Tennessee Department of Health

Communicable & Environmental Diseases and Emergency Preparedness

HIV/STD Programs

Ryan White Part B Program

Medical Services Fee Schedule

Effective Dates: April 1, 2017 – March 31, 2018

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
RYAN WHITE PART B PROGRAM
HIV/STD/VIRAL HEPATITIS PROGRAM
Andrew Johnson Building, 4th FLOOR 710 James Robertson Parkway
NASHVILLE, TENNESSEE 37243

TABLE OF CONTENTS

Authorizing Invoices for Ryan White Part B Medical Services

All providers must be authorized for the current grant year with the Ryan White Part B Program by the stated deadline. If not, the program will not be able to pay for any services for the remainder of that grant year. Every provider must submit an Authorization to Vendor (A to V) form for approval as a provider.

Only outpatient services are covered by the Ryan White Part B Program. Under no circumstances can payment be made for an IN-HOSPITAL stay or confinement to an institution.

All services must be provided to treat only HIV-specific problems or secondary problems directly related to OR expected to negatively impact the patient's HIV disease. Please see other applicable criteria at the beginning of each service listing.

All providers are to charge their usual and customary fee. The fee listed on this Fee Schedule is the maximum amount allowed for reimbursement. The patient may not be charged for any amount regardless of the regular fee charged by the provider.

All invoices must be submitted on a HCFA-1500 or UB-90 Form.

Based on federal guidelines, according to the Health Resources & Services Administration (HRSA), all invoices must be submitted no later than 60 days from date of service of each invoice.

Invoices may not contain two different dates of service. Each date of service must be submitted on a separate invoice.

Ryan White Treatment Modernization Act legislation stipulates that it is payer of last resort. Services provided to eligible clients with insurance and/or another payer source should not be billed to Ryan White Part B Medical Services.

The amount paid by Ryan White Medical Services is considered payment in full. The difference in cost for a procedure cannot be obtained from the patient.

Any charges for procedures not covered by the Medical Services Program are the responsibility of the client.

In order to receive payment for the following services, all claims must be submitted on a form CMS-1500. The UB-92 form may be submitted by hospital based vendors.

A. All providers are to charge their usual and customary fee. The fee listed on this Fee Schedule is the maximum amount allowed for reimbursement. The patient may not be charged for any amount regardless of the regular fee charged by the provider.

B. This fee schedule is for HIV/AIDS patients who have no insurance, reside in Tennessee, and are treated on an OUTPATIENT basis only. Under no circumstances can payment be made for an IN-HOSPITAL stay or confinement to an institution.

C. All services must be provided to treat only HIV-specific problems or secondary problems directly related to OR expected to negatively impact the patient's HIV disease. Please see other applicable criteria at the beginning of each service listing.

MEDICAL SERVICES		
SURGERY – INTEGUMENTARY SYSTEM		
CPT Code	***Billable***	***Description***
0346T*	$41.04	Ultrasound, elastography
10060*	$109.53	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061	$193.15	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
11100	$95.75	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101	$30.62	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (list separately in addition to code for primary procedure) (use 11101 in conjunction with code 11100)
17000*	$61.83	Destruction (e.g., Laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g.. actinic keratoses); first lesion

SURGERY – INTEGUMENTARY SYSTEM cont.		
CPT Code	***Billable***	***Description***
17003	$5.16	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g.. actinic keratoses); second through 14 lesions, each
17004	$139.39	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g.. actinic keratoses), 15 or more lesions
17110*	$102.38	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	$121.49	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

SURGERY – CARDIOVASCULAR		
CPT Code	***Billable***	***Description***
36415	$2.40	Collection of venous blood by venipuncture
36430	$31.26	Transfusion, blood or blood components
36556	$221.46	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
38220	$152.64	Bone marrow; aspiration only
38221	$156.62	Bone marrow; biopsy, needle or trocar
38500	$309.18	Biopsy or excision of lymph node(s); open, superficial
38505	$118.84	Biopsy or excision of lymph node(s); by needle, superficial (e.g., cervical, inguinal, axillary)
38510	$489.09	Biopsy or excision of lymph node(s); open, deep cervical node(s)
38520	$483.06	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad

SURGERY - DIGESTIVE		
CPT Code	***Billable***	***Description***
43235*	$208.42	Esophagogastroduodenoscopy, flexible transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45378*	$352.68	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45380*	$435.66	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with biopsy, single or multiple
45381	$419.41	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with directed submucosal injection(s), any substance
45382*	$734.60	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with control of bleeding, any method
45384	$477.49	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps
45385*	$458.40	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45388	$3003.90	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
46600*	$81.88	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46601*	$129.72	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
46606*	$208.58	Anoscopy; diagnostic, with biopsy, single or multiple
46607*	$180.25	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple
46900*	$225.87	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46924*	$493.14	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

SURGERY – MALE GENITAL		
CPT Code	**Billable**	**Description**
54056*	$132.28	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
54065*	$205.37	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

SURGERY – FEMALE GENITAL		
CPT Code	**Billable**	**Description**
56501*	$122.46	Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515*	$212.24	Destruction of lesion(s), vulva; extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57420	$110.28	Colposcopy of the entire vagina, with cervix if present
57421	$147.94	Colposcopy of the entire vagina, with biopsy(s) of vagina/cervix
57452	$102.54	Colposcopy of the cervix including upper/adjacent vagina
57454	$144.40	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455	$134.22	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456	$126.58	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57522	$246.94	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision

SURGERY – NERVOUS		
CPT Code	**Billable**	**Description**
62270	$148.21	Spinal puncture, lumbar, diagnostic

SURGERY – RADIOLOGY		
CPT Code	***Billable***	***Description***
70450*	$106.87	Computed tomography, head or brain; without contrast material
70460	$149.26	Computed tomography, head or brain; with contrast materials
70470*	$176.34	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70551*	$212.36	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material
70552	$293.49	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast materials
70553*	$347.40	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
71010*	$20.66	Radiologic examination, chest, single view, frontal
71020*	$25.63	Radiologic examination, chest, 2 views, frontal and lateral
71030*	$38.37	Radiologic examination, chest, complete, minimum of four views
71250*	$150.47	Computed tomography, thorax; without contrast material(s)
71260*	$210.66	Computed tomography, thorax; with contrast material(s)
71270*	$252.22	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
72192*	$134.63	Computed tomography, pelvis; without contrast material(s)
72193*	$207.15	Computed tomography, pelvis; with contrast material(s)
72194*	$238.25	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
74150*	$138.00	Computed tomography, abdomen, without contrast material
74160*	$211.73	Computed tomography, abdomen; with contrast material(s)
74170*	$240.71	Computed tomography, abdomen; without contrast material, followed by contrast material(s further sections

SURGERY – RADIOLOGY cont.		
CPT Code	***Billable***	***Description***
74176	$185.38	Computed tomography, abdomen and pelvis; without contrast material(s)
74177	$286.37	Computed tomography, abdomen and pelvis; with contrast material(s)
74178	$324.12	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
76140	$24.60	Consultation on x-ray examination made elsewhere, written report
76700*	$113.93	Ultrasound, abdominal, real time with image documentation; complete
76770*	$104.99	Ultrasound, retroperitoneal (e.g. renal, aorta, nodes), real time with image documentation; complete
77065*	$83.29	Diagnostic mammography, including computer-aided direction (CAD) when performed; unilateral (replaced 77055)
77066	$106.94	Diagnostic mammography, including computer-aided direction (CAD) when performed; bilateral (replaced 77056)
77067	$76.53	Screening mammography, bilateral (2-view study of each breast), including computer-aided (CAD) when performed (replaced 77057)
78598*	$289.02	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed (replaced 78596)

PATHOLOGY and LABORATORY – ORGAN or DISEASE-ORIENTED PANELS		
CPT Code	***Billable***	***Description***
80048	$7.71	Basic Metabolic Panel- This panel must include the following: Calcium (82310), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea Nitrogen (BUN) 84520
80051	$6.48	Electrolyte Panel--This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), and Sodium (84295).

PATHOLOGY and LABORATORY – ORGAN or DISEASE-ORIENTED PANELS cont.		
CPT Code	***Billable***	***Description***
80053	$9.64	Comprehensive Metabolic Panel-This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), Urea Nitrogen (BUN) (84520).
80061	$14.97	Lipid Panel-This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)
80074	$51.46	Acute hepatitis panel-This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709); Hepatitis B core antibody (HbcAb), IgM antibody (86705); Hepatitis B surface antigen (HbsAg) (87340); Hepatitis C antibody (86803).
80076	$7.71	Hepatic Function Panel--This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)

PATHOLOGY and LABORATORY – THERAPEUTIC DRUG ASSAYS		
CPT Code	***Billable***	***Description***
80157	$14.82	Carbamazepine; free
80164	$15.14	Valproic Acid (dipropylacetic acid); total
80173	$16.27	Haloperidol
80178	$7.39	Lithium
80184	$12.81	Phenobarbital

PATHOLOGY and LABORATORY – THERAPEUTIC DRUG ASSAYS cont.		
CPT Code	***Billable***	***Description***
80185	$14.82	Phenytoin; total
80198	$15.82	Theophylline
80202	$15.14	Vancomycin
80305	$16.26	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) including sample validation when performed, per date of service (replaced 80300)
80335	$17.33	Antidepressants, tricyclic and other cyclicals; 1 or 2

PATHOLOGY and LABORATORY – EVOCATIVE/SUPPRESSION TESTING		
CPT Code	***Billable***	***Description***
80438	$56.32	Thyrotropin releasing hormone (TRH) stimulation panel; one hour. This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 3)
80439	$75.10	Thyrotropin releasing hormone (TRH) stimulation panel; 2 hour. This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 4)

PATHOLOGY and LABORATORY – URINALYSIS		
CPT Code	***Billable***	***Description***
81000	$3.54	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	$3.54	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy

PATHOLOGY and LABORATORY – URINALYSIS cont.		
CPT Code	***Billable***	***Description***
81002	$2.86	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	$2.51	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81015	$3.39	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; microscopic only
81025	$7.07	Urine pregnancy test, by visual color comparison methods

PATHOLOGY and LABORATORY – MOLECULAR PATHOLOGY		
CPT Code	***Billable***	***Description***
81250	$50.00	G6PC (glucose-6-phosphatase, catalytic subunit) (e.g., Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (e.g., R83C, Q347X)
81381	$123.00	HLA Class 1 typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57:01P), each

PATHOLOGY and LABORATORY – CHEMISTRY		
CPT Code	***Billable***	***Description***
81401	$400.00	Molecular pathology procedure, Level 2 (eg. 2-10 SNPs, 1 methylated variant, or 1 somatic variant (typically using non-sequencing target variant analysis), or detection of a dynamic mutation disorder/triplet/repeat)
82040	$5.54	Albumin; serum, plasma or whole blood
82105*	$18.75	Alpha-fetoprotein (AFP); serum
82150	$7.25	Amylase

PATHOLOGY and LABORATORY – CHEMISTRY cont.		
CPT Code	***Billable***	***Description***
82175	$21.21	Arsenic
82247	$5.62	Bilirubin; total
82248	$5.62	Bilirubin; direct
82270	$3.59	Blood, occult by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
82274	$17.78	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82310	$5.76	Calcium; total
82373	$20.18	Carbohydrate deficient transferrin
82374	$5.46	Carbon dioxide (bicarbonate)
82435	$5.14	Chloride; blood
82465	$4.86	Cholesterol, serum or whole blood, total
82540	$5.18	Creatine
82550	$7.28	Creatine kinase (CK), (CPK); total
82552	$14.97	Creatine kinase (CK), (CPK); isoenzymes
82565	$5.73	Creatinine ; blood
82607	$16.85	Cyanocobalamin (Vitamin B-12)
82626	$28.25	Dehydroepiandrosterone (DHEA)
82627	$24.86	Dehydroepiandrosterone-sulfate (DHEA-S)
82652*	$43.02	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed
82668	$21.01	Erythropoietin
82728	$15.22	Ferritin

PATHOLOGY and LABORATORY – CHEMISTRY cont.		
CPT Code	***Billable***	***Description***
82746	$16.43	Folic acid; serum
82784	$10.39	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
82945	$4.38	Glucose, body fluid, other than blood
82947	$4.38	Glucose; quantitative, blood (except reagent strip)
82955	$10.84	Glucose-6- phosphate dehydrogenase (G6PD); quantitative
82960	$6.78	Glucose-6- phosphate dehydrogenase (G6PD); screen
83026	$2.64	Hemoglobin; by copper sulfate method, non-automated
83036	$10.85	Hemoglobin; by copper sulfate method, glycosylated (A1C)
83090	$18.86	Homocysteine
83550	$9.77	Iron binding capacity
83690	$7.70	Lipase
83718	$9.15	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83735	$7.49	Magnesium
84075	$5.78	Phosphatase, alkaline
84132	$5.14	Potassium; serum, plasma or whole blood
84152	$20.56	Prostate specific antigen (PSA); complexed (direct measurement)
84153	$20.56	Prostate specific antigen (PSA); total
84154	$20.56	Prostate specific antigen (PSA); free
84155	$4.10	Protein; total, except by refractometry; serum, plasma or whole blood
84165*	$12.01	Protein; electrophoretic fractionation and quantitation; serum
84295	$5.38	Sodium; serum, plasma or whole blood

PATHOLOGY and LABORATORY – CHEMISTRY cont.		
CPT Code	***Billable***	***Description***
84402	$23.42	Testosterone; free
84403	$28.86	Testosterone; total
84436	$7.69	Thyroxine; total
84443	$18.78	Thyroid stimulating hormone (TSH)
84450	$5.78	Transferase; aspartate amino (AST) (SGOT)
84460	$5.92	Transferase; alanine amino (ALT) (SGPT)
84478	$6.43	Triglycerides
84479	$6.45	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84520	$4.41	Urea nitrogen; quantitative
84525	$4.20	Urea nitrogen; semiquantitative (e.g., reagent strip test)
84550	$5.05	Uric acid; blood
84681	$23.26	C-peptide
84702	$16.82	Gonadotropin, chorionic (hCG); quantitative
84703	$8.39	Gonadotropin, chorionic (hCG); qualitative

PATHOLOGY and LABORATORY – HEMATOLOGY and COAGULATION		
CPT Code	***Billable***	***Description***
85007	$3.85	Blood count; blood smear, microscopic examination with manual differential WBC count
85013	$2.65	Blood count; spun microhematocrit
85014	$2.65	Blood count; hematocrit (Hct)
85018	$2.65	Blood count; hemoglobin (Hgb)

PATHOLOGY and LABORATORY – HEMATOLOGY and COAGULATION cont.		
CPT Code	***Billable***	***Description***
85025	$8.69	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85044	$4.81	Blood count; reticulocyte, manual
85049	$5.00	Blood count; platelet; automated
85610	$4.39	Prothrombin time
85651	$3.97	Sedimentation rate, erythrocyte; non-automated
85652	$3.02	Sedimentation rate, erythrocyte; automated

PATHOLOGY and LABORATORY – IMMUNOLOGY		
CPT Code	***Billable***	***Description***
86001	$5.84	Allergen specific IgG quantitative or semiquantitative, each allergen
86038	$13.51	Antinuclear antibodies (ANA)
86308	$5.78	Heterophile antibodies; screening
86318	$14.47	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)
86359	$42.16	T cells; total count
86360	$52.52	T cells; absolute CD4 and CD8 count, including ratio
86361	$29.93	T cells; absolute CD4 count
86403	$11.39	Particle agglutination; screen, each antibody
86430	$6.34	Rheumatoid factor; qualitative
86480	$69.27	Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon

PATHOLOGY and LABORATORY – IMMUNOLOGY cont.		
CPT Code	***Billable***	***Description***
86481	$82.39	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension
86485	$13.61	Skin test; candida
86486	$4.37	Skin test; unlisted antigen, each
86510	$5.34	Skin test; histoplasmosis
86580	$6.94	Skin test; tuberculosis, intradermal
86592	$4.58	Syphilis test; non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)
86593	$4.93	Syphilis test; non-treponemal antibody; quantitative
86609	$14.40	Antibody; bacterium, not elsewhere specified
86644	$16.09	Antibody; cytomegalovirus (CMV)
86677	$16.22	Antibody; Helicobacter Pylori
86704	$13.47	Hepatitis B core antibody (HbcAb); total
86705	$13.15	Hepatitis B core antibody (HbcAb), IgM antibody
86706	$12.01	Hepatitis B surface antibody (HBsAb)
86707	$12.93	Hepatitis Be antibody (HBeAb)
86708	$13.01	Hepatitis A antibody (HAAb); total
86709	$12.58	Hepatitis A antibody (HAAb); IgM antibody
86735	$14.58	Antibody; mumps
86756	$14.41	Antibody; respiratory syncytial virus
86777	$16.09	Antibody; Toxoplasma

PATHOLOGY and LABORATORY – IMMUNOLOGY cont.		
CPT Code	***Billable***	***Description***
86778	$16.10	Antibody; Toxoplasma, IgM
86780	$14.80	Antibody; Treponema Pallidum
86803	$15.95	Hepatitis C antibody

PATHOLOGY and LABORATORY – TRANSFUSION MEDICINE		
CPT Code	***Billable***	***Description***
86870	$8.76	Antibody identification, RBC antibodies, each panel for each serum technique
86900	$3.34	Blood typing, serologic; ABO
86920	$14.87	Compatibility test each unit; immediate spin technique

PATHOLOGY and LABORATORY – MICROBIOLOGY		
CPT Code	***Billable***	***Description***
87015	$7.46	Concentration (any type) for infectious agents
87040	$11.54	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
87045	$10.54	Culture, bacterial; stool, aerobic, with isolation and preliminary examination (e.g., KIA, LIA), Salmonella and Shigella species
87046	$10.54	Culture, bacterial; stool, aerobic, additional pathogens, isolation and presumptive identification of isolates, each plate
87070	$9.62	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates

PATHOLOGY and LABORATORY – MICROBIOLOGY cont.		
CPT Code	***Billable***	***Description***
87071	$10.54	Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87073	$10.54	Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood, or stool
87075	$10.58	Culture, bacterial, any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	$9.03	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87077	$9.03	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87081	$7.41	Culture, presumptive, pathogenic organisms, screening only
87086	$9.02	Culture, bacterial; quantitative, colony count, urine
87101	$8.62	Culture, fungi (mold or yeast), isolation with presumptive identification of isolates; skin, hair, or nail
87103	$10.08	Culture, fungi (mold or yeast), isolation with presumptive identification of isolates; blood
87116	$8.10	Culture, tubercle or other acid-fast bacilli (e.g., TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates
87140	$6.23	Culture typing; immunofluorescent method, each antiserum
87149	$22.42	Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed
87152	$4.67	Culture, typing; identification by pulse field gel typing
87177	$9.94	Ova and parasites, direct smears, concentration and identification

PATHOLOGY and LABORATORY – MICROBIOLOGY cont.		
CPT Code	***Billable***	***Description***
87185	$5.31	Susceptibility studies, antimicrobial agent: enzyme detection (e.g., beta lactamase), per enzyme
87188	$7.42	Susceptibilty studies, antimicrobial agent; macrobroth dilution method, each agent
87206	$5.20	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types
87207	$6.70	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87209	$20.09	Smear, primary source with interpretation; complete special stain (e.g., trichrome, , iron hemotoxylin) for ova and parasites
87210*	$4.58	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps
87252	$29.14	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87253	$18.21	Virus isolation; tissue culture, additional studies or definitive identification (e.g., hemabsorption, neutralization, immunofluorescence stain), each isolate
87254	$21.86	Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus
87340	$9.78	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunoabsorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative and semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87341	$9.78	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunoabsorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative and semiquantitative , multiple-step method; hepatitis B surface antigen (HbsAg) neutralization

PATHOLOGY and LABORATORY – MICROBIOLOGY cont.		
CPT Code	***Billable***	***Description***
87350	$9.78	Infectious agent antigen detection by immunoassay technique, (eg, enzyme Infectious immunoassay [EIA], enzyme-linked immunoabsorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative and semiquantitative, multiple-step method; hepatitis Be antigen (HbeAg)
87385	$12.81	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunoabsorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multi-step method; Histoplasma capsulatum
87427	$12.81	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunoabsorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semi-quantitative, multiple step method; Shiga-like toxin
87491	$39.23	Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique
87497	$47.88	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantification
87517	$47.88	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantification
87522	$47.88	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed
87534	$22.42	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
87535	$39.23	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique, includes reverse transcription when performed
87536	$95.11	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed
87591	$39.23	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, amplified probe technique
87623	$47.76	Human Papillomavirus (HPV), low risk types (e.g., 6,11, 42, 43, 44
87624	$47.76	Human Papillomavirus (HPV), high risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)
87625	$47.76	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed

PATHOLOGY and LABORATORY – MICROBIOLOGY cont.		
CPT Code	***Billable***	***Description***
87797	$22.42	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique, each organism
87798	$39.23	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, amplified probe technique, each organism
87800	$44.82	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801	$78.46	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87899	$12.81	Infectious agent antigen detection by immunoassay with direct optical observation; not otherwise specified
87900	$145.69	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics
87901	$201.02	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV 1, reverse transcriptase and protease regions
87902	$201.02	Hapatitis C Virus
87903	$546.18	Infectious agent phenotype analysis by nucleic acid (DNA and RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested
87904	$29.14	Infectious agent phenotype analysis by nucleic acid (DNA and RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested
87906	$126.54	Infectious agent phenotype analysis by nucleic acid (DNA and RNA); HIV 1, other region (e.g., integrase, fusion)
87910	$197.78	Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus
87912	$197.78	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus

PATHOLOGY and LABORATORY – CYTOPATHOLOGY		
CPT Code	***Billable***	***Description***
87999	$1568.00	Unlisted microbiology procedure (Trofile test)
88104	$70.63	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
88141	$30.54	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician
88142	$22.65	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	$22.65	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	$11.81	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	$11.81	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	$11.81	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	$11.81	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	$11.81	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	$11.81	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88160*	$67.19	Cytopathology, smears, any other source; screening and interpretation
88161*	$60.44	Cytopathology, smears, any other source; preparation, screening and interpretation
88164	$11.81	Cytopathology, slides, cervical or vaginal (the Bethesda system); manual screening under physician supervision
88165	$11.81	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision

PATHOLOGY and LABORATORY – CYTOPATHOLOGY cont.		
CPT Code	***Billable***	***Description***
88166	$11.81	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer assisted rescreening under physician supervision
88167	$11.81	Cytopathology, slides, cervical or vaginal (the Bethesda system); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88184	$68.40	Flow cytometry, cell surface, cytoplasmic or nuclear marker, technical component only; first marker

PATHOLOGY and LABORATORY – SURGICAL PATHOLOGY		
CPT Code	***Billable***	***Description***
88304	$42.04	Level III - Surgical pathology, gross and microscopic examination
88305*	$68.94	Level IV – Surgical pathology, gross and microscopic examination
88321	$97.87	Consultation and report on referred slides prepared elsewhere.
88323	$132.59	Consultation and report on referred material requiring preparation of slides
88325	$164.53	Consultation, comprehensive, with review of records and specimens, with report on referred material.

PATHOLOGY and LABORATORY – OTHER PROCEDURES		
CPT Code	***Billable***	***Description***
89051	$6.16	Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid), except blood; with differential count

MEDICINE – IMMUNIZATION ADMINISTRATION for VACCINES/TOXOIDS		
CPT Code	***Billable***	***Description***
90471	$23.33	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	$11.67	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); each additional vaccine (single or combination vaccine toxoid) (list separately in addition to code for primary procedure)

MEDICINES – VACCINES/TOXOIDS		
CPT Code	***Billable***	***Description***
90632	$42.76	Hepatitis A vaccine (Hep A), adult dosage, for intramuscular use
90633	$21.35	Hepatitis A vaccine (Hep A), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634	$19.42	Hepatitis A vaccine (Hep A), pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90636	$70.60	Hepatitis A and Hepatitis B vaccine (Hep A - Hep B), adult dosage, for intramuscular use
90649	$127.50	Human Papilloma virus (HPV) vaccine, types 6, 11, 16,18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use
90651*	$30.00	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 3 dose schedule, for intramuscular use
90656	$13.90	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL usage, for intramuscular use.
90657	$5.29	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL usage, for intramuscular use
90658	$10.58	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL usage, for intramuscular use
90662	$29.21	Influenza virus vaccine, split virus (IIV), preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

MEDICINES – VACCINES/TOXOIDS cont.		
CPT Code	***Billable***	***Description***
90670	$137.02	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90672	$26.88	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90686	$17.98	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL usage, for intramuscular use
90702	$19.97	Diphtheria and tetanus toxoids absorbed (DT) when administered to individuals younger than 7 years, for intramuscular use
90707	$34.56	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90714	$15.58	Tetanus and diphtheria toxoids adsorbed (Td) , preservative free, when administered to individuals 7 years or older, for intramuscular use
90715	$27.46	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90732	$23.78	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90734	$120.32	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivent MCV4 or MenACWY), for intramuscular use
90744	$19.49	Hepatitis B vaccine (Hep B), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90746	$45.81	Hepatitis B vaccine (Hep B), adult dosage, 3 dose schedule, for intramuscular use
90747	$91.61	Hepatitis B vaccine (Hep B), dialysis or immunosuppressed patient dosage, 4 dose schedu intramuscular use

MEDICINE – CARDIOGRAPHY		
CPT Code	***Billable***	***Description***
93000	$15.80	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

MEDICINE – ECHOCARDIOGRAPHY		
CPT Code	***Billable***	***Description***
93307*	$120.90	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording; when performed, complete, without spectral or color Doppler echocardiography

MEDICINE – PULMONARY		
CPT Code	***Billable***	***Description***
94642	$23.24	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
94726*	$48.62	Plethysmography for determination of lung volumes and, when performed, airway resistance (replaced 93720)
94760	$2.76	Noninvasive ear or pulse oximetry for oxygen saturation; single determination

MEDICINE – HYDRATION		
CPT Code	***Billable***	***Description***
96360	$52.02	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	$14.03	Intravenous infusion, hydration; each additional hour, (List separately in addition to code for primary procedure)

MEDICINE – THERAPEUTIC, PROPHYLACTIC and DIAGNOSTIC INJECTIONS and INFUSIONS and CHEMOTHERAPY		
CPT Code	***Billable***	***Description***
96372	$23.33	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	$51.60	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug

MEDICINE – MEDICAL NUTRITION THERAPY		
CPT Code	***Billable***	***Description***
97802	$33.20	Medical nutritional therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	$28.72	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face, with the patient, each 15 minutes
97804	$14.94	Medical nutrition therapy; initial assessment and intervention, group (2 or more individual(s)), each 30 minutes

MEDICINE – MODERATE (CONSCIOUS) SEDATION		
CPT Code	***Billable***	***Description***
99152	$15.73	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time; patient age 5 years or older
99153	$7.65	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time
99156	$25.09	Moderate sedation services (other than those services described by codes 00100-01999) provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older
99157	$15.73	Moderate sedation services (other than those services described by codes 00100-01999) provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time

MEDICINE – MISCELLANEOUS SERVICES		
CPT Code	***Billable***	***Description***
99058	$32.00	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

EVALUATION and MANAGEMENT – NEW PATIENT		
CPT Code	***Billable***	***Description***
99201	$40.98	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and /or family's needs. Usually, the presenting problems are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	$70.21	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	$101.31	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	$155.22	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient/s and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically,45 minutes are spent face-to-face with the patient and/or family

EVALUATION and MANAGEMENT – NEW PATIENT cont.		
CPT Code	***Billable***	***Description***
99205	$194.95	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

EVALUATION and MANAGEMENT – ESTABLISHED PATIENT		
CPT Code	***Billable***	***Description***
99211	$18.00	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services
99212	$40.79	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and /or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	$68.56	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

EVALUATION and MANAGEMENT – ESTABLISHED PATIENT cont.		
CPT Code	***Billable***	***Description***
99214	$101.31	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and /or family.
99215	$136.65	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and /or family.

EVALUATION and MANAGEMENT – NEW or ESTABLISHED PATIENT		
CPT Code	***Billable***	***Description***
99241	$17.50	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are self- limited or minor. Typically, 15 minutes are spent face-to-face with patient and/or family.

EVALUATION and MANAGEMENT – NEW or ESTABLISHED PATIENT cont.		
CPT Code	***Billable***	***Description***
99243	$57.40	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination or care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	$57.40	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination or care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems (s) and of the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	$68.90	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.

HCPCS – SCREENING, COLORECTAL, OTHER		
CPT Code	***Billable***	***Description***
G0121	$352.68	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
HCPCS – MAMMOGRAPHY		
CPT Code	***Billable***	***Description***
G0202 *	$123.18	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

HCPCS – DIABETIC SUPPLIES		
CPT Code	***Billable***	***Description***
A4245	$1.39	Alcohol wipes, per box
A4253	$29.50	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4259	$9.36	Lancets, per box of 100
E0607	$163.08	Home blood glucose monitor
S8490	$25.00	Insulin syringes (100 syringes, any size)
HCPCS – DRUGS OTHER THAN CHEMOTHERAPY		
CPT Code	***Billable***	***Description***
J0285	$9.51/ 50mg	Injection, amphotericin B, (Abelcent, Amphocin, Fungizone)
J0696	$1.00/ 250mg	Injection, ceftriaxone sodium, (Rocephin)
J0834	$51.90/ 0.25mg	Injection, cosyntropin, (Cortrosyn) (replaced J0835)
J1455	$8.54/ 1000mg	Injection, foscarnet sodium, (Foscavir)
J1570	$34.67/ 500mg	Injection, ganciclovir sodium, (Cytovene)
J3370	$2.76/ 500mg	Injection, vancomycin HCl, (Vancocin)

HCPCS – LABORATORY SERVICES		
CPT Code	***Billable***	***Description***
P9019	$26.14/ unit	Platelet, each unit
P9021	$58.40/ unit	Red blood cells, each unit

HCPCS – VISION SERVICES		
CPT Code	***Billable***	***Description***
V2100	$31.41	Sphere, single vision, plano to plus or minus 4.00, per lens
V2200	$41.11	Sphere, bifocal, plano to plus or minus 4.00d, per lens
EVALUATION and MANAGEMENT – NEW PATIENT		
CPT Code	***Billable***	***Description***
99341	$52.94	Home visit for the evaluation and management of a new patient, which requires these 3 components: a problem focused history, a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

EVALUATION and MANAGEMENT – ESTABLISHED PATIENT		
CPT Code	***Billable***	***Description***
99347	$53.23	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

SKILLED NURSING VISITS

All skilled nursing and physical and occupational therapy are intended to supplement on-going medical care. Prior approval for continuation of services must be obtained for visits totaling more than 30 visits per patient per grant year.

EVALUATION and MANAGEMENT – NEW PATIENT

CPT Code	***Billable***	***Description***
99342 new patient	$76.28	Home visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

EVALUATION and MANAGEMENT – ESTABLISHED PATIENT

CPT Code	***Billable***	***Description***
99348 established patient	$80.80	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

PHYSICAL THERAPY

All skilled nursing and physical and occupational therapy are intended to supplement on-going medical care. Prior approval for continuation of services must be obtained for visits totaling more than 30 visits per patient per grant year.

MEDICINE – PHYSICAL MEDICINE and REHABILITATION

CPT Code	***Billable***	***Description***
97110	$30.65	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97161	$71.60	Physical therapy evaluation: low complexity, requiring these components: a history with no personal factors and/or comorbities that impact the plan of care; an examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; a clinical presentation with stable and/or uncomplicated characteristics; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family. (replaced 97001)
97162	$39.89	Physical therapy evaluation: moderate complexity, requiring these components: a history of present problem with 1-2 personal factors and/or comorbities that impact the plan of care; an examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; an evolving clinical presentation with changing characteristics; and clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family. (replaced 97002)

OCCUPATIONAL THERAPY

All skilled nursing and physical and occupational therapy are intended to supplement on-going medical care. Prior approval for continuation of services must be obtained for visits totaling more than 30 visits per patient per grant year.

CPT Code	***Billable***	***Description***
97165	$80.61	Occupational therapy evaluation, low complexity, requiring these components: an occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits (i.e. relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s) and consideration of a limited number of treatment options. Patient presents with no comorbities that affect occupational performance. Modification or tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family. (replaced 97003)

97166	$49.54	Occupational therapy evaluation, moderate complexity, requiring these components: an occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits (i.e. relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s) and consideration of several treatment options. Patient may present with comorbities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family. (replaced 97004)
97535	$33.23	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assisted technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.

NUTRITIONAL SERVICES

All nutritional assessments must be billed to Ryan White Services on a monthly or quarterly basis. Invoices shall group all clients served during the billing period, with attached documentation consisting of client names, Social Security numbers, CPT codes for services rendered and the date of service for all clients during the billing period. (The reason for this change in billing procedure is to allow for payment of nutritional services, which are not covered by TennCare and many health insurance companies, without qualifying those clients for all Ryan White Services.) Vendors may group uninsured clients, TennCare and private insurance clients on one bill.

Tennessee Department of Health county and regional clinics shall bill via journal voucher, rather than submitting a claim to Ryan White Services via the Fee Schedule. Supporting documentation shall be submitted along with your request for reimbursement.

EVALUATION and MANAGEMENT – PREVENTIVE MEDICINE SERVICES

CPT Code	***Billable***	***Description***
99401	$40.60	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	$68.61	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	$94.82	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	$122.11	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

SUBSTANCE ABUSE COUNSELING/SERVICES

All counseling services are intended to cover therapeutic interventions needed to help patients in dealing with their HIV infection, or secondary mental health issues (addiction, substance abuse) likely to negatively impact their HIV infection.

This component does not reimburse for case management services or for time spent in therapy discussing case management issues. Examples of case management issues include: TennCare/disability eligibility, housing, resource identification and/or referral, financial concerns, transportation, and other community level service needs.

Counseling services must be delivered by one of the following educational levels:

A. Master's level licensed clinician (including licensed substance abuse counselors)

B. Doctoral level licensed psychologist

C. Psychiatrist

Prior approval must be obtained for all visits exceeding 15 visits per patient per grant year.

MEDICINE - PSYCHIATRY

CPT Code	***Billable***	***Description***
90791 Doctoral Level (P)	$128.21	Psychiatric diagnostic evaluation (Psychologist, Ph.D.)
90791 Master's Level (M)	$121.40	Psychiatric diagnostic evaluation (Psychologist, Nurse Practitioner, LCSW)
90791 Psychiatrist (D)	$140.07	Psychiatric diagnostic evaluation (Physician, MD)
90792	$141.59	Psychiatric diagnostic evaluation with medical services
90832 ALL LEVELS	$62.40	Psychotherapy, 30 minutes with patient
90833 ALL LEVELS	$64.20	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service

MEDICINE – PSYCHIATRY cont.		
CPT Code	***Billable***	***Description***
90834 ALL LEVELS	$82.94	Psychotherapy, 45 minutes with patient
90836 ALL LEVELS	$81.48	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837	$124.35	Psychotherapy, 60 minutes with patient
90853 Doctoral Level	$25.05	Group psychotherapy (other than of a multiple-family group)
90853 Master's Level	$23.80	Group psychotherapy (other than of a multiple-family group)
90853 Psychiatrist	$27.37	Group psychotherapy (other than of a multiple-family group)
90863 Psychiatrist only	$39.70	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (replaced 90862)

MEDICINE – CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS		
CPT Code	***Billable***	***Description***
96101 All Levels	$78.25	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these results and preparing the report
96102	$59.02	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS) with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	$26.74	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI) administered by a computer, with qualified health care professional interpretation and report

MEDICINE – CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS cont.		
CPT Code	***Billable***	***Description***
96116	$89.75	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

OPHTHALMIC SERVICES

Ryan White Services will cover the following codes, but the client must be referred to an ophthalmologist by their primary care or infectious disease physician. (All ophthalmology claims must have referral documentation attached in order to receive payment. Long term ophthalmology patients should only be referred for follow-up appointments when there is a medical condition that warrants such examination.)

MEDICINE - OPTHALMOLOGY		
CPT Code	***Billable***	***Description***
92002	$75.85	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	$139.55	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	$80.04	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	$116.35	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92134	$42.42	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92235	$102.43	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92250	$72.12	Fundus photography with interpretation and report

MEDICINE – OPTHALMOLOGY cont.		
CPT Code	***Billable***	***Description***
92081	$35.71	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

PHYSICIAN COMPONENT MODIFIER		
CPT Code	***Billable***	***Description***
G0202	$33.87	With physician component modifier 26
0346T	$28.30	With physician component modifier 26
10060	$16.22	With physician component modifier 26
17000	$24.60	With physician component modifier 26
17110	$16.40	With physician component modifier 26
43235	$225.00	With physician component modifier 26
45378	$285.80	With physician component modifier 26
45380	$250.00	With physician component modifier 26
45382	$225.00	With physician component modifier 26
45385	$550.00	With physician component modifier 26
46600	$14.79	With physician component modifier 26
46601	$91.05	With physician component modifier 26
46606	$15.00	With physician component modifier 26
46607	$122.26	With physician component modifier 26
46900	$14.40	With physician component modifier 26
46924	$80.53	With physician component modifier 26
54056	$33.28	With physician component modifier 26
54065	$207.50	With physician component modifier 26

PHYSICIAN COMPONENT MODIFIER cont.		
CPT Code	***Billable***	***Description***
56501	$46.43	With physician component modifier 26
56515	$275.00	With physician component modifier 26
70450	$41.37	With physician component modifier 26
70470	$61.94	With physician component modifier 26
70551	$72.22	With physician component modifier 26
70553	$111.83	With physician component modifier 26
71010	$8.89	With physician component modifier 26
71020	$10.64	With physician component modifier 26
71030	$15.34	With physician component modifier 26
71250	$49.90	With physician component modifier 26
71260	$60.86	With physician component modifier 26
71270	$67.35	With physician component modifier 26
72192	$53.05	With physician component modifier 26
72193	$56.71	With physician component modifier 26
72194	$59.18	With physician component modifier 26
74150	$58.11	With physician component modifier 26
74160	$61.94	With physician component modifier 26
74170	$68.93	With physician component modifier 26
76700	$39.42	With physician component modifier 26
76770	$35.95	With physician component modifier 26
77065	$34.20	With physician component modifier 26
78598	$40.53	With physician component modifier 26
82105	$37.25	With physician component modifier 26

PHYSICIAN COMPONENT MODIFIER cont.		
CPT Code	***Billable***	***Description***
82652	$67.03	With physician component modifier 26
84165	$17.95	With physician component modifier 26
87210	$13.74	With physician component modifier 26
88160	$26.15	With physician component modifier 26
88161	$25.18	With physician component modifier 26
88305	$38.19	With physician component modifier 26
90651	$12.00	With physician component modifier 26
93307	$44.14	With physician component modifier 26
94726	$12.08	With physician component modifier 26

DENTAL DIAGNOSTICS		
CPT Code	***Billable***	***Description***
D0120	$24.16	Periodic oral evaluation – established patient
D0140	$24.16	Limited oral evaluation – problem focused
D0145	$24.16	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	$28.96	Comprehensive oral evaluation – new or established patient
D0160	$41.51	Detailed and extensive oral evaluation –problem focused, by report
D0170	$24.16	Re-evaluation – limited, problem focused (established patient; not post-operative visit)
D0171	$24.16	Re-evaluation – post operative office visit
D0210	$61.78	Intraoral – Complete series of radiographic images
D0220	$12.55	Intraoral – Periapical first radiographic image
D0230	$9.65	Intraoral – Periapical each additional radiographic image
D0240	$12.55	Intraoral – Occlusal radiographic image

DIAGNOSTICS cont.		
CPT Code	***Billable***	***Description***
D0250	$14.48	Extra-oral 2D projection radiographic image created using a stationary radiation source and detector
D0251	$14.48	Extra-oral posterior dental radiographic image
D0270	$11.58	Bitewing – single radiographic image
D0272	$18.34	Bitewing – two radiographic images
D0273	$23.17	Bitewings – three radiographic images
D0274	$28.00	Bitewings – four radiographic images
D0277	$38.61	Vertical Bitewings – 7 to 8 radiographic images
D0310	$28.96	Sialography
D0330	$49.23	Panoramic radiographic image
D0460	$28.96	Pulp vitality tests
D0470	$53.09	Diagnostic casts

PREVENTIVE SERVICES		
CPT Code	***Billable***	***Description***
D1110	$43.44	Prophylaxis – adult
D1120	$33.79	Prophylaxis – child
D1206	$20.30	Topical application of fluoride varnish
D1208	$20.30	Topical application of fluoride – excluding varnish
D1351	$29.01	Sealant – per tooth
D1352	$29.01	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1353	$29.01	Sealant repair – per tooth
D1354	$29.01	Interim caries arresting medicament application
D1510	$159.27	Space maintainer – fixed – unilateral

PREVENTIVE SERVICES cont.		
CPT Code	***Billable***	***Description***
D1515	$230.70	Space maintainer – fixed – bilateral
D1520	$159.27	Space maintainer – removable – unilateral
D1525	$230.70	Space maintainer – removable – bilateral
D1550	$36.68	Re-cement or re-bond space maintainer
D1555	$46.33	Removal of fixed space maintainer

RESTORATIVE SERVICES		
CPT Code	***Billable***	***Description***
D2140	$62.82	Amalgam – one surface, primary or permanent
D2150	$75.37	Amalgam – two surfaces, primary or permanent
D2160	$85.98	Amalgam – three surfaces, primary or permanent
D2161	$91.77	Amalgam – four or more surfaces, primary or permanent
D2330	$62.82	Resin-based composite – one surface, anterior
D2331	$75.37	Resin-based composite – two surfaces, anterior
D2332	$85.98	Resin-based composite – three surfaces, anterior
D2335	$91.77	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390	$162.16	Resin-based composite crown, anterior
D2391	$62.82	Resin-based composite – one surface, posterior
D2392	$75.37	Resin-based composite – two surfaces, posterior
D2393	$85.98	Resin-based composite – three surfaces, posterior
D2394	$91.77	Resin-based composite – four or more surfaces, posterior
D2710	$157.34	Crown –resin-based composite (indirect)
D2712	$157.34	Crown – ¾ resin-based composite (indirect)

RESTORATIVE SERVICES cont.		
CPT Code	***Billable***	***Description***
D2740	$532.82	Crown – porcelain/ceramic substrate
D2750	$532.82	Crown – porcelain fused to high noble metal
D2751	$532.82	Crown – porcelain fused to predominantly based metal
D2752	$532.82	Crown – porcelain fused to noble metal
D2780	$532.82	Crown – ¾ cast high noble metal
D2781	$532.82	Crown – ¾ cast predominantly based metal
D2782	$532.82	Crown – ¾ cast noble metal
D2783	$532.82	Crown – ¾ porcelain/ceramic
D2790	$532.82	Crown – full cast high noble metal
D2791	$532.82	Crown – full cast predominantly based metal
D2792	$532.82	Crown – full cast noble metal
D2794	$532.82	Crown – titanium
D2910	$43.44.	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2915	$43.44	Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920	$43.44	Re-cement or re-bond crown
D2929	$113.90	Prefabricated porcelain/ceramic crown – primary tooth
D2930	$113.90	Prefabricated stainless steel crown – primary tooth
D2931	$142.86	Prefabricated stainless steel crown – permanent tooth
D2932	$150.58	Prefabricated resin crown
D2933	$158.30	Prefabricated stainless steel crown with resin window
D2934	$120.66	Prefabricated esthetic coated stainless steel crown – primary tooth
D2940	$48.26	Protective restoration
D2950	$125.48	Core buildup, including any pins when required

RESTORATIVE SERVICES cont.		
CPT Code	***Billable***	***Description***
D2951	$34.75	Pin retention – per tooth in addition to restoration
D2952	$164.09	Post and core in addition to crown, indirectly fabricated
D2954	$164.09	Prefabricated post and core in addition to crown
D2955	$82.05	Post removal
D2957	$86.87	Each additional prefabricated post – same tooth
D2975	$164.08	Coping
D2980	$43.44	Crown repair necessitated by restorative material failure
D2981	$43.44	Inlay repair necessitated by restorative material failure
D2982	$43.44	Onlay repair necessitated by restorative material failure
D2983	$43.44	Veneer repair necessitated by restorative material failure

ENDODONTIC SERVICES		
CPT Code	***Billable***	***Description***
D3220	$82.05	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament
D3230	$84.94	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
D3240	$84.94	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D3310	$342.67	Endodontic therapy, anterior tooth (excluding final restoration)
D3320	$410.24	Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330	$500.97	Endodontic therapy, molar (excluding final restoration)
D3331	$126.45	Treatment of root canal obstruction; non-surgical access
D3346	$434.36	Retreatment of previous root canal therapy – anterior
D3347	$474.90	Retreatment of previous root canal therapy – bicuspid
D3348	$565.64	Retreatment of previous root canal therapy – molar

ENDODONTIC SERVICES cont.		
CPT Code	***Billable***	***Description***
D3421	$350.39	Apicoectomy– bicuspid (first root)
D3425	$379.35	Apicoectomy –molar (first root)
D3426	$178.58	Apicoectomy (each additional root)
D3427	$256.76	Periradicular surgery without apicoectomy
D3430	$131.27	Retrograde filling – per root
D3450	$274.00	Root Amputation – per root
D3470	$313.71	Intentional re-implantation (including necessary splinting)
D3920	$187.26	Hemisection (including any root removal), not including root canal therapy

PERIODONTIC SERVICES		
CPT Code	***Billable***	***Description***
D4210	$318.53	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	$96.56	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4240	$319.50	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	$80.12	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant
D4245	$137.07	Apically positioned flap
D4249	$120.66	Clinical crown lengthening – hard tissue
D4260	$504.83	Osseous surgery (including evaluation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	$126.45	Osseous surgery (including evaluation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D4274	$76.26	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)

PERIODONTIC SERVICES cont.		
CPT Code	***Billable***	***Description***
D4275	$506.76	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft
D4276	$506.76	Combined connective tissue and double pedicle graft, per tooth
D4277	$506.76	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278	$506.76	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283	$506.76	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	$506.76	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4320	$260.62	Provisional splinting – intracoronal
D4321	$147.69	Provisional splinting – extracoronal
D4341	$130.31	Periodontal scaling and root planning – four or more teeth per quadrant
D4342	$32.82	Periodontal scaling and root planning – one to three teeth per quadrant
D4355	$91.70	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	$76.26	Periodontal maintenance

REMOVABLE PROSTHODONTICS		
CPT Code	***Billable***	***Description***
D5110	$698.84	Complete denture – maxillary
D5120	$698.84	Complete denture – mandibular
D5130	$723.94	Immediate denture – maxillary
D5140	$724.91	Immediate denture – mandibular
D5211	$529.93	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)

REMOVABLE PROSTHODONTICS cont.		
CPT Code	***Billable***	***Description***
D5212	$534.75	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth
D5213	$772.20	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	$772.20	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5221	$529.93	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222	$534.75	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5223	$772.20	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224	$772.20	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5225	$529.93	Maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5226	$534.75	Mandibular partial denture – flexible base (including clasps, rests and teeth)
D5281	$463.32	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)
D5410	$40.54	Adjust complete denture – maxillary
D5411	$43.44	Adjust complete denture – mandibular
D5421	$43.44	Adjust partial denture - maxillary
D5422	$42.47	Adjust partial denture – mandibular
D5510	$96.53	Repair broken complete denture base
D5520	$82.05	Replace missing or broken teeth – complete denture (each tooth)
D5610	$91.70	Repair resin denture base
D5620	$144.79	Repair cast framework
D5630	$120.66	Repair or replace broken clasp – per tooth

REMOVABLE PROSTHODONTICS cont.		
CPT Code	***Billable***	***Description***
D5640	$82.05	Replace broken teeth – per tooth
D5650	$101.36	Add tooth to existing partial denture
D5660	$120.66	Add clasp to existing partial denture – per tooth
D5670	$164.09	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	$164.09	Replace all teeth and acrylic on cast metal framework (mandibular)
D5710	$265.45	Rebase complete maxillary denture
D5711	$254.83	Rebase complete mandibular denture
D5720	$249.03	Rebase maxillary partial denture
D5721	$247.10	Rebase mandibular partial denture
D5730	$168.92	Reline complete maxillary denture (chairside)
D5731	$168.92	Reline complete mandibular denture (chairside)
D5740	$142.86	Reline maxillary partial denture (chairside)
D5741	$142.86	Reline mandibular partial denture (chairside)
D5750	$220.08	Reline complete maxillary denture (laboratory)
D5751	$212.36	Reline complete mandibular denture (laboratory)
D5760	$205.60	Reline maxillary partial denture (laboratory)
D5761	$205.60	Reline mandibular partial denture (laboratory)
D5810	$384.17	Interim complete denture (maxillary)
D5811	$413.13	Interim complete denture (mandibular)
D5820	$297.30	Interim partial denture (maxillary)
D5821	$314.67	Interim partial denture (mandibular)
D5850	$72.40	Tissue conditioning, maxillary
D5851	$76.26	Tissue conditioning, mandibular

REMOVABLE PROSTHODONTICS cont.		
CPT Code	***Billable***	***Description***
D5863	$698.84	Overdenture – complete maxillary
D5864	$534.75	Overdenture – partial maxillary
D5865	$698.84	Overdenture – complete mandibular
D5866	$534.75	Overdenture – partial mandibular
D5875	$43.44	Modification of removable prosthesis following implant surgery
D5992	$43.44	Adjust maxillofacial prosthetic appliance, by report
D5993	$43.44	Maintenance and cleaning of maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report
IMPLANT SERVICES		
CPT Code	***Billable***	***Description***
D6052	$120.66	Semi-precision attachment abutment
D6058	$667.95	Abutment supported porcelain/ceramic crown
D6059	$665.06	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	$580.12	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	$627.41	Abutment supported porcelain fused to metal crown (noble metal)
D6062	$638.04	Abutment supported cast metal crown (high noble metal)
D6063	$580.12	Abutment supported cast metal crown (predominantly base metal)
D6064	$615.83	Abutment supported cast metal crown (noble metal)
D6068	$652.51	Abutment supported retainer for porcelain/ceramic FPD
D6069	$648.65	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	$605.22	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	$627.41	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	$647.69	Abutment supported retainer for cast metal FPD (high noble metal)

IMPLANT SERVICES cont.		
CPT Code	***Billable***	***Description***
D6073	$613.90	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	$618.73	Abutment supported retainer for cast metal FPD (noble metal)
D6091	$287.64	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	$48.26	Re-cement or re-bond implant/abutment supported crown
D6093	$71.43	Re-cement or re-bond implant/abutment supported fixed partial denture
D6101	$91.70	De-bridgement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102	$126.45	Debridgement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure
D6103	$210.42	Bone graft for repair of peri-implant defect – does not include flap entry and closure
D6104	$210.42	Bone graft at time of implant placement
D6194	$615.83	Abutment supported retainer crown for FPD (titanium)

PROSTHODONTICS, FIXED		
CPT Code	***Billable***	***Description***
D6205	$157.34	Pontic – indirect resin based composite (not to be used as a temporary or provisional prosthesis)
D6210	$532.82	Pontic – cast high noble metal
D6211	$532.82	Pontic – cast predominantly base metal
D6212	$532.82	Pontic – cast noble metal
D6214	$532.82	Pontic – titanium
D6240	$532.82	Pontic – porcelain fused to high noble metal
D6241	$532.82	Pontic – porcelain fused to predominantly based metal
D6242	$532.82	Pontic – porcelain fused to noble metal

PROSTHODONTICS, FIXED cont.		
CPT Code	***Billable***	***Description***
D6245	$532.82	Pontic – porcelain/ceramic
D6250	$532.82	Pontic – resin with high noble metal
D6251	$532.82	Pontic – resin with predominantly based metal
D6252	$532.82	Pontic – resin with noble metal
D6545	$262.55	Retainer – cast metal for resin bonded fixed prosthesis
D6548	$262.55	Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549	$262.55	Resin retainer – for resin bonded fixed prosthesis
D6710	$458.50	Retainer Crown – indirect resin based composite
D6720	$532.82	Retainer Crown – resin with high noble metal
D6721	$532.82	Retainer Crown – resin with predominantly base metal
D6722	$532.82	Retainer Crown – resin with noble metal
D6740	$532.82	Retainer Crown – porcelain /ceramic
D6750	$532.82	Retainer Crown – porcelain fused to high noble metal
D6751	$532.82	Retainer Crown – porcelain fused to predominantly base metal
D6752	$532.82	Retainer Crown – porcelain fused to noble metal
D6780	$532.82	Retainer Crown – ¾ cast high noble metal
D6781	$532.82	Retainer Crown – ¾ cast predominantly base metal
D6782	$532.82	Retainer Crown – ¾ cast noble metal
D6783	$532.82	Retainer Crown – ¾ porcelain/ceramic
D6790	$532.82	Retainer Crown – full cast high noble metal
D6791	$532.82	Retainer Crown – full cast predominantly base metal
D6792	$532.82	Retainer Crown – full cast noble metal
D6794	$532.82	Retainer Crown – titanium

PROSTHODONTICS, FIXED cont.		
CPT Code	***Billable***	***Description***
D6920	$109.08	Connector bar
D6930	$71.13	Re-cement or re-bond fixed partial denture
D6940	$143.83	Stress breaker
D6980	$72.40	Fixed partial denture repair necessitated by restorative material failure
D6985	$72.40	Pediatric partial denture, fixed

SURGICAL PROCEDURES		
CPT Code	***Billable***	***Description***
D7140	$65.64	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	$127.41	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated
D7220	$160.23	Removal of impacted tooth – soft tissue
D7230	$209.46	Removal of impacted tooth – partially bony
D7240	$242.28	Removal of impacted tooth – completely bony
D7241	$338.81	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	$127.41	Removal of residual tooth roots (cutting procedure)
D7251	$338.81	Coronectomy – intentional partial tooth removal
D7260	$851.35	Oroantral fistula closure
D7270	$268.34	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
D7272	$427.61	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)
D7280	$196.91	Exposure of an unerupted tooth
D7283	$35.72	Placement of device to facilitate eruption of impacted tooth
D7285	$147.49	Incisional biopsy of oral tissue - hard (bone, tooth)
D7286	$138.04	Incisional biopsy of oral tissue – soft

SURGICAL PROCEDURES cont.		
CPT Code	***Billable***	***Description***
D7287	$32.82	Exfoliative cytological sample collection
D7290	$271.24	Surgical repositioning of teeth
D7291	$32.82	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310	$128.38	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7311	$64.68	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320	$175.68	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7321	$87.84	Alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant
D7340	$410.24	Vestibuloplasty – ridge extension (secondary epithelialization)
D7350	$506.76	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410	$169.88	Excision of benign lesion up to 1.25 cm
D7413	$381.28	Excision of malignant lesion up to1.25 cm
D7440	$381.28	Excision of malignant tumor – lesion diameter up 1.25 cm
D7450	$256.76	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7460	$201.74	Removal of benign non-odontogenic cyst or tumor –lesion diameter up to 1.25 cm
D7471	$148.65	Removal of lateral exostosis (maxilla or mandible)
D7472	$148.65	Removal of torus palatinus
D7473	$148.65	Removal of torus mandibularis
D7485	$148.65	Surgical reduction of osseous tuberosity
D7510	$116.80	Incision and drainage of abscess – intraoral soft tissue
D7511	$116.80	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

SURGICAL PROCEDURES cont.		
CPT Code	***Billable***	***Description***
D7530	$111.97	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7540	$296.34	Removal of reaction producing foreign bodies, musculoskeletal system
D7880	$398.65	Occlusal orthotic device, by report
D7881	$40.54	Occlusal orthotic device adjustment
D7960	$200.77	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure
D7963	$200.77	Frenuloplasty
D7970	$106.18	Excision of hyperplastic tissue – per arch
D7971	$111.97	Excision of pericoronal gingiva
D7972	$72.40	Surgical reduction of fibrous tuberosity
D7997	$181.47	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D8030	$1133.20	Limited orthodontic treatment of the adolescent dentition
D8080	$1254.83	Comprehensive orthodontic treatment of the adolescent dentition
D8210	$394.79	Removable appliance therapy
D8692	$208.49	Replacement of lost or broken retainer
D8693	$71.43	Re-cement or re-bond fixed retainer

PALLIATIVE SERVICES		
CPT Code	***Billable***	***Description***
D9110	$48.26	Palliative (emergency) treatment of dental pain – minor procedure
D9120	$62.75	Fixed partial denture sectioning
D9219	$60.82	Evaluation for deep sedation or general anesthesia

ADJUNCTIVE GENERAL SERVICES		
ANESTHESIA		
CPT Code	***Billable***	***Description***
D9223	$91.46	Deep sedation/general anesthesia – each 15 minute increment
D9230	$28.96	Inhalation of nitrous oxide/analgesia, anxiolysis
D9243	$81.81	Intravenous moderate (conscious) sedation/analgesia – each15 minute increment
D9248	$85.91	Non-intravenous conscious sedation
DRUGS		
CPT Code	***Billable***	***Description***
D9612	$50.19	Therapeutic parenteral drugs, two or more administrations, different medications
D9630	$26.07	Drugs or medicants dispensed in the office for home use
MISCELLANEOUS SERVICES		
CPT Code	***Billable***	***Description***
D9910	$21.24	Application of desensitizing medicament
D9911	$39.58	Application of desensitizing resin for cervical and/or root surface, per tooth
D9930	$46.33	Treatment of complications (post-surgical) – unusual circumstances, by report
D9940	$265.45	Occlusal guard, by report
D9941	$83.98	Fabrication of athletic mouthguard
D9943	$40.54	Occlusal guard adjustment
D9951	$77.22	Occlusal adjustment - limited
D9971	$59.85	Odontoplasty 1-2 teeth; includes removal of enamel projections