Hillside Family Medicine, LLC
9220 Lake Otis Parkway, Suite 9, Anchorage, Alaska 99507
T (907) 344-0200 – F (907) 344-0214
www.hillsidemedicine.com

2023 10 Most Commonly Performed Services

Published 01/19/2024.

Per state law (Senate Bill 105-passed by the 30th Alaska Legislature during its second session), starting 1/1/2019, we are required to annually post 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:

Category:	CPT Code Range:
Evaluation and Management	99201-99499
Anesthesia	00100-01999;99100-99140
Surgery	10021-69990
Radiology	70010-79999
Pathology and Laboratory	80047-89398
Medicine	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: http://dhss.alaska.gov/Pages/default.aspx

In adherence to the law, Hillside Family Medicine is listing our "undiscounted price." This is the price taken directly from our fee schedule as of the publication date and are also the prices reported to the Alaska Department of Health & Social Services. These prices are subject to change at any time and may be higher than the amount actually paid for the services received depending on the individual's circumstance (i.e., Insurance Coverage, In-Network Contracts, Self-Pay Arrangements, etc.). You are entitled, upon request, to receive a good faith estimate of reasonably anticipated charges for given nonemergency service(s) prior to being provided those services and no later than 10 days following the receipt of your request. This estimate will be provided in the form of your choosing; oral, written, or electronic.

Please do not hesitate to ask any questions.

We are considered an "In-Network Provider" under your insurance policy, if your Insurance Card shows any of the following:

Your insurance might administer its own benefits and coverage but be in network with one of the above-listed companies. If that is the case, we are likely in network with your insurance company as well. Please ask and we would be happy to check for you.

We ARE NOT contracted with the following insurance companies and are not able to see patients who are covered by these insurances:

For all other insurances, we may be considered out-of-network and/or do not maintain the contractual relationships that may reduce the price of our services. Please do not hesitate to ask. If we are an in-network provider with your insurance, the price you pay could be significantly lower than the price listed below.

10 Most Commonly Performed CPT Codes

Evaluation and Management Codes: 99201-99499

CPT Code / Cost	Description of Service
99213 - $195.00	**Level 3 Established Patient Office Visit:** The provider sees an established patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a low level of medical decision making and/or the provider spends 20–29 minutes of total time on the encounter on a single date.
99214 - $300.00	**Level 4 Established Patient Office Visit:** The provider sees an established patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a moderate level of medical decision making and/or the provider spends 30–39 minutes of total time on the encounter on a single date.
99396 - $355.00	**Established Patient Annual Physical (40-64):** The provider performs an established well–patient visit for a patient who is between the ages of 40 and 64.
99395 - $335.00	**Established Patient Annual Physical (18-39):** The provider performs an established well–patient visit for a patient who is between the ages of 18 and 39.

99215 - $405.00	**Level 5 Established Patient Office Visit:** The provider sees an established patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a high level of medical decision making and/or the provider spends 40–54 minutes of total time on the encounter on a single date.
99203 - $295.00	**Level 3 New Patient Office Visit:** The provider sees a new patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a low level of medical decision making and/or the provider spends 30–44 minutes of total time on the encounter on a single date.
99202 - $210.00	**Level 2 New Patient Office Visit:** The provider sees a new patient for an office visit or other outpatient visit involving evaluation and management. The visit involves straightforward medical decision making and/or the provider spends 15–29 minutes of total time on the encounter on a single date.
99385 - $370.00	**New Patient Annual Physical (18-39):** The provider performs a well–patient visit for a new patient who is between the ages of 18 and 39.
99386 - $415.00	**New Patient Annual Physical (40-64):** The provider performs a well–patient visit for a new patient who is between the ages of 40 and 64.

99212 - $125.00	**Level 2 Established Patient Office Visit:** The provider sees an established patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a straightforward level of medical decision making and/or the provider spends 10–19 minutes of total time on the encounter on a single date.

Surgery Codes: 10021-69990

CPT Code / Cost	Description of Service
58300 - $400.00	**IUD Insertion:** The provider places a contraceptive intrauterine device (IUD) in the uterine cavity.
36415 - $10.00	**Venipuncture:** The medical assistant inserts a needle into a vein to collect a blood sample.
20610 - $325.00	**Large Joint/Bursa Injection:** The provider inserts a needle through the skin of a patient and into a major joint or bursa and then uses the syringe attachment to the needle to remove fluid or inject a drug into the joint for therapeutic purposes. They perform this procedure without using ultrasound guidance.
69209 - $70.00	**Ear Irrigation:** The medical assistant flushes or washes out the entrapped wax from a patient’s external ear canal with a stream of water to correct hearing loss or discomfort.

17110 - $342.00	**Destruction:** The provider destroys benign lesions using cryotherapy. This code covers the destruction of 1 to 14 lesions other than skin tags or cutaneous vascular lesions.
11200 - $455.00	**Skin Tag Removal:** The provider removes skin tags in any area of the body, up to and including 15 lesions.
10060 - $525.00	**Incision & Drainage of Abscess:** The provider incises the area of abscess and drains the collection of pus from a lesion, such as a carbuncle, hidradenitis, cyst, furuncle, or paronychia, with the help of surgical instruments. A simple incision and drainage usually involve a single incision of an abscess situated just below the skin's surface.
46600 - $480.00	**Anoscopy:** The provider performs an examination of the anus using a small, rigid, tubular instrument called an anoscope. They may collect samples for analysis by brushing or washing the anal canal.
58301 - $515.00	**IUD Removal:** The provider removes a contraceptive intrauterine device (IUD) from the uterine cavity.
20552 - $300.00	**Trigger Point Injection:** The provider injects an anesthetic or corticosteroid substance into the muscle to relieve a trigger point, which is a painful area or knot in a muscle.

Radiology Codes: 70010-79999

CPT Code / Cost	Description of Service
71046 - $130.00	**2 View Chest X-Ray:** The medical assistant performs a minimum of two views of the chest. They perform this study for the assessment of conditions affecting the chest, its contents, and nearby structures.
72100 - $195.00	**2-3 View Lumbar Spine X-Ray:** The medical assistant takes 2 or 3 views of the vertebrae in the lumbar region which can help evaluate back injuries, persistent numbness, and low back pain.
73630 - $210.00	**3 View Foot X-Ray:** The medical assistant takes a minimum of three views of the foot to assess injury, fracture, arthritis, tumor, or congenital abnormality.
73030 - $240.00	**2 View Shoulder X-Ray:** This procedure is for a minimum of two views of the complete shoulder.
73610 - $210.00	**3 View Ankle X-Ray:** The medical assistant takes three or views of the ankle joint to check for any fracture, swelling, or reason for pain in the ankle area.
72040 - $190.00	**2-3 View C-Spine X-Ray:** The medical assistant performs 2 or 3 views of the cervical neck vertebrae.
73562 - $235.00	**3 View Knee X-Ray:** The medical assistant takes three views of a patient’s knee joint to

	check for any fracture, swelling, or reason for pain in the knee area.
73130 - $190.00	**3 View Hand X-Ray:** The medical assistant takes a minimum of three views of a patient's hand to check for any fracture, swelling, or reason of pain in the hand.
73560 - $208.00	**1-2 View Knee X-Ray:** The medical assistant takes one or two X–ray images of a patient's knee joint to check for any fracture, swelling, or reason for pain in the knee area.
73502 - $150.00	**2-3 View Unilateral Hip X-Ray:** The medical assistant takes X–ray images of one hip, either left or right, from two or three directions or angles to check for any fracture, swelling, or other reason for pain in the hip area, including the pelvis when performed.

Pathology and Laboratory Codes: 80047-89398

CPT Code / Cost	Description of Service
83036 - $41.37	**Hemoglobin A1C:** This test measures the amount of sugar sticking to the red blood cells, displaying the result as a percentage. This gives the providers an understanding about the blood sugar level of the patient for the preceding three months
80061 - $57.03	**Lipid Panel:** The lab tech measures the blood level of cholesterol and fats called triglycerides in the blood.

80050 - $198.00	**CBC/CMP/TSH Panel:** The lab tech performs testing for this specific group of tests in the general health panel. Insurance companies typically consider this panel to apply only when providers order the general health panel specifically as a screening, so the panel code would not apply when providers order these tests for diagnostic purposes.
82306 - $126.10	**Vitamin D Hydroxy 25:** The lab tech measures the vitamin D level in the patient's blood. This analyte, commonly known as vitamin D, is not really a vitamin, but is an important steroid hormone that is produced by the liver.
82570 - $22.05	**Urine Creatinine:** The lab tech measures the amount of creatinine in a patient urine specimen. Creatinine is the waste material generated by the muscle tissue produced from the breakdown of creatine used by the muscles for energy production.
82043 - $24.63	**Urine Microalbumin:** The lab tech measures a urine specimen for albumin present. The specimen collection may occur at any time of day. This is a urine test used to diagnose and/or treat patients who have kidney disease.
80053 - $44.99	**Comprehensive Metabolic Panel:** The lab tech performs a test in which she measures the patient's blood level of 14 chemicals which include albumin, total bilirubin, total calcium, carbon dioxide, chloride, creatinine, glucose, alkaline phosphatase, potassium, total protein,

	sodium, alanine amino transferase, aspartate amino transferase, and blood urea nitrogen. The panel is a screening tool and baseline assessment that provides information about a patient's liver, kidneys, blood glucose, blood proteins, electrolyte, and fluid balance. It helps to diagnose liver or kidney disease, as well as diabetes.
84153 - $78.35	**Prostate Specific Antigen:** The lab tech performs testing on serum or plasma samples using laboratory analyzers. PSA is a protein the prostate gland produces, and providers may use PSA levels to screen for prostate cancer and follow disease progression.
81001 - $13.52	**Urinalysis Complete:** The lab tech uses a microscope to detect substances or cellular material in the urine associated with different metabolic and kidney disorders. It is used to detect urinary tract infections (UTI) and other disorders of the urinary tract. A regular urinalysis often includes color, clarity, odor, specific gravity, pH, protein, glucose, nitrites, WBC, and ketones. The most common method is dipstick or tablet reagent urinalysis, accompanied with a microscopic view, but it can be performed by some other methods as well.
81003 - $9.56	**Urine Dipstick:** The lab tech inserts a dip stick into a freshly collected urine specimen, removes the dipstick, and shakes off the excess

	urine. She places the stick onto a mechanical dip stick reader that will automatically read and record the chemical analytes and other constituents.

Medicine Codes: 90281-99199; 99500-99607

CPT Code / Cost	Description of Service
90471 - $50.00	**Vaccine Administration Fee:** The medical assistant administers a live weakened vaccine using a needle through the skin via an intradermal, subcutaneous, or intramuscular route.
93000 - $85.00	**EKG:** The medical assistant records the electrical conduction of the heart to examine any abnormality in its functioning, based on signals from at least 12 leads, wires that connect the recording device to electrodes placed in different locations on the body.
90715 - $70.00	**Tdap (Boostrix) Vaccine:** The provider uses this combination vaccine as a booster to help protect patients who are 7 years old or older from lockjaw, diphtheria, and whooping cough.
98928 - $250.00	**7-8 Region Manipulation:** The provider performs controlled manual pressure in seven to eight body regions to treat somatic and nonsomatic disorders.
90472 - $30.00	**Vaccine Administration Fee (2 or more):** This code represents each injection of a vaccine after the first.

90686 - $25.00	**Influenza Vaccine 3yrs+:** The medical assistant administers into a muscle of a patient, a preservative–free, four–strain influenza virus vaccine, in a 0.5 mL dose to provide immunity to four forms of influenza
90750 - $180.00	**Shingrix Vaccine:** The medical assistant injects an adjuvanted vaccine into a muscle to protect the patient against varicella zoster infection.
90460 - $50.00	**Vaccine Administration Fee with Provider Counseling:** The medical assistant administers a single live weakened vaccine through an oral, intranasal, intramuscular, or subcutaneous route to a patient up to 18 years of age after the patient is counseled by the provider.
90461	
96372 - $75.00	**Injection Fee:** A therapeutic, prophylactic, or diagnostic substance (fluid/drug/etc.) is injected via intramuscular or subcutaneous route into the patient's body. Injection of a vaccine is not included in this code.

Anesthesiology Codes: 00100-01999; 99100-99140

We do not bill any Anesthesiology codes.

You can find all other listings on https://health.alaska.gov/dph/VitalStats/Pages/transparency/A.aspx