DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE Rule 16

UTILIZATION STANDARDS

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16-1 STATEMENT OF PURPOSE

In an effort to comply with the ~~its~~ legislative charge to assure the quick and efficient delivery of ~~appropriate and timely~~ medical benefits ~~care~~ at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 20~~19~~20. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule.

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A physician selected by the injured worker when the injured worker has the right to select a provider;

(4) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the Director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(C) Billed Service(s) – any billed service, procedure, equipment, or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

(E) Certified Medical Interpreter - certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.

(F) Children's Hospital – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(G) Convalescent Center – licensed by the Colorado Department of Public Health and Environment.

(H) Critical Access Hospital (CAH) – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(I) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

(J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider–based entity.

(K) Hospital – licensed by the Colorado Department of Public Health and Environment.

(L) Long-Term Care Facility –federally qualified, and certified by the Colorado Department of Public Health and Environment.

(M) Medical Fee Schedule – Division's Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(N) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17.

(O) Over-the-Counter Drugs – medications that are available for purchase by the general public without a prescription.

(P) Payer – an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, Third Party Administrators (TPAs), and case management companies, shall not relieve the self-insured employer or insurer from their legal responsibilities for compliance with these Rules.

(Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(R) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(S) Psychiatric Hospital – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(T) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(U) Rural Health Clinic Facility – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(V) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment.

~~(W) Telehealth – a broad term describing a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems.~~

(X) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

(Y) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician." Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following boards:

(i) Colorado Medical Board;
~~(ii) Colorado Board of Chiropractic Examiners;~~
(ii) Colorado Dental Board;.
(iii) Colorado Podiatry Board; ~~or~~
~~(iv) Colorado Dental Board;~~.
(iv) Colorado Optometry Board, or
(v) Colorado Board of Chiropractic Examiners;

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I).

(b) "Non-physician providers" are those individuals who are registered, certified, or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

(iv) Athletic Trainers (ATC) –~~registered~~ licensed by the ~~Office of Athletic Trainer Registration,~~ Colorado Department of Regulatory Agencies;

(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

(x) Massage Therapist (MT) – licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies.

(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiii) Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

~~(xiv) Optometrist (OD) – licensed by the Board of Optometry, Colorado Department of Regulatory Agencies;~~

(xiv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;

(xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

(xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xvii) Physical Therapist Assistant (PTA) –certified by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;

(xix) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;

(xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

(xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

(xxii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;

(xxiii) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

(xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

(2) Upon request, health care providers must provide copies of license, registration, certification, or evidence of health care training for billed services.

(3) Any provider not listed in section 16-3(A)(1)(a) or (b) must comply with section 16-6, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of a~~n ATP's~~ referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from a~~n authorized treating~~ physician provider managing the claim (or NP/PA working under that physician provider). A~~n authorized treating~~ physician making the referral to any listed or unlisted non-physician provider shall, upon request of any party, answer any questions and clarify ~~is required to clarify any questions concerning~~ the scope of the referral, prescription, or the reasonableness or necessity of the care.

~~(c) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.~~

(5) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado workers' compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

~~(b) The authorized treating physician must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker.~~

~~(c) The service is within the scope of the PA's or NP's practice and complies with all applicable provisions of the Colorado Medical Practice Act or the Colorado Nurse Practice Act, and all applicable~~

~~rules promulgated by the Colorado Medical Board or the Colorado Board of Nursing.~~

(b) For services performed by an NP or a PA, the authorized treating physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3). The authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(c) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(B) Out-of-State Provider

(1) Relocated Injured Worker

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change of provider, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(i) Through referral by the injured worker's authorized treating physician; or

(ii) In accordance with § 8-43-404(5)(a).

(2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in section 16-6. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider's qualifications to provide the requested treatment or services.

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its' own internal guidelines or other standards for medical determination. Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable Medical Treatment Guidelines. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of denial~~contest~~, appropriate processes to deny are required. ~~Refer to applicable sections of 16-5, 16-6, 16-7, and/or 16-11.~~

16-5 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-5(D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195). The completed form shall include:

(1) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(2) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(3) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or a denial ~~contest~~ of the proposed treatment.

(1) The payer may limit its approval to the number of treatments or treatment duration specified in the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, additional treatment should ~~may~~ be approved.

(2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-7(B).

(E) Payers may deny ~~contest~~ the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an ATP, or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines.

(F) If the payer denies ~~contests~~ Notification under sections 16-5(E)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-6(E), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

(G) Appeals ~~Contests~~ for denied Notification by a provider shall be made in accordance with the prior authorization appeals ~~dispute~~ process outlined in 16-7(C).

(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification process maybe subject to penalties under the Workers' Compensation Act.

16-6 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT® for the services/procedures requested by the provider pursuant to section 16-6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.

(B) Prior authorization for payment shall only be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;

(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-8(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-6(E). The duty to respond to a provider's request applies regardless of who transmitted the request.

(D) The payer, unless it has previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(E) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure. The following documentation is required:

(1) An adequate definition or description of the nature, extent, and necessity for the procedure;

(2) Identification of the appropriate Medical Treatment Guideline, if applicable; and

(3) Final diagnosis.

(F) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(G) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-6(E) for any unlisted service or procedure for payment.

16-7 DENIAL ~~CONTEST~~ OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-7(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

(B) The payer may deny ~~contest~~ a request for prior authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-11(B)(1). If the payer is denying ~~contesting~~ a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under section 16-6(E) reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers ~~or chiropractors~~ performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written denial

~~contest~~ or approval still needs to be completed within the seven (7) business days specified under this section.

(3) Furnish the provider and the parties with a written denial ~~contest~~ that sets forth the following information:

(a) An explanation of the specific medical reasons for the denial~~contest~~, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion.

(b) The specific cite from the Medical Treatment Guidelines, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the denial ~~contest~~ when applicable; and

(d) Documentation of response to the provider and parties.

(C) Prior Authorization Appeals

(1) The requesting party or provider shall have seven (7) business days from the date of the written denial ~~contest~~ to provide a written response to the payer. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the response to issue a final decision and provide documentation of that decision to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an ATP, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with section 16-7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-7(B).

(1) The IME must occur within 30 days, or upon first available appointment, of the prior authorization request, not to exceed 60 days absent an order extending the deadline.

(2) The IME physician must serve all parties concurrently with his or her report within 20 days of the IME.

(3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report.

(4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME.

(5) The IME shall comply with Rule 8 as applicable.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-8 REQUIRED USE OF THE FEE SCHEDULE

(A) All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

(1) If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

(2) The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

(3) Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

(B) The fee schedule does not limit the billing charges.

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer pursuant to section 16-6, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of these exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism. Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee schedule payment.

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

(A) Medical providers shall use only the billing forms listed below or their electronic reproductions. Any reproduction shall be an exact duplication of the form(s) in content and appearance. If the payer agrees, providers may place identifying information in the margin of the form. Payment for any services not billed on the forms identified in this Rule may be denied. However, the payer shall comply with the applicable provisions set forth in section 16-11.

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home

health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use a UB- 04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit Professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF	Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA
SB	Services rendered in a CAH by a nurse midwife
AH	Services rendered in a CAH by a clinical psychologist
AE	Services rendered in a CAH by a nutrition professional/registered dietitian
AQ	Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using a UB-04.

(3) American Dental Association's Dental Claim Form, Version 20192 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

(5) Bills for services incident to medical services, such as language interpreting or injured worker mileage reimbursement, may be submitted by invoice or other agreed-upon form.

(B) International Classification of Diseases (ICD) Codes

All provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, specific to each patient encounter, and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the February 20191918 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 20191918 edition. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

(D) National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI shall be that of the rendering provider and shall include the correct place of service codes at the line level.

(E) Timely Filing

Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. For claims submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. Proof of timely filing will be accepted up to 10 months from date of service unless extenuating circumstances exist.

Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.

Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) The treating provider shall maintain medical records for each injured worker when billing for the provided services. The rendering provider shall sign the medical records. Electronic signatures are accepted.

(B) All medical records shall legibly document the services billed. The documentation shall itemize each contact with the injured worker. The documentation also shall detail at least the following information per contact or, if contact occurs more than once per week, detail at least once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient's functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) Pain diagrams, where applicable;

(8) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(9) All prior authorization(s) for payment received from the payer (i.e., who approved prior authorization, services authorized, dollar amount, length of time, etc.).

(C) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the April 2018 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

(D) Authorized treating physicians must sign (or counter-sign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

(1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. See Rule 18 for required fields. ~~This form shall include completion of items 1-7 and 11. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if unknown by the provider.~~

(2) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. See Rule 18 for required fields. ~~The form requires the completion of items 1-5, 6.B, 6.C, 7, 9, and 11.~~ If the injured worker has sustained a permanent impairment, item 10 also must be completed and the following information shall be attached to the bill at the time of MMI:

(a) All necessary permanent impairment rating reports, including a narrative report and appropriate worksheets, when the authorized treating physician managing the total workers' compensation claim of the patient is Level II Accredited; or

(b) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(3) At no charge, the physician shall supply the injured worker with one legible copy of the completed Form WC 164 at the time the form is completed.

(4) The provider shall submit to the payer the completed Form WC 164 no later than 14 days from the date of service.

(E) Providers other than hospitals shall provide the payer with all supporting documentation at the time of billing unless the parties have made other agreements. This shall include copies of the examination, surgical, and/or treatment records. Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.).

(F) In accordance with section 16-11(B), the payer may deny ~~contest~~ payment for billed services until the provider submits the relevant required documentation.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits (EOB). If the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made, the payer's written notice shall include:

(a) Name of the injured worker;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was (were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may submit corrected bill or appeal within 60 days;

(g) For compensable services related to a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known; and

(k) Name and address of the third party administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

(2) The payer shall send the billing party written notice that complies with sections 16-11(A)(1) and (B) or (C) within 30 days of receipt of the bill. Any notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement set forth in this section.

(3) Unless the payer provides timely and proper reasons set forth by sections 16-11(B)-(D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is

forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, presumed receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party mayreport the incident to the Division's Carrier Practices Unit to be used during an audit.

(8) Payers shall reimburse injured workers for mileage expenses as required by statute or provide written notice of the reasons for denying reimbursement within 30 days of receipt.

(B) Process for Denying ~~Contesting~~ Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for denying ~~contesting~~ payment include the following: no claim has been filed with the payer; compensability has not been established; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors in the bill; failure to submit medical documentation; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including reasoning and relevant documentation that he or she believes the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-11(C). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service.

(3) In all cases where a billed service is denied ~~contested~~ for non-medical reasons, the payer shall send the billing party written notice of the denial ~~contest~~ within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied ~~contested~~, if submitted on the bill;

(b) If applicable, acknowledgement of specific ~~uncontested and~~ paid items submitted on the same bill as denied ~~contested~~ services;

(c) Reference to the bill and each item of the bill being denied~~contested~~; and

(d) Clear and persuasive reasons for denying ~~contesting~~ the payment of any item specific to that bill, including the citing of appropriate statutes, rules, and/or documents supporting the payer's reasons.

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the 30-day notice requirement set forth in this section.

(4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the EOB the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider disagrees, then the payer shall proceed according to section 16-11(B) or (C), as appropriate.

(5) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment.

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the EOB ~~written notice of contest~~ one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider, or

(b) The provider's requested payment based on an established similar code value.

If the payer disagrees with the provider's recommended code value, the denial ~~payer's notice of contest~~ shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is denying ~~contesting~~ the medical necessity of any non-valued procedure after prior authorization was requested, the payer shall follow section 16-11(C).

(C) Process for Denying ~~Contesting~~ Payment of Billed Services Based on Medical Reasons

When denying ~~contesting~~ payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers ~~or chiropractors~~ performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the ~~contested or paid~~ medical bill.

(2) In all cases where a billed service is denied ~~contested~~ for medical reasons, the payer shall send the provider and the parties written notice of denial ~~the contest~~ within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied~~contested~~, if submitted on the bill;

(b) If applicable, acknowledgement of specific ~~uncontested and~~ paid items submitted on the same bill as denied ~~contested~~ services;

(c) Reference to the bill and each item of the bill being ~~denied~~contested;

(d) Clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Medical Treatment Guidelines, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the denial~~contest~~, when applicable.

(3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(4) If the payer is denying ~~contesting~~ the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-11(C)(1) and (2).

(D) Process for Appealing ~~Ongoing Contest of~~ Billed Service~~s~~ Denials

(1) The billing party shall have 60 days from the date of the EOB to respond to the payer's written notice under section 16-11(A)–(C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) denied ~~contested~~;

(d) Clear and persuasive supporting documentation or reasons for appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with section 16-11(D)(1), the payer shall:

(a) When denying ~~contesting~~ for medical reasons, have the bill and all supporting medical documentation and reasoning reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review.

The physician providers ~~or chiropractors~~ performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the ~~contested or paid~~ medical bill.

(b) When denying ~~contesting~~ for non-medical reasons, have the bill and all supporting documentation and reasoning reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewer may call the provider to expedite communication and timely processing of the ~~contested or paid~~ medical bill.

(3) If before or after conducting a review pursuant to section 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to section 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of denial ~~contest~~ within 30 days of receipt of the response. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied~~contested~~, if submitted by the provider;

(b) If applicable, acknowledgement of specific ~~uncontested and~~ paid items submitted on the same bill as denied ~~contested~~ services;

(c) Reference to the bill and each item of the bill being denied ~~contested~~;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the denial ~~contest~~ is for ~~over~~ a medical reason; and

(e) The explanation shall include the citing of statutes, rules and/or documents supporting the payer's reasons for denying ~~contesting~~ payment.

(5) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date

the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original EOB unless the provider is notified that:

(a) A hearing is requested within the 12 month period, or

(b) A request for utilization review has been filed pursuant to § 8-43-501.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers ~~or chiropractors~~ performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(F) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the

injured worker has directly paid for medical services that are then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(G) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with section 16-11.

(H) Onsite Review of Hospital or Other Medical Charges

(1) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(2) The payer shall comply with the following procedures:

Within 30 days of receipt of the bill, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(a) Name of the injured worker;

(b) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(c) An outline of the items to be reviewed; and

(d) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(3) The hospital or other medical facility shall comply with the following procedures:

(a) Allow the review to begin within 30 days of the payer's notification;

(b) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(c) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(d) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(e) Participate in the exit conference in an effort to resolve discrepancies.

(4) The reviewer shall comply with the following procedures:

(a) Obtain from the injured worker a signed information release form;

(b) Negotiate the starting date for the review;

(c) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(d) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized list of discrepancies at an exit conference upon the completion of the review; and

(e) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in ten (10) business days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

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18-1 INTRODUCTION

Pursuant to § 8-42-101(3)(a)(I) and § 8-47-107, the Director promulgates this Medical Fee Schedule to review and establish maximum fees for health care services falling within the purview of the Workers' Compensation Act of Colorado. This Rule applies to services rendered on or after January 1, 2020. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered. This Rule shall be read together with Rule 16, Utilization Standards, and Rule 17, the Medical Treatment Guidelines.

The unofficial copies of Rule 18, other Colorado Workers' Compensation Rules of Procedure, and Interpretive Bulletins are available on the Division's website, https://www.colorado.gov/pacific/cdle/dwc. The rules also may be purchased from LexisNexis. An official copy of the rules is available on the Secretary of State's webpage, http://www.sos.state.co.us/CCR/Welcome.do, 7 CCR 1101-3.

18-2 INCORPORATION BY REFERENCE

The Director adopts and incorporates by reference the following materials:

(A) National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale), as modified and published by Medicare in February 2019. Copies of RBRVS are available on Medicare's website, www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html.

(B) The Current Procedural Terminology CPT® 2019, Professional Edition, published by the American Medical Association (AMA). All CPT® modifiers are adopted, unless otherwise specified in this Rule; and

(C) Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 36 using MS-DRGs effective after October 1, 2018. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems.

All guidelines and instructions in the referenced materials are adopted, unless otherwise specified in this Rule. The incorporation is limited to the specific editions named and does not include later revisions or additions.

The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Please contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials also are available at any state publications depository library. All users are responsible for the timely purchase and use of these materials.

18-3 GENERAL POLICIES

(A) Billing Codes and Fee Schedule:

(1) The Division establishes the Medical Fee Schedule based on RBRVS, as modified by Rule 18 and its exhibits.

(2) The Division incorporates CPT®, Health Care Common Procedure Coding System (HCPCS), and National Drug Code (NDC) codes and values, unless otherwise specified in Rule 18. The providers may use CPT® Category III codes listed in the RBRVS with payer agreement. Payment for the Category III codes shall comply with Rule 16~~-8(C)~~.

(3) Division-created codes and values (DoWC ZXXXX) supersede CPT®, HCPCS, and NDC codes and values.

(4) Codes listed with RVUs of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization.

(B) Place of Service Codes:

The table below ~~Table #1~~ lists the place of service codes used with the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS.

Place of Service Code	Place of Service Code Description
02	Telehealth Services
19	Off Campus – Outpatient Hospital
21	Inpatient Hospital
22	On Campus - Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgery Center (ASC)
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Hospital
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

(C) Correct Reporting ~~of Services/Procedures~~ and Payment Policies:

(1) Providers shall report codes and number of units based on all applicable code descriptions and Rule 18. In addition, providers shall document all services/ procedures in the medical record.

(2) Providers shall report the most comprehensive code that represents the entire service.

(3) Providers shall report only the primary services and not the services that are integral to the primary services.

(4) Providers shall document the time spent performing all time-based services or procedures in accordance with applicable code descriptions.

(5) Providers shall apply modifiers to clarify services rendered and/or adjust the maximum allowances as indicated in Rule 18. Prior to correcting a modifier, payers shall comply with Rule 16~~-11(B)(4)~~.

(6) The Division does not recognize Medicare's Medically Unlikely Edits.

18-4 PROFESSIONAL FEES AND SERVICES

(A) GENERAL INSTRUCTIONS

(1) Conversion Factors (CFs):

~~The following CFs determine the maximum fees.~~ The maximum fees are determined by multiplying the following CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	$46.50~~50.00~~/RVU
Surgery	$70.00~~72.00~~/RVU
Radiology	$70.00~~72.00~~/RVU
Pathology	$70.00~~72.00~~/RVU
Medicine	$70.00~~72.00~~/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$47.00~~43.75~~/RVU
Evaluation & Management (E&M)	$56.00~~54.81~~/RVU

(2) Maximum Allowance:

(a) Maximum allowance for most ~~all other~~ providers listed in Rule 16~~-3~~ shall be 100% of the RBRVS value ~~or as~~ unless otherwise specified in this Rule.

(b) The maximum allowance for professional services performed by Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs are allowed 100% of the Medical Fee Schedule if the requirements of Rule 16~~-3(A)(5)~~ have been met and one of the following conditions applies:

(i) The service is provided in a rural area. Rural area means:

- a county outside a Metropolitan Statistical Area (MSA) or
- a Health Professional Shortage Area, located either outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.

(ii) The PA or NP is ~~has received~~ Level I accredited~~-ation~~.

(c) The payer may negotiate reimbursement of travel expenses not addressed in the fee schedule (including transit time) to providers traveling to a rural area to serve an injured worker. Rural area is defined in subsection (2)(b)(i) above. This reimbursement shall be in addition to the maximum allowance for services addressed in the fee schedule.

(3) The Division adopts the following RBRVS attributes or modifies them as follows:

(a) HCPCS (Healthcare Common Procedure Coding System) –including any non-listed CPT® codes; Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted);

(b) Modifier;

(c) Description – short description as listed in the file and long description as specified in CPT®;

(d) Status Code:

Code	Meaning
A	Active Code
B	Bundled Code
C	Payer-Priced
D, F & H	Deleted Code or Modifier
E, G, I, N, R, or X	~~Not Valid or Covered for Medicare, but~~ Valid for CO WC
J	Anesthesia Code
M & Q	Measurement or Functional Information Codes - No Value
P	Bundled or Medicare-Excluded Codes
T	Injections

(e) Increment of Service/Billable (when specified);

(f) Conversion Factors (CFs) listed in section 18-4(A)(1) or an exhibit to this Rule to establish value.

(g) Anesthesia Base Unit(s), see section 18-~~4~~5(C~~D~~);

(h) Non-Facility (NF) Total RVUs;

(i) Facility (F) Total RVUs;

(j) Professional Component/Technical Component Indicators:

Indicator	Meaning
0	Physician Service Codes – professional component/ technical component (PC/TC) distinction does not apply.
1	Diagnostic Radiology Tests - may be billed with or without modifiers 26 or TC.
2	Professional Component Only Codes – standalone professional service code (no modifier is appropriate

	because the code description dictates the service is professional only).
3	Technical Component Only Codes - standalone technical service code (no modifier is appropriate because the code description dictates the service is technical only.
4	Global Test Only Codes - modifiers 26 and TC cannot be used because the values equal to the sum of the total RVUs (work, practice expense and malpractice).
5	Incident To Codes - do not apply.
6	Laboratory Physician Interpretation Codes – separate payments may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with modifier TC).
7	Physical Therapy Service – not recognized.
8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

(k) Global Days: the number of follow-up days beginning on the day after the surgery and continuing for the defined period.

Indicator	**Meaning**
000	Endoscopies or some minor surgical procedures, typically a zero day post-operative period. E&M visits on the same day as procedures generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
010	Other minor procedures, 10-day post-operative period. E&M visits on the same day as procedures and during the 10-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
090	Major surgeries, 90-day post-operative period. E&M visits on the same day as procedures and during the 90-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
MMM	Global service days concept does not apply (see Medicare's Global Maternity Care reporting rule).
XXX	Global concept does not apply.
YYY	Identifies primarily "BR" procedures where "global days" need to be determined by the payer.
ZZZ	Code is related to another service and always included in the global period of the other service. Identifies "add-on" codes.

(l) Pre-Operative Percentage Modifier: percentage of the global surgical package payable when pre-operative care is rendered by a provider other than the surgeon.

Indicator	Meaning
%	The physician shall append modifier 56 when performing only the pre-operative portion of any surgical procedure. This column lists the pre-operative percentage of the total surgical fee value.

(m) Intra-Operative Percentage Modifier: percentage of the global surgical package payable when the surgeon renders only intra-operative care.

Indicator	Meaning
%	The surgeon shall append modifier 54 when performing only the intra-operative portion of a surgical procedure. This column lists the intra-operative percentage of the total surgical fee value.

(n) Post-Operative Percentage Modifier: percentage of the global surgical package payable when post-operative care is rendered by a provider other than the surgeon.

Indicator	Meaning
%	The surgeon shall append modifier 55 when performing only the post-operative portion of a surgical procedure. This column lists the post-operative percentage of the total surgical fee value.

(o) Multiple-Procedure Modifier

Payers shall reimburse the highest-valued procedure at 100% of the fee schedule, even if the provider appends modifier 51. Payers shall reimburse the lesser-valued procedures performed in the same operative setting at 50% of the fee schedule, as follows:

Indicator	Meaning
0	No payment adjustment for multiple procedures applies. These codes are generally identified as “add-on” codes in CPT®.
1, 2, or 3	Standard payment reduction applies (100% for the highest-valued procedure and 50% for all lesser-valued procedures performed during the same operative setting).
4, 5, 6, or 7	Not subject to the multiple procedure adjustments.
9	Multiple procedure concept does not apply.

(p) Bilateral Procedures

Indicator	Meaning
0	Not eligible for the bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to the anatomical constraints or another code more adequately describes the procedure.
1	Eligible for bilateral payment adjustment and should be reported on one line with modifier 50 and "1" in the units box. Provider performing the same bilateral procedure during the same operative setting multiple times shall report the second and subsequent procedures with modifiers 50 and 59. Report on one line with one unit for each bilateral procedure performed. The maximum fee is increased to 150% of the fee schedule value. If provider performs bilateral procedures during the same setting, payer shall apply the bilateral payment adjustment rule first, and then apply other applicable payment adjustments (e.g., multiple surgery).
2	Not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.
3	Not eligible for the bilateral payment adjustment. Report these codes on two lines with RT and LT modifiers. There is one payment per line. Indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

(q) Assistant Surgeon, Modifiers 80, 81, 82, or AS

The designation of "almost always" for a surgical code in the Physicians as Assistants at Surgery: 2018 Update (February 2018), published by the American College of Surgeons shall indicate that separate payment for an assistant surgeon is allowed for that code. ~~See section 18-5(E)(1).~~ If that publication does not make a recommendation on a surgical code or lists it as "sometimes" or "almost never," then RBRVS indicators shall determine whether separate payment for assistant surgeons is allowed:

Indicator	Meaning
0	Documentation of medical necessity and prior authorization is required to allow an assistant at surgery.
1	No assistant at surgery is allowed.
2	Assistant at surgery is allowed.

No separate assistant surgeon or minimum assistant fees shall be paid if a co-surgeon is paid for the same operative procedure during the same surgical episode. See section 18-4(D)(1) for additional payment policies.

(r) Co-Surgeons, Modifier 62

Indicator	Meaning
1 or 2	Indicators may require two primary surgeons performing two distinct portions of a procedure. Modifier 62 is used with the procedure and maximum fee value is increased to 125% of the fee schedule value. The payment is apportioned to each surgeon in relation to his or her individual responsibilities and work, or it is apportioned equally between the co-surgeons.
0 or 9	Not eligible for co-surgery fee allowance adjustment. These procedures are either straightforward or only one surgeon is required or the concept does not apply.

(s) Team Surgeons, Modifier 66

Indicator	Meaning
0	Team surgery adjustments are not allowed.
1	Prior authorization is required for team surgery adjustments.
2	Team surgery adjustments may occur as a "BR." Each team surgeon must bill modifier 66. Payer must adjust the values in consultation with the billing surgeon(s).
9	Concept does not apply.

(t) Endoscopy base codes are not recognized for payment adjustments except when other modifiers apply.

(u) All other fields are not recognized.

(BC) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by physician providers as defined in Rule 16-3(A)(1)(a), nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 20189 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7, or Medicare's 1997 Evaluation and Management Documentation Guidelines.

~~Disability counseling should be an integral part of managing workers' compensation injuries. The counseling shall be completely documented in the medical records, including, but not limited to, the amount of time spent with the injured worker and the specifics of the discussion as it relates to the individual patient. Disability counseling shall include, but not be limited to, return to work, temporary and permanent work restrictions, self-management of symptoms while working, correct posture/mechanics to perform work functions, job task exercises for muscle strengthening and stretching, and appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury.~~

~~For adjusted RVUs and rates, see Exhibit #9~~.

(2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each new injury or new Colorado workers' compensation claim even if the provider has seen the injured worker within the last three (3) years.

Any subsequent E&M visits for the same injury billed by the same provider or another provider of the same specialty or subspecialty in the same group practice shall be reported as an "established patient" visit.

Transfer of care from one physician to another with the same tax ID and specialty or subspecialty shall be billed as an "established patient" regardless of location.

(3) Number of Office Visits

All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization is obtained ~~(see Rule 16-6)~~.

(4) Treating Physician Telephone or On-line Services:

Telephone or on-line services may be billed if the medical records/documentation specifies all the following:

(a) The amount of time and date;

(b) The patient, family member, or healthcare provider talked to; and

(c) Specific discussion and/or decision made during the communication.

Telephone or on-line services may be billed even if performed within the one day and seven day timelines listed in CPT®.

(5) Face-to-Face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences

A medical team conference can only be billed if all CPT® criteria are met. A medical team conference shall consist of medical professionals caring for the injured worker. The billing statement shall be prepared pursuant to Rule 16.

(6) Consultation/Referrals/Transfers of Care/Independent Medical Examinations

A consultation occurs when a treating physician seeks an opinion from another physician regarding a patient's diagnosis and/or treatment.

A transfer of care occurs when one physician turns over the responsibility for the comprehensive care of a patient to another physician.

An independent medical exam (IME) occurs when a physician is requested to evaluate a patient by any party or party's representative and is billed in accordance with section 18-7~~6~~(G).

To bill for any inpatient or outpatient consultation codes, the provider must document the following:

(a) Identity of the requesting physician for the opinion.
(b) The need for a consultant's opinion.
(c) Statement that the report was submitted to the requesting provider.

Subsequent Hospital modified RVUs are:

CPT® 99231 = 2.21 RVUs
CPT® 99232 = 3.15 RVUs
CPT® 99233 = 4.22 RVUs

Consultation modified RVUs are:

CPT® 99241, non-facility RVU is 2.57, facility RVU is 2.15
CPT® 99242, non-facility RVU is 3.77, facility RVU is 3.18
CPT® 99243, non-facility RVU is 4.71, facility RVU is 3.96
CPT® 99244, non-facility RVU is 6.39, facility RVU is 5.57
CPT® 99245, non-facility RVU is 8.15, facility RVU is 7.23
CPT® 99251 = 2.79 RVUs
CPT® 99252 = 3.83 RVUs
CPT® 99253 = 4.95 RVUs
CPT® 99254 = 6.39 RVUs
CPT® 99255 = 8.47 RVUs

(7) Prolonged Services:

Providers shall document the medical necessity of prolonged services utilizing patient-specific information. Providers shall comply with all applicable CPT® requirements and the following additional requirements.

(a) Physicians or other qualified health care professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) with or without direct patient contact.

(i) An E&M code shall accompany prolonged services codes.

(ii) The provider must exceed the average times listed in the E&M section of CPT® by 30 minutes or more, in addition to the prolonged services codes.

(iii) If using time spent (rather than three key components) to justify the level of primary E&M service, the provider must bill the highest level of service available in the applicable E&M subcategory before billing for prolonged services.

(iv) The provider billing for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize each record reviewed.

(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified health care professional supervision:

(i) The supervising physician or other qualified health care professional may not bill for the time spent supervising clinical staff.

(ii) Clinical staff services cannot be provided in an urgent care or emergency department setting.

(C~~D~~) ANESTHESIA

(1) All anesthesia base values are set forth in Medicare's 2019~~8~~ Anesthesia Base Values. ~~For adjusted RVUs and rates, see Exhibit #9.~~ Anesthesia services are only reimbursable if the anesthesia is administered by a physician, a Certified Registered Nurse Anesthetist (CRNA), or an anesthesiologist assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When a CRNA or AA administers anesthesia:

(a) CRNAs not under the medical direction of an anesthesiologist shall be reimbursed 90% of the maximum anesthesia value;

(b) If billed separately, CRNAs and AAs, under the medical direction of an anesthesiologist, shall be reimbursed 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA or AA;

(c) Medical direction for administering anesthesia includes the following:

(i) performs a pre-anesthesia examination and evaluation,
(ii) prescribes the anesthesia plan,

(iii) personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,

(iv) ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,

(v) monitors anesthesia administration at frequent intervals,

(vi) remains physically present and available for immediate diagnosis and treatment of emergencies, and

(vii) provides indicated post-anesthesia care.

(2) The supervision of AAs shall be in accordance with the Medical Practice Act.

(3) HCPCS Level II modifiers are required when billing for anesthesia services. Modifier AD shall be used when an anesthesiologist supervises more than four (4) concurrent (occurring at the same time) anesthesia service cases. Maximum allowance for supervising multiple cases is calculated using three (3) base anesthesia units for ~~to~~ each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(4) Physical status modifiers are reimbursed as follows, using the anesthesia CF:

(a)	P-1	Healthy patient	0 RVUs
(b)	P-2	Patient with mild systemic disease	0 RVUs

(c)	P-3	Patient with severe systemic disease	1 RVU
(d)	P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
(e)	P-5	A moribund patient who is not expected to survive without the operation	3 RVUs
(f)	P-6	A declared brain-dead patient	0 RVUs

(56) Multiple procedures are billed in accordance with CPT®. When more than one surgical procedure is performed during a single episode, only the highest-valued base anesthesia procedure value is billed with the total anesthesia time for all procedures.

(67) Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time equals 1 additional RVU. Five minutes or more is considered significant time and adds 1 RVU to the payment calculation.

(78) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's 20198 Anesthesia Base Values

+1 Unit/15 minutes of anesthesia time

+Any physical status modifier units

Total Relative Value Anesthesia Units

Multiplied by the Anesthesia CF in section 18-4(A)(1)

Total Maximum Anesthesia Fees

(89) Non-time based anesthesia procedures shall be billed with modifier 47.

(DE) SURGERY

(1) Assistant Surgeons Payment Policies and Modifiers:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2018 Update (February 2018), available from the American College of Surgeons, Chicago, IL, or from its web page. The incorporation is limited to the edition named and does not include later revisions or additions.

Provider shall document the medical necessity for any assistant surgeon in the operative report.

(b) Payment for more than one (1) assistant surgeon or minimum assistant surgeon requires prior authorization ~~(see Rule 16-6)~~.

(c) Maximum allowance for an assistant surgeon or minimum assistant surgeon, reported by a physician, as indicated by modifier 80, 81 or 82 is 20% of the surgeon's fees.

(d) Maximum allowance for an assistant surgeon or minimum assistant surgeon, reported by a non-physician, as indicated by modifier AS with modifier 80, 81 or 82, is 10% of the surgeon's fees (the 85% adjustment in section 18-45(A)(2)(b) does not apply).

(e) The services performed by registered surgical technologists are bundled fees and are not separately payable.

(f) See section 18-45(AB)(3)(q) for additional payment policies applicable to assistant surgeons.

(2) Global Package

(a) All surgical procedures include the following:

(i) local infiltration, metacarpal/metatarsal/digital block, or typical anesthesia;

(ii) one related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);

(iii) intra-operative services that are normally a usual and necessary part of a surgical procedure;

(iv) immediate post-operative care, including dictating operative notes, talking with the family and other physicians;

(v) evaluating the patient in the post-anesthesia recovery room;

(vi) post-surgical pain management by the surgeon;

(vii) typical post-operative follow-up care during the global period of the surgery that is related to recovery, see section 18-45(AB)(3)(k).

(viii) supplies integral to an operative procedure. See section 18-6(AH) to determine reimbursement for unrelated supplies or Durable Medical Equipment, Orthotics or Prosthetics (DMEPOS). Casting supplies are separately payable only if related fracture or surgical care code is not billed. The HCPCS Level II "Q" code(s) are used for reporting any associated DMEPOS fees.

(ix) pre or post-operative services integral to the operative procedure and performed within the global follow-up period are not separately payable. These services include, but are not limited to the following:

- dressing changes;
- local incisional care;
- removal of operative pack;
- removal of cutaneous sutures and staples, lines, wires, tubes, or drains;
- initial application of casts and splints;
- insertion, irrigation, and removal of urinary catheters;
- routine peripheral IV lines;

- nasogastric and rectal tubes;
- changes and removal of tracheostomy tubes;
- post-surgical pain management by the surgeon;
- all complications leading to additional procedures performed by the surgeon, but not requiring an operating room. Complications requiring an operating room are separately payable with modifier 78.

(b) Modifiers:

Code	Payment policy
22	The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.
54	Surgical care only. This modifier can be combined with either modifier 55 or 56, but not both. Maximum fee is the applicable percentage in the "intra-op %" RBRVS column multiplied by the fee schedule value.
55	Post-operative management only. This modifier can be combined with either modifier 54 or 56, but not both. Maximum fee is the applicable percentage in the "post-op %" RBRVS column multiplied by the fee schedule value.
56	Pre-operative management only. This modifier can be combined with either modifier 54 or 55, but not both. Maximum fee is the applicable percentage in the "pre-op %" RBRVS column multiplied by the fee schedule value.
58	Maximum fee value is 100% of prospective procedures that occur on the same day or staged over a couple of days.
62	Co-Surgeon use when different surgical skills are necessary to perform a surgical procedure.
~~76~~	
78	Maximum fees for this unplanned return to the operating room ~~trip~~ is the intra-operative value of the procedure(s) performed only and the original post-operative global days continue from the initial surgical procedure(s).
~~79~~	

(c) Significant and separately identifiable services performed during the global period are separately payable. The services involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries.

Modifiers 24, 25, and 57 shall be used to over-ride the global package edits/limits:

Modifier	Payment and billing policies	Applicability/Documentation
24	E&M services unrelated to the primary surgical procedure. The reasonableness and necessity for an E&M service that is separate and identifiable from the surgical	Services necessary to stabilize the patient for the primary surgical procedure. Services not considered part of the surgical procedure, including an

	global period shall be documented in the medical record. If possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. Disability management of an injured worker for the same diagnosis requires the physician to identify the specific disability management detail performed during that visit.	E&M visit by an authorized treating physician for disability management. The definitions of disability counseling are located ~~under section 18-5(C)(1) and~~ in Exhibit #7.
25	Initial or follow up visit that occurred on the same day/encounter as a minor surgical procedure.	E&M documentation must support the patient's condition. The visit must be significant and separately identifiable from the minor surgical procedure and the usual pre- and post-operative care required.
57	The surgeon's E&M visit that resulted in the decision for major surgery performed on either the same day or the day after the visit.	The E&M documentation must identify the medical necessity of the procedure and the discussion with the patient.

(3) General Surgical Payment Policies:

(a) Exploration of a surgical site is not separately payable except in cases of a traumatic wound or an exploration performed in a separate anatomic location.

(b) A diagnostic arthroscopy that resulted in a surgical arthroscopy at the same surgical encounter is bundled into the surgical arthroscopy and is not separately payable.

(c) An arthroscopy performed as a "scout" procedure to assess the surgical field or extent of disease is bundled into the surgical procedure performed on the same body part during the same surgical encounter and is not separately payable.

(d) An arthroscopy converted to an open procedure is bundled into the open procedure and is not separately payable. In this circumstance, providers shall not report either a surgical arthroscopy or a diagnostic arthroscopy code.

(e) Only the joints/compartments listed in subsections (4) through (6) below are recognized for separate payment purposes.

(f) Providers shall report only one removal code for removal of implants through the same incision, same anatomical site, or a single implant system during the same episode of care.

(4) Knee Arthroscopies

(a) Medial, lateral, and patella are the knee compartments recognized for purposes of separate payment of debridement and synovectomies.

(b) Chondroplasty is separately payable with another knee arthroscopy only if performed in a different knee compartment or to remove a loose/foreign body during a meniscectomy.

(c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.

(d) Payment for a major synovectomy procedure shall require a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies

(a) Glenohumeral, acromioclavicular, and subacromial bursal space are the shoulder regions recognized for purposes of separate payment.

(b) Limited debridement performed with a shoulder arthroscopy is bundled into the arthroscopy and is not separately payable unless subsection (c) applies.

(c) Limited debridement performed in the glenohumeral region is separately payable if it is the only procedure performed in that region in the surgical encounter.

(d) Extensive debridement (debridement that takes place in more than one location or compartment) is separately payable if documented in the medical record.

(6) Spine and Nervous System

(a) Spinal manipulation is integral to spinal surgical procedures and is not separately payable.

(b) Surgeon performing a spinal procedure shall not report intra-operative neurophysiology monitoring/testing codes.

(c) If multiple procedures from the same CPT® code family are performed at contiguous vertebral levels, provider shall append modifier 51 to all lesser-valued primary codes. See sections 18-5(B)(6)(a)~~(3)(o)~~ and 18-4(A)(3)(o) for applicable payment policies.

(d) Fluoroscopy is separately payable with spinal procedures only if indicated by a specific CPT® instruction.

(e) Lumbar laminotomies and laminectomies performed with arthrodesis at the same interspace are separately payable if the surgeon identifies the additional work performed to decompress the thecal sac and/or spinal nerve(s). If these procedures are performed at the same level, provider shall append modifier 51 to the lesser-valued procedure(s). If procedures are performed at different interspaces, provider shall append modifier 59 to the lesser-valued procedure(s). See sections 18-5(B)(6)(a)~~(3)(o)~~ and 18-4(A)(3)(o) for applicable payment policies.

(f) Only one anterior or posterior instrumentation performed through a single skin incision is payable.

(g) Anterior instrumentation performed to anchor an inter-body biomechanical device to the intervertebral disc space is not separately payable.

(h) Anterior instrumentation unrelated to anchoring the device is separately payable with modifier 59 appended.

(7) Venipuncture maximum fee allowance is covered under Exhibit #8.

(8) Platelet Rich Plasma (PRP) Injections

~~The Medical Treatment Guidelines (Rule 17) govern PRP injections. Any PRP injections outside of the Medical Treatment Guidelines require prior authorization.~~

The provider performing PRP injections in an office setting shall bill DoWC Z0813, maximum total allowance of $758.88, for professional fees.

The provider performing PRP injections in a facility setting shall bill CPT® 0232T, maximum total allowance of $274.50, for professional fees. ~~For adjusted RVUs and rates, see Exhibit #9.~~

The above allowances include and apply to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.

(E~~F~~) RADIOLOGY

(1) General Policies

(a) Payers and providers shall use professional component (26) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.

(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) Payments

(a) The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers ~~separately~~ reporting ~~Z9999~~ technical or total component of these services certify accreditation status. The provider shall supply proof of accreditation upon payer request. ~~The payer may also request proof of accreditation.~~

~~(b) The professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule.~~

(bc) The cost of dyes and contrast shall be reimbursed in accordance with section 18-6(AH).

(cd) Copying charges for X-rays and MRIs shall be $15.00/film regardless of the size of the film.

(de) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(4).

(ef) Providers using film instead of digital X-rays shall append the FX modifier. The fee is 80% of the Maximum Fee Schedule.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one (1) interpretation shall be reimbursed.

If an X-ray consultation is requested, the consultant's report shall include the name of the requesting provider, the reason for the request, and documentation that the report was sent to the requesting provider.

The maximum fee for an X-ray consultation shall be no greater than the maximum fee for the professional component of the original X-ray.

The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician's E&M service code.

(3) Thermography

(a) The provider supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one (1) of the following national organizations and follow their recognized protocols, or have equivalent documented training:

(i) American Academy of Thermology,

(ii) American Chiropractic College of Infrared Imaging, or

(iii) American Academy of Infrared Imaging

(b) Thermography Billing Codes:

DoWC Z0200 Upper body w/ Autonomic Stress Testing	$980.00
DoWC Z0201 Lower body w/ Autonomic Stress Testing	$980.00

(c) Prior authorization (see Rule 16-6) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in the Division's Chronic Regional Pain Syndrome Medical Treatment Guideline (Rule 17, Exhibit #7). The bill shall include a report that supplies the thermographic evaluation and complies with this section 18-5(F)(2).

(4) Urea breath test C-14 (isotopic), acquisition for analysis, and the analysis maximum fees are listed under Exhibit #8.

(F~~G~~) PATHOLOGY

(1) General Policies

(a) Providers and payers shall use professional component (PC) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.

(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only, and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) Clinical Laboratory Improvement Amendments (CLIA)

Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver, or other providers billing for services performed by these laboratories, shall bill using the QW modifier.

Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation, or other providers billing for services performed by these laboratories, do not append the QW modifier to claim lines.

(3) Payments

All clinical pathology laboratory tests, except as allowed by this Rule, are reimbursed at the total component value listed under Exhibit #8 or billed charges, whichever is less. Technical or professional component maximum split is not separately payable. However, the billing parties may agree how to split the total maximum fees listed in Exhibit #8.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum fee is determined by using RBRVS values and the Pathology CF. The Pathology CF determines the Maximum Fee Schedule value when the Pathology CPT® code description includes “interpretation” and “report” or when billing CPT® codes for the following services:

(a) physician blood bank services,

(b) cytopathology and cell marker study interpretations,

(c) cytogenics or molecular cytogenics interpretation and report,

(d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and

(e) skin tests for unlisted antigen each, coccidoidomycosis, histoplasmosis, TB intradermal.

When ordering automated laboratory tests, the ordering physician may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the physician requested additional medical interpretation, judgment, and a separate written report. Upon such a request, the pathologist may bill using the proper CPT® code and RBRVS values, not DoWC Z0755.

(4) Clinical Drug Screening/Testing Codes and Values ~~(for adjusted RVUs and rates, see Exhibit #9)~~:

(a) Clinical drug screening/testing evaluates whether:

(i) prescribed medications are at or below therapeutic or toxic levels (therapeutic drug monitoring); or

(ii) the patient is taking prescribed controlled substance medications; or

(iii) the patient is taking any illicit or non-prescribed drugs.

(b) Billing requirements for clinical drug testing:

(i) the ordering physician shall document the medical necessity of the clinical drug test.

(ii) the ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.

(iii) quantification of illicit or non-prescribed drugs or drug classes requires a physician order.

(iv) Medicare codes used in the 2019~~98~~ Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.

(v) all recognized codes and maximum fee values are listed in Exhibit #8.

(c) Presumptive Tests

All drug class immunoassays or enzymatic methods are considered presumptive. Payers shall only pay for one presumptive test per date of service ~~Providers may only bill one presumptive code per date of service~~, regardless of the number of drug classes tested.

(d) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug. A physician must order definitive quantitative tests. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker.
- Unexpected negative presumptive or qualitative test results and suspected medication diversion.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone and noroxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as

tetrahydrocannabinol (THC) quantitation to document discontinuation of a drug.

- Chronic opioid management - drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
  While the injured worker receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-~~9~~98(A) for examples). Providers may only bill one definitive HCPCS Level II code per day.

- ~~The table below should be used to determine the appropriate drug class(es) when billing G0480-G0483.~~ CPT® may be consulted for a definitive drug classes listing and examples of individual drugs within each class. Each class of drug can only be billed once per day.

~~Definitive classes~~			
~~Alcohol(s)~~	~~Antiepileptics, not otherwise specified~~	~~Gabapentin, non-blood~~	~~Phencyclidine~~
~~Alcohol Biomarkers~~	~~Antipsychotics, not otherwise specified~~	~~Heroin metabolite~~	~~Pregabalin~~
~~Alkaloids, not otherwise specified~~	~~Barbiturates~~	~~Ketamine and Norketamine~~	~~Propoxyphene~~
~~Amphetamines~~	~~Benzodiazepines~~	~~Methadone~~	~~Sedative Hypnotics (nonbenzodiazepines)~~
~~Anabolic steroids~~	~~Buprenorphine~~	~~Methylenedioxyamphetamines~~	~~Skeletal Muscle Relaxants~~
~~Analgesics, non-opioids~~	~~Cannabinoids, natural~~	~~Methylphenidate~~	~~Stereoisomer (enantiomer) analysis~~
~~Antidepressants, serotonergic class~~	~~Cannabinoids, synthetic~~	~~Opiates~~	~~Stimulants, synthetic~~
~~Antidepressants, Tricyclic and other cyclicals~~	~~Cocaine~~	~~Opioids and Opiate analogs~~	~~Tapentadol~~
~~Antidepressants, not otherwise specified~~	~~Fentanyls~~	~~Oxycodone~~	~~Tramadol~~
~~Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified~~			

(GH) MEDICINE

(1) See section 18-6(BM) for medicine home care services.

~~(2) Anesthesia qualifying circumstance values are reimbursed in accordance with section 18-5(D)(5).~~

(23) Biofeedback

Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback providers must hold Clinical Certification from the Biofeedback Certification International Alliance (BCIA), practice within the scope of their training, and receive prior approval of their biofeedback treatment plan from the patient's authorized treating physician, psychologist, or psychiatrist. Professionals integrating biofeedback with any form of psychotherapy must be licensed as a psychologist, a social worker, a marriage or a family therapist, or a licensed professional counselor.

Biofeedback treatment must be provided in conjunction with other psychosocial or medical interventions.

All biofeedback providers shall document biofeedback instruments used during each visit (including, but not limited to, surface *electromyography (SEMG)*, *heart rate variability* (HRV), electroencephalogram (EEG), or temperature training), placement of instruments, and patient response, if sufficient time has passed.

The modified RVUs for biofeedback services are:

CPT® 90901, non-facility RVU is 2.14, facility RVU is 1.14

CPT® 90911, non-facility RVU is 4.76, facility RVU is 2.48

~~For adjusted RVUs and rates, see Exhibit #9.~~

(34) Appendix J of 20198 CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. Electromyography (EMG) and nerve conduction velocity (NCV) values generally include an evaluation and management (E&M) service. However, an E&M service may be separately payable if the requirements listed in Appendix A of 20198 CPT® for billing modifier 25 have been met.

(45) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization ~~(see Rule 16-6)~~ shall be obtained before billing for more than four body regions in one (1) visit. ~~Manipulative therapy is limited to the maximum allowed in the Medical Treatment Guidelines.~~ The provider's medical records shall reflect medical necessity and prior authorization if treatment exceeds these limitations.

(b) Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless provider performs manual therapy in a separate region and meets modifier 59 requirements.

(cb) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirements and an appropriate modifier is used.

(d) The modified RVUs for chiropractic spinal manipulative treatment are:

CPT® 98940 Non-facility RVU is 1.0, facility RVU is 0.79

CPT® 98941 Non-facility RVU is 1.44, facility RVU is 1.22

(dc) ~~For adjusted RVUs and rates, see Exhibit #9.~~

(56) Psychiatric/Psychological Services ~~(for adjusted RVUs and rates, see Exhibit #9)~~:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the Medical Fee Schedule. Other non-physician providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians.

(b) ~~Prior authorization is required if the limitations discussed in this section are exceeded in a single day.~~

Psychological~~iatric~~ diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless it is authorized by ~~prior authorization is received from~~ the payer or is necessary to complete an impairment rating recommendation as determined by the ATP.

(c) Central Nervous System (CNS) Assessments/Tests~~,~~ (neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization.

When testing, evaluation, administration, and scoring services are provided across multiple dates of service, all codes should be billed together on the last date of service when the evaluation process is completed. A base code shall be billed only for the first unit of service of the evaluation process, and add-on codes shall be used to capture services provided during subsequent dates of service.

Documentation shall include the total time and the approximate time spent on each of the following activities, when performed:

- face to face time with the patient
- reviewing and interpreting standardized test results and clinical data
- integrating patient data
- clinical decision-making and treatment planning
- report preparation

If there is a delay in scheduling the feedback session, the provider may incorporate feedback into the first psychotherapy session.

The modified RVUs for psychological and neuropsychological services are:

CPT® 96116 = non-facility RVU is 3.4, facility RVU is 2.98

CPT® 96127 = non-facility and facility RVUs are 0.18

CPT® 96130 = non-facility RVU is 3.63, facility RVU is 3.4

CPT® 96131 = non-facility RVU is 2.92, facility RVU is 2.73

CPT® 96132 = non-facility RVU is 4.11, facility RVU is 3.2

CPT® 96133 = non-facility RVU is 3.11, facility RVU is 2.44

CPT® 96146 = non-facility and facility RVUs are 0.10

CPT® 90791 = non-facility RVU is 9.91, facility RVU is 9.6

CPT® 90792 = non-facility RVU is 11.12, facility RVU is 10.8

CPT® 96150 = non-facility RVU is 0.80, facility RVU is 0.79

CPT® 96151 = non-facility RVU is 0.78, facility RVU is 0.77

CPT® 96152 = non-facility RVU is 0.74, facility RVU is 0.73

CPT® 96153 = non-facility RVU is 0.18, facility RVU is 0.17

CPT® 96154 = non-facility RVU is 0.74, facility RVU is 0.73

CPT® 96155 = non-facility and facility RVUs are 0.73

Brief psychological screens (including, but not limited to, Distress Risk and Assessment Method (DRAM), Primary Care Evaluation of Mental Disorders (PRIME-MD), Zung Self-Rating Depression Scale, Beck Depression Inventory, and CES-D (Center for Epidemiologic Studies Depression Scale) are not equivalent to psychological testing codes listed in the CNS section of CPT®.

~~Most initial evaluations for delayed recovery, exclusive of testing, can be completed in two (2) hours.~~

(d) The limit for psychotherapy services is 60 minutes per visit, unless provider obtains prior authorization. ~~Prior authorization is required any time the 60 minutes per visit limitation is exceeded.~~ The time for internal record review/ documentation is included in this limit.

Psychotherapy for work-related conditions ~~requiring more than 20 visits or~~ continuing for more than three (3) months after the initiation of therapy, ~~whichever comes first,~~ requires prior authorization unless ~~specifically addressed in~~ the Medical Treatment Guidelines recommend a longer duration.

(e) When billing an evaluation and management (E&M) code in addition to psychotherapy:

(i) both services must be separately identifiable;

(ii) the level of E&M is based on history, exam and medical decision-making;

(iii) time may not be used as the basis for the E&M code selection; and

(iv) add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

Non-medical disciplines cannot bill most E&M codes.

(f) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer.

(~~g~~f) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified

health care professional may generate a separate report and bill for that service as a special report.

(6~~7~~) Qualified Non-Physician Provider Telephone or On-Line Services

Reimbursement to qualified non-physician providers for coordination of care with medical professionals shall be based upon the telephone codes for qualified non-physician providers found in the RBRVS Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the non-physician provider's facility(ies) and to the injured worker or his or her family.

For reimbursement of face-to face or telephonic meetings by a treating physician with employer, claim representative, or attorney, see section 18-7~~6~~(A)(1).

(7~~8~~) Quantitative Autonomic Testing Battery (ATB) and Autonomic Nervous System Testing.

(a) Quantitative Sudomotor Axon Reflex Test (QSART) is a diagnostic test used to diagnose Complex Regional Pain Syndrome. This test is performed on a minimum of two (2) extremities and encompasses the following components:

(i) Resting Sweat Test;

(ii) Stimulated Sweat Test;

(iii) Resting Skin Temperature Test; and

(iv) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

(b) Bill DoWC Z0401 QSART, $1,066.00, when all of the services outlined above are completed and documented. This code may only be billed once per workers' compensation claim, regardless of the number of limbs tested.

(8~~9~~) Intra-Operative Monitoring (IOM)

IOM is used to identify compromise to the nervous system during certain surgical procedures. Evoked responses are constantly monitored for changes that could imply damage to the nervous system.

(a) Clinical Services for IOM: Technical and Professional

(i) Technical staff: A qualified specifically trained technician shall set up the monitoring equipment in the operating room and is expected to be in constant attendance in the operating room with the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology. The technician shall be specifically trained in/registered with:

- the American Society of Neurophysiologic Monitoring; or
- the American Society of Electrodiagnostic Technologists

(ii) Professional/Supervisory /Interpretive

A Colorado-licensed physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the monitoring physician is monitoring more than one patient. The monitoring physician's time does not have to be continuous for each patient and may be cumulative. The monitoring physician shall not monitor more than three (3) surgical patients at one time. The monitoring physician shall provide constant neuromonitoring at critical points during the surgical procedure as indicated by the surgeon or any unanticipated testing responses. There must be a neurophysiology-trained Colorado licensed physician backup available to continue monitoring the other two patients if one of the patients being monitored has complications and/or requires the monitoring physician's undivided attention for any reason. There is no additional payment for the back-up neuromonitoring physician, unless he/she is utilized in a specific case.

(iii) Technical Electronic Capacity for Real-Time Communication Requirements

The electronic communication equipment shall use a 16-channel monitoring and minimum real-time auditory system, with the possible addition of video connectivity between monitoring staff, operating surgeon and anesthesia. The equipment must also provide for all of the monitoring modalities that may be applied with the IOM procedure code.

(b) Procedures and Time Reporting

Physicians shall include an interpretive written report for all primary billed procedures.

(c) Billing Restrictions

Intra-operative neurophysiology codes do not have separate professional and technical components. However, certain tests performed in conjunction with these services throughout the surgical procedure have separate professional and technical components, which may be separately payable if documented and otherwise allowed in this Rule.

The monitoring physician is the only party allowed to report these codes.

~~For adjusted RVUs and rates, see Exhibit #9.~~

(9~~10~~) Speech-language therapist/pathology or any care rendered under a speech-language therapist/pathology plan of care shall be billed with a GN modifier appended to all billing codes.

(10~~11~~) Vaccine and toxoids shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In these circumstances, the provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

(1112) IV Infusions Performed in Physicians' Offices or Sent Home with Patient

IV infusion therapy performed in a physician's office shall be billed under the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" and the "Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration" in the Medicine Section of CPT®. The infused therapeutic drugs are payable at cost to the provider's office.

Maximum fees for supplies and medications provided by a physician's office for self-administered home care infusion therapy are covered in section 18-6(BM)(1).

(1213) Moderate (Conscious) Sedation

Providers billing for moderate sedation services shall comply with all applicable 20198 CPT® billing instructions. The Maximum Fee Schedule value is determined using the Medicine CF.

~~(14) Special Services, Procedures and Reports in the Medicine Section of CPT® (for adjusted RVUs and rates, see Exhibit #9):~~

~~(a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate. Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate.~~

~~(b) Post-operative follow-up visit is included in the global package and is not separately payable.~~

~~(ac) Educational supplies are considered "at cost" to the provider and may be billed based upon an agreement between the payer and provider.~~

(bd) ~~Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer.~~

~~(e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization.~~

~~(f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees.~~

(HI) PHYSICAL MEDICINE AND REHABILITATION (PM&R)

(1) General Policies:

(a) Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a GP modifier appended to all codes. Occupational therapy or any care provided under an occupational therapist's plan of care shall be billed with a GO modifier appended to all codes.

(b) Each PM&R billed service must be clearly identifiable. The provider must clearly document the time spent performing each service and the beginning and end time for each session.

(c) Functional objectives shall be included in the PM&R plan of care for all injured workers. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering ATP must also agree with the PM&R continuation or changes to the treatment plan.

(d) The injured worker shall be re-evaluated by the prescribing provider within 30 calendar days from the initiation of the prescribed treatment and at least once every month thereafter.

(e) Unlisted services require a report.

(2) Medical nutrition therapy requires prior authorization.

(3~~5~~) Interdisciplinary Rehabilitation Programs – require prior authorization to determine fees.

An interdisciplinary rehabilitation program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. As defined in the Medical Treatment Guidelines, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

All billing providers shall detail the services, frequency of services, duration of the program, and their proposed fees for the entire program and all professionals. The billing provider and payer shall attempt to agree upon billing code(s) and fee(s) for each interdisciplinary rehabilitation program.

If there is a single billing provider for the entire interdisciplinary rehabilitation program and a daily per diem rate is mutually agreed upon, use code Z0500.

If the individual interdisciplinary rehabilitation professionals bill separately for their participation in an interdisciplinary rehabilitation program, the applicable CPT® codes shall be used to bill for their services. ~~Demonstrated participation in an interdisciplinary rehabilitation program allows the use of the frequencies and durations listed in the relevant Medical Treatment Guideline's recommendations.~~

(4~~6~~) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, dry needling of trigger points, manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques and any unlisted physical medicine procedures.)

~~The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Medical Treatment Guidelines.~~

The maximum amount of time allowed is one (1) hour of procedures per day per discipline unless medical necessity is documented and prior authorization is obtained from the payer. The total amount of billed unit time cannot exceed the total time spent performing the procedures.

For Dry Needling of Trigger Points, ~~single or multiple needles,~~ use DoWC Z0501 or Z0502~~ as appropriate.~~

DoWC Z0501, initial 15 minutes, non-facility RVU is 1.3, facility RVU is 0.77

DoWC Z0502, each additional 15 minutes, non-facility RVU is 0.77, facility RVU is 0.72

The modified RVU for an unlisted procedure, CPT® 97039, is 0.92, non-facility and facility.

(5~~7~~) Modalities

There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day.

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. ~~Rental or purchase of a TENS unit requires prior authorization.~~ For Maximum Fee Schedule value, see section 18-6(A~~H~~).

~~The maximum value for unlisted modalities is equal to the value of an ultrasound.~~

The modified RVUs for an unlisted modality, CPT® 97039, are 0.36 non-facility, 0.00 facility.

(6~~8~~) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (AT~~C~~)

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals and treatment plan or re-evaluation of the treatment plan, as outlined in the 2019~~98~~ CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination of the patient, and the reasoning for recommending the continuation or adjustment of the treatment protocol. Without appropriate supporting documentation, the payer may deny payment. The re-evaluation codes shall not be billed for routine pre-treatment patient assessment.

If a new problem or abnormality is encountered that requires a new evaluation and treatment plan, the professional may perform and bill for another initial evaluation. A new problem or abnormality may be caused by a surgical procedure being performed after the initial evaluation has been completed.

A re-examination, re-evaluation, or re-assessment is different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill a re-evaluation code only if:

(i) professional assessment indicates a significant improvement or decline or change in the patient's condition or a functional status that was not anticipated in the plan of care for that time interval.

(ii) new clinical findings become known.

(iii) the patient fails to respond to the treatment outlined in the current plan of care.

(b) A PT or OT may utilize a Rehabilitation Communication Form (WC196) in addition to a progress note no more than every 2 weeks for the first 6 weeks, and once every 4 weeks thereafter.

The WC196 form should not be used for an evaluation, re-evaluation or re-assessment.

The WC196 form must be completed and include which validated functional tool was used for assessing the patient.

The form shall be sent to the referring physician before or at the patient's follow up appointment with the physician, to aid in communication. ~~Bill~~ DoWC Z0817, $15.30.

(c) Payers are only required to pay for evaluation services directly performed by a PT, OT, or AT~~C~~. All evaluation notes or reports must be written and signed by the PT, OT or AT~~C~~.

(d) A patient may be seen by more than one (1) health care professional on the same day. Each professional may charge an evaluation service with appropriate documentation per patient, per day.

(e) Reimbursement to PTs and OTs for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the Medicine Section of CPT®. Coordination of care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or his or her family.

(f) The RVU for evaluation services performed by ATs shall be equal to the RVU for evaluation services performed by PTs.

(g~~f~~) Interdisciplinary team conferences shall be billed per subsection (3~~5~~) above.

(7~~9~~) Special Tests

(a) The following are considered special tests:

(i) Job Site Evaluation

(ii) Functional Capacity Evaluation

(iii) Assistive Technology Assessment

(iv) Speech

(v) Computer Enhanced Evaluation (DoWC Z0503)

(vi) Work Tolerance Screening (DoWC Z0504)

The facility and non-facility RVU for DoWC Z0503 and Z0504 is 0.93.

(b) Billing Restrictions:

(i) Job site evaluations exceeding two (2) hours require prior authorization. Computer-Enhanced Evaluations and Work Tolerance Screenings for more than four (4) hours per test or more than three

(3) tests per claim require prior authorization. Functional Capacity Evaluations for more than four (4) hours per test or two (2) tests per claim require prior authorization.

(ii) The provider shall specify the time required to perform the test in 15-minute increments.

(iii) The value for the analysis and the written report is included in the code's value.

(iv) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.

(v) Data from computerized equipment shall always include the supporting analysis developed by the PM&R professional before it is payable as a special test.

(c) All special tests must be fully supervised by a physician, PT, OT, speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, PT, OT, speech language pathologist/therapist or audiologist.

(8~~10~~) Physical medicine supplies are reimbursed in accordance with section 18-6(A~~H~~).

(9~~11~~) Use of ~~If a patient uses a~~ facility or ~~its~~ equipment for unattended procedures, in an individual or group setting, may be billed with DoWC Z0505 (once per day), RVU 0.23.

(10~~12~~) Non-Medical Facility Fees

Gyms, pools, etc., and training or supervision by non-medical providers require prior authorization and a written negotiated fee for every three month period.

(11~~14~~) Work Conditioning, Work Hardening, Work Simulation

(a) Work Conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one (1) discipline oversees the patient in meeting goals to return to work.

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work.

(c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis.

(d) Treatment Plan:

(i) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider,

the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.

~~(ii) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization is required.~~

(ii~~i~~) All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

(e) Modified facility and non-facility RVUs are 3.4 for initial 2 hours and 1.7 for each additional hour.

(12~~15~~) Wound Care

Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums). CPT® 97602 is not recognized for payment.

(13) ACUPUNCTURE

(a) ~~Acupuncture is an accepted procedure to relieve pain and tissue inflammation. While commonly used for treatment of pain, it may also be used as an adjunct to physical rehabilitation and/or surgery to hasten functional recovery.~~ Acupuncture may be performed with or without the electrical current on the needles at the acupuncture site.

~~(a) Provider Restrictions~~

All non-physician acupuncture providers must be a Licensed Acupuncturist (LAc) by the Colorado Department of Regulatory Agencies as provided in Rule 16. Both physician and non-physician providers must provide evidence of training, and licensure upon request of the payer.

~~(b) Billing Restrictions~~

~~(i) For treatment frequencies exceeding the maximum allowed in the Medical Treatment Guidelines, the provider must obtain prior authorization.~~

~~(ii) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization, the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.~~

~~(iii) Reimburse acupuncture, including or not including electrical stimulation, per the values listed in the RBRVS, times the appropriate CF.~~

(b) ~~Non-Physician evaluation services:~~

New or established patient evaluation services are payable if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation

notes or reports must be written and signed by the LAc. ~~Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-11)~~

LAc new patient visit: DOWC Z0800, $101.80

(LAc established patient visit: DOWC Z0801, $68.95

~~(c) Herbs require prior authorization and fee agreements (see section 18-6(N)(8)).~~

~~(d) See the appropriate Physical Medicine and Rehabilitation section of the RBRVS for other billing codes and limitations (see also section 18-5(I)).~~

~~(e) Acupuncture supplies are reimbursed pursuant to section 18-6(H).~~

(I~~J~~) TELEMEDICINE~~HEALTH~~

(1) ~~"Telehealth" and "Telemedicine" are defined in Rule 16-2.~~ The healthcare services listed in Appendix P of CPT®, ~~and~~ Division Z-codes (when appropriate), G0459, G0508, and G0509 may be provided via ~~telehealth or~~ telemedicine. Additional services may be provided via telemedicine with prior authorization. The provider shall append modifier 95 to ~~the services listed in Appendix P to~~ indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All healthcare services provided through ~~telehealth or~~ telemedicine shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado Board of Psychologist Examiners.

(2) HIPAA privacy and electronic security standards are required for the originating site(s) and the rendering provider(s).

(3) The physician-patient / psychologist-patient relationship needs to be established.

(a) This relationship is established through assessment, diagnosis and treatment of the patient. Two-way live audio/video services are among acceptable methods to 'establish' a patient relationship.

(b) The patient is required to provide the appropriate consent for treatment.

(4) Payment for ~~telehealth and~~ telemedicine services ~~(for adjusted RVUs and rates, see Exhibit #9)~~:

(a) Telemedicine~~health~~ services performed outside of an authorized originating site must be billed without an originating site fee. The distance (rendering) provider may be the only provider involved in the provision of telemedicine~~health~~ services. The rendering provider shall bill CPT® place of service (POS) code 02~~, with modifier 95~~. This POS code does not apply to the originating site billing a facility fee.

The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)

- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based or critical access hospital based renal dialysis center (including satellites)
- A skilled nursing facility (SNF)
- A community mental health center (CMHC)

(b) Reimbursement is the RBRVS unit value for the CPT® code times the appropriate CF + $5.00 transmission fee per date of service when modifier 95 is appended to the appropriate CPT® code(s).

~~95 Synchronous telemedicine service rendered via a real time interactive audio and video telecommunications system.~~

(c) Telemedicine~~health~~:

(i) ~~Approved telehealth f~~Facilities can bill Q3014 per 15 minutes, $35.00, for the originating fee.

All locations not associated with medical care, such as a private residence where an injured worker is located when receiving telemedicine~~health~~ services may not bill the originating fee. The medical records shall document the physical locations of the rendering provider and the injured worker.

(ii) Payment for ~~telehealth~~ services that have professional and technical components:

The originating site provider shall bill the technical component (modifier TC). The distant site provider interpreting the results shall bill the professional component (modifier 26).

(iii) The equipment or supplies at distant sites are not separately payable.

(iv) Professional fees of the supporting providers at originating sites are not separately payable.

~~(d) Telemedicine:~~

(v~~i~~) The medical providers shall bill codes G0425-G0427 for ~~telehealth~~ consultations, emergency department or initial inpatient. ~~The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M CF listed in section 18-4.~~

(vi~~i~~) The medical providers shall bill codes G0406-G0408 for follow up inpatient ~~telehealth~~ consultations. ~~The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M CF listed in section 18-4.~~

18-5 FACILITY FEES

(A) INPATIENT HOSPITAL FACILITY FEES

~~(1) Provider Restrictions~~

~~All non-emergency, inpatient admissions require prior authorization (see Rule 16-6).~~

(12) Billing:~~s for Services~~

(a) Inpatient hospital facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system in effect at the time of discharge. Exhibit #1 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

The hospital shall indicate the MS-DRG code number FL 71 of the UB-04 billing form and maintain documentation on file showing how the MS-DRG was determined. The hospital shall determine the MS-DRG using the MS-DRGs Definitions Manual in effect at the time of discharge. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding MS-DRG assignment. The payer may deny payment for services until the appropriate MS-DRG code is supplied.

(c) Exhibit #1 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under subsection ~~18-6(I)~~(23)(e) is allowed.

(d) Any inpatient admission requiring the use of both an acute care hospital (admission/discharge) and its Medicare certified rehabilitation facility (admission/discharge) is considered as one (1) admission and MS-DRG. This does not apply to long-term care and licensed rehabilitation facilities.

(2) ~~Inpatient Facility~~ Reimbursement:

(a) The following types of inpatient facilities are reimbursed at 100% of billed inpatient charges:

(i) Children's hospitals

(ii) Veterans' Administration hospitals

(iii) State psychiatric hospitals

(b) The following types of inpatient facilities are reimbursed at 80% of billed inpatient charges:

(i) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3)

(ii) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facilities,

(iii) CDPHE licensed psychiatric facilities that are privately owned.

(iv) CDPHE licensed skilled nursing facilities (SNF).

(c) Medicare Long Term Care Hospitals (MLTCH)

MLTCHs are reimbursed ~~at~~ $3,350 per day, not to exceed 75% of total billed charges. If total billed charges exceed $300,000, reimbursement shall be ~~at~~ 75% of billed charges. All charges shall be submitted on a final bill, unless the parties agree on interim billing. The rate in effect on the last date of service covered by an interim or a final bill shall determine payment.

The total length of stay includes the date of admission but not the date of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay.

(d) All other inpatient facilities are reimbursed as follows:

Retrieve the relative weights for the assigned MS-DRG from the MS-DRG table in effect at the time of discharge in Exhibit #1 and locate the hospital's base rate in Exhibit #2.

The "Maximum Fee Allowance" is determined by calculating:

(i) (MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate).

(ii) For trauma center activation allowance, (revenue codes 680-685) see subsection (B)(6)(e)~~18-6(J)(6)(d)~~.

(iii) For organ acquisition allowance, (revenue codes 810-819) see subsection ~~18-6(I)(3)~~(A)(2)(i).

(e) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under subsection (d) above. To calculate the additional reimbursement, if any:

(i) Determine the "Hospital's Cost":

Total billed charges (excluding any trauma center activation or organ acquisition billed charges) multiplied by the hospital's cost-to-charge ratio.

(ii) Each hospital's cost-to-charge ratio is given in Exhibit #2.

(iii) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any trauma center activation or organ acquisition allowance (see (d) above).

(iv) If the "Difference" is greater than $26,994.00~~27,545.00~~, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(f) Inpatient combined with Emergency Department (ED), Trauma Center or organ acquisition reimbursement.

(i) If an injured worker is admitted to the hospital, the ED reimbursement is included in the inpatient reimbursement under this section ~~18-6(I)(3)~~,

(ii) Trauma center activation fees ~~(see section 18-6(J)(6)(d))~~ and organ acquisition allowance ~~(see section 18-6(I)(3)(i))~~ are paid in addition to inpatient fees ~~(see sections 18-6(I)(3)(d)-(e))~~.

(g) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum value. The per diem value is calculated based upon the transferring hospital's MS-DRG relative weight multiplied by the hospital's specific base rate (Exhibit #2) divided by the MS-DRG geometric mean length of stay (Exhibit #1). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.

(h) The payer shall compare each billed charge type:

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);

(ii) The trauma center activation billed charge to the trauma center activation allowance; and

(iii) The organ acquisition charges to the organ acquisition maximum fees.

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charges and the organ acquisition billed charges from the total billed charges. The final payment is the sum of the lesser of each of these comparisons.

(i) The organ acquisition allowance is calculated using the most recent filed computation of organ acquisition costs and charges for hospitals that are certified transplant centers (CMS Worksheet D-4 or subsequent form) plus 20%.

(B) OUTPATIENT ~~HOSPITAL~~ FACILITY FEES

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization unless the Medical Treatment Guidelines recommend a surgery for the particular condition. All outpatient surgical procedures performed in an ASC shall ~~be reasonable and necessary and~~ warrant performance at an ASC level.

(b) A facility fee is payable only if the facility is licensed as a hospital or an ASC by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency or statute.

(2) Types of Bills for Service:

(a) Outpatient facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.

(b) All professional charges (professional services include, but are not limited to, PT/OT, anesthesia, speech therapy, etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule and applicable to all facilities regardless of whether the facility fees are based upon Exhibit #4 or a percentage of billed charges.

(c) Outpatient hospital facility bills include all outpatient surgery, ED, Clinics, Urgent Care (UC) and diagnostic testing in the Radiology, Pathology or Medicine Section of CPT®/RBRVS.

(3) Outpatient Facility Reimbursement:

(a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees ~~(see section 18-6(J)(2)(b) above)~~:

(i) Children's hospitals

(ii) Veterans' Administration hospitals

(iii) State psychiatric hospitals

(b) The CAHs listed in Exhibit #3 are reimbursed at 80% of billed outpatient facility charges, except for any associated professional fees.

(c) Ambulatory Payment Classifications (APC) Codes and Values:

Hospital reimbursement is based upon Medicare's 2019~~98~~ Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4. Exhibit #4 lists Medicare's Outpatient Hospital APC Codes and the Division's established rates for hospitals and other types of providers as follows:

(i) Column 1 lists the APC code number.
(ii) Column 2 lists APC code description.
(iii) Column 3 is used to determine maximum fees for all hospital facilities not listed under subsections ~~18-6(J)(3)~~(a) and (b).
(iv) Column 4 is used to determine maximum fees for all ASCs when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code number and dollar value, use Medicare's 2019~~98~~ Addendum B. ~~Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC 5115.~~

(d) The following CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall align to the following APC codes for payment:

CPT® 22558 = APC 5116

CPT® 22600, 22610, 22630, 22633, and 22857 = APC 5115

CPT® 22632 = APC 5092

CPT® 22634, 22800, and 22830= APC 5114

CPT® 22846 = APC 5192

CPT® 22849, 22850, 22852, and 22855 = APC 1571

CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 = APC 1575

(4) The APC Exhibit #4 values include the services and revenue codes listed below; therefore, these are generally not separately payable. However, the maximum allowable fee in Exhibit #4 may be exceeded in the rare case a more expensive implant is medically necessary. The facility must request prior authorization for additional payment with a separate report documenting medical reasonableness and necessity and submit an invoice showing cost of the implant(s) to the facility. Payers must report authorized exceptions to the Division's Medical Policy Unit on a monthly basis. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. These are separately payable based on APC values if given in Exhibit #4 or cost to the facility.

Services and Items Included in the APC Value:

(a) nursing, technician, and related services;

(b) use of the facility where the surgical procedure(s) was performed;

(c) drugs and biologicals for which separate payment is not allowed;

(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";

(e) surgical dressings;

(f) equipment;

(g) splints, casts and related devices;

(h) radiology services when not allowed under Exhibit #4;

(i) administrative, record keeping and housekeeping items and services;

(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;

(k) supervision of the services of an anesthetist by the operating surgeon;

(l) post-operative pain blocks; and

(m) implanted items.

Packaged Services	
Rev Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices
0279	Medical/Surgical Supplies and Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia

Packaged Services	
Rev Code	Description
0390	Administration, Processing & Storage for Blood & Blood Components; General Classification
0392	Administration, Processing & Storage for Blood & Blood Components; Processing & Storage
0399	Administration, Processing & Storage for Blood & Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

(5) Recognized Status Indicators from Medicare's Addendum B are applied as follows:

Indicator	Meaning
A	Use another fee schedule instead of Exhibit #4, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or Exhibit #8.
B	Is not recognized by Medicare for Outpatient Hospital Services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	Recognized by Medicare as inpatient-only procedures. However, the Division recognizes these procedures on an outpatient basis with prior authorization. See subsection 18-5(B)(3)(d) for reimbursement of certain procedures with "C" status indicator.
D	Discontinued code.
E1 or E2	Not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.
F	Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals" are separately payable under Exhibit #4 as an APC value.
H	A "Pass-Through Device" is separately payable based on cost to the facility.
J1 or J2	The services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary.
K	A separately payable "Pass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4 APC value.
L	Represents Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Service is bundled and is not separately payable.
P	Partial hospitalization paid based on observation fees outlined in this section ~~18-6(J)~~.
R	Blood and blood products
Q	Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the parties make a prior agreement.
S or T	Multiple procedures, the highest-valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.
U	Brachytherapy source and is separately payable under Exhibit #4 APC value.
V	Represents a clinic or an ED visit and is separately payable for hospitals as specified in section 18-5(B)(6)~~6(J)~~.
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

(6) Total maximum facility value for an outpatient hospital episode of care:

(a) Facility fee reimbursement is limited to a maximum of four (4) procedure codes per episode. The highest valued APC code is reimbursed at 100% of the allowed Exhibit #4 value for the type of facility, plus 50% of the following three highest valued codes.

(i) The use of modifier 51 is not a factor in determining which codes are subject to multiple procedure reductions.

(ii) Bilateral procedures require each procedure to be billed on separate lines using RT and LT modifiers.

(iii) Immune globulins, vaccines, and toxoids, CPT® 90281-90399 and 90476-90756 are exempt from the multiple procedure reduction and shall be paid in addition to the four procedure codes at 100% of the fee schedule.

(iv) When a code is billed with multiple units, multiple procedure reductions apply to the second through fourth units as appropriate. Units may also be subject to other maximum frequency per day policies.

(b) Other surgical payment policies are as follows:

(i) All surgical procedures performed in one operating room, regardless the number of surgeons, are considered one outpatient surgical episode of care for payment purposes.

(ii) If an arthroscopic procedure fails and is converted to an open procedure, only the open procedure is reportable. Thus, arthroscopic procedures are bundled into open procedures. If an arthroscopic procedure and open procedure are performed on different joints, the two procedures may be separately reportable with anatomic modifiers or modifier 59.

(iii) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different knee compartment using G0289.

(iv) Discontinued surgeries require the use of modifier 73 (discontinued prior to the administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier 74 allows reimbursement of 100% of the primary procedure value only.

(v) Facilities receive the lesser of the actual charge or the fee schedule allowance. A line-by-line comparison of charges is not appropriate.

~~(a) The highest-valued CPT® code aligned to APC code per Exhibit #4 plus 50% of any lesser-valued CPT® code aligned APC code values.~~

~~Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure~~

~~reimbursed at 100% of the allowed Exhibit #4 value for the type of facility:~~

~~(i) Hospitals are reimbursed based upon Column 3.~~
~~(ii) ASCs are reimbursed based upon Column 4.~~

(c~~b~~) Hospitals billing type "A" or "B" ED visits shall meet one of the following hospital licensure and billing criteria:

(i) The EDs must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility's state's licensure requirements and billed using revenue code 450 and applicable CPT® codes; or

(ii) A freestanding type "B" ED, must have equivalent operations and staffing as a licensed ED, must be physically located inside of a hospital, and meet Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. All type "B" outpatient ED visits must be billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24/7;

(d) ED level of care is identified based upon one (1) of five (5) levels of care for either a type "A" or type "B" ED visit. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ED staff and other resources) as the level of service increases. Upon request, the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ED levels or critical care codes shall be paid).

(e~~d~~) Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.

Trauma activation fees are as follows:

Revenue Code 681	$3,303.00
Revenue Code 682	$1,433.00
Revenue Code 683	$1,408.00
Revenue Code 684	$954.00

(f~~e~~) If an injured worker is admitted to the hospital through that hospital's ED, the ED reimbursement is included in the inpatient reimbursement under section 18-5~~6~~(A~~I~~)~~(3)~~.

~~(f) Multiple APCs identified by multiple CPT® codes are indicated by the use of modifier 51. Bilateral procedures require each procedure to be billed on separate lines using RT and LT for the procedure to be correctly paid. The 50% reduction applies to all lower-valued procedures, even if they are identified in the CPT® as modifier 51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.~~

~~(i) All surgical procedures performed in one (1) operating room, regardless of the number of surgeons, are considered one (1) outpatient surgical episode of care for purposes of facility fee reimbursement.~~

~~(ii) If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers.~~

~~(iii) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee using G0289.~~

~~(iv) Discontinued surgeries require the use of modifier 73 (discontinued prior to administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier 74 allows reimbursement of 100% of the primary procedure value only.~~

~~(v) The sum of subsection 18-6(J)(3)(c) Columns 1-5 is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line-by-line comparison of billed charges to subsection 18-6(J)(3)(c) maximum allowance is not appropriate.~~

(g) Any diagnostic testing clinical labs or therapies with a status indicator of "A" may be reimbursed using Exhibit #8 or the appropriate CF to the unit values for the specific CPT® code as listed in the RBRVS. Hospital bill types 13x are allowed payment for any clinical laboratory services (even if the SI is "N" for the specific clinical laboratory CPT® code) when these laboratory services are unrelated to any other outpatient services performed that day. The maximum fees are based upon Exhibit #8.

(h) ~~Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization.~~ Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Code is G0378, $45.90 per hour, round to the nearest hour. ~~For adjusted RVUs and rates, see Exhibit #9.~~

(i) Professional fees are reimbursed according to the fee schedule times the appropriate CF regardless of the facility type. Additional reimbursement

is payable for the following services not included in the values found in Exhibit #4:

(i) ambulance services (revenue rode 540), see section 18-6(ER)

(ii) blood, blood plasma, platelets (revenue codes 380X)

(iii) physician or physician assistant services

(iv) nurse practitioner services

(v) licensed clinical psychologist

(vi) licensed social workers

(vii) rehabilitation services (PT, OT, respiratory or speech/language, revenue codes 420, 430,440) ~~are paid based upon the RBRVS unit value multiplied by the applicable CF. Modifiers are required to indicate the type of care plan or therapist being billed. See section 18-5(I) for appropriate modifiers.~~

(j) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee, see section 18-6(CN).

(k) Clinics (part of a hospital or a freestanding clinic) (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x):

(i) Provider Restrictions - types of facilities that are recognized for separate clinic facility fees:

- Rural Health Clinics as identified in Exhibit #5 and/or as certified by the CDPHE~~Colorado Department of Public Health and Environment~~;
- Critical Access Hospitals as identified in Exhibit #3 and/or as certified by the CDPHE~~Colorado Department of Public Health and Environment~~;
- Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.

(ii) Billing and Maximum Fees

- Clinics designated as rural health facilities and listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.
- CAHs listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
- Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4.
- No other clinic facility fees are payable except those listed in section~~s~~ 18-56(I), (J), (K) or (L).

- Maximum fees for hospital urgent care facilities or services are covered under section (C)~~18-6(L)~~. These are identified by either place of service code 20, as billed on a CMS-1500, or by revenue code(s) 516 or 526 on a UB-04.

(iii) Clinic fees are paid based on Exhibit #4 and as outlined in this Rule.

(l) IV infusion therapy performed in an outpatient hospital facility is separately payable in accordance with this ~~reimbursed per~~ section ~~18-6(J)~~.

(m) Off campus (place of service code 19) freestanding imaging centers shall be reimbursed using the RBRVS TC value(s) instead of the APC value.

(C) URGENT CARE FACILITIES

(1) Provider Restrictions

Facility fees are only payable if the facility qualifies as an Urgent Care facility. All Urgent Care facilities shall be certified by the Urgent Care Association of America (UCAOA) or accredited by the Joint Commission to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Fees:

~~(a) Prior authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility certification if requested by the payer.~~

(a~~b~~) Urgent Care Facility Fees:

(i) No separate facility fees are allowed for follow-up care. To receive a separate facility fee, a subsequent diagnosis shall be based on a new acute care situation and not the initial diagnosis.

(ii) No facility fee is appropriate when the injured worker is sent to the employer's designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.

(iii) Hospitals may bill on the UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088, $76.50, with 1 unit. All maximum fees for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate CF.

(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, $76.50, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are reimbursed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(b~~c~~) All professional physician or non-physician fees shall be billed on a CMS-1500 with a Place of Service Code 20. The maximum fees shall be in accordance with the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(cd) ~~The Observation Room allowance is limited to a maximum of three (3) hours without prior authorization (see Rule 16-6).~~ ~~Bill~~ G0378, $45.90 per hour, round to the nearest hour, for observation room services. ~~For adjusted RVUs and rates, see Exhibit #9.~~

(de) All supplies are included in the facility fee for urgent care facilities.

(ef) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee. See section 18-6(C~~N~~).

18-6 ANCILLARY SERVICES

(A) DURABLE MEDICAL EQUIPMENT, PROSTHESES AND ORTHOTICS, SUPPLIES (DMEPOS)

(1) Durable Medical Equipment (DME)

This is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Capped Rental/Purchased Equipment:

(i) Items that cost $100.00 or less must be purchased, not rented.

(ii) Rented items must be purchased or discontinued after 10 months of continuous use or once the total fee scheduled price has been reached.

(iii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the supplier or the provider may have received). When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.

(iv) Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates.

(v) Modifier NU shall be appended for new, UE for used purchased items or modifier RR for rented items.

(b) Take Home Exercise Equipment

Items with a total cost of $50 or less may be billed using A9300 without an invoice at a maximum fee of actual billed charges; however, payers reserve the right to request an invoice, at any time, to validate the provider's cost. Home exercise supplies can include, but are not limited to the following items: therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand

exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.

(c) Electrical Stimulators

Electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 leads and pads, initial battery, electrical adapters, and carrying case. Kits that cost more than $100.00 shall be rented for the first month of use and require documentation of effectiveness prior to purchase (effectiveness means functional improvement and decreased pain.)

(i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with 2 leads or E0730 for a kit with 4 leads;

(ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit;

(iii) Replacement supplies are limited to once per month and are not eligible with a first month rental.

A4595 - electrical stimulator supplies, 2 leads.

A4557 - replacement leads.

(iv) Conductive Garments: E0731.

(d) Continuous Passive Motion Devices (CPMs):

These devices are bundled into the facility fees and not separately payable, unless the Medial Treatment Guidelines recommend their use after discharge for the particular condition.

E0935 – continuous passive motion exercise device for use on the knee only

E0936 – continuous passive motion exercise device for use on body parts other than knee.

(e) Intermittent Pneumatic Devices

These devices (including, but not limited to, Game Ready and cold compression) are bundled into facility fees and are not separately payable. The use of these devices after discharge requires prior authorization.

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use; and

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(2) Prosthesis and Orthotics

Maximum fees for any orthotic created using casting materials shall be billed using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule for Colorado. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.

(3) Supplies

Supplies necessary to perform a service or procedure are considered inclusive and not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure. Reimbursement of supplies to facilities shall comply with the appropriate section of this Rule.

(4) Reimbursement

Unless other limitations exist in this Rule, DMEPOS suppliers and medical providers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2019 DMEPOS schedule for rural (R) or non-rural (NR) areas. The DMEPOS schedule can be found at https://www.cms.gov.

If no code or value exists, reimbursement shall be based on Colorado Medicaid's DME, Upper Payment Limit, January 2019 Interim Rate for rural or non-rural areas. See https://www.colorado.gov/hcpf/provider-rates-fee-schedule.

If no Medicaid fee schedule value exists, reimbursement shall be based on 120% of the cost of the item as indicated by invoice. Shipping and handling charges are not separately payable. Payers shall not recognize the KE modifier.

Auto-shipping of monthly DMEPOS is not allowed.

(5) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

(a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.

(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.

(B) HOME CARE SERVICES

Prior authorization ~~(see Rule 16-6)~~ is required for all home care-services. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B providers. The payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes. ~~For adjusted RVUs and rates, see Exhibit #9~~.

(1) Home Infusion Therapy

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and delivery services necessary to perform the infusion therapy. Per diem rates are only payable when licensed professionals (RNs) are providing "reasonable and necessary" skilled assessment and evaluation services in the patient's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker's home to perform initial and subsequent patient evaluation(s), education, and coordination of care. ~~Skilled nursing fees are billed and payable as indicated under section 18-6(L)(2).~~

(a) Parenteral Nutrition:

Code	Quantity	Max Bill Frequency	Daily Rate
S9364	<1 Liter	once per day	$160.00
S9365	1 liter	once per day	$174.00
S9366	1.1 - 2.0 liter	once per day	$200.00
S9367	2.1 - 3.0 liter	once per day	$227.00
S9368	> 3.0 liter	once per day	$254.00

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than in standard formula are separately payable under section 18-6(C~~N~~).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(C~~N~~)).

Code	Time	Max Bill Frequency	Daily Rate
S9494	hourly	once per day	$158.00
S9497	once every 3 hours	once per day	$152.00
S9500	every 24 hours	once per day	$97.00
S9501	once every 12 hours	once per day	$110.00
S9502	once every 8 hours	once per day	$122.00
S9503	once every 6 hours	once per day	$134.00
S9504	once every 4 hours	once per day	$146.00

(c) Chemotherapy per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9329	Administrative Services	once per day	$0.00

S9330	Continuous (24 hrs. or more) chemotherapy	once per day	$91.00
S9331	Intermittent (less than 24 hrs.)	once per day	$103.00

(d) Enteral nutrition (enteral formula and nursing services are separately payable):

Code	Description	Max Bill Frequency	Daily Rate
S9341	Via Gravity	once per day	$44.09
S9342	Via Pump	once per day	$24.23
S9343	Via Bolus	once per day	$24.23

(e) Pain Management per day or refill + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9326	Continuous (24 hrs. or more)	once per day	$79.00
S9327	Intermittent (less than 24 hrs.)	once per day	$103.00
S9328	Implanted pump (no separate daily rate)	Per refill	$116.00/refill. No separate daily rate.

(f) Fluid Replacement per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency	Daily Rate
S9373	< 1 liter per day	once per day	$61.00
S9374	1 liter per day	once per day	$85.00
S9375	>1 but <2 liters per day	once per day	$85.00
S9376	>2 liters but <3 liters	once per day	$85.00
S9377	>3 liters per day	once per day	$85.00

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP. If ASP is not available, use AWP.

(2) Nursing Services~~— there is a limit of two (2) hours without prior authorization, unless otherwise indicated in the Medical Treatment Guidelines~~:

Code	Type of Nurse	Max Bill Frequency	Hourly Rate
S9123	RN	2 hrs	$111.00
S9124	LPN	2 hrs	$89.00
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill. ~~No prior authorization required.~~	$45.00

(3) Physical medicine procedures are payable at the rates listed in section 18-~~45~~(H~~I~~).

(4) Mileage

The parties should agree upon travel allowances and the mileage rate should not exceed 53 cents per mile ~~the fee schedule rate for DoWC Z0772 per mile~~, portal to portal. Bill Z0772.

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization and shall not exceed $34.68 per hour. Bill ~~the hourly fee schedule rate for~~ DoWC Z0773.

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care

As defined in section 18-6(A~~H~~), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to at-home professional's service are not separately payable.

The maximum fees for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in section 18-6(A~~H~~). All IV infusion supplies are included in the per diem or refill rates listed in this Rule.

(B) DRUGS AND MEDICATIONS

(1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for medications "not recommended" in the Medical Treatment Guidelines for a particular diagnosis or if Rules 16-~~6(B)~~ and 17-4(A) apply.

(2) Prescription Writing

(a) This Rule applies to all pharmacies, whether located in- or out-of-state.

(b) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

(c) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the Rule 16-~~9(A)(2)~~ requirements, providers prescribing a

brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.

(d) The provider shall not exceed a 60-day supply per prescription.

(e) Opioids~~/classified as~~scheduled ~~Schedule II or Schedule III~~ controlled substances that are prescribed for treatment lasting longer than 3~~7~~ days shall be provided through a pharmacy. The prescriber shall comply with applicable provisions of §§ 12-32-107.5, 12-35-114, 12-36-117.6, 12-38-111.6, 12-40-109.5, 12-42.5-404, and other statutes and rules.

(3) Billing

(a) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

(b) All parties shall use one (1) of the following forms:

(i) CMS-1500 – dispensing provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the RBRVS supply code. For repackaged drugs, dispensing provider shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. The dispensing provider shall list the "repackaged" NDC number of the actual dispensed medication first and the "original" NDC number second, with the prefix 'ORIG' appended. Billing providers shall include the units and days supply for all dispensed medications in field 24G example: '60UN/30DY.'

(ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers.

(c) Dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

(4) Average Wholesale Price (AWP)

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as ~~Price Alert,~~ Red Book Online, or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere in this Rule.

(5) Reimbursement for Prescription Drugs & Medications

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement. Supplies are considered integral to the package are not separately reimbursable.

(c) Reimbursement for an opiate antagonist prescribed or dispensed under §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, to an injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

(d) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In this circumstance, provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

(e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the HCPCS Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.

(6) Prescription Strength Topical Compounds

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790, $81.60 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791, $163.20 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792, $270.30 per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793, $377.40 per 30 day supply

Two (2) or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the Medical Treatment Guidelines approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(7) Over-the-Counter Medications

(a) Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as ~~Price Alert,~~ RedBook Online, or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to $30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to $70.00 per 30 day supply.

DoWC Z0794 per 30 day supply for any application (excludes patches).

DoWC Z0795 per 30 day supply for patches.

See subsection ~~18-6(N)~~(65) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines is authorized only by prior agreement of the payer or if specifically indicated in the Medical Treatment Guidelines. The reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized medications, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16-~~11(F)~~.

~~(C)~~ COMPLEMENTARY ~~ALTERNATIVE~~ INTEGRATIVE MEDICINE

Complementary ~~Alternative~~ integrative medicine describes a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of complementary ~~alternative~~ integrative medicine that are not listed in Rule 16 must have completed ~~may be both licensed and non-licensed health practitioners with~~ training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in ~~acupuncture and/or~~ Chinese herbology. ~~Alternative integrative medicine services not priced in the fee schedule or not recommended in the Medical Treatment Guidelines require prior authorization~~.

(E) MEDICAL TRANSPORTATION

(1) Fee Schedule:

The fee schedule for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker to the nearest facility and all items and services associated with such transport are included in the base rate and mileage rate. ~~For adjusted RVUs and rates, see Exhibit #9~~.

(2) General Claims Submission:

(a) All hospitals billing for ground or air ambulance services shall bill on the UB-04. All other providers shall bill on the CMS-1500.

(b) Providers shall use HCPCS codes and origin/destination modifiers.

(c) Providers shall list their name, complete address and NPI number.

(d) Providers shall list the zip code for the origin (point of pickup) in Item 23 of the CMS-1500 or FL 39-41 of the UB-04 with an “AO” code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground Ambulance Services Billing Codes and Fees:

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

HCPCS	Base Rate	URBAN BASE RATE/ URBAN MILEAGE	RURAL BASE RATE/ RURAL MILEAGE	RURAL BASE RATE/ LOWEST QUARTILE	RURAL GROUND MILES
A0425	$18.50	$18.88	$19.05	n/a	$28.58
A0426	$574.78	$712.40	$719.38	$881.95	n/a
A0427	$574.78	$1,127.95	$1,139.00	$1,396.43	n/a
A0428	$574.78	$593.65	$599.48	$734.95	n/a
A0429	$574.78	$949.85	$959.18	$1,175.95	n/a
A0432	$574.78	$1,038.90	$1,049.08	n/a	n/a
A0433	$574.78	$1,632.55	$1,648.58	$2,021.15	n/a
A0434	$574.78	$1,929.38	$1,948.30	$2,388.63	n/a

The “urban” base rate(s) and mileage rate(s) shall apply to all relevant/ applicable ambulance services unless the zip code range area is “Rural” or “Super Rural.” Medicare MSA zip code grouping is listed on Medicare’s webpage with an “R” indicator for “Rural” and “B” indicator for “Super Rural.” See Medicare’s Zip Code to Carrier Locality File, updated May 15, 2019~~8~~, available at https://www.cms.gov.

(4) Non-Emergent Medical Transportation Billing Codes ~~and Fees~~:

The payer shall reimburse for non-emergent medical transportation of the injured worker to and from reasonable and necessary medical services. The payment shall be for the least expensive means appropriate for the injured worker’s condition.

Billing Code	Billing Code Description	Unit
A0130	Wheelchair Van Base Rate	One Way Trip
S0209	Wheelchair Van Mileage	Per Mile
T2005	Stretcher Van Base Rate	One Way Trip
T2049	Stretcher Van Mileage	Per Mile
A0120	Mobility Van Base Rate	One Way Trip

(5) Modifiers

Modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be RH).

Code	Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	Residential, domiciliary, custodial facility, nursing home other than a skilled nursing facility
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
GM	Multiple patients on one ambulance trip
H	Hospital
I	Site of transfer (i.e., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
N	Skilled Nursing Facility
P	Physician's Office (includes non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called.
QM	Ambulance service under arrangement by a provider of service
QN	Ambulance service furnished directly by a provider of service.
R	Residence
S	Scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes non-hospital facility, clinic, etc.)

(6) Mileage

Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. The miles billed must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

18-7 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating physician (as defined by Rule 16-3(A)(1)(a)) or a psychologist (PsyD, PhD, or EdD) with an employer, claim representative, or any attorney, and with or without the injured worker. Claim representatives include physicians or other qualified medical personnel performing payer-initiated medical treatment reviews, but this Rule does not apply to provider-initiated requests for prior authorization (see Rule 16-6). The physician or psychologist may bill for the time spent attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

Before a meeting is separately payable, the following requirements must be met:

(a) Each meeting (including the time to document) shall be a minimum of 8 minutes.

(b) A report or written record signed by the physician is required and shall include the following:

(i) Who was present at the meeting and their role at the meeting;
(ii) Purpose of the meeting;
(iii) A brief statement of recommendations and actions at the conclusion of the meeting;
(iv) Documented time (both start and end times).

(c) Billing code is DoWC Z0701, $43.35, payable in 8-minute increments. The CPT® mid-point rule for attaining a unit of time does not apply to this code. The physician or psychologist may bill multiple units of this code per date of service.

(d) For reimbursement to qualified non-physician providers for coordination of care with medical professionals, see section 18-45(H)(7).

(2) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is not accompanied by a specific report or written record.

Billing Code DoWC is Z0601, $75.48 per 15 minutes, billed to the requesting party.

(3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-6(G)(4)).

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request pursuant to Rule 16-6(E).

Billing Code DoWC is Z0602, $75.48 per 15 minutes, billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

(1) A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment.

The payer shall pay one-half of the usual fee for the scheduled services, or $183.600~~.00~~, whichever is less:

Billing Code is DoWC Z0720. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

For payer-made appointments scheduled for four (4) hours or longer, the payer shall pay one-half of the usual fee for the scheduled service.

Billing Code is DoWC Z0740. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

(2) Missed Appointments:

When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may inquire if the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee according to this section.

(C) COPYING FEES

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. If the requester and provider agree, the copy may be provided on a disc. If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10 per page. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721, $18.53 for first 10 or fewer paper page(s), including faxed documents

DoWC Z0725, $0.85 per paper page for the next 11-40 paper page(s), including faxed documents

DoWC Z0726, $0.57 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727, $1.50 per microfilm page

DoWC Z0728, $14.00 per computer disc or as agreed

DoWC Z0729, $0.10 per electronic page or as agreed

DoWC Z0802 actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

(1) When requesting deposition or testimony from physicians or any other type of provider, guidance should be obtained from the Interprofessional Code, ~~as~~ prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society, and the Denver Medical Society. If the parties cannot agree upon lesser fees for the deposition or testimony services, or cancellation time periods and/or fees, the deposition and testimony rules and fees listed below shall be used.

If~~, in an individual case,~~ a party ~~can~~ shows good cause to an Administrative Law Judge (ALJ) for exceeding the Maximum Fee Schedule ~~value~~, that ALJ may allow a greater fee ~~than listed in this section~~.

(2) By prior agreement, the provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition or for preparation time for testimony.

Preparation Time:

Treating or non-treating physician as defined by Rule 16-~~3(A)(1)(a)~~ or psychologist (PsyD, PhD, or EdD):

DoWC Z0730, $187.00, billed in half-hour increments. Other providers shall be paid 85% of this fee.

(3) Deposition:
Payment for ~~a treating or non-treating provider's~~ testimony at a deposition shall not exceed $187.00, billed in half-hour increments, for a treating or non-treating physician as defined by Rule 16 or a psychologist (PsyD, PhD, or EdD). Bill ~~the hourly rate for~~ DoWC Z0734~~0 for physicians or psychologists, billed in half-hour increments~~. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 85% of this fee.

If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the provider is notified of the cancellation of the deposition at least ten (10) ~~at least seven (7)~~ ~~business~~ days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the deposing party. ~~and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying.~~ ~~Bill~~ DoWC Z0731, $187.00, in half-hour increments.
~~If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill DoWC Z0732.~~

If the provider is notified less than ten (10) ~~less than five (5)~~ ~~business~~ days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. ~~Bill~~

DoWC Z0733, $187.00, in half-hour increments.
~~Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD):~~

~~DoWC Z0734, $183.50, billed in half-hour increments. Other providers shall be paid 85% of this fee.~~

(4) Testimony:
Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD):

DoWC Z0738, $259.00, billed in half-hour increments. Other providers shall be paid 85% of this fee.

Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony.

If the provider is of the cancellation of the testimony at least ten (10) ~~at least seven (7) business~~ days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. ~~and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill~~ DoWC Z0735, $259.00, in half-hour increments.
~~If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the testimony. Bill DoWC Z0736.~~

If the provider is notified less than ten (10) ~~less than five (5) business~~ days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. ~~Bill~~

DoWC Z0737, $259.00, in half-hour increments.
~~Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD):~~
~~DoWC Z0738, billed in half-hour increments. Other providers shall be paid 85% of this fee.~~

(E) INJURED WORKER TRAVEL EXPENSES

The payer shall reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. If a trip has a fraction of a mile, round up to the nearest whole number.

Mileage Expense Billing Code: DoWC Z0723, 53 cents per mile

Other Travel Expenses Billing Code: DoWC Z0724, actual paid

(F) PERMANENT IMPAIRMENT RATING

(1) The payer is only required to pay for one (1) combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an

additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The Level II accredited authorized treating physician (see Rule 5) shall determine the permanent impairment rating.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment

If a physician determines the injured worker is at MMI and has no permanent impairment, the physician should be reimbursed for the examination at the appropriate level of E&M service. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see section 18-6(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records except when the amount of medical records is extensive (see below), determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (Revised), (AMA Guides), and completing the Physician's Report of Workers' Compensation Injury (Closing Report) WC164.

Extensive medical records take longer than one (1) hour to review and a separate report is created. The separate report must document each record reviewed, specific details of the records reviewed and the dates represented by the records reviewed. The separate record review can be billed under special reports for written reports only and requires prior authorization and agreement from the payer for the separate record review fees.

(b) ~~Bill the appropriate~~DoWC code~~s~~:

(i) DoWC Z0759, ~~$586.00,~~ for the Level II Accredited Authorized Treating Physician Providing Primary Care.
(ii) DoWC Z0760, ~~$790.00,~~ for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).
(iii) A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.
(iv) Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:
All physicians providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code and shall forward their portion of the rating to the authorized physician determining the combined whole person rating.

(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16~~-10(D)~~ and by statute. Requests for additional copies of routine reports and for reports not in Rule 16~~-10~~ or ~~in~~ statute are reimbursable under the copying fee section of this Rule. Routine reports include:

(a) Diagnostic testing

(b) Procedure reports

(c) Progress notes

(d) Office notes

(e) Operative reports

(f) Supply invoices, if requested by the payer

(2) Completion of the Physician's Report of Workers' Compensation Injury

(a) Initial Report WC164

The authorized treating physician (ATP) (generally the designated physician) or emergency department/urgent care physician when applicable shall complete the first report of injury. Items 1-7 and 11 must be complete, however item 2 may be omitted if not known by the provider. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0750 Initial Report $50.00

(b) Closing Report WC 164

The ATP managing the workers' compensation claim must complete the WC164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, and 7-11 must be complete. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0752 Closing Report $50.00

If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the ATP, when the ATP managing the workers' compensation claim of the patient is Level II Accredited; or

(ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP managing the workers' compensation claim is not determining the permanent impairment rating.

(c) Initial and Closing Report WC 164 completed on the same form for the same date of service: DoWC Z0753 $50.00

(d) Progress Report WC 164

Any request from the payer or the employer for the information provided on this form is deemed authorization for payment. The provider shall document who requested the WC164, complete items 1, 2, 4-7, and 11, and send it to all parties within three business days of the request. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0751 Progress Report $50.00

(3) Form Completion

The requesting party shall pay for its request for physician to complete additional forms requiring 15 minutes or less, including forms sent by a payer or an employer. This code also may be billed when completing the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge.

DoWC Z0754 Form Completion $50.00

(4) Special Reports

The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rules. Examples include:

(a) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed,

(b meeting with and reviewing another provider's written record, and amending or signing that record.

Billable Hours: Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report.

Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule a patient exam associated with a special report.

DoWC Z0755 Written Report, $93.50 billable in 15 minute increments

DoWC Z0757 Lengthy Form, $93.50 billable in 15 minute increments

DoWC Z0758 Meeting and Report with Non-treating Physician, $93.50 billable in 15 minute increments

In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation.

DoWC Z0761 Report Preparation with Cancelled Patient Exam, $93.50 billable in 15 minute increments

(5) Independent Medical Examinations:

RIME: Respondent-requested Independent Medical Examination

DoWC Z0756 RIME Report with patient exam, $93.50 billable in 15 minute increments

Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician for 12 months and made available by request to any party to the case.

DoWC Z0766 RIME Audio Recording, $35.00 per exam

DoWC Z0767 RIME Audio Copying Fee, $24.00 per copy

CIME: Claimant-requested Independent Medical Examination, $93.50 billable in 15 minute increments to the injured worker, DoWC Code Z0770

DIME: Division Independent Medical Examination - see Rule 11

All IME reports must be served concurrently to all parties no later than 20 calendar days after the examination.

Cancellations:

In cases of a cancelled or rescheduled RIME or CIME, the provider shall be paid the following fees:

- If the provider is notified of the cancellation of the RIME or CIME at least ten (10) business days prior to the scheduled examination, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, $93.50 billable in 15 minute increments.
- If the provider is notified less than ten (10) business days in advance of a cancelled or rescheduled RIME or CIME, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the examination. DoWC Z0763, $93.50 billable in 15 minute increments.

(H) USE OF AN INTERPRETER

Payers shall reimburse for the services of a qualified interpreter in specified settings if the injured worker does not proficiently speak or understand the English language.

A qualified interpreter must be provided via video remote interpreting service or on-site appearance at complex medical treatment appointments, at behavioral health appointments and when otherwise requested by the provider or injured worker. Providers may, but are not required to use bi-lingual staff to provide third party interpretation when a qualified interpreter is not available.

Qualified interpreter is defined as:

- a Certified Medical Interpreter, if this certification is available for the injured worker's language; or
- for all other languages, is fluent in English and the necessary target language, has knowledge of basic medical and/or legal terminology, and knowledge of health care interpreting ethics and standards of practice.

Providers are prohibited from relying on minor children and should refrain from using adult family members, and friends as interpreters. The exceptions are unavailability of a qualified interpreter in the case of "other" languages and in an emergency involving an imminent threat to the safety or welfare of an individual or the public.

Rates and terms shall be negotiated. Prior authorization is required except for emergency treatment. Non-qualified interpreters are not eligible for reimbursement. Bill DoWC Z0722.

18-8 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2019~~8~~ (CDT®-2019~~8~~). However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from the RBRVS. If billed using RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/Anesthesia section and the corresponding CF. See Exhibit #6 for the listing and Maximum Fee Schedule value for CDT®-2019~~8~~ dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18-9 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum fees are payable to the prescribing ATP for a written report with all the following opioid review services completed and documented:

(a) ordering and reviewing drug tests for subacute or chronic opioid management;

(b) ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results;

(c) reviewing the medical records;

(d) reviewing the injured worker's current functional status;

(e) evaluating the risk of misuse and abuse initially and periodically; and

(f) determining what actions, if any, need to be taken.

In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management, as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the treating physician's assessment of the patient's past and current functional status of work, leisure, and activities of daily living.

The patient should initially and periodically be evaluated for risk of misuse or addiction. The ATP may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7. If the patient is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(CN)(5)(c)).

Opioid Management Billing Codes:

Acute Phase:	DoWC Code Z0771, $85.00, per 15 minutes, maximum of 30 minutes per report
Subacute/Chronic Phase:	DoWC Code Z0765, $85.00, per 15 minutes, maximum of 30 minutes per report

(2) Definitions:

(a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or 6 weeks or less for traumatic injuries or post-operatively.

(b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than 6 weeks for traumatic injuries or post-operatively.

(c) Chronic Opioid use refers to the prescription of opioid medications for longer than 90 days.

(3) Acute opioid prescriptions generally should be limited to three (3) to seven (7) days and 50 morphine milliequivalents (MMEs) per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.

(4) When the ATP prescribes long-term opioid treatment, s/he shall comply with the Division's Chronic Pain Disorder Medical Treatment Guideline (Rule 17, Exhibit #9), and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity, and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for subacute or chronic opioid compliance monitoring. Refer to section 18-45(FC)(4) for clinical drug screening testing codes and values.

(a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

(b) While the injured worker is receiving opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include:

(i) Concern regarding the functional status of the patient;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above 50 MMEs.

(B) FUNCTIONAL ASSESSMENTS

(1) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, chiropractor or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following three (3) elements are required:

(a) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

(b) Pre-and post-injection procedure shall have at least three (3) objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaenslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

(c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post-injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least eight (8) hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.

(2) If all three (3) elements are documented, the billing codes and maximum fees are as follows:

DOWC Z0811, $63.00, per episode for the initial functional assessment of pre-injection care, billed with the appropriate E&M code, related to spinal or SI joint injections.

DOWC Z0812, $34.60, for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.

DOWC Z0814, $34.60, for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

(1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;
(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;
(c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

(2) Billing codes and maximum fees: ~~If these elements are met, the billing code and maximum fee are as follows:~~

DOWC Z0815, $81.60, for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816, $40.80, for subsequent visits during which the injured worker provides follow-up functional data that could alter the treatment plan. The provider may use this code if the analysis of the data causes him or her to modify the treatment plan. The provider should not bill this code more than once every 2 to 4 weeks.

(3~~2~~) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(D) PILOT PROGRAMS

Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this Rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models, and to provide a basis for future development and expansion of such models.
The proposal for a pilot program shall meet the minimum standards set forth in § 8-43-602 and shall include:

(1) beginning and end date for the pilot program.

(2) population to be managed (e.g. size, specific diagnosis codes).

(3) provider group(s) participating in the program.

(4) proposed codes and fees.

(5) process for evaluating the program's success.

Participating payers must submit data and other information as required by the Division to examine such issues as the financial implications for providers and patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-10 INDIGENCE STANDARDS

(A) A person shall be found to be indigent for purposes of Rule 11-12 only if:

(1) income is at or below eligibility guidelines with liquid assets of $1,500 or less; or

(2) income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or,

(3) if "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income Eligibility Guidelines:

Family Size	Monthly income guidelines	Monthly income guideline plus 25%
1	$1,301~~265~~	$1,626~~581~~
2	$1,761~~715~~	$2,202~~143~~
3	$2,222~~165~~	$2,777~~706~~
4	$2,682~~615~~	$3,353~~268~~
5	$3,143~~065~~	$3,928~~831~~
6	$3,603~~515~~	$4,504~~393~~
7	$4,064~~3,965~~	$5,079~~4,956~~
8	$4,524~~461~~	$5,655~~577~~

*For family units with more than eight members, add $460~~390~~ per month for "monthly income" or $5,525~~4,675~~ per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

(2) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant's ability to maintain home and employment. "Liquid assets" exclude any equity in any vehicle which the injured worker or his/her family must use for essential transportation unless the

ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising food, clothing, shelter, and transportation needs.

(3) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

18-11 LIST OF EXHIBITS

EXHIBIT #1 – MS-DRG RELATIVE WEIGHTS

EXHIBIT #2 - HOSPITAL BASE RATES AND COST TO CHARGE RATIOS (CCRS)

EXHIBIT #3 - CRITICAL ACCESS HOSPITALS

EXHIBIT #4 - HOSPITAL AND ASC APCS

EXHIBIT #5 - RURAL HEALTH CLINICS

EXHIBIT #6 - DENTAL FEE SCHEDULE

EXHIBIT #7 - EVALUATION AND MANAGEMENT (E&M)

EXHIBIT #8 - CLINICAL LAB

~~EXHIBIT #9 - DIVISION ESTABLISHED RVUS AND Z-CODES~~

Proposed Exhibit #1

List of Medicare Severity Diagnosis-Related Groups (MS-DRGS), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay

Source: CMS-1694-F Table 5

Effective 1/1/2020

MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
001	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.4106	29.1	37.5
002	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.4227	15.1	18.0
003	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.2974	23.4	30.1
004	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.4192	19.5	23.6
005	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2545	14.6	20.0
006	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8655	7.9	8.6
007	PRE	SURG	LUNG TRANSPLANT	10.6510	16.7	20.2
008	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.2490	8.9	10.1
010	PRE	SURG	PANCREAS TRANSPLANT	4.5139	7.8	8.5
011	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W MCC	4.9124	10.9	13.4
012	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W CC	3.8137	8.7	9.8
013	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W/O CC/MCC	2.3265	5.9	6.7
014	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.9503	24.1	27.4
016	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC OR T-CELL IMMUNOTHERAPY	6.5394	17.1	18.4
017	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3811	7.9	10.7
020	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.4253	13.6	16.5

021	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.9056	12.1	13.7
022	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.1575	6.3	8.1
023	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.4601	7.3	10.2
024	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.9194	4.3	5.7
025	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.2775	6.7	8.8
026	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0157	4.3	5.7
027	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.4057	2.1	2.7
028	01	SURG	SPINAL PROCEDURES W MCC	5.3748	9.0	11.8
029	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.1557	4.4	5.8
030	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1757	2.3	3.0
031	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1829	7.2	10.1
032	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.3021	3.3	4.8
033	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6877	1.8	2.3
034	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5998	4.7	6.8
035	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2203	2.1	3.0
036	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7260	1.2	1.4
037	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.2098	5.1	7.4
038	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6717	2.2	3.1
039	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1324	1.3	1.5
040	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9282	7.6	10.7
041	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3584	4.2	5.3

042	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.8715	2.5	3.1
052	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.7004	4.1	5.8
053	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9141	2.7	3.3
054	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3166	3.8	5.1
055	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0472	3.1	4.4
056	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	2.1245	5.5	8.1
057	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.2089	3.9	5.6
058	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.7596	5.0	6.9
059	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0993	3.7	4.5
060	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8327	3.0	3.5
061	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8477	5.0	6.5
062	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9437	3.4	4.0
063	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6280	2.4	2.7
064	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8692	4.4	6.1
065	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0315	3.1	3.8
066	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7268	2.1	2.5
067	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.5014	3.6	4.8
068	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8987	2.3	2.8
069	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7655	2.1	2.5
070	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6453	4.5	6.2

071	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9858	3.3	4.3
072	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7420	2.4	2.9
073	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4111	3.7	5.1
074	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9739	2.9	3.7
075	01	MED	VIRAL MENINGITIS W CC/MCC	1.4816	4.8	6.0
076	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8248	2.8	3.3
077	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5520	4.1	5.2
078	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9701	3.1	3.8
079	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7465	2.1	2.5
080	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.8788	4.5	6.8
081	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.8546	2.7	3.7
082	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1586	3.8	6.0
083	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2950	3.2	4.2
084	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.9233	2.2	2.7
085	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1800	4.7	6.5
086	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2431	3.2	4.1
087	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8453	2.1	2.6
088	01	MED	CONCUSSION W MCC	1.4796	3.6	4.7
089	01	MED	CONCUSSION W CC	1.0675	2.7	3.5
090	01	MED	CONCUSSION W/O CC/MCC	0.7934	1.9	2.3
091	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6120	4.2	5.7
092	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9433	3.0	3.8
093	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7378	2.2	2.7
094	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6779	8.0	11.0

095	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3809	5.7	7.1
096	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.1110	4.4	5.2
097	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.5389	8.4	11.4
098	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8505	5.4	6.9
099	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2729	3.7	4.7
100	01	MED	SEIZURES W MCC	1.8124	4.3	5.9
101	01	MED	SEIZURES W/O MCC	0.8693	2.7	3.4
102	01	MED	HEADACHES W MCC	1.0765	3.0	4.0
103	01	MED	HEADACHES W/O MCC	0.7814	2.3	3.0
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.3027	4.5	6.2
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2551	2.3	2.9
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.3621	3.5	4.5
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.7080	4.0	5.8
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	1.0025	2.3	3.1
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.0593	4.0	5.2
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7058	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7529	2.0	2.5
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.3313	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.8102	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.4310	3.7	5.5
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4912	2.3	2.9
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.6284	4.2	5.7
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5286	2.0	2.5
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	2.0986	4.0	5.8
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1987	2.0	2.5

135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2982	4.4	6.4
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.2125	1.8	2.8
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3771	3.6	4.8
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8452	2.0	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1604	2.1	2.8
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9231	5.3	7.4
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2505	3.7	5.2
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.7238	2.1	2.8
149	03	MED	DYSEQUILIBRIUM	0.7111	2.0	2.5
150	03	MED	EPISTAXIS W MCC	1.3275	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7038	2.2	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0421	3.2	4.1
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7118	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4465	4.0	5.3
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8833	2.9	3.7
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6599	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.6730	4.4	6.1
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8903	2.8	3.6
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6784	2.1	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9193	9.7	12.1
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5689	4.8	5.9
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8524	2.9	3.5
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.4980	7.9	10.2
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8976	4.3	5.6
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3416	2.4	3.0
175	04	MED	PULMONARY EMBOLISM W MCC	1.4649	4.3	5.3
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.8990	2.8	3.4
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8408	5.5	6.8
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.2744	4.3	5.3

179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9215	3.2	4.0
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.6960	4.9	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1409	3.4	4.5
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.7951	2.2	2.8
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4909	4.4	5.5
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0044	3.2	3.8
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7323	2.4	2.8
186	04	MED	PLEURAL EFFUSION W MCC	1.5595	4.4	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0540	3.3	4.1
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7672	2.4	3.0
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2353	3.8	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1907	3.8	4.7
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9139	3.1	3.7
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7241	2.5	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3167	4.2	5.2
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9002	3.3	3.9
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6868	2.6	3.1
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6381	4.8	6.2
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0017	3.3	4.0
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7585	2.5	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.7828	5.3	6.9
200	04	MED	PNEUMOTHORAX W CC	1.0748	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.6989	2.4	3.0
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9401	3.0	3.7
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6970	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7676	2.2	2.8
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5179	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8635	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	5.5965	12.0	13.9

208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.4374	4.9	6.7
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8861	5.2	8.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.8209	12.5	15.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.3628	7.3	8.8
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.9053	4.1	5.5
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6916	9.1	11.1
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2053	6.1	6.7
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.6074	4.2	4.8
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.1372	9.2	11.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.3562	5.3	6.4
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.4247	7.7	9.6
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.7194	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8182	6.5	8.4
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.3167	3.1	4.1
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.5762	6.7	9.7
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.6484	3.4	4.7
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.3989	10.3	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	6.1604	8.0	8.8
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.6377	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.1472	8.1	8.6

235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8099	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.9263	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7093	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.7449	7.0	8.5
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.5960	4.4	5.2
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7369	5.4	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5543	3.3	4.0
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1108	2.3	2.7
245	05	SURG	AICD GENERATOR PROCEDURES	5.0121	4.4	6.1
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2388	4.1	5.4
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.0771	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.1726	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9901	2.4	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5868	3.9	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6778	2.2	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2598	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.5943	4.1	5.4
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8100	2.3	2.8
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5403	6.5	8.1
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7487	5.2	6.2
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1261	3.5	4.3
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.9888	5.0	6.4

259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0970	2.7	3.4
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6195	6.8	9.2
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9918	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6309	2.3	2.7
263	05	SURG	VEIN LIGATION & STRIPPING	2.3922	4.2	6.3
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.1586	6.5	9.2
265	05	SURG	AICD LEAD PROCEDURES	3.1167	3.7	5.1
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.1915	4.0	6.1
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	5.8481	2.3	2.9
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.7037	6.4	9.5
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1509	1.7	2.4
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	5.0617	6.6	9.5
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.4938	4.3	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.6181	2.1	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.6525	5.3	7.3
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.9783	2.0	2.6
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6571	4.2	5.4
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9796	2.6	3.2
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7490	1.8	2.2
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.8047	3.0	4.8
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7666	1.7	2.3

285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5964	1.3	1.6
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.1808	5.2	6.9
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1389	2.4	3.0
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.6941	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7099	5.4	6.7
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0114	3.4	4.3
291	05	MED	HEART FAILURE & SHOCK W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.3454	4.1	5.2
292	05	MED	HEART FAILURE & SHOCK W CC	0.9198	3.3	4.0
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6656	2.4	2.8
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.1608	3.4	4.4
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.5513	2.3	3.1
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.5355	2.0	3.2
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6524	1.3	1.5
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4825	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4504	3.9	5.2
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0237	3.3	4.1
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7262	2.3	2.8
302	05	MED	ATHEROSCLEROSIS W MCC	1.0695	2.7	3.6
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6655	1.9	2.3
304	05	MED	HYPERTENSION W MCC	1.0811	3.0	3.9
305	05	MED	HYPERTENSION W/O MCC	0.7199	2.2	2.7
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4088	3.8	5.2
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8560	2.4	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2036	3.6	4.6

309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7635	2.5	3.0
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5623	1.9	2.2
311	05	MED	ANGINA PECTORIS	0.6872	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.8015	2.3	2.9
313	05	MED	CHEST PAIN	0.7073	1.7	2.1
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	2.0231	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9559	2.8	3.6
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7513	2.0	2.4
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.2559	10.1	13.5
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.4843	4.9	6.7
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5421	2.2	2.8
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9927	10.8	13.4
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5233	6.2	7.4
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6947	3.7	4.2
332	06	SURG	RECTAL RESECTION W MCC	3.3982	6.9	8.8
333	06	SURG	RECTAL RESECTION W CC	1.9278	4.4	5.4
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.3062	2.4	2.9
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.0620	10.1	12.3
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2982	6.3	7.7
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6033	3.9	4.8
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8648	6.6	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7406	4.3	5.2
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1878	2.4	2.9
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2845	4.6	6.3
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4188	2.7	3.5
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0853	1.7	2.0

344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.9872	7.6	10.1
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6376	4.6	5.7
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.2366	3.2	3.8
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4111	5.7	7.8
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4000	3.6	4.7
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.9497	2.1	2.6
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4465	5.1	6.9
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.5001	3.4	4.1
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0535	2.1	2.5
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.9659	6.0	7.8
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7310	3.8	4.7
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3548	2.5	3.0
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9757	7.8	10.3
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1367	4.7	5.9
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3483	2.8	3.5
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.9440	4.7	6.2
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.1088	3.2	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7433	2.2	2.8
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7388	5.4	7.0
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0384	4.0	4.9
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7576	3.1	3.7
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0650	5.6	7.5
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2067	3.7	4.8
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9157	2.5	3.1
377	06	MED	G.I. HEMORRHAGE W MCC	1.7888	4.5	5.7

378	06	MED	G.I. HEMORRHAGE W CC	0.9903	3.0	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6532	2.1	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9460	5.1	6.6
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0950	3.3	4.0
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7678	2.5	2.9
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3510	4.0	5.0
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8553	2.6	3.2
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6979	5.3	7.3
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9801	3.5	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.6967	2.8	3.3
388	06	MED	G.I. OBSTRUCTION W MCC	1.5307	4.8	6.4
389	06	MED	G.I. OBSTRUCTION W CC	0.8432	3.3	4.0
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5910	2.5	2.9
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2215	3.7	4.9
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7554	2.6	3.2
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6326	4.4	6.1
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9411	3.1	4.0
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6765	2.3	2.8
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.3791	9.6	12.8
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.8326	5.6	7.0
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0068	3.8	4.5
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0465	9.2	11.9
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3227	5.6	6.9
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6526	3.7	4.5
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9981	8.3	11.1
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3819	5.5	6.5
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6862	3.5	4.3

414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5772	8.0	9.8
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0188	5.2	6.1
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3931	3.2	3.8
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4234	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6642	3.7	4.4
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3042	2.5	2.9
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.5176	7.7	10.5
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.7791	4.1	5.4
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5076	2.8	3.4
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.9460	8.6	12.3
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.1911	5.6	7.4
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4929	3.4	4.1
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8260	4.7	6.4
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0279	3.3	4.2
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6511	2.3	2.8
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6977	4.8	6.3
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1359	3.5	4.5
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8658	2.4	3.1
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6382	4.6	6.3
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8623	3.2	4.0
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6213	2.5	2.9

441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8572	4.7	6.5
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9389	3.2	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6958	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6109	4.4	5.7
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0676	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7950	2.3	2.7
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.4969	7.6	9.7
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.3368	4.0	4.7
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0000	2.6	3.0
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1252	9.5	11.6
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.5446	5.3	6.1
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.1212	3.2	3.6
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.3848	6.3	7.9
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0375	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.4825	5.6	6.7
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.1941	2.9	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.1319	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9440	5.5	7.0
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8374	2.7	3.5
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.1132	6.6	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4704	3.4	4.1

468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.7914	2.2	2.5
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1742	4.9	6.2
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9898	2.2	2.5
471	08	SURG	CERVICAL SPINAL FUSION W MCC	5.0107	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.9468	2.4	3.2
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.3729	1.5	1.8
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.7951	8.9	11.1
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1488	5.8	7.1
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1507	3.1	4.0
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1384	8.2	10.2
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2792	5.3	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7980	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0304	6.4	7.5
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0623	4.4	4.8
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6645	3.5	3.7
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.3835	1.6	1.9
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.3041	8.0	9.6
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2184	5.3	6.3
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6502	3.7	4.2
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	2.1125	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2974	2.1	2.5

492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.3905	6.1	7.7
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.2461	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7539	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.4623	7.3	9.8
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9609	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.4350	1.9	2.4
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.2780	5.1	6.8
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.1192	2.1	2.6
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0680	7.3	9.7
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6874	4.2	5.2
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2911	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.5622	6.8	8.5
504	08	SURG	FOOT PROCEDURES W CC	1.7295	4.8	5.8
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5798	2.8	3.4
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.4103	3.8	4.8
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9425	4.5	5.9
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4474	2.1	2.6
509	08	SURG	ARTHROSCOPY	1.6703	4.4	5.6
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.7324	5.0	6.3
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.8473	3.4	4.0
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.5221	2.2	2.5
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6396	4.1	5.3
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.9998	2.3	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0820	6.4	8.3

516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8854	3.8	4.7
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3809	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	3.1002	3.4	5.4
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.8620	3.1	4.0
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.3141	1.9	2.3
533	08	MED	FRACTURES OF FEMUR W MCC	1.5305	4.2	5.7
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7755	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2548	3.8	4.9
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7570	2.9	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9105	3.1	3.7
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.7270	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	2.0192	6.1	8.2
540	08	MED	OSTEOMYELITIS W CC	1.2969	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8827	3.2	4.0
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8253	5.2	6.9
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0725	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7984	2.8	3.3
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4791	5.6	8.0
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2144	3.6	4.6
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8576	2.7	3.3
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0672	6.1	7.8
549	08	MED	SEPTIC ARTHRITIS W CC	1.2442	4.1	5.1
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.9238	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5916	4.4	5.7
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.9010	3.0	3.6
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2376	3.9	5.0

554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7569	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.2792	3.7	5.0
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7677	2.7	3.3
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4324	4.6	5.7
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8635	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7987	4.8	6.6
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0217	3.6	4.6
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7561	2.7	3.5
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.4081	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8381	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5722	4.7	6.1
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9758	3.4	4.1
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7623	2.6	3.2
570	09	SURG	SKIN DEBRIDEMENT W MCC	3.0347	7.6	10.2
571	09	SURG	SKIN DEBRIDEMENT W CC	1.7029	5.2	6.5
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1786	3.4	4.2
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	5.2515	10.7	15.3
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	3.0459	7.5	10.4
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7586	4.8	6.0
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.8807	8.4	12.8
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.5092	4.7	6.9

578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.5297	2.7	3.5
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7978	6.5	8.8
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5898	4.1	5.3
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.2364	2.4	3.0
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.5695	2.4	3.4
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3781	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8714	3.6	4.7
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5657	2.2	2.7
592	09	MED	SKIN ULCERS W MCC	1.7082	5.4	7.1
593	09	MED	SKIN ULCERS W CC	1.1294	4.2	5.3
594	09	MED	SKIN ULCERS W/O CC/MCC	0.8102	3.2	3.9
595	09	MED	MAJOR SKIN DISORDERS W MCC	1.9869	5.2	7.1
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	1.0115	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.7200	4.9	6.6
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1623	3.5	4.7
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.7164	2.2	2.9
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9560	3.5	4.3
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6192	2.7	3.0
602	09	MED	CELLULITIS W MCC	1.4440	4.7	5.9
603	09	MED	CELLULITIS W/O MCC	0.8477	3.3	3.9
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4168	3.9	5.0
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8605	2.7	3.3
606	09	MED	MINOR SKIN DISORDERS W MCC	1.3808	4.2	5.8
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.8010	2.8	3.6
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3636	3.5	4.8
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4812	2.0	2.3

616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.1352	10.1	12.7
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0736	5.9	7.0
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1593	3.5	4.3
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	2.9207	3.0	4.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8096	2.0	2.5
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5783	1.5	1.7
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.7980	8.7	12.0
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.9232	5.5	6.6
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.2960	3.3	4.0
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.7833	4.8	7.0
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.6106	2.5	3.6
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0850	1.4	1.7
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.6750	7.3	10.0
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3387	6.0	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.5345	2.9	3.6
637	10	MED	DIABETES W MCC	1.3813	3.9	5.1
638	10	MED	DIABETES W CC	0.8722	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6319	2.1	2.6
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1902	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7519	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2635	3.2	4.3

643	10	MED	ENDOCRINE DISORDERS W MCC	1.6341	5.0	6.3
644	10	MED	ENDOCRINE DISORDERS W CC	1.0125	3.5	4.3
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7429	2.7	3.2
652	11	SURG	KIDNEY TRANSPLANT	3.3146	5.3	6.1
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.4890	10.5	13.5
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8733	6.2	7.3
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.0772	3.7	4.4
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.3276	6.0	7.9
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9474	3.6	4.3
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5664	2.3	2.6
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2.7271	6.1	8.2
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.4476	3.2	4.2
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.0728	2.0	2.3
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.1787	7.3	10.3
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6403	3.9	5.2
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1857	2.0	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1788	8.2	10.5
666	11	SURG	PROSTATECTOMY W CC	1.7791	4.2	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	1.0804	2.2	2.8
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.8146	7.1	9.2
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.5825	4.0	5.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9635	2.1	2.6
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.6835	3.9	5.3
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0569	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5773	7.9	10.9
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3121	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6253	2.8	3.6
682	11	MED	RENAL FAILURE W MCC	1.5320	4.5	5.9
683	11	MED	RENAL FAILURE W CC	0.9190	3.2	4.0
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6198	2.3	2.7
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7176	5.1	6.8

687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0537	3.3	4.3
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.7909	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1116	3.9	4.8
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7941	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6242	3.0	3.9
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1306	2.0	2.4
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3236	3.8	5.1
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7021	2.1	2.6
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.1487	3.6	4.7
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6886	2.4	3.0
697	11	MED	URETHRAL STRICTURE	0.9600	2.5	3.6
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6151	4.9	6.2
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0279	3.4	4.2
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7597	2.5	3.1
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7914	2.3	3.2
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.4065	1.3	1.4
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.0318	3.6	5.8
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.6695	1.7	2.2
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0835	5.2	7.2
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	1.0768	2.4	2.9
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4634	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.9105	1.7	2.1
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.2099	5.4	7.6

716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.4630	1.5	1.8
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9543	4.2	5.8
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2326	2.5	3.0
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6597	5.1	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1015	3.5	4.5
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6892	1.9	2.5
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2143	4.0	5.1
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7645	2.6	3.3
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4380	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7914	3.0	3.6
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0820	3.3	4.5
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5684	1.9	2.3
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.3059	3.7	5.2
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.3650	1.8	2.1
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.0306	8.9	11.6
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0314	4.6	5.4
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3923	2.8	3.1
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5977	6.6	9.4

740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7429	3.0	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.3278	1.7	2.0
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.7140	3.0	3.9
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.1156	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6903	4.1	5.6
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0694	2.1	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6777	3.5	5.1
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9582	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2940	1.6	2.0
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.6020	5.7	7.8
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2239	2.4	2.9
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8414	5.2	7.1
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0699	3.3	4.4
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7801	2.2	2.6
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4409	4.9	6.3
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0204	3.7	4.6
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7107	2.6	3.2
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8717	2.6	3.3
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5494	1.8	2.1
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1314	2.7	4.2

769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4579	3.2	4.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	1.8	2.6
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6590	2.5	3.1
779	14	MED	ABORTION W/O D&C	0.7543	1.7	2.7
783	14	SURG	CESAREAN SECTION W STERILIZATION W MCC	1.7455	4.6	6.3
784	14	SURG	CESAREAN SECTION W STERILIZATION W CC	1.1021	3.4	4.1
785	14	SURG	CESAREAN SECTION W STERILIZATION W/O CC/MCC	0.8455	2.7	3.0
786	14	SURG	CESAREAN SECTION W/O STERILIZATION W MCC	1.5548	4.4	5.9
787	14	SURG	CESAREAN SECTION W/O STERILIZATION W CC	1.0811	3.5	4.2
788	14	SURG	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	0.9007	3.0	3.2
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6637	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4863	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.7470	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2608	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.8489	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3623	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1844	3.1	3.1
796	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	3.4	5.0
797	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W CC	0.8469	2.2	2.4
798	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C WO CC/MCC	0.8469	2.2	2.4
799	16	SURG	SPLENECTOMY W MCC	4.7016	8.3	11.0
800	16	SURG	SPLENECTOMY W CC	2.6268	4.7	6.1
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.5563	2.5	2.8
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3472	7.4	10.0
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7221	4.1	5.2

804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.2305	2.1	2.6
805	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	1.0232	3.0	4.1
806	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	0.7074	2.4	2.7
807	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	0.6140	2.1	2.2
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1492	5.5	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.2045	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9220	2.6	3.2
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3560	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8832	2.7	3.5
813	16	MED	COAGULATION DISORDERS	1.6115	3.7	4.9
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6630	4.5	6.3
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9777	3.1	3.9
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7216	2.2	2.7
817	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W MCC	2.5317	3.8	6.5
818	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W CC	1.3585	2.8	4.1
819	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W/O CC/MCC	0.8390	1.6	2.1
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.4437	10.9	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3943	4.3	6.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2098	1.9	2.4
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.5246	10.4	13.8
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1944	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.3590	2.5	3.5

826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.9479	9.9	12.7
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.2517	4.7	6.1
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6354	3.0	3.7
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1097	6.4	9.6
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.4188	2.6	3.2
831	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W MCC	1.0281	3.2	4.5
832	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W CC	0.7188	2.5	3.6
833	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W/O CC/MCC	0.4803	1.9	2.5
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5078	10.0	16.5
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.1360	4.5	7.1
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2126	2.6	3.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	12.8	18.3
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	5.8	7.8
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2559	4.5	4.9
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.2929	7.0	10.0
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6348	4.2	5.7
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.1211	2.9	3.8
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8460	5.3	7.3
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1788	3.7	4.9
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8662	2.6	3.4
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.8179	6.2	8.7

847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.3265	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9326	2.9	3.3
849	17	MED	RADIOTHERAPY	1.9702	5.0	7.0
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.0571	9.9	12.8
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.2028	5.7	7.1
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.5600	3.6	4.5
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.4883	8.9	12.0
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0567	5.4	6.7
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3801	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8277	5.0	6.6
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9848	3.5	4.3
864	18	MED	FEVER AND INFLAMMATORY CONDITIONS	0.8643	2.8	3.4
865	18	MED	VIRAL ILLNESS W MCC	1.3822	3.9	5.3
866	18	MED	VIRAL ILLNESS W/O MCC	0.8204	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1329	5.6	7.6
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0769	3.6	4.6
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7679	2.7	3.3
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	6.2953	12.4	14.4
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8564	4.8	6.3
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0529	3.7	4.4
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.3014	7.2	14.8
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8111	2.6	3.6

881	19	MED	DEPRESSIVE NEUROSES	0.7585	3.8	5.0
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7750	3.2	4.4
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.3199	4.8	8.0
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.3479	4.3	6.7
885	19	MED	PSYCHOSES	1.1961	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	3.7	6.3
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0645	3.0	4.7
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5169	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.4328	8.6	11.5
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.7468	4.9	6.9
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.8208	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.4649	9.2	13.7
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9204	4.9	6.6
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.1639	2.9	3.7
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2260	6.7	9.8
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.7692	3.5	4.8
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.8432	2.8	4.7
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.2161	7.2	10.2
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9928	4.0	5.2
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.3254	2.5	3.1
913	21	MED	TRAUMATIC INJURY W MCC	1.4719	3.6	5.2
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8378	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6769	3.7	4.9
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6353	1.8	2.2
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4737	3.5	4.8

918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7787	2.3	3.1
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.8243	4.3	6.0
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0031	2.9	3.8
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7066	2.2	2.7
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5584	3.8	5.6
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8698	2.7	3.9
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	18.3845	22.2	29.0
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.8756	10.7	15.0
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.9722	5.8	7.9
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	2.8603	2.6	4.5
934	22	MED	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ	1.8335	4.2	6.0
935	22	MED	NON-EXTENSIVE BURNS	1.8217	3.4	5.3
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.2787	6.5	9.4
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.1745	3.7	5.0
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8514	2.3	3.0
945	23	MED	REHABILITATION W CC/MCC	1.3649	9.4	11.6
946	23	MED	REHABILITATION W/O CC/MCC	1.0427	7.1	7.9
947	23	MED	SIGNS & SYMPTOMS W MCC	1.2056	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7802	2.6	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1462	4.5	6.4
950	23	MED	AFTERCARE W/O CC/MCC	0.7449	3.4	4.8
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	2.5	3.4
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0969	7.4	10.8
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.7838	6.1	7.5

957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.5985	9.7	13.6
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.1798	7.0	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.4507	3.8	4.7
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7950	5.3	8.0
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4749	4.0	4.9
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9743	2.7	3.2
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5987	11.7	15.9
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7877	6.5	8.7
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.7230	6.4	9.0
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.2899	4.1	5.3
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9386	3.1	3.9
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1699	3.4	4.6
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3705	8.4	11.4
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.4529	4.9	6.5
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.5691	2.5	3.3
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3326	8.1	10.8
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6931	4.4	5.9
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0407	2.1	2.8

998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.		
999		**	UNGROUPABLE	.		

Proposed Exhibit #2

Base Rates and Cost-to-Charge Ratios

Source: Medicare FY 2019 IPPS Impact File - Correction Notice (September 2018)

Effective 1/1/2020

Provider Number	Name	Total CCR	Individual Hospital Base Rate
060001	North Colorado Medical Center	0.268	$ 6,916.71
060003	Longmont United Hospital	0.323	$ 6,403.34
060004	Platte Valley Medical Center	0.42	$ 6,310.12
060006	Montrose Memorial Hospital	0.404	$ 6,128.68
060008	San Luis Valley Health	0.386	$ 5,640.01
060009	Lutheran Medical Center	0.235	$ 6,358.15
060010	Poudre Valley Hospital	0.302	$ 6,486.69
060011	Denver Health Medical Center	0.324	$ 8,168.44
060012	Centura Health-St Mary Corwin Medical Center	0.229	$ 6,805.17
060013	Mercy Regional Medical Center	0.287	$ 6,263.90
060014	Presbyterian St Lukes Medical Center	0.154	$ 6,891.45
060015	Centura Health-St Anthony Hospital	0.205	$ 6,352.69
060020	Parkview Medical Center Inc	0.164	$ 6,888.86
060022	University Colo Health Memorial Hospital Central	0.221	$ 6,412.84
060023	St Mary's Medical Center	0.308	$ 6,577.63
060024	University Of Colorado Hospital Authority	0.169	$ 7,889.21
060027	Foothills Hospital	0.218	$ 6,300.19
060028	Saint Joseph Hospital	0.196	$ 6,988.66
060030	Mckee Medical Center	0.366	$ 6,349.59
060031	Centura Health-Penrose St Francis Health Services	0.212	$ 6,374.28
060032	Rose Medical Center	0.136	$ 6,722.61
060034	Swedish Medical Center	0.12	$ 6,526.34
060044	Colorado Plains Medical Center	0.264	$ 6,263.90
060049	UCHealth Yampa Valley Medical Center	0.539	$ 6,194.45
060054	Community Hospital	0.322	$ 6,255.63

060064	Centura Health-Porter Adventist Hospital	0.23	$ 6,258.23
060065	North Suburban Medical Center	0.115	$ 6,584.67
060071	Delta County Memorial Hospital	0.427	$ 5,092.53
060075	Valley View Hospital Association	0.414	$ 6,149.15
060076	Sterling Regional Medcenter	0.495	$ 6,263.90
060096	Vail Health Hospital	0.516	$ 6,201.69
060100	Medical Center Of Aurora, The	0.146	$ 6,452.67
060103	Centura Health-Avista Adventist Hospital	0.3	$ 6,310.12
060104	St Anthony North Health Campus	0.272	$ 7,190.28
060112	Sky Ridge Medical Center	0.115	$ 6,129.38
060113	Centura Health-Littleton Adventist Hospital	0.198	$ 6,176.75
060114	Parker Adventist Hospital	0.231	$ 6,233.61
060116	Good Samaritan Medical Center	0.21	$ 6,191.41
060117	Animas Surgical Hospital, Llc	0.356	$ 6,081.46
060118	St Anthony Summit Medical Center	0.338	$ 6,310.12
060119	Medical Center Of The Rockies	0.257	$ 6,148.60
060124	Orthocolorado Hospital At St Anthony Med Campus	0.184	$ 6,126.33
060125	Castle Rock Adventist Hospital	0.274	$ 6,194.40
060126	Banner Fort Collins Medical Center	0.535	$ 6,263.90
060127	Scl Health Community Hospital- Northglenn	0.223	$ 6,369.26

Final Exhibit #3

Critical Access Hospitals

Source: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

Effective 1/1/2020

Hospital Name	Location in Colorado
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Centura Health - St Thomas More Hospital	Canon City
Colorado Canyons Hospital and Medical Center	Fruita
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Grand River Hospital District	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Keefe Memorial Hospital	Cheyenne Wells
Kit Carson County Memorial Hospital	Burlington
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
Middle Park Medical Center	Kremmling/Granby
Mt San Rafael Hospital	Trinidad
Pagosa Springs Medical Center	Pagosa Springs
Pikes Peak Regional Hospital	Woodland Park
Pioneers Medical Center	Meeker
Prowers Medical Center	Lamar
Rangely District Hospital	Rangely
Rio Grande Hospital	Del Norte
San Luis Valley Hospital	La Jara
Sedgwick County Health Center	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Health Center	Walsenburg
St Vincent General Hospital District	Leadville
The Memorial Hospital	Craig
UC Health Pikes Peak Regional Hospital	Woodland Park
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Proposed Exhibit #4

Outpatient Surgery Facility Codes and Fees

source: 2019 CN2 Addendum A.12212018

Effective 1/1/2020

APC	Short Descriptor	Outpatient Hospital Rate (180% of Medicare $)	ASC Rate (85% of Hospital Rate)	Additional Instructions
0701	Sr89 strontium	$ 2,704.24	$ 2,298.60	
0726	Dexrazoxane HCl injection	$ 413.87	$ 351.79	
0731	Sargramostim injection	$ 67.69	$ 57.54	
0736	Amphotericin b liposome inj	$ 86.52	$ 73.54	
0738	Rasburicase	$ 500.66	$ 425.56	
0751	Mechlorethamine hcl inj	$ 579.10	$ 492.24	
0752	Dactinomycin injection	$ 2,569.80	$ 2,184.33	
0759	Naltrexone, depot form	$ 5.86	$ 4.98	
0800	Leuprolide acetate	$ 2,148.60	$ 1,826.31	
0802	Etoposide oral	$ 136.01	$ 115.61	
0807	Aldesleukin injection	$ 7,448.66	$ 6,331.36	
0809	Bcg live intravesical vac	$ 253.11	$ 215.14	
0810	Goserelin acetate implant	$ 916.24	$ 778.80	
0812	Carmustine injection	$ 7,292.71	$ 6,198.80	
0820	Daunorubicin injection	$ 91.19	$ 77.51	
0823	Docetaxel injection	$ 2.72	$ 2.31	
0825	Nelarabine injection	$ 273.99	$ 232.89	
0836	Interferon alfa-2b inj	$ 61.46	$ 52.24	
0840	Inj melphalan hydrochl	$ 1,466.65	$ 1,246.65	
0843	Pegaspargase injection	$ 27,051.68	$ 22,993.93	
0844	Pentostatin injection	$ 3,773.31	$ 3,207.31	
0850	Streptozocin injection	$ 627.67	$ 533.52	
0851	Thiotepa injection	$ 1,334.84	$ 1,134.61	
0856	Porfimer sodium injection	$ 38,195.22	$ 32,465.94	
0858	Inj cladribine	$ 40.75	$ 34.64	
0864	Mitoxantrone hydrochl	$ 49.25	$ 41.86	
0873	Hyalgan supartz visco-3 dose	$ 153.55	$ 130.52	
0874	Synvisc or synvisc-one	$ 21.29	$ 18.10	
0875	Euflexxa inj per dose	$ 254.65	$ 216.45	
0877	Orthovisc inj per dose	$ 266.02	$ 226.12	
0887	Azathioprine parenteral	$ 412.84	$ 350.91	
0890	Lymphocyte immune globulin	$ 3,746.20	$ 3,184.27	
0901	Alpha 1 proteinase inhibitor	$ 8.03	$ 6.83	
0902	Injection,onabotulinumtoxinA	$ 11.05	$ 9.39	
0903	Cytomegalovirus imm IV /vial	$ 2,032.48	$ 1,727.61	

0910	Interferon beta-1b / .25 MG	$ 683.33	$ 580.83	
0925	Factor viii	$ 1.93	$ 1.64	
0927	Factor viii recombinant	$ 2.39	$ 2.03	
0928	Factor ix complex	$ 2.55	$ 2.17	
0929	Anti-inhibitor	$ 3.75	$ 3.19	
0931	Factor IX non-recombinant	$ 2.01	$ 1.71	
0932	Factor ix recombinant nos	$ 2.71	$ 2.30	
0943	Octagam injection	$ 66.10	$ 56.19	
0944	Gammagard liquid injection	$ 77.65	$ 66.00	
0946	Hepagam b im injection	$ 115.59	$ 98.25	
0947	Flebogamma injection	$ 63.12	$ 53.65	
0948	Gamunex-C/Gammaked	$ 71.09	$ 60.43	
0961	Albumin (human),5%, 50ml	$ 18.88	$ 16.05	
0963	Albumin (human), 5%, 250 ml	$ 94.41	$ 80.25	
0964	Albumin (human), 25%, 20 ml	$ 37.76	$ 32.10	
0965	Albumin (human), 25%, 50ml	$ 94.41	$ 80.25	
1015	Injection glatiramer acetate	$ 362.10	$ 307.79	
1064	I131 iodide cap, rx	$ 37.37	$ 31.76	
1083	Adalimumab injection	$ 2,323.96	$ 1,975.37	
1138	Hepagam b intravenous, inj	$ 115.59	$ 98.25	
1139	Protein c concentrate	$ 27.27	$ 23.18	
1142	Supprelin LA implant	$ 57,303.08	$ 48,707.62	
1150	I131 iodide sol, rx	$ 24.43	$ 20.77	
1166	Cytarabine liposome inj	$ 1,131.06	$ 961.40	
1168	Inj, temsirolimus	$ 132.76	$ 112.85	
1178	Busulfan injection	$ 18.67	$ 15.87	
1203	Verteporfin injection	$ 19.71	$ 16.75	
1207	Octreotide injection, depot	$ 357.32	$ 303.72	
1213	Antihemophilic viii/vwf comp	$ 1.79	$ 1.52	
1214	Inj IVIG privigen 500 mg	$ 71.34	$ 60.64	
1232	Mitomycin injection	$ 241.64	$ 205.39	
1235	Valrubicin injection	$ 2,391.60	$ 2,032.86	
1236	Levoleucovorin injection	$ 0.42	$ 0.36	
1237	Inj iron dextran	$ 25.30	$ 21.51	
1253	Triamcinolone A inj PRS-free	$ 6.94	$ 5.90	
1263	Antithrombin iii injection	$ 6.29	$ 5.35	
1268	Xyntha inj	$ 2.20	$ 1.87	
1274	Edetate calcium disodium inj	$ 10,069.96	$ 8,559.47	
1281	Bevacizumab injection	$ 3.57	$ 3.03	
1289	AbobotulinumtoxinA	$ 15.16	$ 12.89	
1295	Sm 153 lexidronam	$ 26,385.17	$ 22,427.39	
1296	Degarelix injection	$ 6.69	$ 5.69	
1297	Ferumoxytol, non-esrd	$ 1.76	$ 1.50	

1311	Canakinumab injection	$ 199.80	$ 169.83	
1312	Hizentra injection	$ 17.75	$ 15.09	
1327	Imiglucerase injection	$ 74.61	$ 63.42	
1340	Collagenase, clost hist inj	$ 81.09	$ 68.93	
1341	Amobarbital 125 MG inj	$ 101.92	$ 86.63	
1352	Wilate injection	$ 1.82	$ 1.55	
1353	Belimumab injection	$ 79.49	$ 67.57	
1408	Cyclophosphamide 100 MG inj	$ 74.90	$ 63.67	
1413	Lumizyme injection	$ 294.89	$ 250.66	
1415	Glassia injection	$ 8.38	$ 7.12	
1416	Factor xiii anti-hem factor	$ 14.81	$ 12.59	
1417	Gel-one	$ 967.25	$ 822.16	
1420	Aflibercept injection	$ 1,741.19	$ 1,480.01	
1421	Imported lipodox inj	$ 846.72	$ 719.71	
1426	Eribulin mesylate injection	$ 205.81	$ 174.94	
1431	Centruroides immune f(ab)	$ 8,267.04	$ 7,026.98	
1433	Calcitonin salmon injection	$ 4,733.15	$ 4,023.18	
1440	Inj desmopressin acetate	$ 22.69	$ 19.29	
1442	Non-HEU TC-99M add-on/dose	$ 18.00	$ 15.30	
1443	Icatibant injection	$ 646.21	$ 549.28	
1446	Visualization adjunct	$ 6.95	$ 5.91	
1458	Phentolaine mesylate inj	$ 707.12	$ 601.05	
1466	Inj, vincristine sul lip 1mg	$ 5,249.92	$ 4,462.43	
1467	Factor ix recombinan rixubis	$ 2.35	$ 2.00	
1468	Inj Aripiprazole Ext Rel 1mg	$ 9.43	$ 8.02	
1469	Inj filgrastim excl biosimil	$ 1.83	$ 1.56	
1471	Injection, Pertuzumab, 1 mg	$ 21.36	$ 18.16	
1472	Inj beta interferon im 1 mcg	$ 97.40	$ 82.79	
1474	Certolizumab pegol inj 1mg	$ 14.64	$ 12.44	
1475	Golimumab for iv use 1mg	$ 43.21	$ 36.73	
1476	Obinutuzumab inj	$ 112.74	$ 95.83	
1478	Inj human fibrinogen con nos	$ 2.10	$ 1.79	
1480	Elosulfase alfa, injection	$ 425.93	$ 362.04	
1482	Darbepoetin alfa, esrd use	$ 6.79	$ 5.77	
1485	Ferumoxytol, esrd use	$ 1.76	$ 1.50	
1486	Factor ix fc fusion recomb	$ 5.37	$ 4.56	
1488	Injection, ramucirumab	$ 103.82	$ 88.25	
1489	Injection, vedolizumab	$ 35.25	$ 29.96	
1490	Inj pembrolizumab	$ 88.83	$ 75.51	
1491	New Technology - Level 1A ($0-$10)	$ 9.00	$ 7.65	
1492	New Technology - Level 1B ($11-$20)	$ 27.90	$ 23.72	
1493	New Technology - Level 1C ($21-	$ 45.90	$ 39.02	

	$30)			
1494	New Technology - Level 1D ($31-$40)	$ 63.90	$ 54.32	
1495	New Technology - Level 1E ($41-$50)	$ 81.90	$ 69.62	
1496	New Technology - Level 1A ($0-$10)	$ 9.00	$ 7.65	
1497	New Technology - Level 1B ($11-$20)	$ 27.90	$ 23.72	
1498	New Technology - Level 1C ($21-$30)	$ 45.90	$ 39.02	
1499	New Technology - Level 1D ($31-$40)	$ 63.90	$ 54.32	
1500	New Technology - Level 1E ($41-$50)	$ 81.90	$ 69.62	
1502	New Technology - Level 2 ($51 - $100)	$ 135.90	$ 115.52	
1503	New Technology - Level 3 ($101 - $200)	$ 270.90	$ 230.27	
1504	New Technology - Level 4 ($201 - $300)	$ 450.90	$ 383.27	
1505	New Technology - Level 5 ($301 - $400)	$ 630.90	$ 536.27	
1506	New Technology - Level 6 ($401 - $500)	$ 810.90	$ 689.27	
1507	New Technology - Level 7 ($501 - $600)	$ 990.90	$ 842.27	
1508	New Technology - Level 8 ($601 - $700)	$ 1,170.90	$ 995.27	
1509	New Technology - Level 9 ($701 - $800)	$ 1,350.90	$ 1,148.27	
1510	New Technology - Level 10 ($801 - $900)	$ 1,530.90	$ 1,301.27	
1511	New Technology - Level 11 ($901 - $1000)	$ 1,710.90	$ 1,454.27	
1512	New Technology - Level 12 ($1001 - $1100)	$ 1,890.90	$ 1,607.27	
1513	New Technology - Level 13 ($1101 - $1200)	$ 2,070.90	$ 1,760.27	
1514	New Technology - Level 14 ($1201- $1300)	$ 2,250.90	$ 1,913.27	
1515	New Technology - Level 15 ($1301 - $1400)	$ 2,430.90	$ 2,066.27	
1516	New Technology - Level 16 ($1401 - $1500)	$ 2,610.90	$ 2,219.27	

1517	New Technology - Level 17 ($1501-$1600)	$ 2,790.90	$ 2,372.27	
1518	New Technology - Level 18 ($1601-$1700)	$ 2,970.90	$ 2,525.27	
1519	New Technology - Level 19 ($1701-$1800)	$ 3,150.90	$ 2,678.27	
1520	New Technology - Level 20 ($1801-$1900)	$ 3,330.90	$ 2,831.27	
1521	New Technology - Level 21 ($1901-$2000)	$ 3,510.90	$ 2,984.27	
1522	New Technology - Level 22 ($2001-$2500)	$ 4,050.90	$ 3,443.27	
1523	New Technology - Level 23 ($2501-$3000)	$ 4,950.90	$ 4,208.27	
1524	New Technology - Level 24 ($3001-$3500)	$ 5,850.90	$ 4,973.27	
1525	New Technology - Level 25 ($3501-$4000)	$ 6,750.90	$ 5,738.27	
1526	New Technology - Level 26 ($4001-$4500)	$ 7,650.90	$ 6,503.27	
1527	New Technology - Level 27 ($4501-$5000)	$ 8,550.90	$ 7,268.27	
1528	New Technology - Level 28 ($5001-$5500)	$ 9,450.90	$ 8,033.27	
1529	New Technology - Level 29 ($5501-$6000)	$ 10,350.90	$ 8,798.27	
1530	New Technology - Level 30 ($6001-$6500)	$ 11,250.90	$ 9,563.27	
1531	New Technology - Level 31 ($6501-$7000)	$ 12,150.90	$ 10,328.27	
1532	New Technology - Level 32 ($7001-$7500)	$ 13,050.90	$ 11,093.27	
1533	New Technology - Level 33 ($7501-$8000)	$ 13,950.90	$ 11,858.27	
1534	New Technology - Level 34 ($8001-$8500)	$ 14,850.90	$ 12,623.27	
1535	New Technology - Level 35 ($8501-$9000)	$ 15,750.90	$ 13,388.27	
1536	New Technology - Level 36 ($9001-$9500)	$ 16,650.90	$ 14,153.27	
1537	New Technology - Level 37 ($9501-$10000)	$ 17,550.90	$ 14,918.27	
1539	New Technology - Level 2 ($51 - $100)	$ 135.90	$ 115.52	

1540	New Technology - Level 3 ($101 - $200)	$ 270.90	$ 230.27	
1541	New Technology - Level 4 ($201 - $300)	$ 450.90	$ 383.27	
1542	New Technology - Level 5 ($301 - $400)	$ 630.90	$ 536.27	
1543	New Technology - Level 6 ($401 - $500)	$ 810.90	$ 689.27	
1544	New Technology - Level 7 ($501 - $600)	$ 990.90	$ 842.27	
1545	New Technology - Level 8 ($601 - $700)	$ 1,170.90	$ 995.27	
1546	New Technology - Level 9 ($701 - $800)	$ 1,350.90	$ 1,148.27	
1547	New Technology - Level 10 ($801 - $900)	$ 1,530.90	$ 1,301.27	
1548	New Technology - Level 11 ($901 - $1000)	$ 1,710.90	$ 1,454.27	
1549	New Technology - Level 12 ($1001 - $1100)	$ 1,890.90	$ 1,607.27	
1550	New Technology - Level 13 ($1101 - $1200)	$ 2,070.90	$ 1,760.27	
1551	New Technology - Level 14 ($1201- $1300)	$ 2,250.90	$ 1,913.27	
1552	New Technology - Level 15 ($1301 - $1400)	$ 2,430.90	$ 2,066.27	
1553	New Technology - Level 16 ($1401 - $1500)	$ 2,610.90	$ 2,219.27	
1554	New Technology - Level 17 ($1501-$1600)	$ 2,790.90	$ 2,372.27	
1555	New Technology - Level 18 ($1601-$1700)	$ 2,970.90	$ 2,525.27	
1556	New Technology - Level 19 ($1701-$1800)	$ 3,150.90	$ 2,678.27	
1557	New Technology - Level 20 ($1801-$1900)	$ 3,330.90	$ 2,831.27	
1558	New Technology - Level 21 ($1901-$2000)	$ 3,510.90	$ 2,984.27	
1559	New Technology - Level 22 ($2001-$2500)	$ 4,050.90	$ 3,443.27	
1560	New Technology - Level 23 ($2501-$3000)	$ 4,950.90	$ 4,208.27	
1561	New Technology - Level 24 ($3001-$3500)	$ 5,850.90	$ 4,973.27	

1562	New Technology - Level 25 ($3501-$4000)	$ 6,750.90	$ 5,738.27	
1563	New Technology - Level 26 ($4001-$4500)	$ 7,650.90	$ 6,503.27	
1564	New Technology - Level 27 ($4501-$5000)	$ 8,550.90	$ 7,268.27	
1565	New Technology - Level 28 ($5001-$5500)	$ 9,450.90	$ 8,033.27	
1566	New Technology - Level 29 ($5501-$6000)	$ 10,350.90	$ 8,798.27	
1567	New Technology - Level 30 ($6001-$6500)	$ 11,250.90	$ 9,563.27	
1568	New Technology - Level 31 ($6501-$7000)	$ 12,150.90	$ 10,328.27	
1569	New Technology - Level 32 ($7001-$7500)	$ 13,050.90	$ 11,093.27	
1570	New Technology - Level 33 ($7501-$8000)	$ 13,950.90	$ 11,858.27	
1571	New Technology - Level 34 ($8001-$8500)	$ 14,850.90	$ 12,623.27	Also map CPT® 22849, 22850, 22852, 22855 to this APC value.
1572	New Technology - Level 35 ($8501-$9000)	$ 15,750.90	$ 13,388.27	
1573	New Technology - Level 36 ($9001-$9500)	$ 16,650.90	$ 14,153.27	
1574	New Technology - Level 37 ($9501-$10000)	$ 17,550.90	$ 14,918.27	
1575	New Technology - Level 38 ($10,001-$15,000)	$ 22,500.90	$ 19,125.77	Also map CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 to this APC value.
1576	New Technology - Level 39 ($15,001-$20,000)	$ 31,500.90	$ 26,775.77	
1577	New Technology - Level 40 ($20,001-$25,000)	$ 40,500.90	$ 34,425.77	
1578	New Technology - Level 41 ($25,001-$30,000)	$ 49,500.90	$ 42,075.77	
1579	New Technology - Level 42 ($30,001-$40,000)	$ 63,000.90	$ 53,550.77	
1580	New Technology - Level 43 ($40,001-$50,000)	$ 81,000.90	$ 68,850.77	
1581	New Technology - Level 44 ($50,001-$60,000)	$ 99,000.90	$ 84,150.77	

1582	New Technology - Level 45 ($60,001-$70,000)	$ 117,000.90	$ 99,450.77	
1583	New Technology - Level 46 ($70,001-$80,000)	$ 135,000.90	$ 114,750.77	
1584	New Technology - Level 47 ($80,001-$90,000)	$ 153,000.90	$ 130,050.77	
1585	New Technology - Level 48 ($90,001-$100,000)	$ 171,000.90	$ 145,350.77	
1589	New Technology - Level 38 ($10,001-$15,000)	$ 22,500.90	$ 19,125.77	
1590	New Technology - Level 39 ($15,001-$20,000)	$ 31,500.90	$ 26,775.77	
1591	New Technology - Level 40 ($20,001-$25,000)	$ 40,500.90	$ 34,425.77	
1592	New Technology - Level 41 ($25,001-$30,000)	$ 49,500.90	$ 42,075.77	
1593	New Technology - Level 42 ($30,001-$40,000)	$ 63,000.90	$ 53,550.77	
1594	New Technology - Level 43 ($40,001-$50,000)	$ 81,000.90	$ 68,850.77	
1595	New Technology - Level 44 ($50,001-$60,000)	$ 99,000.90	$ 84,150.77	
1596	New Technology - Level 45 ($60,001-$70,000)	$ 117,000.90	$ 99,450.77	
1597	New Technology - Level 46 ($70,001-$80,000)	$ 135,000.90	$ 114,750.77	
1598	New Technology - Level 47 ($80,001-$90,000)	$ 153,000.90	$ 130,050.77	
1599	New Technology - Level 48 ($90,001-$100,000)	$ 171,000.90	$ 145,350.77	
1607	Eptifibatide injection	$ 29.31	$ 24.91	
1608	Etanercept injection	$ 1,161.97	$ 987.67	
1609	Rho(D) immune globulin h, sd	$ 48.63	$ 41.34	
1613	Trastuzumab injection	$ 187.42	$ 159.31	
1630	Hep b ig, im	$ 202.20	$ 171.87	
1643	Y90 ibritumomab, rx	$ 83,990.95	$ 71,392.31	
1656	Factor viii fc fusion recomb	$ 3.62	$ 3.08	
1658	Injection, belinostat, 10mg	$ 67.93	$ 57.74	
1660	Injection, oritavancin	$ 41.55	$ 35.32	
1662	Inj tedizolid phosphate	$ 2.57	$ 2.18	
1669	Erythro lactobionate /500 mg	$ 141.96	$ 120.67	
1670	Tetanus immune globulin inj	$ 460.26	$ 391.22	
1675	P32 Na phosphate	$ 1,314.05	$ 1,116.94	
1683	Basiliximab	$ 6,635.03	$ 5,639.78	

1684	Corticorelin ovine triflutal	$ 15.47	$ 13.15	
1685	Darbepoetin alfa, non-esrd	$ 6.79	$ 5.77	
1686	Epoetin alfa, non-esrd	$ 22.09	$ 18.78	
1687	Digoxin immune fab (ovine)	$ 6,638.93	$ 5,643.09	
1688	Ethanolamine oleate	$ 799.38	$ 679.47	
1689	Fomepizole	$ 13.33	$ 11.33	
1690	Hemin	$ 41.45	$ 35.23	
1694	Ziconotide injection	$ 13.66	$ 11.61	
1695	Nesiritide injection	$ 132.01	$ 112.21	
1696	Palifermin injection	$ 36.52	$ 31.04	
1700	Inj secretin synthetic human	$ 62.61	$ 53.22	
1701	Treprostinil injection	$ 119.04	$ 101.18	
1704	Humate-P, inj	$ 2.02	$ 1.72	
1705	Factor viia	$ 3.71	$ 3.15	
1709	Azacitidine injection	$ 2.65	$ 2.25	
1710	Clofarabine injection	$ 200.31	$ 170.26	
1711	Vantas implant	$ 6,498.58	$ 5,523.79	
1712	Paclitaxel protein bound	$ 20.88	$ 17.75	
1739	Pegademase bovine, 25 iu	$ 662.33	$ 562.98	
1743	Nandrolone decanoate 50 mg	$ 39.04	$ 33.18	
1745	Radium ra223 dichloride ther	$ 245.90	$ 209.02	
1746	Factor xiii recomb a-subunit	$ 26.84	$ 22.81	
1747	Monovisc inj per dose	$ 1,402.82	$ 1,192.40	
1748	Inj tbo filgrastim 1 microg	$ 1.04	$ 0.88	
1761	Rolapitant, oral, 1mg	$ 3.98	$ 3.38	
1809	Injection, alemtuzumab	$ 3,315.83	$ 2,818.46	
1822	Injection, zarxio	$ 1.15	$ 0.98	
1823	Injection, dalbavancin	$ 25.83	$ 21.96	
1824	Ceftaroline fosamil inj	$ 5.21	$ 4.43	
1825	Ceftazidime and avibactam	$ 151.65	$ 128.90	
1826	Hyqvia 100mg immuneglobulin	$ 25.43	$ 21.62	
1827	Factor viii recomb obizur	$ 5.13	$ 4.36	
1829	Penicillin g benzathine inj	$ 25.02	$ 21.27	
1832	Dimethyl sulfoxide 50% 50 ml	$ 964.78	$ 820.06	
1844	Factor viii pegylated recomb	$ 3.09	$ 2.63	
1846	Factor viii nuwiq recomb 1iu	$ 2.55	$ 2.17	
1847	Injection, inflectra	$ 110.45	$ 93.88	
1848	Artiss fibrin sealant	$ 315.21	$ 267.93	
1849	Foscarnet sodium injection	$ 148.08	$ 125.87	
1850	Gamma globulin 1 cc inj	$ 68.49	$ 58.22	
1851	Gamma globulin > 10 cc inj	$ 684.86	$ 582.13	
1852	Interferon beta-1a inj	$ 5,014.75	$ 4,262.54	
1853	Minocycline hydrochloride	$ 2.83	$ 2.41	

1854	Pentobarbital sodium inj	$ 84.74	$ 72.03	
1856	Factor viii recomb novoeight	$ 2.41	$ 2.05	
1857	Inj, factor x, (human), 1iu	$ 12.90	$ 10.97	
1859	Argatroban nonesrd use 1mg	$ 2.21	$ 1.88	
1861	Inj., bendeka 1 mg	$ 42.91	$ 36.47	
1862	Gelsyn-3 injection 0.1 mg	$ 3.92	$ 3.33	
1901	New Technology - Level 49 ($100,001-$115,000)	$ 193,500.90	$ 164,475.77	
1902	New Technology - Level 49 ($100,001-$115,000)	$ 193,500.90	$ 164,475.77	
1903	New Technology - Level 50 ($115,001-$130,000)	$ 220,500.90	$ 187,425.77	
1904	New Technology - Level 50 ($115,001-$130,000)	$ 220,500.90	$ 187,425.77	
1905	New Technology - Level 51 ($130,001-$145,000)	$ 247,500.90	$ 210,375.77	
1906	New Technology - Level 51 ($130,001-$145,000)	$ 247,500.90	$ 210,375.77	
1907	New Technology - Level 52 ($145,001-$160,000)	$ 274,500.90	$ 233,325.77	
1908	New Technology - Level 52 ($145,001-$160,000)	$ 274,500.90	$ 233,325.77	
2616	Brachytx, non-str,Yttrium-90	$ 29,926.58	$ 25,437.59	
2632	Iodine I-125 sodium iodide	$ 68.17	$ 57.94	
2634	Brachytx, non-str, HA, I-125	$ 249.46	$ 212.04	
2635	Brachytx, non-str, HA, P-103	$ 48.82	$ 41.50	
2636	Brachy linear, non-str,P-103	$ 88.79	$ 75.47	
2638	Brachytx, stranded, I-125	$ 65.52	$ 55.69	
2639	Brachytx, non-stranded,I-125	$ 63.02	$ 53.57	
2640	Brachytx, stranded, P-103	$ 134.41	$ 114.25	
2641	Brachytx, non-stranded,P-103	$ 108.23	$ 92.00	
2642	Brachytx, stranded, C-131	$ 143.89	$ 122.31	
2643	Brachytx, non-stranded,C-131	$ 141.05	$ 119.89	
2645	Brachytx, non-str, Gold-198	$ 155.32	$ 132.02	
2646	Brachytx, non-str, HDR Ir-192	$ 523.40	$ 444.89	
2647	Brachytx, NS, Non-HDRIr-192	$ 152.86	$ 129.93	
2648	Brachytx planar, p-103	$ 8.44	$ 7.17	
2698	Brachytx, stranded, NOS	$ 65.52	$ 55.69	
2699	Brachytx, non-stranded, NOS	$ 48.82	$ 41.50	
2731	Immune globulin, powder	$ 68.30	$ 58.06	
2770	Quinupristin/dalfopristin	$ 753.07	$ 640.11	
2993	Gen, neuro, trans sen/stim	$ -	$ -	
4001	Echo guidance radiotherapy	$ 93.42	$ 79.41	
4002	Stereoscopic x-ray guidance	$ 101.20	$ 86.02	

4003	Radiation treatment delivery, MeV <= 5; simple	$ 358.74	$ 304.93	
4004	Radiation treatment delivery, 6-10 MeV; simple	$ 262.73	$ 223.32	
4005	Radiation treatment delivery, 11-19 MeV; simple	$ 262.73	$ 223.32	
4006	Radiation treatment delivery, MeV>=20; simple	$ 262.08	$ 222.77	
4007	Radiation treatment delivery, MeV<=5; intermediate	$ 496.91	$ 422.37	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$ 362.63	$ 308.24	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$ 360.68	$ 306.58	
4010	Radiation treatment delivery, MeV >=20; intermediate	$ 360.68	$ 306.58	
4011	Radiation treatment delivery, MeV<=5; complex	$ 490.43	$ 416.87	
4012	Radiation treatment delivery, 6-10 MeV; complex	$ 480.69	$ 408.59	
4013	Radiation treatment delivery, 11-19 MeV; complex	$ 481.34	$ 409.14	
4014	Radiation treatment delivery, MeV >=20; complex	$ 481.34	$ 409.14	
4015	Radiation tx delivery imrt	$ 652.59	$ 554.70	
4016	Delivery comp imrt	$ 650.65	$ 553.05	
5012	Clinic Visits and Related Services	$ 208.53	$ 177.25	
5021	Level 1 Type A ED Visits	$ 125.51	$ 106.68	
5022	Level 2 Type A ED Visits	$ 230.33	$ 195.78	
5023	Level 3 Type A ED Visits	$ 401.38	$ 341.17	
5024	Level 4 Type A ED Visits	$ 648.67	$ 551.37	
5025	Level 5 Type A ED Visits	$ 945.54	$ 803.71	
5031	Level 1 Type B ED Visits	$ 140.11	$ 119.09	
5032	Level 2 Type B ED Visits	$ 167.11	$ 142.04	
5033	Level 3 Type B ED Visits	$ 294.59	$ 250.40	
5034	Level 4 Type B ED Visits	$ 389.52	$ 331.09	
5035	Level 5 Type B ED Visits	$ 578.29	$ 491.55	
5041	Critical Care	$ 1,332.04	$ 1,132.23	
5045	Trauma Response with Critical Care	$ 1,701.63	$ 1,446.39	
5051	Level 1 Skin Procedures	$ 317.61	$ 269.97	
5052	Level 2 Skin Procedures	$ 565.34	$ 480.54	
5053	Level 3 Skin Procedures	$ 869.20	$ 738.82	
5054	Level 4 Skin Procedures	$ 2,788.13	$ 2,369.91	

5055	Level 5 Skin Procedures	$ 4,979.03	$ 4,232.18	
5061	Hyperbaric Oxygen	$ 205.92	$ 175.03	
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$ 1,042.81	$ 886.39	
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$ 2,475.90	$ 2,104.52	
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$ 4,280.92	$ 3,638.78	
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$ 5,068.82	$ 4,308.50	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$ 8,847.38	$ 7,520.27	Also map CPT® 22632 to this APC value.
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$ 13,407.89	$ 11,396.71	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$ 21,828.85	$ 18,554.52	
5101	Level 1 Strapping and Cast Application	$ 242.32	$ 205.97	
5102	Level 2 Strapping and Cast Application	$ 424.04	$ 360.43	
5111	Level 1 Musculoskeletal Procedures	$ 405.16	$ 344.39	
5112	Level 2 Musculoskeletal Procedures	$ 2,364.01	$ 2,009.41	
5113	Level 3 Musculoskeletal Procedures	$ 4,722.01	$ 4,013.71	
5114	Level 4 Musculoskeletal Procedures	$ 10,259.26	$ 8,720.37	Also map CPT® 22634, 22800, and 22830 to this APC value.
5115	Level 5 Musculoskeletal Procedures	$ 19,284.98	$ 16,392.23	
5116	Level 6 Musculoskeletal Procedures	$ 27,724.43	$ 23,565.77	Also map CPT® 22558 to this APC value.
5151	Level 1 Airway Endoscopy	$ 295.15	$ 250.88	
5152	Level 2 Airway Endoscopy	$ 695.70	$ 591.35	
5153	Level 3 Airway Endoscopy	$ 2,464.72	$ 2,095.01	
5154	Level 4 Airway Endoscopy	$ 4,933.19	$ 4,193.21	
5155	Level 5 Airway Endoscopy	$ 9,265.63	$ 7,875.79	
5161	Level 1 ENT Procedures	$ 371.05	$ 315.39	
5162	Level 2 ENT Procedures	$ 876.83	$ 745.31	
5163	Level 3 ENT Procedures	$ 2,302.38	$ 1,957.02	
5164	Level 4 ENT Procedures	$ 4,016.29	$ 3,413.85	
5165	Level 5 ENT Procedures	$ 7,963.61	$ 6,769.07	
5166	Cochlear Implant Procedure	$ 57,541.99	$ 48,910.69	
5181	Level 1 Vascular Procedures	$ 1,116.02	$ 948.62	

5182	Level 2 Vascular Procedures	$ 1,968.53	$ 1,673.25	
5183	Level 3 Vascular Procedures	$ 4,754.74	$ 4,041.53	
5184	Level 4 Vascular Procedures	$ 7,877.74	$ 6,696.08	
5191	Level 1 Endovascular Procedures	$ 5,058.74	$ 4,299.93	
5192	Level 2 Endovascular Procedures	$ 8,421.35	$ 7,158.15	Also map CPT® 22846 to this APC value.
5193	Level 3 Endovascular Procedures	$ 17,404.27	$ 14,793.63	
5194	Level 4 Endovascular Procedures	$ 27,638.10	$ 23,492.39	
5200	Implantation Wireless PA Pressure Monitor	$ 52,813.31	$ 44,891.31	
5211	Level 1 Electrophysiologic Procedures	$ 1,654.79	$ 1,406.57	
5212	Level 2 Electrophysiologic Procedures	$ 9,175.30	$ 7,799.01	
5213	Level 3 Electrophysiologic Procedures	$ 34,584.73	$ 29,397.02	
5221	Level1 Pacemaker and Similar Procedures	$ 5,634.95	$ 4,789.71	
5222	Level 2 Pacemaker and Similar Procedures	$ 13,327.40	$ 11,328.29	
5223	Level 3 Pacemaker and Similar Procedures	$ 17,782.81	$ 15,115.39	Also map CPT® 22600, 22610, 22630, 22633, and 22857 to this APC value.
5224	Level 4 Pacemaker and Similar Procedures	$ 31,822.22	$ 27,048.89	
5231	Level 1 ICD and Similar Procedures	$ 39,593.63	$ 33,654.59	
5232	Level 2 ICD and Similar Procedures	$ 55,181.48	$ 46,904.26	
5241	Level 1 Blood Product Exchange and Related Services	$ 689.22	$ 585.84	
5242	Level 2 Blood Product Exchange and Related Services	$ 2,244.60	$ 1,907.91	
5243	Level 3 Blood Product Exchange and Related Services	$ 7,060.50	$ 6,001.43	
5244	Level 4 Blood Product Exchange and Related Services	$ 68,206.97	$ 57,975.92	
5301	Level 1 Upper GI Procedures	$ 1,370.79	$ 1,165.17	
5302	Level 2 Upper GI Procedures	$ 2,670.03	$ 2,269.53	
5303	Level 3 Upper GI Procedures	$ 5,084.44	$ 4,321.77	
5311	Level 1 Lower GI Procedures	$ 1,340.80	$ 1,139.68	
5312	Level 2 Lower GI Procedures	$ 1,763.62	$ 1,499.08	
5313	Level 3 Lower GI Procedures	$ 4,202.24	$ 3,571.90	
5331	Complex GI Procedures	$ 8,092.93	$ 6,878.99	

5341	Abdominal/Peritoneal/Biliary and Related Procedures	$ 5,305.18	$ 4,509.40	
5361	Level 1 Laparoscopy and Related Services	$ 8,272.53	$ 7,031.65	
5362	Level 2 Laparoscopy and Related Services	$ 13,934.93	$ 11,844.69	
5371	Level 1 Urology and Related Services	$ 416.56	$ 354.08	
5372	Level 2 Urology and Related Services	$ 1,012.05	$ 860.24	
5373	Level 3 Urology and Related Services	$ 3,131.55	$ 2,661.82	
5374	Level 4 Urology and Related Services	$ 5,268.35	$ 4,478.10	
5375	Level 5 Urology and Related Services	$ 7,236.97	$ 6,151.42	
5376	Level 6 Urology and Related Services	$ 13,770.99	$ 11,705.34	
5377	Level 7 Urology and Related Services	$ 29,375.19	$ 24,968.91	
5401	Dialysis	$ 1,101.11	$ 935.94	
5411	Level 1 Gynecologic Procedures	$ 298.67	$ 253.87	
5412	Level 2 Gynecologic Procedures	$ 491.40	$ 417.69	
5413	Level 3 Gynecologic Procedures	$ 1,004.47	$ 853.80	
5414	Level 4 Gynecologic Procedures	$ 4,250.29	$ 3,612.75	
5415	Level 5 Gynecologic Procedures	$ 7,426.49	$ 6,312.52	
5416	Level 6 Gynecologic Procedures	$ 11,419.94	$ 9,706.95	
5431	Level 1 Nerve Procedures	$ 2,936.66	$ 2,496.16	
5432	Level 2 Nerve Procedures	$ 8,218.91	$ 6,986.07	
5441	Level 1 Nerve Injections	$ 445.46	$ 378.64	
5442	Level 2 Nerve Injections	$ 1,077.86	$ 916.18	
5443	Level 3 Nerve Injections	$ 1,376.71	$ 1,170.20	
5461	Level 1 Neurostimulator and Related Procedures	$ 5,183.64	$ 4,406.09	
5462	Level 2 Neurostimulator and Related Procedures	$ 10,763.15	$ 9,148.68	
5463	Level 3 Neurostimulator and Related Procedures	$ 33,672.89	$ 28,621.96	
5464	Level 4 Neurostimulator and Related Procedures	$ 49,856.13	$ 42,377.71	
5471	Implantation of Drug Infusion Device	$ 28,921.30	$ 24,583.11	
5481	Laser Eye Procedures	$ 893.12	$ 759.15	
5491	Level 1 Intraocular Procedures	$ 3,450.89	$ 2,933.26	
5492	Level 2 Intraocular Procedures	$ 6,552.47	$ 5,569.60	

5493	Level 3 Intraocular Procedures	$ 17,705.34	$ 15,049.54	
5494	Level 4 Intraocular Procedures	$ 29,221.60	$ 24,838.36	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$ 510.34	$ 433.79	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$ 1,453.12	$ 1,235.15	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$ 3,262.82	$ 2,773.40	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$ 5,355.49	$ 4,552.17	
5521	Level 1 Imaging without Contrast	$ 112.14	$ 95.32	
5522	Level 2 Imaging without Contrast	$ 202.52	$ 172.14	
5523	Level 3 Imaging without Contrast	$ 415.01	$ 352.76	
5524	Level 4 Imaging without Contrast	$ 895.48	$ 761.16	
5571	Level 1 Imaging with Contrast	$ 363.13	$ 308.66	
5572	Level 2 Imaging with Contrast	$ 694.58	$ 590.39	
5573	Level 3 Imaging with Contrast	$ 1,245.15	$ 1,058.38	
5591	Level 1 Nuclear Medicine and Related Services	$ 636.28	$ 540.84	
5592	Level 2 Nuclear Medicine and Related Services	$ 819.94	$ 696.95	
5593	Level 3 Nuclear Medicine and Related Services	$ 2,212.88	$ 1,880.95	
5594	Level 4 Nuclear Medicine and Related Services	$ 2,475.97	$ 2,104.57	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$ 222.79	$ 189.37	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$ 579.28	$ 492.39	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$ 2,145.46	$ 1,823.64	
5621	Level 1 Radiation Therapy	$ 210.58	$ 178.99	
5622	Level 2 Radiation Therapy	$ 404.03	$ 343.43	
5623	Level 3 Radiation Therapy	$ 935.73	$ 795.37	
5624	Level 4 Radiation Therapy	$ 1,268.50	$ 1,078.23	
5625	Level 5 Radiation Therapy	$ 1,942.15	$ 1,650.83	
5626	Level 6 Radiation Therapy	$ 3,043.03	$ 2,586.58	
5627	Level 7 Radiation Therapy	$ 13,759.63	$ 11,695.69	
5661	Therapeutic Nuclear Medicine	$ 415.60	$ 353.26	
5671	Level 1 Pathology	$ 91.76	$ 78.00	
5672	Level 2 Pathology	$ 260.51	$ 221.43	
5673	Level 3 Pathology	$ 493.60	$ 419.56	
5674	Level 4 Pathology	$ 1,004.62	$ 853.93	
5691	Level 1 Drug Administration	$ 68.18	$ 57.95	

5692	Level 2 Drug Administration	$ 107.55	$ 91.42	
5693	Level 3 Drug Administration	$ 336.92	$ 286.38	
5694	Level 4 Drug Administration	$ 519.08	$ 441.22	
5721	Level1 Diagnostic Tests and Related Services	$ 244.71	$ 208.00	
5722	Level 2 Diagnostic Tests and Related Services	$ 454.16	$ 386.04	
5723	Level 3 Diagnostic Tests and Related Services	$ 819.49	$ 696.57	
5724	Level 4 Diagnostic Tests and Related Services	$ 1,643.02	$ 1,396.57	
5731	Level 1 Minor Procedures	$ 30.91	$ 26.27	
5732	Level 2 Minor Procedures	$ 57.82	$ 49.15	
5733	Level 3 Minor Procedures	$ 100.62	$ 85.53	
5734	Level 4 Minor Procedures	$ 191.66	$ 162.91	
5735	Level 5 Minor Procedures	$ 626.69	$ 532.69	
5741	Level 1 Electronic Analysis of Devices	$ 66.89	$ 56.86	
5742	Level 2 Electronic Analysis of Devices	$ 211.57	$ 179.83	
5743	Level 3 Electronic Analysis of Devices	$ 504.74	$ 429.03	
5771	Cardiac Rehabilitation	$ 212.67	$ 180.77	
5781	Resuscitation and Cardioversion	$ 947.68	$ 805.53	
5791	Pulmonary Treatment	$ 344.88	$ 293.15	
5801	Ventilation Initiation and Management	$ 917.95	$ 780.26	
5811	Manipulation Therapy	$ 44.60	$ 37.91	
5821	Level 1 Health and Behavior Services	$ 60.08	$ 51.07	
5822	Level 2 Health and Behavior Services	$ 137.50	$ 116.88	
5823	Level 3 Health and Behavior Services	$ 229.59	$ 195.15	
5853	Partial Hospitalization (3 or more services) for CMHCs	$ 217.04	$ 184.48	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$ 397.55	$ 337.92	
5871	Dental Procedures	$ 1,618.52	$ 1,375.74	
5881	Ancillary Outpatient Services When Patient Dies	$ 12,097.15	$ 10,282.58	
7000	Amifostine	$ 1,752.14	$ 1,489.32	
7011	Oprelvekin injection	$ 768.45	$ 653.18	
7035	Teniposide	$ 4,635.28	$ 3,939.99	
7041	Tirofiban HCl	$ 14.87	$ 12.64	

7043	Infliximab not biosimil 10mg	$ 141.90	$ 120.62	
7046	Doxorubicin inj 10mg	$ 690.42	$ 586.86	
7048	Alteplase recombinant	$ 158.00	$ 134.30	
7308	Aminolevulinic acid hcl top	$ 728.26	$ 619.02	
8004	Ultrasound Composite	$ 539.32	$ 458.42	
8005	CT and CTA without Contrast Composite	$ 476.91	$ 405.37	
8006	CT and CTA with Contrast Composite	$ 865.39	$ 735.58	
8007	MRI and MRA without Contrast Composite	$ 979.60	$ 832.66	
8008	MRI and MRA with Contrast Composite	$ 1,540.08	$ 1,309.07	
8010	Mental Health Services Composite	$ 397.55	$ 337.92	
8011	Comprehensive Observation Services	$ 4,296.24	$ 3,651.80	
9002	Tenecteplase injection	$ 219.16	$ 186.29	
9003	Palivizumab	$ 2,169.09	$ 1,843.73	
9005	Reteplase injection	$ 908.96	$ 772.62	
9006	Tacrolimus injection	$ 370.12	$ 314.60	
9012	Arsenic trioxide injection	$ 138.66	$ 117.86	
9014	Inj., cerliponase alfa 1 mg	$ 171.72	$ 145.96	
9015	Inj., haegarda 10 units	$ 17.40	$ 14.79	
9016	Inj., triptorelin xr 3.75 mg	$ 5,088.00	$ 4,324.80	
9018	Inj, rimabotulinumtoxinB	$ 21.66	$ 18.41	
9019	Caspofungin acetate	$ 22.75	$ 19.34	
9024	Amphotericin b lipid complex	$ 31.90	$ 27.12	
9028	Inj inotuzumab ozogam 0.1 mg	$ 3,964.40	$ 3,369.74	
9029	Inj., guselkumab, 1 mg	$ 183.36	$ 155.86	
9030	Inj., copanlisib, 1 mg	$ 140.22	$ 119.19	
9031	Inj, etelcalcetide, 0.1 mg	$ 5.37	$ 4.56	
9032	Baclofen 10 MG injection	$ 316.84	$ 269.31	
9033	Cidofovir injection	$ 860.53	$ 731.45	
9034	Inj cuvitru, 100 mg	$ 24.11	$ 20.49	
9035	Axicabtagene ciloleucel car+	$ 711,684.00	$ 604,931.40	
9036	Injection, renflexis	$ 115.89	$ 98.51	
9038	Inj estrogen conjugate	$ 555.54	$ 472.21	
9042	Glucagon hydrochloride	$ 385.89	$ 328.01	
9043	Inj, afstyla, 1 i.u.	$ 2.45	$ 2.08	
9044	Ibutilide fumarate injection	$ 433.36	$ 368.36	
9052	Fluciciovine F-18	$ 701.19	$ 596.01	
9056	Gallium Ga-68	$ 120.13	$ 102.11	
9058	Buprenorphine implant 74.2mg	$ 2,268.42	$ 1,928.16	

9059	Vonvendi inj 1 iu vwf:rco	$ 3.63	$ 3.09	
9065	Argatroban esrd dialysis 1mg	$ 2.21	$ 1.88	
9067	Lutetium lu 177 dotatat ther	$ 453.15	$ 385.18	
9070	Inj luxturna 1 billion vec g	$ 5,333.92	$ 4,533.83	
9071	Capsaicin 8% patch	$ 5.69	$ 4.84	
9073	Buprenorph xr 100 mg or less	$ 3,014.64	$ 2,562.44	
9074	Makena, 10 mg	$ 50.27	$ 42.73	
9075	Inj, kovaltry, 1 i.u.	$ 2.28	$ 1.94	
9078	Testosterone undecanoate 1mg	$ 2.45	$ 2.08	
9079	Genvisc 850, inj, 1mg	$ 19.08	$ 16.22	
9083	Inj, phenylephrine ketorolac	$ 851.84	$ 724.06	
9084	Florbetapir f18	$ 5,441.69	$ 4,625.44	
9085	Inj sulf hexa lipid microsph	$ 38.24	$ 32.50	
9086	Hepa vacc ped/adol 3 dose	$ 51.65	$ 43.90	
9087	Inj, clevidipine butyrate	$ 5.02	$ 4.27	
9088	Peng benzathine/procaine inj	$ 19.98	$ 16.98	
9089	Oral fludarabine phosphate	$ 146.56	$ 124.58	
9090	Melphalan oral 2 mg	$ 21.60	$ 18.36	
9091	Daunorubicin citrate inj	$ 438.84	$ 373.01	
9092	Interferon alfa-2a inj	$ 304.79	$ 259.07	
9093	Plicamycin (mithramycin) inj	$ 11.02	$ 9.37	
9094	Radiesse injection	$ 853.02	$ 725.07	
9095	Inj, sculptra, 0.5mg	$ 5.90	$ 5.02	
9096	Inj retacrit esrd on dialysi	$ 2.10	$ 1.79	
9097	Inj retacrit non-esrd use	$ 21.05	$ 17.89	
9098	Chorionic gonadotropin/1000u	$ 43.11	$ 36.64	
9099	Inj fosnetupitant, palonoset	$ 973.08	$ 827.12	
9104	Antithymocyte globuln rabbit	$ 1,352.25	$ 1,149.41	
9108	Thyrotropin injection	$ 2,924.02	$ 2,485.42	
9119	Injection, pegfilgrastim 6mg	$ 8,437.89	$ 7,172.21	
9120	Injection, Fulvestrant	$ 176.28	$ 149.84	
9122	Triptorelin pamoate	$ 481.29	$ 409.10	
9124	Daptomycin injection	$ 0.58	$ 0.49	
9125	Risperidone, long acting	$ 16.94	$ 14.40	
9126	Natalizumab injection	$ 35.69	$ 30.34	
9130	Inj, Imm Glob Bivigam, 500mg	$ 126.93	$ 107.89	
9131	Inj, Ado-trastuzumab Emt 1mg	$ 55.40	$ 47.09	
9132	Kcentra, per i.u.	$ 3.48	$ 2.96	
9133	Rabies ig, im/sc	$ 602.98	$ 512.53	
9134	Rabies ig, heat treated	$ 584.90	$ 497.17	
9135	Varicella-zoster ig, im	$ 2,684.47	$ 2,281.80	
9139	Rabies vaccine, im	$ 524.58	$ 445.89	
9140	Rabies vaccine, id	$ 234.02	$ 198.92	

9171	Factor ix idelvion inj	$ 7.70	$ 6.55	
9172	Injection, dexamethasone 9%	$ 1.99	$ 1.69	
9173	Injection, fulphila	$ 663.83	$ 564.26	
9174	Inj, durolane 1 mg	$ 1,860.30	$ 1,581.26	
9175	Puraply 1 sq cm	$ 128.16	$ 108.94	
9176	Puraply am 1 sq cm	$ 124.13	$ 105.51	
9177	Antithrombin recombinant	$ 186.03	$ 158.13	
9179	Injection, Aristada Initio	$ 5.28	$ 4.49	
9180	Injection, patisiran	$ 6.01	$ 5.11	
9181	Injection, risperidone	$ 18.13	$ 15.41	
9182	Inj mogamulizumab-kpkc	$ 361.57	$ 307.33	
9183	Injection, plazomicin	$ 0.59	$ 0.50	
9184	Iodine i-131 iobenguane, dx	$ 576.22	$ 489.79	
9185	Iodine i-131 iobenguane, tx	$ 576.22	$ 489.79	
9186	Inj., rituximab, 10 mg	$ 165.57	$ 140.73	
9187	Injection, burosumab-twza 1m	$ 648.72	$ 551.41	
9188	Inj crotalidae im f(ab')2 eq	$ 2,261.88	$ 1,922.60	
9189	Inj., ibalizumab-uiyk, 10 mg	$ 108.28	$ 92.04	
9190	Inj., vestronidase alfa-vjbk	$ 395.43	$ 336.12	
9191	Inj., fibryga, 1 mg	$ 1.91	$ 1.62	
9192	Inj, bortezomib, nos, 0.1 mg	$ 68.51	$ 58.23	
9193	Nivestym	$ 1.39	$ 1.18	
9194	Tisagenlecleucel car-pos t	$ 881,575.43	$ 749,339.12	
9207	Inj., velcade 0.1 mg	$ 82.00	$ 69.70	
9208	Agalsidase beta injection	$ 316.12	$ 268.70	
9209	Laronidase injection	$ 55.41	$ 47.10	
9210	Palonosetron hcl	$ 30.85	$ 26.22	
9213	Pemetrexed injection	$ 122.79	$ 104.37	
9214	Bevacizumab injection	$ 142.65	$ 121.25	
9215	Cetuximab injection	$ 109.14	$ 92.77	
9217	Leuprolide acetate suspnsion	$ 411.15	$ 349.48	
9224	Galsulfase injection	$ 701.91	$ 596.62	
9225	Fluocinolone acetonide implt	$ 36,234.90	$ 30,799.67	
9228	Tigecycline injection	$ 3.71	$ 3.15	
9229	Ibandronate sodium injection	$ 101.23	$ 86.05	
9230	Abatacept injection	$ 95.27	$ 80.98	
9231	Decitabine injection	$ 25.32	$ 21.52	
9232	Idursulfase injection	$ 965.80	$ 820.93	
9233	Ranibizumab injection	$ 672.06	$ 571.25	
9234	Alglucosidase alfa injection	$ 254.05	$ 215.94	
9235	Panitumumab injection	$ 205.88	$ 175.00	
9236	Eculizumab injection	$ 414.86	$ 352.63	
9237	Inj, lanreotide acetate	$ 105.92	$ 90.03	

9239	Buprenorphine xr over 100 mg	$ 3,014.64	$ 2,562.44	
9240	Injection, ixabepilone	$ 127.78	$ 108.61	
9242	Injection, fosaprepitant	$ 3.94	$ 3.35	
9243	Inj., treanda 1 mg	$ 55.04	$ 46.78	
9245	Romiplostim injection	$ 128.52	$ 109.24	
9251	C1 esterase inhibitor inj	$ 97.66	$ 83.01	
9252	Plerixafor injection	$ 594.74	$ 505.53	
9253	Temozolomide injection	$ 19.00	$ 16.15	
9255	Paliperidone palmitate inj	$ 19.69	$ 16.74	
9256	Dexamethasone intra implant	$ 360.30	$ 306.26	
9257	Inj., emicizumab-kxwh 0.5 mg	$ 87.95	$ 74.76	
9258	Telavancin injection	$ 9.84	$ 8.36	
9259	Pralatrexate injection	$ 488.90	$ 415.57	
9260	Ofatumumab injection	$ 105.39	$ 89.58	
9261	Ustekinumab sub cu inj, 1 mg	$ 343.85	$ 292.27	
9263	Ecallantide injection	$ 860.33	$ 731.28	
9264	Tocilizumab injection	$ 8.52	$ 7.24	
9265	Romidepsin injection	$ 580.64	$ 493.54	
9269	C-1 esterase, berinert	$ 88.10	$ 74.89	
9270	Gammaplex IVIG	$ 93.71	$ 79.65	
9271	Velaglucerase alfa	$ 621.71	$ 528.45	
9272	Inj, denosumab	$ 33.44	$ 28.42	
9273	Sipuleucel-T auto CD54+	$ 78,154.97	$ 66,431.72	
9274	Crotalidae Poly Immune Fab	$ 5,850.94	$ 4,973.30	
9276	Cabazitaxel injection	$ 302.38	$ 257.02	
9278	Incobotulinumtoxin A	$ 9.15	$ 7.78	
9281	Injection, pegloticase	$ 4,202.26	$ 3,571.92	
9284	Ipilimumab injection	$ 271.57	$ 230.83	
9286	Belatacept injection	$ 6.85	$ 5.82	
9287	Brentuximab vedotin inj	$ 270.87	$ 230.24	
9289	Erwinaze injection	$ 746.69	$ 634.69	
9293	Injection, glucarpidase	$ 563.96	$ 479.37	
9294	Inj, taliglucerase alfa 10 u	$ 72.69	$ 61.79	
9295	Injection, Carfilzomib, 1 mg	$ 65.37	$ 55.56	
9296	Inj, ziv-aflibercept, 1mg	$ 14.98	$ 12.73	
9297	Inj, Omacetaxine Mep, 0.01mg	$ 5.36	$ 4.56	
9298	Inj, Ocriplasmin, 0.125 mg	$ 1,505.41	$ 1,279.60	
9300	Omalizumab injection	$ 66.72	$ 56.71	
9301	Aminolevulinic acid, 10% gel	$ 2.49	$ 2.12	
9302	Inj daunorubicin, cytarabine	$ 336.07	$ 285.66	
9441	Inj ferric carboxymaltos 1mg	$ 1.91	$ 1.62	
9445	Injection, ruconest	$ 49.77	$ 42.30	
9448	Oral netupitant, palonosetro	$ 543.49	$ 461.97	

9449	Injection, blinatumomab	$ 198.66	$ 168.86	
9450	Fluocinol acet intravit imp	$ 882.59	$ 750.20	
9451	Injection, peramivir	$ 2.92	$ 2.48	
9452	Inj ceftolozane tazobactam	$ 9.82	$ 8.35	
9453	Injection, nivolumab	$ 49.57	$ 42.13	
9454	Inj, pasireotide long acting	$ 521.32	$ 443.12	
9455	Injection, siltuximab	$ 171.63	$ 145.89	
9456	Injection, isavuconazonium	$ 1.53	$ 1.30	
9460	Injection, cangrelor	$ 27.82	$ 23.65	
9462	Injection, delafloxacin	$ 0.83	$ 0.71	
9463	Inj., aprepitant, 1 mg	$ 3.79	$ 3.22	
9464	Inj., rolapitant, 0.5 mg	$ 1.69	$ 1.44	
9466	Inj., benralizumab, 1 mg	$ 301.45	$ 256.23	
9467	Inj rituximab, hyaluronidase	$ 82.30	$ 69.96	
9468	Factor ix recomb gly rebinyn	$ 6.99	$ 5.94	
9469	Inj triamcinolone ace xr 1mg	$ 33.99	$ 28.89	
9470	Aripiprazole lauroxil 1mg	$ 4.39	$ 3.73	
9471	Hymovis injection 1 mg	$ 34.66	$ 29.46	
9472	Inj talimogene laherparepvec	$ 89.99	$ 76.49	
9473	Injection, mepolizumab, 1mg	$ 53.25	$ 45.26	
9474	Inj irinotecan liposome 1 mg	$ 81.96	$ 69.67	
9475	Injection, necitumumab, 1 mg	$ 10.03	$ 8.53	
9476	Injection, daratumumab 10 mg	$ 94.33	$ 80.18	
9477	Injection, elotuzumab, 1mg	$ 11.55	$ 9.82	
9478	Inj sebelipase alfa 1 mg	$ 974.03	$ 827.93	
9479	Instill, ciprofloxacin otic	$ 53.96	$ 45.87	
9480	Injection trabectedin 0.1mg	$ 541.21	$ 460.03	
9481	Injection, reslizumab	$ 16.73	$ 14.22	
9482	Sotalol hydrochloride IV	$ 17.97	$ 15.27	
9483	Inj, atezolizumab,10 mg	$ 138.44	$ 117.67	
9484	Inj, eteplirsen, 10 mg	$ 302.62	$ 257.23	
9485	Inj, olaratumab, 10 mg	$ 91.87	$ 78.09	
9486	Inj, granisetron, xr, 0.1 mg	$ 6.44	$ 5.47	
9487	Ustekinumab, iv inject,1 mg	$ 22.10	$ 18.79	
9488	Conivaptan hcl	$ 55.97	$ 47.57	
9489	Inj, nusinersen, 0.1mg	$ 1,983.37	$ 1,685.86	
9490	Inj, bezlotoxumab, 10 mg	$ 72.29	$ 61.45	
9491	Injection, avelumab, 10 mg	$ 147.28	$ 125.19	
9492	Inj., durvalumab, 10 mg	$ 133.15	$ 113.18	
9493	Injection, edaravone, 1 mg	$ 34.52	$ 29.34	
9494	Injection, ocrelizumab	$ 103.22	$ 87.74	
9495	Gemtuzumab ozogamicin inj	$ 347.68	$ 295.53	
9497	Loxapine for inhalation 1 mg	$ 271.44	$ 230.72	

9500	Platelets, irradiated	$ 309.44	$ 263.02	
9501	Platelet pheres leukoreduced	$ 875.34	$ 744.04	
9502	Platelet pheresis irradiated	$ 995.24	$ 845.95	
9503	Fr frz plasma donor retested	$ 113.06	$ 96.10	
9504	RBC deglycerolized	$ 596.05	$ 506.64	
9505	RBC irradiated	$ 398.45	$ 338.68	
9507	Platelets, pheresis	$ 606.74	$ 515.73	
9508	Plasma 1 donor frz w/in 8 hr	$ 128.75	$ 109.44	
9509	Frozen plasma, pooled, sd	$ 136.73	$ 116.22	
9510	Whole blood for transfusion	$ 200.12	$ 170.10	
9511	Cryoprecipitate each unit	$ 88.92	$ 75.58	
9512	RBC leukocytes reduced	$ 332.60	$ 282.71	
9513	Plasma, frz between 8-24hour	$ 137.99	$ 117.29	
9514	Plasma protein fract,5%,50ml	$ 48.51	$ 41.23	
9515	Platelets, each unit	$ 194.33	$ 165.18	
9516	Plaelet rich plasma unit	$ 225.41	$ 191.60	
9517	Red blood cells unit	$ 252.22	$ 214.39	
9518	Washed red blood cells unit	$ 640.67	$ 544.57	
9519	Plasmaprotein fract,5%,250ml	$ 138.56	$ 117.78	
9520	Blood split unit	$ 226.91	$ 192.87	
9521	Platelets leukoreduced irrad	$ 300.85	$ 255.72	
9522	RBC leukoreduced irradiated	$ 460.04	$ 391.03	
9523	Cryoprecipitatereducedplasma	$ 159.71	$ 135.75	
9524	Blood, l/r, cmv-neg	$ 316.69	$ 269.19	
9525	Platelets, hla-m, l/r, unit	$ 1,520.69	$ 1,292.59	
9526	Platelets leukocytes reduced	$ 245.90	$ 209.02	
9527	Blood, l/r, froz/degly/wash	$ 537.07	$ 456.51	
9528	Plt, aph/pher, l/r, cmv-neg	$ 801.11	$ 680.94	
9529	Blood, l/r, irradiated	$ 405.85	$ 344.97	
9530	Plate pheres leukoredu irrad	$ 1,124.87	$ 956.14	
9531	Plt, pher, l/r cmv-neg, irr	$ 886.16	$ 753.24	
9532	RBC, frz/deg/wsh, l/r, irrad	$ 404.12	$ 343.50	
9533	RBC, l/r, cmv-neg, irrad	$ 412.72	$ 350.81	
9534	Pathogen reduced plasma pool	$ 74.57	$ 63.38	
9535	Pathogen reduced plasma sing	$ 141.03	$ 119.88	
9536	Platelets pheresis path redu	$ 1,124.87	$ 956.14	

Final Exhibit #5

Rural Health Clinics

Source: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

(effective 1/1/2020)

Facility	City	County
AKRON CLINIC	Akron	Washington
ARKANSAS VALLEY FAMILY PRACTICE, LLC	La Junta	Otero
BANNER FAMILY MEDICINE BRUSH CLINIC	Brush	Morgan
BANNER HEALTH CLINIC FORT MORGAN	Ft. Morgan	Morgan
BASIN CLINIC	Naturita	Montrose
BUENA VISTA HEALTH CENTER	Buena Vista	Chaffee
BUTTON FAMILY PRACTICE	Canon City	Fremont
CENTENNIAL FAMILY HEALTH CENTER	Ordway	Crowley
CORTEZ PRIMARY CARE CLINIC	Cortez	Montezuma
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	Creede	Mineral
CUSTER COUNTY MEDICAL CENTER	Westcliffe	Custer
EADS MEDICAL CLINIC	Eads	Kiowa
EASTERN PLAINS MEDICAL CLINIC OF CALHAN	Calhan	El Paso
FAMILY PRACTICE OF HOLYOKE	Holyoke	Phillips
FLORENCE MEDICAL CENTER	Florence	Fremont
GRAND RIVER HEALTH CLINIC WEST	Parachute	Garfield
GRAND RIVER PRIMARY CARE	Rifle	Garfield
KIT CARSON CLINIC	Kit Carson	Cheyenne
LAKE CITY AREA MEDICAL CENTER	Lake City	Hinsdale
LAMAR MEDICAL CLINIC	Lamar	Prowers
MANCOS VALLEY HEALTH CENTER	Mancos	Montezuma
MEEKER FAMILY HEALTH CENTER	Meeker	Rio Blanco
MEMORIAL HOSPITAL	Craig	Moffat
MIDDLE PARK MEDICAL CENTER	Winter Park	Grand
MIDDLE PARK MEDICAL CENTER	Grandby	Grand
MIDDLE PARK MEDICAL CENTER - KREMMLING CLINIC	Kremmling	Grand
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	Monte Vista	Rio Grande
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	Trinidad	Las Animas
NORTH PARK MEDICAL CENTER - WALDEN	Walden	Jackson
PAGOSA MOUNTAIN CLINIC	Pagosa Springs	Archuleta
PARKE HEALTH CLINIC	Burlington	Kit Carson
PEDIATRIC ASSOCIATION OF CANON CITY	Canon City	Fremont
PRAIRIE VIEW RURAL HEALTH CLINIC	Cheyenne Wells	Cheyenne
RIO GRANDE HOSPITAL CLINIC	Del Norte	Rio Grande
ROCKY FORD FAMILY HEALTH CENTER	Rocky Ford	Otero
SABATINI PEDIATRICS PC	Canon City	Fremont
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	Antonito	Conejos

SAN LUIS VALLEY LA JARA MEDICAL CLINIC	La Jara	Conejos
SOUTHEAST COLORADO PHYSICIANS CLINIC	Springfield	Baca
SOUTHWEST MEMORIAL PRIMARY CARE	Cortez	Montezuma
SOUTHWEST SCHOOL-BASED HEALTH CENTER	Cortez	Montezuma
SOUTHWEST WALK-IN CARE	Cortez	Montezuma
SPANISH PEAKS FAMILY CLINIC	Walsenburg	Huerfano
ST THOMAS MORE RURAL HEALTH CLINIC	Canon City	Fremont
STERLING REGIONAL MEDICAL CENTER	Sterling	Logan
STRATTON MEDICAL CLINIC	Stratton	Kit Carson
VALLEY MEDICAL CLINIC	Julesburg	Sedgwick
WALSH MEDICAL CLINIC	Walsh	Baca
WASHINGTON COUNTY CLINIC	Akron	Washington
YUMA CLINIC	Yuma	Yuma

Proposed Exhibit #6
Dental Fee Schedule
(effective 1/1/2020)

Proc	Description	Rate
D0120	PERIODIC ORAL EVALUATION - EST PATIENT	$ 67.25
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	$ 113.00
D0145	ORAL EVAL PT UND 3 YR AGE CNSL W/PRIM CAREGIVER	$ 105.25
D0150	COMP ORAL EVALUATION - NEW OR EST PATIENT	$ 119.00
D0160	DTL&EXT ORAL EVALUATION - PROBLEM FOCUSED REPORT	$ 238.00
D0170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	$ 79.25
D0171	RE-EVALUATION POST-OPERATIVE OFFICE VISIT	$ 79.25
D0180	COMP PERIODONTAL EVALUATION - NEW OR EST PATIENT	$ 129.25
D0190	SCREENING OF A PATIENT	$ 67.25
D0191	ASSESSMENT OF A PATIENT	$ 47.50
D0210	INTRAORAL-COMPLETE SERIES	$ 182.00
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$ 36.75
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	$ 32.75
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$ 56.50
D0250	EXTRAORAL 2D PRJECTN RAD IMG BY RAD SRCE/ DTECTR	$ 69.50
D0251	EXTRAORAL 2D POSTERIOR DENTAL RAD IMAGE	$ 63.75
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$ 35.25
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$ 56.75
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$ 69.00
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$ 79.50
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$ 120.50
D0310	SIALOGRAPHY	$ 517.50
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM INCL INJ	$ 915.00
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS BY REPORT	BR
D0322	TOMOGRAPHIC SURVEY	$ 742.25
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$ 160.50
D0340	2D CEPHLOMTRIC RAD IMG - ACQSTN MEASRE& ANALYSIS	$ 181.00
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES	$ 86.50
D0351	3D PHOTOGRAPHIC IMAGE	$ 86.50
D0364	CONE BEAM 3	$ 288.25
D0365	CNE BEAM CAPTR INTERPJ W FLD VIEW 1 ARCH MNDBL	$ 367.50
D0366	CNE BEAM CAPTR INTERPJ W FLD VIEW 1 ARCH MAXL	$ 367.50
D0367	CNE BEAM CAPTR INTERPJ W FLD VIEW BTH JAWS	$ 414.50
D0368	CNE BEAM CAPTR INTERPJ FR TMJ 2 OR MORE	$ 426.00
D0369	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$ 241.50
D0370	MAXLFCL US IMAGE CAPTR AND INTRPJ	$ 138.25
D0371	SIALOENDOSCOPY CAPTURE AND INTERPRETATION	BR

D0380	CNE BEAM CAPTR LMTD FLD <1 WHL JAW	$	297.00
D0381	CNE BEAM CAPTR W FLD VIEW 1 ARCH MNDBL	$	402.25
D0382	CNE BEAM CAPTR W FLD VIEW 1 ARCH MAXL	$	402.25
D0383	CNE BEAM CAPTR W FLD VIEW BTH JAWS	$	402.25
D0384	CNE BEAM CAPTR FR TMJ 2 OR MORE	$	431.50
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	$	2,649.00
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$	662.75
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE		BR
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME		BR
D0394	DIGITAL SUBTR OF 2 > IMAGES OF THE SAME MODALITY		BR
D0395	FUSION OF 2/> 3D IMAGE VOLUMES OF 1/> MODALITIES		BR
D0411	HBA1C IN-OFFICE POINT OF SERVICE TESTING		BR
D0412	BLOOD GLCSE LVL TST - IN-OFFICE USING GLCSE MTR		BR
D0414	LAB MICRBAL SPEC CULTRE/SENS/REPORT PREP TRNSMSN	$	70.75
D0415	COLLECTION MICROORGANISMS CULTURE & SENSITIVITY	$	51.25
D0416	VIRAL CULTURE	$	76.25
D0417	CLCT & PREP SALIVA SAMPLE FOR LAB DX TESTING	$	68.75
D0418	ANALYSIS OF SALIVA SAMPLE	$	70.75
D0422	COLLECT/PREP GENETIC SAMPLE FOR LAB ANALYSIS	$	51.25
D0423	GENETIC TEST SUSCEPT TO DSEASE SPECIMEN ANLYS		BR
D0425	CARIES SUSCEPTIBILITY TESTS	$	44.25
D0431	ADJUNCTIVE PREDX TST NOT INCL CYTOLOGY/BX PROC	$	70.75
D0460	PULP VITALITY TESTS	$	70.75
D0470	DIAGNOSTIC CASTS	$	156.25
D0472	ACCESSION OF TISSUE GROSS EXAMINATION PREP/REPRT	$	97.50
D0473	ACCESS TISSUE GR&MIC EXAMINATION PREP/REPRT	$	205.75
D0474	ACCESS TISS GR&MIC EX ASSESS SURG MARG PREP/RPT	$	230.50
D0475	DECALCIFICATION PROCEDURE	$	124.25
D0476	SPECIAL STAINS FOR MICROORGANISMS	$	120.75
D0477	SPECIAL STAINS NOT FOR MICROORGANISMS	$	165.00
D0478	IMMUNOHISTOCHEMICAL STAINS	$	150.75
D0479	TISSUE INSITU HYBRIDIZATION INCL INTERPRETATION	$	230.50
D0480	ACESS EXFOLIATIVE CYTOL SMEAR MIC EXAM PREP/REPT	$	142.00
D0481	ELECTRON MICROSCOPY	$	532.00
D0482	DIRECT IMMUNOFLUORESCENCE	$	177.25
D0483	INDIRECT IMMUNOFLUORESCENCE	$	177.25
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	$	265.75
D0485	CONSULT INCL PREP SLIDES BX MATL SPL REF SRC	$	367.25
D0486	ACCESSION TRANSEPITHELIAL CYTOLOG SAMPL MIC EXAM	$	170.50
D0502	OTHER ORAL PATHOLOGY PROCEDURES BY REPORT		BR
D0600	DX PX QUANT/MNITR/RECRD CHNGS ENAML/DENTN/CEMNTM		BR
D0601	CARIES RISK ASSESS DOCU FINDING OF LOW RISK	$	106.25
D0602	CARIES RISK AX AND DOCU WITH A FNDNG OF MOD RISK	$	106.25

D0603	CARIES RISK AX AND DOCU WITH FNDNG OF HIGH RISK	$	106.25
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE BY REPORT		BR
D1110	PROPHYLAXIS - ADULT	$	117.25
D1120	PROPHYLAXIS - CHILD	$	80.75
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	$	64.25
D1208	TOPICAL APPLICATION OF FLUORIDE EXCL VARNISH	$	43.00
D1310	NUTRITIONAL COUNSELING CONTROL OF DENTAL DISEASE	$	62.75
D1320	TOBACCO CNSL CONTROL&PREVENTION ORAL DISEASE	$	68.00
D1330	ORAL HYGIENE INSTRUCTIONS	$	86.00
D1351	SEALANT - PER TOOTH	$	69.75
D1352	PREV RSN REST MOD HIGH CARIES RISK PT-PERM TOOTH	$	89.50
D1353	SEALANT REPAIR PER TOOTH	$	89.50
D1354	INTERIM CARIES ARRESTING MEDICATION APPLICATION	$	69.75
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	$	425.25
D1516	SPACE MAINTAINER - FIXED - BILATERIAL MAXILLARY	$	595.25
D1517	SPACE MAINTAINER - FIXED - BILATERIAL MANDIBULAR	$	595.25
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	$	467.50
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL MAXILRY	$	722.75
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL MNDBULR	$	722.75
D1550	RECMNT/REBND OF SPACE MAINTAINER	$	91.75
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$	88.50
D1575	DISTAL SHOE SPACE MAINTANR - FIXED - UNILATERIAL	$	467.50
D1999	UNSPECIFIED PREVENTIVE PROCEDURE BY REPORT		BR
D2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	$	201.25
D2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	$	260.50
D2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	$	314.75
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	$	383.50
D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	$	204.25
D2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	$	260.75
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	$	319.00
D2335	RESIN-BASED COMPOSITE 4/> SURFACES INCISAL ANGLE	$	377.50
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	$	418.25
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	$	239.25
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	$	313.00
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	$	389.00
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	$	476.25
D2410	GOLD FOIL - ONE SURFACE	$	352.00
D2420	GOLD FOIL - TWO SURFACES	$	586.75
D2430	GOLD FOIL - THREE SURFACES	$	1,016.75
D2510	INLAY - METALLIC - ONE SURFACE	$	930.50
D2520	INLAY - METALLIC - TWO SURFACES	$	1,055.75
D2530	INLAY - METALLIC - THREE OR MORE SURFACES	$	1,217.00
D2542	ONLAY - METALLIC - TWO SURFACES	$	1,193.50

D2543	ONLAY - METALLIC - THREE SURFACES	$	1,248.25
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	$	1,298.00
D2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	$	1,095.00
D2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	$	1,155.75
D2630	INLAY - PORCELAIN/CERAMIC - THREE/MORE SURFACES	$	1,231.00
D2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	$	1,196.50
D2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	$	1,290.50
D2644	ONLAY - PORCELAIN/CERAMIC - 4 OR MORE SURFACES	$	1,368.75
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE	$	719.50
D2651	INLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$	857.00
D2652	INLAY RESIN BASED COMPOSITE 3 OR MORE SURFACES	$	901.00
D2662	ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$	782.00
D2663	ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES	$	919.75
D2664	ONLAY RESIN BASED COMPOSIT FOUR OR MORE SURFACES	$	985.25
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	$	585.25
D2712	CROWN 3/4 RESIN-BASED COMPOSITE (INDIRECT)	$	585.25
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$	1,442.00
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$	1,351.50
D2722	CROWN - RESIN WITH NOBLE METAL	$	1,381.00
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$	1,480.00
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$	1,460.50
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$	1,360.00
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$	1,392.75
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$	1,401.00
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$	1,318.50
D2782	CROWN - 3/4 CAST NOBLE METAL	$	1,361.50
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$	1,440.50
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$	1,409.25
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$	1,335.25
D2792	CROWN - FULL CAST NOBLE METAL	$	1,360.00
D2794	CROWN - TITANIUM	$	1,442.00
D2799	PROVISIONAL CROWN	$	585.25
D2910	RECMNT/REBND INLAY ONLAY/PART CVRGE RESTORATION	$	131.75
D2915	RECMNT/REBND CAST OR PREFABRICATED POST AND CORE	$	131.75
D2920	RE-CEMENT OR RE-BOND CROWN	$	133.50
D2921	REATTACHMENT OF TOOTH FRAG INCISAL EDGE/CUSP	$	192.25
D2929	PREFABR STAINLESS PORC CROWN - PRIMARY TOOTH	$	528.75
D2930	PREFABR STAINLESS STEEL CROWN - PRIMARY TOOTH	$	363.75
D2931	PREFABR STAINLESS STEEL CROWN - PERMANENT TOOTH	$	411.50
D2932	PREFABRICATED RESIN CROWN	$	439.00
D2933	PREFABR STAINLESS STEEL CROWN W/RESIN WINDOW	$	503.25
D2934	PREFAB ESTHETIC COAT STNLESS STEEL CROWN PRIM	$	503.25
D2940	PROTECTIVE RESTORATION	$	138.75

D2941	INTERIM THERAPEUTIC RESTORATION PRIM DENTITION	$	138.75
D2949	RESTOR FOUNDATION N INDIR RESTOR	$	138.75
D2950	CORE BUILDUP INCLUDING ANY PINS WHEN REQUIRED	$	347.50
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	$	78.75
D2952	POST AND CORE ADDITION TO CROWN INDIRECTLY FAB	$	548.75
D2953	EACH ADDITIONAL INDIRECTLY FAB POST SAME TOOTH	$	274.25
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$	439.00
D2955	POST REMOVAL	$	338.50
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	$	219.50
D2960	LABIAL VENEER (RESIN LAMINATE) - CHAIRSIDE	$	1,060.75
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$	1,203.75
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$	1,307.75
D2971	ADD PROC NEW CRWN UND XSTING PART DENTUR FRMEWRK	$	210.25
D2975	COPING	$	640.00
D2980	CROWN REPAIR BY REPORT	$	256.00
D2981	INLAY REPAIR BY REPORT	$	256.00
D2982	ONLAY REPAIR BY REPORT	$	256.00
D2983	VENEER REPAIR BY REPORT	$	256.00
D2990	RESIN INFILT OF INCIPIENT LESIONS	$	91.75
D2999	UNSPECIFIED RESTORATIVE PROCEDURE BY REPORT		BR
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$	125.00
D3120	PULP CAP - INDIRECT	$	100.50
D3220	TX PULP-REMV PULP CORONAL DENTINOCEMENTL JUNC	$	257.00
D3221	PULPAL DEBRIDEMENT PRIMARY AND PERMANENT TEETH	$	282.00
D3222	PART PULPOTOMY FOR APEXOGENEIS PERM TOOTH	$	260.75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$	252.00
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$	310.25
D3310	ENDODONTIC THERAPY ANTERIOR TOOTH	$	988.00
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH	$	1,210.75
D3330	ENODODONTIC THERAPY MOLAR	$	1,501.25
D3331	TREATMENT RC OBSTRUCTION; NON-SURGICAL ACCESS	$	387.50
D3332	INCOMPLETE ENDO TX; INOP UNRESTORABLE/FX TOOTH	$	736.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	$	339.00
D3346	RETREATMENT PREVIOUS RC THERAPY - ANTERIOR	$	1,317.50
D3347	RETREATMENT PREVIOUS RC THERAPY - PREMOLAR	$	1,550.00
D3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY - MOLAR	$	1,918.00
D3351	APEXIFICATION/RECALCIFICAT INIT VST	$	604.00
D3352	APEXIFICAT/RECALCIFICAT INT MED REPL	$	270.75
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$	833.00
D3355	PULPAL REGENERATION - INITIAL VISIT	$	604.00
D3356	PULPAL REGEN - INTERIM MED RPLCMNT	$	270.75
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT		BR
D3410	APICOECTOMY - ANTERIOR	$	1,197.50

D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	$	1,333.25
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	$	1,510.25
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	$	510.50
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$	1,083.25
D3428	BG IN CONJ PERIRADICULAR SURG/TOOTH SINGLE SITE	$	1,579.00
D3429	BG IN CONJ PERIRADICUL SURG EACH CONTIG TH SSS	$	1,506.00
D3430	RETROGRADE FILLING - PER ROOT	$	375.00
D3431	BIO MAT SFT OSS REGE CONJ PERIR SUR	$	1,854.00
D3432	GTR RESORB BRRER PER SITE IN CONJ PERIRAD SURG	$	1,593.25
D3450	ROOT AMPUTATION - PER ROOT	$	781.00
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$	2,916.00
D3470	INTENTIONAL REIMPLANTATION W/NECESSARY SPLINTING	$	1,489.25
D3910	SURGICAL PROCEDURE ISOLATION TOOTH W/RUBBER DAM	$	208.25
D3920	HEMISECTION NOT INCLUDING ROOT CANAL THERAPY	$	593.50
D3950	CANAL PREPARATION&FITTING PREFORMED DOWEL/POST	$	270.75
D3999	UNSPECIFIED ENDODONTIC PROCEDURE BY REPORT		BR
D4210	GINGIVECT/PLSTY 4/>CNTIG/TOOTH BOUND SPACES-QUAD	$	1,249.50
D4211	GINGIVECT/PLSTY 1-3 CNTIG/TOOTH BOUND SPACE-QUAD	$	555.00
D4212	GINGIVECT/PLSTY 1-3CNTIG PER TOOTH	$	444.25
D4230	ANAT CROWN EXP 4/> CONTIGUOUS TEETH PER QUAD	$	1,749.00
D4231	ANATOMICAL CROWN EXPOSURE 1-3 TEETH PER QUADRANT	$	833.00
D4240	GINGL FLP PROC 4/> CONTIG/TOOTH BOUND SPACE-QUAD	$	1,582.50
D4241	GINGL FLP PROC 1-3 CONTIG/TOOTH BOUND SPACE-QUAD	$	916.25
D4245	APICALLY POSITIONED FLAP	$	1,166.00
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	$	1,734.75
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$	2,637.25
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$	1,416.00
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	$	943.75
D4264	BONE REPLACEMENT GRAFT - EA ADD SITE QUADRANT	$	805.00
D4265	BIOLOGIC MATERIALS AID SOFT&OSSEOUS TISSUE REGEN		BR
D4266	GUID TISSUE REGEN - RESORBABLE BARRIER PER SITE	$	971.50
D4267	GUID TISSUE REGEN - NONRESORB BARRIER PER SITE	$	1,249.50
D4268	SURGICAL REVISION PROCEDURE PER TOOTH		BR
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$	1,873.75
D4273	AUTOGNS CONECTIVE TISSUE GRFT 1ST TOOTH/IMPLANT	$	2,290.25
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$	1,299.25
D4275	NONAUTGNS CONECTV TISSUE GRFT 1ST TOOTH/IMPLANT	$	1,721.25
D4276	COMB CNCTIVE TISSUE&DBL PEDICLE GRAFT PER TOOTH	$	2,567.75
D4277	FREE SOFT TISSUE GRAFT, 1ST TOOTH/ IMPLANT	$	1,943.25
D4278	FREE SOFT TISSUE GRAFT, E/ADNL TOOTH, IMPLNT	$	638.50
D4283	AUTO CNNCTV TISSUE GRFT PROC E/A TOOTH, IMPLANT	$	1,951.50
D4285	NON-AUTO CNNCTV TSSUE GRFT PROC E/A TOOTH/IMPLNT	$	1,468.50
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$	612.50

D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$	556.75
D4341	PRDONTAL SCALING&ROOT PLANING 4/MORE TEETH-QUAD	$	352.50
D4342	PRDONTAL SCALING&ROOT PLANING 1-3 TEETH-QUAD	$	204.25
D4346	SCALNG GNGIVAL INFLAMM FULL MOUTH AFTR ORAL EVAL	$	204.25
D4355	FULL MOUTH DEBRID ENABLE COMP EVALUATION&DX	$	241.25
D4381	LOC DEL ANTIMICROBL AGTS CREVICULR TISS TOOTH BR		BR
D4910	PERIODONTAL MAINTENANCE	$	217.25
D4920	UNSCHEDULED DRESSING CHANGE	$	157.75
D4921	GINGIVAL IRRIGATION PER QUADRANT		BR
D4999	UNSPECIFIED PERIODONTAL PROCEDURE BY REPORT		BR
D5110	COMPLETE DENTURE - MAXILLARY	$	2,383.50
D5120	COMPLETE DENTURE - MANDIBULAR	$	2,383.50
D5130	IMMEDIATE DENTURE - MAXILLARY	$	2,598.50
D5140	IMMEDIATE DENTURE - MANDIBULAR	$	2,598.50
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$	2,011.50
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$	2,337.75
D5213	MAX PART DENTUR-CAST METL FRMEWRK W/RSN BASE	$	2,633.50
D5214	MAND PART DENTUR- CAST METL FRMEWRK W/RSN BASE	$	2,633.50
D5221	IMMED MAXILLARY PARTIAL DENTURE RESIN BASE	$	2,194.25
D5222	IMMED MANDIBULAR PARTIAL DENTURE RESIN BASE	$	2,548.75
D5223	IMMED MAXIL PART DENTURE CAST METL FRAME W/RESIN	$	2,870.50
D5224	IMMED MAND PART DENTURE CAST METL FRAME W/RESIN	$	2,870.50
D5225	MAXILLARY PARTIAL DENTRUE FLEXIBLE BASE	$	2,011.50
D5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	$	2,337.75
D5282	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MXLRY	$	1,535.25
D5283	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MNDBL	$	1,535.25
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$	130.50
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$	130.50
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$	130.50
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$	130.50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	$	261.00
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	$	261.00
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$	217.25
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	$	282.50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	$	282.50
D5621	REPAIR CAST FRAMEWORK, MANDIBULAR	$	304.50
D5622	REPAIR CAST FRAMEWORK, MAXILLARY	$	304.50
D5630	REPAIR OR REPLACE BROKEN CLASP PER TOOTH	$	369.50
D5640	REPLACE BROKEN TEETH - PER TOOTH	$	239.25
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$	326.25
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	$	391.50
D5670	REPLACE ALL TEETH&ACRYLIC CAST METAL FRMEWRK MAX	$	956.75
D5671	REPLACE ALL TEETH&ACRYLIC CAST METL FRMEWRK MAND	$	956.75

D5710	REBASE COMPLETE MAXILLARY DENTURE	$	967.75
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$	924.00
D5720	REBASE MAXILLARY PARTIAL DENTURE	$	913.75
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$	913.75
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	$	546.00
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	$	546.00
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	$	500.25
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	$	500.25
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	$	728.50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	$	728.50
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	$	717.75
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	$	717.75
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$	1,152.50
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$	1,239.50
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	$	891.50
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	$	946.00
D5850	TISSUE CONDITIONING MAXILLARY	$	228.50
D5851	TISSUE CONDITIONING MANDIBULAR	$	228.50
D5862	PRECISION ATTACHMENT BY REPORT		BR
D5863	OVERDENTURE COMPLETE MAXILLARY	$	2,522.25
D5864	OVERDENTURE PARTIAL MAXILLARY	$	3,327.00
D5865	OVERDENTURE COMPLETE MIBULAR	$	2,522.25
D5866	OVERDENTURE PARTIAL MIBULAR	$	3,457.50
D5867	REPLACEMENT REPL PART SEMI-PRCISN/PRCISN ATTCH		BR
D5875	MODIFICATION REMV PROSTH AFTER IMPLANT SURGERY		BR
D5876	ADD MTL SUBSTRUCTR TO ACRYLIC FULL DNTR PER ARCH		BR
D5899	UNS REMOVABLE PROSTHODONTIC PROCEDURE REPORT		BR
D5911	FACIAL MOULAGE (SECTIONAL)	$	604.50
D5912	FACIAL MOULAGE (COMPLETE)	$	604.50
D5913	NASAL PROSTHESIS	$	12,730.25
D5914	AURICULAR PROSTHESIS	$	12,730.25
D5915	ORBITAL PROSTHESIS	$	17,227.25
D5916	OCULAR PROSTHESIS	$	4,595.00
D5919	FACIAL PROSTHESIS		BR
D5922	NASAL SEPTAL PROSTHESIS		BR
D5923	OCULAR PROSTHESIS INTERIM		BR
D5924	CRANIAL PROSTHESIS		BR
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS		BR
D5926	NASAL PROSTHESIS REPLACEMENT		BR
D5927	AURICULAR PROSTHESIS REPLACEMENT		BR
D5928	ORBITAL PROSTHESIS REPLACEMENT		BR
D5929	FACIAL PROSTHESIS REPLACEMENT		BR
D5931	OBTURATOR PROSTHESIS SURGICAL	$	6,854.25

D5932	OBTURATOR PROSTHESIS DEFINITIVE	$ 12,819.50
D5933	OBTURATOR PROSTHESIS MODIFICATION	BR
D5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	$ 11,684.00
D5935	MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	$ 10,166.50
D5936	OBTURATOR PROSTHESIS INTERIM	$ 11,419.00
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	$ 1,435.25
D5951	FEEDING AID	$ 1,865.75
D5952	SPEECH AID PROSTHESIS PEDIATRIC	$ 6,058.50
D5953	SPEECH AID PROSTHESIS ADULT	$ 11,505.75
D5954	PALATAL AUGMENTATION PROSTHESIS	$ 10,662.25
D5955	PALATAL LIFT PROSTHESIS DEFINITIVE	$ 9,861.75
D5958	PALATAL LIFT PROSTHESIS INTERIM	BR
D5959	PALATAL LIFT PROSTHESIS MODIFICATION	BR
D5960	SPEECH AID PROSTHESIS MODIFICATION	BR
D5982	SURGICAL STENT	$ 967.75
D5983	RADIATION CARRIER	$ 2,174.75
D5984	RADIATION SHIELD	$ 2,174.75
D5985	RADIATION CONE LOCATOR	$ 2,174.75
D5986	FLUORIDE GEL CARRIER	$ 217.25
D5987	COMMISSURE SPLINT	$ 3,262.00
D5988	SURGICAL SPLINT	$ 652.50
D5991	VESICULOBULLOUS DISEASE MEDICAMENT CARRIER	$ 250.00
D5992	ADJUST MAXILLOFACIAL PROSTH APPLIANCE BY REPORT	BR
D5993	MAINT / CLEAN MAXILLOFACIAL PROSTH BY REPORT	BR
D5994	PERIDONL MEDIC CARRIER PERIPH SEAL LAB PRCESSD	BR
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS BY REPORT	BR
D6010	SURG PLACEMENT IMPLANT BODY: ENDOSTEAL IMPLANT	$ 3,981.75
D6011	SECOND STAGE IMPLANT SURGERY	BR
D6012	SURG PLCMT INTERIM IMPL TRNSITIONL PROS: ENDOS	$ 3,762.25
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	$ 3,981.75
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	$ 13,700.25
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT	$ 10,220.75
D6051	INTERIM ABUTMENT	BR
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$ 1,687.50
D6055	CONNECTING BAR IMPLANT OR ABUTMENT SUPPORTED	$ 1,196.00
D6056	PREFABRICATED ABUTMENT INCLUDES PLACEMENT	$ 826.50
D6057	CUSTOM FABRICATED ABUTMENT INCLUDES PLACEMENT	$ 1,022.00
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$ 2,292.00
D6059	ABUT SUPP PORCELAIN TO METL CROWN HI NOBLE METL	$ 2,261.50
D6060	ABUT SUPP PORCELAIN TO MTL CROWN PREDOM BASE MTL	$ 2,137.75
D6061	ABUT SUPP PORCELAIN TO METAL CROWN NOBLE METAL	$ 2,181.25
D6062	ABUTMENT SUPP CAST METAL CROWN HIGH NOBLE METAL	$ 2,172.50
D6063	ABUTMENT SUPP CAST METAL CROWN PREDOM BASE METAL	$ 1,891.75

D6064	ABUTMENT SUPP CAST METAL CROWN NOBLE METAL	$	1,979.00
D6065	IMPL SUPP PORCELAIN/CERAMIC CROWN	$	2,255.00
D6066	IMPL SUPP PORCLN FUSED METL CRWN TITNM/HIGH NOBL	$	2,196.25
D6067	IMPL SUPP METAL CROWN TITIANM/HIGH NOBLE METL	$	2,131.25
D6068	ABUT SUPP RETAINER PORCELAIN/CERAMIC FPD	$	2,272.50
D6069	ABUT RETAINR PORCELN TO METL FPD HI NOBL METL	$	2,261.50
D6070	ABUT RETN PORCELN TO METL FPD PREDOM BASE METL	$	2,137.75
D6071	ABUT SUPP RETN PORCELN FUSD METAL FPD NOBLE METL	$	2,181.25
D6072	ABUT SUPP RETN CAST METL FPD HIGH NOBLE METL	$	2,207.00
D6073	ABUT RTNR CAST METL FPD PREDOM BASE METL	$	2,016.00
D6074	ABUTMENT RTNR CAST METAL FPD NOBLE METAL	$	2,142.00
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$	2,255.00
D6076	IMPL SUPP RTNR PORCLN FUSED METL FPD TITNM/HIGH	$	2,196.25
D6077	IMPL SUPP RTNR CST METL FPD TITNM/HIGH NOBLE	$	2,131.25
D6080	IMPL MAINT PROC REMV CLEAN PROSTH & ABUT REINSRT	$	187.25
D6081	SCALNG/DBRDMNT IMPLNT WO FLAP ENTRY/CLOS	$	95.75
D6085	PROVISIONAL IMPLANT CROWN	$	656.75
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT		BR
D6091	REPL ATTACHMNT IMPL/ABUT SUPP PROS PER ATTACHMNT	$	902.50
D6092	RECEMENT / REBOND IMPLANT/ABUTMENT SUPP CROWN	$	176.25
D6093	RECMNT/REBOND IMPL/ABUTMNT SUPP FIX PART DENTURE	$	276.25
D6094	ABUTMENT SUPPORTED CROWN TITANIUM	$	1,793.75
D6095	REPAIR IMPLANT ABUTMENT BY REPORT		BR
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW		BR
D6100	IMPLANT REMOVAL BY REPORT		BR
D6101	DBRDMNT OF PERI-IMPLANT DEFECT	$	645.75
D6102	DBRDMNT OF PERI-IMPLANT DEFECT	$	887.25
D6103	BONE GRFT RPR PERIIMPLNT DFCT W/O FLAP ENTR/CLSE	$	739.50
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	$	739.50
D6110	IMPL/ABUTMENT SUPPORTED RD - MAXILLARY	$	2,972.75
D6111	IMPL/ABUTMENT SUPPORTED RD - MANDIBULAR	$	2,972.75
D6112	IMPL/ABUTMENT SUPPORTED RPD - MAXILLARY	$	2,972.75
D6113	IMPLANT / ABUTMENT SUPPORTED RPD - MANDIBULAR	$	2,972.75
D6114	IMPLANT / ABUTMENT SUPPORTED FD - MAXILLARY	$	5,206.00
D6115	IMPLANT/ABUTMENT SUPPORTED FD - MANDIBULAR	$	5,206.00
D6116	IMPL/ABUTMENT SUPPORTED FD - MAXILLARY - PARTIAL	$	3,992.50
D6117	IMPL/ABUT SUPPORTED FD - MANDIBULAR - PARTIAL	$	3,992.50
D6118	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MANDBLR	$	2,707.25
D6119	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MAXLARY	$	2,707.25
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX BY REPORT	$	402.25
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD	$	1,848.25
D6199	UNSPECIFIED IMPLANT PROCEDURE BY REPORT		BR
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	$	931.25

D6210	PONTIC - CAST HIGH NOBLE METAL	$	1,423.75
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$	1,334.25
D6212	PONTIC - CAST NOBLE METAL	$	1,388.25
D6214	PONTIC - TITANIUM	$	1,432.75
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	$	1,406.00
D6241	PONTIC - PORCELN FUSED PREDOMINANTLY BASE METAL	$	1,298.50
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	$	1,370.00
D6245	PONTIC - PORCELAIN/CERAMIC	$	1,450.75
D6250	PONTIC - RESIN WITH HIGH NOBLE METAL	$	1,388.25
D6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	$	1,280.50
D6252	PONTIC - RESIN WITH NOBLE METAL	$	1,321.75
D6253	PROVISIONAL PONTIC	$	598.25
D6545	RETAINER - CAST METAL RESIN BONDED FIX PROSTH	$	530.25
D6548	RETAINER - PORCELN/CERAMIC RSN BONDED FIX PROSTH	$	582.75
D6549	RESIN RETAINER FOR RESIN BONDED FIXED PROSTHESIS	$	382.00
D6600	RETAINER INLAY - PORCELAIN/CERAMIC TWO SURFACES	$	1,052.25
D6601	RETAINER INLAY - PORC/CERAMIC 3 OR MORE SURFACES	$	1,103.25
D6602	RETAINER INLAY CAST HIGH NOBLE METAL 2 SURFACES	$	1,124.25
D6603	RETAINR INLAY - CAST HI NOBLE METAL 3/MORE SURFS	$	1,237.00
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFS	$	1,102.00
D6605	RTAINR INLAY - CAST PREDOM BASE MTL 3/MORE SURFS	$	1,167.50
D6606	RETAINER INLAY - CAST NOBLE METAL TWO SURFACES	$	1,084.25
D6607	RETNR INLAY CAST NOBLE METAL 3 OR MORE SURFACES	$	1,202.75
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC TWO SURFACES	$	1,143.50
D6609	RETAINER ONLAY PORCELAIN/CERAMIC 3/MORE SURFACES	$	1,193.50
D6610	RETAINER ONLAY - HIGH NOBLE METAL TWO SURFACES	$	1,212.75
D6611	RETAINER ONLAY HIGH NOBLE METAL 3/MORE SURFACES	$	1,326.50
D6612	RETAINER ONLAY CAST PREDOM BASE METAL 2 SURFACES	$	1,206.25
D6613	RETNR ONLAY CAST PREDOM BASE METAL 3/MORE SURFS	$	1,260.75
D6614	RETAINER ONLAY - CAST NOBLE METAL TWO SURFACES	$	1,180.75
D6615	RETNR ONLAY CAST NOBLE METAL 3 OR MORE SURFACES	$	1,227.00
D6624	RETAINER INLAY - TITANIUM	$	1,124.25
D6634	RETAINER ONLAY - TITANIUM	$	1,180.75
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$	1,204.50
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$	1,405.25
D6721	RETAINER CROWN - RESIN WITH PREDOM BASE METAL	$	1,333.00
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$	1,357.25
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$	1,477.50
D6750	RETNR CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	$	1,439.25
D6751	RETNR CROWN PORCELAIN FUSED PREDOM BASE METAL	$	1,342.50
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$	1,374.75
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$	1,357.25
D6781	RETAINER CROWN 3/4 CAST PREDOMINANTLY BASE METAL	$	1,357.25

D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$	1,260.75
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$	1,397.25
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$	1,389.25
D6791	RETAINER CROWN FULL CAST PREDOM BASE METAL	$	1,316.75
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$	1,365.00
D6793	PROVISIONAL RETAINER CROWN	$	570.25
D6794	RETAINER CROWN - TITANIUM	$	1,365.00
D6920	CONNECTOR BAR	$	388.50
D6930	RECEMENT / REBOND FIXED PARTIAL DENTURE	$	226.25
D6940	STRESS BREAKER	$	513.75
D6950	PRECISION ATTACHMENT	$	992.50
D6980	FIXED PARTIAL DENTURE REPAIR BY REPORT		BR
D6985	PEDIATRIC PARTIAL DENTURE FIXED	$	863.25
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE REPORT		BR
D7111	EXTRACTION CORONAL REMNANTS - PRIMARY TOOTH	$	181.50
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	$	241.25
D7210	SURG REMOVAL ERUPTED TOOTH REMV BONE ELEV FLAP	$	360.50
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$	451.75
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$	601.00
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$	705.50
D7241	REMV IMP TOOTH - CMPL BONY W/UNUSUAL SURG COMPS	$	886.25
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$	380.75
D7251	CORONECTOMY INTENTIONAL PARTIAL TOOTH REMOVAL	$	746.50
D7260	OROANTRAL FISTULA CLOSURE	$	3,281.25
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$	1,367.00
D7270	TOOTH REIMPL &OR STBL ACC EVULSED/DISPLCD TOOTH	$	1,025.25
D7272	TOOTH TRANSPLANTATION	$	1,367.00
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	$	956.75
D7282	MOBILIZ ERUPTED/MALPOSITIONED TOOTH AID ERUPTION	$	478.50
D7283	PLCMT DEVICE FACILITATE ERUPTION IMPACTED TOOTH	$	410.00
D7285	BIOPSY OF ORAL TISSUE HARD	$	1,914.00
D7286	BIOPSY OF ORAL TISSUE SOFT	$	820.50
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$	328.00
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	$	328.00
D7290	SURGICAL REPOSITIONING OF TEETH	$	820.50
D7291	TRANSSEPTAL FIBEROT/SUPRA CRESTAL FIBEROT BR		BR
D7292	SURG PLCMT: TEMP ANCHORAGE SCREW RET PLATE FLAP	$	1,312.50
D7293	SURG PLCMT: TEMP ANCHORAGE DEVICE RQR SURG FLAP	$	820.50
D7294	SURG PLCMT: TEMP ANCHORAGE DEVICE W/O SURG FLAP	$	683.50
D7295	HARVEST BONE FOR USE AUTOGENOUS GRAFTING PROC		BR
D7296	CORTICOTOMY 1 - 3 TEETH OR TOOTH SPACES PER QUAD		BR
D7297	CORTCTMY 4 OR MORE TEETH OR TOOTH SPCES PER QUAD		BR
D7310	ALVEOLOPLASTY W/EXTRACTION 4/> TEETH/SPACE QUAD	$	582.50

D7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	$	509.75
D7320	ALVEOLOPLASTY NOT W/EXTRACTIONS 4/> TEETH/SPACE	$	947.00
D7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUAD	$	801.00
D7340	VESTIBULOPLASTY RIDGE EXT SEC EPITHELIALIZATION	$	4,005.25
D7350	VESTIBULOPLASTY RIDGE EXT W/SOFT TISS GRAFTS	$	11,652.25
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$	1,747.75
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$	2,767.50
D7412	EXCISION OF BENIGN LESION COMPLICATED	$	3,058.75
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	$	2,039.00
D7414	EXCISION OF MALIGNANT LESION > 1.25 CM	$	3,058.75
D7415	EXCISION OF MALIGNANT LESION COMPLICATED	$	3,422.50
D7440	EXC MALIG TUMOR-LESION DIAMETER UP TO 1.25 CM	$	2,767.50
D7441	EXC MALIG TUMOR-LESION DIAM GREATER THAN 1.25 CM	$	4,078.25
D7450	REMOVAL BEN ODONTOGENIC CYST/TUMR- UP T0 1.25 CM	$	1,747.75
D7451	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR- > 1.25 CM	$	2,388.50
D7460	REMOVAL BEN NONODONTOGENIC CYST/TUMR- UP 1.25 CM	$	1,747.75
D7461	REMOVAL BEN NONODONTOGENIC CYST/TUMOR > 1.25 CM	$	2,388.50
D7465	DESTRUCTION LESION PHYSICAL/CHEM METHOD BY REPRT	$	947.00
D7471	REMOVAL OF LATERAL EXOSTOSIS	$	2,164.50
D7472	REMOVAL OF TORUS PALATINUS	$	2,572.25
D7473	REMOVAL OF TORUS MANDIBULARIS	$	2,426.50
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$	2,164.50
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	$	17,478.25
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISS	$	626.50
D7511	I & D ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	$	947.00
D7520	INCISION & DRAINAGE ABSCESS-EXTRAORAL SOFT TISS	$	2,983.00
D7521	I & D ABSCESS EXTRAORAL SOFT TISSUE COMPLICATED	$	3,277.00
D7530	REMOVAL FB FROM MUCOSA SKIN/SUBCUT ALVEOL TISSUE	$	1,074.75
D7540	REMV REACT-PRODUC FOREIGN BODIES-MUSCULOSKEL SYS	$	1,191.25
D7550	PART OSTEC/SEQUESTRECTOMY REMOVAL NON-VITAL BONE	$	742.75
D7560	MAXILLARY SINUSOTOMY REMOVAL TOOTH FRAGMENT/FB	$	5,899.00
D7610	MAXILLA-OPEN REDUCTION	$	9,540.00
D7620	MAXILLA-CLOSED REDUCTION	$	7,154.25
D7630	MANDIBLE-OPEN REDUCTION	$	12,403.75
D7640	MANDIBLE-CLOSED REDUCTION	$	7,871.25
D7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$	5,963.00
D7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$	3,516.25
D7670	ALVEOLUS-CLOSED REDUCTION W/STABILIZATION TEETH	$	2,744.00
D7671	ALVEOLUS-OPEN REDUCTION W/STABILIZATION TEETH	$	5,170.50
D7680	FCE BNS - COMP RDUC W/FIX&MX SURG APPRCHES CPT	$	17,888.75
D7710	MAXILLA - OPEN REDUCTION	$	11,212.00
D7720	MAXILLA - CLOSED REDUCTION	$	7,871.25
D7730	MANDIBLE - OPEN REDUCTION	$	16,219.75

D7740	MANDIBLE - CLOSED REDUCTION	$	8,025.50
D7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$	10,207.25
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$	4,095.50
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH	$	5,549.25
D7771	ALVEOLUS CLOSED REDUCTION STABILIZATION OF TEETH	$	4,282.00
D7780	FACIAL BONES-COMP RDUC FIX & MX SURG APPROACHES	$	23,852.00
D7810	OPEN REDUCTION OF DISLOCATION	$	10,492.75
D7820	CLOSED REDUCTION OF DISLOCATION	$	1,718.75
D7830	MANIPULATION UNDER ANESTHESIA	$	984.25
D7840	CONDYLECTOMY	$	14,303.00
D7850	SURGICAL DISCECTOMY WITH/WITHOUT IMPLANT	$	12,351.25
D7852	DISC REPAIR	$	14,143.00
D7854	SYNOVECTOMY	$	14,594.25
D7856	MYOTOMY	$	10,355.75
D7858	JOINT RECONSTRUCTION	$	29,518.00
D7860	ARTHROTOMY	$	12,581.50
D7865	ARTHROPLASTY	$	20,275.00
D7870	ARTHROCENTESIS	$	670.00
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	$	1,339.75
D7872	ARTHROSCOPY - DIAGNOSIS WITH OR WITHOUT BIOPSY	$	7,151.50
D7873	ARTHROSCOPY SURGICAL: LAVAGE&LYSIS ADHESIONS	$	8,611.00
D7874	ARTHROSCOPY SURGICAL: DISC REPSTN&STABILIZATION	$	12,351.25
D7875	ARTHROSCOPY - SURGICAL: SYNOVECTOMY	$	13,531.00
D7876	ARTHROSCOPY - SURGICAL: DISCECTOMY	$	14,588.75
D7877	ARTHROSCOPY - SURGICAL: DEBRIDEMENT	$	12,875.75
D7880	OCCLUSAL ORTHOTIC DEVICE BY REPORT	$	1,608.00
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$	174.50
D7899	UNSPECIFIED TMD THERAPY BY REPORT		BR
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	$	955.50
D7911	COMPLICATED SUTURE - UP TO 5 CM	$	2,385.75
D7912	COMPLICATED SUTURE - GREATER THAN 5 CM	$	4,293.75
D7920	SKIN GRAFT	$	7,035.00
D7921	COLL APPL AUTOLOGOUS BLD CNCNTRT PRODUCT	$	649.50
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES		BR
D7941	OSTEOTOMY - MANDIBULAR RAMI	$	17,915.25
D7943	OSTEOT-MANDIB RAMI W/BONE GRFT;INCL OBTAIN GRAFT	$	16,458.50
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL	$	14,667.50
D7945	OSTEOTOMY - BODY OF MANDIBLE	$	19,517.00
D7946	LEFORT I (MAXILLA - TOTAL)	$	24,178.25
D7947	LEFORT I (MAXILLA - SEGMENTED)	$	20,333.25
D7948	LEFORT II/LEFORT III - W/O BONE GRAFT	$	26,392.00
D7949	LEFORT II OR LEFORT III - WITH BONE GRAFT	$	34,374.00
D7950	OSSEOUS OSTEOPERIOSTEAL/CARTILAGE GRAFT MAND/MAX		BR

D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES	BR
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	BR
D7953	BONE REPLCMT GRAFT RIDGE PRESERVATION PER SITE	$ 990.75
D7955	REPAIR MAXLOFACIAL SOFT &/ HARD TISSUE DEFECT	BR
D7960	FRENULECTOMY SEP PROC NOT INCIDENTL ANOTHER PROC	$ 801.00
D7963	FRENULOPLASTY	$ 1,311.00
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$ 1,165.25
D7971	EXCISION OF PERICORONAL GINGIVA	$ 437.25
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	$ 1,631.50
D7979	NON-SURGICAL SIALOLITHOTOMY	BR
D7980	SURGICAL SIALOLITHOTOMY	$ 1,835.25
D7981	EXCISION OF SALIVARY GLAND BY REPORT	BR
D7982	SIALODOCHOPLASTY	$ 4,340.25
D7983	CLOSURE OF SALIVARY FISTULA	$ 4,165.75
D7990	EMERGENCY TRACHEOTOMY	$ 3,583.00
D7991	CORONOIDECTOMY	$ 8,739.00
D7995	SYNTHETIC GRAFT-MANDIBLE/FACIAL BONES BY REPORT	BR
D7996	IMPLANT-MANDIBLE AUGMENTATION PURPOSES BY REPORT	BR
D7997	APPLIANCE REMOVAL INCLUDES REMOVAL OF ARCHBAR	$ 670.00
D7998	INTRAORAL PLCMT FIX DEVICE NOT CONJUNCTION W/FX	$ 2,913.00
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE BY REPORT	BR
D8010	LIMITED ORTHODONTIC TREATMENT PRIMARY DENTITION	BR
D8020	LTD ORTHODONTIC TREATMENT TRANSITIONAL DENTITION	BR
D8030	LTD ORTHODONTIC TREATMENT ADOLESCENT DENTITION	BR
D8040	LIMITED ORTHODONTIC TREATMENT ADULT DENTITION	BR
D8050	INTERCEPTIVE ORTHODONTIC TX PRIMARY DENTITION	BR
D8060	INTRCPTV ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8070	COMP ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8080	COMPREHENSIVE ORTHODONTIC TX ADOLES DENTITION	BR
D8090	COMPREHENSIVE ORTHODONTIC TX ADULT DENTITION	BR
D8210	REMOVABLE APPLIANCE THERAPY	BR
D8220	FIXED APPLIANCE THERAPY	BR
D8660	PREORTHODONTIC TREATMENT VISIT	BR
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	BR
D8680	ORTHODONTIC RETENTION	BR
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	BR
D8690	ORTHODONTIC TREATMENT	BR
D8691	REPAIR OF ORTHODONTIC APPLIANCE	BR
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	BR
D8693	RE-CEMENT OR RE-BOND FIXED RETAINER	BR
D8694	REPAIR OF FIXED RETAINERS INCLUDES REATTACHMENT	BR
D8695	REMOVAL OF FIXED ORTHO APPLIANCES TX NOT COMPLT	BR
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE BY REPORT	BR

D9110	PALLIATIVE EMERGENCY TX DENTAL PAIN MINOR PROC	$	181.00
D9120	FIXED PARTIAL DENTURE SECTIONING	$	204.75
D9130	TMJ JOINT DYSFUNCTION - NON-INVASIVE PHYSL THERP		BR
D9210	LOCAL ANES-NOT CONJUNCTION W/OP/SURGICAL PROC	$	96.75
D9211	REGIONAL BLOCK ANESTHESIA	$	107.00
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	$	167.00
D9215	LOCAL ANESTHESIA CONJUCTION OPERATIVE/SURG PROC	$	80.25
D9219	EVALUATION FOR DEEP SEDATION / GA	$	190.25
D9222	DEEP SEDATION / GENERAL ANESTHESIA FIRST 15 MIN	$	567.25
D9223	DEEP SEDATION/ GEN ANESTH EACH 15 MIN INCREMENT	$	434.00
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS ANALGESIA	$	160.00
D9239	IV MOD (CONSCIOUS) SEDTION/ANALGSIA FIRST 15 MIN	$	467.00
D9243	IV MOD (CONSCIOUS) SEDATION EACH 15 MIN INCRMENT	$	366.75
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$	233.75
D9310	CONSULT DX SERV DENT/PHY NOT REQUESTING DENT/PHY	$	251.50
D9311	CONSULT WITH A MEDICAL HEALTHCARE PROFESSIONAL	$	251.50
D9410	HOUSE/EXTENDED CARE FACILITY CALL	$	287.25
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	$	465.00
D9430	OFFICE VISIT OBSERVATION NO OTHER SRVC PERFORMED		BR
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	$	157.00
D9450	CASE PRESENTATION DTL&EXT TREATMENT PLANNING	$	78.50
D9610	THERAPEUTIC PARENTERAL DRUG SINGL ADMINISTRATION		BR
D9612	TX PARENTERAL DRUGS 2/> ADMINISTRATIONS DIFF MED		BR
D9613	INFLTRN SUSTND RELSE THRPTIC DRG SNGLE MTPL SITE	$	81.75
D9630	OTHER DRUGS AND/OR MEDICAMENTS BY REPORT		BR
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	$	99.00
D9911	APPLIC DESENZT RSN CERV &OR ROOT SURF-TOOTH	$	138.00
D9920	BEHAVIOR MANAGEMENT BY REPORT		BR
D9930	TX COMPLICATIONS - UNUSUAL CIRCUMSTANCES REPORT		BR
D9932	CLEAN/INSPECT REMOVBL COMPLETE MAXILLARY DENTURE	$	242.50
D9933	CLEAN INSPECT REMVBL COMPLETE MANDIBULAR DENTURE	$	242.50
D9934	CLEAN/ INSPECT REMVBL PARTIAL MAXILLARY DENTURE	$	242.50
D9935	CLEAN INSPECT REMVBL PARTIAL MANDIBULAR DENTURE	$	242.50
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	$	282.25
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	$	338.75
D9943	OCCLUSAL GUARD ADJUSTMENT	$	169.25
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$	818.50
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$	818.50
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH	$	818.50
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	$	536.00
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$	239.75
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$	1,128.75
D9961	DUPLICATE/COPY PATIENT'S RECORDS		BR

D9970	ENAMEL MICROABRASION	$	126.75
D9971	ODONTOPLASTY 1-2 TEETH; INCL REMOVAL ENAMEL PROJ	$	163.75
D9972	EXTERNAL BLEACHING - PER ARCH	$	564.50
D9973	EXTERNAL BLEACHING - PER TOOTH	$	93.25
D9974	INTERNAL BLEACHING - PER TOOTH	$	493.75
D9975	EXTERNAL BLEACHING - PER ARCH	$	564.50
D9985	SALES TAX		BR
D9986	MISSED APPOINTMENT		BR
D9987	CANCELLED APPOINTMENT		BR
D9990	CERT TRNSLATION OR SIGN LANGUAGE SRVCS PER VISIT		BR
D9991	DENTAL CASE MGMT ADDRESS APPNTMNT COMPL BARRIERS	$	99.00
D9992	DENTAL CASE MANAGEMENT - CARE COORDINATION	$	99.00
D9993	DENTAL CASE MGMT - MOTIVATIONAL INTERVIEWING	$	99.00
D9994	DENTAL CASE MGMT - PATIENT EDU IMPRV ORAL HEALTH	$	135.25
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$	451.25
D9996	TELDENTRY ASYNCHRNS INFO FWD DENTIST SBSQNT REVW	$	338.75
D9999	UNSPECIFIED ADJUNCTIVE PROC BY REPORT (01/2019)		BR

Exhibit #7

Evaluation and Management (E&M) Documentation Guidelines

for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2020

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by:

Key Components:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

or

Time (as per CPT® and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT® criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

History Elements	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family, Social, Occupational History (PMFSOH)	None	None	Pertinent 1 of 4 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying his/her condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured worker visit it is necessary for the provider to discuss the causality of the patient's work related injury(s) to the patient's job duties.

For the provider to achieve an *"extended" HPI* in an established patient/injured worker visit it is necessary to document a detailed description of the patient's progress since the last visit with current treatment plan that includes patient pertinent objective functional gains, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS) should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSOH consists of a review of four areas (NOTE: Employers should **not** have access to any patient or family genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.
2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.
3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.
4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused (PF)	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused (EPF)	6 elements identified by a bullet as indicated in this guideline
Detailed (D)	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive (C)	≥13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:
  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI
- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal:

- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes) equals one bullet
- Gait and station assessment equals one bullet

Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)

6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet for any extremity examination/assessment of peripheral vascular system by:
   - Observation (e.g., swelling, varicosities)
   - Palpation (e.g., pulses, temperature, edema, tenderness)
2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
   - carotid arteries (e.g., pulse amplitude, bruits)
   - abdominal aorta (e.g., size, bruits)
   - femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ecchymosis, ulcers.)

Respiratory: One bullet for each examination/assessment.

- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (e.g., dullness, flatness, hyperresonance)
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

- Examination of abdomen with notation of presence of masses or tenderness and liver and spleen
- Examination of presence or absence of hernia
- Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system
2. One bullet for a mental status examination which includes:
   - attention span and concentration; and
   - language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and
   - recent and remote memory; and
   - fund of knowledge (e.g., awareness of current events, past history, vocabulary.)

Eyes: One bullet for both eyes and all three examinations/assessments.

- Inspection of conjunctivae and lids; and
- Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears, Nose, Mouth and Throat: One bullet for all of the following examinations/assessments:

- External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary Male: One bullet for each of the following examinations of the male genitalia:

- The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
- Epididymides (e.g., size, symmetry, masses)
- Testes (e.g., size symmetry, masses)
- Urethral meatus (e.g., size location, lesions, discharge)
- Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)
- Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
- Inspection of anus and perineum

Genitourinary Female: One bullet for each of the following female pelvic examinations (with or without specimen collection for smears and cultures):

- Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
- Examination of urethra (e.g., masses, tenderness, scarring)
- Examination of bladder (e.g., fullness, masses, tenderness)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts:

- Inspection of breasts (e.g., symmetry, nipple discharge); and
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness.)

Lymphatic palpation of lymph nodes: Two or more areas is counted as one bullet:

- Neck
- Axillae
- Groin
- Other

Verify all of the completed examination components listed in the report are documented, including the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES 1,2 & 3

Overall MDM is determined by the highest 2 out of 3 categories below:

Type of Decision Making	A. # of Points for the # of Diagnosis and Management Options	B. # of Points for Amount and Complexity of Data	C. Level of Risk
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE 1 - Number of Diagnosis and Management Options:

Category of Problem(s)	Occurrence of Problem(s)		Value
Self-limited or minor problem	(max = 2)	X	1
Established problem, stable or improved		X	1
Established problem, minor worsening		X	2
Established patient with worsening of condition and no additional workup planned	(max = 1)	X	**3**
Established patient with less than anticipated improvement, Worsening of condition and additional workup planned		X	4
New problem with no additional workup planned	(max = 1)	X	**3**
New problem with additional workup planned		X	4

TABLE 2 - Amount and/or Complexity of Data Reviewed:

Amount and/or Complexity of Data Reviewed	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (CPT® 90701-99199) ordered and /or physical therapy reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care).	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2

TABLE 3 - Table of Risk (the highest one in any one category determines the overall risk for this portion):

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered or Addressed	Management Option(s) Section
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; KOH prep	Rest; Gargles; Elastic bandages; Superficial dressings
Low	Two or more self-limited or minor problems; One stable chronic illness, e.g., well controlled HTN, NIDDM, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, simple sprain, cystitis, acute laceration repair	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; Lab tests requiring arterial puncture; Skin biopsies	Over-the-counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., thoracentesis, lumbar puncture.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids with additives; Closed treatment of fracture or dislocation, without manipulation; Disability counseling and/or work restrictions, Inability to return the injured worker to work and requiring detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for significant permanent work restrictions or total disability which would significantly restrict employment opportunities; Management of addiction behavior or other significant psychiatric condition; Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

New Patient/Office Consultations Level of Service Based on Key Components: CPT® consultation criteria must be met before a consultation can be billed for any level of service.

Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**
99201 / 99241	Problem Focused (PF)	PF	Straight Forward (SF)
99202 / 99242	Extended PF	EPF	SF
99203 / 99243	Detailed (D)	D	Low
99204 / 99244	Comprehensive (C)	C	Moderate
99205 / 99245	Comprehensive (C)	C	High

Established Patient Office Visit Level of Service Based on Key Components

Level of Service (requires at least two of the three key components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**
99211	N/A	N/A	N/A
99212	Problem Focused (PF)	PF	SF
99213	Extended PF	EPF	Low
99214	Detailed (D)	D	Moderate
99215	Comprehensive (C)	C	High

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician his/her desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

- Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
- Return to work, temporary and/or permanent restrictions
- Review of other physician's notes (i.e., IME consultation)
- Self-management of symptoms while at home and/or work
- Correct posture/mechanics to perform work functions
- Exercises for muscle strengthening and stretching
- Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
- Patient/injured worker expectations and specific goals
- Family and other interpersonal relationships and how they relate to psychological/social issues
- Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems)
- Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)
- Discussion of the workers' compensation process (i.e. IMEs, MMI, role of case manager)

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in-person to safely return the patient to work.

New Patient/Office Consultations Based on Time	
Level of Service	**Avg. time (minutes) as listed for the specific CPT® code**
99201 / 99241	10
99202 / 99242	20
99203 / 99243	30
99204 / 99244	45
99205 / 99245	60

Established Patient Office Visit Based on Time	
Level of Service	**Avg. time (minutes) as listed for the specific CPT® code**
99211	5
99212	10
99213	15
99214	25
99215	40

Proposed Exhibit #8

2019 Clinical Diagnostic Laboratory Fee Schedule

source: Medicare file - CLAB2019Q3

HCPCS	MOD	SHORTDESC	INDICATOR	RATE
36415		Routine venipuncture	N	$ 3.00
36416		Capillary blood draw	B	$ 3.00
78267		Breath tst attain/anal c-14	N	$ 11.06
78268		Breath test analysis c-14	N	$ 94.41
80047		Metabolic panel ionized ca	N	$ 13.73
80047	QW	Metabolic panel ionized ca	N	$ 13.73
80048		Metabolic panel total ca	N	$ 9.40
80048	QW	Metabolic panel total ca	N	$ 9.40
80051		Electrolyte panel	N	$ 7.79
80051	QW	Electrolyte panel	N	$ 7.79
80053		Comprehen metabolic panel	N	$ 11.74
80053	QW	Comprehen metabolic panel	N	$ 11.74
80055		Obstetric panel	N	$ 53.12
80061		Lipid panel	N	$ 14.88
80061	QW	Lipid panel	N	$ 14.88
80069		Renal function panel	N	$ 9.65
80069	QW	Renal function panel	N	$ 9.65
80074		Acute hepatitis panel	N	$ 52.93
80076		Hepatic function panel	N	$ 9.08
80081		Obstetric panel	N	$ 83.18
80150		Assay of amikacin	N	$ 16.75
80155		Drug assay caffeine	N	$ 38.57
80156		Assay carbamazepine total	N	$ 16.18
80157		Assay carbamazepine free	N	$ 14.73
80158		Drug assay cyclosporine	N	$ 20.06
80159		Drug assay clozapine	N	$ 20.55
80162		Assay of digoxin total	N	$ 14.75
80163		Assay of digoxin free	N	$ 14.75
80164		Assay dipropylacetic acd tot	N	$ 15.05
80165		Dipropylacetic acid free	N	$ 15.05
80168		Assay of ethosuximide	N	$ 18.15
80169		Drug assay everolimus	N	$ 15.26

80170		Assay of gentamicin	N	$	18.20
80171		Drug screen quant gabapentin	N	$	21.67
80173		Assay of haloperidol	N	$	16.18
80175		Drug screen quan lamotrigine	N	$	14.73
80176		Assay of lidocaine	N	$	16.32
80177		Drug scrn quan levetiracetam	N	$	14.73
80178		Assay of lithium	N	$	7.35
80178	QW	Assay of lithium	N	$	7.35
80180		Drug scrn quan mycophenolate	N	$	20.06
80183		Drug scrn quant oxcarbazepin	N	$	14.73
80184		Assay of phenobarbital	N	$	15.30
80185		Assay of phenytoin total	N	$	14.73
80186		Assay of phenytoin free	N	$	15.29
80188		Assay of primidone	N	$	18.44
80190		Assay of procainamide	N	$	60.00
80192		Assay of procainamide	N	$	18.61
80194		Assay of quinidine	N	$	16.22
80195		Assay of sirolimus	N	$	15.26
80197		Assay of tacrolimus	N	$	15.26
80198		Assay of theophylline	N	$	15.71
80199		Drug screen quant tiagabine	N	$	27.11
80200		Assay of tobramycin	N	$	17.92
80201		Assay of topiramate	N	$	13.24
80202		Assay of vancomycin	N	$	15.05
80203		Drug screen quant zonisamide	N	$	14.73
80299		Quantitative assay drug	N	$	18.64
80305		Drug test prsmv dir opt obs	N	$	12.60
80305	QW	Drug test prsmv dir opt obs	N	$	12.60
80306		Drug test prsmv instrmnt	N	$	17.14
80307		Drug test prsmv chem anlyzr	N	$	64.65
80400		Acth stimulation panel	N	$	36.24
80402		Acth stimulation panel	N	$	96.62
80406		Acth stimulation panel	N	$	86.95
80408		Aldosterone suppression eval	N	$	139.44
80410		Calcitonin stimul panel	N	$	89.31
80412		Crh stimulation panel	N	$	801.62
80414		Testosterone response	N	$	57.37
80415		Estradiol response panel	N	$	62.09
80416		Renin stimulation panel	N	$	209.32
80417		Renin stimulation panel	N	$	48.88
80418		Pituitary evaluation panel	N	$	643.84

80420		Dexamethasone panel	N	$	161.88
80422		Glucagon tolerance panel	N	$	51.19
80424		Glucagon tolerance panel	N	$	56.11
80426		Gonadotropin hormone panel	N	$	164.90
80428		Growth hormone panel	N	$	74.12
80430		Growth hormone panel	N	$	129.33
80432		Insulin suppression panel	N	$	165.61
80434		Insulin tolerance panel	N	$	285.03
80435		Insulin tolerance panel	N	$	114.45
80436		Metyrapone panel	N	$	101.29
80438		Trh stimulation panel	N	$	56.01
80439		Trh stimulation panel	N	$	74.68
81000		Urinalysis nonauto w/scope	N	$	4.02
81001		Urinalysis auto w/scope	N	$	3.52
81002		Urinalysis nonauto w/o scope	N	$	3.48
81003		Urinalysis auto w/o scope	N	$	2.49
81003	QW	Urinalysis auto w/o scope	N	$	2.49
81005		Urinalysis	N	$	2.41
81007		Urine screen for bacteria	N	$	29.98
81007	QW	Urine screen for bacteria	N	$	29.98
81015		Microscopic exam of urine	N	$	3.39
81020		Urinalysis glass test	N	$	4.70
81025		Urine pregnancy test	N	$	8.61
81050		Urinalysis volume measure	N	$	3.64
81105		Hpa-1 genotyping	N	$	135.80
81106		Hpa-2 genotyping	N	$	135.80
81107		Hpa-3 genotyping	N	$	135.80
81108		Hpa-4 genotyping	N	$	135.80
81109		Hpa-5 genotyping	N	$	135.80
81110		Hpa-6 genotyping	N	$	135.80
81111		Hpa-9 genotyping	N	$	135.80
81112		Hpa-15 genotyping	N	$	135.80
81120		Idh1 common variants	N	$	193.25
81121		Idh2 common variants	N	$	295.79
81161		Dmd dup/delet analysis	N	$	279.00
81162		Brca1&2 gen full seq dup/del	N	$	2,027.64
81163		Brca1&2 gene full seq alys	N	$	468.00
81164		Brca1&2 gen ful dup/del alys	N	$	584.23
81165		Brca1 gene full seq alys	N	$	282.88
81166		Brca1 gene full dup/del alys	N	$	301.35
81167		Brca2 gene full dup/del alys	N	$	282.88

81170		Abl1 gene	N	$	300.00
81171		Aff2 gene detc abnor alleles	N	$	137.00
81172		Aff2 gene charac alleles	N	$	274.83
81173		Ar gene full gene sequence	N	$	301.35
81174		Ar gene known famil variant	N	$	185.20
81175		Asxl1 full gene sequence	N	$	676.50
81176		Asxl1 gene target seq alys	N	$	268.77
81177		Atn1 gene detc abnor alleles	N	$	137.00
81178		Atxn1 gene detc abnor allele	N	$	137.00
81179		Atxn2 gene detc abnor allele	N	$	137.00
81180		Atxn3 gene detc abnor allele	N	$	137.00
81181		Atxn7 gene detc abnor allele	N	$	137.00
81182		Atxn8os gen detc abnor allel	N	$	137.00
81183		Atxn10 gene detc abnor allel	N	$	137.00
81184		Cacna1a gen detc abnor allel	N	$	137.00
81185		Cacna1a gene full gene seq	N	$	846.27
81186		Cacna1a gen known famil vrnt	N	$	185.20
81187		Cnbp gene detc abnor allele	N	$	137.00
81188		Cstb gene detc abnor allele	N	$	137.00
81189		Cstb gene full gene sequence	N	$	274.83
81190		Cstb gene known famil vrnt	N	$	185.20
81200		Aspa gene	N	$	47.25
81201		Apc gene full sequence	N	$	780.00
81202		Apc gene known fam variants	N	$	280.00
81203		Apc gene dup/delet variants	N	$	200.00
81204		Ar gene charac alleles	N	$	137.00
81205		Bckdhb gene	N	$	94.99
81206		Bcr/abl1 gene major bp	N	$	182.18
81207		Bcr/abl1 gene minor bp	N	$	160.93
81208		Bcr/abl1 gene other bp	N	$	214.62
81209		Blm gene	N	$	39.31
81210		Braf gene	N	$	175.40
81212		Brca1&2 185&5385&6174 vrnt	N	$	440.00
81215		Brca1 gene known famil vrnt	N	$	375.25
81216		Brca2 gene full seq alys	N	$	185.12
81217		Brca2 gene known famil vrnt	N	$	375.25
81218		Cebpa gene full sequence	N	$	268.77
81219		Calr gene com variants	N	$	135.14
81220		Cftr gene com variants	N	$	556.60
81221		Cftr gene known fam variants	N	$	97.22
81222		Cftr gene dup/delet variants	N	$	435.07

81223		Cftr gene full sequence	N	$	499.00
81224		Cftr gene intron poly t	N	$	168.75
81225		Cyp2c19 gene com variants	N	$	291.36
81226		Cyp2d6 gene com variants	N	$	450.91
81227		Cyp2c9 gene com variants	N	$	174.81
81228		Cytogen micrarray copy nmbr	N	$	900.00
81229		Cytogen m array copy no&snp	N	$	1,160.00
81230		Cyp3a4 gene common variants	N	$	174.81
81231		Cyp3a5 gene common variants	N	$	174.81
81232		Dpyd gene common variants	N	$	174.81
81233		Btk gene common variants	N	$	175.40
81234		Dmpk gene detc abnor allele	N	$	137.00
81235		Egfr gene com variants	N	$	324.58
81236		Ezh2 gene full gene sequence	N	$	282.88
81237		Ezh2 gene common variants	N	$	175.40
81238		F9 full gene sequence	N	$	600.00
81239		Dmpk gene charac alleles	N	$	274.83
81240		F2 gene	N	$	65.69
81241		F5 gene	N	$	73.37
81242		Fancc gene	N	$	36.62
81243		Fmr1 gene detection	N	$	57.04
81244		Fmr1 gene charac alleles	N	$	44.89
81245		Flt3 gene	N	$	165.51
81246		Flt3 gene analysis	N	$	83.00
81247		G6pd gene alys cmn variant	N	$	174.81
81248		G6pd known familial variant	N	$	375.25
81249		G6pd full gene sequence	N	$	600.00
81250		G6pc gene	N	$	58.49
81251		Gba gene	N	$	47.25
81252		Gjb2 gene full sequence	N	$	101.12
81253		Gjb2 gene known fam variants	N	$	61.52
81254		Gjb6 gene com variants	N	$	35.00
81255		Hexa gene	N	$	51.45
81256		Hfe gene	N	$	72.62
81257		Hba1/hba2 gene	N	$	102.26
81258		Hba1/hba2 gene fam vrnt	N	$	375.25
81259		Hba1/hba2 full gene sequence	N	$	600.00
81260		Ikbkap gene	N	$	39.31
81261		Igh gene rearrange amp meth	N	$	219.99
81262		Igh gene rearrang dir probe	N	$	68.55
81263		Igh vari regional mutation	N	$	327.24

81264		Igk rearrangeabn clonal pop	N	$	172.73
81265		Str markers specimen anal	N	$	238.94
81266		Str markers spec anal addl	N	$	304.81
81267		Chimerism anal no cell selec	N	$	230.51
81268		Chimerism anal w/cell select	N	$	289.76
81269		Hba1/hba2 gene dup/del vrnts	N	$	202.40
81270		Jak2 gene	N	$	101.85
81271		Htt gene detc abnor alleles	N	$	137.00
81272		Kit gene targeted seq analys	N	$	329.51
81273		Kit gene analys d816 variant	N	$	124.87
81274		Htt gene charac alleles	N	$	274.83
81275		Kras gene variants exon 2	N	$	193.25
81276		Kras gene addl variants	N	$	193.25
81283		Ifnl3 gene	N	$	73.37
81284		Fxn gene detc abnor alleles	N	$	137.00
81285		Fxn gene charac alleles	N	$	274.83
81286		Fxn gene full gene sequence	N	$	274.83
81287		Mgmt gene prmtr mthyltn alys	N	$	124.64
81288		Mlh1 gene	N	$	192.32
81289		Fxn gene known famil variant	N	$	185.20
81290		Mcoln1 gene	N	$	39.31
81291		Mthfr gene	N	$	65.34
81292		Mlh1 gene full seq	N	$	675.40
81293		Mlh1 gene known variants	N	$	331.00
81294		Mlh1 gene dup/delete variant	N	$	202.40
81295		Msh2 gene full seq	N	$	381.70
81296		Msh2 gene known variants	N	$	337.73
81297		Msh2 gene dup/delete variant	N	$	213.30
81298		Msh6 gene full seq	N	$	641.85
81299		Msh6 gene known variants	N	$	308.00
81300		Msh6 gene dup/delete variant	N	$	238.00
81301		Microsatellite instability	N	$	348.56
81302		Mecp2 gene full seq	N	$	527.87
81303		Mecp2 gene known variant	N	$	120.00
81304		Mecp2 gene dup/delet variant	N	$	150.00
81305		Myd88 gene p.leu265pro vrnt	N	$	175.40
81306		Nudt15 gene common variants	N	$	291.36
81310		Npm1 gene	N	$	246.52
81311		Nras gene variants exon 2&3	N	$	295.79
81312		Pabpn1 gene detc abnor allel	N	$	137.00
81313		Pca3/klk3 antigen	N	$	255.05

81314		Pdgfra gene	N	$	329.51
81315		Pml/raralpha com breakpoints	N	$	230.35
81316		Pml/raralpha 1 breakpoint	N	$	230.35
81317		Pms2 gene full seq analysis	N	$	676.50
81318		Pms2 known familial variants	N	$	331.00
81319		Pms2 gene dup/delet variants	N	$	203.50
81320		Plcg2 gene common variants	N	$	291.36
81321		Pten gene full sequence	N	$	600.00
81322		Pten gene known fam variant	N	$	47.56
81323		Pten gene dup/delet variant	N	$	300.00
81324		Pmp22 gene dup/delet	N	$	758.36
81325		Pmp22 gene full sequence	N	$	769.58
81326		Pmp22 gene known fam variant	N	$	47.56
81327		Sept9 gen prmtr mthyltn alys	N	$	192.00
81328		Slco1b1 gene com variants	N	$	174.81
81329		Smn1 gene dos/deletion alys	N	$	137.00
81330		Smpd1 gene common variants	N	$	47.00
81331		Snrpn/ube3a gene	N	$	51.07
81332		Serpina1 gene	N	$	48.50
81333		Tgfbi gene common variants	N	$	137.00
81334		Runx1 gene targeted seq alys	N	$	329.51
81335		Tpmt gene com variants	N	$	174.81
81336		Smn1 gene full gene sequence	N	$	301.35
81337		Smn1 gen nown famil seq vrnt	N	$	185.20
81340		Trb@ gene rearrange amplify	N	$	232.13
81341		Trb@ gene rearrange dirprobe	N	$	55.10
81342		Trg gene rearrangement anal	N	$	223.88
81343		Ppp2r2b gen detc abnor allel	N	$	137.00
81344		Tbp gene detc abnor alleles	N	$	137.00
81345		Tert gene targeted seq alys	N	$	185.20
81346		Tyms gene com variants	N	$	174.81
81350		Ugt1a1 gene	N	$	234.00
81355		Vkorc1 gene	N	$	88.20
81361		Hbb gene com variants	N	$	174.81
81362		Hbb gene known fam variant	N	$	375.25
81363		Hbb gene dup/del variants	N	$	202.40
81364		Hbb full gene sequence	N	$	324.58
81370		Hla i & ii typing lr	N	$	446.80
81371		Hla i & ii type verify lr	N	$	404.52
81372		Hla i typing complete lr	N	$	403.59
81373		Hla i typing 1 locus lr	N	$	127.43

81374		Hla i typing 1 antigen lr	N	$	80.83
81375		Hla ii typing ag equiv lr	N	$	245.27
81376		Hla ii typing 1 locus lr	N	$	135.80
81377		Hla ii type 1 ag equiv lr	N	$	102.01
81378		Hla i & ii typing hr	N	$	383.96
81379		Hla i typing complete hr	N	$	372.65
81380		Hla i typing 1 locus hr	N	$	196.94
81381		Hla i typing 1 allele hr	N	$	169.90
81382		Hla ii typing 1 loc hr	N	$	137.42
81383		Hla ii typing 1 allele hr	N	$	121.26
81400		Mopath procedure level 1	N	$	63.96
81401		Mopath procedure level 2	N	$	137.00
81402		Mopath procedure level 3	N	$	150.33
81403		Mopath procedure level 4	N	$	185.20
81404		Mopath procedure level 5	N	$	274.83
81405		Mopath procedure level 6	N	$	301.35
81406		Mopath procedure level 7	N	$	282.88
81407		Mopath procedure level 8	N	$	846.27
81408		Mopath procedure level 9	N	$	2,000.00
81410		Aortic dysfunction/dilation	N	$	504.00
81411		Aortic dysfunction/dilation	N	$	1,350.19
81412		Ashkenazi jewish assoc dis	N	$	2,448.56
81413		Car ion chnnlpath inc 10 gns	N	$	649.89
81414		Car ion chnnlpath inc 2 gns	N	$	649.89
81415		Exome sequence analysis	N	$	4,780.00
81416		Exome sequence analysis	N	$	12,000.00
81417		Exome re-evaluation	N	$	320.00
81420		Fetal chrmoml aneuploidy	N	$	759.05
81422		Fetal chrmoml microdeltj	N	$	759.05
81425		Genome sequence analysis	N	$	5,031.20
81426		Genome sequence analysis	N	$	2,709.95
81427		Genome re-evaluation	N	$	2,337.65
81430		Hearing loss sequence analys	N	$	1,625.00
81431		Hearing loss dup/del analys	N	$	679.57
81432		Hrdtry brst ca-rlatd dsordrs	N	$	754.50
81433		Hrdtry brst ca-rlatd dsordrs	N	$	487.70
81434		Hereditary retinal disorders	N	$	597.91
81435		Hereditary colon ca dsordrs	N	$	649.89
81436		Hereditary colon ca dsordrs	N	$	649.89
81437		Heredtry nurondcrn tum dsrdr	N	$	487.70
81438		Heredtry nurondcrn tum dsrdr	N	$	487.70

81439		Hrdtry cardmypy gene panel	N	$	649.89
81440		Mitochondrial gene	N	$	3,324.00
81442		Noonan spectrum disorders	N	$	2,143.60
81443		Genetic tstg severe inh cond	N	$	2,448.56
81445		Targeted genomic seq analys	N	$	597.91
81448		Hrdtry perph neurphy panel	N	$	649.89
81450		Targeted genomic seq analys	N	$	759.53
81455		Targeted genomic seq analys	N	$	2,919.60
81460		Whole mitochondrial genome	N	$	1,287.00
81465		Whole mitochondrial genome	N	$	936.00
81470		X-linked intellectual dblt	N	$	914.00
81471		X-linked intellectual dblt	N	$	914.00
81490		Autoimmune rheumatoid arthr	N	$	840.65
81493		Cor artery disease mrna	N	$	1,050.00
81500		Onco (ovar) two proteins	N	$	260.50
81503		Onco (ovar) five proteins	N	$	897.00
81504		Oncology tissue of origin	N	$	520.00
81506		Endo assay seven anal	N	$	74.67
81507		Fetal aneuploidy trisom risk	N	$	795.00
81508		Ftl cgen abnor two proteins	N	$	54.30
81509		Ftl cgen abnor 3 proteins	N	$	1,487.37
81510		Ftl cgen abnor three anal	N	$	55.54
81511		Ftl cgen abnor four anal	N	$	153.50
81512		Ftl cgen abnor five anal	N	$	69.52
81518		Onc brst mrna 11 genes	N	$	3,873.00
81519		Oncology breast mrna	N	$	3,873.00
81520		Onc breast mrna 58 genes	N	$	2,789.12
81521		Onc breast mrna 70 genes	N	$	3,873.00
81525		Oncology colon mrna	N	$	3,116.00
81528		Oncology colorectal scr	N	$	508.87
81535		Oncology gynecologic	N	$	579.46
81536		Oncology gynecologic	N	$	177.56
81538		Oncology lung	N	$	2,871.00
81539		Oncology prostate prob score	N	$	760.00
81540		Oncology tum unknown origin	N	$	3,750.00
81541		Onc prostate mrna 46 genes	N	$	3,873.00
81545		Oncology thyroid	N	$	3,600.00
81551		Onc prostate 3 genes	N	$	2,030.00
81595		Cardiology hrt trnspl mrna	N	$	3,240.00
81596		Nfct ds chrnc hcv 6 assays	N	$	72.19
82009		Test for acetone/ketones	N	$	5.02

82010		Acetone assay	N	$	9.08
82010	QW	Acetone assay	N	$	9.08
82013		Acetylcholinesterase assay	N	$	12.41
82016		Acylcarnitines qual	N	$	16.49
82017		Acylcarnitines quant	N	$	18.74
82024		Assay of acth	N	$	42.91
82030		Assay of adp & amp	N	$	28.67
82040		Assay of serum albumin	N	$	5.50
82040	QW	Assay of serum albumin	N	$	5.50
82042		Other source albumin quan ea	N	$	7.78
82042	QW	Other source albumin quan ea	N	$	7.78
82043		Ur albumin quantitative	N	$	6.42
82043	QW	Ur albumin quantitative	N	$	6.42
82044		Ur albumin semiquantitative	N	$	6.23
82044	QW	Ur albumin semiquantitative	N	$	6.23
82045		Albumin ischemia modified	N	$	37.71
82075		Assay of breath ethanol	N	$	30.00
82085		Assay of aldolase	N	$	10.79
82088		Assay of aldosterone	N	$	45.28
82103		Alpha-1-antitrypsin total	N	$	14.93
82104		Alpha-1-antitrypsin pheno	N	$	16.07
82105		Alpha-fetoprotein serum	N	$	18.64
82106		Alpha-fetoprotein amniotic	N	$	18.64
82107		Alpha-fetoprotein l3	N	$	71.57
82108		Assay of aluminum	N	$	28.31
82120		Amines vaginal fluid qual	N	$	5.99
82120	QW	Amines vaginal fluid qual	N	$	5.99
82127		Amino acid single qual	N	$	15.41
82128		Amino acids mult qual	N	$	15.41
82131		Amino acids single quant	N	$	22.98
82135		Assay aminolevulinic acid	N	$	18.28
82136		Amino acids quant 2-5	N	$	19.61
82139		Amino acids quan 6 or more	N	$	18.74
82140		Assay of ammonia	N	$	16.19
82143		Amniotic fluid scan	N	$	9.35
82150		Assay of amylase	N	$	7.20
82150	QW	Assay of amylase	N	$	7.20
82154		Androstanediol glucuronide	N	$	32.04
82157		Assay of androstenedione	N	$	32.53
82160		Assay of androsterone	N	$	27.78
82163		Assay of angiotensin ii	N	$	22.80

82164		Angiotensin i enzyme test	N	$	16.22
82172		Assay of apolipoprotein	N	$	21.09
82175		Assay of arsenic	N	$	21.08
82180		Assay of ascorbic acid	N	$	10.98
82190		Atomic absorption	N	$	16.56
82232		Assay of beta-2 protein	N	$	17.97
82239		Bile acids total	N	$	19.03
82240		Bile acids cholylglycine	N	$	29.53
82247		Bilirubin total	N	$	5.57
82247	QW	Bilirubin total	N	$	5.57
82248		Bilirubin direct	N	$	5.57
82252		Fecal bilirubin test	N	$	5.06
82261		Assay of biotinidase	N	$	18.74
82270		Occult blood feces	N	$	4.38
82271		Occult blood other sources	N	$	5.32
82271	QW	Occult blood other sources	N	$	5.32
82272		Occult bld feces 1-3 tests	N	$	4.23
82274		Assay test for blood fecal	N	$	17.67
82274	QW	Assay test for blood fecal	N	$	17.67
82286		Assay of bradykinin	N	$	5.73
82300		Assay of cadmium	N	$	25.72
82306		Vitamin d 25 hydroxy	N	$	32.89
82308		Assay of calcitonin	N	$	29.77
82310		Assay of calcium	N	$	5.73
82310	QW	Assay of calcium	N	$	5.73
82330		Assay of calcium	N	$	15.20
82330	QW	Assay of calcium	N	$	15.20
82331		Calcium infusion test	N	$	13.34
82340		Assay of calcium in urine	N	$	6.70
82355		Calculus analysis qual	N	$	12.86
82360		Calculus assay quant	N	$	14.30
82365		Calculus spectroscopy	N	$	14.33
82370		X-ray assay calculus	N	$	13.92
82373		Assay c-d transfer measure	N	$	20.06
82374		Assay blood carbon dioxide	N	$	5.43
82374	QW	Assay blood carbon dioxide	N	$	5.43
82375		Assay carboxyhb quant	N	$	13.69
82376		Assay carboxyhb qual	N	$	14.07
82378		Carcinoembryonic antigen	N	$	21.07
82379		Assay of carnitine	N	$	18.74
82380		Assay of carotene	N	$	10.25

82382		Assay urine catecholamines	N	$	27.30
82383		Assay blood catecholamines	N	$	29.08
82384		Assay three catecholamines	N	$	28.06
82387		Assay of cathepsin-d	N	$	20.06
82390		Assay of ceruloplasmin	N	$	11.93
82397		Chemiluminescent assay	N	$	15.69
82415		Assay of chloramphenicol	N	$	14.08
82435		Assay of blood chloride	N	$	5.11
82435	QW	Assay of blood chloride	N	$	5.11
82436		Assay of urine chloride	N	$	5.75
82438		Assay other fluid chlorides	N	$	5.43
82441		Test for chlorohydrocarbons	N	$	6.67
82465		Assay bld/serum cholesterol	N	$	4.84
82465	QW	Assay bld/serum cholesterol	N	$	4.84
82480		Assay serum cholinesterase	N	$	8.75
82482		Assay rbc cholinesterase	N	$	9.81
82485		Assay chondroitin sulfate	N	$	22.95
82495		Assay of chromium	N	$	22.53
82507		Assay of citrate	N	$	30.89
82523		Collagen crosslinks	N	$	20.76
82523	QW	Collagen crosslinks	N	$	20.76
82525		Assay of copper	N	$	13.79
82528		Assay of corticosterone	N	$	25.02
82530		Cortisol free	N	$	18.57
82533		Total cortisol	N	$	18.11
82540		Assay of creatine	N	$	5.15
82542		Col chromotography qual/quan	N	$	24.09
82550		Assay of ck (cpk)	N	$	7.23
82550	QW	Assay of ck (cpk)	N	$	7.23
82552		Assay of cpk in blood	N	$	14.88
82553		Creatine mb fraction	N	$	12.83
82554		Creatine isoforms	N	$	13.19
82565		Assay of creatinine	N	$	5.69
82565	QW	Assay of creatinine	N	$	5.69
82570		Assay of urine creatinine	N	$	5.75
82570	QW	Assay of urine creatinine	N	$	5.75
82575		Creatinine clearance test	N	$	10.51
82585		Assay of cryofibrinogen	N	$	14.14
82595		Assay of cryoglobulin	N	$	7.18
82600		Assay of cyanide	N	$	21.55
82607		Vitamin b-12	N	$	16.75

82608		B-12 binding capacity	N	$	15.91
82610		Cystatin c	N	$	18.52
82615		Test for urine cystines	N	$	9.55
82626		Dehydroepiandrosterone	N	$	28.08
82627		Dehydroepiandrosterone	N	$	24.71
82633		Desoxycorticosterone	N	$	34.43
82634		Deoxycortisol	N	$	32.53
82638		Assay of dibucaine number	N	$	13.61
82642		Dihydrotestosterone	N	$	32.53
82652		Vit d 1 25-dihydroxy	N	$	42.78
82656		Pancreatic elastase fecal	N	$	12.81
82657		Enzyme cell activity	N	$	22.17
82658		Enzyme cell activity ra	N	$	44.03
82664		Electrophoretic test	N	$	61.50
82668		Assay of erythropoietin	N	$	20.88
82670		Assay of estradiol	N	$	31.04
82671		Assay of estrogens	N	$	35.89
82672		Assay of estrogen	N	$	24.11
82677		Assay of estriol	N	$	26.87
82679		Assay of estrone	N	$	27.73
82679	QW	Assay of estrone	N	$	27.73
82693		Assay of ethylene glycol	N	$	16.56
82696		Assay of etiocholanolone	N	$	26.24
82705		Fats/lipids feces qual	N	$	5.66
82710		Fats/lipids feces quant	N	$	18.67
82715		Assay of fecal fat	N	$	22.97
82725		Assay of blood fatty acids	N	$	18.77
82726		Long chain fatty acids	N	$	20.06
82728		Assay of ferritin	N	$	15.15
82731		Assay of fetal fibronectin	N	$	71.57
82735		Assay of fluoride	N	$	20.60
82746		Assay of folic acid serum	N	$	16.34
82747		Assay of folic acid rbc	N	$	19.25
82757		Assay of semen fructose	N	$	19.26
82759		Assay of rbc galactokinase	N	$	23.87
82760		Assay of galactose	N	$	12.44
82775		Assay galactose transferase	N	$	23.41
82776		Galactose transferase test	N	$	11.74
82777		Galectin-3	N	$	44.25
82784		Assay iga/igd/igg/igm each	N	$	10.34
82785		Assay of ige	N	$	18.29

82787		Igg 1 2 3 or 4 each	N	$	8.91
82800		Blood ph	N	$	11.00
82803		Blood gases any combination	N	$	26.07
82805		Blood gases w/o2 saturation	N	$	78.77
82810		Blood gases o2 sat only	N	$	9.77
82820		Hemoglobin-oxygen affinity	N	$	13.34
82930		Gastric analy w/ph ea spec	N	$	6.71
82938		Gastrin test	N	$	19.66
82941		Assay of gastrin	N	$	19.59
82943		Assay of glucagon	N	$	15.88
82945		Glucose other fluid	N	$	4.37
82946		Glucagon tolerance test	N	$	17.77
82947		Assay glucose blood quant	N	$	4.37
82947	QW	Assay glucose blood quant	N	$	4.37
82948		Reagent strip/blood glucose	N	$	5.04
82950		Glucose test	N	$	5.27
82950	QW	Glucose test	N	$	5.27
82951		Glucose tolerance test (gtt)	N	$	14.30
82951	QW	Glucose tolerance test (gtt)	N	$	14.30
82952		Gtt-added samples	N	$	4.36
82952	QW	Gtt-added samples	N	$	4.36
82955		Assay of g6pd enzyme	N	$	10.77
82960		Test for g6pd enzyme	N	$	6.72
82962		Glucose blood test	N	$	3.28
82963		Assay of glucosidase	N	$	23.87
82965		Assay of gdh enzyme	N	$	13.15
82977		Assay of ggt	N	$	8.00
82977	QW	Assay of ggt	N	$	8.00
82978		Assay of glutathione	N	$	15.84
82979		Assay rbc glutathione	N	$	10.49
82985		Assay of glycated protein	N	$	16.76
82985	QW	Assay of glycated protein	N	$	16.76
83001		Assay of gonadotropin (fsh)	N	$	20.65
83001	QW	Assay of gonadotropin (fsh)	N	$	20.65
83002		Assay of gonadotropin (lh)	N	$	20.57
83002	QW	Assay of gonadotropin (lh)	N	$	20.57
83003		Assay growth hormone (hgh)	N	$	18.52
83006		Growth stimulation gene 2	N	$	75.60
83009		H pylori (c-13) blood	N	$	74.84
83010		Assay of haptoglobin quant	N	$	13.97
83012		Assay of haptoglobins	N	$	26.89

83013		H pylori (c-13) breath	N	$	74.84
83014		H pylori drug admin	N	$	8.73
83015		Heavy metal qual any anal	N	$	20.94
83018		Heavy metal quant each nes	N	$	24.41
83020		Hemoglobin electrophoresis	N	$	14.30
83021		Hemoglobin chromotography	N	$	20.06
83026		Hemoglobin copper sulfate	N	$	4.01
83030		Fetal hemoglobin chemical	N	$	10.74
83033		Fetal hemoglobin assay qual	N	$	8.00
83036		Glycosylated hemoglobin test	N	$	10.79
83036	QW	Glycosylated hemoglobin test	N	$	10.79
83037		Glycosylated hb home device	N	$	10.79
83037	QW	Glycosylated hb home device	N	$	10.79
83045		Blood methemoglobin test	N	$	6.49
83050		Blood methemoglobin assay	N	$	8.20
83051		Assay of plasma hemoglobin	N	$	8.12
83060		Blood sulfhemoglobin assay	N	$	9.19
83065		Assay of hemoglobin heat	N	$	9.00
83068		Hemoglobin stability screen	N	$	9.47
83069		Assay of urine hemoglobin	N	$	4.39
83070		Assay of hemosiderin qual	N	$	5.27
83080		Assay of b hexosaminidase	N	$	18.74
83088		Assay of histamine	N	$	32.81
83090		Assay of homocystine	N	$	18.74
83150		Assay of homovanillic acid	N	$	22.41
83491		Assay of corticosteroids 17	N	$	19.47
83497		Assay of 5-hiaa	N	$	14.33
83498		Assay of progesterone 17-d	N	$	30.19
83500		Assay free hydroxyproline	N	$	25.17
83505		Assay total hydroxyproline	N	$	27.01
83516		Immunoassay nonantibody	N	$	12.81
83516	QW	Immunoassay nonantibody	N	$	12.81
83518		Immunoassay dipstick	N	$	9.64
83518	QW	Immunoassay dipstick	N	$	9.64
83519		Ria nonantibody	N	$	18.40
83520		Immunoassay quant nos nonab	N	$	17.27
83520	QW	Immunoassay quant nos nonab	N	$	17.27
83525		Assay of insulin	N	$	12.70
83527		Assay of insulin	N	$	14.39
83528		Assay of intrinsic factor	N	$	19.82
83540		Assay of iron	N	$	7.19

83550		Iron binding test	N	$	9.71
83570		Assay of idh enzyme	N	$	9.83
83582		Assay of ketogenic steroids	N	$	15.75
83586		Assay 17- ketosteroids	N	$	14.22
83593		Fractionation ketosteroids	N	$	29.22
83605		Assay of lactic acid	N	$	11.87
83605	QW	Assay of lactic acid	N	$	11.87
83615		Lactate (ld) (ldh) enzyme	N	$	6.71
83625		Assay of ldh enzymes	N	$	14.22
83630		Lactoferrin fecal (qual)	N	$	21.81
83631		Lactoferrin fecal (quant)	N	$	21.81
83632		Placental lactogen	N	$	22.47
83633		Test urine for lactose	N	$	11.25
83655		Assay of lead	N	$	13.45
83655	QW	Assay of lead	N	$	13.45
83661		L/s ratio fetal lung	N	$	24.43
83662		Foam stability fetal lung	N	$	21.01
83663		Fluoro polarize fetal lung	N	$	21.01
83664		Lamellar bdy fetal lung	N	$	21.01
83670		Assay of lap enzyme	N	$	10.18
83690		Assay of lipase	N	$	7.65
83695		Assay of lipoprotein(a)	N	$	14.39
83698		Assay lipoprotein pla2	N	$	46.31
83700		Lipopro bld electrophoretic	N	$	12.51
83701		Lipoprotein bld hr fraction	N	$	33.86
83704		Lipoprotein bld quan part	N	$	35.06
83718		Assay of lipoprotein	N	$	9.10
83718	QW	Assay of lipoprotein	N	$	9.10
83719		Assay of blood lipoprotein	N	$	12.93
83721		Assay of blood lipoprotein	N	$	10.60
83721	QW	Assay of blood lipoprotein	N	$	10.60
83722		Lipoprtn dir meas sd ldl chl	N	$	35.06
83727		Assay of lrh hormone	N	$	19.10
83735		Assay of magnesium	N	$	7.44
83775		Assay malate dehydrogenase	N	$	8.19
83785		Assay of manganese	N	$	27.33
83789		Mass spectrometry qual/quan	N	$	24.11
83825		Assay of mercury	N	$	18.06
83835		Assay of metanephrines	N	$	18.82
83857		Assay of methemalbumin	N	$	11.93
83861		Microfluid analy tears	N	$	22.48

83861	QW	Microfluid analy tears	N	$	22.48
83864		Mucopolysaccharides	N	$	28.50
83872		Assay synovial fluid mucin	N	$	6.51
83873		Assay of csf protein	N	$	19.12
83874		Assay of myoglobin	N	$	14.35
83876		Assay myeloperoxidase	N	$	50.86
83880		Assay of natriuretic peptide	N	$	39.26
83880	QW	Assay of natriuretic peptide	N	$	39.26
83883		Assay nephelometry not spec	N	$	15.11
83885		Assay of nickel	N	$	27.23
83915		Assay of nucleotidase	N	$	12.39
83916		Oligoclonal bands	N	$	27.39
83918		Organic acids total quant	N	$	23.60
83919		Organic acids qual each	N	$	18.28
83921		Organic acid single quant	N	$	21.21
83930		Assay of blood osmolality	N	$	7.35
83935		Assay of urine osmolality	N	$	7.57
83937		Assay of osteocalcin	N	$	33.16
83945		Assay of oxalate	N	$	14.45
83950		Oncoprotein her-2/neu	N	$	71.57
83951		Oncoprotein dcp	N	$	71.57
83970		Assay of parathormone	N	$	45.86
83986		Assay ph body fluid nos	N	$	3.98
83986	QW	Assay ph body fluid nos	N	$	3.98
83987		Exhaled breath condensate	N	$	3.98
83993		Assay for calprotectin fecal	N	$	21.81
84030		Assay of blood pku	N	$	6.11
84035		Assay of phenylketones	N	$	4.07
84060		Assay acid phosphatase	N	$	8.21
84066		Assay prostate phosphatase	N	$	10.73
84075		Assay alkaline phosphatase	N	$	5.75
84075	QW	Assay alkaline phosphatase	N	$	5.75
84078		Assay alkaline phosphatase	N	$	8.26
84080		Assay alkaline phosphatases	N	$	16.43
84081		Assay phosphatidylglycerol	N	$	18.35
84085		Assay of rbc pg6d enzyme	N	$	10.49
84087		Assay phosphohexose enzymes	N	$	11.47
84100		Assay of phosphorus	N	$	5.27
84105		Assay of urine phosphorus	N	$	5.78
84106		Test for porphobilinogen	N	$	5.82
84110		Assay of porphobilinogen	N	$	9.38

84112		Eval amniotic fluid protein	N	$	98.11
84119		Test urine for porphyrins	N	$	13.36
84120		Assay of urine porphyrins	N	$	16.35
84126		Assay of feces porphyrins	N	$	39.11
84132		Assay of serum potassium	N	$	5.11
84132	QW	Assay of serum potassium	N	$	5.11
84133		Assay of urine potassium	N	$	4.79
84134		Assay of prealbumin	N	$	16.21
84135		Assay of pregnanediol	N	$	21.27
84138		Assay of pregnanetriol	N	$	21.05
84140		Assay of pregnenolone	N	$	22.97
84143		Assay of 17-hydroxypregneno	N	$	25.34
84144		Assay of progesterone	N	$	23.18
84145		Procalcitonin (pct)	N	$	29.77
84146		Assay of prolactin	N	$	21.53
84150		Assay of prostaglandin	N	$	41.77
84152		Assay of psa complexed	N	$	20.44
84153		Assay of psa total	N	$	20.44
84154		Assay of psa free	N	$	20.44
84155		Assay of protein serum	N	$	4.07
84155	QW	Assay of protein serum	N	$	4.07
84156		Assay of protein urine	N	$	4.07
84157		Assay of protein other	N	$	4.07
84157	QW	Assay of protein other	N	$	4.07
84160		Assay of protein any source	N	$	5.75
84163		Pappa serum	N	$	16.73
84165		Protein e-phoresis serum	N	$	11.93
84166		Protein e-phoresis/urine/csf	N	$	19.81
84181		Western blot test	N	$	18.92
84182		Protein western blot test	N	$	29.21
84202		Assay rbc protoporphyrin	N	$	15.94
84203		Test rbc protoporphyrin	N	$	9.74
84206		Assay of proinsulin	N	$	26.69
84207		Assay of vitamin b-6	N	$	31.22
84210		Assay of pyruvate	N	$	14.48
84220		Assay of pyruvate kinase	N	$	10.49
84228		Assay of quinine	N	$	12.93
84233		Assay of estrogen	N	$	87.88
84234		Assay of progesterone	N	$	72.09
84235		Assay of endocrine hormone	N	$	71.23
84238		Assay nonendocrine receptor	N	$	40.63

84244		Assay of renin	N	$	24.44
84252		Assay of vitamin b-2	N	$	22.49
84255		Assay of selenium	N	$	28.37
84260		Assay of serotonin	N	$	34.43
84270		Assay of sex hormone globul	N	$	24.15
84275		Assay of sialic acid	N	$	14.93
84285		Assay of silica	N	$	26.15
84295		Assay of serum sodium	N	$	5.35
84295	QW	Assay of serum sodium	N	$	5.35
84300		Assay of urine sodium	N	$	5.40
84302		Assay of sweat sodium	N	$	5.40
84305		Assay of somatomedin	N	$	23.63
84307		Assay of somatostatin	N	$	20.31
84311		Spectrophotometry	N	$	8.10
84315		Body fluid specific gravity	N	$	3.28
84375		Chromatogram assay sugars	N	$	39.00
84376		Sugars single qual	N	$	6.11
84377		Sugars multiple qual	N	$	6.11
84378		Sugars single quant	N	$	12.81
84379		Sugars multiple quant	N	$	12.81
84392		Assay of urine sulfate	N	$	5.49
84402		Assay of free testosterone	N	$	28.30
84403		Assay of total testosterone	N	$	28.68
84410		Testosterone bioavailable	N	$	56.98
84425		Assay of vitamin b-1	N	$	23.59
84430		Assay of thiocyanate	N	$	12.93
84431		Thromboxane urine	N	$	35.11
84432		Assay of thyroglobulin	N	$	17.84
84436		Assay of total thyroxine	N	$	7.63
84437		Assay of neonatal thyroxine	N	$	7.18
84439		Assay of free thyroxine	N	$	10.02
84442		Assay of thyroid activity	N	$	16.43
84443		Assay thyroid stim hormone	N	$	18.67
84443	QW	Assay thyroid stim hormone	N	$	18.67
84445		Assay of tsi globulin	N	$	56.51
84446		Assay of vitamin e	N	$	15.75
84449		Assay of transcortin	N	$	20.00
84450		Transferase (ast) (sgot)	N	$	5.75
84450	QW	Transferase (ast) (sgot)	N	$	5.75
84460		Alanine amino (alt) (sgpt)	N	$	5.89
84460	QW	Alanine amino (alt) (sgpt)	N	$	5.89

84466		Assay of transferrin	N	$	14.18
84478		Assay of triglycerides	N	$	6.38
84478	QW	Assay of triglycerides	N	$	6.38
84479		Assay of thyroid (t3 or t4)	N	$	7.18
84480		Assay triiodothyronine (t3)	N	$	15.75
84481		Free assay (ft-3)	N	$	18.82
84482		T3 reverse	N	$	17.51
84484		Assay of troponin quant	N	$	12.47
84485		Assay duodenal fluid trypsin	N	$	8.00
84488		Test feces for trypsin	N	$	8.11
84490		Assay of feces for trypsin	N	$	9.93
84510		Assay of tyrosine	N	$	11.56
84512		Assay of troponin qual	N	$	10.09
84520		Assay of urea nitrogen	N	$	4.39
84520	QW	Assay of urea nitrogen	N	$	4.39
84525		Urea nitrogen semi-quant	N	$	5.13
84540		Assay of urine/urea-n	N	$	5.56
84545		Urea-n clearance test	N	$	7.35
84550		Assay of blood/uric acid	N	$	5.02
84550	QW	Assay of blood/uric acid	N	$	5.02
84560		Assay of urine/uric acid	N	$	5.27
84577		Assay of feces/urobilinogen	N	$	18.67
84578		Test urine urobilinogen	N	$	4.47
84580		Assay of urine urobilinogen	N	$	9.55
84583		Assay of urine urobilinogen	N	$	6.05
84585		Assay of urine vma	N	$	17.22
84586		Assay of vip	N	$	39.26
84588		Assay of vasopressin	N	$	37.71
84590		Assay of vitamin a	N	$	12.90
84591		Assay of nos vitamin	N	$	17.06
84597		Assay of vitamin k	N	$	15.24
84600		Assay of volatiles	N	$	17.87
84620		Xylose tolerance test	N	$	13.16
84630		Assay of zinc	N	$	12.65
84681		Assay of c-peptide	N	$	23.13
84702		Chorionic gonadotropin test	N	$	16.73
84703		Chorionic gonadotropin assay	N	$	8.36
84703	QW	Chorionic gonadotropin assay	N	$	8.36
84704		Hcg free betachain test	N	$	16.73
84830		Ovulation tests	N	$	12.70
85002		Bleeding time test	N	$	5.01

85004		Automated diff wbc count	N	$	7.18
85007		Bl smear w/diff wbc count	N	$	3.82
85008		Bl smear w/o diff wbc count	N	$	3.82
85009		Manual diff wbc count b-coat	N	$	5.07
85013		Spun microhematocrit	N	$	7.00
85014		Hematocrit	N	$	2.63
85014	QW	Hematocrit	N	$	2.63
85018		Hemoglobin	N	$	2.63
85018	QW	Hemoglobin	N	$	2.63
85025		Complete cbc w/auto diff wbc	N	$	8.63
85025	QW	Complete cbc w/auto diff wbc	N	$	8.63
85027		Complete cbc automated	N	$	7.18
85032		Manual cell count each	N	$	4.79
85041		Automated rbc count	N	$	3.35
85044		Manual reticulocyte count	N	$	4.79
85045		Automated reticulocyte count	N	$	4.44
85046		Reticyte/hgb concentrate	N	$	6.19
85048		Automated leukocyte count	N	$	2.82
85049		Automated platelet count	N	$	4.97
85055		Reticulated platelet assay	N	$	35.74
85130		Chromogenic substrate assay	N	$	13.21
85170		Blood clot retraction	N	$	16.30
85175		Blood clot lysis time	N	$	20.37
85210		Clot factor ii prothrom spec	N	$	14.43
85220		Blooc clot factor v test	N	$	19.61
85230		Clot factor vii proconvertin	N	$	19.89
85240		Clot factor viii ahg 1 stage	N	$	19.89
85244		Clot factor viii reltd antgn	N	$	22.69
85245		Clot factor viii vw ristoctn	N	$	25.49
85246		Clot factor viii vw antigen	N	$	25.49
85247		Clot factor viii multimetric	N	$	25.49
85250		Clot factor ix ptc/chrstmas	N	$	21.16
85260		Clot factor x stuart-power	N	$	19.89
85270		Clot factor xi pta	N	$	19.89
85280		Clot factor xii hageman	N	$	21.50
85290		Clot factor xiii fibrin stab	N	$	18.15
85291		Clot factor xiii fibrin scrn	N	$	9.88
85292		Clot factor fletcher fact	N	$	21.04
85293		Clot factor wght kininogen	N	$	21.04
85300		Antithrombin iii activity	N	$	13.17
85301		Antithrombin iii antigen	N	$	12.01

85302		Clot inhibit prot c antigen	N	$	13.35
85303		Clot inhibit prot c activity	N	$	15.37
85305		Clot inhibit prot s total	N	$	12.90
85306		Clot inhibit prot s free	N	$	17.03
85307		Assay activated protein c	N	$	17.03
85335		Factor inhibitor test	N	$	14.30
85337		Thrombomodulin	N	$	17.27
85345		Coagulation time lee & white	N	$	4.79
85347		Coagulation time activated	N	$	4.73
85348		Coagulation time otr method	N	$	4.49
85360		Euglobulin lysis	N	$	9.34
85362		Fibrin degradation products	N	$	7.65
85366		Fibrinogen test	N	$	80.46
85370		Fibrinogen test	N	$	12.62
85378		Fibrin degrade semiquant	N	$	9.72
85379		Fibrin degradation quant	N	$	11.31
85380		Fibrin degradj d-dimer	N	$	11.31
85384		Fibrinogen activity	N	$	9.72
85385		Fibrinogen antigen	N	$	14.46
85390		Fibrinolysins screen i&r	N	$	15.48
85397		Clotting funct activity	N	$	30.86
85400		Fibrinolytic plasmin	N	$	8.56
85410		Fibrinolytic antiplasmin	N	$	8.56
85415		Fibrinolytic plasminogen	N	$	19.10
85420		Fibrinolytic plasminogen	N	$	7.26
85421		Fibrinolytic plasminogen	N	$	11.32
85441		Heinz bodies direct	N	$	4.67
85445		Heinz bodies induced	N	$	7.57
85460		Hemoglobin fetal	N	$	8.59
85461		Hemoglobin fetal	N	$	9.36
85475		Hemolysin acid	N	$	9.86
85520		Heparin assay	N	$	14.55
85525		Heparin neutralization	N	$	13.15
85530		Heparin-protamine tolerance	N	$	14.55
85536		Iron stain peripheral blood	N	$	7.18
85540		Wbc alkaline phosphatase	N	$	9.56
85547		Rbc mechanical fragility	N	$	9.56
85549		Muramidase	N	$	20.83
85555		Rbc osmotic fragility	N	$	7.47
85557		Rbc osmotic fragility	N	$	14.84
85576		Blood platelet aggregation	N	$	24.91

85576	QW	Blood platelet aggregation	N	$	24.91
85597		Phospholipid pltlt neutraliz	N	$	19.97
85598		Hexagnal phosph pltlt neutrl	N	$	19.97
85610		Prothrombin time	N	$	4.37
85610	QW	Prothrombin time	N	$	4.37
85611		Prothrombin test	N	$	4.38
85612		Viper venom prothrombin time	N	$	17.49
85613		Russell viper venom diluted	N	$	10.64
85635		Reptilase test	N	$	10.94
85651		Rbc sed rate nonautomated	N	$	4.27
85652		Rbc sed rate automated	N	$	3.00
85660		Rbc sickle cell test	N	$	6.12
85670		Thrombin time plasma	N	$	6.41
85675		Thrombin time titer	N	$	7.61
85705		Thromboplastin inhibition	N	$	10.70
85730		Thromboplastin time partial	N	$	6.67
85732		Thromboplastin time partial	N	$	7.18
85810		Blood viscosity examination	N	$	12.97
86000		Agglutinins febrile antigen	N	$	7.76
86001		Allergen specific igg	N	$	7.82
86003		Allg spec ige crude xtrc ea	N	$	5.80
86005		Allg spec ige multiallg scr	N	$	8.85
86008		Allg spec ige recomb ea	N	$	19.93
86021		Wbc antibody identification	N	$	16.73
86022		Platelet antibodies	N	$	20.41
86023		Immunoglobulin assay	N	$	13.84
86038		Antinuclear antibodies	N	$	13.43
86039		Antinuclear antibodies (ana)	N	$	12.40
86060		Antistreptolysin o titer	N	$	8.11
86063		Antistreptolysin o screen	N	$	6.41
86140		C-reactive protein	N	$	5.75
86141		C-reactive protein hs	N	$	14.39
86146		Beta-2 glycoprotein antibody	N	$	28.28
86147		Cardiolipin antibody ea ig	N	$	28.28
86148		Anti-phospholipid antibody	N	$	17.85
86152		Cell enumeration & id	N	$	273.00
86155		Chemotaxis assay	N	$	17.76
86156		Cold agglutinin screen	N	$	8.07
86157		Cold agglutinin titer	N	$	8.96
86160		Complement antigen	N	$	13.33
86161		Complement/function activity	N	$	13.33

86162		Complement total (ch50)	N	$	22.58
86171		Complement fixation each	N	$	11.12
86200		Ccp antibody	N	$	14.39
86215		Deoxyribonuclease antibody	N	$	14.72
86225		Dna antibody native	N	$	15.27
86226		Dna antibody single strand	N	$	13.45
86235		Nuclear antigen antibody	N	$	19.93
86255		Fluorescent antibody screen	N	$	13.39
86256		Fluorescent antibody titer	N	$	13.39
86277		Growth hormone antibody	N	$	17.49
86280		Hemagglutination inhibition	N	$	9.10
86294		Immunoassay tumor qual	N	$	25.57
86294	QW	Immunoassay tumor qual	N	$	25.57
86300		Immunoassay tumor ca 15-3	N	$	23.13
86301		Immunoassay tumor ca 19-9	N	$	23.13
86304		Immunoassay tumor ca 125	N	$	23.13
86305		Human epididymis protein 4	N	$	23.13
86308		Heterophile antibody screen	N	$	5.75
86308	QW	Heterophile antibody screen	N	$	5.75
86309		Heterophile antibody titer	N	$	7.18
86310		Heterophile antibody absrbj	N	$	8.19
86316		Immunoassay tumor other	N	$	23.13
86317		Immunoassay infectious agent	N	$	16.65
86318		Immunoassay infectious agent	N	$	18.09
86318	QW	Immunoassay infectious agent	N	$	18.09
86320		Serum immunoelectrophoresis	N	$	29.92
86325		Other immunoelectrophoresis	N	$	24.85
86327		Immunoelectrophoresis assay	N	$	29.92
86329		Immunodiffusion nes	N	$	15.61
86331		Immunodiffusion ouchterlony	N	$	13.31
86332		Immune complex assay	N	$	27.08
86334		Immunofix e-phoresis serum	N	$	24.83
86335		Immunfix e-phorsis/urine/csf	N	$	32.61
86336		Inhibin a	N	$	17.32
86337		Insulin antibodies	N	$	23.79
86340		Intrinsic factor antibody	N	$	16.75
86341		Islet cell antibody	N	$	23.57
86343		Leukocyte histamine release	N	$	13.84
86344		Leukocyte phagocytosis	N	$	10.39
86352		Cell function assay w/stim	N	$	150.96
86353		Lymphocyte transformation	N	$	54.47

86355		B cells total count	N	$	41.92
86356		Mononuclear cell antigen	N	$	29.75
86357		Nk cells total count	N	$	41.92
86359		T cells total count	N	$	41.92
86360		T cell absolute count/ratio	N	$	52.20
86361		T cell absolute count	N	$	29.75
86367		Stem cells total count	N	$	77.78
86376		Microsomal antibody each	N	$	16.17
86382		Neutralization test viral	N	$	18.79
86384		Nitroblue tetrazolium dye	N	$	13.61
86386		Nuclear matrix protein 22	N	$	21.78
86386	QW	Nuclear matrix protein 22	N	$	21.78
86403		Particle agglut antbdy scrn	N	$	11.54
86406		Particle agglut antbdy titr	N	$	11.82
86430		Rheumatoid factor test qual	N	$	6.30
86431		Rheumatoid factor quant	N	$	6.30
86480		Tb test cell immun measure	N	$	68.87
86481		Tb ag response t-cell susp	N	$	100.00
86590		Streptokinase antibody	N	$	12.66
86592		Syphilis test non-trep qual	N	$	4.75
86593		Syphilis test non-trep quant	N	$	4.89
86602		Antinomyces antibody	N	$	11.31
86603		Adenovirus antibody	N	$	14.30
86606		Aspergillus antibody	N	$	16.73
86609		Bacterium antibody	N	$	14.31
86611		Bartonella antibody	N	$	11.31
86612		Blastomyces antibody	N	$	14.34
86615		Bordetella antibody	N	$	14.65
86617		Lyme disease antibody	N	$	17.21
86618		Lyme disease antibody	N	$	18.92
86618	QW	Lyme disease antibody	N	$	18.92
86619		Borrelia antibody	N	$	14.86
86622		Brucella antibody	N	$	9.92
86625		Campylobacter antibody	N	$	14.58
86628		Candida antibody	N	$	13.34
86631		Chlamydia antibody	N	$	13.14
86632		Chlamydia igm antibody	N	$	14.09
86635		Coccidioides antibody	N	$	12.75
86638		Q fever antibody	N	$	13.47
86641		Cryptococcus antibody	N	$	16.01
86644		Cmv antibody	N	$	15.99

86645		Cmv antibody igm	N	$	18.72
86648		Diphtheria antibody	N	$	16.90
86651		Encephalitis californ antbdy	N	$	14.65
86652		Encephaltis east eqne anbdy	N	$	14.65
86653		Encephaltis st louis antbody	N	$	14.65
86654		Encephaltis west eqne antbdy	N	$	14.65
86658		Enterovirus antibody	N	$	14.47
86663		Epstein-barr antibody	N	$	14.58
86664		Epstein-barr nuclear antigen	N	$	16.99
86665		Epstein-barr capsid vca	N	$	20.16
86666		Ehrlichia antibody	N	$	11.31
86668		Francisella tularensis	N	$	14.16
86671		Fungus nes antibody	N	$	13.62
86674		Giardia lamblia antibody	N	$	16.35
86677		Helicobacter pylori antibody	N	$	16.85
86682		Helminth antibody	N	$	14.45
86684		Hemophilus influenza antibdy	N	$	17.60
86687		Htlv-i antibody	N	$	9.32
86688		Htlv-ii antibody	N	$	15.56
86689		Htlv/hiv confirmj antibody	N	$	21.51
86692		Hepatitis delta agent antbdy	N	$	19.07
86694		Herpes simplex nes antbdy	N	$	15.99
86695		Herpes simplex type 1 test	N	$	14.65
86696		Herpes simplex type 2 test	N	$	21.51
86698		Histoplasma antibody	N	$	13.88
86701		Hiv-1antibody	N	$	9.87
86701	QW	Hiv-1antibody	N	$	9.87
86702		Hiv-2 antibody	N	$	15.02
86703		Hiv-1/hiv-2 1 result antbdy	N	$	15.23
86704		Hep b core antibody total	N	$	13.39
86705		Hep b core antibody igm	N	$	13.08
86706		Hep b surface antibody	N	$	11.93
86707		Hepatitis be antibody	N	$	12.85
86708		Hepatitis a antibody	N	$	13.76
86709		Hepatitis a igm antibody	N	$	12.51
86710		Influenza virus antibody	N	$	15.06
86711		John cunningham antibody	N	$	16.89
86713		Legionella antibody	N	$	17.00
86717		Leishmania antibody	N	$	13.61
86720		Leptospira antibody	N	$	16.20
86723		Listeria monocytogenes	N	$	14.65

86727		Lymph choriomeningitis ab	N	$	14.30
86732		Mucormycosis antibody	N	$	15.00
86735		Mumps antibody	N	$	14.50
86738		Mycoplasma antibody	N	$	14.71
86741		Neisseria meningitidis	N	$	14.65
86744		Nocardia antibody	N	$	15.99
86747		Parvovirus antibody	N	$	16.70
86750		Malaria antibody	N	$	14.65
86753		Protozoa antibody nos	N	$	13.76
86756		Respiratory virus antibody	N	$	15.89
86757		Rickettsia antibody	N	$	21.51
86759		Rotavirus antibody	N	$	18.23
86762		Rubella antibody	N	$	15.99
86765		Rubeola antibody	N	$	14.31
86768		Salmonella antibody	N	$	14.65
86771		Shigella antibody	N	$	24.48
86774		Tetanus antibody	N	$	16.44
86777		Toxoplasma antibody	N	$	15.99
86778		Toxoplasma antibody igm	N	$	16.01
86780		Treponema pallidum	N	$	14.71
86780	QW	Treponema pallidum	N	$	14.71
86784		Trichinella antibody	N	$	13.96
86787		Varicella-zoster antibody	N	$	14.31
86788		West nile virus ab igm	N	$	18.72
86789		West nile virus antibody	N	$	15.99
86790		Virus antibody nos	N	$	14.31
86793		Yersinia antibody	N	$	14.65
86794		Zika virus igm antibody	N	$	18.72
86800		Thyroglobulin antibody	N	$	17.67
86803		Hepatitis c ab test	N	$	15.85
86803	QW	Hepatitis c ab test	N	$	15.85
86804		Hep c ab test confirm	N	$	17.21
86805		Lymphocytotoxicity assay	N	$	189.51
86806		Lymphocytotoxicity assay	N	$	52.88
86807		Cytotoxic antibody screening	N	$	78.65
86808		Cytotoxic antibody screening	N	$	32.98
86812		Hla typing a b or c	N	$	28.67
86813		Hla typing a b or c	N	$	64.44
86816		Hla typing dr/dq	N	$	30.95
86817		Hla typing dr/dq	N	$	106.14
86821		Lymphocyte culture mixed	N	$	40.62

86825		Hla x-math non-cytotoxic	N	$	109.49
86826		Hla x-match noncytotoxc addl	N	$	36.53
86828		Hla class i&ii antibody qual	N	$	64.19
86829		Hla class i/ii antibody qual	N	$	64.19
86830		Hla class i phenotype qual	N	$	95.52
86831		Hla class ii phenotype qual	N	$	81.88
86832		Hla class i high defin qual	N	$	323.75
86833		Hla class ii high defin qual	N	$	325.80
86834		Hla class i semiquant panel	N	$	397.29
86835		Hla class ii semiquant panel	N	$	358.85
86850		Rbc antibody screen	N	$	9.77
86880		Coombs test direct	N	$	5.99
86885		Coombs test indirect qual	N	$	6.36
86886		Coombs test indirect titer	N	$	5.75
86900		Blood typing serologic abo	N	$	3.32
86901		Blood typing serologic rh(d)	N	$	3.32
86902		Blood type antigen donor ea	N	$	6.35
86904		Blood typing patient serum	N	$	16.34
86905		Blood typing rbc antigens	N	$	4.25
86906		Bld typing serologic rh phnt	N	$	8.61
86940		Hemolysins/agglutinins auto	N	$	9.11
86941		Hemolysins/agglutinins	N	$	13.45
87003		Small animal inoculation	N	$	18.71
87015		Specimen infect agnt concntj	N	$	7.42
87040		Blood culture for bacteria	N	$	11.47
87045		Feces culture aerobic bact	N	$	10.49
87046		Stool cultr aerobic bact ea	N	$	10.49
87070		Culture othr specimn aerobic	N	$	9.57
87071		Culture aerobic quant other	N	$	10.49
87073		Culture bacteria anaerobic	N	$	10.49
87075		Cultr bacteria except blood	N	$	10.52
87076		Culture anaerobe ident each	N	$	8.97
87077		Culture aerobic identify	N	$	8.97
87077	QW	Culture aerobic identify	N	$	8.97
87081		Culture screen only	N	$	7.36
87084		Culture of specimen by kit	N	$	27.07
87086		Urine culture/colony count	N	$	8.97
87088		Urine bacteria culture	N	$	8.99
87101		Skin fungi culture	N	$	8.56
87102		Fungus isolation culture	N	$	9.34
87103		Blood fungus culture	N	$	20.46

87106		Fungi identification yeast	N	$	11.47
87107		Fungi identification mold	N	$	11.47
87109		Mycoplasma	N	$	17.10
87110		Chlamydia culture	N	$	21.77
87116		Mycobacteria culture	N	$	12.00
87118		Mycobacteric identification	N	$	14.61
87140		Culture type immunofluoresc	N	$	6.19
87143		Culture typing glc/hplc	N	$	13.92
87147		Culture type immunologic	N	$	5.75
87149		Dna/rna direct probe	N	$	22.28
87150		Dna/rna amplified probe	N	$	38.99
87152		Culture type pulse field gel	N	$	7.74
87153		Dna/rna sequencing	N	$	128.17
87158		Culture typing added method	N	$	7.74
87164		Dark field examination	N	$	11.93
87166		Dark field examination	N	$	12.56
87168		Macroscopic exam arthropod	N	$	4.75
87169		Macroscopic exam parasite	N	$	4.75
87172		Pinworm exam	N	$	4.75
87176		Tissue homogenization cultr	N	$	6.54
87177		Ova and parasites smears	N	$	9.89
87181		Microbe susceptible diffuse	N	$	5.27
87184		Microbe susceptible disk	N	$	7.66
87185		Microbe susceptible enzyme	N	$	5.27
87186		Microbe susceptible mic	N	$	9.61
87187		Microbe susceptible mlc	N	$	40.17
87188		Microbe suscept macrobroth	N	$	7.38
87190		Microbe suscept mycobacteri	N	$	7.31
87197		Bactericidal level serum	N	$	16.69
87205		Smear gram stain	N	$	4.75
87206		Smear fluorescent/acid stai	N	$	5.99
87207		Smear special stain	N	$	6.66
87209		Smear complex stain	N	$	19.97
87210		Smear wet mount saline/ink	N	$	5.82
87210	QW	Smear wet mount saline/ink	N	$	5.82
87220		Tissue exam for fungi	N	$	4.75
87230		Assay toxin or antitoxin	N	$	21.93
87250		Virus inoculate eggs/animal	N	$	21.73
87252		Virus inoculation tissue	N	$	28.97
87253		Virus inoculate tissue addl	N	$	22.45
87254		Virus inoculation shell via	N	$	21.73

87255		Genet virus isolate hsv	N	$	37.62
87260		Adenovirus ag if	N	$	14.43
87265		Pertussis ag if	N	$	13.32
87267		Enterovirus antibody dfa	N	$	13.42
87269		Giardia ag if	N	$	13.61
87270		Chlamydia trachomatis ag if	N	$	13.32
87271		Cytomegalovirus dfa	N	$	13.42
87272		Cryptosporidium ag if	N	$	13.32
87273		Herpes simplex 2 ag if	N	$	13.32
87274		Herpes simplex 1 ag if	N	$	13.32
87275		Influenza b ag if	N	$	13.32
87276		Influenza a ag if	N	$	16.07
87278		Legion pneumophilia ag if	N	$	15.60
87279		Parainfluenza ag if	N	$	16.43
87280		Respiratory syncytial ag if	N	$	13.42
87281		Pneumocystis carinii ag if	N	$	13.32
87283		Rubeola ag if	N	$	60.80
87285		Treponema pallidum ag if	N	$	13.32
87290		Varicella zoster ag if	N	$	13.42
87299		Antibody detection nos if	N	$	16.10
87300		Ag detection polyval if	N	$	13.32
87301		Adenovirus ag ia	N	$	13.32
87305		Aspergillus ag ia	N	$	13.32
87320		Chylmd trach ag ia	N	$	15.00
87324		Clostridium ag ia	N	$	13.32
87327		Cryptococcus neoform ag ia	N	$	13.42
87328		Cryptosporidium ag ia	N	$	13.82
87329		Giardia ag ia	N	$	13.32
87332		Cytomegalovirus ag ia	N	$	13.32
87335		E coli 0157 ag ia	N	$	13.32
87336		Entamoeb hist dispr ag ia	N	$	16.00
87337		Entamoeb hist group ag ia	N	$	13.32
87338		Hpylori stool ia	N	$	15.98
87338	QW	Hpylori stool ia	N	$	15.98
87339		H pylori ag ia	N	$	16.00
87340		Hepatitis b surface ag ia	N	$	11.48
87341		Hepatitis b surface ag ia	N	$	11.48
87350		Hepatitis be ag ia	N	$	12.81
87380		Hepatitis delta ag ia	N	$	18.36
87385		Histoplasma capsul ag ia	N	$	13.32
87389		Hiv-1 ag w/hiv-1 & hiv-2 ab	N	$	26.75

87389	QW	Hiv-1 ag w/hiv-1 & hiv-2 ab	N	$	26.75
87390		Hiv-1 ag ia	N	$	24.06
87391		Hiv-2 ag ia	N	$	21.90
87400		Influenza a/b ag ia	N	$	14.13
87420		Resp syncytial ag ia	N	$	13.91
87425		Rotavirus ag ia	N	$	13.32
87427		Shiga-like toxin ag ia	N	$	13.32
87430		Strep a ag ia	N	$	16.81
87449		Ag detect nos ia mult	N	$	13.32
87449	QW	Ag detect nos ia mult	N	$	13.32
87450		Ag detect nos ia single	N	$	10.66
87451		Ag detect polyval ia mult	N	$	10.66
87471		Bartonella dna amp probe	N	$	38.99
87472		Bartonella dna quant	N	$	47.60
87475		Lyme dis dna dir probe	N	$	22.28
87476		Lyme dis dna amp probe	N	$	38.99
87480		Candida dna dir probe	N	$	22.28
87481		Candida dna amp probe	N	$	38.99
87482		Candida dna quant	N	$	55.74
87483		Cns dna amp probe type 12-25	N	$	463.09
87485		Chylmd pneum dna dir probe	N	$	22.28
87486		Chylmd pneum dna amp probe	N	$	38.99
87487		Chylmd pneum dna quant	N	$	47.60
87490		Chylmd trach dna dir probe	N	$	22.75
87491		Chylmd trach dna amp probe	N	$	38.99
87492		Chylmd trach dna quant	N	$	53.47
87493		C diff amplified probe	N	$	38.99
87495		Cytomeg dna dir probe	N	$	30.03
87496		Cytomeg dna amp probe	N	$	38.99
87497		Cytomeg dna quant	N	$	47.60
87498		Enterovirus probe&revrs trns	N	$	38.99
87500		Vanomycin dna amp probe	N	$	38.99
87501		Influenza dna amp prob 1+	N	$	57.02
87502		Influenza dna amp probe	N	$	95.80
87502	QW	Influenza dna amp probe	N	$	95.80
87503		Influenza dna amp prob addl	N	$	29.22
87505		Nfct agent detection gi	N	$	142.54
87506		Iadna-dna/rna probe tq 6-11	N	$	262.99
87507		Iadna-dna/rna probe tq 12-25	N	$	463.09
87510		Gardner vag dna dir probe	N	$	22.28
87511		Gardner vag dna amp probe	N	$	38.99

87512		Gardner vag dna quant	N	$	46.40
87516		Hepatitis b dna amp probe	N	$	38.99
87517		Hepatitis b dna quant	N	$	47.60
87520		Hepatitis c rna dir probe	N	$	31.22
87521		Hepatitis c probe&rvrs trnsc	N	$	38.99
87522		Hepatitis c revrs trnscrpj	N	$	47.60
87525		Hepatitis g dna dir probe	N	$	29.80
87526		Hepatitis g dna amp probe	N	$	39.26
87527		Hepatitis g dna quant	N	$	46.40
87528		Hsv dna dir probe	N	$	22.28
87529		Hsv dna amp probe	N	$	38.99
87530		Hsv dna quant	N	$	47.60
87531		Hhv-6 dna dir probe	N	$	58.00
87532		Hhv-6 dna amp probe	N	$	38.99
87533		Hhv-6 dna quant	N	$	46.40
87534		Hiv-1 dna dir probe	N	$	22.28
87535		Hiv-1 probe&reverse trnscrpj	N	$	38.99
87536		Hiv-1 quant&revrse trnscrpj	N	$	94.55
87537		Hiv-2 dna dir probe	N	$	22.28
87538		Hiv-2 probe&revrse trnscripj	N	$	38.99
87539		Hiv-2 quant&revrse trnscripj	N	$	58.62
87540		Legion pneumo dna dir prob	N	$	22.28
87541		Legion pneumo dna amp prob	N	$	38.99
87542		Legion pneumo dna quant	N	$	46.40
87550		Mycobacteria dna dir probe	N	$	22.28
87551		Mycobacteria dna amp probe	N	$	48.24
87552		Mycobacteria dna quant	N	$	47.60
87555		M.tuberculo dna dir probe	N	$	26.88
87556		M.tuberculo dna amp probe	N	$	41.68
87557		M.tuberculo dna quant	N	$	47.60
87560		M.avium-intra dna dir prob	N	$	27.29
87561		M.avium-intra dna amp prob	N	$	38.99
87562		M.avium-intra dna quant	N	$	47.60
87580		M.pneumon dna dir probe	N	$	22.28
87581		M.pneumon dna amp probe	N	$	38.99
87582		M.pneumon dna quant	N	$	302.62
87590		N.gonorrhoeae dna dir prob	N	$	26.88
87591		N.gonorrhoeae dna amp prob	N	$	38.99
87592		N.gonorrhoeae dna quant	N	$	47.60
87623		Hpv low-risk types	N	$	38.99
87624		Hpv high-risk types	N	$	38.99

87625		Hpv types 16 & 18 only	N	$	40.55
87631		Resp virus 3-5 targets	N	$	142.63
87631	QW	Resp virus 3-5 targets	N	$	142.63
87632		Resp virus 6-11 targets	N	$	237.14
87633		Resp virus 12-25 targets	N	$	463.09
87633	QW	Resp virus 12-25 targets	N	$	463.09
87634		Rsv dna/rna amp probe	N	$	77.99
87634	QW	Rsv dna/rna amp probe	N	$	77.99
87640		Staph a dna amp probe	N	$	38.99
87641		Mr-staph dna amp probe	N	$	38.99
87650		Strep a dna dir probe	N	$	22.28
87650	QW	Strep a dna dir probe	N	$	22.28
87651		Strep a dna amp probe	N	$	38.99
87651	QW	Strep a dna amp probe	N	$	38.99
87652		Strep a dna quant	N	$	46.40
87653		Strep b dna amp probe	N	$	38.99
87660		Trichomonas vagin dir probe	N	$	22.28
87661		Trichomonas vaginalis amplif	N	$	38.99
87662		Zika virus dna/rna amp probe	N	$	57.02
87797		Detect agent nos dna dir	N	$	30.03
87798		Detect agent nos dna amp	N	$	38.99
87799		Detect agent nos dna quant	N	$	47.60
87800		Detect agnt mult dna direc	N	$	44.57
87801		Detect agnt mult dna ampli	N	$	77.99
87801	QW	Detect agnt mult dna ampli	N	$	77.99
87802		Strep b assay w/optic	N	$	13.32
87803		Clostridium toxin a w/optic	N	$	16.00
87804		Influenza assay w/optic	N	$	16.55
87804	QW	Influenza assay w/optic	N	$	16.55
87806		Hiv antigen w/hiv antibodies	N	$	32.77
87806	QW	Hiv antigen w/hiv antibodies	N	$	32.77
87807		Rsv assay w/optic	N	$	13.32
87807	QW	Rsv assay w/optic	N	$	13.32
87808		Trichomonas assay w/optic	N	$	15.29
87808	QW	Trichomonas assay w/optic	N	$	15.29
87809		Adenovirus assay w/optic	N	$	21.76
87809	QW	Adenovirus assay w/optic	N	$	21.76
87810		Chylmd trach assay w/optic	N	$	35.29
87850		N. gonorrhoeae assay w/optic	N	$	24.56
87880		Strep a assay w/optic	N	$	16.53
87880	QW	Strep a assay w/optic	N	$	16.53

87899		Agent nos assay w/optic	N	$	16.07
87899	QW	Agent nos assay w/optic	N	$	16.07
87900		Phenotype infect agent drug	N	$	144.83
87901		Genotype dna hiv reverse t	N	$	286.05
87902		Genotype dna/rna hep c	N	$	286.05
87903		Phenotype dna hiv w/culture	N	$	542.95
87904		Phenotype dna hiv w/clt add	N	$	28.97
87905		Sialidase enzyme assay	N	$	13.58
87905	QW	Sialidase enzyme assay	N	$	13.58
87906		Genotype dna/rna hiv	N	$	143.03
87910		Genotype cytomegalovirus	N	$	286.05
87912		Genotype dna hepatitis b	N	$	286.05
88130		Sex chromatin identification	N	$	19.97
88140		Sex chromatin identification	N	$	8.88
88142		Cytopath c/v thin layer	N	$	22.51
88143		Cytopath c/v thin layer redo	N	$	23.04
88147		Cytopath c/v automated	N	$	50.56
88148		Cytopath c/v auto rescreen	N	$	16.88
88150		Cytopath c/v manual	N	$	14.99
88152		Cytopath c/v auto redo	N	$	27.64
88153		Cytopath c/v redo	N	$	24.03
88155		Cytopath c/v index add-on	N	$	14.65
88164		Cytopath tbs c/v manual	N	$	14.99
88165		Cytopath tbs c/v redo	N	$	42.22
88166		Cytopath tbs c/v auto redo	N	$	14.99
88167		Cytopath tbs c/v select	N	$	14.99
88174		Cytopath c/v auto in fluid	N	$	25.37
88175		Cytopath c/v auto fluid redo	N	$	29.44
88230		Tissue culture lymphocyte	N	$	129.44
88233		Tissue culture skin/biopsy	N	$	156.36
88235		Tissue culture placenta	N	$	163.63
88237		Tissue culture bone marrow	N	$	143.75
88239		Tissue culture tumor	N	$	163.91
88240		Cell cryopreserve/storage	N	$	13.07
88241		Frozen cell preparation	N	$	12.09
88245		Chromosome analysis 20-25	N	$	192.42
88248		Chromosome analysis 50-100	N	$	192.42
88249		Chromosome analysis 100	N	$	192.42
88261		Chromosome analysis 5	N	$	264.34
88262		Chromosome analysis 15-20	N	$	138.49
88263		Chromosome analysis 45	N	$	166.99

88264		Chromosome analysis 20-25	N	$	144.61
88267		Chromosome analys placenta	N	$	199.75
88269		Chromosome analys amniotic	N	$	184.81
88271		Cytogenetics dna probe	N	$	23.80
88272		Cytogenetics 3-5	N	$	40.70
88273		Cytogenetics 10-30	N	$	35.70
88274		Cytogenetics 25-99	N	$	42.38
88275		Cytogenetics 100-300	N	$	51.19
88280		Chromosome karyotype study	N	$	33.47
88283		Chromosome banding study	N	$	76.22
88285		Chromosome count additional	N	$	26.91
88289		Chromosome study additional	N	$	38.26
88371		Protein western blot tissue	N	$	24.70
88372		Protein analysis w/probe	N	$	26.22
88720		Bilirubin total transcut	N	$	5.57
88738		Hgb quant transcutaneous	N	$	5.57
88740		Transcutaneous carboxyhb	N	$	9.37
88741		Transcutaneous methb	N	$	9.37
89050		Body fluid cell count	N	$	5.25
89051		Body fluid cell count	N	$	6.12
89055		Leukocyte assessment fecal	N	$	4.75
89060		Exam synovial fluid crystals	N	$	7.95
89125		Specimen fat stain	N	$	5.88
89160		Exam feces for meat fibers	N	$	4.85
89190		Nasal smear for eosinophils	N	$	5.79
89300		Semen analysis w/huhner	N	$	9.92
89300	QW	Semen analysis w/huhner	N	$	9.92
89310		Semen analysis w/count	N	$	9.57
89320		Semen anal vol/count/mot	N	$	13.39
89321		Semen anal sperm detection	N	$	13.39
89321	QW	Semen anal sperm detection	N	$	13.39
89322		Semen anal strict criteria	N	$	17.22
89325		Sperm antibody test	N	$	11.86
89329		Sperm evaluation test	N	$	21.76
89330		Evaluation cervical mucus	N	$	10.99
89331		Retrograde ejaculation anal	N	$	21.76
0001U		Rbn dna hea 35 ag 11 bld grp	N	$	720.00
0002M		Liver dis 10 assays w/ash	N	$	503.40
0002U		Onc clrct 3 ur metab alg plp	N	$	25.00
0003M		Liver dis 10 assays w/nash	N	$	503.40
0003U		Onc ovar 5 prtn ser alg scor	N	$	950.00

0004M		Scoliosis dna alys	N	$	79.00
0005U		Onco prst8 3 gene ur alg	N	$	760.00
0006M		Onc hep gene risk classifier	N	$	150.00
0006U		Detc ia meds 120+ analytes	N	$	246.92
0007M		Onc gastro 51 gene nomogram	N	$	375.00
0007U		Rx test prsmv ur w/def conf	N	$	114.43
0008U		Hpylori detcj abx rstnc dna	N	$	597.91
0009M		Fetal aneuploidy trisom risk	N	$	132.86
0009U		Onc brst ca erbb2 amp/nonamp	N	$	107.00
0010U		Nfct ds strn typ whl gen seq	N	$	427.26
0011M		Onc prst8 ca mrna 12 gen alg	N	$	760.00
0011U		Rx mntr lc-ms/ms oral fluid	N	$	114.43
0012M		Onc mrna 5 gen rsk urthl ca	N	$	760.00
0012U		Germln do gene reargmt detcj	N	$	2,515.60
0013M		Onc mrna 5 gen recr urthl ca	N	$	760.00
0013U		Onc sld org neo gene reargmt	N	$	2,515.60
0014U		Hem hmtlmf neo gene reargmt	N	$	2,515.60
0016U		Onc hmtlmf neo rna bcr/abl1	N	$	182.18
0017U		Onc hmtlmf neo jak2 mut dna	N	$	101.85
0018U		Onc thyr 10 microrna seq alg	L	$	-
0019U		Onc rna tiss predict alg	L	$	-
0021U		Onc prst8 detcj 8 autoantb	L	$	-
0022U		Trgt gen seq dna&rna 23 gene	L	$	-
0023U		Onc aml dna detcj/nondetcj	L	$	-
0024U		Glyca nuc mr spectrsc quan	N	$	35.06
0025U		Tenofovir liq chrom ur quan	N	$	95.30
0026U		Onc thyr dna&mrna 112 genes	N	$	3,600.00
0027U		Jak2 gene trgt seq alys	N	$	150.52
0029U		Rx metab advrs trgt seq alys	L	$	-
0030U		Rx metab warf trgt seq alys	L	$	-
0031U		Cyp1a2 gene	N	$	174.81
0032U		Comt gene	N	$	174.81
0033U		Htr2a htr2c genes	N	$	349.62
0034U		Tpmt nudt15 genes	N	$	466.17
0035U		Neuro csf prion prtn qual	L	$	-
0036U		Xome tum & nml spec seq alys	N	$	4,780.00
0037U		Trgt gen seq dna 324 genes	N	$	3,500.00
0038U		Vitamin d srm microsamp quan	N	$	32.89
0039U		Dna antb 2strand hi avidity	N	$	15.27
0040U		Bcr/abl1 gene major bp quan	N	$	455.45
0041U		B brgdrferi antb 5 prtn igm	L	$	-

0042U		B brgdrferi antb 12 prtn igg	L	$	-
0043U		Tbrf b grp antb 4 prtn igm	L	$	-
0044U		Tbrf b grp antb 4 prtn igg	L	$	-
0045U		Onc brst dux carc is 12 gene	N	$	3,873.00
0046U		Flt3 gene itd variants quan	N	$	165.51
0047U		Onc prst8 mrna 17 gene alg	N	$	3,873.00
0048U		Onc sld org neo dna 468 gene	L	$	-
0049U		Npm1 gene analysis quan	N	$	246.52
0050U		Trgt gen seq dna 194 genes	L	$	-
0051U		Rx mntr lc-ms/ms ur 31 pnl	N	$	205.63
0052U		Lpoprtn bld w/5 maj classes	N	$	33.86
0053U		Onc prst8 ca fish alys 4 gen	L	$	-
0054U		Rx mntr 14+ drugs & sbsts	N	$	165.52
0055U		Card hrt trnspl 96 dna seq	L	$	-
0056U		Hem aml dna gene reargmt	L	$	-
0058U		Onc merkel cll carc srm quan	N	$	358.85
0059U		Onc merkel cll carc srm +/-	N	$	358.85
0060U		Twn zyg gen seq alys chrms2	N	$	759.05
0061U		Tc meas 5 bmrk sfdi m-s alys	N	$	27.85
0080U		Onc Lng 5 Clin Rsk Factr Alg	N	$	3,520.00
G0027		Semen analysis	N	$	7.23
G0103		Psa screening	N	$	20.44
G0123		Screen cerv/vag thin layer	N	$	22.51
G0143		Scr c/v cyto,thinlayer,rescr	N	$	27.05
G0144		Scr c/v cyto,thinlayer,rescr	N	$	43.97
G0145		Scr c/v cyto,thinlayer,rescr	N	$	29.44
G0147		Scr c/v cyto, automated sys	N	$	14.99
G0148		Scr c/v cyto, autosys, rescr	N	$	31.94
G0306		Cbc/diffwbc w/o platelet	N	$	8.63
G0307		Cbc without platelet	N	$	7.18
G0328		Fecal blood scrn immunoassay	N	$	18.05
G0328	QW	Fecal blood scrn immunoassay	N	$	18.05
G0432		Eia hiv-1/hiv-2 screen	N	$	19.57
G0433		Elisa hiv-1/hiv-2 screen	N	$	18.29
G0433	QW	Elisa hiv-1/hiv-2 screen	N	$	18.29
G0435		Oral hiv-1/hiv-2 screen	N	$	13.32
G0471		Ven blood coll snf/hha	N	$	5.00
G0472		Hep c screen high risk/other	N	$	46.35
G0472	QW	Hep c screen high risk/other	N	$	46.35
G0475		Hiv combination assay	N	$	26.75
G0475	QW	Hiv combination assay	N	$	26.75

G0476		Hpv combo assay ca screen	N	$	38.99
G0480		Drug test def 1-7 classes	N	$	114.43
G0481		Drug test def 8-14 classes	N	$	156.59
G0482		Drug test def 15-21 classes	N	$	198.74
G0483		Drug test def 22+ classes	N	$	246.92
G0499		Hepb screen high risk indiv	N	$	31.41
G0659		Drug test def simple all cl	N	$	64.65
G9143		Warfarin respon genetic test	N	$	134.13
P2028		Cephalin floculation test	N	$	5.50
P2029		Congo red blood test	N	$	5.50
P2031		Hair analysis	N	$	5.50
P2033		Blood thymol turbidity	N	$	5.50
P2038		Blood mucoprotein	N	$	5.50
P3000		Screen pap by tech w md supv	N	$	14.99
P9612		Catheterize for urine spec	N	$	3.00
P9615		Urine specimen collect mult	N	$	3.00
Q0111		Wet mounts/ w preparations	N	$	14.99
Q0112		Potassium hydroxide preps	N	$	5.83
Q0113		Pinworm examinations	N	$	4.75
Q0114		Fern test	N	$	9.74
Q0115		Post-coital mucous exam	N	$	25.00