SECTION 4
PROCEDURE CODES

TABLE OF CONTENTS

SECTION 4
PROCEDURE CODES

TABLE OF CONTENTS

SECTION 4
PROCEDURE CODES

TABLE OF CONTENTS

SECTION 4
PROCEDURE CODES

TABLE OF CONTENTS

SECTION 4 PROCEDURE CODES

GENERAL INFORMATION

MEDICAL JUSTIFICATION AND DOCUMENTATION

This section contains dental procedure codes that are covered by the South Carolina Medicaid Dental Program for Medicaid beneficiaries under age 21 and Mentally Retarded/Related Disabilities (MR/RD) Waiver beneficiaries that are justified as medically necessary. "Medical necessity" means the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. **For Medicaid beneficiaries age 21 and over, services are limited to emergency procedures. See Section 2 for services for adults 21 and over.**

The dental provider's treatment record on each beneficiary must substantiate the need for services, including all findings and information supporting medical necessity and detailing all treatment provided. As a condition of participation in the Medicaid dental program, dental providers are required to maintain and provide access to records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients. SCDHHS requires that documentation (including appropriate pre- and post-treatment radiographs, copies of laboratory prescription slips, and laboratory tests [*i.e.*, pathology reports]) be included in the beneficiary's treatment record. A Release of Information form signed by the child's parent or guardian authorizing the release of any medical information is necessary to process Medicaid claims. This is required for requesting payment of government benefits on behalf of the child. This may be incorporated into a Consent for Treatment form.

Medicaid providers are generally required to maintain on-site all medical and fiscal records pertaining to Medicaid beneficiaries for a period of three years. Other Medicaid provider agreements and/or contracts may require differing periods of time for record retention. These requirements pertain to retention of records for Medicaid purposes only; other state and federal rules may require longer retention periods.

SECTION 4 PROCEDURE CODES

Adoption of New Codes

The American Dental Association (ADA) issues an updated Current Dental Terminology (CDT) codebook effective biannually, at the start of odd-numbered years. This codebook indicates changes to the code of dental procedures and nomenclature. SCDHHS will adopt the code changes, but may not update to the latest claim form. Contact the Medicaid dental program area for information on which version of the claim form is acceptable. A Medicaid Bulletin indicating code and/or claim form changes will be sent to dental providers prior to the effective date. Claims that are billed with codes that are invalid for the date of service will reject with an appropriate edit code.

Effective in January of each year, the American Medical Association issues an updated codebook containing the Current Procedural Terminology (CPT) codes. Oral and maxillofacial surgeons who file claims with codes that are invalid for the date of service will receive a rejection with an appropriate edit code.

PROCEDURE CODE TABLE

The following covered services have been set up utilizing a table format. This table is divided into four columns. An explanation of each column is listed below:

- **Column one** (Code) lists the Current Dental Terminology (CDT) procedure code and billing instructions specific to SCDHHS, if any. *If a single asterisk (*) appears in the CODE column for the next procedure code, use the same billing instructions as the previous procedure code.* In the Emergency Oral and Maxillofacial Surgery Services section, the Current Procedural Terminology (CPT) procedure code is listed. *A double asterisk (**) listed in column one in this section indicates that reimbursement is allowed for an assistant surgeon. A triple asterisk (***) indicates that both a tooth and surface code must be used for this procedure.*
- **Column two** (Description) lists the nomenclature and descriptor of the CDT procedure code in bold print; SCDHHS frequency limitation(s) is in italics. In the Emergency Oral and Maxillofacial Surgery Services section, the CPT procedure code is listed in bold print and the SCDHHS frequency limitation(s) is in italics.

SECTION 4 PROCEDURE CODES

PROCEDURE CODE TABLE (CONT'D.)

- **Column three** (Fee) lists the reimbursement amount paid to the provider for this procedure code. ***Although this is the SCDHHS reimbursement, you must bill your usual and customary rate (UCR).*** Procedure code D9999 has manual pricing in this column. Manually priced procedures are resolved by a dental program coordinator, dental program supervisor, and dental consultant. Amounts may vary from case to case.
- **Column four** (Group) lists the age groups covered by the procedure code. Some procedure codes may cover more than one group. Children Only (C.O.) refers to children from birth through the month of their 21st birthday. Adult Services (A.S.) refers to beneficiaries 21 and over who are limited to emergency dental services only. Refer to Section 2 for a detailed explanation of dental coverage for adult beneficiaries. Mentally Retarded/Related Disabilities (MR/RD) refers to beneficiaries who have qualified for the MR/RD Waiver program. Participation in this waiver will be announced on the IVRS or you may see it specified on the printout from your point of sale device in the "special programs" section. These beneficiaries can receive the same dental services as the group classified as C.O. Eligibility can vary from month to month. See Section 2 for information on eligibility.

CLAIM FORMS/ PROCEDURE CODES REQUIRED FOR DENTAL REIMBURSEMENT

SCDHHS will reimburse licensed general dentists enrolled in the South Carolina Medicaid Program for the CDT procedure codes listed in this section. CDT procedure codes must be filed on the ADA claim form. Contact the Medicaid dental program area for information on which version of the claim form is acceptable. Filing procedures on the wrong claim form can result in a rejected claim.

SCDHHS will reimburse licensed oral and maxillofacial surgeons enrolled in the South Carolina Medicaid Program for both the CDT and CPT procedure codes listed in this section. Oral and maxillofacial surgeons must file, due to HIPAA regulations, the CDT procedure codes on the ADA claim form and the CPT procedure codes on the CMS-1500 claim form. Filing procedures on the wrong claim form can result in a rejected claim.

SECTION 4 PROCEDURE CODES

PROCEDURE CODES NOT LISTED

Procedure codes not listed in this section, but considered medically necessary as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination or any covered service that extends beyond the normal limitations of the procedure as described in the provider manual, may be considered. You must submit either the original EPSDT screening results or medical documentation and justification on the DHHS 214 Prior Authorization Form. See the Forms section of this manual for a blank DHHS 214 Prior Authorization Form with instructions. See Section 2 for information on prior authorization and billing.

SECTION 4 PROCEDURE CODES

PROCEDURE CODES

PROCEDURAL KEY

C.O.	**(Children Only) Indicates that these services are covered for Medicaid beneficiaries from birth through the month of their 21st birthday.**	**Remember: Always bill your UCR.**	
A.S.	**(Adult Services) For beneficiaries 21 and over. Limited to emergency dental services only. Refer to Section 2 for a detailed explanation of dental coverage for adult beneficiaries.**		
MR/RD	**Mentally Retarded/Related Disabilities Waiver client of any age.**		
*****	**Tooth number required.**		
******	**Assistant surgeon allowed.**		
*******	**Tooth number and surface codes required.**		

DIAGNOSTIC

Clinical Oral Evaluations

Code	Description	Fee	Group
D0120	**Periodic Oral Evaluation – Established Patient: An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.** *SCDHHS reimburses for this code once every six months.*	$22.00	C.O. MR/RD
D0140	**Limited Oral Evaluation – Problem Focused: An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.** **Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.** *SCDHHS limits this procedure to twice within a 365-day period.*	$37.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Clinical Oral Evaluations (Cont'd.)

Code	Description	Fee	Group
D0150	**Comprehensive Oral Evaluation – New or Established Patient: Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report; or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.** **This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.**	$30.00	C.O. MR/RD

RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)

Film(s) must be of diagnostic quality and labeled with the beneficiary's name and date taken. Film(s) must be a part of the patient's treatment record. Periapical x-rays will not be reimbursed in lieu of additional bitewings. Periapical and occlusal radiographs must be medically necessary and may not be billed for routine recalls.

Code	Description	Fee	Group
D0220*	**Intraoral — Periapical first film**. *SCDHHS requires clinical diagnosis and medical justification for this film. SCDHHS will reimburse this procedure at one per date of service. Actual tooth number required.*	$13.00	A.S. C.O. MR/RD
D0230 *	**Intraoral — Periapical each additional film.** *SCDHHS will reimburse this procedure at 3 films per date of service. SCDHHS requires clinical diagnosis and medical justification for these films. Actual tooth number required.*	$10.00	A.S. C.O. MR/RD
D0240 *	**Intraoral — Occlusal film**. *SCDHHS will reimburse this procedure at 2 films per date of service. SCDHHS will not reimburse when this film is billed in combination with a panoramic radiograph (D0330). SCDHHS requires clinical diagnosis and medical justification for these films. Actual tooth number required.*	$13.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION) (CONT'D.)

Code	Description	Fee	Group
D0270	**Bitewing — Single film.** *SCDHHS will reimburse this code once every six months. SCDHHS will not reimburse when this code is billed in combination with two bitewing films (D0272). If four bitewings are taken on the same date of service, additional bitewings cannot be substituted under the periapical film codes or any other film codes.*	$13.00	A.S. C.O. MR/RD
D0272	**Bitewings — Two films**. *SCDHHS will reimburse for this code once every six months. SCDHHS will not reimburse for this procedure if it is billed in combination with a single bitewing (D0270). If four bitewings are taken on the same date of service, additional bitewings cannot be substituted under the periapical film codes or any other film codes.*	$21.00	A.S. C.O. MR/RD
D0330	**Panoramic Film.** *SCDHHS will reimburse for this code once every three years. SCDHHS will not reimburse for this procedure if it is billed in combination with an intraoral occlusal(D0240). An additional panoramic film may be allowed when medically justified. Contact the dental program area.*	$55.00	A.S. C.O. MR/RD

PREVENTATIVE

Dental Prophylaxis

Code	Description	Fee	Group
D1110	**Prophylaxis — adult: Removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.** *SCDHHS reimburses for this code once every six months for beneficiaries ages 12 through 21; it includes scaling and polishing to remove coronal plaque, calculus, and stains.*	$35.00	C.O. MR/RD
D1120	**Prophylaxis — child: Removal of plaque, calculus, and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors.** *SCDHHS reimburses for this code once every six months for beneficiaries under age 12; it includes scaling and polishing to remove coronal plaque, calculus, and stains.*	$31.00	C.O.

SECTION 4 PROCEDURE CODES

Topical Fluoride Treatment (Office Procedure)

Code	Description	Fee	Group
D1203	**Topical Application of Fluoride (prophylaxis not included) — child. Used when reporting prophylaxis and fluoride separately.** *SCDHHS reimburses for this procedure once every six months for beneficiaries under age 12. SCDHHS does not reimburse for this procedure when billed on the same date of service with procedure code D1206.*	$17.00	C.O.
D1204	**Topical Application of Fluoride (prophylaxis not included) — adult. Used when reporting prophylaxis and fluoride procedures separately.** *SCDHHS reimburses for this procedure once every six months for beneficiaries ages 12 through 21. SCDHHS does not reimburse for this procedure when billed on the same date of service with procedure code D1206.*	$17.00	C.O. MR/RD
D1206	**Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.** *SCDHHS does not reimburse for this procedure when billed on the same date of service with procedure code* D1203 or D1204.	$17.00	C.O. MR/RD

Other Preventive Services

Code	Description	Fee	Group
D1351 *	**Sealant — per tooth: Mechanically and/or chemically prepared enamel surface sealed to prevent decay.** *SCDHHS will reimburse for this procedure for children through the month of their 15th birthday, once every three years, on first and second permanent molars only. (2, 3, 14, 15, 18, 19, 30, 31). SCDHHS will not reimburse for sealants placed over previously restored (first and second molar) teeth.*	$27.00	C.O.

SECTION 4 PROCEDURE CODES

Space Maintenance (Passive Appliances)

Passive appliances are designed to prevent tooth movement. *SCDHHS will reimburse for these services for beneficiaries up through the month of their 14th birthday. Appliances must be seated prior to submitting a claim for reimbursement.*

Code	Description	Fee	Group
D1510 *	**Space Maintainer — Fixed — Unilateral:** *SCDHHS reimburses this code once a lifetime, per quadrant and when performed to maintain a space for the eruption of a permanent tooth. The reimbursement includes follow-up care and/or re-cementing, if necessary. To bill a quadrant code, you must put UR, UL, LL, or LR in the "tooth number" column on the claim form. If you put them in the "surface column", your claim will reject. SCDHHS will not reimburse if this code is billed on the same date of service, in the same arch, with a fixed bilateral space maintainer (D1515).*	$174.00	C.O.
D1515 *	**Space Maintainer — Fixed — Bilateral:** *SCDHHS will reimburse this code once a lifetime, per arch and when performed to maintain a space for the eruption of a permanent tooth. The reimbursement includes follow-up care and/or re-cementing, if necessary. SCDHHS will not reimburse if this code is billed on the same date of service, in the same arch, with a fixed unilateral space maintainer (D1510).*	$230.00	C.O.

RESTORATIVE

SCDHHS will reimburse these services for ***beneficiaries under age 21 and MR/RD Waiver beneficiaries.*** *Documentation must include tooth number, surfaces, and material used. Restorations are to be used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not to be used as a preventive procedure. SCDHHS's reimbursement includes local anesthesia, bases, occlusal adjustment, and polishing. Restoration services include tooth surface(s) M–mesial, D–distal, O–occlusal/incisal, B–buccal/facial, or L–lingual, and* ***must*** *be indicated in the appropriate combinations. SCDHHS will not reimburse for duplicate restorations on a single surface. Surface "O" must be used for occlusal and incisal. Surface "B" must be used for buccal and facial.*

Multiple restorations on the same tooth on the same date of service will be combined by SCDHHS and reimbursed at a combined surface rate. The tooth numbers, letters, and surfaces must be the same as documented in the patient's medical record. SCDHHS will not reimburse separately for sealants that are placed over previously restored first and second permanent molar teeth. ***SCDHHS requires medical justification and documentation (including appropriate pre- and post-treatment radiographs) to be included in the beneficiary's treatment record.***

SECTION 4 PROCEDURE CODES

Amalgam Restorations (Including Polishing)

Code	Description	Fee	Group
D2140***	**Amalgam — One Surface, Primary or Permanent.**	$58.00	C.O. MR/RD
D2150***	**Amalgam — Two Surfaces, Primary or Permanent.**	$75.00	C.O. MR/RD
D2160***	**Amalgam — Three Surfaces, Primary or Permanent.**	$91.00	C.O. MR/RD
D2161***	**Amalgam — Four or More Surfaces, Primary or Permanent.**	$91.00	C.O. MR/RD

Resin-Based Composite Restorations — Direct

Code	Description	Fee	Group
D2330***	**Resin-Based Composite — One Surface, Anterior.**	$69.00	C.O. MR/RD
D2331***	**Resin-Based Composite — Two Surfaces, Anterior.**	$88.00	C.O. MR/RD
D2332***	**Resin-Based Composite — Three Surfaces, Anterior.**	$107.00	C.O. MR/RD
D2335***	**Resin-Based Composite — Four or More Surfaces or involving incisal angle, Anterior. Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth.**	$107.00	C.O. MR/RD
D2391***	**Resin-Based Composite — One Surface, Posterior. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.**	$58.00	C.O. MR/RD
D2392***	**Resin-Based Composite — Two Surfaces, Posterior.** *SCDHHS will reimburse for this procedure if it is used to restore a carious lesion into the dentin. Not a preventive procedure.*	$75.00	C.O. MR/RD
D2393***	**Resin-Based Composite — Three Surfaces, Posterior.** *SCDHHS will reimburse for this procedure if it is used to restore a carious lesion into the dentin. Not a preventive procedure.*	$91.00	C.O. MR/RD
D2394***	**Resin-Based Composite — Four or More Surfaces, Posterior.** *SCDHHS will reimburse for this procedure if it is used to restore a carious lesion into the dentin. Not a*	$91.00	C.O. MR/RD

SECTION 4 PROCEDURE CODES

Code	Description	Fee	Group
	preventive procedure.		

OTHER RESTORATIVE SERVICES

Re-cementing is inclusive and is considered follow-up care. SCDHHS does not reimburse for replacement crowns. ***SCDHHS requires medical justification and documentation and appropriate pre-treatment radiographs to be included in the beneficiary's treatment record.***

Code	Description	Fee	Group
D2930 *	**Prefabricated Stainless Steel Crown — Primary Tooth.** *SCDHHS will reimburse for six per date of service when performed in a dental office.*	$139.00	C.O. MR/RD
D2931 *	**Prefabricated Stainless Steel Crown — Permanent Tooth.** *SCDHHS will reimburse for six per date of service when performed in a dental office.*	$157.00	C.O. MR/RD
D2932 *	**Prefabricated Resin Crown —** *SCDHHS will reimburse this code on either permanent or primary teeth. SCDHHS will reimburse for six per date of service when performed in a dental office.*	$171.00	C.O. MR/RD
D2940 *	**Sedative Filling: Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.** *SCDHHS will not reimburse if this code is billed in combination with therapeutic pulpotomies (D3220) and final restorations (*i.e.*, amalgams, composites, or crowns). The pulp vitality test is inclusive with this code.*	$53.00	C.O. MR/RD
D2950 *	**Core Buildup, including any pins: Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form or concave irregularity in the preparation.** *SCDHHS reimburses for crown codes D2930, D2931 and D2932 only. SCDHHS does not reimburse for this procedure when billed on the same date of service with procedure code D2954.*	$133.00	C.O. MR/RD
D2951 *	**Pin Retention — Per Tooth, In Addition To Restoration.** *The pulp vitality test is inclusive with this code. Permanent teeth only.*	$28.00	C.O. MR/RD
D2954 *	**Prefabricated Post and Core in Addition to Crown: Core is built around a pre-fabricated post. This procedure includes the core material.** *SCDHHS reimburses for crown codes D2930, D2931 and D2932 only. SCDHHS does not reimburse for this procedure when billed on the same date of service with*	$168.00	C.O. MR/RD

SECTION 4 PROCEDURE CODES

Code	Description	Fee	Group
	procedure code D2950.		

ENDODONTICS

Pulpotomy

The pulp vitality test is inclusive with this code and can be performed on permanent and primary teeth.

Code	Description	Fee	Group
D3220 *	**Therapeutic Pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament. Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary and permanent teeth. This is not to be construed as the first stage of root canal therapy.** *SCDHHS will not reimburse for this code if billed in combination with the sedative filling (D2940). SCDHHS will reimburse for six per date of service.*	$87.00	C.O. MR/RD

Endodontic Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)

SCDHHS will reimburse these procedures on <u>permanent teeth only</u>. SCDHHS requires medical justification and documentation (including appropriate pre- and post-treatment radiographs, laboratory prescription slips and laboratory tests [i.e., pathology reports]) to be included in the beneficiary's treatment record.

Code	Description	Fee	Group
D3310 *	**Anterior (excluding final restoration).** *Only for tooth numbers: 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27. Once a lifetime.*	$367.00	C.O. MR/RD
D3320 *	**Bicuspid (excluding final restoration).** *Only for tooth numbers: 4, 5, 12, 13, 20, 21, 28, and 29. Once a lifetime.*	$448.00	C.O. MR/RD
D3330 *	**Molar (excluding final restoration).** *Only for teeth numbers: 2,3, 14,15, 18,19, 30,31, once a lifetime.*	$579.00	C.O. MR/RD

SECTION 4 PROCEDURE CODES

PROSTHODONTICS (REMOVABLE)

SCDHHS will reimburse once every three years for beneficiaries ages 14 – 21. Appliances must be seated prior to submitting a claim for reimbursement. These codes are used as replacement for permanent dentition and relining is inclusive. Prior authorization is required for patients under age 14. SCDHHS requires medical justification and documentation (including appropriate pre- and post-treatment radiographs, laboratory prescription slips, and laboratory tests [i.e., pathology reports]) to be included in the beneficiary's treatment record. Contact the program area for beneficiary eligibility for the procedure.

Complete Dentures (Including Routine Post-Delivery Care)

Code	Description	Fee	Group
D5110	**Complete Denture — Maxillary.**	$651.00	C.O. MR/RD
D5120	**Complete Denture — Mandibular.**	$651.00	C.O. MR/RD

Partial Dentures (Including Routine Post-Delivery Care)

SCDHHS does not reimburse for Removable Unilateral Partial Dentures (D5281).

Code	Description	Fee	Group
D5211	**Maxillary Partial Denture — Resin Base (including any conventional clasps, rests, and teeth). Includes acrylic resin base denture with resin or wrought wire clasps.**	$550.00	C.O. MR/RD
D5212	**Mandibular Partial Denture — Resin Base (including any conventional clasps, rests, and teeth). Includes acrylic resin base denture with resin or wrought wire clasps.**	$639.00	C.O. MR/RD

Repairs to Complete Dentures

Code	Description	Fee	Group
D5510	**Repair Broken Complete Denture Base.**	$71.00	C.O. MR/RD
D5520 *	**Replace Missing or Broken Teeth — Complete Denture (each tooth).**	$59.00	C.O. MR/RD

SECTION 4 PROCEDURE CODES

Repairs to Partial Dentures

Code	Description	Fee	Group
D5610	**Repair Resin Denture Base.**	$77.00	C.O. MR/RD
D5640 *	**Replace Broken Teeth — Per Tooth.**	$65.00	C.O. MR/RD

ORAL AND MAXILLOFACIAL SURGERY

*SCDHHS allows reimbursement for the following codes to include residual tissue, treatment of dry socket, and all other routine post-operative care. SCDHHS requires medical justification and documentation (including appropriate pre- and post-treatment radiographs, laboratory prescription slips, and laboratory tests [*i.e., *pathology reports]) to be included in the beneficiary's treatment record. SCDHHS will not reimburse for multiple extractions for adult beneficiaries 21 and over that are non-symptomatic at the time of the service. See Section 2 of this manual for further information on adults 21 and over. SCDHHS will not reimburse for multiple procedures performed on the same date of service on the same site (*i.e., *cyst removal and extraction procedures or surgical access to aid eruption and extraction codes).*

Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)

Code	Description	Fee	Group
D7111 *	**Extraction, Coronal Remnants — Deciduous Tooth. Removal of soft tissue-retained coronal remnants.**	$31.00	A.S. C.O. MR/RD
D7140 *	**Extraction — Erupted Tooth or Exposed Root (elevation and/or forceps removal). Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary**.	$62.00	A.S. C.O. MR/RD

Surgical Extractions (Includes Local Anesthesia, Suturing, if needed, and Routine Postoperative Care)

Code	Description	Fee	Group
D7210 *	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.**	$124.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Surgical Extractions (Includes Local Anesthesia, Suturing, if needed, and Routine Postoperative Care) (Cont'd.)

Code	Description	Fee	Group
D7220 *	**Removal of Impacted Tooth — Soft Tissue: Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.**	$155.00	A.S. C.O. MR/RD
D7230 *	**Removal of Impacted Tooth — Partially Bony: Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.**	$207.00	A.S. C.O. MR/RD
D7240 *	**Removal of Impacted Tooth — Completely Bony: Most of or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.**	$243.00	A.S. C.O. MR/RD
D7241 *	**Removal of Impacted Tooth — Completely Bony with Unusual Surgical Complications: Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, or aberrant tooth position.**	$306.00	A.S. C.O. MR/RD
D7250 *	**Surgical Removal of Residual Tooth Roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure.**	$131.00	A.S. C.O. MR/RD

Other Surgical Procedures

Code	Description	Fee	Group
D7270 *	**Tooth Reimplantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth: Includes splinting and/or stabilization.**	$267.00	C.O. MR/RD
D7280 *	**Surgical Access of An Unerupted Tooth – An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.** *SCDHHS will reimburse for this procedure only on permanent teeth and for two per date of service. SCDHHS will not reimburse for this procedure when billed in combination with extraction codes on the same tooth number and date of service.*	$248.00	C.O. MR/RD

SECTION 4 PROCEDURE CODES

Other Surgical Procedures (Cont'd.)

Code	Description	Fee	Group
D7285	**Biopsy of Oral Tissue — Hard (Bone, Tooth): For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/ periradicular surgery.** *SCDHHS will not reimburse for a biopsy procedure that is billed separately when it is in conjunction with another surgical procedure and is part of that procedure. Documentation in the patient's treatment record must include pathology report.*	$518.00	A.S. C.O. MR/RD
D7286	**Biopsy of Oral Tissue — Soft: For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage.** *SCDHHS will not reimburse for a biopsy procedure that is billed separately when it is in conjunction with another surgical procedure and is part of that procedure. SCDHHS requires that documentation in the patient's treatment record must include a pathology report.*	$212.00	A.S. C.O. MR/RD

SURGICAL EXCISION OF SOFT TISSUE LESIONS

*SCDHHS requires medical justification and documentation (including appropriate pre- and post-treatment radiographs, laboratory prescription slips, and laboratory tests [*i.e.*, pathology reports]) to be included in the beneficiary's treatment record.*

Code	Description	Fee	Group
D7410	**Excision of Benign Lesion Up To 1.25 cm.**	$461.00	A.S. C.O. MR/RD
D7411	**Excision of Benign Lesion Greater Than 1.25 cm.**	$788.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

SURGICAL EXCISION OF SOFT TISSUE LESIONS (CONT'D.)

Code	Description	Fee	Group
D7412	**Excision of Benign Lesion, Complicated. Requires extensive undermining with advancement or rotational flap closure.**	$788.00	A.S. C.O. MR/RD
D7413	**Excision of Malignant Lesion Up To 1.25 cm.**	$815.00	A.S. C.O. MR/RD
D7414	**Excision of Malignant Lesion Greater Than 1.25 cm.**	$1,266.00	A.S. C.O. MR/RD
D7415	**Excision of Malignant Lesion, Complicated. Requires extensive undermining with advancement or rotational flap closure.**	$1,266.00	A.S. C.O. MR/RD
D7465	**Destruction of lesion(s) by physical or chemical method, by report. Examples include using cryo, laser, or electro surgery.**	$263.00	A.S. C.O. MR/RD

Surgical Excision of Intra-Osseous Lesions

Code	Description	Fee	Group
D7440	**Excision of Malignant Tumor — Lesion Diameter up to 1.25 cm.**	$815.00	A.S. C.O. MR/RD
D7441	**Excision of Malignant Tumor — Lesion Diameter greater than 1.25 cm.**	$1,266.00	A.S. C.O. MR/RD
D7450	**Removal of Benign Odontogenic Cyst or Tumor — Lesion diameter up to 1.25 cm.**	$461.00	A.S. C.O. MR/RD
D7451	**Removal of Benign Odontogenic Cyst or Tumor — Lesion diameter greater than 1.25 cm.**	$725.00	A.S. C.O. MR/RD
D7460	**Removal of Benign Nonodontogenic Cyst or Tumor — Lesion diameter up to 1.25 cm.**	$461.00	A.S. C.O. MR/RD
D7461	**Removal of Benign Nonodontogenic Cyst or Tumor — Lesion diameter greater than 1.25 cm.**	$743.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Surgical Incision

Code	Description	Fee	Group
D7510 *	**Incision and Drainage of Abscess — Intraoral Soft Tissue. Involves incision through mucosa, including periodontal origins.**	$138.00	A.S. C.O. MR/RD
D7520 *	**Incision and Drainage of Abscess — Extraoral Soft Tissue. Involves incision through skin**.	$659.00	A.S. C.O. MR/RD
D7530	**Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue.** *SCDHHS will reimburse for one maximum per date of service.*	$237.00	A.S. C.O. MR/RD
D7550	**Partial Ostectomy/Sequestrectomy for Removal of Non-Vital Bone: Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.** *SCDHHS will not reimburse for this procedure when used for treatment of dry socket.*	$164.00	A.S. C.O. MR/RD

Treatment of Fractures — Simple

Code	Description	Fee	Group
D7670	**Alveolus — Closed Reduction, May Include Stabilization of Teeth: Teeth may be wired, banded, or splinted together to prevent movement.**	$1,028.00	A.S. C.O. MR/RD
D7671	**Alveolus — Open Reduction, May Include Stabilization of Teeth. Teeth may be wired, banded, or splinted together to prevent movement.**	$1,028.00	A.S. C.O. MR/RD

Treatment of Fractures — Compound

Code	Description	Fee	Group
D7770	**Alveolus — Open Reduction Stabilization of Teeth. Fractured bone(s) are exposed to mouth or outside the face. Surgical incision required to reduce fracture.**	$1,226.00	A.S. C.O. MR/RD
D7771	**Alveolus — Closed Reduction Stabilization of Teeth. Fractured bone(s) are exposed to mouth or outside the face.**	$1,226.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Repair of Traumatic Wounds

Excludes closure of surgical incisions

Code	Description	Fee	Group
D7910	**Suture of Recent Small Wounds up to 5 cm.**	$211.00	A.S. C.O. MR/RD

Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)

Excludes closure of surgical incisions

Code	Description	Fee	Group
D7911	**Complicated Suture — Up to 5 cm.**	$527.00	A.S. C.O. MR/RD
D7912	**Complicated Suture — Greater than 5 cm.**	$949.00	A.S. C.O. MR/RD

ADJUNCTIVE GENERAL SERVICES

Anesthesia

Code	Description	Fee	Group
D9220	**Deep Sedation/General Anesthesia — First 30 Minutes: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.** *SCDHHS will reimburse for ONE thirty-minute unit per date of service and only when performed in the office. SCDHHS will not reimburse when this code is billed in combination with IV Sedation (D9241), Non-IV Conscious Sedation (D9248), Behavior Management (D9920), or Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (D9230).*	$192.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Anesthesia (Cont'd.)

Code	Description	Fee	Group
D9230	**Analgesia, Anxiolysis, Inhalation of Nitrous Oxide.** *SCDHHS will reimburse for this code once per date of service. SCDHHS will not reimburse when this procedure is billed in combination with Deep Sedation/General Anesthesia (D9220) and Behavior Management (D9920).*	$26.00	A.S. C.O. MR/RD
D9241	**Intravenous Conscious Sedation/Analgesia — First 30 Minutes: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.** *SCDHHS reimburses for ONE thirty-minute unit per date of service. SCDHHS will not reimburse for this code when billed in combination with Deep Sedation/General Anesthesia (D9220), Non-IV Conscious Sedation (D9248), or Behavior Management (D9920). SCDHHS will not reimburse for intramuscular, submucosal, or subcutaneous administration.*	$189.00	A.S. C.O. MR/RD
D9248	**Non-Intravenous Conscious Sedation: A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.** *SCDHHS will reimburse for this code once per date of service. SCDHHS allows payment for this code when performed in the office, acquired and administered at that visit. SCDHHS will not reimburse for this code when billed in combination with Deep Sedation/General Anesthesia (D9220), IV Conscious Sedation (D9241) or Behavior Management (D9920).*	$105.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Miscellaneous Services

Code	Description	Fee	Group
D9920	**Behavior Management, by report. May be reported in addition to treatment provided. Should be reported in 15-minute increments**. *SCDHHS will reimburse for ONE 15-minute unit per date of service. This unit is for EXTRA time, beyond the normal appointment time, required to render services on patients with disabilities and/or special health care needs. SCDHHS reimburses this code for children under age 21 and MR/RD waiver beneficiaries who present themselves with disabilities and/or special health care needs (*i.e., *mental retardation, Down syndrome, cerebral palsy, seizure disorder, heart defect, etc.).* ***Documentation in the patient's record must be unique to that visit and must include a description of the known condition of the patient and additional time required to provide treatment.*** *SCDHHS will not reimburse for this procedure when billed in combination with IV Conscious Sedation/Analgesia (D9241), Non-IV Conscious Sedation (D9248), Deep Sedation/General Anesthesia (D9220), and Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (D9230).*	$55.00	C.O. MR/RD
D9999	**Unspecified adjunctive procedure, by report. Used for procedure that is not adequately described by a code. Describe procedure.** *Procedure codes not listed in this section, but considered medically necessary as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination or any covered service that extends beyond the normal limitations of the procedure as described, may be considered. You must submit either the original EPSDT examination results or detailed medical documentation and justification on the SCDHHS 214 Prior Authorization Form. See the Forms section for a blank form and instructions. See Section 2 for further information on prior authorization.*	Manual Pricing	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

EMERGENCY ORAL AND MAXILLOFACIAL SURGERY SERVICES

SCDHHS limits the following Current Procedural Terminology (CPT) codes for use by licensed Oral and Maxillofacial Surgeons enrolled in the South Carolina Medicaid Program. Effective 9/1/04, due to HIPAA requirements, CPT (medical) codes must be filed on the CMS-1500 (08/05) claim form. Filing CPT codes on the incorrect claim form can result in a rejected claim. See Section 3 for further billing instructions.

Prior authorization is required before reimbursement can be made when an assistant surgeon actively assists the primary surgeon (see Prior Authorization Form, the Forms section). *All Medicaid guidelines and policies that apply to the operating surgeon apply to the assistant surgeon. The assistant surgeon will be reimbursed at 20% of the total allowable fee per procedure. Procedure codes that allow an assistant surgeon are indicated by the double asterisks (**).*

Repair

Complex

Code	Description	Fee	Group
13132	**Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm.**	$237.83	A.S. C.O. MR/RD

General

Introduction or Removal

Code	Description	Fee	Group
20670	**Removal of Implant —** **superficial, (*e.g.*, buried wire, pin or rod) (separate procedure)**	$85.40	A.S. C.O. MR/RD
20680	**deep (*e.g.*, buried wire, pin, screw, metal band, nail, rod, or plate).**	$186.70	A.S. C.O. MR/RD

Grafts (or Implants)

Code	Description	Fee	Group
20900	**Bone graft, any donor area;** **minor or small (*e.g.*, dowel or button)**	$220.73	A.S. C.O. MR/RD
20902	**major or large.**	$329.09	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Head

Excision

Code	Description	Fee	Group
21025	**Excision of bone (*e.g.*, for osteomyelitis or bone abscess); mandible**	$291.60	A.S. C.O. MR/RD
21026	**facial bone(s).**	$213.31	A.S. C.O. MR/RD
21029	**Removal by contouring of benign tumor of facial bone; (*e.g.*, fibrous dysplasia).**	$380.00	A.S. C.O. MR/RD
21030	**Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage.**	$266.17	A.S. C.O. MR/RD
21031	**Excision of torus mandibularis:** *SCDHHS does not reimburse for this procedure for beneficiaries 21 and above when done in preparation for a prosthesis.*	$156.10	C.O. MR/RD
21032	**Excision of maxillary torus palatinus:** *SCDHHS does not reimburse for this procedure for beneficiaries 21 and above when done in preparation for a prosthesis.*	$225.88	C.O. MR/RD
21034	**Excision of malignant tumor of maxilla or zygoma.**	$620.62	A.S. C.O. MR/RD
21040	**Excision of benign cyst or tumor of mandible by enucleation and/or curettage.**	$131.36	A.S. C.O. MR/RD
21044 **	**Excision of malignant tumor of mandible**	$575.11	A.S. C.O. MR/RD
21045 **	**radical resection.**	$805.93	A.S. C.O. MR/RD
21050 **	**Condylectomy, temporomandibular joint (separate procedure).**	$617.94	A.S. C.O. MR/RD
21060 **	**Meniscectomy, partial or complete, temporomandibular joint (separate procedure).**	$583.82	A.S. C.O. MR/RD
21070 **	**Coronoidectomy (separate procedure).**	$403.59	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Introduction or Removal

Code	Description	Fee	Group
21100	**Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure).**	$143.57	A.S. C.O. MR/RD
21110	**Application of interdental fixation device for conditions other than fracture or dislocation, includes removal.**	$318.41	A.S. C.O. MR/RD
21116	**Injection procedure for temporomandibular joint arthrography.**	$42.62	A.S. C.O. MR/RD

Repair, Revision, and/or Reconstruction

Code	Description	Fee	Group
21210 **	**Graft, bone; nasal, maxillary, or malar areas (includes obtaining graft) (For cleft palate repair, see 42200–42225).**	$603.59	A.S. C.O. MR/RD
21215 **	**Mandible (includes obtaining graft).**	$795.63	A.S. C.O. MR/RD
21240 **	**Arthroplasty temporomandibular joint,** **with or without autograft (includes obtaining graft)**	$1,014.36	A.S. C.O. MR/RD
21242	**with allograft**	$1,010.55	A.S. C.O. MR/RD
21243	**with prosthetic joint replacement.**	$931.87	A.S. C.O. MR/RD

Fracture and/or Dislocation

Code	Description	Fee	Group
21310	**Closed treatment of nasal bone fracture;** **without manipulation**	$32.65	A.S. C.O. MR/RD
21315	**without stabilization**	$89.38	A.S. C.O. MR/RD
21320	**with stabilization.**	$124.08	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Fracture and/or Dislocation (Cont'd.)

Code	Description	Fee	Group
21325	**Open treatment of nasal fracture;** **uncomplicated**	$215.72	A.S. C.O. MR/RD
21330 **	**complicated, with internal and/or external skeletal fixation**	$319.97	A.S. C.O. MR/RD
21335 **	**with concomitant open treatment of fractured septum**	$588.82	A.S. C.O. MR/RD
21340 **	**Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or nasolacrimal apparatus.**	$529.01	A.S. C.O. MR/RD
21344	**Open treatment of complicated (*e.g.*, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches.**	$733.90	A.S. C.O. MR/RD
21345	**Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint**	$430.81	A.S. C.O. MR/RD
21346	**Open treatment of nasomaxillary complex fracture (LeFort II type),** **with wiring and/or local fixation**	$537.42	A.S. C.O. MR/RD
21347	**requiring multiple open approaches**	$621.18	A.S. C.O. MR/RD
21348	**with bone grafting (includes obtaining graft)**	$763.01	A.S. C.O. MR/RD
21356	**Open treatment of depressed zygomatic arch fracture (*e.g.*, Gillies approach)**	$265.13	A.S. C.O. MR/RD
21360	**Open treatment of depressed malar fracture, including zygomatic arch and malar tripod**	$370.50	A.S. C.O. MR/RD
21365 **	**Open treatment of complicated (*e.g.*, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.**	$741.93	A.S. C.O. MR/RD
21366	**with bone grafting (includes obtaining graft)**	$783.10	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Fracture and/or Dislocation (Cont'd.)

Code	Description	Fee	Group
21385 **	**Open treatment of orbital floor blowout fracture;** **transantral approach (Caldwell-Luc type operation)**	$504.73	A.S. C.O. MR/RD
21386 **	**periorbital approach**	$507.33	A.S. C.O. MR/RD
21387 **	**combined approach**	$515.16	A.S. C.O. MR/RD
21390 **	**periorbital approach, with alloplastic or other implant**	$592.92	A.S. C.O. MR/RD
21395 **	**periorbital approach with bone graft (includes obtaining graft)**	$623.07	A.S. C.O. MR/RD
21400	**Closed treatment of fracture of orbit, except blowout;** **without manipulation**	$74.78	A.S. C.O. MR/RD
21401	**with manipulation**	$149.95	A.S. C.O. MR/RD
21406 **	**Open treatment of fracture orbit, except blowout;** **without implant**	$332.71	A.S. C.O. MR/RD
21407**	**with implant**	$462.61	A.S. C.O. MR/RD
21408	**with bone grafting (includes obtaining graft)**	$560.69	A.S. C.O. MR/RD
21421**	**Closed treatment of palatal or maxillary fracture (LeFort I type); with interdental wire fixation or fixation of denture or splint**	$302.59	A.S. C.O. MR/RD
21422**	**Open treatment of palatal or maxillary fracture (LeFort I type);**	$488.69	A.S. C.O. MR/RD
21423	**complicated (comminuted or involving cranial nerve foramina), multiple approaches**	$543.85	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Fracture and/or Dislocation (Cont'd.)

Code	Description	Fee	Group
21431**	**Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint**	$351.43	A.S. C.O. MR/RD
21432**	**Open treatment of craniofacial separation (LeFort III type) with wiring and/or internal fixation.**	$413.62	A.S. C.O. MR/RD
21433 **	**complicated (*e.g.*, comminuted or involving cranial nerve foramina), multiple surgical approaches**	$1,162.81	A.S. C.O. MR/RD
21435 **	**complicated, utilizing internal and/or external fixation techniques (*e.g.*, head cap, halo device, and/or intermaxillary fixation)**	$785.88	A.S. C.O. MR/RD
21436	**complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)**	$1,030.06	A.S. C.O. MR/RD
21440	**Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)**	$204.95	A.S. C.O. MR/RD
21445	**Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)**	$307.64	A.S. C.O. MR/RD
21450	**Closed treatment of mandibular fracture;** **without manipulation**	$155.56	A.S. C.O. MR/RD
21451	**with manipulation**	$294.56	A.S. C.O. MR/RD
21452	**Percutaneous treatment of mandibular fracture; with external fixation**	$143.39	A.S. C.O. MR/RD
21453	**Closed treatment of mandibular fracture; with interdental fixation**	$325.50	A.S. C.O. MR/RD
21454	**Open treatment of mandibular fracture;** **with external fixation**	$455.90	A.S. C.O. MR/RD
21461 **	**Open treatment of mandibular fracture;** **without interdental fixation**	$492.01	A.S. C.O. MR/RD
21462 **	**with interdental fixation**	$648.79	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Fracture and/or Dislocation (Cont'd.)

Code	Description	Fee	Group
21465	**Open treatment of mandibular condylar fracture**	$546.41	A.S. C.O. MR/RD
21470 **	**Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation and/or wiring of dentures or splints**	$951.49	A.S. C.O. MR/RD
21485	**Closed treatment of temporomandibular dislocation,** **complicated (e.g., recurrent requiring inter-maxillary fixation or splinting), initial or subsequent**	165.05	A.S. C.O. MR/RD
21497	**Interdental wiring, for condition other than fracture**	$209.80	A.S. C.O. MR/RD

Endoscopy/Arthroscopy

Code	Description	Fee	Group
29800	**Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)**	$259.26	A.S. C.O. MR/RD
29804	**Arthroscopy, temporomandibular joint, surgical**	$548.28	A.S. C.O. MR/RD

Accessory Sinuses

Incision

Code	Description	Fee	Group
31000	**Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)**	$40.67	A.S. C.O. MR/RD
31020	**Sinusotomy, maxillary (antrotomy);** **intranasal**	$152.11	A.S. C.O. MR/RD
31030	**radical (Caldwell-Luc) without removal of antrochoanal polyps**	$380.68	A.S. C.O. MR/RD
31040	**Pterygomaxillary fossa surgery, any approach**	$486.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Excision

Code	Description	Fee	Group
31225	**Maxillectomy;** **without orbital exenteration**	$1,003.99	A.S. C.O. MR/RD
31230	**with orbital exenteration (en bloc)**	$1,229.38	A.S. C.O. MR/RD

Trachea and Bronchi

Incision

Code	Description	Fee	Group
31603	**Tracheostomy, emergency procedure;** **transtracheal**	$238.99	A.S. C.O. MR/RD
31605	**cricothyroid membrane**	$216.05	A.S. C.O. MR/RD

Lips

Excision

Code	Description	Fee	Group
40500	**Vermilionectomy (lip shave), with mucosal advancement**	$302.62	A.S. C.O. MR/RD
40510	**Excision of lip;** **transverse wedge excision with primary closure**	$291.92	A.S. C.O. MR/RD
40520	**V-excision with primary direct linear closure**	$251.27	A.S. C.O. MR/RD
40530	**Resection of lip, more than one-fourth, without reconstruction**	$286.76	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Repair (Cheiloplasty)

Code	Description	Fee	Group
40650	**Repair Lip, full thickness;** **vermilion only**	$222.50	A.S. C.O. MR/RD
40652	**up to half vertical height**	$260.58	A.S. C.O. MR/RD
40654	**over one-half vertical height, or complex**	$323.85	A.S. C.O. MR/RD
40700	**Plastic repair of cleft lip/nasal deformity;** **primary, partial or complete, unilateral**	$576.22	A.S. C.O. MR/RD
40701	**primary bilateral, one stage procedure**	$948.35	A.S. C.O. MR/RD
40702	**primary bilateral, one of two stages**	$606.16	A.S. C.O. MR/RD
40720	**secondary, by recreation of defect and reclosure**	$636.19	A.S. C.O. MR/RD
40761	**with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle**	$698.92	A.S. C.O. MR/RD

Tongue and Floor of Mouth

Incision

Code	Description	Fee	Group
41000	**Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth;** **lingual**	$64.40	A.S. C.O. MR/RD
41008	**submandibular space**	$108.16	A.S. C.O. MR/RD
41009	**masticator space**	$162.66	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Incision (Cont'd.)

Code	Description	Fee	Group
41015	**Extraoral incision and drainage of abscess, cyst or hematoma of floor of mouth;** **sublingual**	$129.45	A.S. C.O. MR/RD
41016	**submental**	$205.68	A.S. C.O. MR/RD
41017	**submandibular**	$136.07	A.S. C.O. MR/RD
41018	**masticator space**	$212.32	A.S. C.O. MR/RD

Excision

Code	Description	Fee	Group
41112	**Excision of lesion of tongue with closure;** **anterior two-thirds**	$124.62	A.S. C.O. MR/RD
41113	**posterior one-third**	$157.26	A.S. C.O. MR/RD
41116	**Excision, lesion of floor of mouth**	$121.25	A.S. C.O. MR/RD
41120**	**Glossectomy; less than one-half tongue**	$449.71	A.S. C.O. MR/RD
41130 **	**hemiglossectomy**	$539.76	A.S. C.O. MR/RD
41135 **	**partial, with unilateral radical neck dissection**	$910.72	A.S. C.O. MR/RD
41140 **	**complete or total, with or without unilateral tracheostomy, without radical neck dissection**	$1,184.46	A.S. C.O. MR/RD
41145 **	**complete or total, with or without tracheostomy, with unilateral radical neck dissection**	$1,408.36	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Excision (Cont'd)

Code	Description	Fee	Group
41150 **	**composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection**	$1,075.63	A.S. C.O. MR/RD
41155 **	**composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)**	$1,660.50	A.S. C.O. MR/RD

Repair

Code	Description	Fee	Group
41250	**Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue**	$81.85	A.S. C.O. MR/RD
41252	**Repair of laceration of tongue, floor of mouth; over 2.6 cm or complex**	$146.87	A.S. C.O. MR/RD

Dentoalveolar Structures

Incision

Code	Description	Fee	Group
41800	**Drainage of abscess, cyst, hematoma from dentoalveolar structures**	$45.92	A.S. C.O. MR/RD
41805	**Removal of embedded foreign body from dentoalveolar structures;** **soft tissues**	$54.66	A.S. C.O. MR/RD
41806	**bone**	$119.24	A.S. C.O. MR/RD

Excision, Destruction

Code	Description	Fee	Group
41825	**Excision of lesion or tumor, dentoalveolar structures;** **without repair**	$81.61	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Excision, Destruction (Cont'd)

Code	Description	Fee	Group
41826	**with simple repair**	$131.10	A.S. C.O. MR/RD
41828	**Excision of hyperplastic alveolar mucosa, each quadrant (specify)**	$80.93	A.S. C.O. MR/RD
41874	**Alveoloplasty, each quadrant (specify)**	$30.00	C.O. MR/RD

Palate and Uvula

Excision, Destruction

Code	Description	Fee	Group
42106	**Excision, lesion of palate, uvula, without closure;** **with simple primary closure**	$128.61	A.S. C.O. MR/RD
42120 **	**Resection of palate or extensive resection of lesion**	$344.39	A.S. C.O. MR/RD

Repair

Code	Description	Fee	Group
42200	**Palatoplasty for cleft palate, soft and/or hard palate only**	$532.96	A.S. C.O. MR/RD
42205	**Palatoplasty for cleft palate, with closure of alveolar ridge;** **soft tissue only**	$543.90	A.S. C.O. MR/RD
42210 **	**with bone graft to alveolar ridge (includes obtaining graft)**	$619.64	A.S. C.O. MR/RD
42215 **	**Palatoplasty for cleft palate;** **major revision**	$450.77	A.S. C.O. MR/RD
42220	**secondary lengthening procedure**	$450.77	A.S. C.O. MR/RD
42225	**attachment pharyngeal flap**	$450.77	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Repair (Cont'd.)

Code	Description	Fee	Group
42235 **	**Repair of anterior palate, including vomer flap**	$429.30	A.S. C.O. MR/RD
42260	**Repair of nasolabial fistula**	$226.68	A.S. C.O. MR/RD

Salivary Gland and Ducts

Incision

Code	Description	Fee	Group
42330	**Sialolithotomy;** **submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral**	$90.82	A.S. C.O. MR/RD
42335	**submandibular(submaxillary), complicated, intraoral**	$153.50	A.S. C.O. MR/RD

Excision

Code	Description	Fee	Group
42408	**Excision of sublingual salivary cyst (ranula)**	$213.66	A.S. C.O. MR/RD
42409	**Marsupialization of sublingual salivary cyst (ranula)**	$153.26	A.S. C.O. MR/RD
42440 **	**Excision of submandibular (submaxillary) gland**	$422.21	A.S. C.O. MR/RD
42450	**Excision of sublingual gland**	$224.19	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Other Procedures

Code	Description	Fee	Group
42550	**Injection procedure for Sialography**	$34.15	A.S. C.O. MR/RD

CYTOPATHOLOGY

These codes require CLIA certification and can only be billed by Oral and Maxillofacial Pathologists.
(See CPT 95, page 326 for Surgical Pathology Exam descriptions.)

Code	Description	Fee	Group
88160	**Cytopathology, smears, any other source; screening and interpretation**	$20.28	A.S. C.O. MR/RD

SURGICAL PATHOLOGY

Code	Description	Fee	Group
88300	**Level I — Surgical pathology, gross examination only**	$8.58	A.S. C.O. MR/RD
88302	**Level II — Surgical pathology, gross and microscopic examination**	$17.89	A.S. C.O. MR/RD
88304	**Level III — Surgical pathology, gross and microscopic examination**	$25.81	A.S. C.O. MR/RD
88305	**Level IV — Surgical pathology, gross and microscopic examination**	$53.71	A.S. C.O. MR/RD
88307	**Level V — Surgical pathology, gross and microscopic examination**	$93.75	A.S. C.O. MR/RD
88309	**Level VI — Surgical pathology, gross and microscopic examination**	$126.36	A.S. C.O. MR/RD
88311	**Decalcification procedure (List separately in addition to code for surgical pathology examination).**	$10.86	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

SURGICAL PATHOLOGY (CONT'D.)

Code	Description	Fee	Group
88312	**Special stains (List separately in addition to code for primary service); Group 1 for microorganisms (*e.g.*, Gridley, acid fast, methenamine silver), each**	$19.04	A.S. C.O. MR/RD

EVALUATION AND MANAGEMENT

Office or Other Outpatient Services

(Places of Service: Outpatient Hospital [23], Office [11], Patient's Home [12], Other [99], Ambulatory Surgery Center [31])

New Patient

Code	Description	Fee	Group
99201	**Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 10 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD
99202	**Office or other outpatient visit for the evaluation and management of a new patient, which requires these three 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 providers 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. Physicians typically spend 20 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD
99203	**Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination and medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 30 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New Patient (Cont'd.)

Code	Description	Fee	Group
99204	**Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 45 minutes face-to-face with the patient and/or family.**	$50.00	A.S. C.O. MR/RD
99205	**Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 60 minutes face-to-face with the patient and/or family.**	$50.00	A.S. C.O. MR/RD

Established Patient

Code	Description	Fee	Group
99211	**Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services**.	$5.50	A.S. C.O. MR/RD
99212	**Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 10 minutes face-to-face with the patient and/or family.**	$21.50	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Established Patient (Cont'd.)

Code	Description	Fee	Group
99213	**Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, a expanded problem focused examination and medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family.**	$21.50	A.S. C.O. MR/RD
99214	**Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes face-to-face with the patient and/or family.**	$35.00	A.S. C.O. MR/RD
99215	**Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 40 minutes face-to-face with the patient and/or family.**	$35.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Hospital Observation Services

(Place of Service: Outpatient Hospital [23])

Observation Care Discharge Services

Code	Description	Fee	Group
99217	**Observation Care Discharge day management: this code is to be utilized to report all services provided to a patient on discharge from "observation status" if discharge is other than the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services (including Admission and Discharge Services, 99234-99236, as appropriate).**	$24.70	A.S. C.O. MR/RD

Initial Observation Care

(Place of Service: Outpatient Hospital [23])

New or Established Patient

Code	Description	Fee	Group
99218	**Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.**	$28.50	A.S. C.O. MR/RD
99219	**Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.**	$38.00	A.S. C.O. MR/RD
99220	**Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity**.	$50.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Hospital Inpatient Services

(Place of Service: Inpatient Hospital [22])

Initial Hospital Care for New or Established Patient

Code	Description	Fee	Group
99221	**Initial hospital care, per day, for the evaluation and management of a patient that requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.**	$28.50	A.S. C.O. MR/RD
99222	**Initial hospital care, per day, for the evaluation and management of a patient that requires these three key components: a comprehensive history; a comprehensive examination; and medical decision of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.**	$38.00	A.S. C.O. MR/RD
99223	**Initial hospital care, per day, for the evaluation and management of a patient that requires these three key components: a comprehensive history; a comprehensive examination; and medical decision of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.**	$50.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Subsequent Hospital Care

(Place of Service: Inpatient Hospital [22])

Code	Description	Fee	Group
99231	**Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.**	$11.40	A.S. C.O. MR/RD
99232	**Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.**	$16.15	A.S. C.O. MR/RD
99233	**Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history, a detailed examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.**	$26.60	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Observation and Inpatient Care Services (Including Admissions and Discharge Services)

(Places of Service: Inpatient Hospital [22] and Outpatient Hospital [23])

Code	Description	Fee	Group
99234	**Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers 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) requiring admission are of low severity.**	$40.00	A.S. C.O. MR/RD
99235	**Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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) requiring admission are of moderate severity.**	$55.00	A.S. C.O. MR/RD
99236	**Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers 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) requiring admission are of high severity.**	$66.00	A.S. C.O. MR/RD
99238	**Hospital Discharge Day Management; 30 minutes or less**	$24.70	A.S. C.O. MR/RD
99239	**Hospital Discharge Day Management; more than 30 minutes**	$40.20	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Office or Other Outpatient Consultations

(See CPT 95 page 18 for definition of consultation)

(Places of Service: Outpatient Hospital [23], Office [11], Patient's Home [12], Nursing Home [33], Skilled Nursing Facility [32], Other [99] and Ambulatory Surgery Center [31])

New or Established Patient

Code	Description	Fee	Group
99241	**Office consultation for a new or established patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD
99242	**Office consultation for a new or established patient, which requires these three 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 providers 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. Physicians typically spend 30 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD
99243	**Office consultation for a new or established patient, which requires these three key components: a detailed history, a detailed examination, and straightforward medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 40 minutes face-to-face with the patient and/or family.**	$30.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New or Established Patient (Cont'd.)

Code	Description	Fee	Group
99244	**Office consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and straightforward medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 60 minutes face-to-face with the patient and/or family.**	$50.00	A.S. C.O. MR/RD
99245	**Office consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination, and straightforward medical decision making of high complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 80 minutes face-to-face with the patient and/or family.**	$50.00	A.S. C.O. MR/RD

Inpatient Consultations

(Places of Service: Other [99], Inpatient Hospital [22], Nursing Home [33], Skilled Nursing Facility [32], and Ambulatory Surgery Center [31])

New or Established Patient

Code	Description	Fee	Group
99251	**Inpatient consultation for a new or established patient, which requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.**	$23.75	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New or Established Patient (Cont'd.)

Code	Description	Fee	Group
99252	**Inpatient consultation for a new or established patient, which requires these three 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 providers 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. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.**	$28.50	A.S. C.O. MR/RD
99253	**Inpatient consultation for a new or established patient, which requires these three key components: a detailed history, a detailed examination and medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.**	$38.00	A.S. C.O. MR/RD
99254	**Inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit. Usually, the presenting problem(s) are of moderate to *high* severity.**	$42.75	A.S. C.O. MR/RD
99255	**Inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit. Usually, the presenting problem(s) are of moderate to *high* severity.**	$52.25	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Emergency Department Services

(Place of Service: Outpatient Hospital [23] or Emergency Room [24])

New or Established Patient

Code	Description	Fee	Group
99281	**Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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.**	$19.00	A.S. C.O. MR/RD
99282	**Emergency department visit for the evaluation and management of a patient, which requires these three 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 providers 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.**	$29.45	A.S. C.O. MR/RD
99283	**Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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.**	$29.45	A.S. C.O. MR/RD
99284	**Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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 high severity, and require urgent evaluation by the physician but do not pose an immediate threat to life or physiologic function.**	$39.90	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New or Established Patient (Cont'd.)

Code	Description	Fee	Group
99285	**Emergency department visit for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers 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 high severity and pose an immediate significant threat to life or physiologic function.**	$39.90	A.S. C.O. MR/RD

Other Emergency Services

(Places of Service: Inpatient Hospital [22], Outpatient Hospital [23], and Office [11])

Critical Care Services

Code	Description	Fee	Group
99291	**Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.**	$61.75	A.S. C.O. MR/RD
99292	**each additional 30 minutes (List separately in addition to code for primary service.)**	$30.87	A.S. C.O. MR/RD

Initial Nursing Facility Care

(Places of Service: Inpatient Hospital [22], Nursing Home [33], and Skilled Nursing Facility [32])

New or Established Patient

Code	Description	Fee	Group
99304	**Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity.**	$28.50	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New or Established Patient (Cont'd.)

Code	Description	Fee	Group
99305	**Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes with the patient and/or family or caregiver.**	$38.00	A.S. C.O. MR/RD
99306	**Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.**	$50.00	A.S. C.O. MR/RD

Subsequent Nursing Facility Care

(Places of Service: Inpatient Hospital [22], Nursing Home [33], and Skilled Nursing Facility [32])

New or Established Patient

Code	Description	Fee	Group
99307	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes with the patient and/or family or caregiver.**	$11.40	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New or Established Patient (Cont'd.)

Code	Description	Fee	Group
99308	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three 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 providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes with the patient and/or family or caregiver.**	$16.15	A.S. C.O. MR/RD
99309	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes with the patient and/or family or caregiver.**	$26.60	A.S. C.O. MR/RD
99310	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.**	$26.60	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Domiciliary, Rest Home (*e.g.*, Boarding Home), or Custodial Care Services

(Places of Service: Other [99], Inpatient Hospital [22], Nursing Home [33], and Skilled Nursing Facility [32])

New Patient

Code	Description	Fee	Group
99324	**Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 20 minutes with the patient and/or family or caregiver.**	$28.50	A.S. C.O. MR/RD
99325	**Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three 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 providers 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. Physicians typically spend 30 minutes with the patient and/or family or caregiver.**	$28.50	A.S. C.O. MR/RD
99326	**Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 45 minutes with the patient and/or family or caregiver.**	$38.00	A.S. C.O. MR/RD
99327	**Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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 high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.**	$38.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New Patient (Cont'd.)

Code	Description	Fee	Group
99328	**Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.**	$50.00	A.S. C.O. MR/RD

Established Patient

Code	Description	Fee	Group
99334	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 15 minutes with the patient and/or family or caregiver.**	$11.40	A.S. C.O. MR/RD
99335	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes with the patient and/or family or caregiver.**	$16.15	A.S. C.O. MR/RD
99336	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 40 minutes with the patient and/or family or caregiver.**	$16.15	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Established Patient (Cont'd.)

Code	Description	Fee	Group
99337	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers 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. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.**	$26.60	A.S. C.O. MR/RD

Home Services

(Place of Service: Patient's Home [12])

New Patient

Code	Description	Fee	Group
99341	**Home visit for the evaluation and management of a new patient that requires these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 20 minutes face-to-face with the patient and/or family.**	$25.00	A.S. C.O. MR/RD
99342	**Home visit for the evaluation and management of a new patient that requires these three 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 providers 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. Physicians typically spend 30 minutes face-to-face with the patient and/or family.**	$35.00	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

New Patient (Cont'd.)

Code	Description	Fee	Group
99343	**Home visit for the evaluation and management of a new patient that requires these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 45 minutes face-to-face with the patient and/or family.**	$45.00	A.S. C.O. MR/RD
99344	**Home visit for the evaluation and management of a new patient that requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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 high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.**	$47.48	A.S. C.O. MR/RD
99345	**Home visit for the evaluation and management of a new patient that requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.**	$56.83	A.S. C.O. MR/RD

Established Patient

Code	Description	Fee	Group
99347	**Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family.**	$14.91	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Established Patient (Cont'd.)

Code	Description	Fee	Group
99348	**Home visit for the evaluation and management of an established patient that requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination and medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes face-to-face with the patient and/or family.**	$21.94	A.S. C.O. MR/RD
99349	**Home visit for the evaluation and management of an established patient that requires at least two of these three key components: a detailed interval history, a detailed examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 40 minutes face-to-face with the patient and/or family.**	$32.22	A.S. C.O. MR/RD
99350	**Home visit for the evaluation and management of an established patient that requires at least two of these three key components: a comprehensive interval history, a comprehensive examination and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers 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. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.**	$46.40	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

Case Management Services

(Places of Service: Inpatient Hospital [21], Outpatient Hospital [22], Office [11], Patient's Home [12], Nursing Home [33], Skilled Nursing Facility [32], and Other [99])

Telephone Calls

Code	Description	Fee	Group
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.	$4.75	A.S. C.O. MR/RD

SECTION 4 PROCEDURE CODES

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