RIA - BR

83965 Paraldehyde, blood, quantitative - $19.45

83970 Parathormone (parathyroid hormone), RIA - $58.04

83971 Penicillin, urine - BR

83972 Pentazocine - $24.64

83973 Pentose, urine, qualitative - $5.51

83974 Pepsin, gastric - $19.45

83975 Pepsinogen, blood - $12.97

83985 Pesticide other than chlorinated hydrocarbons, blood, urine, or other material - $5.51

83992 Phencyclidine (PCP) - $15.24

83995 Phenol, blood or urine - $19.45

84005 Phenolsulfonphthalein (PSP) test, urine, - $6.48

84021 Phenothiazine, urine; qualitative, chemical - $32.42

84022 quantitative, chemical - BR

84030 Phenylalanine (PKU), blood; Guthrie - $3.89

84031 Fluorometric - BR

84033 Phenylbutazone - BR

84035 Phenylketones; blood, qualitative - BR

84037 urine, qualitative - $3.25

84038 Phenylpropanolamine - BR

84039 Phenylpyruvic acid; blood - BR

84040 urine - $6.48

84045 Phenytoin - $25.94

84060 Phosphatase, acid; blood - $7.77

84065 prostatic fraction - $12.97

84075 Phosphatase, alkaline, blood; - $7.77

84078 heat stable (total not included) - $4.86

84080 isoenzymes, electrophoretic method - $21.40

84082 Phosphates, tubular reabsorption of (TRP) - $19.45

84083 Phosphoglucomutase, isoenzymes - $24.64

84085 Phosphogluconate, 6-, dehydrogenase, RBC - $7.46

84087 Phosphohexose isomerase - $12.32

84090 Phospholipids, blood - $9.72

84100 Phosphorus (phosphate); blood - $7.77

84105 urine - $7.77

84106 Porphobilinogen, urine; qualitative - $4.21

84110 quantitative - $6.48

84118 Porphyrins, copro-, urine; quantitative - $12.32

84119 qualitative - $11.02

84120 Porphyrins; copro- and uro-, fractionated, urine - $20.75

84121 uro-, copro- and porphobilinogen, urine - $24.64

84126 Porphyrins, feces, quantitative - $32.42

84128 Porphyrins, plasma - BR

84132 Potassium; blood - $7.77

84133 urine - $7.77

84136 Pregnanediol - $19.45

84139 Pregnantriol - $19.45

84141 Primidone - $24.64

84142 Procainamide - $24.64

84144 Progesterone, any method - $46.04

84146 Prolactin (mammotropin), RIA - $92.40

84147 Propoxyphene - $24.64

84149 Propranolol - $7.77

84150 Prostaglandin, any one, RIA - $92.73

84155 Protein, total, serum; chemical - $6.48

84160 refractometric - $3.89

84165 electrophoretic fractionation and quantitation - $19.45

84170 Protein, total, and albumin/globulin ratio - $12.97

84175 Protein, other sources, quantitative - $7.77

84176 Protein, special studies (eg, monoclonal protein analysis) - BR

84180 Protein, urine; quantitative, 24-hour specimen - $7.77

84185 Bence-Jones - $3.89

84190 electrophoretic fractionation and quantitation - $25.94

84195 Protein, spinal fluid; semi-quantitative (Pandy) - $6.48

84200 electrophoretic fractionation nad quantitation - $25.94

84202 Protoporphyrin, RBC; quantitative - $11.02

84203 screen - BR

84205 Protriptylene - $27.56

84206 Proinsulin, RIA - BR

84207 Pyridoxine (Vitamin B-6) - $27.89

84208 Pyrophosphate vs urate, crystals (polarization) - $5.51

84210 Pyruvate, blood - $9.72

84220 Pyruvic kinase, RBC - $9.72

84228 Quinine - BR

84230 Quinidine, blood - $12.97

84231 Radioimmunoassay (RIA) not elsewhere specified - BR

84232 Releasing factor - BR

84244 Renin (RIA) - $30.80

84250 Resin uptake T-3, or T-4 (RT3U); - $6.49

84251 with total thyroxine, any method - $15.61

84252 Riboflavin (Vitamin B-2) - $21.08

84255 Selenium, blood, urine or tissue - $32.42

84260 Serotonin, blood - $38.91

84275 Sialic acid, blood - $16.21

84285 Silica, blood, urine or tissue - $32.42

84295 Sodium; blood - $7.77

84300 urine - $7.77

84310 Sorbitol dehydrogenase, serum - $7.77

84315 Specific gravity (except urine) - $3.56

84317 Starch, feces, screening - $2.63

84324 Strychnine - $30.80

84375 Sugars, chromatographic, TLC or paper chromatography - $24.64

84382 Sulfobromophthalein (BSP) - $10.37

84395 Sulfonamide; blood, chemical - $6.48

84397 crystals, qualitative - BR

84401 Testosterone, blood; double isotope - BR

84403 RIA - $43.12

84404 Testosterone, urine; double isotope - BR

84405 RIA - $49.28

84406 Testosterone, binding protein - BR

84407 Tetracaine - BR

84408 Tetrahydrocannabinol THC (marijuana) - BR

84409 Tetrahydrocortisone or tetrahydrocortisol - $43.12

84410 Thallium, blood or urine - $32.42

84420 Theophylline, blood or saliva - $19.45

84425 Thiamine (Vitamin B-1) - $25.29

84430 Thiocyanate, blood - $9.72

84434 Thioridazine - BR

84441 Thyroxine (T-4), specify method (eg, CPB, RIA) - $22.04

84442 Thyroxine binding globulin (TBG) - $20.75

84443 Thyroid stimulating hormone (TSH), RIA - $19.45

84444 Thyrotropin releasing factor, RIA; - BR

84445 plus long acting (LATS) - $120.29

84446 Tocopherol alpha (Vitamin E) - $15.24

84447 Toxicology, screen; general - BR

84448 sedative (acid and neutral drugs, volatiles) - $18.48

84450 Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method - $7.77

84455 colorimetric or fluorometric - $6.48

84460 Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method - $7.77

84465 colorimetric or fluorometric - $6.48

84472 Trichloroethanol - $19.45

84474 Trichloroacetic acid - $14.92

84476 Trifluoperazine - BR

84478 Triglycerides, blood - $9.72

84480 Triiodothyronine (true T-3), RIA - $30.80

84483 Trimethadione - BR

84485 Trypsin, duodenal fluid - $9.72

84488 Trypsin, feces; qualitative, 24-hour specimen - $9.72

84490 quantitative - $9.72

84510 Tyrosine, blood - $12.97

84520 Urea nitrogen, blood (BUN); quantitative - $7.13

84525 stick test - $2.60

84540 Urea nitrogen, urine - $6.48

84545 Urea nitrogen, clearance - $12.97

84550 Uric acid; blood, chemical - $6.49

84555 uricase, ultraviolet method - $8.43

84560 Uric acid, urine - $6.48

84565 Urobilin, urine; qualitative - $3.89

84570 quantitative, timed specimen - $7.77

84575 Urobilin, feces, quantitative - $19.45

84577 Urobilinogen, feces, quantitative - BR

84578 Urobilinogen, urine; qualitative - BR

84580 quantitative, timed specimen - $7.77

84583 semiquantitative - $6.16

84584 Uropepsin, urine - BR

84585 Vanillymandelic acid (VMA), urine - $19.45

84588 Vasopressin (antidiuretic hormone), RIA - BR

84589 Viscosity, fluid - $13.94

84590 Vitamin A, blood; - $12.97

84595 including carotene - $19.45

84597 Vitamin K - BR

84600 Volatiles (acetic anhydride, carbon tetrachloride, dichloroethane, dichloromethane, diethylether) - $18.48

84605 Volume, blood, dye method (Evans blue); - $9.72

84610 including total plasma and total blood cell volume - $16.21

84613 Warfarin - $17.50

84615 Xanthurenic acid - $37.61

84620 Xylose tolerance test, blood (administration, see 99070) - $12.97

84630 Zinc, quantitative; blood - $32.42

84635 urine - $32.42

84645 Zinc sulfate turbidity - $6.48

84999 Unlisted chemistry or toxicology procedure - BR

HEMATOLOGY

85000 Bleeding time; Duke - $3.25

85002 Ivy - $9.72

85003 Adelson-Crosby immersion method - BR

85005 Blood count; basophil count, direct - $3.25

85007 differential WBC count (includes RBC morphology and platelet - $2.60

85009 differential WBC count, buffy coat - $2.60

85012 eosinophil count, direct - $3.88

85014 hematocrit - $2.60

85018 hemoglobin, colorimetric - $2.60

85021 hemogram, automated RBC, WBC, Hgb, Hct and indices only) - $3.89

85022 hemogram, automated (CBC) with differential WBC count - BR

85031 hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices) - $7.77

85041 red blood cell (RBC) - $2.60

85044 reticulocyte count - $4.54

85048 white blood cell (WBC) - $2.60

85095 Bone marrow; aspiration only - $12.97

85100 aspiration, staining and interpretation - $45.40

85101 aspiration and staining only (smears) - $30.80

85102 biopsy core (needle) - $30.80

85103 cell block or biopsy, stain and interpretation - $24.64

85105 interpretation only - $32.42

85109 staining and preparation only - $12.32

85150 Calcium clotting time - $12.97

85160 Calcium saturation clotting test - $12.97

85165 Capillary fragility test, Rumpel-leede (separate procedure) - $6.48

85170 Clot retraction; screen - $2.60

85171 quantitative - $6.16

85172 inhibition by drugs - BR

85175 Clot lysis time, whole blood dilution - BR

85210 Clotting; factor II, prothrombin, specific - $12.97

85220 factor V (AcG or proaccelerin), labile factor - $12.97

85230 factor VII (proconvertin, stable factor) - $12.97

85240 factor VIII (AHG), one stage - $12.97

85242 factor VIII (AHG), two stage - $43.12

85250 factor IX (PTC or Christmas) - $12.97

85260 factor X (Stuart-Prower) - $12.97

85270 factor XI (PTA) - $12.97

85280 factor XII (Hageman) - $12.97

85290 factor XIII (fibrin stabilizing) - $12.97

85291 factor XIII (frbrin stabilizing), screen solubility - $12.32

85300 Clotting inhibitors or anticoagulants; antithrombin III - $12.97

85310 antithromboplastin - $12.97

85311 antiprothrombinase - BR

85320 antiprothromboplastin - $12.97

85330 antifactor VIII - $12.97

85340 cross recalcification time (mixtures) - $12.97

85341 PTT inhibition test - BR

85345 Coagulation time; Lee and White - $9.72

85347 activated - $6.48

85348 other methods - BR

85360 Euglobulin lysis - $12.97

85362 Fibrin degradation (split) products (FDP) (FSP); agglutination, slide - $4.86

85363 ethanol gel - $4.21

85364 hemagglutination inhibition (Merskey), micro-titer - $14.92

85365 immunoelectrophoresis - BR

85367 precipitation - $7.46

85368 protamine paracoagulation (PPP) - BR

85369 staphylococcal clumping - $4.86

85371 Fibrinogen, semiquantitative; latex - $5.51

85372 turbidimetric - $9.41

85376 Fibrinogen; thrombin with plasma dilution - $9.72

85377 thrombin time dilution - $14.92

85390 Fibrinolysins; screening - $6.48

85392 with EACA control - BR

85395 semiquantitative - $9.72

85396 lysis of homologous clot - $4.54

85398 Fibrinolysis, quantitative - BR

85400 Fibrinolytic mechanisms; plasmin - BR

85410 antiplasmin - BR

85420 plasminogen - BR

85441 Heinz bodies; direct - $3.56

85445 induced, acetyl phenylhydrazine $8.11

85460 Hemoglobin, fetal, differential lysis (Kleihauer) - $10.37

85520 Heparin assay - $19.45

85530 Heparin-protamine tolerance test - $19.45

85535 Iron stain (RBC or bone marrow smears) - $7.46

85538 Ledger stain (esterase) blood or bone marrow - $12.32

85540 Leukocyte alkaline phosphatase with count - $6.48

85544 Lupus erythematosus (LE) cell prep - $10.37

85547 Mechanical fragility, RBC - $12.32

85548 Morphology of red blood cells, only - $3.56

85549 Muramidase, serum - $21.40

85550 Nitroblue tetrazolium test (NBT) - $14.92

85555 Osmotic fragility, RBC; - $6.48

85556 incubated, qualitative - $19.45

85557 incubated, quantitative - $19.45

85560 Peroxidase stain, WBC - $6.48

85575 Platelet; adhesiveness (in vivo) - $19.45

85577 aggregation (glass bead) - $12.32

85580 count (Rees-Ecker) - $4.54

85585 estimation on smear, only - $3.23

85590 phase microscopy - $6.48

85595 electronic technique - $6.48

85610 Prothrombin time; - $5.19

85612 Russell viper venom type (includes venom) - $14.92

85614 two stage - $14.92

85615 Prothrombin utilization (consumption) - $12.97

85618 Prothrombin-Proconvertin, P & P (Owren) - $6.48

85630 Red blood cell size (Price-Jones) - $12.97

85632 Red blood cell peroxide hemolysis - BR

85635 Reptilase test - $13.62

85650 Sedimentation rate (ESR); Wintrobe type - $3.25

85651 Westergren type - $4.54

85660 Sickling of RBC, reduction, slide method - $4.54

85665 Streptokinase titer (plasminogen activator) - BR

85670 Thrombin time; plasma - $6.48

85675 titer - BR

85700 Thromboplastin generation test; screening (Hicks-Pitney) - $12.97

85710 definitive, with platelet substitute - $43.12

85711 with patient's platelets - $52.20

85720 all factors - BR

85730 Thromboplastin time, partial (PTT); plasma or whole blood - $9.72

85732 substitution, plasma - $8,76

85810 Viscosity; blood - $12.97

85820 serum or plasma - $12.97

85999 Unlisted hematology procedure - BR

IMMUNOLOGY

86000 Agglutinins; febrile, each - $4.53

86002 panel (typhoid O & H, paratyphoid A & B, brucella and Proteus OX-19 - $19.45

86004 warm - $14.92

86006 Antibody, qualitative, not otherwise specified; first antigen, slide or tube - $4.86

86007 each additional antigen - $3.25

86008 Antibody, quantitative titer, not otherwise specified; first antigen - $7.46

86009 each additional antigen - $4.86

86011 Antibody, detection, leukocyte antibody - $17.83

86012 Antibody absorption, cold auto absorption; per serum - $12.32

86013 differential - $18.48

86014 Antibody, platelet antibodies (agglutinins) - $18.48

86016 Antibodies, RBC, saline; high protein and antihuman globulin technique - $12.32

86017 with ABO+Rh(D) typing (for holding blood instead of complete crossmatch) - $9.72

86018 enzyme technique including antihuman globulin - $6.81

86019 elution, any method - $18.48

86021 Antibody indentification; leukocyte antibodies - $24.64

86022 platelet antibodies - $30.80

86024 RBC antibodies (8-10 cell panel) standard technique - $15.24

86026 RBC antibodies (8-10 cell panel), with enzyme technique including antihuman globulin - $21.40

86028 saline or high protein, each (Rh, AB, etc) - $5.51

86031 Antihuman globulin test; direct (Coombs) 1-3 dilutions - $6.48

86032 indirect, qualitative (broad, gamma or nongamma, each) - $9.72

86033 indirect, titer (broad, gamma or nongamma each) $5.51

86034 enzyme technique, qualitative - $18.80

86035 drug sensitization, identification (eg, penicillin) - $30.80

86045 Antistreptococcal carbohydrate, anti-A CHO - BR

86060 Antistreptolysin O; titer - $6.50

86063 screen - $6.16

86067 Antitrypsin, alpha-1, determination - $15.04

86068 Blood crossmatch, complete standard technique, includes typing and antibody screening of recipient and donor; first unit - $19.45

86069 each additional unit - $18.48

86072 Blood crossmatch; enzyme technique - $4.21

86073 screening for compatible unit saline and/or high protein - $10.37

86074 antiglobulin technique - $6.16

86075 Blood crossmatch, minor only (plasma, Rh immune globulin), includes recipient and donor typing and antibody screening; first unit - $17.83

86076 each additional unit - $11.02

86080 Blood typing; ABO only - $3.89

86082 ABO and Rho(D) - $7.46

86090 MN - $6.48

86095 Blood typing, RBC antigens other than ABO or Rho(D); antiglobulin technique, each antigen - $3.89

86096 direct, slide or tube, including Rh subtypes, each antigen - $3.89

86100 Blood typing; Rho(D) only - $3.89

86105 Rh genotyping, complete - $5.19

86115 anti-Rh immunoglobulin testing (RhoGAM type) - $22.04

86120 special (Kell, Duffy) - BR

86128 Blood autotransfusion, including collection, processing and storage - $30.80

86129 Blood component processing not otherwise specified - BR

86131 Blood unit for direct transfusion, up to 50 ml - BR

86134 Blood unit for transfusion; processing by blood bank, includes collection - $30.80

86138 replacement - BR

86139 splitting, open or closed, system, each - $3.89

86140 C-reactive protein - $6.48

86149 Carcinoembryonic antigen; gel diffusion - BR

86151 RIA - $24.64

86155 Chemotaxis assay, specify method - BR

86158 Complement; C'1 esterase - $16.53

86159 C'2 esterase - $21.40

86162 total (CH 50) - $24.64

86171 Complement fixation tests, each (eg, cat scratch fever, coccidioidomycosis, histoplasmosis, leptospirosis, psittacosis, rubella, streptococcus MG, syphilis) - $12.97

86185 Counterelectrophoresis, each antigen - $9.72

86201 Cryoprecipitate, preparation; each unit - $12.32

86202 with thawing and pooling, each unit - $00.66

86215 Deoxyribonuclease, antibody - $12.97

86225 Deoxyribonucleic acid (DNA) antibody - $12.97

86235 Extractable nuclear antigen (ENA), antibody - $12.32

86240 Factor VIII; concentrate, lyophilized unit, 100 units - BR

86241 dilution, each bottle - $1.29

86243 Fc receptor assay, specify method - BR

86245 Fibrinogen, unit - $33.72

86255 Fluorescent antibody; screen - $9.72

86256 titer - $12.97

86265 Frozen blood, preparation for freezing, each unit including processing and collection; - BR

86266 with thawing - BR

86267 with freezing and thawing - BR

86272 Globulin, gamma 1 ml - $9.08

86273 Globulin Rh immune, 1 ml - $24.64

86274 Globulin vaccinia, immune, 1 ml - BR

86280 Hemagglutination inhibition tests (HAI), each (eg, amebiases, rubella, viral) - $19.45

86281 Hemolysins, acid (for paroxysmal hemoglobinuria) (Ham test) - $19.45

86282 Hemolysins and agglutinins, auto, screen, each; - $12.32

86283 incubated with glucose (eg, ATP) - $30.80

86285 Hepatitis associated agent (Australian antigen) (HAA); - $7.46

86286 counterelectrophoresis with concentration of serum - $12.32

86287 RIA method - $12.97

86300 Heterophile antibodies; screening (includes monotype test), slide or tube - - $6.50

86305 quantitative titer - BR

86310 plus titers after absorption with beef cells and guinea pig kidney - $9.72

86315 Hyaluronidase, antibody - $19.45

86320 Immunoelectrophoresis; serum, each specimen (plate) - $32.42

86325 other fluids (eg, urine) with concentration, each specimen - $32.42

86329 Immunodiffusion; quantitative, each lgA, lgD, lgG, lgM, ceruloplasmin, transferrin, alpha-1 feto protein, alpha-2, macroglobulin, complement fractions, alpha-1 antitrypsin, or other (specify) - $25.94

86331 gel diffusion, qualitative (Ouchterlony) - $19.45

86335 Immunoglobulin typing (Gc, Gm, Inv), each - BR

86343 Leukocyte histamine release test (LHR) - BR

86344 Leukocyte phagocytosis - BR

86345 Leukocyte poor blood, nylon filter preparation, including collection and processing - $33.72

86346 Leukocyte poor blood, invert spin preparation; including collection and processing - $27.56

86347 not including collection and processing - $3.56

86351 Lymphocyte storage, liquid nitrogen, including preparation - BR

86353 Lymphocyte transformation, PHA or other - $49.28

86357 Lymphocytes; T & B differentiation - $67.76

86358 B-cell evaluation - BR

86365 Mast cell degranulation test (MDT) - BR

86377 Microsomal antibody (thyroid) - $12.32

86378 Migration inhibitory factor test (MIF) - BR

86382 Neutralization test, viral - BR

86384 Nitroblue tetrazolium dye test (NTD) - BR

86385 Paternity testing, ABO+Rh factors+MN (per individual); - $32.42

86386 each additional antigen system - BR

86388 Plasma, single donor, fresh frozen - BR

86389 Plasmapheresis, each unit - $30.80

86391 Plasma protein fraction unit - BR

86392 Platelet concentrate; preparation - $18.48

86393 mix and pool, each unit - $00.66

86398 Platelet rich plasma, preparation - $14.92

86402 Precipitin determination, gel diffusion, in aspergillosis, bagassosis, farmer lung, pigeon breeder disease, silo filler disease, other alveolitis (specify) - BR

86405 Precipitin test for blood (species identification) - BR

86415 Prothrombin complex; dilute and pretest - $3.25

86416 lyophilized, unit - $55.44

86421 Radioallergosorbent test (RAST); up to 5 antigens - $7.13

86422 6 or more antigens - $6.16

86423 Radioimmunosorbent test (RIST) lgE, quantitative - $18.48

86424 Rat mast cell technique (RMCT) - BR

86425 Red blood cells, packed; preparation gravity method, unit in addition to collection and processing - $2.60

86426 centrifuge method in addition to collection and processing - $3.56

86427 processing by blood bank, includes collection - $24.64

86450 Skin test; actinomycosis - $6.48

86460 blastomycosis - $6.48

86470 brucellosis - $6.48

86480 cat scratch fever - $6.48

86490 coccidioidomycosis, each test - $6.48

86495 diphtheria (Schick) - $6.48

86500 echinococcosis - $6.48

86510 histoplasmosis - $6.48

86520 liptospirosis - $6.48

86530 lymphogranuloma (lymphopathia) venereum (Frei test) - $6.48

86540 mumps - $6.48

86550 psittacosis - $6.48

86565 sarcoidosis (Kveim test), skin test only - BR

86570 trichinosis - $6.48

86580 tuberculosis, patch or intradermal - $6.48

86585 tuberculosis, tine test - $3.89

86590 Streptokinase, antibody - $25.94

86592 Syphilis, precipitation or flocculation tests, qualitative VDRL, RPR, DRT - $3.89

86593 Syphilis, precipitation or flocculation tests, quantitative - $6.48

86594 Thyroid autoantibodies - $29.18

86595 Tissue; culture - BR

86597 typing - BR

86600 Toxoplasmosis, dye test - $25.94

86630 Transfer factor test (TFT) - BR

86650 Treponema antibodies, fluorescent, absorbed (FTA-abs) - $9.72

86660 Treponema pallidum immobilization (TPI) - $25.94

86662 Treponema pallidum test, other, specify (eg, TPIA, TPA, TPMB, TPCF, RPCF) - $6.48

86670 Washed red blood cells for transfusion, preparation not including unit collection and processing - $30.80

86999 Unlisted immunology procedure - BR

MICROBIOLOGY

87001 Animal inoculation, small animal; with observation - $25.94

87003 with observation and dissection - $25.94

87015 Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB) - $6.48

87040 Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen) - $15.57

87045 stool - $14.92

87060 throat or nose - $11.02

87070 any other source - $14.92

87075 Culture, bacterial, any source; anaerobic (isolation) - $14.92

87076 definitive identification, including gas chromatography in anaerobic culture - $24.64

87081 Culture, bacterial, screening only, for single organisms - $5.19

87086 Culture, bacterial, urine; quantitative, colony count - $12.79

87087 commerical kit - $4.86

87088 identification, in addition to quantitative or commercial kit - $4.86

87101 Culture, fungi, isolation; skin - $6.16

87102 other source - $7.46

87106 definitive identification, by culture, per organism, in addition to skin or other source - $12.32

87109 Culture, mycoplasma, any source - $19.45

87116 Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria); any source, isolation only - $19.45

87117 concentration plus isolation - $19.45

87118 definitive identification, per organism, (does not include isolation and/or concentration) - $19.45

87140 Culture, typing; fluorescent method, each antiserum - $6.48

87143 gas liquid chromatography (GLC) method - $18.48

87145 phage method - $12.79

87147 serologic method, agglutination grouping, per antiserum - $6.48

87151 serologic method, speciation - $6.48

87155 precipitin method, grouping, per antiserum - $4.86

87158 other methods - BR

87163 Culture, special extensive definitive diagnostic studies, beyond usual definitive studies - BR

87164 Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection - $19.45

87166 without collection - $18.48

87173 Endotoxin, bacterial (pyrogens); animal inoculation - $14.92

87174 chemical - $9.72

87176 homogenization, tissue, for culture - $6.16

87177 Ova and parasites, direct smears, concentration and identification - $6.50

87181 Sensitivity studies, antibiotic; agar diffusion method, each antibiotic - $1.30

87184 disc method, each plate (12 or less discs) - $9.72

87186 microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics - $18.48

87188 tube dilution method, each antibiotic - $12.97

87190 tubercle bacillus (TB, AFB), each drug - $19.45

87205 Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types - $6.50

87206 fluorescent and/or acid fast stain for bacteria, fungi, or cell types - $19.45

87207 special stain for inclusion bodies or intracellular parasites (eg. malaria, kala azar) - $9.72

87208 direct or concentrated, dry, for ova and parasites - $6.48

87210 wet mount with simple stain and interpretation, for bacteria, fungi, ova, and/or parasites - $6.50

87211 wet and dry mount, with interpretation, for ova and parasites - $19.45

87250 Virus, inoculation of embryonated eggs, suitable tissue culture, or small animal, includes observation and dissection - BR

87300 Vaccine, autogenous - $45.39

87999 Unlisted microbiology procedure - BR

ANATOMIC PATHOLOGY

Postmortem Examination

88000 Necropsy (autopsy), gross examination only; without CNS - $129.70

88005 with brain - $194.54

88007 with brain and spinal cord - $194.54

88012 infant with brain - BR

88014 stillborn or newborn with brain - BR

77016 macerated stillborn - BR

88020 Necropsy (autopsy), gross and microscopic; without CNS - $259.38

88025 with brain - BR

88027 with brain and spinal cord - $324.23

88028 infant with brain - BR

88029 stillborn or newborn with brain - BR

88036 Necropsy (autopsy), limited, gross and/or microscopic; regional - BR

88037 single organ - BR

88040 Necropsy (autopsy); forensic examination - BR

88045 coroner's call - BR

88099 Unlisted necropsy (autopsy) procedure - BR

Cytopathology

88104 Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation - $18.48

88106 filter method only with interpretation - $18.48

88107 smears and filter preparation with interpretation - $24.64

88109 smears and cell block with interpretation - $36.96

88125 Cytopathology, forensic (eg, sperm) - $30.80

88130 Sex chromatin identification; Barr bodies - $12.97

88140 peripheral blood smear, polymorphonuclear "drumsticks" - $12.97

88150 Cytopathology, smears, cervical or vaginal (eg, Papanicolaou), screening and interpretation, up to three smears; - $9.72

88155 with difinitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) - $12.97

88160 Cytopathology, any other source (eg, sputum), screening and interpretation - $12.97

88199 Unlisted cytopathology procedure - BR

Cytogenetic Studies

88260 Chromosome analysis; lymphocytes, count 1-4 cells, screening - $73.92

88261 count 1-4 cells, 1 karyotype - $153.68

88262 count 1-20 cells for mosaicism, 2 karyotypes - $215.28

88265 Chromosome analysis; myeloid cells, 2 karyotypes (Philadelphia chromosome) - $92.40

88267 amniotic fluid, count 1-4 cells, 1 karyotype - $246.08

88268 skin, count 1-4 cells, 1 karyotype - $246.08

88270 other tissue cells, count 1-4 cells, 1 karyotype - BR

88280 additional karyotyping - $30.80

88285 additional cells counted - $6.16

88299 Unlisted cytogenetic study - BR

SURGICAL PATHOLOGY

88300 Surgical pathology, gross examination only - $6.48

88302 Surgical pathology, gross and microscopic; examination for identification and record purposes (eg, uterine tubes, vas deferens, sympathetic ganglion) - $24.64

88304 diagnostic exam, small or uncomplicated specimen (eg, skin lesion(s), needle biopsy) - $30.80

88305 diagnostic exam, larger specimen or multiple small specimens (eg, prostate clippings, uterine curettings, segment of stomach) - $43.12

88307 complex diagnostic exam, large specimen(s), organs or multiple tissues requiring multiple slides - $61.60

88309 comprehensive diagnostic exam (eg, specimen with regional nodes, detailed anatomic dissection or diagnostic problem) - BR

88311 decalcification procedure - $4.86

88312 Special stains; Group I stains for microorganisms, (eg, Gridley, acid fast, methenamine silver, Levaditi) - $10.37

88313 Group II, all other special stains - $4.86

88317 Interpretation by treating physician of previously diagnosed histologic slide (without consultation) - BR

88321 Consultation and report on referred slides prepared elsewhere - $49.28

88323 Consultation and report on referred material requiring preparation of slides - BR

88325 Comprehensive review of records and slides, with report on referred material - BR

88329 Consultation during surgery; - $24.64

88331 with frozen section(s) - $36.96

88332 each additional frozen section during same visit to surgical operating suite - $12.32

88345 Immunofluorescent study - $49.28

88348 Electron microscopy; diagnostic - $153.68

88349 scanning - BR

88360 Whole organ sections for special studies - $64.85

88399 Unlisted surgical pathology procedure - BR

MISCELLANEOUS

89000 Basal metabolic rate (BMR) - $12.97

89005 Test combinations assigned individual procedure numbers for secretarial convenience only; CBC and urinalysis (includes 85022 or 85031 and 81000) - BR

89006 CBC, urinalysis, and serology (includes 85022 or 85031, 81000 and 86592) - BR

89007 CBC, urinalysis, serology, blood typing, and Rh grouping (includes 85022 or 85031, 81000, 86592, 86082 and 86100) - BR

89050 Cell count, miscellaneous body fluids (eg, CSF, joint fluid, except blood); - $3.89

89051 with differential _ $6.48

89070 Cerebrospinal fluid, complete examination (chloride, glucose, protein, and cell count) - BR

89080 Colloidal gold, spinal fluid - $6.48

89100 Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure - $12.97

89105 collection of multiple fractional specimens, single or double lumen tube (eg, pancreatic zymose secretion) with or without cytology preparation - BR

89125 Fat stain, feces, urine, sputum - $6.16

89130 Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; - $6.48

89132 after stimulation - $18.48

89135 Gastric intubation, aspiration, and fractional collections; for one hour (eg, gastric secretory study) - $24.64

89136 two hours - $36.96

89140 two hours including gastric stimulation (eg, histalog, pentagastrin) - $43.12

89141 three hours, including gastric stimulation - $49.28

89160 Meat fibers, feces - $4.86

89180 Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify) - $5.51

89205 Occult blood, any source except feces - $4.21

89210 Pharmacokinetic analysis, specify individual drug and fluid/ tissue - BR

89300 Semen analysis; presence and/or motility of sperm including Huhner test - $3.88

89310 motility and count - $12.97

89320 complete (volume, count, motility and differential) - $25.94

89323 Sperm immobilization - BR

89325 Sperm agglutination, with antibody titer - BR

89345 Sputum examination for hemosiderin or foreign material - BR

89350 Sputum, obtaining specimen, aerosol induced technique (separate procedure) - $6.48

89355 Starch granules, feces - $4.21

89360 Sweat collection by iontophoresis - $16.20

89365 Water load test - BR

89399 Unlisted miscellaneous pathology test - BR

3. The Department has thoroughly considered all verbal and written commentary received:

Comment

Incorporating the 1974 Montana Medical Association Relative Value Schedule by reference may entail a violation of the Sherman Anti-Trust Act and 30-15-205 MCA.

Response

To clear up even the suggestion of impropriety, the Department has dropped its reference to the 1974 Montana Medical Association Relative Value Schedule and has in turn incorporated a new schedule. The schedule incorporated is attached to the CPT-4 codes and reflects no change from the reimbursement rates initially proposed in this rule.

Comment

The notification for hearing indicates that the Montana Foundation for Medical Care supports the reimbursement level offered by the state; this is not so.

Response

The original notice merely indicates that comments were solicited from the Foundation; that statement merely indicates that the Department sought input for this rule from the Foundation. The Department does not mean to imply that it sought assistance in setting reimbursement levels from the Foundation or that the Foundation ever supported or acquiesced in the rates the Department was able to offer.

Comment

If a provider doesn't accept assignment from Medicare, he bills the recipient for full costs. This Medicaid schedule is tied to Medicare and cannot exceed Medicare. This allows a major difference in pay for the two programs.

Response

42 CFR 447.15 requires that the provider accept Medicaid payment as payment in full. The Department must follow 42 CFR 447.341 when structuring its reimbursement schedule:

447.341. Individual practitioners: Upper limits of payment.

(a) This section applies to doctors of medicine, dentistry, osteopathy, podiatry, and any other individual practitioner services the agency chooses to include.

(b) The agency must not pay the individual practitioner more than the lowest of--

(1) His actual charge for service;

(2) His reasonable charge for the same service under part B, medicare (Part 405, Subpart D, of this chapter); or

(3) His median charge for a given service.

(c) The median charge for a given service is determined from claims submitted during all of the calendar year preceding the fiscal year in which the determination is made.

(d) The agency must not pay more than the highest of--

(1) The 75th percentile of the range of weighted customary charges in the same locality that are set under medicare during the calendar year preceding the fiscal year in which the determination is made; or

(2) The prevailing reasonable charge under part B, medicare.

Comment

The reimbursement rate as proposed will not meet operating costs in many cases. Inflation has outstripped Medicaid reimbursement causing physicians and the paying public to subsidize Medicaid through increased charges to them or direct dollar loss to the physician. Soon many providers will refuse nonemergency Medicaid patients.

Response

Under Montana law, the Department may not deficit spend. Appropriations to the Department for Medical Assistance did not fully recognize the situation alluded to in the comment. Hopefully, appropriations will be given by the next legislature in an amount sufficient to properly address this problem.

Comment

The last raise in the reimbursement rate was in 1976. The legislature approved a raise in 1979; it is now just before elections and the increase is offered, why now?

Response

This increase is being made now as we understand the financial effects of the conversion to CPT-4. We could not previously compute the fiscal impact of this conversion, as it was not possible to predict what codes each provider would use.

Comment

The proposed reimbursement to a physician is not the formula used by the fiscal agent (Dikewood).

Response

The fiscal agent will follow the reimbursement schedule published in the final rule.

Kenneth F. Colby
Director, Social and Rehabilitation Services

Certified to the Secretary of State June 13, 1980.

DECLARATORY RULING
DEPARTMENT OF PUBLIC SERVICE REGULATION

IN THE MATTER Of The Application For a Declaratory Ruling On The Commission's Jurisdiction Of The Rates, Terms And Conditions For The Use Of Public Utility Facilities By Cable Television Operators.	))))))	DECLARATORY RULING

On August 10, 1979, the Montana Power Company (MPC) applied to the Commission for a declaratory ruling that the Commission "has jurisdiction of the rates, terms and conditions for the joint use of public utility facilities by non-utility Cable Television operators."

Mountain Bell intervened in support of the petition; Montana-Dakota Utilities, Inc., Tele-Communications, Inc., the Montana Cable Television Association, Inc. and Teleprompter Corporation intervened in opposition to the petition.

A hearing was held on October 23, 1979, and all parties submitted briefs.

DECISION

The petition for declaratory ruling is denied. The Commission finds that the Montana statutes which give the Commission its general authority to regulate the rates and services of public utilities do not give it the authority to regulate rates and conditions for the use of a utility's facilities by cable television operators in the manner described in this Docket.

REASON FOR DECISION

In support of their position, MPC and Mountain Bell place heavy reliance on a number of statutes in Title 69, MCA, which refer to service rendered "in connection with" a public utility, 69-3-201, 69-3-305(1)(a), 69-3-301(1), 69-3-306, MCA.

Should the Commission accept the very broad interpretation of the phrase "in connection with" urged by MPC and Mountain Bell, virtually every activity of a public utility would be subject to this Commission's jurisdiction. Such an interpretation would be contrary to the Montana Supreme Court's decision in State ex rel. Mountain States Telephone & Telegraph Company vs. District Court, 160 Mont. 443, 503 P.2d 526 (1972), which drew a distinction between a utility's "public function" and its private function, noting that "yellow pages advertising is outside Mountain States' area of public service." 160 Mont. at 448.

MPC and Mountain Bell further argue that because the poles are "dedicated to public use," cable television attachments must necessarily be considered a utility service subject to the Commission's ratemaking jurisdiction. The Commission cannot agree with this interpretation. The Montana statute defining public utilities speaks in terms of the kinds of services offered; it is the Commission's interpretation of this statute that whether a utility's activities are subject to Commission

jurisdiction depends primarily on whether they are in connection with provision of the enumerated services in 69-3-101, MCA.

MPC alleges that pole attachments are similar to services previously denoted "utility services" because only utilities have poles available. The Commission agrees with MDU that this factual allegation should not be considered in the absence of supporting evidence. In any case, an affirmative determination would not be dispositive of the issue.

Finally, the Commission agrees with intervenors' point that pole attachments lack an essential element of utility service, which is the requirement to serve. City of Polson vs. Public Service Commission, 155 Mont. 464, 473 P.2d 508 (1970). Utilities are under no legal duty to provide pole attachments for cable television operators; in fact, it is possible that such attachments might be ordered removed should they ever interfere with a utility's ability to provide utility service.

In summary, the Commission finds that neither the statutes which establish its authority nor the court cases interpreting those statutes grant jurisdiction over rates and conditions of service for pole attachments to utility poles by cable television operators.

APPROVED BY THE COMMISSION May 5, 1980.

BY ORDER OF THE MONTANA PUBLIC SERVICE COMMISSION.

GORDON E. BOLLINGER, Chairman

CLYDE JARVIS, Commissioner

JAMES R. SHEA, Commissioner

THOMAS J. SCHNEIDER, Commissioner
(Voting to concur)

ATTEST:
Madeline L. Cottrill
Secretary

(SEAL)

GEORGE TURMAN, Commissioner
(Voting to concur)