2021 State of Alaska Required Posting of 10 Most Commonly Performed Services

Per state law (Senate Bill 105-passed by the 30th Alaska Legislature during its second session), we are required to post annually a list of our 10 most frequently billed service codes from the six sections of Category I of the Current Procedural Terminology ("CPT codes") book, as adopted by the American Medical Association.*

The six sections are as follows:

Evaluation & Management	**Codes 99202-99499**
Anesthesia	**Codes 00100-01999;99100-99157**
Surgery	**Codes 10021-69990**
Radiology	**Codes 70010-79999**
Pathology & Laboratory	**Codes 80047-89398**
Medicine	**Codes 90281-99199; 99500-99607**

The state department responsible for overseeing this law is the State of Alaska Department of Health and Social Services (DHSS). Their website is: https://dhss.alaska.gov/Pages/default.aspx.

By law, we are required to tell you that the "undiscounted price" that we are required to report may, in the state's words, "be higher or lower" than the amount an individual or their insurance will actually pay for the healthcare services described on these lists. To translate this required statement, it means that if we are an in-network provider with your insurance, the price could be significantly lower than the price we are required to list here by the state's regulation. If we are not in-network with your insurance, our price will be no higher than the price listed here. We work with our patients to give you the best price for those insurances we are not in-network with. Each individual's circumstances will vary by their insurance and by the arrangements made with this office individually.

We are an in-network provider with the following insurances:

Aetna
Cigna
Medicaid
Medicare
Moda
Premera/Blue Cross Blue Shield
United Healthcare

For all other insurances, we are not considered an in-network provider. However, we are willing to work with you to provide the best care for the best price possible. **Please note that even if we are in-network, not all plans for a particular insurance will necessarily be covered under our contract – please contact your insurance plan to ensure that you are truly covered under our network contract.**

As required by the law, you may request to be provided with an estimate of the anticipated charges for your non-emergency care. Please do not hesitate to ask for this information. This estimate will only include **our** estimated fees. We cannot provide estimates for the costs of other facilities or providers (Example: The cost of your hospital stay for surgery or the cost of anesthesia services). These providers will need to be contacted directly in order to obtain an estimate of their costs. We will provide you with contact information so that you can obtain estimates from those offices whom we believe may be involved in your care. We are not and cannot be responsible, however, for any errors made by another office regarding their care estimates for services we do not perform, such as anesthesia, hospital care, physical therapy, etc.

Tower Joint's 10 Most Commonly Performed Evaluation & Management Codes for 2021:

99203 NEW PATIENT office visit or outpatient visit to assess and manage a new patient. This requires the provider to perform a history and examination which has a low level of decision making. Coding for time for this CPT is 30-44 minutes of total time spent on the date of the visit– including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.

$354.57-UNADJUSTED cost-not including in-network/negotiated discounts.

99204 NEW PATIENT office visit or outpatient visit to assess and manage a new patient. This requires the provider to perform a history and examination which has a moderate level of decision making. Coding for time for this CPT is 45-59 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.

$525.71-UNADJUSTED cost-not including in-network/negotiated discounts.

99205 NEW PATIENT office visit or outpatient visit to assess and manage a new patient. This requires the provider to perform a history and examination which has a high level of decision making. Coding for time for this CPT is 60-74 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.

$660.54-UNADJUSTED cost-not including in-network/negotiated discounts.

99212 ESTABLISHED PATIENT office visit or outpatient visit to assess and manage an established patient. This requires the provider to perform a history and examination which has a less complicated, straightforward level of decision making. Coding for time for this CPT is 10-19 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.
$153.47-UNADJUSTED cost-not including in-network/negotiated discounts.

99213 ESTABLISHED PATIENT office visit or outpatient visit to assess and manage an established patient. This requires the provider to perform a history and examination which has low level of decision making. Coding for time for this CPT is 20-29 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.
$231.13-UNADJUSTED cost-not including in-network/negotiated discounts.

99214 ESTABLISHED PATIENT office visit or outpatient visit to assess and manage an established patient. This requires the provider to perform a history and examination which has moderate level of decision making. Coding for time for this CPT is 30-39 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.
$343.30-UNADJUSTED cost-not including in-network/negotiated discounts.

99215 ESTABLISHED PATIENT office visit or outpatient visit to assess and manage an established patient. This requires the provider to perform a history and examination which has high level of decision making. Coding for time for this CPT is 40-54 minutes total time spent on the visit – including the doctor reviewing records, x-rays, histories, lab work, etc, either during or prior to or after the visit on the day of the visit.
$463.40-UNADJUSTED cost-not including in-network/negotiated discounts.

99221 HOSPITAL CARE-FIRST DAY OF CARE, for care and evaluation of patient, usually for problems which are not very severe. Typically 30 minutes are spent talking to the patient or coordinating care on the hospital unit where the patient is located (example: working with physical therapist, home health care, or with primary care provider).
$564.44-UNADJUSTED cost-not include in-network-negotiated discounts.

99231 HOSPITAL CARE-SUBSEQUENT DAY (any day after the 1st day), for care and evaluation of patient, usually for problems which are stable, recovering, or improving. Typically 15 minutes are spent talking to the patient or coordinating care on the hospital unit where the patient is located (example: working with physical therapist, home health care, or with primary care provider).
$564.44-UNADJUSTED cost-not include in-network-negotiated discounts.

99251 INPATIENT CONSULTATION, for a new or established patient, usually for problems which are usually minor in nature. Typically 20 minutes are spent talking to the patient or coordinating care on the hospital unit where the patient is located (example: talking with other doctors or healthcare providers to coordinate the patient's ongoing care).
$266.77-UNADJUSTED cost-not include in-network-negotiated discounts.

Tower Joint's 10 Most Commonly Performed Surgery Codes for 2021:

20610 A procedure in which a sterile needle and syringe are used to either drain fluid from a joint or to insert medicine into the joint for therapeutic purposes. This code is for LARGE joints, which includes the shoulder, hip, and knee. This procedure is done by the medical provider directly, without any x-ray assistance.
$445.99-UNADJUSTED cost-not include in-network-negotiated discounts.

27130 Surgery in which the diseased ball and socket of the hip joint are completely removed and replaced with artificial materials. A metal ball with a stem (a prosthesis) is inserted into the top of the thigh bone; an artificial plastic cup socket is placed in the cup-shaped part of the pelvic bone called the acetabulum, where the hip joint meets the body. This is a TOTAL HIP REPLACEMENT.
$16,004.14-UNADJUSTED cost-not include in-network-negotiated discounts.

27447 Surgery in which the diseased knee joint is replaced with artificial material. The end of the thigh bone closest to the knee is removed and replaced with a metal shell. The end of the lower leg bone, beneath the knee, is removed and replaced with a plastic-metal piece. A plastic "button" MAY be added to the underside of the kneecap. This is a TOTAL KNEE REPLACEMENT.
$10,823.24-UNADJUSTED cost-not include in-network-negotiated discounts.

20605 A procedure in which a sterile needle and syringe are used to either drain fluid from a joint or to insert medicine into the joint for therapeutic purposes. This code is for MEDIUM-sized joints, which includes the wrist, elbow, or ankle areas. This procedure is done by the medical provider directly, without any x-ray assistance.
$376.98-UNADJUSTED cost-not include in-network-negotiated discounts.

27134 Surgery in which a PREVIOUSLY REPLACED ball and socket of the hip joint are completely removed and replaced with NEW artificial materials. A metal ball with a stem (a prosthesis) is inserted into the top of the thigh bone and an artificial plastic cup socket is placed in the cup-shaped part of the pelvic bone called the acetabulum, where the hip joint meets the body. This is a REVISION TOTAL HIP.
$20,636.05-UNADJUSTED cost-not include in-network-negotiated discounts.

23120 Surgical removal of part of the clavicle (also known as the collarbone). Sometimes called a Mumford procedure. Used to help with shoulder pain at the end of the collarbone.
$2,991.12-UNADJUSTED cost-not include in-network-negotiated discounts.

20600 A procedure in which a sterile needle and syringe are used to either drain fluid from a joint or to insert medicine into the joint for therapeutic purposes. This code is for SMALL-sized joints, which includes the fingers and toes. This procedure is done by the medical provider directly, without any x-ray assistance.
$364.62-UNADJUSTED cost-not include in-network-negotiated discounts.

23472 Surgery to remove the diseased parts of the shoulder and replace with artificial parts; includes replacing the ball part of the joint and socket part of the joint where the ball inserts into it, using a new plastic surface. This is a TOTAL SHOULDER REPLACEMENT.
$12,536.13-UNADJUSTED cost-not include in-network-negotiated discounts.

27792 Surgery to repair a broken bone on the outside part of the ankle (lateral malleolus). This surgery may require that hardware, such as pins or screws or a metal plate, be placed to help the bone heal. Sometimes another procedure (separate surgery and separate charge) may be required to later remove the hardware if it starts to stick out or becomes irritating or painful to the patient.
$4,121.03-UNADJUSTED cost-not include in-network-negotiated discounts.

20680 Surgery to remove a previously placed wire, pin, screw, metal band, nail, rod, or plate. The part being removed depends on the previous surgery done – when the hardware was originally put into one's body. This procedure requires the surgeon to cut into tissue well below the surface of the skin, which will then require sutures or stitches to close that cut.
$2,241.28-UNADJUSTED cost-not include in-network-negotiated discounts.

Tower Joint's 10 Most Commonly Performed Anesthesiology Codes for 2021:

We do not bill any Anesthesiology codes.

Tower Joint's 10 Most Commonly Performed Radiology Codes for 2021:

We do not bill any Radiology codes.

Tower Joint's 10 Most Commonly Performed Pathology/Laboratory Codes for 2021:

We do not bill any Pathology/Laboratory codes.

Tower Joint's 10 Most Commonly Performed Medicine Codes for 2021:

We do not bill any Medicine codes.

THIS DOCUMENT AND ALL OF THESE SAME CODES CAN BE FOUND ON OUR WEBSITE AT:
https://www.towerorthopedic.com