

Medicare Leading Part B Procedure Codes Based on Allowed Charges (continued)
Calendar Year 2005

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges ¹
80053	Comprehen metabolic panel	\$263,447,451	0.2
76075	Dxa bone density, axial	\$261,014,113	0.2
72193	Ct pelvis w/dye	\$260,535,338	0.2
92004	Eye exam, new patient	\$251,675,138	0.2
71260	Ct thorax w/dye	\$245,108,484	0.2
74160	Ct abdomen w/dye	\$243,672,564	0.2
93015	Cardiovascular stress test	\$240,317,282	0.2
99239	Hospital discharge day	\$238,679,202	0.2
17304	1 stage mohs, up to 5 spec	\$238,320,675	0.2
77427	Radiation tx management, x5	\$232,994,328	0.2
70450	Ct head/brain w/o dye	\$228,516,799	0.2
78815	Tumorimage pet/ct skul-thigh	\$221,225,977	0.2
78478	Heart wall motion add-on	\$215,689,471	0.2
99211	Office/outpatient visit, est	\$214,765,834	0.2
78480	Heart function add-on	\$212,319,873	0.2
33533	CABG, arterial, single	\$206,102,656	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 13,779.

³ Allowed charges were aggregated by procedure code and include both the physician and ASC allowed charges. The above listed 74 procedure codes (out of a total of 8,563 Level I codes) account for approximately 45% of all allowed charges.

NOTES: The Current Procedural Terminology (CPT) codes, descriptions and other data only are Copyright 2005 American Medical Association All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA). For fuller description of each procedure, see the above publication.

SOURCE: CMS/ORDI

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