Medicare Leading Part B CPT Procedure Codes Based on Allowed Charges
Calendar Year 2001

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
All Procedure Codes[2]		$67,102,164,550	100.0%
Leading Procedure Codes[3]		33,513,923,001	50.0
99213	Office/outpatient visit, est	4,875,761,305	7.3
99214	Office/outpatient visit, est	2,939,613,677	4.4
99232	Subsequent hospital care	2,383,982,403	3.6
66984	Cataract surg w/iol, i stage	1,966,046,439	2.9
99233	Subsequent hospital care	1,052,786,546	1.6
99212	Office/outpatient visit, est	1,014,363,177	1.5
99231	Subsequent hospital care	858,312,427	1.3
99223	Initial hospital care	770,467,458	1.1
88305	Tissue exam by pathologist	751,484,439	1.1
99285	Emergency dept visit	671,700,424	1.0
99254	Initial inpatient consult	665,491,257	1.0
99244	Office consultation	656,743,444	1.0
92014	Eye exam & treatment	651,149,562	1.0
99215	Office/outpatient visit, est	641,232,039	1.0
78465	Heart image (3d), multiple	635,332,004	0.9
93307	Echo exam of heart	603,035,151	0.9
90921	ESRD related services, month	516,440,911	0.8
99284	Emergency dept visit	508,629,779	0.8
99255	Initial inpatient consult	460,806,855	0.7
99243	Office consultation	432,722,657	0.6
99312	Nursing fac care, subseq	427,726,968	0.6
99238	Hospital discharge day	423,679,924	0.6
99291	Critical care, first hour	415,612,276	0.6
99222	Initial hospital care	399,807,563	0.6
99203	Office/outpatient visit, new	391,141,057	0.6

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
92012	Eye exam established pat	359,407,576	0.5
97110	Therapeutic exercises	358,175,868	0.5
90806	Psytx, off, 45-50 min	352,222,968	0.5
99204	Office/outpatient visit, new	351,709,783	0.5
99245	Office consultation	345,050,564	0.5
45378	Diagnostic colonoscopy	331,071,284	0.5
99283	Emergency dept visit	318,454,921	0.5
70553	Mri brain w/o&w dye	312,988,223	0.5
99253	Initial inpatient consult	309,339,727	0.5
27447	Total knee arthroplasty	299,817,681	0.4
71020	Chest x-ray	289,756,983	0.4
93000	Electrocardiogram, complete	289,484,536	0.4
20610	Drain/inject, joint/bursa	270,554,344	0.4
92980	Insert intracoronary stent	264,327,737	0.4
93320	Doppler echo exam, heart	262,287,153	0.4
98941	Chiropractic manipulation	254,802,648	0.4
93325	Doppler color flow add-on	254,511,328	0.4
11721	Debride nail, 6 or more	248,704,618	0.4
45385	Lesion removal colonoscopy	247,420,369	0.4
33533	CABG, arterial, single	240,878,717	0.4
77427	Radiation tx management, x5	239,779,700	0.4
43239	Upper GI endoscopy, biopsy	234,981,149	0.4
66821	After cataract laser surgery	233,510,262	0.3
93510	Left heart catheterization	232,601,563	0.3
90862	Medication management	226,848,515	0.3

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
93880	Extracranial study	222,085,298	0.3

99311	Nursing fac care, subseq	218,411,602	0.3
17000	Detroy benign/premal lesion	217,215,423	0.3
72148	Mri lumbar spine w/o dye	213,064,056	0.3
84443	Assay thyroid stim hormone	202,348,745	0.3
99211	Office/outpatient visit, est	198,039,918	0.3

[1] Allowed charges are shown as a percent of all physician and supplier allowed charges submitted to Part B carriers.

[2] The total number of procedure codes is approximately 10,000.

[3] Allowed charges were aggregated by procedure code. The above listed 56 codes account for approximately 50% of the allowed charges.

SOURCE: CMS/OIS Mar-03