Table V.6a
Medicare Leading Part B Procedure Codes Ranked by Allowed Charges
Calendar Year 2008

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
All Procedure Codes[2] (Levels I, II, and III)		$113,919,681,013	100.0
Leading Procedure Codes[3] (Level I only)		50,129,734,516	44.0
99214	Office/outpatient visit, est	6,031,239,662	5.3
99213	Office/outpatient visit, est	5,910,130,389	5.2
99232	Subsequent hospital care	3,241,808,414	2.8
66984	Cataract surg w/iol, 1 stage	2,072,478,375	1.8
99233	Subsequent hospital care	1,885,333,732	1.7
99285	Emergency dept visit	1,311,734,269	1.2
88305	Tissue exam by pathologist	1,174,412,562	1.0
78465	Heart image (3d), multiple	1,097,124,917	1.0
99244	Office consultation	1,082,579,794	1.0
99215	Office/outpatient visit,est	1,017,088,079	0.9
92014	Eye exam & treatment	1,013,706,754	0.9
97110	Therapeutic exercises	998,754,263	0.9
99223	Initial hospital care	990,222,995	0.9
99254	Inpatient consultation	924,052,534	0.8
99291	Critical care, first hour	857,507,371	0.8
93307	Echo exam of heart	845,047,028	0.7
99212	Office/outpatient visit, est	720,156,010	0.6
77418	Radiation tx delivery, imrt	696,239,940	0.6
99243	Office consultation	585,211,652	0.5
99284	Emergency dept visit	574,375,950	0.5
99255	Inpatient consultation	573,993,089	0.5
99231	Subsequent hospital care	526,191,345	0.5
99245	Office consultation	500,731,643	0.4
99308	Nursing fac care, subseq	498,622,406	0.4
99203	Office/outpatient visit, new	465,265,005	0.4
92012	Eye exam established pat	448,303,789	0.4
99204	Office/outpatient visit, new	447,111,893	0.4

Table V.6b
Medicare Leading Part B Procedure Codes Ranked By Allowed Charges
Calendar Year 2008

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
98941	Chiropractic manipulation	$445,382,677	0.4
90806	Psytx, off, 45-50 min	442,417,229	0.4
99309	Nursing fac care, subseq	430,443,752	0.4
93320	Doppler echo exam, heart	380,144,489	0.3
27447	Total knee arthroplasty	379,793,544	0.3
96413	Chemo, iv infusion, 1 hr	372,625,304	0.3
97140	Manual therapy	360,933,979	0.3
99253	Inpatient consultation	351,990,583	0.3
43239	Upper GI endoscopy, biopsy	351,703,352	0.3
99238	Hospital discharge day	350,002,513	0.3
93880	Extracranial study	346,646,796	0.3
99222	Inpatient hospital care	346,612,323	0.3
20610	Drain/inject, joint/bursa	339,310,303	0.3
85025	Complete cbc w/auto diff wbc	335,298,843	0.3
84443	Assay thyroid stim hormone	319,947,326	0.3
78815	Pet image w/ct, skull-thick	315,498,109	0.3
45378	Diagnostic colonoscopy	315,084,308	0.3
45385	Lesion removal colonoscopy	308,931,214	0.3
93325	Doppler color flow add-on	301,487,832	0.3
80061	Lipid panel	295,856,309	0.3
45380	Colonoscopy and biopsy	295,143,521	0.3
80053	Comprehen metabolic panel	292,816,014	0.3
92135	Ophth dx imaging post seg	287,900,276	0.3
11721	Debride nail, 6 or more	286,732,046	0.3
70553	Mri brain w/o & w/dye	282,703,614	0.2
72148	Mri lumbar spine w/o dye	282,700,320	0.2
99239	Hospital discharge day	280,272,567	0.2
93000	Electrocardiogram, complete	259,768,195	0.2
92980	Insert Intracoronary stent	258,636,149	0.2
17000	Destruct premalg lesion	257,996,479	0.2
90862	Medication management	249,952,878	0.2

Table V.6c
Medicare Leading Part B Procedure Codes Ranked By Allowed Charges
Calendar Year 2008

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
70450	Ct head/brain w/o dye	$237,343,036	0.2
99283	Emergency dept visit	236,741,929	0.2
71020	Chest x-ray	236,738,222	0.2
74160	Ct abdomen w/dye	234,676,276	0.2
92004	Eye exam, new patient	232,471,278	0.2
93510	Left heart catheterization	229,619,698	0.2
72193	Ct pelvis w/dye	227,581,993	0.2
93015	Cardiovascular stress test	227,441,759	0.2
17311	Mohs, 1 stage, h/n/hf/g	222,880,449	0.2
77427	Radiation tx management, x5	222,402,659	0.2
66821	After cataract laser surgery	219,906,579	0.2
71260	Ct thorax w/dye	210,206,853	0.2
00142	Anesth, lens surgery	196,416,887	0.2
52000	Cystoscopy	195,555,827	0.2
36415	Routine venipuncture	193,357,032	0.2
11100	Biopsy, skin lesion	192,237,335	0.2

[1] Allowed charges for leading Level I procedure codes are shown as a percent of all physician and supplier allowed charges (Levels I, II, and III) submitted to Part B carriers.
[2] The total number of procedure codes (Levels I, II, and III) is approximately 14,644.
[3] Allowed charges were aggregrated by procedure code and include both the physician and ASC allowed charges. The above listed 74 procedure codes (out of a total of 9,285 Level I codes) account for approximately 44% of all allowed charges.

SOURCE: CMS/ORDI December 2009